When Passions Run High

A phenomenological exploration of the emotional experience of the therapeutic relationship in existential psychotherapy

Victoria Brown
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Acknowledgements

Abstract

This dissertation explores the emotional experience of the psychotherapeutic relationship for existential therapists. The intent of this research is to explore therapists' reflections and descriptions of their emotional experience as they engage in therapeutic relationships with their clients, and how they themselves make sense of and understand the emotions in the therapeutic relationship. Eight participants were interviewed using semi-structured interviews. The material was analysed using Van Manen's hermeneutic phenomenology. Five themes were identified: i) the idea that the relationship is the therapy; ii) the primacy of emotions in this relationship; iii) the emotional work required by the therapist, iv) the fact that emotions are embodied and v) the idea of the dance of therapy and moments of meeting. Existing literature on the therapeutic relationship and more broadly from existential philosophy was employed in order to illuminate themes arising from the results. The results provide a compelling description of existential therapists' experiences of emotions in the therapeutic relationship and help to fill an absence of published phenomenological studies in this subject area. The clinical significance of the study includes a recommendation for increased awareness and focus on the emotional work of psychotherapy in training and practice. The study highlights the important role that the profession of counselling psychology plays in advocating for the importance of the therapeutic relationship. Further qualitative work on studies that delve into more specific aspects of emotions in the therapeutic relationship were called for.

Keywords

Statement of Authorship

This dissertation is written by Victoria Brown and has ethical clearance from the New School of Psychotherapy and Counselling and the Psychology Department of Middlesex University. It is submitted in partial fulfilment of the requirements of the New School of Psychotherapy and Counselling and the Psychology Department of Middlesex University for the Degree of Doctor of Existential Counselling Psychology and Psychotherapy. The author reports no conflicts of interest, and is alone responsible for the content and writing of the dissertation.

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1 Introduction

"It's the relationship that heals, the relationship that heals, the relationship that heals" (1989, p.91) states Irvin Yalom, an American existential psychotherapist. Evidence supports him: the research on the fundamental importance of the therapeutic relationship for successful therapeutic outcomes is clear, credible and consistent and overwhelming in its volume. Despite this, there remains debate and divergence, with differing theoretical perspectives about the nature of this relationship and the role of emotions within it.

This study aims to add to that debate by increasing understanding of the *emotional dimensions* of the *therapeutic relationship* in *existential psychotherapy.*

The power and role of emotional relatedness in therapy has been debated since the very beginnings of the 'talking cure'. Existential philosophers and practitioners of existential therapy have contributed to this debate but a holistic review of existential perspectives on the emotional aspects of the therapeutic relationship is lacking. In addition, there is a scarcity of empirical research in this area. This phenomenological study explores the lived experience of the emotional aspects of the therapeutic relationship as currently practiced in existential psychotherapy, with a particular focus on the experience of emotional connection.

1.1 Background to Study

The first and over-riding principle of the methodology that I am adopting for this research, Van Manen's hermeneutic psychology, is that we should first turn to a phenomenon "which seriously interests us and commits us to the world" (Van Manen, 1997, p.30).

The impetus for this research came from my own questions about the therapeutic relationship. In entering and experiencing personal therapy for the first time I was acutely surprised by the emotional intensity of the encounter. Expecting a professional, although supportive, encounter I instead developed a level of personal intimacy I had barely experienced before in my life, resonating with Baur's (1997) description of therapy as "the intimate hour". I felt myself run through a gamut of emotions from initial frustration, anxiety and anger to then find deeply tender and loving feelings emerging towards my therapist, which for a brief time included erotic desire and passion before morphing into a feeling of warmth and acceptance.

I do not know what my therapist's emotional experience was during this time, but as a client I experienced him as also offering warmth, affection, and what felt like a 'loving' stance (although one that felt entirely in accordance with ethical therapy). Using words such as love and erotic desire in relation to therapy is fraught with difficulty for a number of reasons, and I will discuss this and the various theoretical perspectives in my literature review below. However, from a reflexive phenomenological perspective what I experienced to me felt like a unique kind of loving relationship and it was this that was healing. I was both surprised and intrigued by this and I wanted to make sense of it.

Despite this experience in my own therapy, I was surprised again when two years later I began working as an existentially-informed therapist for the first time and witnessed my own clients' deep emotional responses to our therapeutic relationship. This surprise is not mine alone, with respected psychotherapists commenting on the lack of preparation and training they received for the 'roller coaster' of the affective experience of practicing therapy. Indeed Maroda (2010, p.140) outlines how unprepared she was for the emotional experience of therapy and states "the therapist has the enormous task of both managing his own feelings and helping his client manage hers".

As a trainee counselling psychologist I turned to the literature to explore this phenomenon. While I have an existential focus in my training, I consider myself a pluralistic therapist (e.g. see Cooper & McLeod, 2011), and so I read broadly across all approaches but was particularly interested in what existential theory and research could tell me about the phenomenon of the therapeutic relationship and working with its emotionality. The theoretical nature of the literature about the therapeutic relationship contrasted to its intensity in practice. Additionally, there was a paucity of empirical research concerning therapists' experience of the emotional relationship in existential counselling psychology. This led to the empirical research I have undertaken here.

1.2   A note on the study focus

This research explores the emotional experience of the therapeutic relationship, but with a particular focus on the experience and impact of instances of emotional connection between therapist and client. This focus on emotional connection was informed by my own positive experience of therapy and Lodge's (2010) research on 'moments' of emotional connection as significant for the client.

The research is broader than Lodge's (2010) in that I also explore the general emotional demands placed upon the therapist, such as the amount of emotion work required by them and the embodied experience of emotion. However, the focus on emotional connection does bias the research towards fulfilling experiences of therapy as opposed to entanglement or disconnection. Given the level of impact the emotional experience of the relationship can have emerging from this research, an important area for further research is to focus more deeply on counter-experiences such as where therapists and clients feel little connection, or there is an entanglement and difficult experiences.

1.3 My Identity and Orientation as a Counselling Psychologist

The belief that the therapeutic relationship is a core factor of psychotherapy is significant to my research and identity as an existential counselling psychologist. Woolfe (1990) suggests that one of the variables behind the rise in Counselling Psychology as a profession is the importance of the therapeutic relationship as itself as a *key factor* in working with clients. Counselling Psychology takes pride in sustaining a clear philosophical stance (Woolfe, Strawbridge, Douglas & Dryden, 2009) and the description of what Counselling Psychology is references its debt to the humanistic and anti-psychiatry movement, its questioning of underlying assumptions and the way it balances a scientist-practitioner approach by prizing an engagement with subjectivity drawing on phenomenological models of practice. In practice this means that Counselling Psychologists do not "assume the automatic superiority of any one way of experiencing, feeling, valuing and knowing" (Division of Counselling Psychology, 2013, p2.) and prize the individual relationships they have with their clients and the phenomenological exploration of their clients' subjective worlds. Counselling Psychology embraces within it existential viewpoints which also honour the importance of subjectivity and interpersonal relations. As such many of its practitioners e.g. Spinelli (1994), regard the therapeutic relationship as the core of therapy (discussed below in the literature review). This research therefore fits with my underlying orientation.

1.4 Overview of Study

The study will commence with a review of existing literature in the area, briefly outlining definitions of the therapeutic relationship and its emotional dimensions before introducing three existential literature sections: philosophical foundations, practitioner perspectives and empirical research. Following the literature review, I describe the methodology where I outline

the epistemological and ontological basis for this research before detailing the specific methodological approach of Van Manen's interpretive phenomenology and its value for this topic. The most extensive chapter is the results chapter which starts with a holistic narrative summary of the participants' experiences of the emotional dimensions of the therapeutic relationship before detailing five broad themes common to most or all participants. The discussion chapter reviews the results in light of the prior literature review, adding new literature that appears to be relevant given the findings obtained, along with some of the author's own interpretations. The discussion also outlines research and methodological limitations. The conclusion sums up the clinical importance of these findings, indications for further research and comments on the dissemination and implications of this current study for counselling psychologists.

2 Literature Review

2.1 Introduction

The research and literature on the therapeutic relationship is vast. It encompasses extensive qualitative and quantitative research exploring both the nature and effectiveness of the therapeutic relationship from diverse perspectives including different theoretical orientations, audiences and aspects of the relationship (e.g. see Norcross et al., 2011 for a review). Horvarth et al.'s (2011) meta-analysis included over 30 different alliance measures in use in psychotherapy research. A number of these focus on or include emotional aspects of the therapeutic relationship as Geller, Greenberg & Watson's (2011) measures of presence and the working alliance inventory (WAI), which includes ratings of the affective bond between therapist and client.

However, there are limitations to these research efforts. They are largely quantitative, self-report and look on the therapeutic relationship as an objective static phenomenon, something that can be objectively measured at a moment in time. Geller et al. (2011) suggest that "self-report may have limitations on capturing such a subtle and complex internal experience as therapeutic presence" (p.608) and there is a lack of phenomenological research into the lived experience of the therapeutic relationship including for existential therapists. No published literature was identified that specifically researched the *emotional dimensions* of the therapeutic relationship in existential psychotherapy.

Lodge (2010) found that this issue extends beyond research involving existential practitioners; her review (which was not focused on existential therapists) found an overwhelming amount of literature on 'emotions' and 'the therapeutic relationship' but a lack of published research on the discrete topic of emotional connection or emotional relatedness in therapy. Given this paucity of direct empirical research, a very broad review of the literature was conducted across relevant fields including research and writing on emotions and the therapeutic relationship in general, followed by a more thorough review of the existential literature - both from a philosophical and a practitioner perspective.

The literature review is structured as follows.

- The importance of the therapeutic relationship

- Defining the therapeutic relationship, and scope of this research
- Defining emotional and emotional experience
- Emotional experience in psychotherapy and the therapeutic relationship
  - The CBT Perspective
  - Psychoanalytic Perspectives
  - The Humanistic Perspective
  - Emotion-focused Therapies
  - Existential Perspectives
- Summary and Research Questions

Throughout the literature review I refer to 'patient' or 'client' depending on the term used within the literature I am discussing as I believe this use of language conveys something about how the relationship is conceived and so there is benefit in staying close to the original terms.

2.2 The Importance of the Therapeutic Relationship

"The therapeutic relationship is the best predictor of success in psychotherapy"
(Bohart & Greenberg, 1997)

Research has consistently confirmed that psychotherapy is remarkably effective (Lambert, 2013) with a robust effect size hovering around .60 (Lambert, 2013) and up to .80 (Wampold, 2010). The quality of the therapeutic relationship has been confirmed as a key factor of this therapeutic effectiveness and one that transcends individual approaches or techniques (Luborsky et al., 1975, Wampold, 2010). This finding has stood the test of time and multiple replications: a meta-analytic review by Orlinsky & Howard (1986) of over 1,100 outcome studies concluded that the crucial factor was "the bond that therapists formed with their clients". Lambert (2001) states that decades of research indicates that the main curative component is psychotherapy is the nature of the therapeutic relationship and notes that relationship variable correlations (e.g. empathy, genuineness) to therapy outcome are much higher than those of specific treatments and outcome (Lambert, 2013). Wampold (2010) cites studies showing that measurements of the alliance early in therapy are strongly associated with outcome and states that much therapist variability in effectiveness can be attributed to variability in forming a therapeutic alliance. Orlinsky (1994) has concluded that findings regarding the therapeutic value of the patient-therapist relationship are now so well replicated they can be viewed as established facts.

It is thus hard to under-estimate the impact of the therapeutic relationship, and both the research and psychological theory have led a number of writers to suggest that "the relationship is the therapy" (Khan, 1991, p.1). Norcross (2011) states that 80% of psychotherapists, when asked to provide a single answer as to what makes therapy effective, answer 'the relationship' and client research finds the same. Norcross argues that a neutral scientific panel from outside the field would argue that the most powerful phenomenon we should be studying, practising and teaching, and that is empirically validated, is the emergent therapeutic relationship, regardless of technique or school of therapy, and individual therapist differences.

From as far back as the 1880s, when the psychoanalyst Bleuler realized that even desperately troubled clients could be helped if a personal relationship was developed with them (e.g. see Bentall, 2004), all the main theoretical models acknowledged this primary importance of the therapy relationship. Rozensweig, writing in 1936, first introduced the term "common factors" in attempting to account for the fact that many different forms of psychotherapy all had positive results, suggesting that there was something beyond the specific theory and methods employed. Frank (1961) advocated that these 'common factors' were the source of healing in psychotherapy and the therapeutic relationship was seen as the fundamental core of this. This finding has been extensively replicated and confirmed (e.g. Luborsky et al., 1975; Wampold, 2010). Duncan (2010) outlines how the recognition of the importance of the therapeutic relationship as a critical common factor was widespread from 1940, when an influential panel agreed 'the relationship is central' in accounting for therapeutic success and this led to increasing research and publications regarding the common factors.

The following decade accounts began to appear discussing the *emotional aspects* of the relationship. Garfield (1957) identified a 'sympathetic non-moralizing healer' and 'the emotional and supportive relationship' as two of the common factors in therapeutic effectiveness. In his common factors research, Frank emphasized the affective aspects of the relationship concluding that all effective therapies include an "emotionally charged, confiding relationship with a helping person". (1973, p7). Bordin (1979) outlined three specific dimensions of the working alliance which he felt essential for effective therapy and which was presented as a trans-theoretical formulation of the alliance. First was agreement on the goals of therapy, secondly definition and implementation of therapeutic tasks and thirdly, the quality of the bond between therapist and client that develops. Bordin conceived of this bond as the ways in which the therapeutic dyad perceive and respond to each other emotionally as individuals, over and above their formal roles as patient and therapist. Emotional bond has been variously defined as feelings of warmth, trust, liking, friendliness, acceptance and a feeling

of being understood. For example, Stiles et al. (1986, p. 172) found that "warm involvement" was a key therapeutic factor. Norcross (2011) supports the importance of the emotional bond with factors such as warmth, affirmation, experiences of empathy, collaboration and the personal relationship between client and therapist being cited as critical.

Theory and evidence thus suggest that the affective aspects of the relationship are central, however more detailed understanding of the nature and role of this affective bond is still being researched. Safran and Muran (2006) suggest that the critical task for research on the therapeutic alliance is to understand the "role that relational factors play in the change process" (p.290). Horvarth (2006) also points out the need for further explanations of *how* the therapeutic alliance works across therapies. In particular Safran and Muran (2006) call for investigation of the role of mutual regulation between client and therapist in the change process and examining how mutual regulation influences the client's capacity for affect regulation.

2.3   Defining the Therapeutic Relationship (and Scope of this Research)

There are numerous definitions of the therapeutic relationship, and many of these point to a multi-factorial concept (i.e. the relationship refers to more than one thing) which reflect different aspects of the relationship over time, or with different clients or when working from different modalities. Norcross (2011), after Bordin (1979), suggests that the therapeutic relationship includes emotional bonds between therapist and client (for example mutual trust), but also more cognitive aspects including commitment to therapeutic goals, and accomplishment of therapeutic tasks (Norcross, 2011). Spinelli (2005) makes a similar distinction between the 'being' and the 'doing' elements of psychotherapy. Clinical experience and research evidence point to a complex reciprocal interaction between the *interpersonal* affective relationship and the more *instrumental* elements of the alliance (e.g. Rector et al., 1999; Barber et al., 2006 discussed in Norcross, 2011), leading Norcross to suggest that "treatment methods are relational acts" (2011, p.5). This study however, is focused on the emotional aspects of the relationship.

Norcross' recent definition fits well with this focus. He states that the client-therapist relationship can be operationally defined as:

"The feelings and attitudes that therapist and client have toward one another
and how these are expressed" (Norcross et al., 2011, p.114).

I am using a slightly expanded version of this definition for my research, with the inserted words underlined: *"The feelings and attitudes that therapist and client have toward one another and how these are* _experienced and_ *expressed".* I am interested in exploring therapists' experience of the emotional dimensions of the therapeutic relationship, as well as any expression of these dimensions. This includes:

- The therapist's emotional experience – his or her feeling about the client, him or herself in relation to the client, and the therapeutic relationship between them
- The therapist's perception and experience of the client's emotional experiencing – including the client's feelings about the therapist, the client's feelings about themselves in relation to the therapist, and the client's feelings about the therapeutic relationship between therapist and client

2.4   Defining Emotion and Emotional Experience

"The heart has its reasons which reason knows nothing of" (Blaise Pascal, Pensees, 1662)

Perhaps as a counter to the extensive focus on cognition and development of cognitive behavioural theory, there appears to have been a resurgence in focus on affect and emotion in therapy. Schore (2003) goes so far as to suggest we have been through the throes of an 'emotional revolution' in psychotherapy and Ryan (2007) states that "after three decades of the dominance of cognitive approaches, motivational and emotional processes have come back into the limelight" (p.1).

In parallel, recent developments in neuropsychology have led to new theory and research about the role of emotions in the therapeutic relationship and in driving therapeutic change. Taylor, Bagby & Parker (1997) suggest that affect dysregulation is a fundamental mechanism of all psychiatric disorders and Bradley (2000) suggests that all psychotherapies show a similarity in promoting affect regulation (although they may get there by different means perhaps). These scientifically and empirically based views echo previous theoretical opinions from some psychotherapists that all psychological disorders can be seen as disorders of relation (Stack-Sullivan, 1968).

However, despite the resurgence of interest and research in emotions, there is no formally agreed answer to what an emotion or feeling is, although various definitions have been proposed. Emotions have been studied as biological functions of the nervous system or as

psychological states independent of brain mechanisms (Damasio, 2000). Schacter & Singer's (1962) two-factor theory contrasts the underlying physiological arousal that occurs when an emotion is experienced and the cognitive label that is then applied.

Greenberg (2003) suggests that:

- *Affect* is an unconscious biological response to stimulation, involving automatic neural processes connected with the evolutionary adaptive behavioural response system;
- *Feeling* involves awareness of the basic sensations of affect
- *Emotions* are experiences that arise when action tendencies and feeling states are joined with evoking situations and the self.

Damasio (2010) makes a similar distinction between physiological arousal and subjective state and Schore (2003b) also regards affective states as somatically driven.

Bridges (2006) concludes that most emotion theorists agree on four key components of emotion:

1. Emotional arousal: physiological aspects
2. Emotional experience: subjective felt sense of quality and intensity of emotion
3. Emotional expression: verbal and non-verbal emotion displays
4. Emotional processing: meaning of the emotion and integration of emotion & cognition

From a psychotherapy perspective, it is useful to think about the function of emotion as well as its nature. Emotions are intentional, they are oriented towards something (van Deurzen-Smith, 1997). Schore (2003b) regards affective states as highly efficient forms of interpersonal emotional communication that are essentially non-verbal, and serve to inform our attachment and relations. Bohart and Greenberg (1997) also comment on the function of emotion, suggesting it is emotion that guides our lives, setting goals, regulating mental functioning and organizing thought and action, and that cognition simply finds a way to meet the goals set by emotion. He argues that it is not possible to change a person's emotional schema by working at a conceptual level. Our emotions are how we connect with the world and what motivates us to action.

Research also suggests that human emotional and cognitive processing systems may be separate (e.g. Greenberg & Paivio, 2003; Langs, 1996, although there is dispute on this). Whether the emotional processing system is unconscious or pre-reflective (e.g. see Spinelli,

1994) is a matter of debate, however this research does highlight the difference between more logical, analytic thinking and a more experiential processing concerned with implicit emotional meanings (Greenberg, 2003). This separation has been supported by some neuropsychological research suggesting that the brain contains different systems for cognition and emotion (e.g. LeDoux, 1998).

Expression of emotions can similarly be within or outside of our awareness, and may include things both within and outside of our control (For example, freeze-frame video analysis – (see Beebe, 2000) shows that we are constantly demonstrating micro-emotions of which we are not aware and cannot necessarily inhibit, whereas organizational psychology research includes research on 'emotional labour' (Hochschild, 1983) where we are attempting to demonstrate and express a particular emotion, e.g. warmth and smiling as a customer service representative, while withholding or suppressing a different emotion. Rather than thinking of experiencing and expression of emotion as a linear process, it may be more appropriate to think of them as a circular process. Our expression of our emotion can inform our emotional experience and vice-versa. As Collingwood (1958) states: "Until a man has expressed his emotion, he does not yet know what emotion it is. The act of expressing it is therefore an explanation of his own emotions. He is trying to find out what these emotions are" (p.111).

This interplay between emotional experiencing and emotional expression is interpersonal and well as intrapersonal. Emotions can be seen as intentional and relational; they are aroused in response to the other, expressed toward the other, and regulated and modified through the other. It has long been known that others influence how we feel, for example the theories of groupthink (Janis, 1972) and emotional contagion (Hatfield et al., 1994) demonstrate how emotion influences others in a group. Discursive psychology research and narrative analysis shows how emotion talk is used purposefully in relation to the other (e.g. Edwards, 1999), for example to construct and justify narrative sequences or to establish or undermine rational accountability.

Interpersonal emotional interplay also occurs on less verbal and explicit levels. Beebe's (2000) freeze-frame video recordings of mother child interactions demonstrated how affect comes to be mutually regulated through facial gestures and tone of voice. Recent neuroscientific research has suggested that interpersonal affect regulation is occurring almost continuously through right-brain to right-brain unconscious communication (e.g. see Schore, 2003). Schore (2006) points out that a large body of interdisciplinary data now suggests that unconscious affect regulation is more essential than conscious emotion regulation in development,

psychopathology and psychotherapy. De Gelder et al. (2005) state that "we cannot simply consciously 'think away' or remove our unconscious fears" (p. 18682).

If accepted, this view has clear implications for working affectively in the therapeutic relationship. For example, given the relational, interactive nature of the affect regulation process, Schore (2009) asserts that the patient is best served when the main focus is not on increasing the client's autoregulatory skills but on helping them reactivate their ability to use interactive regulation. Perhaps paradoxically it is through the interactive regulation that the client learns the autoregulatory capacities to independently regulate their arousal.

While much of this emotion research is not directly from the psychotherapy field, it is relevant in thinking about therapists' experiencing and expression of emotion in the therapeutic relationship. In conclusion then we have seen that:

- Emotion can include physiological arousal as well as subjective experience
- Some aspects of emotional experiencing (both physiological and subjective experiencing) may be outside of our awareness and easy control
- Emotional experiences may be processed separately from more cognitive analysis
- Emotions are intentional; they function as a form of communication, a means to attach us to others and as a motivation for action
- Expression of our emotions can be both verbal and non-verbal, and again consists of different levels of awareness and control
- Experience and expression of emotion can be thought of as a dynamic process; where our experience influences our expression which in turn informs our experiencing
- Emotions are interpersonal as well as intrapersonal; they are intentional, relational, aroused in response to the other, influenced and regulated by the other

2.5 Emotional Experiences in Psychotherapy and the Therapeutic Relationship

van Deurzen provides an articulate and succinct broad summary of how dominant psychotherapy modalities approach emotions in therapy:

> "Some therapeutic approaches favour the free expression of emotions, in the belief that cathartic experiences will…give relief…usually within the humanistic tradition. Other approaches favour rational solutions, aiming to minimize passion and maximize

reasoning…broadly speaking within the cognitive-behavioural tradition. Other approaches try to understand the reasons behind the emotional experiences, encouraging a continuous process of self-reflection…these are…the psychodynamic and psychoanalytic approaches" (p. 65)

Therapeutic approaches vary to the extent to which they focus on the therapeutic relationship as an enabler of change or as a source of change in itself, whether they focus on the client's intrapersonal emotional world or his or her affective ways of relating to the world, whether they focus on working with interpretation versus experientially and whether the therapeutic relationship is seen as 'real' or also 'transferential'. Each of these perspectives also offers a view (sometimes implicitly) of the therapist's role in emotional relatedness and experiencing with his or her client.

2.5.1 Emotion and the therapeutic relationship in cognitive behavioural therapy (CBT)

The dominant modality of psychotherapy in the UK, and the one recommended by the NICE treatment guidelines (NICE, 2010) is Cognitive Behavioural Therapy (CBT). Cognitive behavioural therapy regards thoughts and emotions as intricately linked, however the primary focus is on breaking out of negative chains of cognition, behaviour and emotion via the cognitive and behavioural ports of entry (Scott & Dryden, 2003, p.161).

Beck et al. (1979) outlining his cognitive therapy for depression, emphasizes the importance of a sound therapeutic relationship in order for therapy to be successful. This includes the therapist's affective capacity to "respond to the patient in an atmosphere of a human relationship – with concern, acceptance and sympathy" (p.25).

Beck (1979) dedicates a chapter to the role of emotions in cognitive therapy and in the therapeutic relationship. He sets out to correct any misunderstandings that cognitive therapy does not consider emotions as important and in fact states that the goal of cognitive therapy is to relieve emotional distress and other symptoms of depression. Beck argues that the therapist should take the stance that any feelings the therapist has may be appropriately discussed during the session. However, the aim of the therapeutic relationship is to establish sufficient positive rapport and collaboration *in order* to work with the specific tools and techniques of cognitive therapy. Beck states: "In contrast to 'supportive' or 'relationship' therapy is used not simply as *the* instrument to alleviate suffering but as a vehicle to facilitate a common effort in carrying out specific goals" (1979, p.54).

The role of the therapist then is as an expert, one who can teach the client tools and approaches to modulate his thinking. Affective relations are important to the extent they serve to build a positive relationship in order for the therapist and client to work effectively together. Broadly, this approach reflects a realist and positivist stance – the client is seen as having problems which can be objectively assessed and quantified and the therapist works with the client as an object on which to affect intrapersonal change.

In contrast to CBT are psychoanalytic and humanistic schools where the relationship is seen as a therapeutic factor in itself.

2.5.2 Emotional and the therapeutic relationship in psychoanalytic therapies

   a) *Freud: The Transference Relationship*

The focus on the emotional aspects of the relationship in modern psychotherapy began with Freud. He stated that it was the first aim of therapy to *attach* the patient to the therapy and "to the person of the doctor" (Freud, 1913a/1958, p.139). He then went on to develop the theory of 'transference' (Freud, 1915a/2001) to explain emotional experiences in therapeutic relationships.

In this theory, clients' emotional responses, and in particular the common experience of patients falling in love with their analysts, were attributable to the analytic situation and reflected the 'transferring' of affect from earlier infantile relationships, typically with parents. Freud viewed these intense loving feelings as often functioning as a form of resistance to the analysis. However, while he sees the source of the love as induced by the analytic environment, he acknowledges the loving feelings themselves as real, stating: "we have no right to dispute that the state of being in love which makes it appearance in the course of analytic treatment has the character of a 'genuine' love" (1915a/2001, p.168).

In parallel, emotional feelings the analyst has towards the patient were attributed to counter-transference, which either reflected the analyst's unresolved transferred feelings from infantile relations or his response to the patient engendered by the analytic situation. Freud asserted that the analyst should remain 'neutral' and a 'mirror', working with a detached attitude, similar to that of a 'surgeon' (Freud, 1912/1958). Freud's writing on the therapeutic relationship reflects his focus on intra-psychic forces at play within the patient or analyst, rather than the inter-relational meeting between two human beings. The therapist is not emotionally

involved himself but works to analyse and interpret the patient's emotional transference and defences with the aim of resolving unconscious dynamics and conflicts.

Similar to CBT, in this view the relationship is of therapist as expert and client as patient to be treated by objectively analysed data. It reflects a positivist 'medical model' of Cartesian reductionism where the patient is thought of as a mind to be treated upon, where reality is seen as objective and realism dominates. A difference with CBT is that there is a focus on the client and therapist's affective experience in relation to one another, as a way to understand the client's interpersonal relations.

The concept of transference as the basis of the therapeutic relationship has been significantly criticized from an existential perspective. Handley (1995), in his existentially-based critique, cites concerns raised by May (1967), Boss (1979) and Binswanger (1962). There have been numerous other existential criticisms of transference including Szasz (1963), Yalom (1980), and Davis (2007). These criticisms are worth discussing as they make explicit the existential assumptions about relationships in general and the affective therapeutic relationship in particular.

First, from an existential perspective, it is impossible for the analyst to be 'opaque' and neutral: our very existence is embodied, relational and intentional and we cannot avoid being in relation. Even the stance to try to be distant and neutral is in itself a way of being in relation that communicates to the other. Davis (2007) asserts that both psychoanalysis and existential therapy are grounded in the analysis of the relationship but suggests that psychoanalysis distances and disengages the therapist from a mutual encounter as the other is transformed to an 'it' – an object to be determined against a pre-determined theoretical framework.

Secondly, existentialists criticize the fact that the impact of the analytic situation and the behaviour of the analyst are ignored with all emotion seen as being intrapsychically rather than interpersonally and contextually generated. Boss (1979) has written passionately and compellingly about the impact of the analyst and the analytic situation on the patient's emotions arguing that the therapeutic relationship is in fact as gratifying and frustrating as any parent-child relationship and has every reason to invoke strong affect (discussed further below).

Thirdly, existentialists posit that the 'real' relationship is neglected and it is impossible and artificial to attempt to distinguish between the 'real' relationship and the transference relationship. Spinelli (2005), while acknowledging that we may bring sedimented patterns of

relating into new relationships argues that phenomenologically we cannot distinguish between a real and a transference relationship.

Fourthly, existentialists have suggested that transference is used as a concept to maintain boundaries and professional distance, and to allow the therapist to attempt to conceal themselves from their clients adopting a detached, objectifying stance. Szasz (1963) suggests that transference is a useful defence for the therapist to hide behind in order to defend himself from the therapeutic encounter. Yalom (1980) also feels it allows the therapist to conceal herself from her clients by maintaining a detached, objectifying, interpretation only encounter. Indeed Gabbard (1994, p.156) states "the term erotic transference has a reassuring clinical ring to it. By contrast, to hear a patient say 'I love you' sounds too personal, too close for comfort".

Fifthly, transference is seen as a direct replication and projection of past relationships onto the current situation, but this ignores the constructivist nature of our memories whereby what and how we remember past relationships is influenced by our current perspective and objectives, and the context in which we recall things (Spinelli, 2005).

b) *Ferenczi, Alexander, Bowlby and Beyond: The Attachment Relationship*

In contrast to the classic Freudian approach, Ferenczi (1924) advocated a much warmer relationship between therapist and client. In his view the task of the analyst was to stimulate and encourage reproducing of past emotional experiences in treatment. This focus on affective lived experience is seen as more valuable than an intellectual attitude that favours theoretical explanation and understanding and Palvarini (2010) discusses Ferenczi's deep emotional involvement with his clients.

Alexander and French drew heavily on Ferenczi's ideas and in 1946 introduced the term "corrective emotional experience" to describe the idea that the client re-experiences old unsettled conflicts with a new ending by working through painful emotional experiences in new and more adaptive ways through an affective relationship with the therapist. In some cases, the therapist may intentionally seek to provide to the patient a new emotional experience to meet the patient's unmet needs. Alexander went on to assert that the "emotional experience… is the only source of real insight" (p.590) and this experience is the therapeutic factor. The analyst assumes a different attitude toward the client than the parent had assumed toward the child.

In contrast to Freudian psychoanalysis then this approach may be seen to place more importance on emotional re-experiencing, to see the client's affective ways of relating as driven

by forces other than resistance, and to advocate for a warmer involvement of the therapist. Casement (1990) in line with others, argues it is necessary there is an actual affective experience for the patient rather than an intellectual analysis of those needs.

Perhaps the extreme of this approach is where the therapist sets out to deliberately provide a loving stance toward the client with the aim of 'reparenting' in some way. Early more experimental approaches of this included actively facilitating the regression of the patient and fostering the establishment of a parent-child emotional relationship such as the case of Mary Barnes (Barnes and Berke, 1973).

Bowlby's (1969, 1998) paradigm shifting work on attachment theory developed the theory and understanding behind such approaches. He demonstrated the different relational patterns people adopt and apply throughout life based on their early bond and emotional security. Therapists can thus act as stand-in, temporary attachment figures offering their clients a secure base from which to (psychologically) safely explore and grow.

Recent psychoanalytic and psychodynamic approaches have veered more towards an interpersonal and affective bias in what is known as 'the relational turn' (e.g. Renolds, 2007), influenced partly by the shift psychotherapy took as humanistic approaches developed and as (in the USA) the practice of psychotherapy was increasingly undertaken by counsellors and psychologists in addition to analytically trained psychiatrists. Contemporary analytic techniques then, put simply, focus on emotional experiencing as much as interpretation, and are discussed in a separate section below.

c) *Contemporary Psychoanalysis: Intersubjective, Relational and Neuroscientific Views*

Psychoanalytic theory and practice, in common with other fields such as post-modernism, has taken a more intersubjective turn since Freud's time. The 'interpersonal' and 'relational' schools of psychoanalysis focus much more on interpersonal patterns of relating than intrapsychic drives. Object relations and attachment theory already moved the focus to the client's interpersonal ways of relating to others, based on early experiences of childhood. Intersubjectivity theory and recent neuroscientific developments have moved these approaches somewhat closer to a more existential formulation of the self and relations with others as fluid, dynamic and inter-dependent. Safran and Muran (2000) have proposed a reconceptualization of the therapeutic alliance for example as an ongoing process of intersubjective negotiation.

Maroda (2010) is a well-known American psychoanalyst who has directly addressed working with emotion in the therapeutic relationship. She emphasizes the primary importance of emotional experiences in therapy, including the affective interplay between therapist and client, and states that these must come first – that intellectual insights only follow emotional shifts. Maroda (1999) argues that therapists should engage in a mutual emotional relationship with the client, being emotionally engaged with and touched by them. Furthermore, she suggests therapists should disclose their emotional experience of the client and that the most beneficial therapeutic exchanges involve the mutual expression of deep feeling.

From this perspective, therapists are affectively involved with their clients, although in contrast to a Rogerian approach they may still consider the extent to which patterns of relating have been transferred from others in the past.

Maroda (1999) claims that a patient knows if the therapist loves them. She refers to the therapeutic relationship as a mutual (psychological) seduction process and will refer a potential client on if she does not feel some emotional pull to want to help them in the first meeting. She suggests there is some reluctance to talk about this issue of 'match' and how this emotional engagement takes place but that this issue would benefit from more open discussion and reflection, particularly as she suggests much of this 'seduction' takes place via largely unconscious-to-unconscious communication, over which we have little control. The idea that warmth or unconditional positive regard is important for the therapeutic relationship raises interesting questions given that this isn't something we can simply 'decide to feel' (Hendricks, 2001). Lodge (2010) states that there is some literature which suggests that the therapeutic match between a therapist and client may be important.

Maroda (1999) also suggests it may be important to have a good match between therapist and client in respect of enactment which she defines as a jointly created unconscious emotional interaction – a living out of affective experience accompanied by a working through (p.125). Maroda sees the emotional response evoked in the analyst as something engendered by the client, and is therefore referring to 'countertransference' – and the notion that while the emotional engagement is in the here and now, it relates specifically to historical emotional material of the client.

2.5.3   Emotion and the therapeutic relationship in humanistic therapy

Carl Rogers was the founder of the humanistic approach, in part as a reaction against the psychoanalytic approach to the therapeutic relationship. He focused extensively on the

therapist-client dynamic and argued that his 'core conditions' of empathy, unconditional positive regard and genuineness/congruence from the therapist were both necessary and sufficient to change (1957). Rogers concludes that these conditions amount to a kind of love (1980) and other research supports this powerful and real emotional connection.

Rogers' conclusions were based on extensive empirical research, in contrast to some of the more individual theorizing of psychoanalysts. It also represented a major milestone in the movement of psychotherapy theory and research from a solely *intrapersonal* focus to one of more *interpersonal* focus that considered the person and the impact of the therapist working with the client. In contrast to Freud's 'mirror', Rogers was advocating that therapists both opened themselves to experiencing and shared some of this emotional experiencing with their clients. In its 'client-centric' perspective his approach also formed a critical antithesis to the previously dominant 'therapist as expert' view of psychoanalysis.

He states: "If the therapy were optimal, intensive as well as extensive, then it would mean that the therapist has been able to enter into an intensely personal and subjective relationship with the client – relating not as an object or study, not as a physician expecting to diagnose and cure, but as a person to a person."(1961, p.21).

One of the significant assertions of this paper was that the only clinically important facet for successful psychotherapy was having clients experience their relationship with their therapist as offering this genuinely felt empathy and affirmation (unconditional positive regard or non-possessive warmth). Theories and techniques were of no significance beyond the extent to which they facilitated the relationship which in turn was there to unleash and enable the client's own capacities for healing. Bozarth sums up this view of humanistic therapy as when the client is seen as ''the source of his or her own resources and expertise when empathically understood and unconditionally accepted by a congruent person'' (2001: 132).

Rogers (1961) emphasised the importance of congruence – acting and using words in accordance with his genuine feelings. For example, if he was feeling angry and critical with a client he found it unhelpful to act calmly and pleasantly. He believed that congruence was the most importance of his three core relationship conditions and that it was only once the therapist was real and perceived as such that the other conditions could be considered as effective. For Rogers, congruence and acceptance of feeling was linked to client change, and that the more he was willing to just be himself and accept the complexities of the other, the more change seemed to be stirred up.

Rogers' concept of unconditional positive regard or non-possessive warmth was perhaps a clearer and less contentious articulation of the idea that the therapist provides a particular type of loving emotional environment for the client. Rogers found that warm regard or unconditional positive regard was present within successful therapeutic relationships:

> *"When the therapist is experiencing a warm, positive, and acceptant attitude toward what is in the client, this facilitates change….it means the therapist cares for the client, in a non-possessive way. By this I mean that he does not simply accept the client when he is behaving in certain ways, and disapprove of him when he is behaving in other ways. It means an outgoing positive feeling without reservations, without evaluations" (Rogers, 1969, p.22).*

This then is a clear assertion that the therapist seeks to provide a certain type of affective experience. Rogers believed that the emotional relationship between the client and therapist was critical, and that if characterized by unconditional positive regard, it would be healing within itself. RD Laing similarly articulates: "the main agent in uniting the patient, in allowing the pieces to come together and cohere, is the physician's love, a love that recognizes the patient's total being, and accepts it, with no strings attached" (1960, p.165).

Lodge's (2010) recent empirical research supported this idea that a particular kind of therapeutic relationship can be directly healing, with the clients in her study valuing their affective bond with their therapist above other aspects of therapy or the therapeutic relationship. One other interesting aspect of Rogers' writing, given recent neuroscientific and video-based research, was his view that a subliminal emotional level of bonding is more important than the verbal level. He regarded the words as having minimal importance compared to the emotional relationship (1950). This again was confirmed in Lodge's research where both therapists and clients described a sense of an important non-verbal connection.

Lodge (2010) suggests there may be multiple emotional processes or connections at different levels occurring in therapy – a conscious articulated emotional engagement and a non-verbal emotional level at which the idea of unconditional positive regard or corrective emotional experience may be more relevant. Her research supported this notion finding that there was a deep, implicit level of emotional connection between therapist-client dyads that ran alongside the more manifest emotional levels. Therapist and client descriptions of moments of intense emotional connection contained many non-verbal aspects and emotions and feelings in the pair were visualized rather than articulated. Lodge suggests that rather than this being 'unconscious' it is perhaps a different kind of awareness - one that is emotionally felt rather

than verbal, or perhaps at 'the edge of awareness'. This ties back to Bridges (2006) summary of the different ways of conceptualizing emotion from conscious constructed expression to non-verbal somatic experience.

There are a number of contemporary approaches that emphasize the therapist's being with the client with the idea of 'healing through meeting' (Friedman, 1975, 2008). Mearns & Cooper (2005) describe working at 'relational depth' and suggest it is the encounter between the therapist and client that is the key to the healing process, rather than the provision of any particular set of conditions. They suggest psychological difficulties arise when a person's capacity to engage with others becomes disrupted, and suggests this points to a therapeutic approach that prizes and focuses on supporting dialogue and mutual interaction.

They address the role of the therapist in working in this way: "listening to clients…involves more than providing them with an opportunity to talk. What we mean is really attending to the client, and attuning to their being at an emotional, cognitive and embodied level" (p.119).

From this humanistic view then the therapist may be seen as a healer. Reality is seen as more interpretive, it is the client's *experience* of the therapist's stance that is essential and knowledge and reality are a hermeneutic process, uncovered through dialogue. The nature of the 'essential self' still reflects a realist position however – there is thought to be a 'real' core self which needs the right environment in which to emerge and flourish and healing is thought to emerge from within the client given the right conditions rather than be intersubjectively and dialectically constructed.

Humanism's focus on an *essential* self is somewhat at odds with the existential *construction* of self, and Rogers' advocacy of unconditional positive regard has been challenged as being unrealistic and potentially at odds with the condition of congruence or genuineness. Wilkins (2001) discusses the issue that unconditional positive regard for the client can be seen as conflicting with the condition of congruence. Rogers himself did not see such a dilemma. In discussing this, Lodge (2010) suggests it is a false dilemma based on a particular understanding of unconditional positive regard when in fact by definition it is unconditional and therefore not conditional on the client evoking only pleasant feelings in us. Lietaer (1984) discusses this issue also and makes a distinction between an ongoing underlying unconditional valuing of the deeper core of who the client is and who they may become, versus specific behaviours and the feelings they may evoke in the moment. He stresses the importance of an unconditional openness to hearing all of the client's experiences so that he is not experienced emotionally as reluctant or rejecting.

This openly warm affective approach has also been challenged by rational emotive behaviour therapists who are critical of offering clients 'undue counsellor warmth' (warmth being one of Rogers' synonyms for unconditional positive regard). This, Dryden (1990, p.18) goes on, is because: "First, counsellor warmth may unwittingly reinforce clients' dire need for love and approval — an irrational belief which is believed to lie at the core of much psychological disturbance. Secondly, counsellor warmth may also reinforce the philosophy of low frustration tolerance that many clients have."

2.5.4 Emotion and the therapeutic relationship in emotion-focused therapies

There are a number of recent approaches that prize emotional experiencing and reprocessing within the therapeutic relationship (e.g. experientially oriented psychodynamic therapy (Fosha, 2000); emotion focused therapy (Johnson, 2004); experiential process therapy (Greenberg, 1993). They are somewhat pluralistic in their theoretical base which is why I have not discussed them specifically under the specific modalities above.

While these approaches share some similarities with the concept of corrective emotional experience and with Rogers and the humanistic approach in calling for an actively involved, identifiably warm therapist they also advocate a more explicit active role for the therapist. The therapist works to support increased emotional regulation and processing through a dialectical process, involving emotional experiencing in session followed by the meaningful integration of cognition and emotion that aims to improve the client's capacity to both understand their own emotional experiencing and to respond to others with a deepened perspective of interpersonal emotional dynamics.

Typically this more structured approach may involve:

a) helping clients tune into and then identify their emotions, perhaps somatically,

b) find words and language in order to be able to express them,

c) reflect on them in order to understand them,

d) experience safe reprocessing in order to better regulate them,

f) reflecting on this experience in order to gain insight into the nature of his or her emotional patterns and construct a meaningful and cohesive narrative (Fosha, 2001; Elliott & Greenberg, 2007).

From this approach one of the outcomes of successful therapy is emotional congruence between emotional arousal, experiencing and self-report, and emotional expression in order that the client can demonstrate emotional responsiveness and flexibility in order to respond to changing conditions (Frederickson & Losada, 2005) while generally maintaining an optimal level of emotional arousal (Bridges, 2006.).

In line with Alexander & French (1946) proponents from these approaches assert the importance of emotional re-experiencing within the therapy. For example, Greenberg (2003) suggests that change can only take place if the client has a 'hot' emotional experience; that is, the client relives an emotional experience in the presence of the therapist which then becomes available for reprocessing. Bridges (2006) states that there is an impressive body of research to support the view of the necessity of in-session experiencing and processing of emotions and Lodge's (2010) recent empirical research highlighted the importance clients placed on actually having an emotional experience in therapy, and their view that this was the most important factor of their therapeutic experience.

A critical aspect of this experience and reprocessing is verbalizing emotions, which has been recognized as a core activity from a number of therapists and perspectives. Rogers suggests the therapeutic process involves increasing recognition, ownership and expression of emotions (1961, p.64) and Rogers and a number of others emphasize the importance of finding the right language to describe currently unarticulated lived feelings (e.g. Gendlin, 1996). Strasser (1999), from an existential perspective suggests it is one of the aims of therapy to explore emotions and particularly to "facilitate the unreflective emotions to emerge into reflective ones so that they can be examined, discussed and challenged". (p.27)

Debate and critique of these approaches includes questioning of what exactly the therapist does to bring about a corrective emotional experience as well as what types of emotions should be accessed, how intensely they should be expressed, how expression relates to physiological arousal (Kennedy-Moore &Watson, 1999; Littrell, 1998). Littrell (1998) has challenged whether re-experiencing of painful emotion is in fact therapeutic, and his review of the research suggests this process is harmful if done in an unstructured way without attendant focus on re-structuring the memory and developing a new response to the emotion-evoking material.

Palverini (2010) provides a case study using experiential psychotherapy in which he describes the patient reliving an emotional experience from her childhood and gradually shifting her emotions from a dominant affect of shame to other feelings including grief, tenderness and compassion towards herself, what Fosha (2000) calls 'healing affects.' Palvarini (2010) argues that these sessions fall within the concept of corrective emotional experience as outlined by Alexander & French (1946).

Bridges (2006) states that as depth of emotional processing increases, the patient experiences positive affects such as relief or compassion, which in turn broaden the patient's perspective, renew hope and continue to enhance more adaptive emotional processing. It is a dialectical rather than a linear process.

Palvarini (2010) addresses some of the desired characteristics and attitudes of the therapist working experientially including a willingness to be spontaneous and genuine, a lack of need for neutrality and abstinence and instead a focus on real involvement by the therapist, including the therapist's own affective involvement and self-disclosure of this with the client as he or she works on emotionally attuning in order to be able to resonate emotionally with the client. In this view therapy then, is not about the client simply re-living emotional experiences in the presence of the therapist but a mutually affective process where the therapist becomes part of the client's currently lived emotional experience and at the same time is having his or her own emotional experience of the client and their relationship.

From my perspective as a reader, there appears to be some differences between experiential approaches where the therapist acts as a kind of guide referring the client back and through a past emotional experience and providing affect regulation and support throughout this process (the focus is on the event being recalled), to a slightly different approach where the therapist and client in their relation with each other provide a re-experiencing of emotional relatedness with a new outcome (the focus is on the relationship in the here and now). Both approaches concur however with the need for the therapist's real human involvement in the therapeutic relationship. Palvarini (2010) uses an interesting metaphor when he talks about the therapist 'facilitating the birth' (p.192) of the emotion. Perhaps in the former approach we think of therapist as midwife, whereas the latter therapist is more directly involved.

Within these approaches, I am including those that work to help clients safely experience and express emotions, perhaps in a new way. Gendlin (1981) developed an approach called focusing as a means of helping clients access a "felt sense" of their emotional arousal as a way of deepening their emotional processing. Bridges (2006) suggests this can be seen as a "bottom

up" form of emotional processing that starts by directing the client to focus on nonverbal sensations, feelings and images as a way of accessing core emotions (in contrast to a 'top-down' method that uses more verbally mediated methods such as interpretations or cognitive challenges). For example, he talks of pauses and struggles to articulate feelings into words as a sign of moving to a deeper level of emotional processing. In empirical research using physiological measures of emotional arousal including heart rate monitoring, Bridges (2006) demonstrated that deeper emotional processing led to more rapid cardiovascular recovery from emotional arousal.

Recent neuroscientific evidence has again added value and weight to this debate. Cozolino, (2002) discusses the fact that if feelings remain unsymbolized then emotional arousal (affect dysregulation) cannot be managed in a more conscious verbal fashion. "Language, in combination with emotional attunement, creates the opportunity to blend words with feelings, a means of neural growth and neural network integration" (p.10). Dales and Jerry (2008) suggest the process of putting feelings into words enables the left and right hemispheres to become integrated.

Schore's (2003) extensive publications on affect regulation and disorders of the self and affect regulation on repair of the self makes three profound claims about the importance of emotion in therapeutic relationship.

- First, he asserts that the therapist-patient therapeutic relationship is analogous to the caregiver-infant relationship in involving interactive right-brain-to-right-brain emotional transactions.
- Secondly, he suggests that the therapist must be attuned and in synchrony with the patient's shifting affective state. In this way their relationship is intersubjective.
- Thirdly, that the therapist is able to help the client regulate their own affective state through this intersubjective attunement and that this can lead to change and growth in both the clients' own emotional experiences and his or her ability to cognitively interpret and reflect on these experiences. Schore's (2003) neuroimaging work suggests this results in visible and measureable changes to the brain. Given the intersubjective nature of the relationship this expansion occurs in the brain/mind/bodies of both therapist and client.

2.6 Existential Perspectives on Emotion and the Therapeutic Relationship

Having reviewed the literature from other fields, I will now focus in on existential perspectives.

One of the criticisms levied at the existential approach is that it extensively critiques other approaches, while failing to clearly define and delineate an alternative (Cooper, 2003). However, one of the reasons for this is that the existential perspective is not a homogenous approach and is perhaps better thought of as a school of theoretical and therapeutic approaches based on some underlying philosophical assumptions about human existence and behaviour. For example, Cooper's (2003) book Existential Therap*ies* (my italics) outlines several forms of existential psychotherapy and du Plock suggests that "there are as many ways [to practice] as there are practitioners" (1997, p.5). Wilkes and Martin (2006) suggest that it is an accepted tradition that differences exist yet also state that it is apparent there are sufficient similarities in the way existential-phenomenological therapy is understood and practiced for the term to have shared meaning, permit training and for likeminded groups to identify themselves (such as in the Society for Existential Analysis). It is also the case that existential approaches tend to draw upon the same core philosophers and theorists, share many common underlying beliefs and values and also common criticisms of aspects of other approaches such as those outlined above. This existence of a plurality of approaches united by core underlying values can be seen as reflective of the profession of Counselling Psychology as a whole in the UK as evidenced by the annual conference by the BPS Division of Counselling Psychology (2011) – "Celebrating Pluralism in Counselling Psychology?"

There are two streams of literature relevant for understanding the existential approach to the emotional experience of the therapeutic relationship. The first is the underlying existential philosophical foundations about the nature of relationships and the second consists of particular accounts of the therapeutic relationship in existential psychotherapy. I discuss each in turn.

2.6.1 Existential philosophical foundations

Heidegger (1927/1962), Merleau-Ponty (1945/1962), Buber (1970) and Sartre (1943) are among the existential philosophers who have commented upon our irreducibly relational position (e.g. see van-Deurzen-Smith, 1997). From the moment of conception we are inescapably 'thrown' into being-in-the-world-with-others and as examples from feral children show we do not become fully human without relation (Karen, 1994) or what Groth (1997) refers to as existential validation. From an existential perspective, relationships are not just passively and unavoidably

'out there'; they are also the way in which we create, construct and re-construct ourselves and, from a Sartrean (1943) perspective, how others attempt to construct us.

Human existence is therefore not a self-contained phenomenon but something that is both dependent on others and reaches out beyond its own being. While we exist within our embodied selves, we come into the world physically dependent – our very survival is dependent on our relations, and our sense of self is formed through our bodily and relational encounters (Schore, 2003). Biological research studies confirm that we actively seek relation (Duncan et al., 2010).

However, our relational reaching out for and dependence on others is not just based on meeting of physical needs; we are emotional beings who require love and affection in order to thrive. Harlow's (1958) famous experiments with rhesus monkeys showed that the search for 'contact comfort' was predominant to physical needs for nourishment. Furthermore, as adults these monkeys could not perform sexually, were unable to nurse their young and were often abusive (Harlow, 1958). Studies of separated, abandoned or orphaned children (e.g. see Karen, 1994, for a detailed review) also highlight the effects of early relational deprivation on both immediate physical, cognitive and emotional development – the 'failure to thrive' phenomenon - and mature relational patterns. Recent neuroscience research has shown that relational interactions in early life are responsible for the 'laying down' of neurological pathways and affective responses early in life: our brains are literally created through and perhaps for relation (Schore, 2003). Emotions are therefore social and mediated through relationships and responses from the moment of birth (Maroda, 2010).

In this Heideggarian view, the individual can be considered as the nexus of a network of interactions (van-Deurzen-Smith, 1997) or as Merleau-Ponty states: "there is no inner man, man is in the world, and only in the world does he know himself" (1962: xi)). Our interactions with others occur through the discourse of language as well as our embodied experience of touch, gaze, presence and language. Butt (2007) refers to the notion of 'joint action': the idea that in conversation and dialogue we discover and create ourselves in ways that would not be possible alone. The social act "draws from me thoughts I had no idea I possessed…the social act draws us out and extends us, conjuring up selves that outrun us" (p.7). This mutual engagement and openness to the other and the ensuing interaction is reflected in the writing of Buber in 'I and Thou '(1970). There is no 'I' as singular entity, rather the 'I' is in relation to the 'Thou' or 'It'. The encounter between two subjects – the I-Thou encounter where neither is an object of the other - creates a shared possibility that exceeds the potential of either (see Davis, 2007).

Existential philosophers have written how we relate to the other in a variety of ways: as embodied beings through our body, and bodily senses and touch (e.g. Merleau-Ponty, 1962), through the gaze (Sartre, 1943), through language (Macquarrie, 1972, Heidegger, 1927/1962) and through mood, attunement or emotion (Heidegger, 1927/1962). Merleau-Ponty writes how we are our bodies and the very way in which we encounter, engage and relate to our world is embodied. Our emotions are also embodied and therefore our affective relationships with others and experienced physically or as Cooper states, in a "bodily-felt" way (2003, p.21). While this may appear obvious, it is somewhat in contrast to the Cartesian split of mind and body and leads Heidegger (1927/1962) to state that we are always 'in a mood' – that we are intrinsically attuned to our world and to others.

Our existence and self therefore is not just dependent on the others, it also reaches out towards others in an embodied emotional way. Buber states that the most significant growth of the self is accomplished in relation between oneself and the other (1970, p.28). Human existence can therefore be defined as being towards otherness (as well as outwards towards the world in general).

Some of the existential philosophical assumptions then which underlie approaches to and understanding of the therapeutic relationship include:

- Existence is fundamentally relational, existence is co-existence
- Existence is embodied, we are always in our bodies
- Existence is emotional, we are always in a mood, always attuned
- Emotions are intentional, they are oriented towards something
- Self is a network not a defined object, it is constructed and reconstructed through relations
- Emotions are also socially constructed and mediated
- Therefore our emotional experience of the therapeutic relationship is actively constructed within the therapeutic relationship.

2.6.2 The therapeutic relationship in existential psychotherapies

The philosophical foundations outlined above have direct and significant implications for an understanding and approach to the therapeutic relationship in existential psychotherapies.

It suggests that therapy is relational and interpersonal, involving both the therapist and the client, and is always a unique encounter between each therapist and each client. In this way the therapist and client are intricately bound together in co-constructing realities about each other in order to discover new possibilities and new more rewarding ways of relating to self and other. This is in contrast to a classic view of transference which suggests that the client's emotional response to her therapist is an individual reaction which may be expected to manifest itself in similar form with different therapists.

This approach also suggests that there is mutual impact - that the therapist is also open to being rather than just a reflective neutral 'mirror'. Cooper (2003, p.138) suggests that "therapists tend to be relatively genuine and direct with their clients rather than adopting the role of the blank screen" and for those existential therapies that put greater emphasis on the immediate therapeutic relationship there is also increased openness to self-disclosure.

The therapist is also deeply involved and may be impacted or experience changes to his or her ways of understanding and being also. The therapist inevitably has emotions in the therapeutic relationship because we cannot not be in some form of mood or attunement in relation to the world and others. Davis (2007) concludes that "for existential therapists, the therapist's approach must encompass equality, openness and the ability to be *emotionally affected* by the client's material" (p.350, my italics).

This more interpersonal philosophy reflects a general 'relational turn' which can be seen across different fields both within and outside of therapy such as post-modernism and social constructivism and the rise of 'relational psychoanalysis' (Mitchell and Black, 1995). It suggests that reality is constructed between and in relation with people and that narrative is flexible and open for modification, including our narrative and experience of past and current relationships. This is another difference from more classically drive-based theories of psychoanalytic relations. It is a less reductionist and deterministic approach which suggests our ways of being in relation are not fully and rigidly determined by our primary relationships but instead may reflect merely somewhat restricted or sedimented ways of being which may manifest differently within different relationships and are able to be reconstructed or 'opened' (Boss, 1979).

Despite these common core foundations, existential therapies vary in the extent to which they focus the therapeutic work around the immediate therapeutic relationship or pay less attention to the therapist-client dynamic. Cooper (2003) outlines the variations between these approaches and lists those he believes have more focus on immediacy, including Laing, 'The

American School' and Boss' Daseinanalysis. I will discuss three existential approaches to the therapeutic relationship I feel most relevant to the emotional experience of the therapeutic relationship: Boss, 'The American School' and Spinelli.

a) Medard Boss

van Deurzen-Smith (1997) suggests that as a result of his close relationship and long-term work with Heidegger, Boss' writings represent existential therapy in its purest form. His views are also important because he provides a direct critique of transference and outlines an alternative approach to the therapeutic interaction within his 'Daseinanalytic' approach that specifically addresses emotional experiences in therapeutic relations. Boss (1979) states that all illness and treatment develops out of the patient's disturbed human relationships, particularly pathogenic incidents in childhood where the child feels unloved, criticized or punished. The physician-patient relationship is therefore the true locus of all therapeutic work and the basis of all forms of treatment.

He felt that while Freud had been wise in recognizing the relationship as central to the therapeutic encounter, he went on to undermine and degrade the nature of this phenomenon by describing it as something transferred from somewhere else. Boss (1979) argues that the whole notion of transference is based on unfounded assumptions such that emotions can exist as isolated, detachable feelings that can be transferred from one love object to another. Transference suggests that people are initially isolated subjects an 'ego-pole' but human communication does not exist like this. Instead we are with each other from the very instant we encounter and perceive each other (even hearing or reading of the other) and so emotions are generated in-relation.

Boss also criticizes the idea that 'transference' love is somehow different and less real. Instead the therapeutic relationship is a real and mutual encounter and all phenomena are what they are. Indeed, Boss states: "Transference is not mere deception based on a faulty linking of affects and instincts to the 'wrong' object as Freud thought. Transference is always a genuine relationship between the analysand and the analyst" (Boss, 1963, p.123). In his view, the therapeutic relationship is always real. It is what we are "in", what we experience, and it is always mutual. 'Transference' therefore, should be seen in terms of how one perceives and relates to the world. It is a real event happening within the relationship between the therapist and client. Boss argues that nothing can redeem the theory of transference, including the later division of the relationship into a transference component and a 'real' relationship. As the

existential view is that we exist primarily in a state of relatedness it is meaningless to distinguish between these two; we are always in relation.

This relationship cannot be anything but emotional because human existence is always attuned to one mood or another, attunement being one of the basic features of human nature. Thus while Freud's views on transference developed out of a belief that there was nothing in the therapeutic relationship that could evoke love or hate and that these passions must thus be transferred from elsewhere, Boss disputed this and countered that the relationship could be as gratifying and frustrating as any parent-child relationship. Thus the intense feelings stimulated by the therapeutic relationship can be considered as genuine emotions, appropriate and relevant to the therapeutic situation (Davis, 2007).

The therapist must also be ready to open himself to whatever manifests itself in the interpersonal space cleared by therapy and allow their being-together to ripen. The therapist must be willing to recognize all phenomena as real which frees the client to open themselves to new possibilities of related existence and experience previously disowned ways of being. The therapist will also have an emotional relatedness to the client and must maintain constant awareness of the way she relates to the client, no matter how the relationship changes. In contrast to Freud's encouragement of surgical neutrality Boss refers to a 'lively interest and enduring benevolence' and argues that selfless, respectful nurturing is a necessity in the therapeutic relationship. To adopt a supposedly neutral stance is in itself an inadequate and restricted mode of relating. Boss (1963) suggests that therapists should be supportive and warm, genuine and real, adopting an attitude of loving acceptance to all aspects of a client's existence. The safe, loving relationship with the therapist can provide a new place for the client's existence to dwell in the world.

b) *The American School*

Cooper (2003) notes the similarities between Boss' advocacy of a warm loving acceptance and Carl Roger's (1957) stance of unconditional positive regard. Cooper (2003) argues that American existentialists have been strongly influenced by humanistic psychology including adopting Rogers' core conditions (1957). His grouping of an 'American school' includes Yalom, Bugental and Schneider. These therapists are also influenced by the Interpersonal psychoanalysis of Stack Sullivan (1968) which understands psychological disturbance in terms of an individual's dysfunctional interactions with others, echoing Boss' sentiments.

Bugental suggests there is no other relationship that is fully comparable to that between a therapist and her client, describing it thus: "A friendship; … a love affair; …a partnership; …a blood bond; …a duel; …all of these and none of them and something more" (1978, p.72)

The American School emphasizes working with the therapeutic relationship and its attendant emotions in the 'here and now', helping clients to express how they feel in the immediate moment, and in relation to their therapist, and helping clients to label and differentiate between various emotions including those felt towards the therapist (Yalom, 1989). While these therapists will also support a client's inner search, they try and facilitate a client's presence to another: their ability to communicate and express their authentic, in-the-moment experiencing (Bugental 1978, 1999), including immediate presence with the therapist.

The therapist's emotions about the clients are also seen as important and real and a source of genuine information in the present moment rather than a classic 'countertransference' in terms of its original definition as affect transferred from elsewhere in the analyst's life. Yalom (1989) for example uses his feelings of boredom and disinterest in the client as an indication she is not fully present.

Unlike other existential approaches however, the American School does not abandon the existence of transference and counter-transference in its classical formulation. Bugental, for example, suggests that the "client tires to recreate a collaboration such as he has had in the past with some important person" (Bugental, 1981, p.137) and by so doing avoid the anxiety of being fully present to a unique, unfamiliar and unpredictable other. 'Analysing the transference' can therefore be an important element of existential-humanistic psychotherapy. This school suggests that helping clients to see how and from what source they misperceive their therapists and by extension other people in their lives they can be helped to relate to others in a more important way.

In order to facilitate this process of working with immediate emotions and reviewing the client's relations towards others, Yalom and Bugental outline the need for the therapist to be genuinely present to her clients (Bugental, 1978). The primary focus is the development of an authentic, genuine relationship between therapist and client (Bugental, 1978). All other aspects are secondary. Yalom concludes (1989, p.91): "It's the relationship that heals, the relationship that heals, the relationship that heals". The therapist must be open and willing to self-disclose to a client and also be aware of when their own feelings prevent them from being fully present with the client. This includes the therapists' feelings towards their client in the immediate here-and-now: whether tenderness, disinterest or an uncertainty about how to progress. For

example, Yalom's (1989) discussion of his 'Fat Lady' client where he acknowledges that his disgust at her obesity prevents his full presence. Authenticity is not only defined in terms of one's willingness to know oneself but also in terms of their willingness to be known by others, and to being open to the authentic being of others as much as expressing one's own authenticity (Bugental, 1978).

There is a close focus therefore on the space between therapist and client and the relationship that emerges between them. It is perhaps in this 'betweenness' that the client can clarify and then explore new ways of being in relation and being ones' self, including new emotional experiences.

c) *Spinelli & The British School*

Spinelli (2005) is one of the most recent existential writers to directly address working inter-relationally in existential therapy. He places an explicit and overriding emphasis on what he terms the 'we-focused' realm which relates to 'our experience of 'us' being in relation with each other. He states that the we-focused realm of encounter is characterized by its experiential immediacy within the therapy. While acknowledging the sedimented patterns of relating that we may bring to new relationships, he argues that phenomenologically, a real and a 'transference' relationship cannot be distinguished. As existential therapists we must respond to the phenomena we are presented with, whatever their origins in the moment of meeting. He urges against using transference concepts and discourse to minimize or avoid the impact of the client's presence when challenging or disturbing. To deal directly with the genuine and passionately felt emotions that can arise in the therapeutic encounter requires courage on the part of the therapist. As van Deurzen-Smith states "there can be no excuses and no soft options. In the therapeutic encounter all phenomena have their own direct reality and they have to be dealt with in this manner" (1997, p.155).

One of the few papers I found that described a therapist's lived experience of this type of emotional encounter was by Smith-Pickard (2006). He recounts a clinical example of experiencing a client who expressed strong loving desires for him and his supervisor emphatically directing him that this was a case of erotic transference with the client actually expressing feelings for her father. He argued with his supervisor as this did not fit with his experience which was that it "was the closeness in the sessions that brought these feelings about" (2006, p.225). He developed an understanding that as embodied beings desire and love are intersubjective phenomena that can be present within the therapeutic encounter as we seek and desire to make a difference to the other and be existentially validated by them, and

seek to be desired by them in return. He recounts a close personal and emotional involvement with this client, one of only two clients to ever move him to tears during his work. He concludes "I think we both met each other and met ourselves meeting each other at a profound level while maintaining a therapeutic focus" (p.235).

This idea of a deep, affective meeting between therapist and client has been expressed in Stern's description of 'now moments' (2004). He states that all therapists and patients establish a way of working together and that much of this is unique to the therapist and the dyad. This established intersubjective dynamic can then however be dramatically changed through spontaneous moments of 'meeting'. These moments are highly emotionally charged and hurtle both parties fully in the present and with each other. They threaten the previous nature of the relationship and allow for a shift in relationship to occur. Stern emphasises the emotional force involved in such moments suggesting that they are primarily *felt* rather than verbalized and stresses the need for an authentic, personal response from the therapist. He refers to the therapist's anxiety and feeling of being disarmed as prompting a spontaneous response specific to the dyad.

Neuroscientific research confirms the inevitability, importance and mutuality of emotional experience in important intimate relationships such as have with our parents (or caregivers), partners and therapists e.g. Schore (2003). The work of Schore (2003) and others shows that we are conveying and communicating emotions constantly through minute facial expressions and prosody. From this perspective, therapy is inevitably an emotional encounter and it would be naïve to think that the therapist can remain 'neutral' and unaffected by both the client's experience and expression of emotions about the therapeutic relationship and vice-versa.

Smith-Pickard's paper (2006) and this study speak to me personally because of my own experience of being surprised to have an intensely emotional encounter in entering personal therapy for the first time and having a therapist who was brave enough to 'meet me' with this experience. I attribute the quality of our relationship as enabling transformative therapeutic change. Amini et al. (1996) found that in order for implicit learning to take place, the patient must have a vivid affective experience of the therapist. Risking a genuine emotional encounter with the client can provide new emotional experiences that literally reshape our neurological pathways; our very selves are created through relationship (Schore, 2003).

2.7 Summary and Research Questions

The review of the literature has shown that:

- The therapeutic relationship has been repeatedly demonstrated to be the essential factor in psychotherapy
- The relationship is multi-faceted including more cognitive aspects such as consensus on goals and tasks and more affective aspects such as the emotional bond between therapist and client
- All modalities of therapy, to various extents, have a body of literature which suggests that what takes place on an emotional level in the therapeutic relationship is significant in respect of client change
- Recent neuroscientific research has added additional weight and credibility to this view
- Existential approaches have proposed that therapy is a relational and interpersonal endeavour with mutual (but not reciprocal) impact, where therapists adopt a relatively warm, supportive, genuine and open stance with their clients. There is an active focus on the relationship in the here-and-now.
- Despite the importance and relevance of this topic there is a lack of direct qualitative empirical research about existential therapists' emotional experiences of the therapeutic relationship

This research evidence therefore suggests the emotional experience of the therapeutic relationship is critical and lends further importance to the need to explore therapists' lived experiences of this in therapeutic practice.

It is my goal to provide to existential and other therapists, and clients in therapy, further understanding of therapists' experiences by posing the following research question:

What is the emotional experience of the therapeutic relationship in existential psychotherapy?

I intend to explore how these therapists experience their own and their client's emotions, and their sense of the emotional relatedness between them in order to enhance understanding in this area.

In addition to enhancing understanding, this research also offers a counter-perspective to dominant cognitive modalities provided through the National Health Service and is intended to

contribute to a growing discourse about the limitations of a adopting a limited cognitive perspective to the exclusion of emotion-focused approaches.

3 Methodology

"'Methodology' refers to the philosophic framework, the fundamental assumptions … the general orientation to life, the view of knowledge, and the sense of what it means to be human…"
(Van Manen, 1997, p.27)

3.1 Introduction

In hermeneutic phenomenology, the first criterion for research question is that is a phenomenon that "seriously interests us and commits us to the world" (Van Manen, 1997, p.30).

My research question arose out of my own experience of the therapeutic relationship as both a client and a therapist as discussed in the introduction. In turning to reading and writing about the nature of my experiences my interest was piqued further. When I turned to the literature I found that despite extensive writing and research on the therapeutic relationship in general, there was lack of qualitative exploration from an existential perspective. This lack of existing in-depth qualitative research on the therapeutic relationship in existential psychotherapy, including the emotional aspects of the relationship, supports the timeliness and relevance of conducting this empirical qualitative research.

The focus of this research then is to explore, describe and gain insight into the particular phenomenon of the *lived experience* and *meaning* of the therapeutic relationship in existential psychotherapy, and in particular the experience and meaning of emotional aspects of the relationship.

Van Manen (1997) states that the methodology one chooses for the research should be in harmony with the nature of the research question. He distinguishes between research *methodology* and research method, techniques and procedures. Methodology referring to the philosophic framework, and the fundamental assumptions and characteristics of the research paradigm, it is the theory behind the method.

This philosophical theory includes questions about the nature of ontology (the nature of reality), epistemology (the nature of knowledge, what can be known and the relationship of the researcher and the knowledge) and methodology (how can the researcher attempt to gather

this knowledge of 'reality'). Lincoln & Guba (1985) argue that answering these questions is critical in conducting research.

Therefore this chapter contains two sections. The first section outlines my philosophical framework, where I outline the ontological, existential and epistemological position of this research, followed by an account of how I determined to adopt a hermeneutic phenomenological methodology for this study. I then provide an overview of the specific methodological approach I am adopting, Van Manen's hermeneutic phenomenology, explaining my reasons for choice and consideration of alternative methods. I conclude with an account of my own reflexivity and reflexive process in arriving at these conclusions.

The second section of the chapter outlines my research method and design, including information about the practice of the research including selection of participants, data collection and the process of data analysis.

3.2   Section 1: Philosophical and Methodological Framework

3.2.1   Ontology and epistemology

Ontology asks 'what is the nature of reality?' and Epistemology asks 'what is the nature of knowledge: what can be known and what is the relationship of the knower to the known?'. Ontology and epistemology are closely related in that our belief about the way we gain knowledge is related to our understanding of what the nature of this knowledge is.

A paradigm is defined as a world view or basic belief system that guides the researcher's approach. Willig (2008) outlines four paradigms related to the study of human nature: positivism, interpretivism, hermeneutics and social constructivism that reflect different epistemological viewpoints. These four paradigms can be considered as on a continuum aligning against views of ontology or reality that move from a position of realism (objective reality) to critical realism (subjective reality) to relativism (reality as constructed).

Figure 1 - Ontological Position

Epistemological Position | Positivist | Post-positivist | Interpretivist | Hermeneutic | Constructivist

Ontological Position

Realist | Critical Realist | Relativist
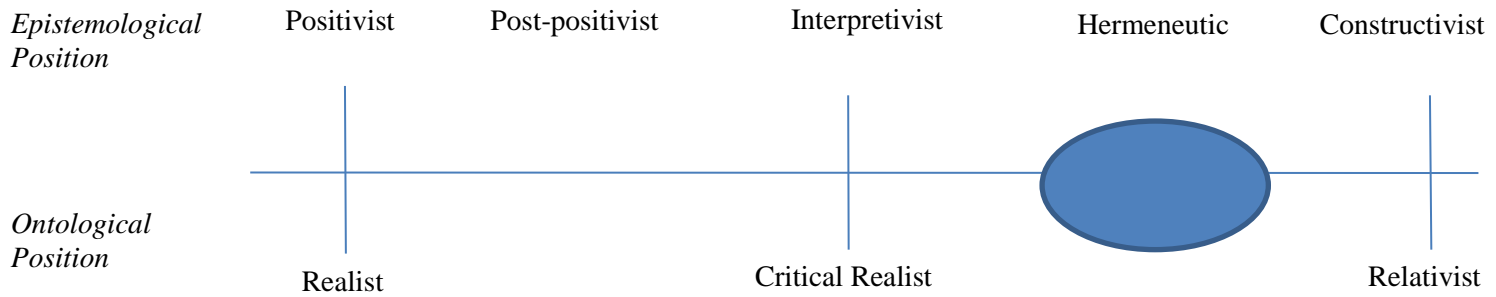
Science and mainstream psychology typically adopt a realist and positivist approach in which reality is viewed as 'out there' (Denzin & Lincoln, 2000) in a way that can be objectively measured by a distanced and neutral researcher with the aim of codifying and controlling phenomena.

In contrast to this, phenomenological psychology pays more heed to subjective human experience and the meaning accorded to this 'lived experience', while also recognizing the role of the researcher in perceiving, describing or interpreting this meaning (Langdridge, 2007). Reality is perceived to exist, but meanings and interpretations of it are relative. The post-modern constructivist perspective contends that there is no fully objective or subjective reality and that reality and our knowledge of it is constantly created – or constructed –and recreated through language and dialogue in relation with others; reality is relative.

Finlay and Evans (2009, p.27) state that many psychotherapists are likely to be drawn to methodologies which embrace ontological realism (a belief that experiences are real and that there is a real social world out there to investigate) and epistemological relativism (a position which acknowledges multiple perspectives, realities, understandings and interpretations). Finlay and Evans (2009) describes critical realism as a pragmatic position, suggesting researchers from this position consider meanings to be fluid while accepting their participants' stories reflect something of their subjective perceptions of their experience.

3.2.2 Ontological and epistemological position for this research

Ontologically, for this research I am adopting a position between critical realism and relativism; I accept that there is a *real* phenomenon of the therapeutic relationship, the subjective

experiences of which is of value to research. However, I also believe that the meaning of this is open to interpretation *and* is socially constructed through dialogue.

Epistemologically, for this research I am adopting a hermeneutic perspective that looks at the subjective experiences. While not focusing my research on the use of language, I will pay attention to the way language is used intersubjectively to both convey and construct the nature of therapeutic relationship. However, the primary focus is on the subjective lived experience and meaning of this experience.

My ontological and epistemological positions have been influenced by my studies of existentialism and psychotherapy.

First, I see human nature as having ontological existential givens, even though the ontic experience of these may be very diverse. We are all in lived body, lived space, lived time and lived human relation (Van Manen, 1997). We are unique in having consciousness of our being, including the knowledge of the inevitability of our death but the lack of knowledge about how this will occur.

Secondly, we are always a being-in-the-world (Heidegger, 1927/1962) and it is never possible for us to stand outside of this world as a purely neutral observer. Even positivist research will be influenced by the context that we are in – the culture, the timeframe for the study, the historical period of knowledge.

Thirdly, I have been particularly influenced by the notion of relationality, and the dialogical nature of human existence and the role of language in mutuality. Therefore, although I perceive subjective experiences of the person as a meaningful foci of study, I believe that the language used to convey this experience is inevitably influenced by the relationship of the person to both the phenomena under investigation but also their relationship to the research and the researcher. My own position may be seen as a dialectical process between subjectivity and intersubjectivity.

Thus, while I acknowledge the subjective individual and 'internal' reality of each of my research participants, I believe the knowledge and nature of 'reality' gained through the research interviews will be contextually influenced by:

     (i)   Research context: the research activity and *context* itself

(ii)   Researcher relationship: the nature of the unique dialogue and *relationship* between interviewer and interviewee

(iii)   Researcher interpretive process: my own process of engaging with, analysing and interpreting the data.

Thus this study will take a phenomenological approach that looks at the lived *experience* of the therapeutic relationship, but that accepts that the *account* of this experience will be unique to the *context* of this study, the dialogue of this *relational encounter* and the *interpretation* made by this researcher.

Regarding (i) the *research context*, it can be considered for example that the same participant, when asked to elucidate on the therapeutic relationship, may do so very differently if in private supervision, or as a Doctoral research participant, when lecturing novice therapists in an educational setting or if defending him or herself in front of an ethics panel. As corporeal, spatial, temporal and relational beings (Van Manen, 1997) our self views and constructions, including how we conceptualize ourselves as therapists within the therapeutic relationship, is likely to be dynamic and fluid, open to the ongoing influence of experience.

Regarding (ii) the *research relationship*, knowledge is to some extent here considered a co-creation, dependent upon, communicated through and mediated by the nature of the dialogue between researcher and participant. This reflects the overall philosophical assumptions of this research and this researcher, that we are relational beings and always in relation with others. Drawing on Merleau-Ponty, Butt's (2007) notion of 'joint action' reflects this idea that truth and knowledge exist in the 'betweenness' of the social act rather than existing fully within an individual. King et al. (2008) state that the interview is a process of *construction* as well as discovery.

Regarding (iii) *the research process* I will inevitably bring my own background and structure to the research as I interpret it. I hope to work closely with the descriptions of experience provided by the participants and to use much of their language as I story the results. However, I will bring my own interpretation and narrative to the data in choosing what to highlight and how to structure the results. Even my choice of method and form of data analysis reflects the impact of my own research process on the data. Analysis is a creative process of discovery (Van Manen, 1997) and therefore is inevitably influenced by my own being and worldviews.

3.2.3 Methodological position for this research: Phenomenology

Methodologically, this will be a qualitative study as qualitative research aims to capture, describe and explore lived experiences and subjective meaning, offering rich, textured, nuanced descriptions of emotions, thoughts or experiences (Finlay & Evans, 2009). Its focus is to understand and make sense of phenomena rather than explain, control or predict them (Finlay & Evans, 2009). There are a number of qualitative approaches, but the one most suited to the nature of my research question is phenomenology, which I discuss below, after outlining the existential and relational influences on my philosophical framework. This research is grounded specifically in hermeneutic phenomenology.

Phenomenology is the study of human experience and the way in which things are perceived as they appear to consciousness (Langdridge, 2007). In other words, it is an approach interested in description of subjective experience and the exploration of the lifeworld (Van Manen, 1997) and this makes this a natural fit for my study which is looking to explore the lived experience of the therapeutic relationship.

Phenomenology encompasses a range of approaches which arise from different philosophical orientations, theoretical preferences and methodological approaches (Finlay, 2009). The two classic approaches to phenomenology are hermeneutic and transcendental phenomenology, although each of these should be considered as a collection of approaches.

The philosophical movement of phenomenology began with Husserl and his admonition to 'return to the things themselves' (1900/2001). He proposed that what *is* (meaning a person's experience of what is) should be taken as reality and rejected the notion that there was something 'more real' underlying human experience. Therefore, phenomenological research is the study of lived experience as we experience it, rather than as we conceptualize or categorize it; it is the attempt to uncover and describe the meanings of lived experience though careful description and reflection. Husserl believed that we can set aside our 'natural attitude', the way our everyday way of seeing the world colours our experiences. In conducting phenomenological research, he therefore advocated epoche, the 'bracketing' off and transcending of our own experience of the world as researchers. He believed that as we immerse ourselves in lived descriptions and conduct a process of phenomenological reduction, imaginative variation and reflection we are able to move from individual descriptions to identify the underlying universal structure or *essence* of a phenomenon. Hence this approach came to be known as 'transcendental phenomenology' – we transcend ourselves and our own preconceptions as

researchers, we transcend the individual subjective experience, we transcend any one aspect of the phenomenon to arrive at its very essence.

Heidegger and other existentialists challenged this notion of 'transcendental phenomenology' and the idea that we can somehow transcend ourselves. Heidegger instead stressed our inextricably related nature as beings-in-the-world: we are always embodied, in relation, in time and embedded in the world. These challenges gave rise to a second major branch of phenomenology – hermeneutic phenomenology.

Hermeneutic phenomenology

Hermeneutics is the study of the theory and practice of interpretation. Hermeneutic phenomenological approaches have some common dimensions that differentiate them from descriptive phenomenology, however there are also some differences between different hermeneutic methods.

Like descriptive phenomenology, hermeneutic phenomenology is also concerned with human experience as it is lived, or the 'lifeworld'. It is research grounded in "concrete lived experiences by means of language" (Van Manen, 1997, p.23). As for descriptive phenomenological approaches, a hermeneutic approach also begins in the pre-reflective life world of the natural attitude, as we attempt to gain insightful descriptions of experience and the meanings we attach to phenomena. The aim is to construct an animating, evocative description of human experiences, actions, behaviours and intentions "as we meet them in the lifeworld" (Van Manen, 1997, p.19). This experiential understanding comes from the lived descriptions themselves; the research aims to be presuppositionless (p.29).

However, in contrast to Husserlian descriptive phenomenology, hermeneutics, informed by Heideggerian philosophy and first developed methodologically by Gadamer and Ricoeur, views people and the world, and therefore researchers and the knowledge they engage with, as inextricably entwined. We are embedded in a world of language and social relationships and the inescapable historicity of all understanding (Finlay & Evans, 2009). Heidegger states: "the meaning of phenomenological description of a method lies in interpretation" (1927/1962, p.37). The researcher can never bracket themselves from themselves; research is always situated because man is always in the world. Van Manen (1997) outlines how we are always situated within lived space (spatiality), lived time (temporality), lived body (corporeality) and lived human relation (relationality). In line with Nietzsche's philosophy (e.g. see Langdridge,

2007, p.27), all meaning then is meaning that we impose on the world and a phenomenological reduction that enables pure transcendence of this is impossible.

Although a significant over-simplification, a key difference then is that transcendental phenomenology is more descriptive and hermeneutic phenomenology being more interpretive (Cresswell, 2007).

Interpretation

A hermeneutic approach therefore acknowledges the inevitability and centrality of interpretation. Van Manen (1997) refers to the explication of a phenomena as it presents itself to consciousness; we do not just study the phenomena (the fallacy of realism) but nor do we just study the consciousness (the fallacy of idealism). In interpreting the lived experience we conduct a 'double hermeneutic' (Smith & Osborn, 2003) between the phenomena, then the person's subjective interpretation and then our interpretation of the subjective interpretation. As Gadamer said "when we interpret the meaning of something we actually interpret an interpretation" (1986, p.68).

This interpretive process is dialectical and dialogical. It occurs through a dialectical encounter as the researcher and 'texts' (including the dialogue with the participants as well as the resulting 'data') are engaged in an active and mutual meaning-making process. We work with the participants' descriptions of their experience which are also a retrospective interpretation as experience is always recounted retrospectively (Van Manen, 1997). As we work in dialogue with our participants and their texts it becomes an intersubjective research process.

The role of the researcher

Hermeneutic approaches therefore modify Husserl's concept of bracketing. Instead of being able to see a world 'out there' more clearly through epoche, this approach focuses on seeing *ourselves* more clearly by attempting to make our understandings, beliefs, assumptions and biases explicit (Van Manen, 1997) in order to then open ourselves up to new ways of seeing. Van Manen argues that if we try to forget what we already know then presuppositions may slip back into our interpretations whereas by familiarizing ourselves with them he suggests we can better hold them aside and even to "turn to knowledge against itself" (p.47).

There is some tension between the idea of epoche and the stance of interpretation. Van Manen acknowledges that phenomenological research "is always a project of someone: a real person,

who, in the context of particular individual, social, and historical life circumstances, sets out to make sense of a certain aspect of human existence" (Van Manen, 1997, p. 31). He also acknowledges the creative, interpretive role of the researcher: "composing linguistic transformations is not a mechanical procedure. Rather, it is a creative, hermeneutic process." (p.98)

Finlay (2009) suggests we see description and interpretation as a continuum and Van Manen also discusses this issue. He draws on Gadamer's (1986) distinction between two senses of interpretation: a pointing to something (illustrating the descriptive nature of the experience) and a pointing out the meaning of something (referring to the interpretation of the experience). While acknowledging that some people believe all description is interpretation, he asserts that the researcher can make a distinction.

My general position is probably more interpretive than Van Manen's in that I am not sure, even with making our biases explicit, we are ever able to hold them aside. However, for the purpose of this study I attempted to engage in a dialectical process of epoche when engaging with the texts, through staying close to the participant's language and working with original descriptions in the findings as well as my interpretations so that the reader may also mediate for themselves.

The hermeneutic circle

Laverty (2003) describes the 'hermeneutic circle' through which the interpretive process occurs as we move from parts of the text to the whole and back again in a way that deepens engagement and understanding. In human sciences research, this can take place through the dialogue we have with our participant as we express ourselves and seek to understand and interpret one another through language and narrative as well as through the circular process of analysis, writing and reflection (Van Manen, 1997). In this approach the researcher is seen to mediate between different meanings (Van Manen, 1997), and to provide a unique interpretation, informed by the unique interpretation conveyed in each of the texts.

3.2.4 My choice of Van Manen's hermeneutic phenomenology

There are a number of different types of hermeneutic or interpretive phenomenological methodology and the one I am adopting is Van Manen's hermeneutic phenomenology. IPA (Interpretive Phenomenological Analysis) is probably the most widely known interpretive

approach to phenomenology today (Langdridge, 2007) and was the other method I most closely considered. However, Langdridge (2007) also considers Van Manen as one of the most complete and popular hermeneutic methods. IPA and Van Manen's hermeneutic phenomenological approaches share some considerable common features, even according to the developer of IPA (Smith et al., 2009, p.201). They are both interested in lived experience and explicating the meaning of this lived experience, they both acknowledge and embrace interpretation (Langdridge, 2007), both work with the data as it emerges by not pre-imposing meaning or structure but engaging with lived descriptions as an act of discovery.

However there are also some philosophical/theoretical and some procedural differences and I have highlighted three significant differences that influenced my choice of Van Manen.

Attempt at a Universal Holistic Essence

Langdridge (2007) identifies Van Manen as within the interpretive school and suggests this approach moves away from the search for essences seen in descriptive phenomenology, a view also taken by Giorgi and Giorgi themselves. Finlay (2009) however, suggests his approach adheres reasonably closely to Giorgi's descriptive phenomenology. Van Manen (1990) suggests that his research approach attempts to straddle both descriptive and interpretive phenomenology, more in line with Finlay's (2009) suggestion that rather than a categorical distinction it can be helpful to view description to interpretation as a continuum.

In my careful reading of van Manen's text (1997), I sensed a greater closeness to some Husserlian concepts and in particular a more nomothetic orientation than in IPA with a focus on trying to identify universal structures of experience and the development of a generalizable meaning "essence" of the phenomenon.

For example, Van Manen clearly states in his introductory chapter that "phenomenological research is the study of essences" (p.10), a seeking for the universal or essential nature of the phenomenon, the 'whatness' that makes something what it is and without which it could not be what it is (Husserl, 1982; Merleau-Ponty, 1962). This essence is a universal that one discovers through the systematic attempt to uncover the structures that govern the instances or particular manifestations of the phenomena i.e. we can only grasp the universal or essence through a study of instances of lived experience.

He returns to this view repeatedly throughout his book, arguing again that "the purpose of phenomenological reflection is to try to grasp the *essential* meaning of something" (p.77, my

italics) and then in his section on seeking meaning he asks 'what is the essence or eidos?' of the phenomena.

This raised a paradox for me in wondering how to reconcile the view that all understanding is historically and culturally situated (Gadamer, 1975) with Van Manen's assertion that phenomenology is concerned with bringing attention to a universal structure and is fundamentally different from ethnographic studies that focus on experience within a specific time, or place, or people?

In re-reading, there emerged some important differences from Husserl in Van Manen's acknowledgement of the role of interpretation in developing this universal essence and his notion that an essence can never get to an "ultimate core" (ibid., p.39). He acknowledges that a complete explanation is an impossible task: "to do human science hermeneutic phenomenology is to attempt to accomplish the impossible: to construct a full interpretive description, knowing that life is always more complex than any explication of meaning can reveal" (p. 18). In my view Van Manen's approach is hermeneutic as he acknowledges "a phenomenological description is always *one* interpretation" (p.31, original italics).

However, it is also clear that this focus on the universal essence is stronger than in IPA which is "invariably idiographic" (Langdridge, 2007, p.108). It Van Manen's view "phenomenology is "neither mere particularity, nor sheer universality" (1997, p.23). However, he moves closer to the nomothetic end of the continuum than I sensed from my readings about IPA, stating that phenomenology aims at "making explicit and seeking *universal* meaning" (p.19, my italics).

One of the ways this manifest itself in reading a selection of papers utilizing IPA and Van Manen was that the Van Manen papers were more likely to include an overarching statement at the start about the essence of the phenomenon before a discussion of themes in line with the IPA papers. I enjoyed this more holistic presentation which aimed to bring together themes into a whole rather than present them solely as parts and which mirrored for me the idea of the hermeneutic circle as I as the reader was then able to circulate between whole and parts.

A Focus on Language: Stories, Writing and Poetizing

Langdridge (2007) outlines two core concerns of Van Manen's approach related to language, which made it an ideal fit for this study and this researcher:

1. That language reveals being within particular cultural and historical contexts – it is situated
2. Understanding emerges through a fusion of the researcher and participant's language through the interview discourse

Language is recognized as central in Van Manen's approach with its strong grounding in Gadamer's (1975) philosophy. Language forms our access point to the world, it is the way we engage with reality and the essential way in which we can seek to understand the world (Gadamer, 1975). Language can be used through conversation to reveal something about lived experience that was previously hidden and through conversation we can move toward a fusion of horizons where we come to consensus in our worldviews (Gadamer, 1975).

There were three ways that Van Manen's (1997) emphasis on language very much appealed to me:

- The focus on stories, anecdotes and metaphors as a way to access the experience and meaning of the lifeworld.
- The emphasis on writing as an act of research
- His appeal to provide a poetizing account.

Van Manen (1997, p.116) states that "anecdote is a methodological device in human science to make comprehensible some notion that easily eludes us" and refers to the way biographers will use the power of an anecdote to reveal the true character of a person which is hard to capture another way (Fadiman, 1985). He regards anecdotes as rather like a poetic narrative which describes a universal truth and lists a number of characteristics and benefits of working with anecdotes. Van Manen (1997, p.49) also discusses how we may understand the meaning people give a lived experience through the metaphors that are used and refers to Nietzsche's view that all language is metaphoric in origin.

Thus while IPA is also likely to ask people for stories of lived experience there seemed to be a particular emphasis here that appealed to me because of my own background in narrative therapy and working as a professional trainer in storytelling in my work as an organizational psychologist.

The focus on language, and in particular, writing, is present throughout Van Manen's approach. He regards research and writing as inseparable: "human science research *is* a form of writing" (p.111, original italics). He places much more emphasis than any other qualitative research

methods on the act of writing and re-writing as a way to engage with a phenomenon and reflect and then show something to the world by bringing an evocative description to the reader that engages them in a conversational relation (p.111). I have a passion for creative writing and frequently use writing as a way to help explore my life experiences and the meaning I give to them. I am aligned with Merleau-Ponty's view that language and thinking are difficult to separate. As he says "When I speak, I discover what it is that I wished to say" (1973, p.142) I have kept an anonymous online journal for the last few years writing about my journey of personal therapy and becoming a therapist and so this approach was a good personal fit for me.

Finally, Van Manen stresses hermeneutic phenomenology as a 'poetizing project'. He quotes Merleau-Pony in saying that his approach to phenomenology tries an incantative, evocative speaking, a primal telling, wherein we aim to involve the voice in an original signing of the world (Merleau-Ponty, 1973). Studies using this approach are therefore "much more likely to involve the use of creative writing in an attempt to bring the topic to life, revealing the lifeworld richly in the telling". (Langdridge, 2007, p.114). The emphasis is not just on the results but the way they are conveyed. "We cannot separate the results from the way they are obtained: there is no summary of punch-line in phenomenological research because like in poetry, the research is the thing. As he states "to summarize a poem in order to present the result would destroy the result because the poem itself is the result" (Van Manen, 1997, p.13).

van Manen speaks compellingly of phenomenology as a call to say something worth saying and argues that the value of a hermeneutic phenomenological text can be judged by the extent it is oriented, strong, rich and deep – a text which has an impact on the reader and invites a dialogic response from us (ibid. p.21). A poetic or creative telling can help evoke this response in the reader. This echoes Heidegger's view that poetic language is the most powerful way of disclosing the world (Heidegger, 1925/1985). Again my selection of Van Manen's (1997) hermeneutic approach also reflects a particular epistemological value of mine that we can come to know things through the act of writing, and especially via more poetic approaches. Ohlen (2003) also discusses 'poetic condensation' of her participants' narratives as a way to allow a more emotional and expressive tone to survive the research process. In reading extensively as I became a therapist I found more poetic, narrative and creative accounts invaluable in fostering my own engagement and understanding of existential philosophy and psychotherapy.

Methodological Openness and Flexibility, With Thoughtfulness

While Van Manen does propose some general research activities, the process of analysis is much less constructed than IPA. His basis in Gadamer means that there is a reluctance to formalize method, with researchers preferring to see method emerging uniquely in the context of the phenomenon being investigated (Langdridge, 2007, p.109). Indeed, Van Manen (1997, p.30) informed by Gadamer even states that "the method of phenomenology and hermeneutics is that there is no method!". Even the six general research activities Van Manen outlines he says are not meant to prescribe or be mechanistic but instead animate inventiveness and stimulate insight. He cautions us not to receive his text as a how-to primer.

Instead of process and procedure, van Manen (2007) focuses more on the approach one should bring to the research, arguing for a scholarly and thoughtful approach (p.34) and that the research process should be informed by our deep, caring stance and strong oriented position towards the research. "Knowing is not a purely cognitive act" (ibid. p.6) and we can only understand something for which we care. This means that the process of bringing a phenomenological text to life is not a mechanical procedure, but a creative hermeneutic process. It is "a process of insightful invention, discovery or disclosure – grasping and formulating a thematic understanding is not a rule-bound process but a free act of seeing' meaning" (ibid. p.79). During the Doctorate I carried out a pilot using a more 'mechanical' qualitative thematic analysis and found myself distanced from the very experience I was attempting to engage with the meaning of and so this again appealed based on personal experience.

Finally, Van Manen's approach reflects some of my values of the researcher – that this research is designed to support my knowledge, personal development and capability as a therapist, and therefore requires my full engagement, as well as to contribute to the broader counselling psychology profession. As van Deurzen-Smith states (1997, p.5): "Our…journey requires us to be touched and shaken by what we find on the way."

3.2.5 Alternative methods

I have already outlined my consideration of IPA above. There were two other approaches that I briefly considered.

One, given my interest in language, was Discourse Analysis. The power of language and narrative as a way we construct our experience resonates with me, as does the notion that through the use of language we do more than convey our experience but also subjectively and intersubjectively shape the experience and our understanding of it. However, the focus on

language and constructionism moves away from a phenomenological focus on subjective experience. While hermeneutic phenomenology pays attention to narrative and language it remains focused on the *experience of a phenomenon* rather than the way the language itself is used to *construct a phenomenon* as would be the cases in more socially constructivist approaches such as discourse or Foucauldian analysis (Foucault, 1969/1982; Kendall & Wickham, 2003; Potter & Wetherall, 1987).

This reflects my general ontological position and the position of this research. I think a Foucauldian inspired discourse analysis such as the approach outlined by Kendall and Wickham (2003) of accounts of the therapeutic relationship and the way the client is constructed in the therapist's narrative would be very interesting. This is because this explicitly looks at issues of power, a core theme in the therapeutic relationship and one perhaps overlooked by therapists themselves (Masson, 1990). However, my interest was in the *experience* of the therapeutic relationship and I did not want to move the focus of my attention and interpretation to concentrate on the linguistics and what they imply about the construction of the relationship. I do however plan to be attentive to language and to not exclude it from my interpretation of the data.

The other alternative research methodology I strongly considered was heuristic research, developed by Moustakas (1997). This approach met some of the criteria for this study formed by the nature of the research question and my own philosophical values: it was qualitative, phenomenological, acknowledged the person of the researcher as central. The researcher's own experience is more prominent in this form of research, as outlined below:

The heuristic process is a way of knowing that starts with the self of the researcher: whatever is within the consciousness of the researcher is an invitation for further investigation – such investigation casting light not just on knowledge about the thing being investigated but also on the self of the researcher:

"I begin the heuristic research with my own self-awareness and explicate that awareness with reference to a question or problem until an essential insight is achieved, one that will throw a beginning light onto a critical human experience" (Moustakas, 1990, p.11).

In research also focusing on emotions in the therapeutic relationship, Lodge (2010) used heuristic research in her investigation of clients' and therapists' experiences of emotional connection in therapy. Her research included accounts and exploration of her own therapeutic experience which is fully in line with Moustakas' view that there is an unshakeable connection

between what is 'out there' and what is "*within me in reflective thought, feeling and awareness" (Moustakas, 1990, p.12).*

Giorgi (1994) argues that work like Moustakas' (1990) use of "self-dialogue" is not consistent with the phenomenological project as the goal appears to be the researcher's own growth and development rather than the explication of a phenomenon (Finlay, 2009). In the end, I decided that I would like to approach this research more focused on my participant's experiences partly due to some hesitation about so fully involving and exposing myself and partly because of my general interest in seeing if it was possible to open up to new possibilities and meanings of the experience of the therapeutic relationship by making explicit my own assumptions and setting them aside, and so hermeneutic phenomenology was a better fit.

3.2.6   Reflexivity

"We do not 'store' experience as data, like a computer: we story it" (Winter, 1988, p.1)

"We don't see things as they are, we see them as we are" (Nin, p.124)

Finlay & Evans (2009, p.21) state that all qualitative research methodologies recognise that the researcher is implicated in the research process to at least some degree. Our worldview, or ways of being in the world, shape our relational encounter with the participant and the data they share with us. Langdridge (2007) states that this "process of recognition of the researcher in co-producing psychological knowledge stands in stark contrast to the tradition of researcher as detached observer in search of some objective truth" (p.59).

Because the researcher is acknowledged to impact the research, the relationship with participants and the emergent data, the researcher engages in the process of 'reflexivity' to develop self-awareness. Finlay (2003a) defines this as "involving sustained critical self-reflection, focusing on the ways a researcher's social background, assumptions, positioning, values, feelings, unconscious processes and behaviour impact on the research process" (p.21). Bolton (2005) similarly defines reflexivity as "finding strategies for looking at our own thought processes, values, prejudices and habitual actions, as if we were onlookers…"(p.7) and "examining taken-for-granted roles and values in relation to individuals, organizations and systems, models and metaphors unwittingly lived and worked by". (p.110)

There are a number of different approaches to reflexivity, depending on its role within the research process. Finlay & Evans (2009) provide a number of examples such as reflexive analysis as part of the 'bracketing' process or to recognise the importance of context and cultural assumptions.

These can reflect different understandings of the role of the researcher. Willig (2008) outlines how different methodologies can see the researcher as either being the 'author' or the 'witness' of their research findings.

In classic Husserlian phenomenology, reflection and reflexivity are designed to facilitate a 'bracketing' of one's assumptions so that the 'transcendental essence' of a phenomena may be revealed. However, in the hermeneutical approach this study will be utilizing, the researcher's biases and assumptions are considered both un-bracketable (we cannot transcend ourselves for we are always part of ourself) and essential to the interpretive process. The researcher's role is expanded rather than reduced with overt naming of assumptions and influences which are embedded in the research results (e.g. see Laverty, 2003).

Willig (2008), somewhat similarly, outlines two types of reflexivity:

1. *Personal reflexivity* – where one reflects on the ways in which personal experience, values, social identities and so on have shaped and are implicated in the research. This also includes how the research might have affected and changed us as people and researchers. As psychotherapists conducting research we may also ask ourselves how the research might have informed and shaped us as therapists.
2. Epistemological reflexivity. This is about reflecting on our epistemological and ontological assumptions about the nature of reality and knowledge, and how these assumptions have implicated our research.

In line with Finlay & Evans (2009) I adopted a middle position in that I attempted to elicit and describe participant's experiences as a witness, but also then also author them by making interpretations about these descriptions. Reflexivity allows researchers to bring themselves into their research and this reflexive analysis occurs both during the encounter and afterwards, e.g. when one may make reflexive notes on the data. There is a need for a reflexive exploration of how the researcher and the research-relationship impact on both the research process and research findings. However, the researcher should be never so preoccupied with their own experience however that they privilege the researcher over the participant (Finlay & Evans, 2009).

I used a number of techniques designed to support a reflexive approach. First, I kept a research diary where I engaged in self-reflection throughout the process. Secondly, I appreciated and utilized Langdridge's (2007, p.59) list of questions designed to encourage a reflexive approach. He suggests the researcher explore these questions before, during and after the research (before the write up). Thirdly, in line with Finlay & Evans' (2009) recommendation, I worked with my research supervisor who is also a psychotherapist to engage with dialogically to support my reflexivity and fourthly, I also collaborated with two peers in this regard: one colleague from the New School whose research followed a similar timeline to mine and one colleague from Regent's College who was also using Van Manen's hermeneutic phenomenology. My peer collaboration was invaluable. While it was not a formal collaboration and the research was both undertaken and authored by me, our conversations and their questions and challenges helped me engage in a process of reflexivity by focusing my thoughts on the purpose, nature and expression of my research.

My perspective is that reflexivity is an ongoing and integral part of the research process in phenomenological research, rather than something that is engaged in and reproduced separately. In line with this I have attempted to weave my reflexivity throughout this paper. In the introduction I answer Langdridge's first two questions about why this study and what I hope to achieve with this research. Throughout this methodology section I engage with epistemological reflexivity in articulating the process of determining my philosophical and methodological position for this research.

Langdridge's next question is about the relationship of the researcher to the topic, and here I will try to articulate some of my own beliefs and biases about the therapeutic relationship. First, I approach this research somewhat as an 'insider' having had my own experiences as a therapist and a client of the therapeutic relationship. However, I also have a somewhat 'outside' perspective in that I am still determining my therapeutic identity, working with tensions between my existential training and a practice which is informed significantly by psychodynamic theory, specifically object relations, attachment theory and relational psychoanalysis and some aspects of humanistic approaches. One of the way these tensions manifest is around the therapeutic relationship, and I was interested to try and understand more existential psychotherapists' experience of the therapeutic relationship and what makes them thus.

Reflexivity: Before the research

My reflexive process about the nature of the therapeutic relationship began before I even started my Doctoral degree and has continued throughout my studies and the research process as I engaged with the participants, their emerging texts and then the description and analysis of data. My personal experience as a client in therapy and tensions in my therapeutic identity between my existential and psychodynamic sympathies led me to this topic.

I have a number of biases and stances towards the therapeutic relationship which informed this research. Personal reflexivity around these brought to light some of my 'core beliefs' or assumptions prior to this project and I have included these in the so that the reader may share in this process (see Appendix 1 – Core Assumptions). Having written them, I then attempted to put them aside for the research.

Reflexivity: During the research

During the research my reflexive processes seemed more oriented around the research method than the topic of the emotional aspects of the therapeutic relationship. Having made some of my biases explicit I attempted to 'open myself up' in "a free act of seeing" (Van Manen, 1997, p.79) to hearing my participant's experiences of the therapeutic relationship.

Towards the end of my research, I found out about Lodge's research on the emotional connection in the therapeutic relationship and felt some regret that I had allowed myself to be quickly persuaded to conduct research with only therapists because of the ethical difficulties in attempting to work with therapist-client dyads, which was my original hope for this research. I also questioned the process of conducting the research by telephone, which I explore further in below.

The other key debate I had with myself, informed by my supervisor, was about the fact that 2 of the research participants were somewhat known to me before the research. I discuss this in the ethics section below.

Like Lodge (2010), while in the midst of the analysis and writing process I found the boundaries between different types of phenomenological methods became less clear. At times I seemed to be coding the data in a manner very similar to IPA and sometimes found myself staying closer to the text rather than looking for the meaning (Van Manen, 1997). Other times, I seemed to

be looking for a meaning behind the experience moving closer to the hermeneutics of suspicion (after Ricouer, discussed in Langdridge, 2007).

I valued the flexibility of Van Manen's approach and made certain changes to the interview guide after my first two interviews. Van Manen (1997) states that such openness and flexibility in human science research: "A certain openness is required in human science research that allows for choosing directions and exploring techniques, procedures and sources that are not always foreseeable at the outset of a research project" (Van Manen, 1997, p.12).

In the discussion I have included a section on my personal reflexivity emerging after and as a result of the research.

3.3   Section 2: Research Design

While eschewing prescriptive methodological technique, Van Manen (1997, p.30-31) outlines a six step methodological structure which I adopted for this study:

1. Turning to a phenomenon which seriously interests us and commits us to the world
2. Investigating experience as we live it rather than as we conceptualize it
3. Reflecting on the essential themes which categorize the phenomenon
4. Describing the phenomenon through the art of writing and rewriting
5. Maintaining a strong and oriented [pedagogical*] relation to the phenomenon
6. Balancing the research context by considering parts and whole.

*Langdridge (2007) puts brackets around pedagogical as this reflects Van Manen's focus and I am in line with him in wishing to replace this with 'psychological'.

3.3.1   Sample and recruitment

This study was performed using purposive and homogenous sampling (Langdridge, 2007) to ensure they share the experience of the phenomenon of the therapeutic relationship in existential psychotherapy.

Criteria for the eight participants was that they should identify themselves as some form of existential psychotherapist, be highly experienced (defined as 10 years and over for the

purpose of this study) and currently be in some form of clinical practice, and therefore have current lived experiences of the therapeutic relationship.

This sampling strategy is driven by research evidence suggesting that experienced therapists may practice somewhat differently from novice therapists, and that a personal relational style becomes privileged over adherence to 'schoolism' or technique (Stein & Lambert, 1995). Experienced therapists are also ideal participants because of their greater length and depth of experience of the pluralistic possibilities of the therapeutic relationship.

Based on the aims of this study and the literature review, the most significant characteristics of my sample are that they should be existential in training/orientation and have experience. As this study is a qualitative phenomenological inquiry, I am not seeking to standardize or generalize findings to a particular cohort of therapists and thus other characteristics (e.g. therapist age, sex, race) will not be used to further refine sampling criteria. Furthermore, literature on therapist effectiveness as summarized in Duncan et al. (2010) has shown that demographic variables such as age and gender do not account for variability among practitioners.

The existential training/background and experience of the participants comprised:

- All 8 participants working currently as existential therapists and supervisors
- 6 of 8 participants working as teachers and/supervisors on existential psychotherapy training courses
- 4 of 8 participants published papers on aspects of existential therapy
- Existential training and teaching affiliations including: New School of Psychotherapy and Counselling, Regent's College, Metanoia Institute, Saybrook University, Existential-Humanistic Institute of San Francisco, Fordham University
- Professional existential affiliations included: Society for Existential Analysis, Heidegger Circle

Van Manen does not indicate a specific sample size for his method. Haase (1997) states that 6-12 is typical and Smith, Flowers and Larkin (2009, p.52) recommendation between four and ten interviews. (Given the considerable overlap between Van Manen's approach and IPA, I have used some of the more detailed information from Smith et al (ibid) to help inform my approach where this information was not as forthcoming/prescribed in Van Manen). I had originally proposed 6-10 in my research proposal but was advised that for the purposes of the fulfilment

of the Doctoral degree I was required to have a minimum sample size of 8. Smith et al. (2009, p.52) state that it "is important not to see higher numbers of being indicative of 'better' work".

Following ethical approval, participants were recruited via the New School for Psychotherapy & Counselling staff contacts list and through contacting registered existential therapists. One of my eight participants was identified via a 'snowball' approach having been put in touch with me via a previous participant. Potential participants were contacted originally by email which briefly outlined the research and stressed the voluntary nature of participation. A research information sheet was attached to the email (see Appendix 5) which outlined the research details and time commitment required, stressed the voluntary nature of the study and the ability to withdraw at any time should they proceed and detailed confidentiality arrangements. Participants who responded that they were willing to participate were then sent a second email which included a consent form and a copy of the interview guide to ensure their comfort in participating (discussed in the ethics section below).

Given Cooper's (2003) delineation between the British and the American schools of existential psychotherapy and as a resident of America at the time of the research, I was interested in a variety of voices and my final sample consisted of 6 participants who live in the UK and 2 in America.

All interviews took place over the telephone at a date and time of the participants' choosing. The rationale for this was primarily pragmatic in that it would have been difficult to schedule all the interviews face to face when I was in England, therefore for consistency I decided to do them all by telephone. I am an experienced telephone researcher from my work as a management consultant, however it seems this is less typical in qualitative research in psychology and psychotherapy. Novick (2008) suggests there is a bias against telephone interviews in qualitative research and discusses the view that absence of visual cues may result in loss of contextual and nonverbal data and to compromise rapport, probing, and interpretation of responses. In contrast, telephone research may allow respondents to feel relaxed and able to disclose sensitive information. She concludes that evidence is lacking that telephone research produces lower quality data. In one empirical study to investigate this Sturges and Hanrahan (2004) compared telephone and face to face interview transcripts in qualitative interviews and concluded there was no difference and the telephone is therefore suitable for qualitative research. Given this, I felt it acceptable to proceed with telephone interviews.

All interviews were digitally recorded and the digital recordings were securely stored. Some of the digital recordings, with express permission from participants on a separate section of the consent form, were professionally transcribed using a firm that regularly conducts legal transcription work. These recordings were sent via encrypted files and a confidentiality contract was agreed with the professional transcription agency that included their permanent deletion of the files following confirmation from me of acceptable transcriptions. These professional transcriptions were all edited and finalized by the researcher. The other recordings were transcribed fully by the researcher. The interviews typically lasted around 60 minutes, with one shorter interview of 39 minutes and two which ran to 75-80 minutes.

3.3.2   Data collection: Interview guide and process

Langdridge (2007) states that there is more flexibility with the interview process in Van Manan's hermeneutic phenomenology than with IPA. As a result interviews were designed to be loosely semi-structured, starting with an open question about the therapist's lived experience of the therapeutic relationship in existential psychotherapy. This was designed to be as open as possible so that I could see what came up first for the participants and also to ensure further questions specific to the emotional aspects of the relationship were grounded in a sense and context of the experience of relationship as a whole.

After the experience of my pilot interview, and with supervisory feedback I modified the guide to include some initial questions about the participant's background and what drew them to existential psychotherapy and how long they have been practising. On the advice of my supervisor, I also included a question about whether they identified themselves as being informed by any particular school of existential therapy (after Cooper, 2003) or aligned with any particular existential author. This served to help inform the analysis but also to put the participant and myself more at ease which felt particularly important in conducting research via the telephone. A copy of the final interview guide is included in Appendix 6.

The material from the first interview was regarded as a pilot but was still seen as valuable for the research as a whole despite subsequent modifications and was incorporated into the data with my supervisor's agreement.

Van Manen (1997, p.67) does provide specific recommendations about the design and process of conducting interviews which I followed. He cautions that we should stay close to an experience as lived and ensure interviews contain sufficient concreteness in the forms of stories and examples of experiences. Therefore I included questions to elicit specific anecdotal

examples, for example, "can you describe your experience of a *particular* therapeutic relationship, session or moment where you and a client had an intense emotional connection together?". Alongside these questions about experience I also asked "is there a metaphor that comes to mind that conveys something of the therapeutic relationship in existential psychotherapy?". These questions are designed to elicit narrative ('can you tell me a time') and metaphor as Langdridge outlines Ricoeur's views that "it is through these two forms of discourse that we witness the creation of new meaning" through synthesizing parts and creating new attributions (2007, p.51).

One question I asked was not experientially oriented which was "is there anything unique about the therapeutic relationship in existentially informed psychotherapy?". As I was not coming back to my research participants later during the research, this was an opportunity for them to offer reflection and interpretation. It was also of interest in helping to elucidate the 'whatness' of the therapeutic relationship in existential psychotherapy as opposed to what it is not.

As a novice phenomenological researcher, it is clear to me that I became somewhat more skilled throughout the interview process and more adept at eliciting descriptions of lived experience, whereas my first interview moved more into a reflective conceptual realm. Van Manen (1997, p.63) states that the two acts of 'gathering' and 'analysing' the data are not really separable and that the conversational interview may serve either to mainly gather lived experience material to serve as an occasion to reflect with the partner depending on where in the research process it occurs.

3.3.3   Data analysis: Reflecting on the essential themes which categorize the phenomenon

In analysing and working with the data I felt torn between desires to try and codify the data to some extent – to keep it neatly within a small number of themes, to count the instances of a theme appearing and Van Manen's more artistic focus on evocation. Van Manen (1997) states that the project of phenomenology is not to translate (reduce) the primordial relation of [of parenting in this example] into clearly defined concepts so as to dispel its mystery, but rather the object is to bring the mystery more fully into our presence (Marcel, 1950). The phenomenon is a mystery in need of evocative comprehension, not a problem requiring solutions.

He suggests there are three approaches to uncovering thematic aspects of a phenomenon in some text (p.93):

i) The wholistic or sententious approach where we ask 'what sententious phrase may capture the fundamental meaning or main significance of the text as a whole?'

ii) The selective or highlighting approach where we ask 'what statements or phrases seem particularly essential or revealing about the phenomenon or experience being described?'

iii) The detailed, line by line approach where we look at every single sentence cluster and ask what it reveals about the phenomenon being described.

Informed by this delineation, the process I followed is outlined below.

First I worked with the transcriptions, listening to the recording and reading the printed version a number of times allowing myself to be surprised or notice things but avoiding a desire to start classifying so that I would remain as open as possible to all the texts.

Next, I commenced with a more formal analysis. For my first two interviews I started with a detailed line by line approach, analysing the data in Microsoft Excel and developing a number of 'topics' and initial 'themes' under a column headed 'what does the sentence reveal about the nature of the therapeutic relationship in existential psychotherapy'. While I kept the topics consistent for easy sorting of the data, I allowed the themes to remain unstructured so that I could see the variety and nuances of what was emerging around each topic as I creatively interpreted how best to represent them. For a number of the sentences I also added a description in my own words – this was less interpretive than the 'theme' and I only did this where it seemed a necessary intermediate step. An example of this is included in the table below.

Figure 2 - Anonymized transcript excerpt

Verbatim	Topic	Description	What does sentence reveal about the nature of the TR in EP?	Notes/Thoughts/Questions
It's the kind of being or not doing. Umm, I don't think being an existential therapist is *just* about being with a client because you're being there. You're... you're being paid and you're being there in a particular umm, job which is to help a client make sense of their own dilemmas and their own world view. And so my listening is... is different to how I might listen with a friend or ummm, yeah, I'm much more attentive and much more focused to hearing...	Therapeutic Relationship	The therapeutic relationship is a lot about being not doing. But it's a particular way of being that is focused and attentive on the client.	Therapeutic relationship is a particular kind of 'being with'.	Being not Doing but not just being: a special kind of listening.

Next, I switched to doing a more selective reading approach to move up from such a granular level of analysis and went through each of the transcripts one by one and extracted what I considered to be significant statements about the research topic, removing all bits that were not relevant, and taking out 'ums', 'errs' and repetition. I printed the condensed transcript (i.e. solely consisting of the significant statements) for each participant on clean Word documents

before then returning to complete the remaining line by line analysis for each participant in Excel.

This process and the outputs of a detailed Excel file with a more selective collection of word documents supported me in the hermeneutic circling between part and whole. I continued this circling through my analysis process alternating working with the topics and themes and then with the narratives of significant statements.

Working at a narrative level helped keep me close and oriented to each participant's experience. I was conscious of Van Manen's view that a phenomenological text should be more than a journalistic report of the themes identified but should elucidate lived experience, which according to Van Manen (1997, p. 27) "the meaning of which is usually hidden or veiled".

Van Manen (1997) spends time discussing the nature of phenomenological themes. He states:

"Phenomenological themes are not objects or generalizations; metaphorically speaking they are more like knots in the webs of our experiences, around which certain lived experiences are spun and thus lived as meaningful wholes" (Van Manen, 1997, p.90).

3.3.4 Data expression: Describing the phenomenon through the art of writing and rewriting

Given my appreciation of writing as a form of research and understanding, I decided to write in a number of ways that also fostered the hermeneutic circling between part and whole. This included:

- *Statement of results.* Based on the development of the topics and themes , along with my understanding of each individual's experience, I then developed an overarching statement of results in order to write out what it was I believed I was seeing across all or the majority of the interviews. This provided a nomothetic and somewhat reflective perspective.
- *Narrative statement of results.* After Willig (2007) I provided a narrative consolidation created as an integrated articulation using verbatim statements from all the participants. This, also nomothetic, was designed to give a more experiential and less reflective perspective.

- *Thematic analysis.* Turning to the detailed analysis file I then sorted, alphabetised and consolidated themes within each of the topics and went through both an inductive and deductive process to develop emergent themes. In the end I had 5 super-ordinate themes without which the phenomenon would not be the same. Within these themes were subthemes which reflected less common perspectives but still seemed important to the individual's attempt to make sense of their experiences (Smith et al., 2009, p.79). This provided a thematic perspective.
- *Poetizing analysis.* Sadly, I am not a poet! However inspired by the attempts at poetic narrative in Willig (2008), Ohlen (2003) and Rodriguez (2009) and impressed with the experiential resonance they evoked in me I then attempted a number of poetic 'condensations' following Ohlen's technique. This provided a poetic perspective.

3.3.5 Ethics

As a member of the British Psychological Society (BPS), I worked in accordance with their code of ethics and conduct (2009), including their ethical principles of respect, integrity, competence and responsibility. Langdridge's discussion of key ethical issues (2007) including consent, confidentiality, protection from discomfort and harm was also helpful to me. This research study was granted ethical approval by the New School of Psychotherapy and Counselling's and Middlesex Psychology Department's Ethic Committee. (Appendix 2 – Ethical Clearance and Appendix 3 -Risk Assessment).

Participants were given full knowledge about the nature of the research during the process of recruitment, and there was no deception involved. The information sheet and consent form, plus my availability to answer any questions, aimed to ensure informed consent. Participants were reminded of their right to withdraw their consent at any stage of the research process – including withdrawal of their data following the interview process. (Please see Appendix 4 - Consent Form and Appendix 5 - Personal Information Sheet.)

All information gathered from the participants will remain confidential and in some cases where specified by the participant or where I believe details could identify them I have anonymized details within the data extracts. The information sheet explained what would happen with the digital recordings of the interviews and the transcripts, which involved their confidential storage and disposal after the confirmation of my doctorate.

The BPS guidelines are explicit in making the researcher primarily responsible for protecting participants from mental and physical harm. Investigating personal experiences of the therapeutic relationship may be considered a 'sensitive' issue, especially given the sometimes intense emotional experience of this relationship and that I was directly asking therapists about their emotional relationships with their clients. While psychology has been guilty of past ethical abuses, Langdridge (2007) discusses the risks also inherent in "unwarranted and unnecessary" (p.61) increases in ethical concerns at the cost of research itself, driven by "paranoia about human fragility"(p.61) and a fear of litigation.

There is a strong case of researching sensitive areas such as the therapeutic relationship when this has been shown to be so instrumental to therapeutic success; however it is my responsibility to protect participants from mental harm and to support this I undertook a number of steps including only selecting experienced therapists who have more tenure in working with and managing therapeutic relationships and have been through the process of counselling themselves, sending the interview guide in advance as recommended by Langdridge (2007), debriefing with participants at the end of the interview.

Laverty (2003) states that the interview process in hermeneutic psychology demands "safety and trust, that needs to be established at the outset and maintained throughout the project" (p.19). Interviews are an interactive process that take context within the place of a relationship, so I am ethically behoven to support the creation of a safe, trusting and caring relationship both to ensure no discomfort and harm comes to my participants as is my duty within BPS rules, but also to facilitate ethical generation of valid data.

Two of my eight participants were somewhat known to me. One had briefly been a class teacher on my Doctoral studies and one I had briefly worked with as an existential supervisor. This raises a question of ethics and whether there are any methodological implications. The person who had briefly been my supervisor I contacted via email with the option of participating as a pilot participant as the research was on a topic we had discussed in supervision. After the interview, he had the choice to remove the pilot data from the research if he wished but we both felt it had been a useful interview and he was willing for his data to be included. The person who had been my teacher for 1 week responded to an email for participants from the school contact list. Other than the pilot element, both participants had the same process and structure of informed consent and confidentiality. One could wonder whether the participants felt any pressure to participate given they were known to me despite the fact the email was phrased as an inquiry. I would partly respond to this by turning to the philosophical foundations of this research in that at its very heart it was about relational

matters and designed to be situated. This reflects the way some other phenomenological work has been done within the context of existing relationships e.g. Yalom's twice-told tale (1974) and in sociological and anthropological research traditions such as participant observation.

One of the limitations of my approach as currently proposed is that I have not planned to return either transcripts or my interpretive analysis to participants for further comment after the initial interview. King et al. (2008) state that by involving their research participant in this way they strengthen the trustworthiness and ethical base of their research. Willig (2007) also returns to participants with her final statement for a 'validation' process and Finlay and Evans (2009) outline multiple examples of this more dialogical development of the output. This raises the question of what specific ethical considerations need to be made for hermeneutic phenomenological research. What is ethical from a positivist perspective (e.g. no researcher 'bias') is unethical or at least inauthentic when one is informed by Heideggerian phenomenology and believes that it is impossible to separate self and object since phenomena emerge at the interface between self and world.

While it is ethical to identify and explicitly elucidate on my own assumptions within hermeneutic phenomenology, there is a balance to be struck as it would also be unethical to privilege my own experience over that of my participants. Laverty states (2003) it is "necessary to account for one's position and trace one's movement throughout the research process using a hermeneutic circle". Finlay and Evans (2009) devote a chapter to the issue of 'relational ethics' and acknowledge that in relational centred research where participants are closer to participants, there are specific ethical considerations.

One further point worth stating is that in using Van Manen's (1997) approach in particular writing itself becomes an ethical act as he believes this forces one into a reflective attitude through which the production of meaning occurs. One of the advantages of this approach is its ability to utilize emotive expressions to bring insight. Van Manen (1997: p.353) states "Evocation means that experience is brought vividly into presence so that we can phenomenologically reflect on it".

In presenting phenomenological research, one has to demonstrate that a definitive interpretation is never possible, and acknowledge other possibilities. Rigor, trustworthiness, credibility and authenticity are indicators of ethically sound phenomenological research practices (Laverty, 2003). Part of being an ethical hermeneutic phenomenological researcher is a full commitment to the research process and the ongoing task of self-reflection and reflexivity that this paper has stimulated.

3.3.6   Study quality

Guidelines for validity and reliability are more complex in qualitative research, and in particular using interpretive hermeneutic methodologies that see knowledge and reality as always subjective. Applying the language and positivist conceptualizations of validity and reliability to phenomenological studies is problematic.

Reliability in the sense of being able to repeat results is not an aim (Finlay & Evans, 2009). There is a clear acknowledgement in Van Manen's (1997) hermeneutic phenomenology that it is one interpretation provided, and in the qualitative field more broadly that what emerges is the product of the specific interpersonal and social context.

It is however important to address the issue of validity: whether the research truly measures that which it was intended to measure or how truthful and credible the research results are.

Given the different paradigmatic assumptions of qualitative research, attention has focused on developing criteria for high quality research in *qualitative* inquiry and a number of different models have been proposed (e.g. Lincoln & Guba, 1985; Bochner, 2000, 2001; Yardley, 2000, 2011; Polkinghorne, 1989; Finlay & Evans, 2009). I found these models fairly similar although there is some variation in their emphasis with, for example, Lincoln & Guba's model aligns most closely more quantitative approaches whereas Bochner's views include the moral and ethical quality of the study in ensuring underheard voices are represented.

I was informed most by Finlay & Evans and Yardley in this research.

Yardley (2011)	Finlay & Evans (2009)
- Sensitivity to Context - Commitment and Rigour - Transparency and Coherence - Impact and Importance	- Rigour - Relevance - Resonance - Reflexivity

Rigour is about the thoroughness of the research and is practiced in this study through the extensive focus on the philosophical and methodological basis of my work and opening this up

to review and audit by my supervisor and peer supervisors and through the inclusion of extensive participant material within the results. This also addresses the issue of transparency.

Relevance concerns the value of the research in terms of its applicability and contribution. It is not possible for me to judge the value of the research, but by carefully selecting a research topic that has been deemed vital for success in psychotherapy and also under-researched from an existential perspective I hope to be able to offer something new to the field, and I have attempted to draw out a number of the implications of my research in the discussion.

The impact or resonance of the research is a central value of Van Manen (1997) whose focus is on brining the phenomenon vividly into presence in order to evoke reflective responses in the reader such as wondering or questioning and bringing them to a new understanding. His 'model' of study quality is that the research should be strong, oriented, rich and deep, in order to have an engagement with the reader (1997). Bochner (2000, p.244) also addresses the concept of resonance as "what moves the reader at an emotional as well as a rational level". For Finlay & Evans (2010) resonance also includes whether the results resonate with readers' own experiences and understanding in what Van Manen (1997) refers to as the validating circle.

My attempts at a creative as well as a thematic presentation of results are one of the ways I hope to make my research resonate. Conversations with my supervisor and peer supervisors will also help guide me towards presenting a resonant response as they are existentially informed therapists themselves.

I have already addressed my own reflexivity above and throughout this report and hope that this demonstrates my self-awareness and openness and careful consideration of my own subjectivity, also supported by the dialogical conversations I have had about this research with my supervisor.

4 Results

4.1 Introduction

I approached my analysis and presentation of the results both holistically and thematically.

My experience reading phenomenological research was that papers presenting purely thematic analyses missed taking a broader view across the phenomenon on which they were researching. You were only able to look at the phenomenon in sections and not in the round. Therefore the holistic description is designed to capture the overarching sense of the quality and nature of therapists' experiences of the emotional aspects of the therapeutic relationship. It brings all the themes together.

Informed by Willig (2007), I created two forms of holistic description or 'final statement' informed from all the participants' transcripts. The first version is a statement that constitutes my attempt, in my own words, to provide an overarching summation of therapists' experience of the therapeutic relationship in existential psychotherapy. It is included in Appendix 7 – Essential Statement of Results.

The second holistic summary is a consolidated 'poetic' narrative that uses a selection of all the participants' verbatim statements to convey the dimensions of this experience. This ensures the presence of the participants' voices in giving a holistic view, and is included below.

This is followed by a more detailed thematic analysis, based on the following five major themes which were identified:

1. The relationship is the therapy

The therapeutic relationship is seen as the fundamental feature of existential therapy. It is a relationship of openness and being with that creates the ground for a mutually emotional encounter.

2. Emotions matter - feeling is first

Therapy is an emotionally powerful experience for both therapists and clients, and, according to the therapists, it is this emotional experience that is healing for clients. The emotional landscape is complex, dynamic, relational and challenging – a tangle of both the therapist's and the client's emotions that continually shift as they interact and relate with each other. The therapist offers the client a unique emotional bond.

3. Emotion work – applying emotional wisdom

The therapist actively attends and works with this emotional complexity using focus, courage, skill and discipline. The conscious, deliberate and careful reflections and judgments about their own and their clients' emotions reflected a sense of emotional responsibility and the application of a sometimes implicit but always present 'emotional wisdom'.

4. More than words - emotions are embodied

A central part of this emotional experiencing and emotional wisdom is the embodied experience of emotion. Therapists listen with their bodies and use their bodily wisdom in the therapeutic relationship.

5. The dance of therapy and moments of meeting

There is a rhythmic ebb and flow in the dynamic emotional relationship between therapist and client. As they dance towards each other, 'moments of meeting' may occur when they feel fully emotionally connected with each other. In these moments, the therapist also feels connected to humanity – by connecting to one other, we connect to all others.

These themes are all inter-related, with recurring motifs, but are presented separately in order to bring the reader's attention to defining characteristics of the experience of the affective therapeutic relationship.

Throughout the thematic analysis I include a number of poetic condensations (after Ohlen, 2003) which aim to both bring the sentiment of the results to life in a more evocative manner, and to provide a more idiographic view of the participants. The poetic condensations were made from the sections of the interview where the participant was sharing stories of real therapeutic relationships they have experienced (as opposed, for example, to more reflective

sections where they were describing their experience or understanding of the therapeutic relationship in general terms.) These are spread throughout the results chapter and capture actual lived experiences of therapeutic relationships from which readers can see the themes enacted.

Key to Verbatims:

…   natural pause in conversation

--   omission of text in order to abridge quotation

[text]   insertion of text to provide context

Stress   word or phrase emphasized by interviewee in original audio recording

4.2   Holistic Narrative Description

This description is composed entirely of verbatim comments from the participants and is designed to summarise and reflect at a high level all the super-ordinate themes that emerged. This description is designed to be evocative, to stimulate and arouse the reader's interest for the detailed analysis that follows.

It really is the relationship that ultimately heals.

It's life saving, in the sense of existence saving. When I'm working with someone it seems to me that what's useful is that we are simply being in relation in a slightly more aware manner in a way which is primarily focusing on assisting the other. We're just two humans in a room and you're trying to be the best kind of human you are in service of the other. That seems to me almost to sum up existential therapy. You're just being with. I'm not hiding behind theory or any technique that is distancing, the essential thing is this not knowing things, because you never know, do you?

I take my cue from ee cummings, the American poet, who once wrote 'feeling is first'. The healing work of therapy happens at the emotional level; this emotional connection is healing in itself irrespective of the work that's going in as well in therapy. It is more effective if the client, you know, is experiencing emotions in the room rather than just talking about things. There's a

deep desire for the human being to connect with the other and when there's an open field for it and there's a sense of safety and security. But there's has to be this container and the client has to feel it and it's built over time, it just simply doesn't happen.

We are all relating in an emotional way to each other all the time; feelings are being co-generated, feeling is not something in me, it's not something in the client, it's something between us. So, it's not necessarily me having really strong emotions or really powerful things. But it's like the whole kind of texture and flavour of what's going on. I'm checking up on where I'm emotionally before I see the person and then pretty much from the moment the person comes in to the room until the person leaves the room, I guess I'm sort of moving in and out of the dialog we're having. My reading of it is of course different than the client's but it's that rich, there doesn't have to be one reading that is correct, but that it's a source of guidance for the verbal.

We can't be afraid. I need to do this more but what always helps is talking about the relationships, what's happening now and sometimes it's having the courage to do that and I'm not always feeling courageous. One of the things that was so striking to me about beginning to work with Irv [Yalom] was his willingness to risk asking his client you know, how are we doing now? And what was good for you about the therapy and what was difficult and what didn't you like? And I think that without that, the therapy has a deadness to it because there's sort of an unspoken agreement. We won't go that those negative places. Opening it up just keeps everything very, very fresh. Always for me is how much to bring, how much of that do I bring into the room is going to be useful?

If we can tolerate it and we hold it and we invite it and we make it it's okay then we're promoting the person to work through it and go to a deeper level and that's that deeper level of experiencing. And so because existential therapy values this being alive in the room, that, I think that what makes it so, so effective really. It's not a talking about. It's about what's happening right now between you and I.

What immediately comes to mind is a sense of intimacy, connection with the other that everything else fades away and words don't really have to be spoken. There's such a connection in an unspoken way. I'm listening with my body rather than just simply my ears or whatever and I'm very aware of the sort of subtle changes in my body as the discomfort or comfort ebbs and flows and as the client pulls away from me and as the client comes closer and closer to me. I'm very, aware of what's happening to me physically in that space. And sometimes that can feel very emotional in the sense that I might feel overwhelmed and I might even feel tears if

something terribly sad is being spoken about. I let myself be guided by those feelings to understand what is probably happening in this emotional field, this embodied field, what Merleau-Ponty calls flesh that connects us.

It feels for that 50 minutes, I usually have no sense of time, there is no awareness of nothing else existing really in that moment except her and me in the room, talking about what we're talking about. It almost reduces my world into just that relationship at that time. I'm really involved and usually feel very energized and very connected. In that moment, you are not thinking at all, you're just being with. The sense I got, without sounding too mystical, was a sense of total wonder. Buber's notion of that sort of I -Thou experience perhaps sums it up quite well. When I feel like that with some clients, there's something connecting to humanity about it. I've not actually put that in words before. But I do have a strong sense of being alive in the world with her, with people... with this world of ours full of people and it's crystallized I think when... when you're really connected with someone. I don't think anything quite better has been said than what Irv has said, that we're fellow travellers.

4.3 Thematic Analysis Overview

The table below provides a breakdown of each of the sub-themes within the five major themes.

Figure 3 – Thematic Analysis Overview

1. The Relationship is the Therapy	2. Therapy is an Emotional Endeavour	3. Emotion Work: Applying Emotional Wisdom	4. More than Words: Emotions are Embodied	5. The Dance of Therapy and Moments of Meeting
• It is the relationship that heals • A relationship of openness • Being not doing, being together • A unique experience • Attending to relationship	• Emotions matter – feeling is first, both powerful and important • Emotions in the therapeutic relationship are complex, dynamic and relational • The therapeutic relationship offers a unique emotional bond • Emotionally challenging too!	• Building a safe therapeutic space • Finding the courage to feel • Working with their own emotion • Bringing the relationship into the here and now • Working with the client's emotions • Learning emotional wisdom	• Opening the body • Feeling it in the body, seeing it in the body • Bringing the body into the room • The power of the gaze and being seen • Touching on the tricky topic of touch • Relating beyond words – the body knows best	• The dance of therapy (rhythm in relation) • Therapists' experience of connectedness • Moments of meeting: clients' experience of connectedness • Identifying with the client • Connecting to humanity

4.4 Major Theme 1: The Relationship is the Therapy

"It really is the relationship that ultimately heals" – Phoebe:312

Sub-Themes:

- It is the relationship that heals
- A relationship of openness: opening to the other, in service of the other
- Being not doing, being together
- A unique experience
- Attending to relationship

There is a particular kind of relationship that the therapist attempts to create with her client and the emotional dimensions of the therapeutic relationship, and therapists' experience of this, occur within this context of this specific type of relationship. This theme emerged from all the interviews.

This existential therapeutic relationship is seen as being unique: unique compared to non-therapeutic relationships, unique to every client and possibly unique compared to other types of therapeutic relationship. This relationship is also seen as vital for the therapy to succeed, and as a foundational base for all other aspects of the therapy. It is seen as having particular characteristics that foster the experience and expression of affectivity. One understands the emotional dimensions of the relationship therefore within the context of the therapeutic relationship.

4.4.1 The relationship is the therapy: It is the relationship (that heals)

All the therapists described prizing and prioritizing the relationship they have with their clients. It is seen as being the fundamental basis of existential therapy, as Donna expresses:

Tim talks about how this fundamental way of relating to the client is always present, even if he is working with a particular tool or technique.

> *"Even when I'm doing other things like dabbling in CBT or cognitive analytic therapy because I think the relationship is fundamental, well healing is difficult word but the fundamentally useful aspect of what I'm trying to do with someone else, the existential and the phenomenological is pretty much invariably present."* - Tim: 41

Susan concurs: *"I think the emotional connection is healing in itself irrespective of the work that's going in as well in therapy."* (251)

Some of the therapists described what it was that was healing about the experience of this relationship. Neil, for example, describes the impact of his own therapy, stating that the relationship was *"life saving, in the sense of existence saving"* (215) and was extremely powerful in giving him a sense of being taken seriously and an experience of re-validation. He, along with others, talks about how this experience and relationship is hard to describe but that

you know it for sure when you have experienced it and '*it sticks*'. For Orla, she describes how some of her clients have their first experience of a safe, warm and 'loving' relationship with her. Phoebe also states that "*it really is the relationship that ultimately heals*" (312), and that this is by providing the client with a relational *experience* that is intimate, close and safe. The essential experiential aspect of this relationship was stressed by a few of the therapists, and meant that the affective components of the therapeutic relationship were vital. The emotional experience will be discussed in the next theme.

4.4.2   The relationship is the therapy: A relationship of openness - opening to the other, in service of the other

Following their conviction that the therapeutic relationship is the fundamental part of therapy, the therapists described an attempt to create this relationship in the room by opening up themselves to the client and opening up the space in the room. All the therapists described the experience of openness in the therapeutic relationship in existential psychotherapy. Tim saw this as a defining characteristic:

> "*If you can hold yourself open to relationship in a way which is primarily focusing on assisting the other then that seems to me almost to sum up existential therapy*" – Tim:153

Neil also saw this as central. Each of the interviewees was asked if there was a metaphor, a word or image that for them conveyed something of their experience of the therapeutic relationship, and I will share these throughout this findings section. He stated that the metaphor of openness worked for him – the idea and sense of an opening and openness for the client, for the therapist and the relationship between them.

This openness is a particular *way* of being that the therapists bring into the relationship.

> "*Every relationship is different so ummm it's a bit… all I can is say is I am coming to my work with an attitude. That is quite open. And sometimes you, you will get somebody who can respond to that.*" - Karin:45

Richard and Karin discussed the idea that this openness also allows the client to notice and meet themselves in new ways.

"For me, that… yeah, that's what therapy is about. It's giving somebody the space to meet themselves in ways that they've not done before quite often or ways in which they've been too frightened to in the past."- Richard:333

Orla describes how a key part of this is that she remains herself in the relationship and is present and engaged as she would be in non-therapeutic relationships. A number of therapists echoed this experience of being in the relationship in a way that was not distancing and created closeness between the therapist and client.

Three of the therapists described actively seeking closeness and intimacy. Tim states that in his attempt to be present and engage with the client he is seeking to ideally have an encounter which he describes as similar to Buber's notion of I-Thou experiences, although he states this doesn't always happen. Phoebe states her intention is to build an intimate relationship and she sets out to do this with each new client and Richard described actively trying to bring the other person into contact with him through his presence.

This openness to the other is accompanied by a particular stance of the therapist in which they are focused on the client. Orla states it as: "*I want to serve. I want to be of service to that person*" (*168)*. Some of the therapists explicitly discussed how this influenced their way of being in the therapeutic relationship compared to other relationships including an attentive listening, an attempt to suspend judgment and a willingness to enter into and tolerate relationships that the therapist would avoid or challenge outside of the therapy room. Orla for example describes working with an adult client who sexually abused children and how she would not have had the same relationship with this person in a non-therapeutic setting.

"I become less judgmental… I become more open. I become less willing to categorize whereas it's very easy for me to do that in the world in general because it's… it's easy to -- refer to somebody either as a paedophile or as a criminal or whatever it is. You know, just to greet people and not experience them individually. So -- when I did work with somebody who had sexually abused children, young children when he is an adult male, I have to experience him as a man who chose to behave in a particular way -- it gave me an opportunity to try and understand him and be open to his humanity and that… -- that would not have been something I would have been… allowed myself to be exposed to in the world in general." - Orla: 164

4.4.3   The relationship is the therapy: Being not doing, being together

An important part of this 'openness' was the absence of specific goals and techniques and an avoidance of '*doing to*' the client in favour of '*being with*'. This relationship was seen as co-created and of some mutuality (although non-reciprocal in that it was focused on the client).

Alongside opening themselves to relationship, therapists described an experience of keeping the space open for the client by placing no expectations on the client and by not trying to present themselves in any particular way to the client. This space was described as allowing new possibilities to unfold and freeing and 'making way' for the client, rather than stepping in in a 'helping' way which actually reduces the agency of the client. Neil states:

> *"I can be most to the patient by being nothing to the patient which um, I can be anything to the patient by being nothing to the patient, that's the best way of saying it." – Neil:23*

Some of the therapists described the fact that this openness and space encapsulated their approach, i.e. there was no 'doing' of anything more than this but a sole focus on presence and engagement with the client. Phoebe emphatically states "*you're just being with" (114)* and Susan states "*we are not going to apply theory at all" (27).* For these therapists this manifest itself as what I started to think of as 'the naked therapist' and its significance became apparent in subsequent discussions about the emotional dimensions of therapy because of the sense of vulnerability and exposure of the existential therapist in the room. Orla states "*I'm not hiding behind theory or any technique that is distancing*." *(14)*

This sense of 'being not doing' included a stance of 'unknowing' in which the therapist attempts to bracket their own assumptions, work descriptively with the client, and offer any insights and interpretations in an exploratory way which is collaboratively discussed with the client. Susan describes this experience:

> *"You know for me I suppose the essential thing is this not knowing things.--We're going to step in completely unknown of the process that's happening and we're gonna let it unfold.-- It's a kind of back and forth of their point of view, my point view and the whole and how we are together and kind of untangling that."*
> *Susan:72*

A number of other therapists agreed that this unknowing stance is one of the defining characteristics of the therapeutic relationship in existential psychotherapy, and prompts the therapist to ask questions even when these might seem '*naïve*'. In this way the therapists saw themselves as '*facilitator'* rather than an expert on the client. This was in line with a focus on *process* that came through clearly in the interviews where the therapist was there to help the client become the expert on the client through a process of hearing, feeding back and illuminating.

The therapists' openness and their focus on 'being with', created an experience for therapists of being '*alongside*' their clients. Therapists described feeling that the relationship had a sense of equality in that, although the therapy was focused on the client, both therapist and client wrestle with the dilemmas and challenges of being human and in relationship, including being in relationship with each other. As a result, therapists described the therapeutic relationship as a mutually emotionally impactful relationship where therapists were involved in a relational experience of being with along with their clients. This sense of 'togetherness' emerged in some of the metaphors:

> *"I don't think anything quite better has been said than what Irv has said that we're fellow travellers. I think… I think there is something so well said and simple that… that he expresses in that because to feel the connection… with the other as simply, I am a traveller, you're a traveller. And there's nothing that makes me any more above, better, different than you. We face the same challenges…… of living our lives, of working through… of meeting the challenges of working through whatever it is that, you know, is difficult for us. We suffer, we hurt, we cry, we laugh, you know. And I think that… I hold that always when I'm with people. Always." – Phoebe:152*

> *"I feel like I'm on a park bench chatting, talking, discussing the world with the sun up, sun shining down sometimes and then rain around some other times and that kind of togetherness but separate, but separateness too." – Orla:257*

4.4.4   The relationship is the therapy: A unique experience

This openness towards the client and being with the client's experience of the world, whatever it may be, creates a relationship that may be unique for the client. The majority of the therapists discussed feedback from clients that the therapeutic relationship had given them something they had not experienced before.

Karin described one of her 'best' therapeutic relationships which with someone who had a schizophrenic diagnosis: "*He thanked me at the end as he said I was the <u>only</u> person who had ever taken him <u>seriously</u> (512)."* In this particular instance this included taking the client's stories as serious, even if they appeared delusional. Karin states he felt taken seriously *"Because every time he came out with a story, I went with it further, I went with it further, I went with it further" (516).*

In a somewhat similar vein, Donna talks about a client becoming very emotional because he felt able to be himself with her. He had told her things he had told no one else, and also openly discussed and accepted a paradoxical feeling in his life. Donna felt that he felt accepted as who he was, he did not have to choose one side of this paradox or the other but was free to be. This tied in to an experience of '*being seen*' which I discuss in the next section on embodiment, because it seemed somewhat tied with a literal sense of being seen.

This experience of being seen and validated by the other is accompanied by the client being able to meet, see or accept themselves in a new way. Richard describes a client feeding back about his therapeutic experience with Richard after a number of previous attempts at relationship and that he had felt *"this was a different sort of therapy; this was a therapy where he felt safe to allow himself to come out and to meet himself."(331)*

A possible nuance on this experience was for some therapists who described their client's emotional experience as one of being loved and cared for in relation, which also leads to them being able to relate to themselves differently. Phoebe and Orla discussed this view with client's experiencing a certain kind of 'love' for the first time. Recounting one adolescent client who was subject to extensive abuse at home and have never experienced a warm intimate relationship, she says: *"I remember him saying, I never expected you know when I phone [telephone counselling service] that I would get a relationship, yet I've got you (261)"*. Although this therapeutic relationship was by telephone, with the client calling from a park on his mobile, this client said "*I feel like you're on the park bench with me*" (257).

Two of the therapists referred to the unique experience they had as clients in their own therapy in this way. Neil, about his experience of his existence and himself as a person being taken seriously for the first time, of an existential 're-validation'.

In all these experiences, whether it was the client being validated, taken seriously of experiencing a warm loving relationship, therapists talked about it being a first experience for

the client of this. The therapeutic relationship was emotional partly because it gave the client something they had never experienced before.

4.4.5   The relationship is the therapy: Attending to relationship

One of the distinctive features of the therapeutic relationship in contrast to some relationships outside therapy is the explicit prizing of, attending to and discussion of the relationship in the room. This again influenced therapists' experience of the emotional aspects of the relationship as it meant these were focused on and discussed at points within the therapy room.

> *"When I'm working with someone it seems to me that what's happening or what's possibly useful is that we are simply being in relation in a slightly more aware manner. So the sense of the quality of relationship and the openness or closeness that somebody perhaps might have to being in relation to me, with me, seems to me to be probably the crux of the therapy. It is what I think is therapeutic." – Tim:84*

All the therapists described this 'attending' aspect of the relationship which included their own internal 'noticing' of the relationship and it's affective dimensions as well as bringing the client's attention to the relationship between them, or responding to the client's relational statements or affect.

Focusing on the relationship and its emotional currents was seen to keep the therapy fresh, alive and honest, and three of the therapists referred to the power of

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An Experience that Sticks

My experience as a client
When I was younger
Was extremely powerful

I can say I walked away from that experience
With a sense of *intactness*
And all these nice things we talk about
Self-esteem
And all of the positive psychological attributes
We like to assign people as being effective, adaptive
And all the rest

But it's still really, *really* difficult
To say, [to] describe
What that experience is like

Only this, I can say for sure
Without labouring it too much
And that is you can't *think* it
You **know** it, for sure

It's one of those things
Like perhaps love
That you can't doubt
You can distinguish it from infatuation
You can understand when someone loves you
And there is no doubt about it

The only problem with the comparison
Is that the other person can change their mind
And fall out of love with you
But they cannot take back
That they took you seriously
That sticks

That sticks.

(Neil)

working in the 'here and now' and the beneficial impact of bringing the relationship into the room by talking about it with the client.

The client's way of relating with the therapist is also seen as a microcosm of how they relate in the world. Four of the therapists specifically discussed their therapeutic approach as relation*al* as well as oriented around the therapeutic relationship and the fact that as humans we are always in some form of relation. The therapeutic relationship serves as a way to reflect back to the client aspects of their style of relatedness and ways of being in relationship that extend beyond the therapy.

Some of the therapists used the word 'illumination' to describe this way of reflecting back to the client what they were seeing, hearing and experiencing. (This illumination aspect of the therapy was also broader than the therapeutic relationship and applied to all of the client's ways of being.) For Donna, the metaphor she chose conveyed this reflective aspect:

Reflecting Water (A Metaphor)

I see it as a client and me
And then between us
Would be kind of a space
Maybe water

We're both kind of looking in
Being ourselves
And then the world reflected back to us
I think that would be it
Yeah.

(Donna)

In discussing their experiences of attending to the therapeutic relationship, most therapists described their experiences of the relationship as constantly shifting. Although we may bring certain dispositions or sedimented ways of relating, there is also a dynamic component in which we are interacting with the other in a way which then influences us. This notion of fluidity and dynamism also applied to the nature of the self and therefore the idea that the therapist and client were also constantly shifting as well as the relationship between them. Therapists' descriptions accorded with the existential view of the self as continually dynamic and fluid and

interpersonally influenced, as opposed to having a fixed character structure that is intrapsychically determined. This has implications for the therapeutic relationship as it suggests this relationship will also constantly be shifting, and therapists have to attend to the dynamic rhythms and shifts.

> *"I simply have to forget any [assumptions] that I might have made and the rationale for that is of course that this is not the same person who sat before me the day before. They have changed, we change continually and it's this view of identity and personality and traits that has pretty much been part of the psychotherapeutic tradition for a long time that I think existential analysis challenges "(Neil:27)*

Two of the therapists commented on the importance of constantly attending to the client and the therapeutic relationship throughout the therapy by treating every session as if it were the first time and "*literally to meet the person as if you had never met the person before*" *(Neil: 9).* These therapists talked about the need to keep attending to the shifts and possibilities in the relationship so that neither therapist nor client become 'fixed' or totalized in the other's mind. In this way, the therapeutic space remained free for new feelings, possibilities of relatedness and surprises to occur. A third therapist who did not explicitly describe this experience of meeting clients as if for the first time also talked about a sense of clients continually '*unfolding*', even while at the same time being very known. Interestingly, and in line with their respective theoretical underpinnings, one of the therapists who described herself as existential-humanistic described her experience of working with a client in which parts of the client were '*known*' and labelled in the room which represents perhaps a different view of self with core elements that are more fixed.

4.5   Major Theme 2: Therapy is an Emotional Endeavour

> *"We live in the emotional experience" – Susan:249*

Sub-Themes:

- Emotions matter – feeling is first, emotions are powerful and important
- Emotions in therapy are complex, dynamic and relational
- The therapeutic relationship is a unique emotional bond
- Emotionally challenging too! – dealing with anger and the erotic

The characteristics of the therapeutic relationship described above create an environment for a deeply powerful affective experience for both client and therapist. Everyone who was interviewed talked about being emotionally impacted *by* their clients, and all talked about therapy being an affective experience *for* their clients, and the critical nature of this for the success of the therapy.

4.5.1 Therapy is an emotional endeavour: Emotions matter - feeling is first

"I take my cue from ee cummings, the American poet, who once wrote 'feeling is first'" – Neil:107

Like the relationship itself, emotions are seen as a critical factor within psychotherapy and in the experience of therapeutic relationship. The emotional experience of therapy is both powerful and important. It connects the client to something essential about themselves and how they relate with the world.

Regarding the powerful nature of emotions in psychotherapy, the majority of therapists described experiences of being deeply affected by clients. Therapists described crying, laughing, worrying, feeling sad, angry, frustrated, loving, warm, affectionate, somewhat erotically aroused, overwhelmed, made shy, and embarrassed by their clients. In other words, as Orla asserted, any emotion that can exist in other relationships can also exist in the therapeutic relationship. Therapists described the work as emotionally demanding and challenging, but also felt that this deep emotional engagement and relatedness was part of what made therapy '*very fulfilling*' and for Orla "*doing something that I love"(12).*

Therapists bring their own emotions towards the clients and open themselves to their clients' affectivity and emotional relatedness. It's hard to predict what might be especially touching or moving. Karin and Orla both described being touched by '*the small things*'. Orla had experienced that she often came tearful or touched at client's demonstrations of courage or acts of human kindness, especially in the face of their own challenges.

Therapy is seen as just as affectively powerful for clients, if not more so due to the context and nature of the therapeutic relationship, with its focus on the client.

"I think also you can count on the fact that the err the perception of the emotional field will be -- particularly poignant that is perhaps more poignant than it is for you"
– Neil: 225.

While therapists' described having some control over their emotion in terms of how open they let themselves be to their own and their client's affect, how closely they attended to their emotions, and how they chose to work with it, there was also a sense that emotions are so powerful they could overtake you at times and be overwhelming to the point of where it was difficult to think, or describe what the experience was:

"Emotions, Hilman says, visit us from the Gods. What it means by, it's a metaphor what he means by that is that we don't have a choice we're involved in something and all of a sudden we become overwhelmed with an emotion." – Richard:171

All therapists commented on the importance of emotions. For Susan, this was about their potential for change and healing.

"You know cognitive behavioural therapy has this model of thoughts, feelings, and behaviour being connected. And, therefore, attempt to change the thoughts and the behaviour in order to change the feelings but I think almost the exact opposite of that, that they are connected, I agree, but to me emotions are much, much more powerful than thoughts and emotions are much more likely to drive the way that we think about things and, therefore, until the kind of emotional healing has taken place with the thoughts and behaviours are not going to change. So for me, it's very important to pay attention to that level and to work at that level." Susan:241

The idea that our emotions are a source of 'inner wisdom' about ourselves was discussed by the majority of the therapists who gave primacy to their and their client's emotional experience over verbal or intellectual explorations. Emotions were seen as reflecting a greater or deeper truth than we may be able to express in words and Neil suggested that we base psychotherapy on the emotional field because they provide a richer understanding.

"I think we have a -- far better understanding of our emotions than we do of what we're saying so that it's preferable to base the analysis of psychotherapy on uh what we know of the feelings" - Neil: 107

As well as the value of the emotions in the room as a guide for the therapy, there was also the sense that emotions could be a navigator within the client's life – a signifier and a guide to choices, decisions and ways of being. It was suggested that they indicate what is important to the client, and right or wrong for them in the world. Helping the client become more familiar and at ease with their emotional life and emotional self, including their emotional relatedness, can give the client insights about themselves and their relation to the world. These insights can act as a compass, as Orla poetically put it:

> *"A kind of navigation, and the process of navigating us safely through or trying to make it safely through these kind of tumultuous bays" (286)*

There was a sense that working at an emotional level in the therapy and the therapeutic relationship got to something essential (i.e. of an essence) about the client and that even when talking about behaviours or thoughts this was the focus:

> *"Clients can come up with theories and all sorts. But that's not them, they haven't noticed them. And that's what you're trying to get back people noticing themselves." Karin:203*

> *"It's all got emotional content and so I think yeah, it's a… you know it's part of this thing I said about meeting one's self is allowing one's self to actually meet one's emotions…… to actually bear those emotions, to actually not try and escape from them but to actually bear them and be with them." Richard:353*

Karin believes that working with thoughts can exacerbate already distorted thinking, whereas instead our emotions take us back to our essential self.

> *"Why you're getting to this hermeneutic trap of, of already if the, if the thinking is distorted… the thinking would get more distorted and it will justify more thinking distortion… no so you know you never get out of it. But if you go back to the why, now to the why, to the feelings, that's… that's… that's the starting point, that is the, what does Husserl call it the ummm the something or other self. It's almost like the reduced self, it's when you get right back to the bit and that's when you can start to build from that outwards, the transcendental something or other self. Do you know that? You've got to take it back right back to the person."(179)*

Given these beliefs, and the view that talking about difficult emotions could change them, the therapists talked about giving primacy to the emotional experience and working with emotions in therapy and the therapeutic relationship.

Donna for example states:

> *"I supervise lots of people and I would, you know, given how many choices you make as a therapist in any session about, you know, what you're going to address with your client. I mean, I would invariably…if there is a choice to be had and you know my client had expressed his emotions verbally or expressed an emotion in an embodied way that would be the choice. So most times I would choose to help my client address their emotions to the best of their ability. That's the thing that I would choose". (202)*

In order to have this emotional impact, the majority of therapists described feeling that the client must have an affective *experience* in the room rather than simply talking about their emotions. The nature of this experiential aspect varied – for some therapists it was about the client receiving an experience of a warm relationship, for some the experience of being validated or taken seriously, for some it included getting the client in touch with their embodied emotion in the room rather than intellectually talking about emotion.

> *"The therapeutic work itself is more effective if the client, you know, is experiencing emotions in the room rather than just talking about things." Susan:247*

4.5.2 Therapy is an emotional endeavour: Emotions in the therapeutic relationship are complex, dynamic and relational

In addition to the sheer power of the emotional relationship, what also emerged consistently from analysing the interviews was the rich complexity of this emotional environment. Therapists' emotional experiences in the therapeutic relationship included emotions *within* them, the emotions they feel *towards* their clients, their experience of receiving and emotionally *reacting* to the expression of their client's emotional relatedness towards them and their emotional experiences of particular client *stories and encounters*. In a similar way, clients brought in emotions relating to themselves, their therapist and the relationship between them as well as affectivity relating to specific narratives or experiences from outside of therapy. The therapist is trying to attend to all of this – both their own and their clients' emotions.

In terms of their own emotions, therapists described their affective relatedness to their clients in a number of ways including descriptions that expressed more stable 'dispositions' towards their clients in contrast to specific examples of experiences of affect provoked by a particular story or incident in the therapy.

A distinction thus began to emerge between an underlying *enduring emotional relatedness* towards the client, which echoed some of the theory around a warm bond, unconditional positive regard and so on, and transient *discrete emotional feelings* which were aroused in response to client stories or events in the room.

Two of the therapists explicitly discussed this contrast between a more stable affective relatedness or disposition and more short-term discrete affectivity in an emotional encounter. Susan talked about a 'background' undertone of emotional relatedness, which can be subtle but imbues the whole therapeutic experience, within which very different affectual experiences can arise.

> *"It can be very subtle, it's not, it's almost like a kind of back drop. So, it's not necessarily me having really strong emotions or really, powerful things. But it's like the whole kind of texture and flavour of what's going on. -- That kind of analogy would be, you could be thinking of intimate relationship. You could be in a relationship with somebody and at the core of it; you love and respect that person. But in the moment you might hate them or be furious with them in that moment. That's the kind of almost surface emotion, but underneath that you still have some level at which you can connect with that person, you understand them, you have some whole positive feeling towards them." – Susan:147*

Whereas Susan alludes to the positive aspect of an underlying disposition of relatedness in being able to do the therapeutic work effectively, Richard feels that a more stable, established way of the therapist and client emotionally relating to each other can be harmful by encouraging a cosy complicity.

> *"I make a distinction between the therapeutic relationship and the therapeutic encounter. But the encounter is the here and now immediate encounter of two people in a room, whereas the relationship is something that is built up over a series of encounters. And it has a sort of residue of previous encounters.-- And, so if you want to protect what feels wholesome and comfortable about that relationship. You will avoid difficult encounters. And you will avoid some of the more difficult things in*

therapy sometimes. I'm not saying you will. There's a tendency to do so." – Richard:52

The descriptions demonstrate that emotions are experienced by therapists as existing and emerging both *within* the person of the therapist and the client and *between* them. Therapists bring their own emotional self into the relationship with the client.

"When I feeing myself becoming distant to or affected by or wanting to hide from something in the relationship that means I'm wanting to hide then I'd be looking at it more existentially considering what am I creating here or what am I imposing or what am I frightened of or what am I affected by rather than putting the focus completely on the client or what the client's bringing off with me, although obviously that's also there. That's also the part of the relationship, how the client affects me, but I'm not using terms or using theory to take away or to diminish my part in the kind of quality of the relationship." Orla:14

Orla's description shows how *intra*personal and *inter*personal emotions come together in the room. For example, while therapists' emotions may have been evoked in responding to the client, therapists were clear that these were mutually constructed and that they 'own' their own emotions, which are informed by both their "*stuff*" as well as the context of the therapy room and experience of the client and the relationship between them. Neil is more focused on the interpersonal nature of emotions:

"I think of emotion as a field I think or a force --feelings are being co-generated, feeling is not something in me, it's not something in the client, it's something between us." Neil:110

Some of the therapists commented that we are always in some form of emotional relatedness to the client or always in some form of 'mood' or emotional attunement. Tim discussed the fact that the attunement is always there, whether or not we attend to it. From the descriptions of therapists' lived experiences with clients it appears that this attunement is likely to consist of multiple emotions towards different aspects of our world and relations. Neil states:

"We are all relating in an emotional way to each other all the time some of it is both sexual and erotic some of it is intellectual some of its pedagogical and maternal and parental" – Neil:142

One of the challenges in experiencing and working with the affect in the therapeutic relationship is not only the complexity described above but also that emotions are constantly shifting. They shift because of the stories told and experiences brought into the therapy room, so for example, the client shifts between and within sessions as they recount past experiences. They also shift due to the dynamic emotional relationship between the therapist and the client; our own experience of emotions is influenced by the emotions of the other in what I came to think of as 'the dance of therapy'.

> *"You continually try but you can never get it into words because it's flowing and it's changing but you can become attuned to it and this is what I think is the sense of the Heideggarian perspective. He uses this term Stimmung or attunement quite a lot and I think this is what I think you get." Neil:130*

As well as the constant movement therapists described in terms of their affect in the therapy room and in relation with their clients, therapists also gave a sense of movement towards or away from the client in both emotional experience and relatedness. Donna states:

> *"So, you know, I don't think there's one moment and sometimes I'm very connected and with my client and she or he was very connected with me and then at there's other times you know it's there between us but in a different way." Donna:76*

Phoebe recounts the experience of working with a client who was very angry with her and used to come and tell her what a '*horrible therapist*' she was, and how as his anger lessened he dropped into a deep pain, fear and sadness. Tim also talked about a client's switch in emotional relatedness with a client who had been very aggressive towards him then expressing that he had fallen in love with him. (I talk in the next section about how therapists work with this dynamism).

Karin described how the experience of working with emotions can also change them:

> *"What is she experiencing and then sat together that explicit discussion may lead my client to a new exploration of a different emotion that is even more uncomfortable for instance anger." Karin:60*

Emotions within and relating to the therapeutic relationship are hard to separate from the emotional arousal resulting from client's stories brought into the room because the dynamic

nature of emotion means the impact of this experience often serves to shift the affective tone of the relationship in some way.

Tim gave a good illustration of this. He describes feeling *sorry* that a client's mother is very ill. This expands into a sense of *compassion* for the client as a person and fellow human being, which then evokes Tim's own sense of *loss* about the client's intended termination of therapy. Tim shares this sense of loss with the client, wondering if he is feeling it too and the client and therapist then have a shared sense of loss which somehow brings them into a very powerful emotional experience of feeling as if they are coming together, during which Tim feels a great sense of *affection*.

All of this happens within one session and is an illustration of how the emotions flow and change within and between the therapist and client. Emotions may be seen, sensed, felt and expressed and they may be any combination of these.

4.5.3 Therapy is an emotional endeavour: The therapeutic relationship is a unique emotional bond

Underlying the dynamic complexity of emotions in the moment is the more enduring emotional relatedness therapists seek to offer their clients. As discussed in theme 1, clients experience the therapeutic relationship as unique and sometimes as a first instance of something they have never experienced before. Whether it was the client being validated, taken seriously or experiencing a warm loving relationship for the first time, this makes it a powerful emotional experience.

Three of the therapists referred to feeling love for their clients and another two as feeling great affection and warmth for their clients. Orla and Phoebe saw this experience of therapeutic 'love' as a powerful experience for the client and both described working with a client whom they felt had not experienced a safe loving relationship before. Orla describes this:

> *"Having a first experience and allowing her to have a first experience of this type of care, of this type of love where the... the expectations aren't there, there are no demands made."(76)*

The metaphor Richard selected to convey something of the therapeutic relationship in general was "*the lover's gaze*" *(219*) and he described trying to apply this metaphor within therapy in

the sense that "*Lovers tell each other their stories in a way that they don't tell their stories to anybody else." (221)* In the same way that lovers relate differently to each other than in other relationships, so the therapeutic relationship has some unique facets.

Orla states that she thinks a warm emotional stance from the therapist is hugely important, and is quite happy to admit this is her bias although she does not always feel as warm as she would like. She becomes passionate about therapists who are cold, indifferent, unwelcoming or uninvolved stating this stance is "*bullshit*" and that she is "*really, really and quite politically against that*" *(233).* She describes hearing about a relative's recent experience of therapy where the therapist did not respond when her relative asked where she should sit and would not engage in any small talk and states:

> *"I could feel my rage coming up because I thought I mean how rude, but how much power is being used in that. You've got somebody vulnerable who's coming to see you and coming into a session and you're not wanting to welcome them or build the rapport, just reach out to them as one human being to another human being. I find that disgusting". Orla:237*

The notion of love and even the use of the word love in therapy is complex; therapists' descriptions conveyed something of this complexity. Orla for example qualifies her experience by saying "*I mean, I'd call it love" (54)* but then also uses other feelings to describe her relationship – care, concern, fondness. It is clear these 'loving' feelings are indeed affective, she is emotionally moved when describing a past client and tells me her eyes are full of tears as she exclaims "*God, I really loved that boy*"(*259).* Richard was less troubled by the notion of love for his clients and stated that he sometimes feels a lot of love for some of his clients. He describes working with a particular client for whom he has a huge amount of affection and warmth. The idea of being 'in service' to the client again arises here with therapists talking about it being the kind of love in terms of wanting the best for the client.

In grappling with trying to express what this underlying sense of emotional relatedness is, Susan discusses how she has to feel a strong kind of 'pull' or emotional connection to be able to work with a client, and uses the first session to ensure this exists.

> *"For me I wouldn't work with somebody if I, if I couldn't in some sense grasp them or feel whole towards them. It's… it's I mean, it's… it's to me unconditional positive regard is kind of a useful concept and I think it's very, very misunderstood and it's also a poor descriptor of what is actually is. But for me there is definitely something*

about needing to feel that, it's not about liking the client and it's not about approving of what they've done or haven't done. It's something about, I mean I'm thinking of Buber here, it's something about his I-Thou, you know can I relate to this person as a real Thou to be really open to this person and not feel you know afraid of them or it's… it's a kind of bedrock underneath on top of which all the other emotions come." Susan:143

When she has not felt this sense of the client, she has referred them on although as she has matured and her self-knowledge and self-acceptance has increased, she finds it increasingly easy to be able to accept the other so this now happens rarely. Like Karin, Susan does not think she works well if she really dislikes a client.

Tim expressed doubt about the concept of love stating he is sometimes puzzled by what humanists mean when they use this word, but describes a particular client for whom he feels a great affection.

There were mixed opinions on whether therapists felt strong emotions about all their clients, or whether some therapeutic relationships were much more affectively involved than others. Neil, Richard and Karin felt that all therapeutic relationships were affectively powerful and that they had "*quite strong emotions about all my clients*", although this could be of any kind. In contrast, Orla states:

> *"Some therapeutic relations feel deeply moving and you know, all those intense feelings that go with that and others feel quite light and you know, I probably forget the person and my time with them not long after they have worked with me".*
> *Orla:210*

For some therapists, certain emotional experiences were impacted by the length of the relationship with shared resonances building up '*layer on layer*', however Karin describes an extremely powerful experience with a client she saw for only seven sessions.

There was less discussion about the therapist's experience of negative feelings about the client, other than in response to the client's expression of anger towards the therapist, which I discuss below. Some underlying sense of emotional connection or warmth towards the client was seen as essential to be able to do good therapeutic work.

Karin describes a relationship which was difficult because the client was very deceitful. She describes her experience:

> *"…a young man and I just couldn't stand him. He's probably the only, most clients I don't know why, I just tend to like most people. And he really made my skin crawl and he wanted to be my friend. There was just something about him; I don't even want to think about him. And I don't think I worked very well with him."*
> *Karin:532/536*

She also describes a particular 'type' of client she finds it difficult to work with because they are hard and impenetrable. Susan concurs:

> *"If just really disliked somebody, then for me I wouldn't work with them. I would just feel that I wasn't doing them a service." Susan: 149*

4.5.4 Therapy is an emotional endeavour: Emotionally challenging too! – dealing with anger and the erotic

The open nature of the therapeutic relationship and its focus on attending to emotions within the relationship means that a space is created for clients to express all sorts of emotions. The client's expressions of emotions about the therapist and therapeutic relationship are sometimes easier to receive and work with, and sometimes difficult. A number of the therapists described experiencing a particular affective relation as challenging for them, and that this was something they had worked with due to their own issues. For two of the therapists (Orla, Karin) this was the experience of the client's gratitude, for others it was the experience of the client's anger or client's expressions of the sexual desire each of which I discuss below as these issues were both mentioned by the majority of therapists.

Five therapists talked about their difficulties in dealing with their client's anger or aggression toward them. Susan recounted a vivid experience of feeling verbally attacked by a client.

> *"[There was] really a kind of fury at me. She felt I hadn't understood her, that I had misinterpreted her words, -- so there became a lot of question about my competence -- And so a lot of kind of untangling as to who said what and then, you know, it became quite kind of personal with her, ummm, attacking my… I think she asked me what my qualifications were and then when I told her being very*

dismissive and contemptuous, I suppose you think you're so clever and so much better than anybody else so, yeah. [Laughs]That really was strong, strong emotions expressed in the relationship.--I could feel the full force of this furious anger directed at me. It was really, really difficult." Susan:171

The challenge for the therapist at this point is that they are emotionally aroused themselves and so it becomes increasingly difficult to 'hold' the emotion in the room to work with it. Instead of the emotion being in the middle it is somewhat absorbed by the therapist with her own resulting feelings of being overwhelmed, and having trouble thinking, processing or dealing with it. Phoebe describes feeling "*swallowed up in it*" (191) and "*losing a sense of myself*" (181).

Because the client's emotions have evoked an affective response in the room, the therapist then has a '*tangle*' of emotions to deal with, and for some of the therapists this came with a recognition that their affective response was due to particular personal difficulties in dealing with anger because of past experiences that the client's response '*tapped into*'. Susan's experience was early in her career which she thinks made it particularly difficult and Phoebe and Tim also talked about the learning and growth involved in being able to effectively receive a client's anger, including working with their own personal history.

> *"I know personally for me, anger is one of the more challenging…when either I'm feeling angry or my client is feeling angry there's a definite challenge for me to sit still and work with it. And that's taken a lot of learning and growing and uhmmm, understanding about my own issues around anger." Phoebe:168*

> *"He seemed to find being in relationship, you know, making the attachment incredibly difficult and so he was actually really quite aggressive. I did find that quite seriously challenging. I think if I have an Achilles' heel, I'm not fantastically good with aggression. I think it was a question of sticking with it." Tim:306*

This ability to be able to accept and '*welcome*' anger was seen as important, with Phoebe feeling that anger is often not *'allowed'* in the therapy room and is a struggle for many therapists. She suggests that most of us have an affect that may be especially challenging for us to deal with. In common with others, she talked about how her ability to be welcoming to anger had required work and learning and was more challenging early in her career.

"That's taken a lot of learning and growing and uhmmm, understanding about my own issues around anger." Phoebe:172

She pointed out that there is not a single reference to anger in any of Carl Rogers' books. Two therapists suggested that clients tend to express their negative emotions by not turning up for therapy sessions rather than addressing them in the session, which makes the ability to accept or even 'welcome' anger particularly important.

Five therapists discussed the experience of a client's expression of attraction or sexual desire. While some saw this as making for a more complex working relationship in which the therapist had to attune carefully to the client, it was felt that this was a phenomenon of relatedness like any other, although one that may be elicited somewhat by the intimate nature of the therapeutic relationship. Therapists did not find this as hard to experience as clients' anger, although it did result in some cases in various affective responses: shock, shyness, erotic feelings.

Again, there was a sense of courage in needing to be unafraid of receiving whatever clients bring into the room (and for the client to have courage in order to express these feelings). The therapists stressed the attitude of acceptance and non-reciprocation, with two of the therapists discussing a desire not to shame the client.

There is a clear distinction between feelings and actions and none of the therapists in these interviews discussed a challenge in maintaining boundaries, which they saw as an important responsibility of theirs within the therapeutic relationship, despite the fact that two therapists admitted there could be very strong erotic feelings in the room at times.

"If the patient feels the need to express that kind of uh strong physical reaction then again with what I know as my purpose there I'm certainly not going to say 'no you can't do that' -- I think there is far too much worry that that kind of expression of what is affectively a more primitive sort of relationship will turn into some sort of adult sexual um relationship. I don't see any reason for assuming that that's what's going to happen. We can't be afraid of that---we simply sit down and continue and look and see where we have gone next. I think it's important not to look back at the client at that point in disdain or disapproval or say 'now what was that all about?' It was what it was." Neil:150-154

"There's somebody I'm working with who is attracted to me, physically attracted closely. --- that obviously is a strong emotion and has meant for a more complicated working relationship. --I think when she first expressed that and could find me attractive and pretty attractive and also that she was very, she kind of cared about me, it was quite a relief in one way because I had felt that that was the case.--But you haven't you know, I haven't voiced it and she hadn't. So a relief that she had been courageous enough to bring that up in the session. --I felt a responsibility that I wanted to respond well. I wanted to respond in a way that didn't shame her, that didn't embarrass her or silence her, but also didn't make too much of it." Orla:84-96

The non-reciprocal nature of the therapeutic relationship creates a particular atmosphere which may heighten the possibility for strong emotions. Orla describes how the therapeutic space can be emotionally '*seductive*' for some clients in its intimacy, intensity, and dedicated focus on the client. The combination of this dedicated attention coupled with a relative lack of knowledge of the therapist creates a space for the client to imagine freely about the therapist. As the client also learns that the therapist will not act upon or retaliate to emotion which is expressed, "*the client can feel safer to fall in love or to fall in hate or whatever it is with the therapist*" *(Orla:145).* Richard echoes this view.

While this seductive atmosphere can evoke deep loving feelings or feelings of desire and sexual attraction in some clients there are other clients who feel nothing strong, or even nothing at all, for their therapist according to Orla. This links back to the complexity of the emotional dynamic or 'recipe' in that it is created by both what the client brings into the room, what the experience of the therapeutic relationship means for this client, and also likely the nature and quality of this particular therapeutic relationship. However, the context itself probably "*does heighten the possibility of strong emotions arising*" *(Orla:139),* whatever form they take.

The freedom for the client to imagine and invent is felt by Orla to be beneficial:

"I think that can have quite a seductive quality, which I think can be really useful. Because whatever they're imagining about the therapist is revealing something about the client. It can be you know, really important to... to explore or to consider." Orla:143

This non-reciprocal space, combined with the powerful relationship that therapists offer their client can also lead clients to '*over estimate*' their therapists or idealize them. Neil described

experiencing his own therapist as '*heroic*' during his therapy and for some time afterwards, and sees it as our job as therapists to keep it in perspective.

Like clients' expressions of anger, the experience therapists had in receiving clients' expressions of sexual attraction depended on where they were in their career and in the journey of this particular therapeutic relationship. Orla describes it being easier to work with client's sexual attraction now that she has experienced this a number of times and had supervision around it and Karin describes not being bothered that a client masturbated while thinking about her because this happened in a relationship that was very solid and honest.

Two of the therapists discussed the fact that the clients themselves did not want their expressions of desires or love acted upon, the therapeutic relationship has an 'as if' quality – a place for the client to imagine, explore, experiment in ways of relating that may be new or different for them:

> *"if I was to say if I'm attracted to you too, I think… well, I know the therapy would end, and she would run. Absolutely. Because that's not actually what she wants. She wants somewhat to explore what it means to be attracted to somebody who …and what that brings up for her." Orla:147*

> *"We are not going to have an erotic or a physical, you know, relationship. It's not something which is on offer… which is something – I did actually say at one point that to him. That was quite tricky. It was absolutely fascinating because when I…when I just sort of gently reminded the two of us as it were and what we might be attempting to do in the room or what we might not be attempting to do he pretty much then went to the opposite end of the spectrum as it were and sort of was astonished that I needed to tell him this, and perhaps I was needing to remind myself!" – Tim: 340*

Only one of the therapists openly explored his own erotic feelings. For him, this was not an impediment to working effectively provided his eroticism was not overwhelming, again because there is a shared realization that the relationship is not physical and does not go outside of the therapeutic space and the therapist holds those boundaries.

> *"I mean I had a young woman as a client who, you know expressed, you the fact that know she had liked me very, very much and you know there was a very strong sexual charge taking place in the room -- the atmosphere in the room at times was*

incredibly powerful, you could almost feel it, taste it, smell it in the room. And I don't think that actually had a detrimental effect on the work we did. --So I think you can have very strong warm, loving, even slightly sort of sexualized attraction, slightly I'm saying which doesn't damage the therapy. It can actually help it."
Richard:479

In dealing with emotions that the therapists found challenging what emerged was the importance of courage and the sense of increasing emotional wisdom as they grew as therapists, which I discuss in the next theme below.

4.6   Major Theme 3: Emotion Work – Applying Emotional Wisdom

"Trying to be the best kind of human you are" – Orla:241

Sub-Themes:

- Building a safe therapeutic space
- Finding the courage to feel
- Working with their own emotion: Therapists attend to and work with their own emotions
- Working with emotion in the therapeutic relationship: Bringing it in & working in the here and now
- Working with the client's emotions
- Learning emotional wisdom

The complexity and dynamic nature of the emotional relationship demanded skills and judgement from the therapist in attuning to, attending and responding to emotional stimuli. Therapists described their experiences of working within this emotionally rich, complex and dynamic atmosphere in active terms. This was emphasized by the language used which contained a lot of verbs in this regard: open, attend, accept, hold, tolerate, bring-in, attune, discern, model, teach. Holistically, the descriptions conveyed therapy as undertaking emotion work that requires focus, courage, skill and discipline.

The theme of '*emotional wisdom*', although not a term used by any of the therapists, was my interpretation of the therapists' descriptions of consciously, deliberately and carefully focusing on their own and their client's emotions and assuming an emotional 'responsibility' which

required careful reflections and judgments about disclosure, boundaries, when to challenge the client and so on.

The various ways in which the therapists are working with emotions and using this emotional wisdom – attending to their own affect, deciding what to express, holding the emotion in the room and so on – are frequently occurring concurrently, which is part of what makes the therapeutic relationship emotionally complex and demanding. However, for the purposes of attempting to unpack all the different aspects of this phenomenon I have broken this down into separate emotion 'tasks'.

4.6.1 Emotion work: Building a safe therapeutic space

Therapists discussed the need to create a safe, open and therapeutic space for the client in order for the client to feel able to attend to and express their affect.

Karin described how this process started for her before she even met her clients when she consciously put aside any of her own assumptions and feelings she may have about the client (i.e. that maybe brought up by their name of referral information.).   Richard described how this process of building a safe space started with putting the client at ease, being a "nice guy" to capture them and bring them into therapy and relationship. Richard also emphasized the need for listening and the way we listen as enabling our clients to bring themselves and their emotions into the room: *"Speaking doesn't come first. It's the listening that comes first. It's how you listen which influences…what is said. It's not somebody says something and you listen to it and then you have a… you know, you listen first. And in that listening, somebody feels able to fill that space that you're listening in."(225)*

This sense of safety was then seen as a feeling that developed further over time as the therapist continually focused on the client and demonstrated her ability to tolerate and accept whatever the client expressed in the therapy room or regarding the therapeutic relationship without criticism or retaliation.

> *"There's a deep desire for the human being to connect with the other and when there's an open field for it and there's a sense of safety and security. But there's has to be this container… and the person, the client has to feel it and it's built over time it just simply doesn't happen." Phoebe:283*

This acceptance included demonstrating to the client that there are no repercussions or retaliation for feelings or opinions the client may express.

> *"It's also this idea that it's non-reciprocal and it means that the client can feel safer to fall in love or to fall in hate or whatever it is with the therapist, but feel safe that it's not going to come back and the therapist will stay steady and that's you know just respond or open a discussion about it." Orla:145*

This does not mean that therapists do not challenge their clients, but "it's that challenge but showing and demonstrating that this is ok to go to" (Phoebe: 334).

Most of the therapists talked about the idea of their acceptance of the client playing a key role in therapeutic impact beyond the creation of a safe space by allowing the client to also accept themselves. For example, as I described above Donna described a client who felt that he could be paradoxical and that was ok- he did not have to choose one way of being and was not judged for holding both these positions.

4.6.2 Emotion work: Finding the courage to feel

> *"We can't be afraid" – Neil:154*

However safe the space and relationship begins to feel, working at an emotional level remains demanding precisely because it is emotional. One of the themes that emerged from all the therapists was the courage and risk-taking required of both therapists and clients to work at this affective level.

The therapist's courage

The first 'act of courage' described by the therapists was the courage to open themselves and their bodies in the space and therefore to open themselves up for emotional impact by 'really putting yourself in the space' and not 'coasting'.

Other aspects of courage for the therapists include the courage to receive and accept, even welcome, emotional expression of any kind even when it is difficult for the therapist or creates a more complex working relationship. Courage also related to responding to the client in the way that was felt to be most therapeutic even if this may be challenging, and to find the courage to address the relationship or bring the therapist's own feelings into the room when

this might be beneficial. Richard and Neil both talked about the importance of not being afraid or backing off.

"I there's a sort of judgment that takes place as to whether this is important to speak out or not. And even though the client gets angry or ruffled or whatever, if you trust that feeling, then you can stay with it. You don't back off and apologize or but you just hold that space". Richard:426

This includes '*not being threatened*', or '*pulling back*' and not '*being afraid*' of passions running high – not backing away from a client's expressions of affection or desire or anger of whatever they may be feeling.

Phoebe and Orla both talked about the importance of finding this courage and the ability to take a risk to ask the client about the therapeutic relationship:

"One of the things that was so striking to me about beginning to work with Irv [Yalom] was his willingness to risk asking his client you know, how are we doing now? And what was good for you about the therapy and what was difficult and what didn't you like, and opening it up to a client's criticism, frustration, negative perspective, negative feelings about what happened, what I did, what evolved in our work together. And I think that that – without that, the therapy has a deadness to it because there's sort of an unspoken agreement. We won't go that those negative places. Opening it up just keeps everything very, very fresh." Phoebe:186

Orla admits that she can't always find the courage she would like:

"When I feel a disconnect, when I feel, um, yeah, alienated about it… from the client then what always helps and I don't do this enough, I need to do this more but what always helps is and I don't do it enough… is talking about the relationships, what's happening now and sometimes it's having the courage to do that and I'm not always feeling courageous. And sometimes accept that I'm not… and that's okay and sometimes I don't … You know, I beat myself up afterwards." Orla:184

Orla discussed courage quite extensively and particularly with regard to both the therapist and client expressing their feelings about one another. Like Phoebe, she also prized this '*bringing the relationship into the room*' and I discuss this further below.

One of the other ways therapists talked about their need for courage was in allowing and facilitating dissonance and discomfort in the therapeutic relationship. Richard talks about how much easier it is to stay with the comfort and complicity of a 'cosy' feeling but, like Phoebe, believes that this means there are important things that emerge in the discomfort of more difficult encounters. Three of the therapists talked of the need to keep this sort of 'edge' or openness for difficult feelings.

"If you get into that sort of space that it becomes a relationship rather than an encounter and you want to protect the warmth and the good feelings you have about yourself, and the vanity that it creates can stop you from being tough in the therapy." Richard:487

"I think if you don't have strong emotions before they come in the room. You're not going to do them, you're coasting. Have you ever done any acting? And I think every time, I get a client knock on the door or it depends where I'm working or every time I go down to pick a client up, there is a flutter within my stomach. There always has to be." Karin:612

Fostering and appreciating the client's courage

Therapists also described their experience of their clients' courage and bravery, for example, in expressing their feelings about the therapist. Orla describes her relief and admiration at the courage of a client who expresses her sexual attraction in the room, Donna admires her client's courage in expressing her hesitation in confiding in her because of her constant yawning and talks about the courage required by another client who is normally very 'defended' and is having to push herself to bring her emotions into the room. The therapeutic relationship in existential psychotherapy then can be seen to demand courage to face and work with emotions in ways we may not do in other relationships. This kind of direct interpersonal feedback is less common in non-therapeutic relationships and is particularly demanding for the client as, as Phoebe outlines, they are less likely to have had this kind of experience than the therapist.

Phoebe also talks about the courage both therapist and client need to '*take on*' the client's '*shadow side*' or '*hated parts*' of herself and that the therapist needs to help the client with this by demonstrating courage in addressing and challenging things but in a non-critical way.

Donna again highlights this dynamic dance of emotions that can occur when a client is courageous in that the therapist then responds with some emotional openness of her own:

"I'm thinking about how moved I am by that and just the openness to her being courageous if you like with me and then I'm quite likely in that situation talk to her about what it is I'm experiencing when she's telling me about her mother."
Donna:58

Orla is admiring or touched by the client's courage outside of the therapy room also and talks about being very moved by her clients' courage in dealing with some sometimes very difficult life circumstances. Sharing these positive feelings with the client can be a source of powerful affective feedback for them.

4.6.3 Emotional work: Therapists work with their own emotions

All the therapists talked about actively attending to their own emotions in the therapy and using this as a guide and source of feedback (whether or not their feelings are shared with the client). Neil states, for example:

"My reading of it is of course different than the client's but it's that rich, there doesn't have to be one reading that is correct, but that it's a source of guidance for the verbal" – Neil:114

Attending at multiple levels

At the same time they are attending to their own emotions, therapists are also noticing the client's emotions and the material that the client is sharing. There was a sense of the therapists actively working with their selective attention in order to be able to attend at different levels.

Karin for example talks about consciously 'dropping down' into her own emotions in order to increase her awareness of her affective response at certain times. Tim talks about this constant emotional attunement, and the way he is constantly moving in and out of the dialogue as he moves his attention to his affect in order to 'check in' and then back to the client's narrative, while at the same time occasionally making the decision to share something. The therapists are engaging in self-monitoring of their own emotions.

"I guess I'm checking up on where I'm emotionally before I see the person and then pretty much ummm from the moment the person comes in to the room until the person leaves the room, I guess I'm sort of moving in and out of the dialog we're having. I'm checking myself and checking what's going on for me and what that

might tell me a little about what might be going on for them as well. I'm not talking about transference in any particular sense, I mean you know certainly not in that sort of rather crass sense of the client sort of putting something into you. But just that sort of feeling of ummm it maybe something as basic ummm, you know am I feeling hungry or as I'm feeling tired or you might feel there's something on Ummm, perhaps like do I feel hot, cold, tired, hungry, nauseous, so well I think for me, there's pretty much the whole time popping in and out of that and noticing how I'm feeling. And sometimes though, just if it seems genuinely worthwhile ummm, sometimes I will share something." Tim:214

Tim's language reflects the dynamism of this process, the fact the therapist's attention is frequently shifting: 'moving in and out', 'popping in and out', 'checking myself'.

Susan's metaphor for the therapeutic relationship reflects this dual attention:

"It's something about entering the client's world--having one foot in the client's world and one foot out of the client's world. I can kind of fearlessly jump into the client's world without worrying too much about imposing something on it. So trying to make sense of what it's like for them, at the same time having one foot out of it so being very aware of myself as well in relationship and my feelings and my experiences and therefore, you know this whole, the client and me, together and the space between us which is where it starts to sound a bit clichéd. But it's always like, you know, instead of just seeing the relationship from my point of view. It's a kind of back and forth of their point of view, my point view and the whole and how we are together and kind of untangling that." Susan:86

Managing their own emotional arousal

As well as 'noticing' their emotions, the therapist is also working on their own affect management as well as making decisions about what and when to share any of their emotional experiences. Richard talked about having to manage his degree of openness to the client so he does not become so immersed in the client's emotions it is difficult to work. He recounts an experience of a client who was viciously attacked with an ice pick and who lay in the road screaming, badly injured and that after hearing this description Richard was unable to get 'horrendous' images out of his head for months. He also describes working with a client who has an almost overbearing grief and how he "*sometimes have to pull back from offering myself into that space because it's just too painful.*"(303)

Above, I had discussed how when Susan felt she was not able to 'hold' a client's anger in the room she became overwhelmed and unable to think and work with it as much as she would have liked.

At other times, the therapist is emotionally impacted and makes a decision about whether and how much of this to reveal and share with the client or whether to contain their own emotion. Tim for example describes a particular emotional encounter and says: *"I mean, I actually felt slightly tearful, I didn't go there and you know, I didn't think it was going to be terribly helpful if I did anyway". (230)*

For therapists, who are working with multiple clients, the topic also arose of how to manage their affect after and outside the therapeutic session. Orla describes '*ranting and raving around the house*' and getting extra supervision when particularly emotionally aroused. Interestingly, Karin felt that while she gets aroused and sometimes very upset in the room she is somehow able to put those emotions aside outside of therapy. She suggests that our clients are '*somewhere else in our bodies, in ourselves*' and discusses the fact that she has never dreamt of a client, despite being a 'massive dreamer' and dreaming of all sorts of people from her past, as further evidence of this emotional segregation.

However, Karin also states that she has never cried with a client, although her eyes have pricked and this is in contrast to some of the other therapists who openly describe experiences of being tearful in the therapy room which raises the fact that different therapists are likely to have different levels of their own emotional arousal and affect regulation capabilities.

Working with dissonance

As the therapist moves their attention between the client's narrative, the client's observed affect and their own affect, they are very observant of the degree of concordance or dissonance between these aspects. The majority of the therapists talked about the power and value of working with this emotional dissonance in the room and in the therapeutic relationship, using it to help generative tentative hypotheses or questions about what might be occurring.

The excerpt from Susan's interview below, although lengthy, describes this experience well when she is attending to both the client's narrative and her own affect:

"Sometimes a client could bring a very strong emotion, say they're bringing a narrative of something quite distressing in their life and sometimes I will really feel that distress as well. There'll be a kind of meeting in that distress. But equally it could be that client is bringing a distressing narrative and they are perhaps crying or giving some signals of distress, but I'm not feeling anything which is also interesting and then the other way is where a client brings a narrative and they're showing no signs of distress but I feel distressed.

So I suppose what I'm saying is that sometimes the emotion is very attuned and I'm kind of understanding and connecting with the client at that emotional level. Sometimes, there seems to be a mis-attunement -- I mean in the example of the person bringing the narrative and me feeling the distress and they don't seem to be feeling it. I would almost be thinking, they... you know I'm, I'm being distressed for them. And they're actually not yet able to, they're cutting off from that aspect of their experience from the emotional aspect.

-- If I'm not feeling anything but they seems to be, it could also be something about them. --I would wonder about genuine emotional self-responses in the body as supposed to more instrumental or kind of put on emotional response. You know, the client almost using emotions as a communication as a way to get something from the other person. I'm just speculating, but I suppose all these things would be, would be going through my mind." Susan:107-135

A number of other therapists also talked about working with dissonance in similar ways, for example feeling emotional about a particular narrative when their client did not, or that the client's embodied and vocalized emotion seemed to be at odds with each other. These experiences are seen as something to work with to help the client get in touch with their underlying feelings. Richard and Orla also describe this:

"Sometimes I think you know... I have to sort of hold somebody back and bring them back to what they've just said... and get them, to sort of look at it again because I can feel the emotional content in there that they are not acknowledging."Richard:365

"Because we've voiced it [our loving, warm feelings of connection] we've been able to talk about it as part of the work and our conversations, [in that] what it means when she experiences herself as unlovable how can it be that what she elicits with

me is a love, is a care, is a concern, is an affection? So how does that come about?
And that's a big question. She doesn't understand it. She's still struggling to work out
why, how I could possibly care about her. So I think the making it explicit and she
knows that's the truth, that's what she sees, and what she experiences and it feels to
her genuine when we've talked about that. It's not a 'put on' kind of care." Orla:80

Therapists' confidence in working with dissonance grew with experience. Richard, for example, talked about how he used to feel much more comfortable with cohesion and avoiding difficult encounters, but gradually learnt that this is where a lot of the work of therapy is done.

Emotional disclosure dilemmas

Whatever the emotional phenomena the therapist is noticing, whether it is her own affect or some dissonance for example, deciding whether to choose to disclose this is a judgment call. A number of the therapists pointed out that this was a *managed* transparency and it would be irresponsible and not in the interest of the therapy to fully disclose their emotions (and thoughts) at some points.

Richard describes an example of meeting with a hygienically challenged prostitute who he felt some physical disgust and revulsion for, but that this would not be useful for the client in this instance because she is used to receiving expressions of disgust from people so he instead tapped into his compassion for her. This reminded me of the descriptions of the emotional relationship as multi-layered and multi-dimensional as well as dynamic, i.e. we may have a number of different feelings about our client at any one time.

Orla talks about the careful balancing act required here, and this issue of disclosure and transparency was an area where descriptions suggested that the therapists moved into a more reflective and cognitive focus on their emotions as they thought things through.

"And I think that's always for me is how much to bring, how much of that do I bring
into the room is going to be useful? How much to hold back? And if I'm holding back
then am I feeling disingenuous and then if I am feeling disingenuous then that's not,
I am not affected, it's not effective and there's a disconnect happening but if I bring
too much of that in, then that can be unhelpful too. So it's always this thing about
how to get the balance." Orla:180

Richard also talks about the thought that goes into this issue:

"I think that I've got to be very careful in how I communicate what I'm experiencing and what I'm feeling from what I'm thinking because it can be misconstrued very easily--there's a sort of judgment that takes place as to whether this is important to speak out or not". Richard:424

Karin and Richard also talked about the need to be careful with language when deciding to disclose something of their own thoughts and feelings to the client, with the knowledge that what is expressed is not what is received by the client.

"Wittgenstein says that whatever you say, whatever you say you're opening yourself to being misunderstood. So if you say something and then you explain yourself and you explain yourself, each time you explain yourself you can be sending somebody further in the wrong direction." Karin:352

"So I don't see that there is sort of a direct correspondence between communicating and receiving. There's a lot of misperception that takes place in that space between." Richard:424

Another factor that goes into disclosure decisions for some of the therapists is thinking about trying to be at their best with the client, in their role of being of service to the client. One of the things my therapist talked about with me when I was becoming a therapist was the idea that we bring our 'best self' into the therapy room. Perhaps because this was personally meaningful to me, I really resonated with Orla's statement below.

"Perhaps trying to be the best kind of human you are. Because there's lots of parts of me, of my being human, that are not so pretty and I don't mind showing clients that I fail and I get things wrong and I make mistakes and all that stuff but I don't want them to see, I don't want them to know. I don't think it's helpful for them to know all of what I might be thinking or feeling about anyone, you know, any particular point. That's the responsibility stuff. That's what you choose to keep out but you… But I do that with any relationship. I'll choose to keep out certain things when I am with my sisters or with my friends or my partner."(241)

One of the things therapists tended to 'keep out' was personal disclosure relating to their own past history, with much more focus on process or relational disclosure pertaining to the client and the therapy.

"I don't know that it's necessary to disclose too much of one's own experience, although I think there are times when it's really helpful to do so because otherwise they think they are the only person who has ever had this sort of feeling, but I think just in one's… responses, and the way one responds, and the way one attends to a person, they kind of a sense that you've got the T-shirt for some of this stuff."
Richard:359

The descriptions about disclosure felt somewhat contradictory at times, as on the one hand therapists felt emotional disclosure would be unhelpful at times and on the other hand they felt that transparency was somewhat inevitable. This was particularly the case when it came to descriptions of embodied emotionality which I explore in the next theme, whereby disclosure of affect may well be taking place albeit unintentionally by the client observing their embodied response or in the client having a 'felt sense' in the same way they have a felt sense about the client.

At least two of the therapists pointed out that some level of disclosure was unavoidable because for example, the client sees the therapist tearing up. Richard again addresses this:

"What I would say is that, [on using your own emotions] I mean there's a level of transparency which I can't help. People read it anyway. You know it's in that sort of non-verbal language… non-verbal communication that takes place. But then of the stuff I can help, I think you know in terms of choice, the idea of total transparency is irresponsible. I think it has to be a managed transparency."Richard:418

Of course, the client's understanding and interpretation of the therapist's affect may be incorrect but that is different from the emotion being hidden from the client.

4.6.4 Emotion work: Bringing the therapeutic relationship into the here and now

One particular area where therapists did value some disclosure, although in a responsible way, was around the therapeutic relationship. Therapists felt that the relationship and the therapy inevitably benefited from these discussions. Keeping the emotions between therapist and client aired keeps the relationship 'alive', 'open' and 'fresh'. This included keeping an 'edge' to the relationship and avoiding collusion or complicity. Phoebe describes this sense:

"And this opportunity for you and I to really understand this way of being, how you are with me, you know gives therapy an aliveness that often talking 'about' absolutely never can do. And so because existential therapy values this being alive in the room. That, I think that what makes it so, so effective really. It's not a talking about. It's about what's happening right now between you and I, can you allow yourself to be present to what are you experiencing now between. Between us right now." Phoebe:365

Orla shares this view that turning the attention to the therapeutic relationship is a powerful way of getting back in touch or feeling reconnected in relationship with the client. One way the therapist may do this is to ask the client explicitly about the relationship, another way is for the therapist to draw from their own affect to feedback to the client the experience of being in relationship with her.

"That's where the therapeutic work was for her to get an understanding of why she [laughs] might have these poor relationships with other people because, you know, this so if I had been able to somehow feedback to her in a way that she could hear, that look when you shout at me, this is… This is how it makes me feel." Susan:203

For Richard, this growing relationship also involves becoming more authentic over time. At first he is a '*nice guy*' as he wants to put the client at ease and '*capture*' them to bring them into the therapeutic space, and he then works on gradually having a more authentic encounter which includes challenging the client, or holding them to look at something and will also include more of his own emotions towards things.

Karin also talks about raising it explicitly with the client when they are not working emotionally as a pair:

"I would say to a client we have a problem because we're not talking emotionally we're talking academically. So that would be one way I would actually, I'd actually tell the client this is the way we're communicating."(149)

This reflects the general focus there was on attempting to make all the client's significant emotions explicit, not just those pertaining to the therapeutic relationship. The therapists' descriptions about working to bring emotions into the room and particularly those relating to the therapeutic relationship, demonstrates a value that 'emotions matter' in line with those who discussed this explicitly.

4.6.5 Emotional work: Ways of working with the client's emotions

Therapists described a number of different ways of working with the client's emotions. These included working phenomenologically, emotional containment, and emotional modelling or teaching.

Working phenomenologically, never assuming "Because you never know, do you?" Karin:71

One of the themes that rose repeatedly was that therapists seek to avoid making assumptions about the client's affect, instead asking with them explicitly. This builds off the idea of the relationship stance as being one of 'unknowing' as described in theme 1.

Susan for example describes an encounter where she felt there was an intense emotional connection between her and her client, yet despite this felt sense of closeness she states:

> "Obviously I can't tell you, you would have to ask her as to what her side of the experience was.—I simply can't speak for her." Susan:219

Interestingly, this idea of always asking the client to describe their affect and what was going on for them seemed to dissolve at moments of particular emotional connectedness when '*no words are needed*'. Therapists were also confident, when I asked them, that clients knew their feelings during these moments.

Holding and containing

Therapists described their responsibility of holding or containing the client's emotions in the room, in order to help the client work with or work through the emotion.

> "If we can tolerate it and we hold it and we invite it and we make it okay then we're promoting the person to work through it and go to a deeper level and that's that deeper level of experiencing that I am talking about." Phoebe:206

> "Part of dealing with strong emotions and therapies, for me anyway, is about me successfully being able to hold that in the middle between us still and look at it" – Susan:177

In trying to explore and interpret this phenomenon of 'holding' my finding was that it was about being able to keep the attention of both therapist and client on the emotion whilst managing the level of affect regulation in the room. (Therapists did not use the term of affect regulation but did talk about the importance of "managing" emotions).

Therapists also talked about making judgment calls about how able the client was to be with their emotions. Sometimes this including "holding" the client to keep looking at something in a way that may increase their emotional arousal. Richard states: "*the actual holding somebody, to actually look at how awful this thing is that they're making little of*" (183) *a*nd that sometimes he has to "*sort of hold somebody back and bring them back to what they've just said and get them, to sort of look at it again because I can feel the emotional content in there that they are not acknowledging*". (365)

Orla and Richard talked about using humour to keep a lightness about things, even when they are very difficult but that this holding role remains: "t*o actually help him enter those uncomfortable places and not use the humour to deflect it all*". (Richard:329)

Modelling behaviours & teaching emotional wisdom

Two of the therapists discussed more active modelling and teaching of some of these 'emotional wisdom' skills. For some clients this starts by helping them to attend to their own emotion whether that is by being directed to more closely observe their embodiment or the therapist sharing their affect in response to a story and questioning whether the client is able to sense any of this in themselves. Donna talks about helping increase awareness of embodied emotionality:

> "*You know and I will draw attention to the embodiment of that as well and you know I might ask them… just make them aware of… do you have a sense that in your body anywhere? --So I will kind of help in helping them understand that the… they're when they are feeling something strong or reporting something that is strong there is probably an embodied aspect to it as well, so that they can kind of learn.*"
> *Donna:212*

In contrast Karin describes working with a client who was unable to notice anything about himself or connect to any sense of emotion, which made the therapy very difficult.

Orla talked about modelling acceptance of feelings, whatever they may be, in order to try and help the client's self-acceptance.

Finally, Donna also talks about working with her clients to verbalize emotions that have previously been kept out of the client's own awareness or kept from others. Talking about emotions changes them as a result. In the example below, Donna describes working with a client to help her understand the impact hiding emotions can have.

Talking About It

It really helped the relationship
That she was able to bring that up
And then we could talk about all of it

What that was like
Her understanding that holding
Such a huge secret

Might have had an impact on the way other people were around her

(Donna)

Rupture & Repair

Therapists did not always get it right when working with the therapeutic relationship and emotions in the room, but ruptures and challenges in relation could lead to an eventual strengthening of the relationship.

The excerpt below from Tim reveals several aspects of emotional wisdom – the courage to stick with a client, the attempt at emotional attunement, the dilemma over whether to say something and then a modelling (albeit unintentional!) of fallibility and failure. This therapeutic relationship is interesting in that the affective experience of both therapist and client went through several changes, with a deepening of the emotional connection that only came after an affective rupture.

"He seemed to find being in relationship, you know, making the attachment incredibly difficult and so he was actually really quite aggressive. -- I think it was a question of sticking with it and it was pretty bad for 2 or 3 months and then sort of flipped over. And then about a few months in, he just sort of threw in that he had fallen in love with me. I was sort of sitting there and so carefully trying to stay attuned to you know the slightest nuance that he might be tapping his foot or whatever. And suddenly this massive things sort of came hurdling towards me, you know, these words. And... so in about sort of I don't know, 30 seconds, I went from you know, did he say it? No, he couldn't have said it. I came back to yes, he did say it. I think he said it. What the hell do I now say? And so I didn't say anything

The following week, when he came, he was absolutely incandescent and sort of said, you know, I've had an appalling week and I've felt so depressed and you know, you clearly aren't interested in really working with me at all. There's no point trying to look clever here. You're just going to have to be slightly stupid. I mean, Spinelli talks about allowing yourself to be dumb really. "When you said something which sort of was obviously hugely important, I was just thrown". I sort of needed to – actually, apologize to some extent because clearly this had been so important. I said, "you know, I feel – you know really quite angry with myself actually". I didn't get let off the hook. I mean, I got told for about 3 or 4 weeks that I was rubbish. Things are dramatically different. I've discovered he's got a sense of humour and is actually a really very likeable guy actually. I think there was something about the therapist being human and fallible which on some level enabled this client to risk getting a bit closer." Tim:288-332

Emotion work: Learning emotional wisdom

The majority of the therapists mentioned the importance of learning and development in all aspects of this emotional wisdom. Therapists mentioned four different types of learning:

1. Learning from their own crises of existence
2. Learning from their experience of their own therapy
3. Learning from practice, clients and supervision
4. Learning from teaching and training

Four therapists openly discussed their own existential crises in the journey to becoming an existential therapist, and it is significant to me that this came up predominantly in later interviews where I had learnt better to contain my interview anxiety and to foster more rapport (partly based on feedback from Susan which I will discuss below). This seemed like the existential version of Jung's concept of the 'wounded healer' – that these therapists had either had an existential crisis of some sort or grappled with existential issues.

Richard for example talks of entering therapy after his marriage fell apart, Tim of growing up in a parentified role where he was ontologically insecure in a somewhat dysfunctional family, Susan of having "grappled" with her own existential issues and Neil of the experience of his own therapy as being profound in helping him feel his existence as an adult was validated.

Because of the belief of critical occurrence of the *experience* of therapy for the client i.e. what they feel in the room, not just what they talk about, Neil outlines his view that the best preparation for being an existential therapist, or analyst as he prefers to call it, is to through therapy oneself. In fact, he states:

> *"It seems to me that this kind of experience in the hands of somebody who is capable of this kind of therapeutic relationship with somebody is essential". (223)*

Similarly, Phoebe feels some of the ways of being as an existential therapist cannot be 'objectively' taught through training in technique but need to be subjectively experienced through repeated practice and reflection. (*It is interesting that these were my two interviewees from the USA, where practice requirements are almost eight times the size as the UK e.g. 3,500 hours in New York state vs 450 in the UK.*)

Deepening practice benefited therapists in a number of ways. Neil and Susan both describe developing an increased capacity to open to a broader spectrum of clients. Neil for example, mentions that when he was very first practicing he thought the emotional field was especially intense compared to other clients, but that he came to realize he wasn't letting the other clients affect him enough. Donna describes early experiences of the significance of when something in her embodiment was unusual taught her to pay more attention to this and therapists also described their increasing ability to handle clients' emotional expressions.

Development as a therapist continues beyond qualification. Karin describes continually working at tuning in to her emotions and working at an emotional level having benefited significantly

from a focusing workshop with Greg Madison. Orla discusses the value she places on supervision, particularly when faced with challenges.

From their theoretical training, therapists talked about the perspective on 'existence' that they bring. This does not relate directly to the emotional experience of the therapeutic relationship but does suggest something of a stance the therapist has in the room which may influence how they make sense of certain affect (e.g. is anxiety pathological or existential).

> *"And I guess what I would say then is that what existential brings is that we know that that is also part of the ontological approach to living, that being in relationship with my client is an ontic example of always being in relationship with people which is ontological. You know the constant interplay between the two which may never, the ontological may never ever -- that ontological aspect may never ever ever be brought up for explicit discussion with my client but it would be very much part of what I'm seeing as a therapist."* Donna:18

Tim also talked about this focus on existence and described a sense of compassion for his clients that occurred at times when he became somehow in touch with their mortality. Unfortunately, none of the articulations about this ontological/existence focus included explicit examples of how this influenced the therapists' emotional experiences of the therapy, although it seems clear to me that this was the grounding for the kind of therapeutic relationship these therapists tried to create (for example, a position of openness and illumination which paved the way for emotional vulnerability.)

4.7 Major Theme 4: More Than Words – Emotions are Embodied

"The Flesh that connects us" - Merleau-Ponty, cited by Neil

Themes:

- Opening the body
- Feeling it in the body, seeing it in the body
- Bringing the body into the room
- The power of the gaze and being seen
- Touching on the tricky topic of touch
- Relating beyond words – the body knows best

All of the participants referred to the non-verbal and embodied nature of the emotional aspects of the therapeutic relationship. Emotions were experienced as essentially embodied, i.e. there is *always* a bodily aspect to an emotion and emotions demonstrate that we are in our bodies, there is no mind-body split. Richard describes this as one of the defining differences of existential psychotherapy:

> *"It's that it's got that sort of very Gestalt immediacy to it for me. It's... there's no mind body split and it's a whole person." Richard:263*

However, as discussed above, although emotions are seen as experienced within our bodies intrapersonally, they were also regarded as a field that existed between therapist and client. From an embodied perspective this manifested itself in a dynamic affective relationality where the emotion perceived or observed in one of the therapeutic couple bodily impacted in turn upon the other,

Emotions are Embodied

I think the first thing I would say
Is in our emotional dimension
We are embodied

So they are very much part of my experiencing
And my client's experiencing
And how we experience them together
But they are not separate

That word embodied
Is thrown around a lot
But, to me
Emotions go hand in hand
With thoughts
With the body
With sensing
With touch
With all those inner guides

I know that it is quite important
When I think about emotionally responding to my clients
Or my clients responding with me
Then we will embody this response.

(Donna)

Opening the Body

I think I need to be open and strong
And looking very much at the body
And embodiment
Not just paying attention
To the words

I'm sensing my client
In an embodied way
And that means I need to be open
Very open
To my client's experiencing
And again my client needs to be open
To me being present with my client
That probably brings in that feeling of presence.

(Donna)

which then influenced the original emotion. The bodily sense of affective states and relationship constantly shifts in an ebb and flow.

> *"I think of emotion as a field I think or a force very much difficult to distinguish from bodily feeling, here the idea that physical sensations emotional reactions are the same thing holds pretty clearly as far as I can tell" – Neil:107*

4.7.1   More than words: Opening the body

By opening the body to the experience of the other we are able to make contact with the other, and sometimes move beyond contact to impress upon or absorb the other. It is as if we in some ways become permeable. The boundaries between self and other are opened. The next theme talks about this experience of meeting from an emotional perspective, however, the embodied aspect of this seemed especially important.

Phoebe conveys this sense of permeability when she says: "*You deeply take somebody in*" – *Phoebe:304*

Richard also talks about embodied resonance and impact:

> *"I do try and be present and try and bring the other person into contact with me--
> And this is very much about bodily awareness. But it's about learning to experience
> it. It's…learning to listen with the body. Learning to put your body into that space
> and allow things to happen to it." Richard:120*

In contrast to this, one therapist described how she could not connect and found it very difficult to work with a certain type of client who was 'hard' and 'impenetrable' (Karin). This openness and permeability was also expressed in other language. Susan describes an experience with a furious client where she became overwhelmed with the 'full force' of the client's anger and 'absorbed' the emotion to the point where she was 'unable to think' and 'not able to hold it in the middle'. Richard talks about the risk of opening the body and that it can become traumatized or seduced.

4.7.2 More than words: Feeling it in the body, seeing it in the body

By opening their body to the other, therapists open themselves to being viscerally impacted by their clients and their client's stories. They may feel sick, become tearful, become physically exhausted, are left traumatized. They also laugh, blush – all the physical manifestations we have of every feeling. This is an area over which therapists have less control perhaps.

Above, I discussed how therapists attend to and use their own affect. Frequently, this involves observing their bodily states.

> *"What I think working emotionally is something that I have to work at it's not something that comes naturally to me… So I have to really ummm somebody used the phrase dropping down into your emotions and so I try to keep that image in mind. -- And so I do use that focusing -- this idea of, of really feeling things and noticing where you're feeling them. Ummm is that emotion?, it's almost physical, you know that feeling of discomfort and I'm using my discomfort as a phenomenon."* Karin:141

> *"I listen with my body. Ahhh, rather than just simply my ears or whatever and I'm very aware of the sort of subtle changes in my body as the discomfort or comfort ebbs and flows and as the client pulls away from me. And as the client comes closer and closer to me and that ebb and flow that takes place during the therapy. I'm very, aware of what's happening to me physically in that space. And, and sometimes that can feel very emotional in the sense that I might feel overwhelmed and I might even feel tears if something terribly sad is being spoken about.".* Richard:124

Therapists also talk about observing the embodiment of their clients.

> *"I'll tell you something else that happens is that somebody can tell me something and I'll say to them … you know … there's a lot of feeling hidden in what you've just said there. And it's so subtle, it's just a slight change of voice or the voice falters very, very slightly. Sometimes the emotion comes pouring out when you do that. But you've got to really be paying attention to spot that. And it's not about listening just to the content of speech. It's listening to how it's spoken. In fact without the feeling coming up you know, that slight change of timbre of voice is felt in my body. It's not an oral thing necessarily. It's sort of… there's a sort of little resonance that takes place there."* Richard:369

"It's [emotion] embodied and again I find myself responding to feelings that I have in my head and in my fingers and in my groin and in my knees and they are all sorts of different feelings and wherever they show up that's where I go and I let myself be guided by those feelings to understand what is probably happening in this emotional field, this embodied field, what Merleau-Ponty calls flesh that connects us." Neil:114

4.7.3   More than words: Bringing the body into the room

As well as their visceral sense of embodied emotion in the therapeutic relationship, therapists also work with this explicitly bringing into discussion both their own sense of embodiment and observations and interpretations of their client's embodiment, particularly when this is dissonant with the client's verbalized emotionality or the therapist's felt sense.

Donna describes how she learned from an early experience of dynamic embodied relating in therapy to notice and "bring in" anything unusual about her embodiment. For some clients, this can include almost a teaching moment where therapists will ask the client about their embodied emoting to help them learn and be able to attend to their embodiment more readily.

"If a client ever touches their body, I will always say and what that is about. So you know sometime they put their hands up to their chest or they put their hand to their head or they'll say ummm they'll hold a bit of their body and it might be a contradiction. So they'll say I think and then they holding it to the stomach. Or they'll say I feel and they put something to the, their hand to their head or something. So I'd use the phenomena with the words of the feeling. If, if I feel… if something in their material is making me nervous or frustrated or ummm well anything really I mean we can keep going can't we. I will reflect it especially feelings in my body." Karin:164

4.7.4   More than words: The power of the gaze and being seen

When asked to describe their experience of the emotional aspects of the therapeutic relationship, the gaze and eye contact was explicitly mentioned by six therapists. One therapist discussed the gaze as fundamental in the experience of a client 'being seen'.

Eye contact can represent connection to the client, recognition of the client and recognition between the therapist and client, an acknowledging of something between them with '*a glance, a look*' where both therapist and client would know what they meant.

Eye contact is experienced as intimate and two therapists talked about clients who were unable to make sustained eye contact early in their therapeutic relationship, with the contact increasing as the therapeutic relationship deepened. Significant and emotional moments in the therapy were experienced and remembered as being marked by eye contact: "*and our eyes met*" (Phoebe:259), "*and then he looked me straight in the eyes*" (Donna:113).

This discussion of the literal gaze connected with a theme of the experience of therapy for clients as one of '*being seen*'. While the experience of being seen was more than just the visual seeing, there was a sense that the actual eye contact and gaze was a critical part of this.

> "*People it seems to me need to be recognised and need to be seen. There is, in the exchange between one person's gaze and another, a direct line it seems to me between the existence of the person and the other. It doesn't have to ever be accompanied by words and it doesn't have to be accompanied by touch. If it is it's enhanced but in a certain sense the gaze is really the fundamental line of connection between one existence and another. We see the other in this mutual gaze, and it must be mutual.*" Neil:69

Donna describes an experience of a moment of meeting with a client, an encounter of '*huge emotion*' and after talking about her client looking her straight in the eyes, she later in the narrative talks about "*a very strong sense between us that he felt <u>seen</u> by me*".(130)

The eye contact between therapist and client, and the power of the gaze of the therapist is seen as very significant and two of the therapists compare the gaze in therapy to that between lovers or a mother and infant.

Neil discussed his view that the gaze in therapy reiterates something of the mother-infant relationship in validating one's existence:

> "*The individual who ends up in existential analysis is there primarily to have her existence revalidated and so that what happens in that mothering relationship with the infant girl or infant boy is repeated and I think that's essentially what goes on in analysis. Everything else is secondary to this existential revalidation, that's what*

people crave-- this relationship then is functioning in a very fundamental way at err a primitive pre-verbal level as well as err at the obvious level of chit chat and conversation" Neil:54

Richard's metaphor for the experience of the therapeutic relationship is the lover's gaze.

"The metaphor [is] the lover's gaze. And I was looking at the idea that lovers tell each other their stories in a way that they don't tell their stories to anybody else. And they can meet themselves in that space in a different way. I mean if you are telling your GP your life story, it would be different to your lover. And what I was saying is that you know the way a therapist attends and listens with their body because I was saying that you know speaking doesn't come first. It's the listening that comes first. It's how you listen which influences... Is what influences what is said--And in that listening, somebody feels able to fill that space that you're listening in. and what I was saying was that if you can listen like a lover, the way a lover listens to a life story, you're going to get a much more real and interesting life story. The lover's gaze." Richard:219

4.7.5   More than words: Touching on the tricky topic of touch

Interestingly, Neil and Richard were also the two therapists who brought up the topic of touch.

While they were the only therapists to raise touch I thought it would be worth including their views given this was raised unprompted (there were no questions about touch) and I am not seeking to make generalizations form this research. Both of them thought touch could be powerful in therapy.

Neil believes that the gaze, touch and voice of the therapist work together for maximum impact.

"Psychotherapy is has lost a great deal of its potential by limiting the amount of physical contact that can occur between a therapist and err a client. here I think the key word is comfort because um immediately touch in our culture is read as stimulation rather than umm a calming kind of touch and err So these 3 things optimally working separately or together give us I think a slightly different perspective than the strictly verbal--In sum these three [voice, gaze, touch] go quite

naturally together in the mother -infant relationship probably the classic picture of a mother holding the infant looking at err into the infant's eyes and saying its name would be uttering some monosyllabic can and should serve as a model [for therapy]" – Neil:75

He shakes or clasps the hand of his clients while looking at them and greeting them or saying goodbye at the start and end of each session.

Richard recounts giving a client a hug that was deeply appreciated by the client:

"When I left the clinic where I was working I met this young woman who'd probably been very beautiful in her time. she came into the clinic and she had her… she had beaten up and she'd her drug stolen off her and she came in and she was crying and she was all sorts of snot and tears and she stank of urine and she had the most miserable-looking face that you could imagine. I mean, her face really, really downturned and I didn't know what to say to her. So… and then I said, "Come here. Let me give you a hug." And I hugged her and she just cried and cried and cried for ages and then she just stopped crying and then tidied herself up and left the room. When I left the clinic, she came in and she had a card that she'd written and she said, "You know, when I was in that state, you know, no one in the world was prepared to help me. But you held me in your arms and let me cry. And I know that there's no one else that would have done that." And just that act was a therapeutic I suppose in a sense. So, whilst it wasn't a very comfortable experience or a pleasant experience for me it meant a huge amount to her. And again as an example I guess of in the early days of me realizing that I could use my body as an instrument in the therapy." Richard:446

4.7.6   More than words: Relating beyond words - the body knows best

'We have already grown beyond whatever we have words for.' (Nietzsche, 1889/2003, p.96)

'What we can find words for is already dead in our hearts' – attributed to Nietzsche

Therapists described their embodied relating with their clients as deeper or more powerful than their verbal relating at times. The relationship is seen to transcend the need for words with the idea that 'the body knows best'. For Phoebe, this non-verbal nature was at the core of

her definition of the experience of the therapeutic relationship in existential psychotherapy. In response to the first question of our interview about how she would describe her experience of the therapeutic relationship, she says:

"When I go into that place of reflecting on it [the experience of the therapeutic relationship], what immediately comes to mind is a sense of intimacy, connection with the other that everything else fades away and words don't really have to be spoken. There's such a connection in an unspoken way." Phoebe:86

Karin described a very powerful therapeutic relationship where she worked with a client through an interpreter and there was a lot less language than usual.

"The strength of emotions because we didn't speak the same language was just very powerful. It was really powerful because there was less going on, there was less there. That's what I thought was the really interesting paradox is that you know, we think about the power of language. But somehow in terms of getting in touch with that emotional self, that power is amplified when there is less of it--the more you talk the less you say." Karin:350

Karin reflected further on this experience at the end of the interview when we were debriefing. She said:

"I thought it was interesting that of all the relationships that came out, the one that was the strongest was the one that couldn't speak English. And that means you're going right back to the emotion as opposed to the distractions of language.--It is stripped. And that I think makes you realize, maybe I should be saying less altogether." (920)

Richard also talks about working with his body "*rather than trying to intellectually sort out what's going on" (245).* Neil echoes this view. He feels we have a far better understanding of our emotions than we do of what we are saying and therefore that it is preferable to base the analysis of psychotherapy on "*what we know of the feelings that are being co-generated--It's far more reliable."(107)*

He conveys this sense of therapist and client trying to grasp in words the emotions that are constantly flowing between them, thus another reason for the inferiority of the verbal domain is that it is always retrospective.

"I am reminded of a saying by Nietzsche 'what we can find words for is already dead in our hearts' and of course what's alive in our hearts is this emotion that I am talking about. So the verbal will always lag behind the emotion.--You continually try but you can never get it into words because it's flowing and it's changing but you can become attuned to it and this is what I think is the sense of the Heideggarian perspective. He uses this term Stimmung or attunement quite a lot and I think this is what I think you get." Neil:118

Therapists particularly experienced this sense of unspoken or embodied relating in what, after Stern, I am calling 'moments of meeting' – experiences of close therapeutic encounter with the client. These moments were described as particularly powerful for the therapists and so I have described them in the section below. In addition to no words being needed at the time of the encounter, it is also interesting that therapists found the experience hard to articulate with words during their interviews, stating that 'i*t's hard to describe*', '*indescribably really*'.

For some of the therapists, this embodied relating eradicated the need for thought as well as for language. It seemed to be a more immediate way of relating and experiencing the other, preceding more cognitive ways of engaging. Phoebe states: *"In that moment, you are not thinking at all, you're just being with."(114)*

This importance placed on the embodied self and embodied emotionality and relating was seen by a number of the therapists to be possibly a unique or particularly important aspect of the existential approach.

4.8   Major Theme 5: The Dance of Therapy and Moments of Meeting

"The sense I got, without sounding too mystical, was a sense of total wonder" – Karin:384

Sub- Themes:

- The dance of therapy
- Moments of meeting – therapists' experiences of connectedness
- Moments of meeting – clients' experiences of connectedness
- Identifying with the client
- Connecting to humanity (transcendence)

One of the themes that emerged repeatedly from interpreting therapists' descriptions of the emotional experience of the therapeutic relationship was the fact that this experience is both intersubjective and dynamic; emotions 'move' the therapist or the client. The therapeutic couple impact each other emotionally through both their embodied experiencing and the way they express and receive the other's emotion verbally.

This emotional dynamic in therapy, while complex, is not random but has a rhythmic element to the way the therapeutic relationship shifts. I was reminded of the idea of tides or dancing as there was this notion of being pulled towards the other or retreating again. The dyadic interaction can therefore be seen as a rhythmic relationship. For some clients the rhythm was of an ebb and flow as therapist and client move somewhat closer to each other emotionally and then move away again, in some a pattern of gradually coming closer as they 'tested' the safety of the relationship with relationship ruptures leading to retreats in openness and intimacy. At other times, the emotion in one of the dyad was a catalyst for a change in emotion or experience in the other. At times this rhythm, which I came to think of as the dance of therapy, resulted in moments in which the therapist felt fully emotionally connected and present with the client in some sort of 'moment of meeting' at which point the dancers are in full contact with each other, fully open and known. During these times of emotional connection, some therapists also described a sense of transcendence.

4.8.1   The dance of therapy: Rhythm in relation

There were multiple descriptions where this intersubjective emotional experience seemed to be at play, and in a number of different ways. For example

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Dancing Towards Each Other

This was an extraordinary moment,
She was telling me
That she again was feeling unlovable
I said can you try and let yourself open
To what you're experiencing right now

She took several deep breaths
And her expression slowly changed.
And then she turned to me
And she looked at me
With tears in her eyes
And she said I'm afraid
I'm too much to love.

And then her eyes filled with tears
She turned away from me
And she seemed to be disconnecting
From me
And her painful feelings
Of being too much to love

And I mirrored that back to her
That she'd turned away from me
And what I thought,
And imagined what was going on for her.
And I asked her
Would she make eye contact with me?
And she tried
Then she had to look away again…

She tries to make,
To maintain eye contact with me again
But she can't
She looks away
And I just say to her
'And now you go away again'.

And I'm silent and waiting
What's happening for me is just
I'm silently trying to call her back
To me
And be in the present with me
Rather than be in past.

(Continued on next page)

And I asked her
Where are you now
And she says
'I move away and I watch'
And I smiled at her
 And she look quickly away.

And then I asked her
As I notice that there's suddenly now
Replacing her expression of sadness
Is a smile on her face

And I say to her
'What's happening now'?
And she says to me.
'I'm sitting on a curb.
I'm little
And you're sitting right next to me'.

I don't have to do anything
And looking at me
She says
'You're okay with me'.
And I said to her
Yes I am Claudia,
Very okay.

And our eyes met
 Full of tears
And we just grinned at each other

And no need for words.

(Phoebe)

therapists talked at different times about holding, containing, absorbing or withdrawing from the client's emotion as if the emotion can be passed around the room. (It is important to note, that these experiences were not described as projective identification, where the client 'puts something into' the therapist, but more as a kind of affective empathy).

The poetic condensation by Phoebe to the right has been abridged but is still long. However I have decided to include it because it explicitly conveys this sense of dance, with a client turning toward and turning away, eye contact made and then broken off again and the way that this is played out during the session. The therapist describes how this leads to a sense of connection and then disconnection as they lose contact with each other. It demonstrates how this dance is an interweaving of embodied and verbal dance steps.

Susan describes some of her own research with therapists and clients where descriptions also conveyed this rhythmic dance.

"He [the client] talks about feeling very understood but moving in and out of it so then there are times when he's wondering 'does she really understand?' and then the therapist talked about moving in and out of her client's experience feeling totally immersed in it but then stepping back out of it." Susan:321

Donna gives another example from her own experiences which again talks about this feeling of resonance that may not be verbally spoken about.

Sometimes this dance is not an intricate dance towards each other but a movement of affect from one to the other. Two of the therapists described their experience of having the client's emotions "dumped" on them as if the expression of affect from the client with the therapist acted as a cathartic 'discharge' of emotional force. The idea of intersubjectivity

was suggested through the fact that therapists talked as if they had "absorbed" the emotion. I had the idea reading these descriptions that emotionally, we are translucent and semi-permeable. Richard gives such a description:

> "I've got a client whose son fell off his bike in the park and died when he was 7. And I've been working with her for a long time now. But I find certain times with her I come out of that room absolutely drained that I sometimes have to pull back from offering myself into that space because it's just too painful and there are times when she goes into this incredibly painful place where she virtually goes into a completely different altered state and she has the ability eventually to snap out of it. She calls it 'the shutters come down'. And boom, she's there and she can smile and she's okay again. I'm left with it. It's almost like if I absorb enough of it, she can let go of it."
> Richard:301

The language in Richard's description conveys the sense that we have some control over the level of exposure of our emotions and emotional availability (to both ourselves and others). We 'snap out of it' or 'bring the shutters down' or 'offer ourselves'. Other therapists also talked about the client "shutting themselves off" which again reflected this ebb and flow as the client moved in and out of relation to their emotions as well as to the therapist. Richard also powerfully conveys the experience of this dyadic interaction with the other's emotions. We are 'drained' by them or 'absorb' their emotion.

In another example, he describes how the client's observation of his own emotional response leads to an affective change in the client:

> "And it was listening to her and her reaction to that and how humbling it had been for her. You know I had tears rolling down my cheeks. It was just such an emotional thing she's talking about. And what was weird was she stopped being emotional and said... well, she snapped out of it immediately and said, "Oh, Richard. I'm really sorry. I didn't mean to upset you." [Chuckles] But then when she saw me having tears rolling down my cheeks...Absolutely choked with emotion and she snapped out of it straight away." Richard:289

Orla describes how her own affective response is 'brought out' by the client.

> "I feel very moved by her often to the point of being tearful at times. She brings out a real tender side of me." Orla:62

4.8.2 The dance of therapy: Therapists' experience of connectedness

In the ebb and flow dance of the therapeutic relationship five therapists talked about specific powerful experiences of emotional connectedness with their clients.

These experiences did not happen with every client or in every session, and represented an experience of an increased emotional intensity and greater sense of closeness and 'knownness' in the therapeutic relationship with the client, generally accompanied by a feeling of warmth and affection.

There were differences in the descriptions of these experiences with some therapists (Phoebe, Tim) talking about discrete vivid affective *moments* that occurred – a particular session or experience within a session, whereas others including Orla talked about an ongoing sense of presence and intense emotional connection to a client in their therapeutic relationship. This difference also came through in that some therapists (Orla, Donna, Tim) referred to the fact this connection occurred within the context of a long-term relationship where things were known about the client and closeness had built over time, yet Karin described an emotionally intense connection with a client she saw only for seven sessions.

Phenomenologically, there were similarities in the descriptions of therapists' experiences whether the therapist was talking more about a specific encounter moment or a more holistic experience of relatedness. Therefore I discuss them both in this section, but highlight which the therapist is discussing.

This experience of 'meeting' was a sense of being intimately and powerfully connected to the client in a way

A Moment of Connection

And then the second thing
I need to describe
Is that when they are very strong
And very resonating
We have that moment

And there's a moment of connection
Where it feels very strong
And that is unspoken
Very often what is shared between us
May not be spoken about

My client is saying
'I'm just very emotional'
And I can feel very emotional
I mean that happens as well

It isn't necessarily got at with words
But there is a real incidence
There is something of that
being shared between you
And is going to be shared between you

And in fact
It would particularly be the case
With clients I see long-term

Those kind of shared resonances build up
And they kind of almost build layers
So that that recognition is there
You know
Kind of more acknowledging between us

With a glance
With a look
With a kind of understanding
That wouldn't have been there before

(Donna)

that was different from other clients or other sessions, but in a way that was somewhat intangible.

Elements of these 'connectedness' experiences included a sense of exclusive focus on the client, a narrowing of the world down to just the couple in the room and obliviousness to time. The 'connectedness' feeling was hard to describe - it was "*extraordinary*" or "*full of wonder*" but it included a sense of the therapist and client fully knowing each other in that moment and was generally affectively powerful and embodied with no need for words. For some therapists, this connection to the client led to a transcendence and feeling of broader connection to humanity, which I discuss at the end of this section.

Orla describes her lived experience of this:

> *"It's a woman that I am currently working with. I mean I love working with her. The experience has changed obviously over time and so I could describe my experience from the beginning, but right now as of, you know, as a result of working with her for a year and a half is... is very... when I'm with her, God I'm incredibly, incredibly focused. It feels for that 50 minutes, I mean it does, I usually have no sense of time, although we've never gone overtime 'cause she's always sort of very aware of endings (laughs) but [there is no awareness of], of nothing particular, nothing else existing really in that... in that moment except her and me... in the room, talking about what we're talking about, so a real with her. It almost reduces my world into just that relationship at that time. So I'm very... I'm really involved I'd say and she…I experience her as being very involved. So I usually feel very energized and very connected and I feel connected to... to her, to me." Orla:48*

Both Orla and Tim described this experience of emotional connectedness as energizing for them, even, in Tim's case when a session had occurred at the end of a long day with both therapist and client feeling tired and ambivalent about being there at the start of the session. These two therapists also mentioned their feelings of warmth, affection and 'a kind of love' for these clients which also included feeling very moved by the client to the point, for Orla, of tears at times.

Another feature of this experience of connectedness mentioned by a couple of therapists was the sense of being able to project or imagine forward and have a sense of who their client might be in the future, or some of the potential they have.

"I feel a lot of care for her, concern, fondness. I mean I'd call it love, but you know, love in terms of wanting the best for her and knowing... almost a having a sense of who she might be as well as who she is now. -- My emotional connection is kind of tied up in a very temporal dimensions I think in some ways, because I can see her in my head as how she was when I first met her -- what that would look like and the kind of growing confidence and the change in her appearance and, the way she moves is different. -- And part of… I guess when you feel, I have an image of her as a woman that she has yet to be--the woman she is possibly going to become as she becomes more confident and more at ease, at peace with who she is and the choices she makes, becomes braver." Orla:56

Donna, Phoebe and others talked about the necessity of a safe and strong relationship with the client for this experience of meeting to be able to occur and both also discussed the importance of 'presence' – the therapist and client being in the 'here and now' of the room with the therapist very open to the client's experiencing and sensing the client in an embodied way. One of the things that may make such moments significant is that it is the first time the client has had this experience of safe intimacy or has shared a particular topic with anyone.

Part of the therapist's affective response is in realizing how much she means to the client or in seeing the client's openness, moving towards them or impact of the therapy. Karin describes a powerful experience with a client she worked with through an interpreter.

"The sense I got, without sounding too mystical, was a sense of total wonder. It's amazing. This woman she came from a different world. I mean entirely, from a village off a mountain in Turkey.--It's just it is full of wonder. You could be 2 women and you could just see, I know it was good for her because she wanted to carry on afterwards. I could tell

Coming Together

I feel we've gone on a journey
There was an extraordinary sense in the room
I think
Of us almost coming together
And it was almost as though
You know
We'd start and finish each other's sentences
It is relatively intangible.

(Tim)

Feeling the Other

I actually felt slightly tearful.
She said actually that what had been really helpful
Was that I seemed to be very much
Well, there you go
In tune with her
when she was talking
I think it was possible for me
To be quite present there
And I suspect it was obvious to her
That I was feeling quite emotional as well.

(Tim)

and in fact, when she left she just, she could not stop looking at me. It was just like I've actually met a human being. And we did connect and we weren't, she in fact, she had her haircut and she started wearing a bra. And so I think I influenced her because I always dressed you know presentably. And I think she began to think about herself differently. And I was so struck by the fact that she was so lost and yet she managed to find me. I mean, I'm so different. I'm so privileged but despite all of the privilege I've got, we are 2 women and we completely met. And that is full of, I don't want to say it's wonderful. But it is full of wonder." Karin:384

One of my participants had done some empirical research of emotional attunement so described the experience of this research as well as her own direct experience of connectedness. This research found a very high level of emotional attunement at a nonverbal level, with both therapist and client describing things in the same way for particular moments of the session including for example what a smile connoted even though these things had not been discussed verbally.

4.8.3   The dance of therapy: Clients' experience of connectedness

Most of the therapists were able to offer their perspective on their clients' experiences of this emotional connectedness, either through their own observation or through things the client had told them. They also talked more broadly about the role and impact of this kind of connectedness.

Orla and Phoebe talked about the importance of their warmth and presence in enabling the client to have a first experience of this particular kind of 'loving' care and acceptance that eventually enabled the client to open up and then 'meet' the therapist.

Orla also discussed how she used her affect to challenge the client's notion that she is unlovable, a theme that also emerges implicitly from Phoebe's narrative.

"Because we've voiced it [our loving, warm feelings of connection] we've been able to talk about it as part of the work and our conversations--So I think the making it explicit and she knows that's the truth, that's what she sees, and what she experiences and it feels to her genuine when we've talked about that. It's not a 'put on' kind of care." Orla:80

Therapists' felt that the client experienced increasing acceptance of themselves and freedom leading up to these 'moments of meeting' and that in the closeness of the meeting experience with the therapist, the client also meets themselves in a new way in the presence of the other.

This ties in to the emotional experience discussed in the section above about the client feeling 'seen' in the therapy and experienced as 'ok' and acceptable to the therapist in all their seen-ness i.e. things that they have not let others see about them.

> *"A very strong sense between us that he felt seen by me, and that he felt being by himself in a new way so it's almost like in that encounter--he could be seen by me as someone, that that was alright. That it was alright, to feel that… this way and that, so he didn't feel judged about that and I think that's what he experienced himself, that he was able to experience himself in a much bigger, in a bigger sense I suppose"*
> *– Donna:142*

Susan raised the challenge in not knowing for sure what the client was feeling in this experience of close connectedness, even though her strong sense was that the client had felt it too. It was interesting that the idea she could not know what the client was thinking only came to her in the 'cool' reflection on this experience and the implicit feeling I got from some of these descriptions was of a tension between a value of the existential-phenomenological approach (that we do not assume we ever know what the client is feeling) and the actual experience of these connected moments (we have a shared sense of emotion and there is no need for words or to ask the client about this experience at the time of its occurrence).

> *"The client where there was a very strong kind of emotional connection between us which I can talk about and this is a slightly different experience in that, you know, the emotion was kind of positive in a sense that I felt very connected to her. There was a lot of you know, I really liked her on a human level and it felt like kind of very-- you see I'm thinking it's interesting when I think about it because so much of it is not directly expressed so I can kind of tell you how I was feeling about her…But obviously I can't tell you, you would have to ask her as to what her side of the experience was"*
> *Susan:215*

Susan went on to further reflect on this paradox in the context of 'moments of meeting'. She seemed to start reflecting on her experience of connectedness with this client in a new way. Having previously felt intimately connected with and using it as an example of intense

emotional connection she then raised the concern that perhaps this experience could actually be a sign of a client's poor ego-boundaries.

> *"See what I'm immediately thinking of, I don't know if you've read Yalom's 'A tale twice told', he felt very powerfully connected to the client but when you read the client side of the story, you know, my feeling was reading that, was that he'd completely missed her. So I'm cautious because what I'm thinking is that having a strong connection and feeling about someone in itself may be saying something but it may not be exactly what you think it is. In other words, you could… In that case in the Yalom book, umm because the client was slightly schizoid and slightly not expressive, you could almost see it that Yalom was almost projecting his own stuff on to her. She was becoming the client he wanted her to be. You know, so it's weird to talk about feeling connected to the client, you know, some… If the client doesn't have a strong sense of self then or if you identify, you know… so well, say if you really strongly identify with the client, it may be about poor boundaries. Maybe the client has weak boundaries and this client certainly did, so in other words, feeling connected to her may have some therapeutic meaning about the way that she is in the world, um as well as about the way that we are together." Susan:233*

While an individual perspective, I thought this was a point worth including because of its challenge to the general concept that these moments of meeting included a deep empathic component where the therapist is able to feel what the client is feeling. Clearly, because I only interviewed therapists the level of synchronicity of these experiences of meeting cannot be explored, although the therapists felt as if it was a mutual affective connection. Asking Susan if she thought the client knew *her* feelings (i.e. rather than Susan being accurate about the client's feelings) and her response was "*definitely, yes*".

4.8.4   The dance of therapy: Identifying with the client

Three of the therapists referred to feelings of personal identification with the client with whom they discussed this experience of attunement or strong connection. This personal identification included feelings of having had a 'similar-enough' experience or identifying with the client's gender and current life circumstances. With a client with whom she felt a strong positive emotional connection Susan talked about how she liked the client and also felt that she understood her narrative and could relate to it. Susan also discussed how she felt this applied generally, and that emotional connectedness between therapist and client is stimulated by the "*match*" in the dyad.

"I really enjoyed working with this client and really, you know, it felt a lot easier to work with her because I felt connected to her. I felt, you know, I understood her narrative and the things that she brought. I thought I could really understand and relate to [her]." Susan:213

"And I think it's something that can't necessarily be brought about by technique. It may be much more about how the client and therapist match or interact with each other." Susan:253

I asked Tim about the role of this similarity and he said that he found the issue interesting because what he teaches and believes is that the less you have in common with a client, the more likely you are to build a therapeutic alliance because there is less bracketing involved. On the other hand, in looking at his lived experience, he was clear that he felt there was something significant with this client about their shared childhood experiences. For Orla a sense of emotional connectedness with her client also came through a shared humour with the client, she couldn't imagine a session they hadn't laughed in together.

"You sometimes work with people who you feel a lot of love for. You know, the guy I'm going to see tonight -- Well, and this guy… his journey. I can so identify with this young man, you know, with what it's like being a young man at that time of your life and you know everything in your life seems to be going pear-shaped and he's really doing his best to, as he says, 'sort his shit out'." Richard:323

One of the other aspects Tim referred to was a sense of noticing existential themes in common with clients with whom he had these experiences of connectedness – "*the big themes*" that one might say are ontological such as isolation, loss of identity and alienation – and that it was fairly easy to connect around these (because they are ontological and so therefore common to all of us). This idea of connected with humanity came up repeatedly.

4.8.5 The dance of therapy: Connecting to humanity

Four therapists discussed an emotional sense of connection to a shared humanity, and this feeling of transcendence of the self to this broader level most often occurred through these attuned moments of feeling an intense emotional connection with the client. It seemed as if in connecting to one person and their humanness, one is connected to everyone; by connecting to one other, we connect to all others. Karin, for example, in describing a particularly resonant

relationship states "*it was just like I have actually met a human being*". Orla and Tim echoed this experience:

> "*When I feel like that with some clients, there's something connecting to humanity about it. I've not actually put that in words before. But I do have a strong sense of being alive in the world with her, with people... with this world of ours full of people and it's crystallized I think when... when you're really connected with someone or when I'm really connected with working with her.*" Orla:54

> "*And I have that sense of him going into the future, um, probably without our meetings and there was a sense to me of being with another human being.--There's a sense of a sort of humanity, shared humanity I suppose. I find it very rich. So you know, when we finished, I felt actually quite energized, and yet we were meeting you know middle of the evening and it had been quite a long day.*" Tim:125

For Tim, these moments have a poignancy about them because of our mortality:

> "*Buber's notion of that sort of I -Thou experience perhaps sums it up quite well. When they occur [these moments], I take them quite seriously. There's just something incredibly basic and poignant. I think it is that notion of being able to see the skull beneath the skin. I'm sitting with somebody and I'm actually sort of very aware of somebody's mortality; almost the very thing which defines as a human being frankly.*" Tim:137

This sense of shared humanity also came through in two of the metaphors that therapists gave to convey the experience of the therapeutic relationship.

> "*I don't think anything quite better has been said than what Irv [Yalom] has said that we're fellow travellers. I think… I think there is something so well said and simple that… that he expresses in that because to feel the connection… with the other as simply, I am a traveller, you're a traveller. And there's nothing that makes me any more above, better, different than you. We face the same challenges…… of living our lives, of working through… of meeting the challenges of working through whatever it is that, you know, is difficult for us. We suffer, we hurt, we cry, we laugh, you know. And I think that… I hold that always when I'm with people. Always.*" Phoebe:152

Tim's metaphor is the final one and it captures this sense of therapist and client being human together, alongside each other, separate but touching at points.

> *"A sense of swimming sort of in a common existence as it were with somebody else and we're both swimming and occasionally we will be able to touch and we will be able to swim in the same direction and we might get to see similar things and have similar experiences although they are never identical." Tim:171*

5 Discussion

In this chapter, the main findings of the study are summarized and discussed in the light of pre-existing research and literature. As is accepted in hermeneutic phenomenology, new literature in addition to that covered by the literature review may be utilized where the findings have suggested a new avenue to study. In addition to discussing the results I briefly reflect on the significance of these findings for the conceptualization of the therapeutic relationship. I also include a discussion of my personal reflexivity. Finally, methodological and theoretical considerations are discussed and evaluated.

5.1   Discussion of the Results

Eight semi-structured interviews were conducted with experienced existential therapists, with the aim of conducting a phenomenological exploration of their experiences of the emotional dimensions of the therapeutic relationship. Van Manen's (1997) hermeneutic phenomenological techniques were employed and five major themes were identified:

1. The relationship is the therapy
2. Emotions matter - feeling is first
3. Emotional wisdom
4. More than words - emotions are embodied
5. The dance of therapy and moments of meeting

Together, the results confirmed the centrality of the therapeutic relationship in existential psychotherapy, and the fundamental role that emotions play in this relationship. Emotional experiences are complex and dynamic, experienced in an embodied way and often in some kind of rhythm or dance with clients. This requires skill and wisdom from the therapist is attuning, attending and responding to both their clients' and their own affective experience.

5.1.1   Theme 1: The relationship is the therapy

Consistent with extensive research and literature across multiple modalities (e.g. see Norcross, 2011), the therapeutic relationship emerged as a (if not *the*) core component of existential psychotherapy. The relationship was seen as a therapeutic factor in and of itself, rather than just as a 'vehicle' to facilitate more effective delivery of technique (c.f. Beck, 1979). The

strength of feeling about the importance of the relationship brought to mind Rogers (1957) assertions that the relationship is both necessary and *sufficient* to change. That is, provided the therapist displays unconditional positive regard, empathic connection and congruence which is communicated to the client then no other conditions are necessary. This active attending to and focus on the relationship within the therapy is in line with Davis' (2007) assertion that both psychoanalysis and existential therapy are grounded in the analysis of the relationship. However, in contrast to psychoanalytic approaches which seek to analyse and interpret the relationship using theory and technique, the therapists here talked about being with the client in a more open way.

The existential therapeutic relationship was defined as a relationship of openness including i) opening oneself to meeting the other, ii) opening one's own self to experiences, and iii) keeping the therapeutic space open. Davis (2007) and van Deurzen-Smith (1997) both discuss 'openness' as one of the fundamental features of the therapeutic relationship in existential psychotherapy. The therapist's openness to the other reflects Buber's (1970) notion of the I-Thou relationship, which he fundamentally distinguishes from the I-It relationship. In the I-It relationship, the other is experienced as an 'object' and therefore one's openness automatically starts to be restricted as the other is systematized, analysed and evaluated in a thing-like way. In the I-Thou way of being, we meet the other with our whole being and seek to experience the whole being of the other, as they are in the present, and in openness to and loving confirmation of their otherness (Cooper, 2003). For some therapists, this openness to the other in the present means attempting to 'meet' them as a new client each time, based on the view of the self and existence as dynamic (Merleau-Ponty, 1945/1962). The therapist seeks to be unknowing (Spinelli, 2006), bracketing previous knowledge and assumptions.

In line with the I-Thou attitude of relating, all of the therapists described fostering their *own* openness as well as their openness to their client; they were actively involved *in* the relationship. This mutually involved alliance reflects the "intersubjective turn" (Crossley, 1996) seen in other forms of psychotherapy such as relational psychoanalysis (e.g. Mitchell, 2004) as well as other fields such as social psychology and cultural anthropology (Boskovic, 2002), as post-modern and constructivist approaches have become more dominant in epistemological discourse challenging the classic subject-object divide.

The third and related area of openness discussed was in keeping the therapy itself open. The existential therapist is focused on being-with not doing-to (see Spinelli, 2004); the therapist does not seek to impose specific goals, expectations or techniques other than in the way they relate and listen to the client. This raised a strong resonance for me with Rogers' (1957) focus

on being with the client. Schmid (1999) draws a parallel between Rogers and Buber's work in that the relationship is not a precursor for some therapeutic 'means' to then be applied but that the encounter only happens when any 'means' falls apart. Similarly Mearns and Cooper's (2005) focus on working at relational depth shows some resonance between person-centred and existential views of the therapeutic relationship in their emphasis on an open form of encounter between therapist and client.

Despite this shared agreement about the importance of the therapeutic relationship, Cooper (2003) outlines variations in the extent to which different existential approaches actively focus the therapeutic work around the immediate therapeutic alliance. This variation was expressed by the therapists in this study who suggested variations are likely to exist between each practitioner and even for each therapist-client dyad and four of whom provided cautionary voices in trying to more formally define this therapeutic relationship.

Three of them talked about the "*really wide*" spectrum of ways that people work within an existential approach or under an umbrella term of 'existential psychotherapy'. Susan suggested a distinction between those who are more explicitly philosophically oriented and those who are more relationally oriented drawing on their own existential issues or philosophy more implicitly. Richard suggested that every existential practitioner works in their own way.

On a related note, Susan was the only person that brought up the point that how people say they practice and what they actually do in the room may be two different things, and that this applies for therapists from any orientation so that we may not actually practice the way our philosophical values and theoretical underpinnings might suggest.

Reflecting on these comments, two thoughts came up for me. One is that this research is not intended to generalize or make declarative statements about the therapeutic relationship and its emotional dimensions in existential psychotherapy; it is instead seeking therapists' lived experiences and meanings. The second, more interpretive reflection, is that these comments describe something of the value-base of existential psychotherapy in honouring freedom and the choice of the individual in contrast to a more mechanistic view of therapy as the application of technique or a manualised approach.

What was consistent in the research was that all the therapists saw the therapeutic relationship as critical, and that it's open and mutually-involving nature led to rich emotional experiences for therapists and clients.

5.1.2   Theme 2: Emotions matter - feeling is first

The emotional dimensions of the therapeutic relationship were seen as powerful, and therapists gave primacy to their and their client's emotional experience over more or solely intellectual explorations. In line with other literature (e.g. Lodge, 2010; Rogers, 1961; Maroda, 1999; Greenberg & Paivio, 2003) it was seen as important that the therapeutic relationship offered an emotional *experience* not just the opportunity to verbally reflect on past emotional experiences. This is in line with Greenberg's (2002) view that emotional schema are open to change during 'hot' emotional experiences. One of the therapists explicitly outlined her critique of a more cognitively based formulation of therapeutic change which works primarily on changing thoughts and behaviours. Instead, she sees our emotions as more influential on our ways of being in the world, in line with Greenberg's (2002) views that it is emotion that guides and motivates our lives.

This is tied to an understanding of the nature and function of emotions. The word emotion comes from the Latin emovere, where e- (variant of ex-) means 'without, move out, remove, agitate', and movere means 'move'. (http://www.etymonline.com). Our emotions are intentional; they are oriented at something and serve, among other things, to focus our attention (Frijda, 1986). They indicate what we are moving toward or retreating from in the world (van Deurzen, 2005) and can act as a compass in navigating one's direction in life (van Deurzen, 2005). From an existential perspective, all emotions have a functional capacity, even those that may be pathologised from other theoretical orientations such as anxiety. For example, from an existential perspective such as Kierkegaard's, anxiety is an inevitable and central part of our existence as we face our life choices; anxiety is the 'dizziness of freedom' (Kierkegaard, 1844/1980, p61) and brings our attention to the decisions we have to make. Similarly, Langdridge (2010) outlines an existential understanding of fear and sadness and the adaptive role these can play.

Researchers have also addressed the 'interpersonal' functions of emotions, showing that emotions function similarly in our social relationships with others, determining who we move towards and away from and helping with relationship establishment and maintenance (Niedenthal & Brauer, 2011). Ethological studies suggest how emotions guide social interactions such as courtship and appeasement rituals (Eibl-Eibesfeldt, 1989) and emotions have been demonstrated to structure relationships between parents and children (e.g.Bowlby, 1969), siblings (Dunn & Munn, 1985), and romantic partners (Levenson & Gottman, 1983). Although they may be generated intrapersonally, emotions such as anger and embarrassment have been shown to have systematic effects on other individuals (e.g. Averill, 1980; Keltner & Buswell,

1997; Miller & Leary, 1992), and disruptions in emotion processes – the abilities to understand, express and experience emotion – lead to the loss of social support (Niedenthal & Brauer, 2011) Discursive approaches shows how emotion talk is used purposefully in relation to the other (e.g. Edwards, 1999), and therefore emotion communication and processing is a requirement of successful social living.

Infants display inborn physiological differences that relate to emotional sensitivity (Koole, 2009), however developmental research indicates that caregivers may play a key role in regulating children's emotional states (Southam-Gerow & Kandell, 2002) and the child's developing competencies at emotion regulation are strongly influenced by the quality of their social interactions with their caregivers (Mikulincer, Shaver, & Pereg, 2003; Southam-Gerow & Kendall, 2002).

The premise of attachment theory is that an infant needs to develop a relationship with at least one primary caregiver for this social and emotional development to occur normally (Bowlby, 1969) in ways that facilitate the development of further relationships and exploration into the world. Empirical research demonstrates that early maltreatment leads to difficulties in understanding and regulating responses to the emotions of others (Pollack, 2008) as well as influencing our emotional disposition and ongoing behaviour towards ourselves and the world, for example the degree to which we feel secure and explore the world as adults (Hazan& Shaver, 1987). Some argue that chronic deficits in emotion regulation contribute to all major forms of psychopathology (Bradley, 2000; Kring & Werner, 2004).

Literature from multiple fields (child development, social psychology, emotion research and psychotherapy literature) all advocates for the important role emotions play in human relationships. The emotional experience of the therapeutic relationship can offer a number of benefits to the client.

As Karen (1994) states:

> "Therapy can do many things. It can provide a new model of what a close
> relationship can be; it can teach one how to reflect on feelings, events and the
> patterns of one's own behaviour in a way that one was unable to do before; it can
> compensate to some degree for nurturing experiences one never had as a child…it
> can provide a context where the portion of the self that has always been ready to
> relate in a new, more trusting, more direct and healthy way can emerge…and it can

offer a safe haven where feelings of shame no longer present such a terrible barrier to self-exploration"(p.402).

Therefore emotions can be seen to 'matter' in therapy for a number of reasons: 1. They tell us about what is important to our client and how she or he is relating to the world, 2. Experience of emotions in the room may lead to reprocessing or changes in affect regulation capabilities, reducing emotional dysfunction as in the case of PTSD or trauma (Fosha, 2000), and 3. Therapy can provide a model of emotional behaviour and a safe place to learn new emotional skills and capabilities (Fosha, 2000).

The emotional relationship between therapist and client may play a particular role serving as a quasi-attachment relationship, leading to changes in attachment style (Karin, 2004). A number of the therapists talked about their clients having an experience of relationship they had not had before and this is in line with research findings demonstrating therapeutic outcome of attachment style change (e.g. Fonagy, 1996; Diamond et al., 2003). Psychotherapeutic treatment thus seems to be able to shift adult attachment patterns in the direction of greater security (Daniel, 2010).

The research revealed the rich, complex and dynamic nature of emotions in the therapeutic relationship. Emotions in therapy included both those that exist in the relationship between therapist and client created in the therapy room, as well as the therapist's and client's own intrapsychic emotions they bring into room. This may include more dispositional affective states, which may relate to attachment security for example, as well as more situational emotions, such as anxiety about a particular event.

Emotions are therefore seen as being both *within* the therapist and client and *between* them. Together, this created a complex emotional environment. In line with Bridges' (2006) view therapists discussed varying components of emotional experience including:

- Emotional arousal: physiological aspects
- Emotional experience: subjective felt sense and intensity of emotion
- Emotional expression: verbal and non-verbal emotion displays
- Emotional processing: meaning of the emotion and integration of emotion and cognition

These components existed independently for both therapist and client and are also intertwined in the relationship between them and therefore constantly dynamic. For example, the client may experience an emotion that leads to emotional arousal in the therapist. The therapist may express her emotion or ask the client about his emotional experience, and the client's expression of their emotion may impact the client's subjective experience and as they process the meaning of the emotional experience both of their physiological arousal shifts.

Therapists therefore do not just perceive their clients' emotions, they are impacted by them, and also recount experiences of their own affect seeming to impact and shift that of their clients. Cooper (2005) also discusses how therapists felt 'impacted' upon by their client - using language such as affected, touched, moved, influenced. From an existential perspective, this brought to mind Heidegger's notion of attunement, which suggests that we resonate with the world around us, always in some kind of mood (stimmung) (1927/1962). May (1983) discusses his experience of this attunement in the therapeutic encounter, using the analogy of plucking a violin string and another violin in the room resonating accordingly (p.22).

While Heidegger acknowledges our attunement to the outside world, Binswanger (1942, discussed in Frie, 2003) sees his position as one in which one ultimately achieves authenticity in isolation rather than in 'dialogue' with each other. This is in contrast with existential philosophers who adopt a more relational perspective on the nature of human existence and the self (e.g. Buber, 1970; Jaspers, 1986; Marcel, 1950). Nanda (2006) discusses Buber's I-Thou in relation to psychotherapy and the notion that the self emerges in this dialogue with another, in what Binswanger calls the "we-self" (in Frie, 2003). As Friedman (2008) states, in Buber's I-Thou relationship, the partners are neither two nor one but stand in the relationship between them where each partner becomes more in tune with their own self as they move to respond more fully to the other. This raises the underlying philosophical tension about the nature of the self –the self 'within' and 'the self between'. As Stern (2004) states, a differentiated self is a condition of intersubjectivity, as without it there would be only fusion. The same question applies about the nature of psychological dis-ease; today's mainstream approach is that common complaints such as anxiety or depression exist and should be worked with intra-personally caused by faulty thinking or depleted neuro-transmitters, and treated by CBT or medication. A more relational or systemic understanding of the origin of such experiences would imply solutions that are more systemically focused. The findings here echoed the complexity of emotions and the self as existing both within and between.

Merleau-Ponty (1945/1962) brings together both this view of the body-subject and a relational understanding of the world, and this philosophy guides existential therapists in their practice. Richard stated during his interview:

> *"There's a beautiful piece by Merleau-Ponty, where he's talking about his relationship with the world and with objects and it's not about people, this but I think it equally applies to people. Where he says, yeah, there is this magical relation where with objects where I lend them my body and they—impress themselves upon me and give hem, me their resemblance. In other words you only experience the world by allowing your body to be in the world and having the world impact on it"* (122).

5.1.3 Theme 3: Emotion work – applying emotional wisdom

This theme reflected the fact that therapy and the therapeutic relationship emerged as involving sophisticated emotional work requiring focus, courage, skill and discipline. The theme of '*emotional wisdom*' was my interpretation of the therapists' descriptions of consciously, deliberately and carefully working with emotion.

These descriptions reminded me somewhat of research and work I have done in my other career as an organizational psychologist on Emotional Intelligence, which is defined as "the subset of social intelligence that involves the ability to monitor one's own and others' feelings and emotions, to discriminate among them and to use this information to guide one's thinking and actions" (Salovey & Major, 1997, p.5).

Geller and Greenberg (2002, p.83) sum this up well in discussing their own research on therapeutic presence, stating that presence involves "a careful balance of contact with the therapist's own experience and contact with the client's experience, while maintaining the capacity to be responsive". They describe a dynamic continually shifting experience as therapists move from internal to external focus, from self to other from being open and receiving to being responsive. Other writing supports this notion of a therapist attending at different levels. Robbins (1998) for example, describes presence as involving a "dual level of consciousness" (p.11), and Schmid (2002) describes presence as "joint experiencing with the client" (p.65). Bohart and Tallmen (1997) also discuss the need for the therapist to listen with "dual attention" (p.403) - both to their own internal reactions and that of the client. Geller & Greenberg (2010, p.599) conclude: "The inner receptive state involves therapists' complete openness to clients' multidimensional internal world, including their bodily and verbal expressions, as well as openness to their own bodily experience of the moment".

As well as attending to both themselves and the client, the therapist may also be attending to different levels of emotional relatedness between them. Lodge (2010) suggested a distinction between two distinct emotional levels operating within the therapeutic relationships, a manifest level at which the work was taking place and a deeper more implicit level that was not articulated.

One of the implications of this is that many of the skills required related to the therapist themselves, rather than techniques for use with the client, including their own self-monitoring, self-awareness, self-soothing /regulation when required along with self-control. Skills and decision-making was also required over self-disclosure and expression of emotional experience, although sometimes expression (verbal or non-verbal) is unavoidable or unintentional. As Wosket (2002) states: "only part of self-disclosure is in the conscious control of the counsellor" (p.51).

Wosket distinguishes between *personal* self-disclosure, which in her opinion is rarely useful, and *relational* self-disclosure in which the therapist is disclosing some of her experience, including emotional experience, to the client. Yalom (1980) agrees, stating "I feel it is often important to reveal my here-and-now feelings to the patient" (p.414) in contrast to details of his personal past and current life. Wosket states that her relational self-disclosure arises from her felt response in relationship with her client including feelings, bodily sensations and changes in energy. She discusses this within the context of 'immediacy' – the name given to feedback that occurs in moments of direct, mutual dialogue between counsellor and client (Wosket, 2002) which she regards as a catalyst for change. Research on self-disclosure suggests that the more therapists self-disclose, provided the alliance is positive, the more likely they are to be seen as likeable, warm and attractive by their clients (Dowd & Boroto, 1982; Myers & Hayes, 2006). Cooper (2008) notes that the number of times therapists self-disclosed was still moderate and it is likely that moderate self-disclosure is better than no self-disclosure or extensive self-disclosure, the skill then and the wisdom required of the therapist in determining when and how to self-disclose their emotional and relational experience.

5.1.4   Theme 4: Emotion is embodied

One of the ways in which therapists attended to emotion was in observing and tuning in to their embodied affectivity, and it was striking that in the moments of particularly deep emotional connection experienced by therapists, they described using a minimum of language, interpretation or conceptualization.

There are many embodied ways in which emotions unfold, including facial expressions, bodily postures, voluntary and involuntary motor movements, and psycho-physiological responses (see Mauss & Robinson, 2009, for a review). Other research, particularly from experiential and person-centred therapists, supports the focus on embodied feeling found in this study. Geller and Greenberg (2010) describe therapists using their bodily sense as a barometer and navigational tool in tuning into what is happening for the client and how to respond. Mearns (1994, p.6) states when present with a client: "I could feel his body with my own". Cooper (2005) in a qualitative study of therapists found that participants typically stated that relational depth may be manifested in a non-verbal way. Bohart and Tallmen (1997) state that people can 'directly' perceive and recognise meanings in another's communications and behaviours without deliberate conscious activity (p.402). They refer to the bodily based recognition and perceptions of meaning that occur naturally in everyday life, contrasting this with conceptually analysing meanings. The therapeutic relationship is both experienced viscerally and emotionally.

Lodge's (2010) research into emotional attunement between therapist and client offers some confirmation of this, suggesting a high level of consensus on nonverbal emotional attunement with both therapist and client describing key moments similarly, e.g. the meaning of a smile between them, even though the emotional experiences may not have been addressed verbally in the session. Interestingly, this is in contrast to some of the research on alliance strength where therapists and clients' ratings show less accord. For example, Duncan & Moynihan (1994) found therapists' self-ratings of presence were not found to significantly relate to clients' reported session outcome or the therapeutic alliance. It is the client's experience that counts: clients' experiences of the therapist are strongly associated with session outcome and alliance whereas therapists' experience of themselves is less significant with respect to the therapeutic alliance, process and outcome (Geller, Greenberg & Watson, 2010).

The distinctions made at times between active thinking and more pre-reflective being in the therapeutic relationship, and between verbal communication and more embodied ways of sensing raises interesting questions about the nature of knowledge and consciousness. Existentialist practitioners have challenged classical psychoanalytic notions of the unconscious and repression (e.g. Spinelli, 2005), partly because of their binary simplicity. Instead some (e.g. van Deurzen, 1997), have proposed that we explore the complexity of consciousness, with our different levels of awareness and access to information, in the same phenomenological way we do other phenomena.

Theoretically, as discussed in the literature review, some have proposed separate processing systems for cognition and the emotions (e.g. Geller & Greenberg, 2003; le Doux, 1998, Zajonc, 2001), although this is a highly –debated topic (e.g. Storbeck & Clore, 2007), and some that emotions may exist at different levels of consciousness such as Strasser's (1999) distinction between reflective and pre-reflective emotions. Emotion research also suggests that learning guided by our emotions may be unconscious; tests using skin conductance response (SCR), thought to be an indicator of an emotional response, shows that emotion-associated learning can occur without conscious awareness (Carter, 2003).

Emotion research has explored the notion of 'vicarious emotion' – where one experiences an emotion because we observe another person experiencing an emotion (Niedenthal & Brauer, 2012). For example, people wince in pain when they see someone else get hurt (Bavelas, 2007) and cringe with embarrassment for someone else even when their own personal identity is not threatened (Miller, 1987). Niedenthal & Brauer (2012) discuss results that show a distinction between this 'vicarious emotion' from the experience of empathic concern, the first experienced when research participants were asked to imagine themselves in the same embarrassing situation as the target were witnessing and the second when participants were asked to imagine how the target felt. They suggest that vicarious emotions, as well as the motivations and action tendencies they produce, are distinct from the cognitive components of empathy. This is in line with other contemporary views and research on empathy which define it as consisting of separate cognitive and affective components (e.g. see Bohart & Greenberg, 1997, Bachelor 1988).

Gardner's (1993) theory of 'multiple intelligences' suggests that intelligence is a biological and psychological potential that exists in a number of realms beyond our classic conceptualization of cognitive intelligence. Among others, he proposes 'interpersonal' and 'bodily-kinaesthetic' intelligence and suggests these different forms can be relatively autonomous. His 'interpersonal' realm of intelligence may be similar to the idea of emotional intelligence discussed above.

Similarly, Van Manen (1997) also discusses the idea of 'noncognitive knowing' including knowledge residing in the body in which we have an immediate corporeal sense of things and knowledge residing in relations with others. This idea of a 'bodily wisdom' is in line with Gendlin's (2003) notion of 'felt sense'. From an existential perspective, the notion of embodied relationality is in line with Merleau-Ponty's conceptualization of the individual as the 'body-subject' who develops and relates through other body-subjects, and where knowledge may be pre-reflective and pre-linguistic.

Facial feedback theory suggests that the reproduction of perceived facial gestures is important in aiding our emotional understanding. By mimicking a target's facial expression the perceiver is provided with affective feedback that can provide clues to infer the internal state of the target (McIntosh, 1996; Zajonc et al., 1989). This has a number of implications for the practice of psychotherapy which I will discuss in the conclusion – beyond the fact that therapists should carefully consider whether to proceed with Botox injections which has been shown to dampen affective feedback! (Neal & Chartrand, 2011). Niedenthal and Brauer (2012) are careful to point out that emotion processing can also be achieved through perceptual analysis and the application of pre-existing emotion beliefs.

This sense of embodied relationality is in line with Merleau-Ponty's (1945/1962) conceptualization of the individual as the 'body-subject' who develops and relates through other body-subjects. In neuroscience, the reproduction of perceived emotional gestures and states has also been interpreted in terms of mirror neurons and mirror systems, with the idea that brains can resonate with the states of perceived objects (e.g. Gallese, 2007). Research in monkeys showing touch-sensitive neurons that respond to the sight of another animal being touched in the same location (see Kilner & Lemon, 2013) has led to Ramachandran (20009), a trailblazer for the significance of mirror neurons and leader in the field, to call these 'Gandhi cells' because he says they dissolve the barriers between human beings. While the premises ascribed to mirror neurons are not without critique (e.g. see Jarrett, 2013), and much research remains to be done on exactly the role they play, a recent review of 25 animal studies (Kilner & Lemon, 2013) shows a number of ways in which the animal's internal world is activated through and in response to the other. Mukamel et al. (2010) has demonstrated the existence of mirror neurons in humans.

As Youell (2007) asserts, the discovery of mirror neurons along with other recent neuroscientific developments (e.g. dyadic affect regulation, and unconscious communication) are all consistent with Merleau-Ponty's portrayal of the profoundly intersubjective and bodily characterisation of human development. We are permeable.

Emotion researchers have therefore proposed that we have an embodied or simulated emotion approach to the processing of emotion in social context. Emotion simulation refers to the idea that in order to understand emotions in others, individuals process facial expressions and use their own body and brain representational capacities to infer what the other person is feeling (Niedenthal &Brauer, 2012).

If the emotional relationship between therapist and client is somewhat analogous to the emotionally attuning and regulating attachment relationship between mother and child, this also raises interesting questions about the dominance of the verbal sphere in psychotherapy. The infant's development starts with touch, moves to visual dominance and the final stage of early emotional development of the brain is the development of a verbal self (Dales & Jerry, 2008). In verbal development, recent research confirms what we know intuitively: that the baby picks up and infers intentions based on the mother's prosody (rhythm, stress and intonation of speech) rather than the speech content (Sakkalou & Gattis, 2012). Therapist tonality and prosody have been stressed in experiential therapeutic approaches that focus on reprocessing of painful emotional experiences such as AEDP (Accelerated Experiential Dynamic Psychotherapy, see Fosha, 2000), through dyadic affect regulation.

Language elaborates and carries forward our experience only after bodily sensing which is in the present (Gendlin, 2003). It is always retrospective and is always a translation of our experience. Emotions reside in this nonverbal affective domain. Binswanger uses the example of romantic love stating "the real expression of love is not language, but rather the 'silent' look…the silent embrace of love" (Binswanger 1942/1993:146 – cited in Frie, 2003, p.152).

5.1.5   Theme 5: The dance of therapy and moments of meeting

One specific phenomenon of the dynamic and mutually impactful nature of the emotional experience of the therapeutic relationship is the rhythmic nature of this interplay - which I am calling the dance of therapy - and the fact that for some therapists, with some clients, this leads to 'moments of meeting' or times of feeling very close and connected to one's client and possibly broader humanity.

The existential perspective is that we are always in the process of becoming, and our experience of being is dynamic and ever-changing (van Deurzen & Arnold-Baker, 2005: p.160). Our self is a process, not a thing. This would imply that the therapeutic relationship is also ever shifting as client and therapist and the relationship between them continually adjust. However, there is a felt sense of rhythm to this ongoing adjustment suggesting the metaphor of the 'dance of therapy'. Others have also described the mutually empathic dialogue that can occur in therapy as a "dance" (Bohart & Rosenbaum, 1995) and Trevarthen (1993) suggests that an empathic conversation is like "a musical duet, in which two performers….seek harmony". Lodge (2010) also found this dancelike pattern, for example in one of her therapeutic dyads the client described moving in and out of feeling understood and the therapist described moving in and out of feeling connected to the client's experience.

We can think about this phenomenon on multiple levels, including biological, psychological, philosophical and spiritual.

Biologically, normal interaction between babies and caregivers is characterized by moves from affectively positive, mutually co-ordinated states to affectively negative, mis-coordinated states and back again on a frequent basis (Tronick & Cohn, 1989) that also reflects something of a mutual dance. Research shows that mothers and babies synchronize their heartbeats to within milliseconds of each other through this synchrony of gaze, affect and vocalizations (in other words by looking and smiling at each other) and this heat-rate concordance reduces in non-synchronous moments (Feldman et al., 2011).

This physiological synchronization has also been found in adults, for example when the elevation levels of cardiovascular or electrodermal (ED, also known as the galvanic skin response) indicators of one person are affected closely in time by the same indicators of another person during an interaction (e.g. Levinson & Gottman, 1983). As long ago as 1957 research demonstrated that physiological synchronization can occur between a therapist and patient when conflict is anticipated (Dimasco, Boyd, & Greenblatt, 1957; Malmo, Boag, & Smith, 1957) and so one way of understanding this 'dance' and the 'moments of meeting' is as a process of dyadic affective and physiological arousal leading to moments of synchronicity.

Psychologically, synchronization can be observed as a patterning of verbal exchanges between a therapist and patient (Hartkamp & Schmitz, 1999), or in conversation partners such as Guastello et al.'s research showing increasing synchronicity of electrodermal response during conversation progression (2006). Nonverbal types of synchronization are also observed, such as the development of coordinated task sequences among work team members who cannot talk to each other (Guastello, Bock, Caldwell, & Bond, 2005; Guastello & Guastello, 1998), or the patterns by which two people shift their weight from the left foot to the right while in conversation (Shockley, 2003).

Such non-verbal attunement may be accompanied by both affective and cognitive empathy that coalesces to create this feeling of a moment of meeting. Different words and explanations have been used in therapy to attempt to describe this sense of shared psychological and emotional experiencing between client and therapist including empathic resonance (Bohart & Rosenbaum, 1995), empathic attunement (Greenberg & Elliot, 1997), affect attunement (Stern, 1985) and affective empathy (Bachelor, 1988).

Bohart & Greenberg (1997) discuss the various conceptualizations of empathy including views that see it a hermeneutic process of coming to know the mind of another and others who see empathy as closer to affect contagion; where the therapist comes to *feel* some of what the client is feeling. There is debate about whether the therapist's experiences are in harmony with or identical to the client's, and to what extent cognitive functions are also involved. Stern (1985) suggests that affect attunement is different from empathy as it occurs mostly automatically and largely out of awareness. Although both processes (affect attunement and empathy) include emotional resonance, for Stern, empathy also involves mediation of cognitive processes. Maroda (2010), writing about emotion in psychotherapy, advocates the idea that therapist and patient will be engaging in unconscious to unconscious communication and talks about the importance of a good enough therapeutic match in order that this can occur.

It was interesting that therapists gave quite similar descriptions of these experiences of emotionally 'meeting' their clients. Some of the characteristics (time appearing to stop, a narrowing of focus) are similar to Csikszentmihalyi's (1990) concept of 'flow' in which one's motivations and energies are fully absorbed, which made me think perhaps this is about a narrowing of consciousness, reflected by one of the participants who stated that it is as if the world is reduced to her and her client at these moments. This fits quite well with some theories of emotion (e.g. Frijda, 1986) that emotions serve to narrow and focus our attention.

Finally, more philosophical and spiritual descriptions and accounts may also be explored as a way of understanding these moments of meeting, and particularly the somewhat transcendent experience of connecting not just with the client but with all of humanity. van Deurzen (2002) made explicit the spiritual dimension of existence, adding this to the physical, psychological and social dimensions outlined by Binswanger (see van Deurzen, 1997), although she and Arnold-Baker also acknowledge that this is the most controversial level of human experience. This spiritual dimension of life and relatedness has been addressed by existential philosophers such as Buber (1970), Tillich (1952) and Jaspers (1986). Philosophically, Buber (1970), as discussed above, has addressed this notion of fully encountering the other and four of the therapists explicitly referenced Buber in describing their experiences of the therapeutic relationship and these moments of connection.

Clarkson (1995) uses the term 'the transpersonal relationship' to describe the spiritual or inexplicable dimensions of relationship in psychotherapy and Rowan (2002) suggests that the transpersonal relationship occurs alongside the instrumental and authentic relationship and suggests that in this transpersonal realm "the boundaries between therapist and client may fall away" (p.4). This is echoed by Hart's (1999) view of three levels of empathy which Rowan

encapsulates as treating, meeting and linking. It is at this third level, 'linking' that Hart suggests two selves connect on a dimension beyond the bodily and the verbal. Rogers' (1980) attempts to describe this experience:

> *"When I can relax and be close to the transcendental core of me...it seems that my inner spirit has reached out and touched the inner spirit of the other. Our relationship transcends itself and becomes a part of something larger. Profound growth and healing and energy are present" (p.129).*

Jung's (1959) notion of the collective unconscious perhaps offers one way of thinking of about this sense of transcendence. Geller and Greenberg (2002) discuss 'expansion' as one of three components of therapists' experiences of presence. In line with those therapists who described feeling connected to humanity in this research, they similarly describe therapists "experiencing an expansive state as if part of something larger" (p.80).

Therefore there are different ways of making sense of this 'attunement' – it may be seen as something spiritual (from a transpersonal perspective), or as the communication between the therapist's and the client's unconscious (from a psychoanalytic perspective) or the collective unconscious at work (Jung) or as the giving and receiving of subliminal/beyond awareness emotional cues and body language to convey our affective experience to another and mutually regulate affective states (as documented in work on mother/child interactions e.g. Tronick, 1989; Beebe & Lachmann, 1988; and in recent work on emotional contagion and affect regulation e.g. Schore, 2003 and in certain types of therapy e.g. Fosha, 2001).

5.2   Personal Reflexivity on the Study

5.2.1   Reflexivity on study origins

As stated in the introduction, this research was stimulated by my experiences of personal therapy, and the questions this raised for me about the nature of the therapeutic relationship. I was surprised by the emotional intensity of the encounter, and by the centrality of the relationship to my therapeutic experience. I would not have been able to word it this way at the time, but it felt like the relationship *was* the therapy.

As my personal therapy continued while I began to train as a counselling psychologist I had fundamental questions about what exactly was therapy and what made a successful therapeutic relationship. The questions 'who am I when I am being a therapist?' and 'what am I doing when I am doing therapy?' occupied my brain for weeks. I began my training eager to learn 'content' about how to 'do' therapy *for* my clients, but gradually became much more concerned with 'process' and 'being' a therapist *with* my clients. This is a crude and over-simplified distinction but hopefully reveals some of my underlying queries.

One of the ways in which I resonate with the profession of counselling psychology is that it draws influences and assumptions from both the scientist-practitioner and the reflective-practitioner models of psychology and psychotherapy (Woolfe, Strawbridge, Douglas, & Dryden, 2009). In reading, thinking and reflecting about the therapeutic relationship I found myself drawn to phenomenological, narrative, philosophical and transpersonal/spiritual literature on the one hand and yet fascinated by neuroscientific and empirical research advances in exploring the nature of relationships and emotions on the other.

Having previously considered clinical psychology training courses in the UK, I was drawn to counselling psychology because of this embracing of a more pluralistic perspective than I perceived in the clinical training (professional practice guidelines, Division of Counselling Psychology, 2013), although my explorations of multiple perspectives has also led to tensions and paradoxes. I don't think my identity of who I am as a therapist or as a counselling psychologist has fully crystallized (if it ever will), but this research has reconfirmed for me both the importance and the wonder of the therapeutic relationship.

5.2.2   Reflexivity on study process

I have completed a journey over the past five years where my own epistemological and ontological positions have moved to more intersubjective, constructivist and relativist ways of looking at the world. I see the centrality of relationships for our existence in philosophical, psychological and even biological terms. Heidegger's (1927/1962) notion of 'being-in-the-world', though simple to express, conveys a broader way of understanding the world for me.

In my initial stages of thinking how I might research the therapeutic relationship, I had considered including my own experiences of therapy as part of the data. I have kept a series of narrative accounts about my experiences of therapy. I was very aware however, that the act of researching something changes its nature, the so-called 'Hawthorne' effect (Mayo, 1993) and that this has been observed in clinical as well as industrial/organizational settings (e.g.

McCarney et al., 2007) and decided not to risk intruding on what felt like an important relationship, especially at the time of commencing this research. If I am being honest, I was also not sure I was brave enough to outline my own experiences for the world to see. Unlike my participants I would not have had the benefit of anonymity. I had also initially considered conducting the research with therapist-client dyads but teachers and advisors had warned of the ethical complications of such a design, and given the complexity of already living outside the country in which my studies are based I decided to abandon this idea. I return to this when I discuss further research avenues in the conclusion.

In terms of the process of the research, it felt very dialectical. Each time I engaged with the literature my focus broadened and deepened. I had started with research about the centrality of relationships in general - from a philosophical, psychological, and biological basis. I moved on to look at the research on the therapeutic relationship and its centrality to effective therapy. This led to wide reading about the nature of the therapeutic relationship across multiple modalities and from different professional perspectives. As I got closer to my research I then honed in on existential therapy and emotional aspects of the therapeutic relationship. As Lodge (2010) states, there is an overwhelming amount of literature on 'emotions' and 'the therapeutic relationship' but much of this literature did not overlap. My participants also contributed to my learning. Although I had completed much of my literature review before commencing the research, they prompted new areas of investigation.

The research experience was demanding. I think this was for a number of reasons, partly influenced by the initial looseness of my area of interest (experiences of the therapeutic relationship) and the breadth of reading that I chose to engage in, and partly because of the duration. It has taken some years from initial proposal writing to submission, a considerable investment of time given the majority of Counselling Psychology professional doctorates are positioned as three or four year programs with the thesis only forming one part of this. At points I berated myself for not having selected the clinical training programs I had previously rejected, having had past experience of quickly and successfully completing quantitative post-graduate research.

However, despite, or perhaps because of, the pain and time invested in this process, I have felt much more personally involved and invested in this research, which I hope has and will directly impact my own position and practice as a therapist and have something of value to offer to the profession of counselling psychology. Moustakas (1990) discusses how a heuristic enquiry actively transforms and awakens the self, leading to increased self-understanding and discovery. Etherington (2004) also discusses how reflexive research may involve profound

personal development and transformation. For the duration of this study I was simultaneously a researcher, a therapist and a client and it felt these varying experiences all informed each other. I am a better therapist than before I began this research and am grateful for that.

One of my outstanding questions about the research is whether my deep personal involvement in the topic, and my own assumptions and biases have been appropriately utilized. The analysis of the results and the writing of this dissertation has been an exercise in balance between avoiding too many assumptions, yet still allowing my familiarity with the area to be of use. It is striking to me how many of my own assumptions and personal experiences of the therapeutic relationship also emerged during this research (see Appendix 1 – Core Assumptions). I was reassured by Lodge's (2010) reflections on the similarity between her own therapeutic experiences and some of her results. However, I do not present this study as an articulation of 'the truth' about therapists' emotional experiences in the therapeutic relationship, only one way of understanding this phenomenon. The fact that there were some surprises for me in the data (along with the methodological rigour, supervisor involvement etc.) provide some assurance that I remained open to the words and experiences of my participants and Etherington (2004) revalidated my belief that personal experience could indeed be a valid basis for a research enquiry.

5.2.3   Reflexivity on study findings and impact

One of the things this work has helped me do is to reflect on the broad nature of therapy and the multi-dimensional character of the therapeutic relationship. The importance, form and way of understanding emotional experiences of the therapeutic relationship is likely to be informed depending on one's underlying philosophy about the role of the therapist and nature of therapeutic change. In the gross simplification for illustrative purposes below, I would suggest that shifts in emphasis on the role of the therapist have followed general developments in psychotherapeutic theory and clinical practice through the decades.

The therapist began as *The Doctor*, an expert. Within the psychoanalytic field this was as an interpreter of unconscious desires through the transference relationship, and so emotions were projections, reflections of defences and conflicts, there to be analysed. The rise of humanism in the 1960's led this to be replaced by the therapist as *The Healer* – a provider of love and acceptance that enabled the client to heal themselves and self-actualize. In the 1980's and on with the rise of behaviourism and then cognitive theory the therapist can be conceptualized as *The Teacher* – again an expert, but this time at imparting knowledge and skills to the patient about how to influence their thoughts, feelings and actions. Emotions between therapist and

client were about establishing a collaborative working relationship as a vehicle for technical skills, and for the client as a dependent variable that followed changes in thought patterns. The rise of intersubjectivity and re-focus on attachment theory has perhaps led to *The Partner* – where therapy is a relational and mutually affective experience. Emotions here may on some levels be similar to some older ideas of therapy as 'reparative' or even reparenting (e.g. see Clarkson, 2003) but with an increased understanding of their dyadic nature.

The metaphors given by the participants in this study mainly emphasize this mutual involvement. They were:

1. opening and illuminating,
2. sitting together on a park bench,
3. looking together into reflecting water,
4. having a foot in each world,
5. being a fellow traveller and
6. swimming together.

However, while therapy is mutually affective, the therapist is there in service of the client. The metaphors that originally came to me regarding the therapist's role in the emotional experience of the therapeutic relationship were that the therapist is the 'shepherd' , 'guardian' or 'caretaker' of emotions in the room, and while these metaphors get at something of the role, they did not capture the proactive and reactive way in which therapists deliberately worked with emotions.

In terms of my own practice, there are a number of immediate applications of this research for me. I work as a psychotherapist, a coach and an organizational psychology management consultant. In each of these roles the client relationship is central to the experience and I have become much more aware of and reflective about the roles I am adopting with different clients, in different contexts and at different times.

One of the areas that surprised me was the predominance given to the non-verbal domains of experience and communication, and I decided I would like to better honour my bodily wisdom (Nietzsche, 1885) and deepen my skills in the non-verbal arena. Since conducting the research I have already completed a Mindfulness Based Stress Reduction program which included extensive exercises on becoming more aware of our bodily states. I am keen to do some work on focusing. I have become more willing to be silent with my clients at what feel like pivotal

moments and concentrate less on what I am doing and more on how I am being. I think some of this is probably a natural course of development but it has been aided by this research.

Ultimately, I have moved closer to the existential position which highlights the integrated and relational character of our lifeworld. Our thoughts, emotions, bodily states, behaviours and experiences and the meaning-making we apply to these do not exist in separation from our social world, they co-exist and are inextricably connected and co-created (Buber, 1970, Heidegger 1927/1962, Merleau-Ponty, 1945/1962).

5.3 Methodological Considerations and Critical Reflections

5.3.1 Strengths

This study has drawn attention to an as yet undeveloped area in research, existential therapists' experience of the therapeutic relationship, and in particular its emotional dimensions. It is hoped that the findings will stimulate further discussion and reflection on the therapeutic relationship in existential psychotherapy and counselling psychology, and in particular the role of emotions and nature of emotional experiences in therapy.

The use of Van Manen's (1997) hermeneutic phenomenology has enabled participants to reveal rich details of their experience of the therapeutic relationship. The interviews were conducted in a flexible manner, which allowed themes to emerge from therapists' own lived experiences.

The coherence of the analysis of the data was ensured through multiple discussions with the research supervisor and study peers, as well as through an ongoing hermeneutic process of diving into the raw verbatim data and then back to the interpretive analysis. Writing and rewriting became its own reflective process with thoughts crystallizing and interpretations emerging over time. A number of different interpretations of the same data are possible, indeed inevitable, in interpretive phenomenology which rejects positivist assumptions of one reality. However, the discussions and reflective processes did ensure the fit between the themes and the excerpts (Henwood & Pigeon, 1992). This 'rigour' of analytic process reflects one of Finlay & Evans (2009) criteria outlined in my methodology chapter for evaluating qualitative research. Their others are relevance, resonance and reflexivity. If I reflect on these I feel the work does have some strengths in terms of my own reflexive process and I discuss its relevance to others in the conclusion below.

5.3.2 Limitations

Limitations can be considered of the research question itself, the overall epistemological and methodological approach and the specific methodology.

In terms of the research question, it is clear this has been informed by my personal experience and unresolved questions in how I consider and reconcile my own views on the therapeutic relationship. In focusing specifically on therapists' experiences of the emotional dimensions of the relationship there is much that is excluded and the research itself is pointing in a clear direction. Willig (2007) suggests that the researcher's choice of label for the phenomena of interest and the way questions are worded are not merely descriptive acts but constitutive ones. This raises an important point about how the way I conducted the research informed the outcomes. If I had asked therapists to simply describe their experience of working as an existential therapist would they have then brought out and placed the same emphasis on the therapeutic relationship and in discussing emotion?

King et al.'s (2008) polyvocal qualitative analysis demonstrates how different approaches can draw out different meanings. Interpretive research requires engaging with possible meanings and any one approach (and any one researcher) will provide variations in interpretations. From a phenomenological perspective, the outcome of the research is assessed based on what value it provides. Therefore, I accept that my research was a constitutive act focusing therapists' attention onto the relationship but this is purposefully so.

A more descriptive approach, for example based on Giorgi or Collazi (e.g. see Langdridge, 2007), would likely be less interpretive and more focused on identifying and describing the 'essence' of the therapeutic relationship. Discourse analysis could have been very revealing in contrasting how psychoanalytic and existential therapists language their conceptualization and approach to the relationship, and given the rich psychoanalytic terminology around this area this is an interest of mine for future study. One could go on to show how grounded theory or even quantitative approaches could be used to research the therapeutic relationship in existential therapy, but this is designed merely to illustrate the array of possible alternatives. Phenomenology was considered most suitable because of the focus on the lived experience of the therapists.

Privileging the verbal and conscious

Looking at a more tactical level at my methods, two of the key limitations of interviews is that they privilege the verbal account of experience and that they are always retrospective as they rely on the participant's interpretive recollection of a prior experience. King et al. (2008) state that it is when research participants struggle for words or lose clarity that phenomenological discoveries are more close to the surface. At times my therapists struggled to put their experiences into words, particularly when trying to describe non-verbal phenomena.

Embodied and non-verbal experiences emerged as one of the key themes of the findings in this study suggesting that the limitations of solely verbal accounts may be particularly key when investigating affective and relational phenomena. Finlay talks about her embodied sense of intersubjectivity (1005) and Willig (2007) also refers to knowledge that is embodied and not expressed in words. One can imagine how different and richer understandings of the therapeutic relationship may emerge for example with video tapes of sessions used in conjunction with interviews. Recent neuropsychological research (e.g. Schore, 2003) has begun to open up new ways of exploring the impact of therapy in non-verbal ways such as through the use of fMRI studies.

One concern of mine is that the nature of the relationship and the way it is used in therapy may be out of explicit awareness so there may be some difficulty in verbally reflecting on something of which aspects may be deeply pre-reflective. Schore (2003) suggests that much of our emotional communication is made up of micro expressions of which we are not consciously aware. Emotion research also suggests that learning guided by our emotions may be unconscious; tests using skin conductance response (SCR), thought to be an indicator of an emotional response, shows that emotion-associated learning can occur without conscious awareness (Carter, 2003). Lodge's (2010) research on emotional connection in the therapeutic dyad also led her to conclude that "the deep emotional connection really does seem to lie beyond or beneath words". Phenomenological research acknowledges that our descriptions and interpretations of phenomena can never be more than that: "deep thought may be reached for by means of the text but it should not be confused with the text itself". (Van Manen, 1997, p.53).

Therapist perspective only

One other clear limitation is my sampling approach which focuses solely on therapists. Many of the studies on the therapeutic relationship are one-sided (using either therapists or patients as

participants) and studies that have included both have found typically low accordance on, for example, the helpful factors of the relationship (e.g. see Duncan et al, 2010) suggesting there is value in this joint view. When what we are studying is a relationship, the unit of analysis could ideally be the dyad - a co-constructed account of the relationship by those in the relationship. Like King et al. (2008) this may have provided additional value by generating both consensual and individual accounts of the relationship. My preferred approach therefore was to include therapist-client dyads within the research as in Yalom's account co-written with a past patient (Yalom & Elkin, 1974). However, this raises significant ethical concerns and is not practical for the scope of this thesis, and using patients at all was very quickly dismissed for the same reason despite the fact that research shows client's contribution to and perceptions of therapist alliance (rather than therapist) best predict outcomes (e.g. see Duncan et al., 2010). One of the clear limitations of this research is that it presents only the therapists' perspectives. Lodge's (2010) work is to be commended for its research methodology of working with therapist-client dyads and the iterative process of circling back with all participants in an approach that is clearly more dialogical and hermeneutic than the one adopted for this study.

Despite therapists' proclamations of experiencing their client's emotions or key moments of emotional attunement between them, research has repeatedly shown that therapist and client ratings do not accord (Duncan & Moynihan, 1994). Findings abound that the client's perceptions of the relationship or alliance, more so than the therapist's, correlate more highly with therapeutic outcome (Horvarth, 1995, Orlinsky et al., 1994).

Therapists' self-ratings of presence were not found to significantly relate to clients' reported session outcome or the therapeutic alliance. It is the client's subjective experience that counts, with consistent evidence that client ratings of the alliance are stronger predictors of treatment outcome than are counsellor ratings (Connors, Carroll, DiClemente, Longabaugh, & Donovan, 1997; Horvath & Symonds, 1991; Luborsky, 1994).

One way researchers have tried to address this is by triangulating perspectives on the therapeutic relationship by using independent observers, however yet again "when assessments of the relationship are made from the patient's perspective, the cumulative research record strongly supports the salience of relationship factors as predictive of outcome (Orlinsky, Grawe and Parks, 1994) but not when the assessments are made by independent observers!". Orlinsky and Ronnestad (2000) criticize much of the research done on the therapeutic relationship which often depended on quantitative ratings by independent observers. They state that research of the relationship from the separate perspectives of patient, therapist and outside observer typically fail to agree (Orlinsky& Ronnestad, 2000).

Given how fluid, dynamic and constantly constructed the therapeutic relationship was revealed to be in this research, it may be that more refined measurement processes are required to track things more sensitively. This continually dynamic nature of the emotional experience of relatedness in therapy has implications for effective measurement. Feltham (1999) in discussing some of the issues of research measures of the therapeutic relationship, discusses the fact that measures typically do not focus on the interactive nature of the relationship but the personal qualities and contributions of therapist and client.

A benign view of the therapeutic relationship

One of the implications of only speaking with therapists is that we are perhaps likely to take a benign view of our work and of human relationships given that therapy is a human endeavour. Yet, there is a dynamic tension in our relationships with others. van Deurzen (1997, p.160) states:

"To live with the paradoxes of proximity and distance, dominance and submission, togetherness and aloneness, belonging and isolation, is a whole world in itself. It requires careful modulation of our experience and a life-long process of learning to get it right".

The issue of domination and objectification by the Other is elaborated by Sartre (1943/1991) who regards this as an intrinsic part of our relating with others. There is a power imbalance in therapy and the emotional influence therapists have over their clients is regarded by some as a form of social control (Szasz, 1974), as leading to inevitable abuse of that power (Masson, 1988) or creating opportunities for sexual exploitation (Baur, 1997). While some of the therapists acknowledged the power they had, none discussed its potential abuse.

In contrast to the relational perspective of philosophers like Buber, other existentialists discuss the importance of individuation, of finding our authentic selves and will to power through separation not relation. van Deurzen-Smith (1997) in contrasting Jaspers' philosophy states that the in contrast to Jasper's view of the other as a vital and positive presence "in a way that is unthinkable for Husserl and his solipsistic universe, Heidegger and his insistence that we gain authenticity away from others, to Sartre and his claim that the other is hell" (p.73).

 It is interesting to consider what these philosophers would make of an emotionally intense therapeutic relationship, especially one where the client may be seen as temporarily regressed and dependent on the therapist as a form of transitional attachment object.

6 Conclusion

In this chapter I briefly summarise the research findings. I then discuss the significance of the study for the training and practice of counselling psychology and existential psychotherapy before looking at professional and political implications. I discuss its validity before indicating some potential areas for further research.

6.1 Summary of Research Findings

The results presented here support the often quoted view that it is the therapeutic relationship that heals. This research suggests that it is what takes place in the emotional relationship between client and existential therapist that is relevant, both at a manifest verbal level and at a more implicit bodily level. As Lodge (2010) states, this emotional aspect of the therapeutic relationship has been under-researched by Counselling Psychologists.

6.2 Significance of the Study for the Training and Practice of Psychotherapy

Being with rather than doing to

The findings support the idea of Counselling Psychologists and existential therapists 'being with' clients rather than 'doing to' clients (Spinelli, 2005). This provides a challenge to the notion of Counselling Psychologists as technical experts applying theoretical models to clients and has implications for both training and practice.

From a training perspective, there are skills involved in 'being with' just as there are in approaches more akin to 'doing to'. Lodge (2010) makes the suggestion that technical skills remain relevant but should be addressed to the therapist rather than the client. The counselling psychologist is 'doing to' him or herself by thinking about the therapeutic process, attending to and processing his or her own emotional responses, and being self-aware in order to be with the client as fully as possible, rather than doing things to the client. There is evidence that certain skills can be learned that can enhance an optimal therapeutic relationship, such as accurate empathy, reflection, and self-disclosure (Egan, 2007; Goldfried et al., 2003).

Increased self-awareness and self-assessment of our own emotional dispositions and aptitudes may also be beneficial here. Psychometric assessments I have used in my work as an

organizational psychologist would suggest there are enduring dispositional differences in our emotional experiencing and expression (e.g. extraversion/introversion as on the Myers Briggs Type Indicator, the dimension of 'affection' on the FIRO_B scale). The accuracy, use and implied biological basis of such indicators is controversial and beyond the scope of this discussion other than to recommend that trainee Counselling Psychologists may use a range of methods to help them explore and learn about their own emotional characteristics given that "the therapist's use of self" (Wosket, 2002) is so fundamental here.

It's the relationship

Given the lack of evidence for any one theoretical method over any other, and the compelling evidence about the importance of the alliance, training in the therapeutic relationship should be a clear focus of training for Counselling Psychologists in the UK.

While the importance of the common factors and specifically the therapeutic relationship are acknowledged within the very ethos of counselling psychology (Woolfe et al., 2009) the academic components (and indeed in many cases the practical components) of Doctoral courses in the UK seem to be organized by theoretical orientation so for example one studies the therapeutic relationship from a psychodynamic, then a humanistic, then an existential then a client-centred perspective.

From my perspective as an organizational psychologist, I began to think through how a course may be structured differently if we placed the quality of the therapeutic relationship and emotional wisdom skills at the heart of our training. This could include for example:

- specific skills training such as focusing or mindfulness training to better attune to our own affective and bodily states
- training designed to increase empathy and emotional intelligence (which is used in the business world)
- cross-theoretical teaching on concepts such as empathy rather than addressing this consecutively in different theoretical modules
- more explicit focus on analysis of therapist-client practice dyads to look at experiences of emotional connection and disconnection- a focus on session process rather than outcome – using video and other techniques to permit detailed reflection
- role-plays and experiential sessions on working with highly emotional experiences given that a number of the therapists explicitly commented on how highly emotional

situations - particularly issues of client's sexual attraction, dealing with anger or how to handle and explore emotional dissonance – were harder for them earlier in their career.

One of the other implications for training is the value that an existential perspective may provide within more mainstream training courses where this approach is not specifically addressed. Existential philosophy and therapeutic approaches have much to offer in providing ways to conceptualize and frame the therapeutic relationship beyond the classic position of a subject-object divide between 'doctor' and 'patient' where one dispenses treatment upon the other.

Buber was cited by a number of the participants as providing important insights for them and offers a different way of understanding relations to the other. Interestingly, some recent research in the medical field has also addressed training for clinicians to develop effective healing relationships based on Buber (Scott et al., 2009). This research identified a number of clinician competencies necessary for clinicians to participate in healing relationships: self-confidence, emotional self-management, mindfulness, and clinical knowledge and their definition of emotional self-management and mindfulness in particular echo themes from this research. They define emotional self-management as "the ability of the clinician to be aware of her own emotional response to the patient's story, and to calibrate that response appropriately" (p.2) and mindfulness as "the ability of the clinician to be aware simultaneously and in the moment of the effect of the relationship on both himself and the patient". (p.2)

In the research, the therapists talked about learning from their experience of their own therapy, from practice, clients and supervision as well as learning from teaching and training.

Several of the therapists felt that some of the ways of being as an existential therapist cannot be fully objectively taught through training and technique but require extensive subjective experience through one's own therapy and practice with repeated practice and reflection. Interestingly, the importance of practice was explicitly stressed by my two American participants where practice requirements are almost eight times the size as the UK e.g. 3,500 hours in New York vs 450 in the UK- although this is partly due to the fact that learning and progression to becoming a licensed psychologist is structured differently here.

An embodied experience, being seen

The repeated and extensive focus placed by therapists on eye contact, embodied experiencing and physical presence raises interesting questions about the potential limitations of telephone

or online therapy, which has rapidly grown over the last decade (Novotney, 2011). The 2012 Psychotherapy Networker Conference, which is a major annual USA mental health care conference, featured multiple sessions on alternate delivery of therapeutic approaches including online and virtual options. Indeed, some of these alternative approaches are already in place in the UK such as the 'Beating the Blues' self-study CBT computer based therapeutic approach. One participant raised this issue explicitly stating that his opinion was that online therapy could be valuable in certain ways e.g. educative, but could not have the same therapeutic effect as the "*real physical presence of the other person as an embodied existence*" (Neil, Line 103). Early research studies do not however, support a differentiation between online and face to face therapy, finding no statistically significant differences (Richardson et al., 2009; Grady et al., 2009). Further research is necessary to delineate when and where it may be necessary to ensure face to face delivery of therapy versus online, and to explore how emotional connection is experienced in alternative forms of therapy.

The fact that so much of the experience of emotionally connecting in therapy was felt to be implicit, embodied and not verbalized has increased my own advocacy for deep personal therapy for training psychologists – so that we acquire a 'felt sense' (Gendlin, 1981) of what this relationship may be.

A match between therapist and client

Both my own and Lodge's (2010) research suggest that this deep level of emotional connection does not happen with all patients. This raises a further practice implication to consider: the important issue of fit or match between therapist and client. If it is the good fit between therapist and client that is most important then it may be important that clients have a choice of therapist. Lodge (2010) suggests that "clients should perhaps be encouraged to be proactive in their choices and encouraged to be experts of what they need".

There are a number of ways to think about therapist-client match. One area that has received attention is cultural match and research has demonstrated that minority groups benefit from a counsellor from the same group, yet found no real preference for members of the majority group (Atkinson, 1985). In contrast to a dominant paradigm arguing that certain 'primary' emotions and expressions are universal (e.g. Tomins, 1962, Ekman, 1972),more recent research suggests that Western approaches to psychology are prone to pathologising the way different cultures experience emotion (Hoffman et al., 2011, Gendron et al., 2014). They illustrate different ways of perceiving, experiencing, and expressing emotion, all of which can be healthy within their own cultural context, but often be oppressive and problematic in others. Therefore

matching may be more critical for clients from minority cultures. From a training perspective, Hoffman et al. (2011) suggest that cultural exchanges and training may help the therapist develop the necessary skills to work with client emotions in a culturally sensitive manner.

Aside from culture, another way of thinking about the therapist-client match is Lodge's (2010) research suggesting that the effectiveness of the therapist-client dyad may be impacted by the degree to which they have 'matching wounds', having experienced similar enough psychological issues. This is similar to Jung's notion of the 'wounded healer' where he suggests "it is his own hurt that gives a measure of his power to heal" (1951/1993, p.116). From an existential perspective van Deurzen (2006) has consistently made the case that life experience and a therapist's own grappling with the complexity of life and its existential givens are critical characteristics for an existential therapist. She suggests that working with our clients' passions is not so much a matter of skill or technique or empathy as a matter of resonance or co-presence and that one can only tune in to the level of the client's concern to the extent one has reached those levels oneself. However, the idea of needing a specific match based on culture or own "wounds" would perhaps be challenged from an existential perspective which emphases our shared givens of existence. It also behoves us as therapists to consider the best way to proceed in the absence of an emotional connection. Should we more regularly refer on clients with whom we do not feel a sense of connection? Or is this opening the risk of certain clients and client groups being passed over for treatment because they are more 'emotionally demanding'?

6.3   Professional and Political Implications

Fostering pluralism

Lodge (2010) suggests that the finding that the deep healing in therapy takes place at an emotional level does not fit well with the current demand for randomised controlled trial evidence-based therapy, not with the current pre-eminence given to cognitive behavioural therapy. CBT emphasises helping a person change their thoughts in order to change their emotion structures, whereas this research suggests it is experienced by these participants as more effective to start with the emotion structure by facilitating the client having actual 'live' visceral emotional experiences with the therapist and with the therapist engaging in a mutual genuine emotional relationship.

In order for therapists to engage fully and genuinely in the client relationship, Lodge (2010) suggests there should be more emphasis on allowing different practitioners to practice different models according to their own histories, values and beliefs rather than having to prescribe to prescriptive guidelines about provision of CBT under IAPT and NICE guidelines.

The idea of a non-structured unique relational encounter is directly counter to the approach of 'manualised therapy' introduced within the managed care system driven by private health insurers in the USA, which has been heavily criticized by existential therapists such as Yalom (in interview with Howes, 2013), and some of the applications of the IAPT programme in the UK which again advocates a more standardized approach. Since conducting this research I have been employed as an IAPT psychotherapist and the 'stepped care' model included computerized and telephone 'guided self-help' following a standardized approach before moving into still structured group and then individual therapy. Schmid (2002c) has argued that such goal- and skill-oriented approaches in psychotherapy are en vogue mainly because of socio-political claims for efficiency but this research suggests such claims may be misguided or at least not the full picture, and therapists should be less constrained in order to focus on being with their clients.

Issues of professional identity have dogged the Division of Counselling Psychology (Kasket & Gil-Rodriguez, 2011) and have been debated extensively within the field. The fact that this and other research consistently supports the importance of effective therapeutic dyads whatever the model of therapy, provides research-based evidence against the prescription of any one modality. Instead it suggests that the pluralism that is both a blessing and a curse to the profession may in fact be a clinical necessity in order for us to have the flexibility to build intimate human relationships, all of which are unique.

A continued professional focus and dialogue on the therapeutic relationship

In the USA, the task force investigating the therapeutic relationship (Norcross, 2011) has made a number of recommendations for the American Psychological Association (and profession) which are relevant to the topic of my research and the profession of Counselling Psychology in England.

These include:

1. We recommend that the American Psychological Association and other mental health organizations advocate for the research-substantiated benefits of a nurturing and responsive human relationship in psychotherapy.
2. Finally, administrators of mental health services are encouraged to attend to the relational features of those services. Attempts to improve the quality of care should account for treatment relationships and adaptations.

The American Psychological Association has concluded that: "Practice and treatment guidelines should explicitly address therapist behaviours and qualities that promote a facilitative therapy relationship." (APA, 2011).

The provision of the majority of psychotherapy through the UK's public health system means that there are political and financial pressures that are different than in a private psychotherapy agreement. NICE's role of developing national clinical guidelines with the aim of providing secure consistent, high quality, evidence based therapy for patients using the National Health Service is admirable but also creates a therapeutic context which is more difficult to reconcile with a therapeutic approach that is more relationship driven, individualized and emotionally-led.

There is a paradox between the richness, intimacy, mystery and wonder of a personal therapeutic relationship between a therapist and her client and the extent to which demands are appropriately made to explicate, measure and quantify the qualities of this relationship in an evidence-based public healthcare model. Just as we as individuals exist within a social and physical world, so do our therapeutic relationships take place in a world outside.

Greenhaigh & Heath (2010) provided a discussion paper to The King's Fund on measuring quality in the therapeutic relationship that explored some of the complexity and nuances that are not addressed in the NICE guidelines. They explore multiple ways of measuring the therapeutic relationship including e.g. patient satisfaction surveys, rate-your-relationship surveys, narrative analysis and demonstrate how conversation analysis that may score very highly on conventional quality criteria, can reveal a failure of the therapist to emotionally engage the client, instead using their own power and control to dominate a conversation.

They outline a number of ways of thinking about the therapeutic relationship:

- A forum for info exchange and decision making
- A reflection of unconscious and internal forces
- A co-construction of a story by teller and listener
- An unequal power struggle
- A service transaction
- As part of a wider care network

One of the benefits of their approach is that they consider the context within which the relationship is established. Levi (2010) in her Counselling Psychology Doctoral thesis on the power of the therapeutic relationship in cognitive behavioural therapy, reports the surprising level of influence the setting where therapy is practiced on the relationship. Time constraints and guidelines shape the nature of relationship formed and the style of practice. I would argue that the overriding cultural ethos of the context in which we practice also impacts our professional identity and practice.

This ties back to how we understand the therapeutic relationship at a very fundamental level. Is this an instrumental alliance, constructive and collaborative but ultimately designed as a vehicle for the transmission of 'treatment' from an expert clinician onto a receiving patient within a medical model? Or is this a more co-created union which has the power to heal in itself and whose residing in a healthcare context is complex? Are we doctors, teachers, healers *to* our clients or partners *with* them?

Benefitting from Existential Perspectives

One of the interesting things to reflect on is the extent to which any of these themes represent a particularly or uniquely existential approach to emotion in the therapeutic relationship. It is likely that some of the findings here, such as the centrality of the therapeutic relationship, are consistent with other approaches such as a person-centred or humanistic approach. The focus on embodiment, the awareness of characteristics of existence and the therapist's openness and mutual engagement in the relationship along with an absence of expectations, goals and specific techniques ('unknowingness') may be features more salient to or in some cases unique to existential therapy. The 'technique' of existential therapy is perhaps a way of holding oneself open in relationship in a way that "*permits the unfolding of possibilities that were foreclosed at some point*" (Neil, Line 182). Nanda (2006) suggests that nonverbal intersubjective communication is relevant for existential therapy as it highlights the relational stance of the connectedness of human existence and ourselves, rejecting the Cartesian distinction between mind and body.

Together, these demand, it seems to me, a sort of therapeutic courage that may be one of the distinctive features of more existentially oriented therapy.

One therapist felt that it was hard to define if existential therapy was unique because he can only comment on his own practice, and thinks that everyone is likely to practice uniquely. This freedom has been commented on as one of the defining features of the field (e.g. Cooper, 2003) and perhaps is another representation of this underlying value of openness, although other therapists did name the aspects detailed above as being key notes of the existential approach.

One therapist felt that the kind of deep emotionally connected relationships discussed during the research were not unique to existential therapy, although they were not something achieved by all therapists and depended on the therapist's skill and openness for this. However, she did feel that the existential approach places a value on this kind of therapeutic relationship that is not seen across all other approaches.

My experience has been that some of my clinically and CBT trained colleagues have very little awareness of existential theories and perspectives. From whatever modality we practice, an increased knowledge and understanding of some of the principles and philosophical foundations of existential psychotherapy seem likely to support one's thinking and engagement in rich therapeutic relationships.

Political implications

The findings of this research raise a number of direct implications then for mental health and psychotherapy service provision in the UK. First, the predominance of the relationship suggests personal psychotherapy should be given more importance alongside or in contrast to some of the current methods of treatment used such as self-study DVDs, bibliotherapy and educative skills-based groups. Secondly, the importance of forming an emotional connection with the therapist means that therapists should have time and space to create a personal bond at the beginning of the relationship. This can be hindered by current practices such as conducting telephone triage appointments and then assessment interviews and extensive paperwork and measures before connecting a patient with their actual therapist. These events are likely to be experienced by the patient as being 'done to' rather than the experience of 'being with'. Thirdly, the research support for a unique relational encounter means that pluralism should be welcomed; therapists should be allowed and supported in a way that works for them and the patient in enabling a constructive relationship to be formed and the importance of this should

be acknowledged. Fourthly, there is still education to do to health providers, commissioners and politicians who apply the same principles to mental health care as they do to physical health care, and who therefore under-estimate such relational factors.

6.4 These implications are inconvenient in a financially constrained public-health service model, but the costs of ongoing and unresolved mental health issues are acknowledge to be extensive and increased investment upfront may pay dividends as well as being morally imperative. The King's Fund states that Mental health problems account for 23 per cent of the burden of disease in the United Kingdom, but spending on mental health services consumes only 11 per cent of the NHS budget. The consequences of this under-funding are significant: people with the most severe mental illnesses die on average 15 to 20 years earlier than the general population (King's Fund, 2015).Validity of the Study

While I have considered specific strengths and weaknesses in the Discussion above, I wanted to reflect briefly on the validity of the study. Yardley (2011) and Finlay and Evans (2009) regard relevance, resonance and impact as one of the key hallmarks of validity in qualitative research.

Did the topic of this research and then the Results chapter, with the snippets of poetic condensations it contained, resonate for you as readers and practitioners?

If so, it has done part of what I hoped for, in arousing interest and reflection amongst therapists and Counselling Psychologists. From my perspective, the importance and relevance of this study is in providing a counter voice to the continued dominance of a CBT paradigm, and further support to the advocacy for a more pluralistic view of therapy that places the emotional experience of the therapeutic relationship at the heart of what takes place.

6.5 Future Research

As a phenomenological study, my research explored the subjective experience of a small number of experienced existential therapists. It is not intended to be research from which generalizations or comparisons can be drawn. However, it does offer a voice and a perspective to this ongoing debate as well as suggest avenues for future research.

There are various directions for future research suggested by this study. From an existential perspective, this research is as far as I know, one of the first empirical studies investigating the therapeutic relationship in existential psychotherapy beyond the excellent 'case study' descriptions by individual existential psychotherapy practitioners (e.g. du Plock, 1997, van Deurzen, 1998, Spinelli, 2006). This is not surprising given that the field of existential psychotherapy has only recently rapidly expanded, particularly at a Doctoral level in the UK. Further work on the therapeutic relationship in existential psychotherapy is called for, including research that goes beyond the focus on emotional experience explored here.

A personal area of interest is in the dynamic patterning of emotional communication and attunement between therapist and client, and also the extent to which this is dependent on an embodied presence. In particular, research that works with therapist-client dyads, while ethically complex and demanding, is vital in order to understand a dyadic relationship. Advances in technology and some of the cutting edge work on measuring and evaluating mother-infant dyads (e.g. Beebe, 2000, Schore, 2003) offers new ways for us to explore the intimate and special nature of the therapeutic relationship. It may be that this is a view I am particularly likely to take as I seek to hold the tensions and the value of being both a scientist-practitioner and a reflexive-practitioner.

6.6   Concluding Note

This study was designed to fit a gap in the literature, as well as advance my own development, in understanding the emotional experience of the therapeutic relationship.

Norcross' (2011) operational definition of the therapeutic relationship is:

"The feelings and attitudes that therapist and client have toward one another and how these are expressed" (p.114)

His definition reaches widely and deeply because of his position as Chair of the American Psychology Association Task Force on Evidence-Based Therapy Relationships.

This research has confirmed the importance of the felt-sense, affective and non-verbal elements of the relationship, many of which are not expressed. Therefore I have become more attached to the suggested minor modification, as below:

*"The feelings and attitudes that therapist and client have toward one another
and how these <u>are experienced </u>and expressed".*

This journey started with my own experience of personal therapy. This research and my reading have helped elucidate many of the aspects of and experiences within this relationship that helped it be personally transformative.

The wonder of the experience was not reduced by this analysis, although neither did this analysis fully capture my experience of emotional 'dancing' and attunement with my therapist. Lodge (2010) states this when researching emotional connection between therapists and clients finding accounts other than her own (which she also analysed) used many of the same descriptions but could not be *felt*. If we think about other human emotional relationships, such as love, we turn to art, literature, poetry and music to help capture and convey something of the experience that can never be captured fully through scientific research and academic writing. Our therapeutic relationships, and the power they hold to heal, can only fully be known by us when we reside in them.

Rogers (1961, p. 32) captures up the personal implications of this research when he states:

"In my early professionals years I was asking the question: How can I treat, or cure, or change this person? Now I would phrase the question in this way: How can I provide a relationship which this person may use for his own personal growth?"

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8 Appendices

Appendix 1: Personal Assumptions about the Therapeutic Relationship

This page documents the assumptions I noticed I had about the therapeutic relationship as part of my reflexivity around this research.

- I believe the quality and experience of the therapeutic relationship was the most important part of my own therapeutic experience as a client; more than any specific kind of technique, although interpretations were also valuable
- My therapeutic relationship was unique with each therapist I have worked with and each client I have worked with
- Despite this uniqueness, I brought to those relationships (as a client and probably as a therapist) habitual consistent ways of relating which were not fully in my awareness and I believe reflected childhood experiences which determined a particular attachment style
- Changing those patterns was not an intellectual and rational process of insight followed by a free choice to behave differently, it required an alternative emotional experience and a gradual process
- I felt "loved" and taken care of in therapy and believe it was a place where I felt safe to open myself up to loving someone
- It was helpful to have a therapist who acted as a knowledgeable 'expert' offering interpretations of some of my actions and ways of being that offered me new ways of understanding myself
- There were moments of intense emotional connection in therapy where I felt what I would now call an I-Thou moment, but at the time termed to my therapist as feeling 'completely connected'
- There were also moments of emotional dissonance which were very powerful. The relationship felt emotionally dynamic and moved in waves of closeness and distance.
- For a time, and with only 1 of the 4 therapists I have worked with in my life, I experienced sexual desire for my therapist which I believe arose from a number of factors unique to the therapeutic relationship and situation and initially struggled to make sense of. Psychoanalytic explanations of transference and projection did not resonate, but neither could I find much material in existential psychotherapeutic literature that helped me provide meaning to this experience.

- Both as a client and as a therapist, therapy seemed an emotional process but more so for the client
- The physical presence and eye contact of the therapist felt to me at times to be a key enabler of those moments of emotional connection
- I was fascinated by Beatrice Beebe's (2000) research on emotional attunement in mother-baby pairs and by Schore's (2003) work on dyadic affect regulation and wondered about the role of emotional 'connection' in therapy
- Yalom & Elkin's 'twice told tale' (1974) was also very intriguing for me as there was an interesting juxtaposition about the different interpretations and emphasis they put on therapeutic moments and yet the overall relationship had a sense of emotional closeness
- I felt I had a 'felt sense' of some vague notion of what the therapeutic relationship might feel like from psychoanalytic, humanistic and cognitive perspectives, but was curious to get closer to the experience of the therapeutic relationship in existential therapy
- I felt much closer and attuned to some existential writings than others, and found some were more philosophical and less relationally oriented than the way it seemed to be I was emerging as a therapist and I was intrigued about this and the variation in the writing
- I was not sure that the reality of the therapeutic practice and therapeutic relationship with therapists from different modalities would be as different as some of the theoretical writing suggested

Appendix 2: Ethical Approval Form

New School of Psychotherapy and Psychology Department

REQUEST FOR ETHICAL APPROVAL

Applicant (specify): UG **PG** (Module:Thesis.) PhD STAFF   *Date submitted:....August5,2010......*

Research area (please circle):

Clinical	Cognition + emotion	Developmental	Forensic	Health
Occupational	Psychophysiological	Social	Sport + exercise	

Other __Counselling Psychology (D.Psych)__

Methodology:

Empirical/experimental   Questionnaire-based   **Qualitative**   Other _____

No study may proceed until this form has been signed by an authorised person indicating that ethical approval has been granted. For collaborative research with another institution, ethical approval must be obtained from all institutions involved.

This form should be accompanied by any other relevant materials (e.g. questionnaire to be employed, letters to participants/institutions, advertisements or recruiting materials, information and debriefing sheet for participants[1], consent form[2], including approval by collaborating institutions).

- Is this the first submission of the proposed study?   **Yes**/No

- Is this an amended proposal (resubmission)?   Yes/**No**
  Psychology Office: if YES, please send this back to the original referee

- Is this an urgent application? (To be answered by Staff/Supervisor only)[1]   Yes/**No**

  Supervisor to initial here_____

Name(s) of investigator(s) **Victoria Brown**

Name of supervisor(s)   **Jill Mytton**

Title of study:
"When Passions Run High: A Phenomenological Exploration of the Emotional Experience of the Therapeutic Relationship in Existential Psychotherapy".

Results of Application:

REVIEWER - please tick and provide comments in section 5:

APPROVED   APPROVED WITH AMENDMENTS   NOT APPROVED

[1] see Guidelines on OasisPlus

SECTION 1 (to be completed by all applicants)

1. Please attach a brief description of the nature and purpose of the study, including details of the procedure to be employed. Identify the ethical issues involved, particularly in relation to the treatment/experiences of participants, session length, procedures, stimuli, responses, data collection, and the storage and reporting of data.

SEE ATTACHED PROJECT PROPOSAL

2. Could any of these procedures result in any adverse reactions?   YES/**NO**

If "yes", what precautionary steps are to be taken?

I do not believe the interviews I am undertaking could result in any adverse reaction. However, the BPS guidelines are explicit in making the researcher primarily responsible for protecting participants from mental and physical harm and investigating personal experiences of the therapeutic relationship may be considered a 'sensitive' issue, especially given the sometimes intense emotional experience of this relationship.

There is a strong case of researching sensitive areas such as the therapeutic relationship when this has been shown to be so instrumental to therapeutic success; however it is my responsibility to protect participants from mental harm and to support this I will:
1. Seek ethical approval for this project and adhere to any feedback in that process
2. Only select experienced therapists who have more tenure in working with and managing therapeutic relationships and have been through the process of counselling themselves
3. Ensure full informed consent with an information sheet and a signed consent form
4. Send the interview questions in advance as recommended by Langdridge (2007)
5. Remind participants they can withdraw at any time
6. Empathically 'check-in' with participants if it becomes clear that material has become emotionally demanding using my therapeutic skills, and if necessary provide them with details of support services.
7. Debrief participants at the end of the interview and provide contact details for me following the interview.

3. Will any form of deception be involved that raises ethical issues?

YES/**NO**

(Most studies in psychology involve mild deception insofar as participants are unaware of the experimental hypotheses being tested. Deception becomes unethical if participants are likely to feel angry, humiliated or otherwise distressed when the deception is revealed to them).

Note: if this work uses existing records/archives and does not require participation per se, tick here ....
and go to question 10. (Ensure that your data handling complies with the Data Protection Act).

4. If participants other than Middlesex University students are to be involved, where do you intend to recruit them? *(A full risk assessment must be conducted for any work undertaken off university premises)*[6,7]

Participants will be experienced existential therapists. They will be recruited via NSPC Ltd and Regents College. Interviews will be conducted via telephone or on NSPC premises.

[1,2,3,4,5,6,7] Guidelines are available from the Ethics folder on Oas!sPlus, General Psychology Area

5a. Does the study involve
    Clinical populations   YES/**NO**
    Children (under 16 years)   YES/**NO**
    Vulnerable adults such as individuals with mental or physical health problems,
    prisoners, vulnerable elderly, young offenders?   YES/**NO**

5b. If the study involves any of the above, the researcher needs CRB (disclosure of criminal record)
    -Staff and PG students are expected to have CRB – please tick   YES/NO
    -UG students are advised that institutions may require them to have CRB – please confirm
    that you are aware of this by ticking here   _____

6. How, and from whom (e.g. from parents, from participants via signature) will informed consent
    be obtained? (*See consent guidelines[2]; note special considerations for some questionnaire research*)
From participants via signature

7. Will you inform participants of their right to withdraw from the research at any time,
    without penalty? (*see consent guidelines[2]*)   **YES**/NO

8. Will you provide a full debriefing at the end of the data collection phase?   **YES**/NO
    (*see debriefing guidelines[3]*)

9. Will you be available to discuss the study with participants, if necessary, to monitor
    any negative effects or misconceptions?   **YES**/NO
        If "no", how do you propose to deal with any potential problems?

10. Under the Data Protection Act, participant information is confidential unless otherwise
    agreed in advance. Will confidentiality be guaranteed? (*see confidentiality guidelines[5]*)   **YES**/NO
        If "yes" how will this be assured (*see[5]*)
        **All information gathered from participants will remain confidential. Participants will be
        given a written information sheet that informs them of this. Interviews will be digitally tape
        recorded but without participants names. The digital recorder will remain in the locked
        possession of the researcher for transcribing purposes and recordings will be destroyed
        once transcription is complete. In phenomenological research, 'raw' data including
        extracts of the participant's language and the discourse will be included within the report
        and therefore data will be anonymized as necessary in submitting the final report. This
        may include removing any identifying details and only selecting data extracts that are fully
        anonymous. Anonymized transcripts will be kept within the locked possession of the
        researcher.**

If "no", how will participants be warned? (*see[5]*)

[1,2,3,4,5,6,7] **Guidelines are available from the Ethics folder on Oas!sPlus, General Psychology Area**

(NB: You are not at liberty to publish material taken from your work with individuals without the prior agreement of those individuals).

11. Are there any ethical issues which concern you about this particular piece of research, not covered elsewhere on this form? If "yes" please specify:	YES/**NO**

(NB: If "yes" has been responded to any of questions 2,3,5,11 or "no" to any of questions 7-10, a full explanation of the reason should be provided -- if necessary, on a separate sheet submitted with this form).

SECTION 2 (to be completed by all applicants – please tick as appropriate)

	YES	NO
12. Some or all of this research is to be conducted away from Middlesex University	X	
If "yes" tick here to confirm that a Risk Assessment form has been submitted	X	
13. I am aware that any modifications to the design or method of this proposal will require me to submit a new application for ethical approval	X	
14. I am aware that I need to keep all the materials/documents relating to this study (e.g. consent forms, filled questionnaires, etc) until completion of my degree / publication (as advised)	X	
15. I have read the British Psychological Society's *Ethical Principles for Conducting Research with Human participants*[4] and believe this proposal to conform with them	X	

SECTION 3 (to be completed by academic staff -- for student approval, go to Section 4)

Researcher....................... *Vidmacfun* date ......**August 10 2010**...........

PSY OFFICE received

Signatures of approval: Ethics Panel .... date .... date:..............
(signed pending approval of Risk Assessment form) date:..............

If any of the following is required and not available when submitting this form, the Ethics Panel Reviewer will need to see them once they are received and before the start of data collection – please enclose with this form when they become available:

- letter of acceptance from other institution
- any other relevant document (e.g., ethical approval from other institution):_____

PSY OFFICE received

Required documents seen by Ethics Panel .... date .... date:...............

SECTION 4 (to be completed by student applicants and supervisors)

Researcher (student signature) *Vidmacfun* .... date ......**Aug 10 2010**........

CHECKLIST FOR   **SUPERVISOR** – please tick as

[1,2,3,4,5,6,7] Guidelines are available from the Ethics folder on Oas!sPlus, General Psychology Area

appropriate

	YES	NO
1. Is the UG/PG module specified?	✓	
2. If it is a resubmission, has this been specified and the original form enclosed here?	N/A	
3. Is the name(s) of student/researcher(s) specified?	✓	
4. Is the name(s) of supervisor specified?	✓	
5. Is the consent form attached?	✓	
6. Are debriefing procedures specified? If appropriate, debriefing sheet enclosed – appropriate style?	✓	
7. Is an information sheet for participants enclosed? appropriate style?	✓	
8. Does the information sheet contain contact details for the researcher and supervisor?	✓	
9. Is the information sheet sufficiently informative about the study?	✓	
10. Has Section 2 been completed by the researcher on the ethics form?	✓	
11. Any parts of the study to be conducted outside the university? If so a Risk Assessment form must be attached – Is it?	✓	
12. Any parts of the study to be conducted on another institution's premises? If so a letter of acceptance by the institution must be obtained - Letters of acceptance by all external institutions are attached.		✓
13. Letter(s) of acceptance from external institutions have been requested and will be submitted to the PSY office ASAP.	N/A	
14. Has the student signed the form? If physical or electronic signatures are not available, an email endorsing the application must be attached.	✓	
15. Is the proposal sufficiently informative about the study?	✓	

Signatures of approval: Supervisor.......... date 9/2/11   PSY OFFICE received date:...........

Ethics Panel .... date 9.2.11   date:...........
(signed pending approval of Risk Assessment form)   date:...........

If any of the following is required and not available when submitting this form, the Ethics Panel Reviewer will need to see them once they are received – please enclose with this form when they become available:

- letter of acceptance from other institution
- any other relevant document (e.g., ethical approval from other institution):_____

PSY OFFICE received date:...........

Required documents seen by Ethics Panel .... date ....

[1,2,3,4,5,6,7] **Guidelines are available from the Ethics folder on Oas!sPlus, General Psychology Area**

SECTION 5 (to be completed by the Psychology Ethics panel reviewers)

	Please Tick or Use NA	Recommendations/comments
1. Is UG/PG module specified? (student appl.)		
2. If it is a resubmission, has this been specified and the original form enclosed here?		
3. Is the name(s) of student/ researcher(s) specified? If physical or electronic signatures are not available, has an email endorsing the application been attached?		
4. Is the name(s) of supervisor specified? (student appl.) If physical or electronic signatures are not available, has an email endorsing the application been attached?		
5. Is the consent form attached?		
6. Are debriefing procedures specified? If appropriate, is the debriefing sheet attached? Is this sufficiently informative?		
7. Is an information sheet for participants attached?		
8. Does the information sheet contain contact details for the researcher?		
9. Is the information sheet sufficiently informative about the study? Appropriate style?		
10. Has Section 2 (points 12-15) been ticked by the researcher on the ethics form?		
11. Any parts of the study to be conducted outside the university? If so a fully completed Risk Assessment form must be attached – is it?		
12. If any parts of the study are conducted on another institution/s premises, a letter of agreement by the institution/s must be produced. Are letter/s of acceptance by all external institution/s attached?		
13. Letter/s of acceptance by external institution/s has/have been requested.		
14. Has the applicant signed? If physical or electronic signatures are not available, an email endorsing the application must be attached.		
15. Is the proposal sufficiently informative about the study? any clarity issues?		
16. Is anyone likely to be disadvantaged or harmed?		
17. If deception or protracted testing are involved, do the benefits of the study outweigh these undesirable aspects?		
18. Any other comments?		

[1,2,3,4,5,6,7] **Guidelines are available from the Ethics folder on Oas!sPlus, General Psychology Area**

Appendix 3: Risk Assessment

INDEPENDENT FIELD/LOCATION WORK RISK ASSESSMENT   FRA1

This proforma is applicable to, and must be completed in advance for, the following fieldwork situations:

All fieldwork undertaken independently by individual students, either in the UK or overseas, including in connection with proposition module or dissertations. Supervisor to complete with student(s).

All fieldwork undertaken by postgraduate students. Supervisors to complete with student(s).

Fieldwork undertaken by research students. Student to complete with supervisor.

Fieldwork/visits by research staff. Researcher to complete with Research Centre Head.

FIELDWORK DETAILS

Name ……Victoria Brown…….   Student No

Research Centre (staff only)……………………………

Supervisor …Jill Mytton…….   **Degree course** ………DPsych Counselling Psychology NSPC Ltd……

Telephone numbers and name of next of kin who may be contacted in the event of an accident	NEXT OF KIN
	Name …………Nic & Jean Brown…………………………………..
	Phone …………01752 782317…………………………………………..
Physical or psychological limitations to carrying out the proposed fieldwork	…………None…………………………………………………………………………
	…………………………………………………………………………………………
	…………………………………………………………………………………………
	…………………………………………………………………………………………

Any health problems (full details) Which may be relevant to proposed fieldwork activity in case of emergencies.	……………None……………………………………………………………………… ……………………………………………………………………………………… ……………………………………………………………………………… ………………………………………………………………………………
Locality (Country and Region)	Permanent Home Location: New York, USA Temporary Accommodation when conducting Research: Islington, London. Fieldwork Location: NSPC Premises, London or via Telephone. …………………………………………………………………………. ………………………………………………………………………………
Travel Arrangements	For the researcher: I will conduct research around times when I am already in London and attending the NSPC for study. For the participants: Participants will have reasonable travel expenses to the NSPC paid by the researcher. Participants may also choose to participate by telephone. ……………………………………………………………………………
NB: Comprehensive travel and health insurance must always be obtained for independent overseas fieldwork.	………………………………………………………………………………
Dates of Travel and Fieldwork	Jan-April 2011……………………………………………

PLEASE READ THE INFORMATION OVERLEAF VERY CAREFULLY

Hazard Identification and Risk Assessment   **PLEASE READ VERY CAREFULLY**

List the localities to be visited or specify routes to be followed **(Col. 1).** Give the approximate date (month / year) of your last visit, or enter 'NOT VISITED' **(Col 2).** For each locality, enter the potential hazards that may be identified beyond those accepted in everyday life. Add details giving cause for concern **(Col. 3).**

Examples of Potential Hazards :
Adverse weather: exposure (heat, sunburn, lightening, wind, hypothermia)
Terrain: rugged, unstable, fall, slip, trip, debris, and remoteness. Traffic: pollution.
Demolition/building sites, assault, getting lost, animals, disease.
Working on/near water: drowning, swept away, disease (weils disease, hepatitis, malaria, etc.), parasites', flooding, tides and range.
Lone working: difficult to summon help, alone or in isolation, lone interviews.
Dealing with the public: personal attack, causing offence/intrusion, misinterpreted, political, ethnic, cultural, socio-economic differences/problems. Known or suspected criminal offenders.
Safety Standards (other work organisations, transport, hotels, etc.), working at night, areas of high crime.
Ill health: personal considerations or vulnerabilities, pre-determined medical conditions (asthma, allergies, fitting) general fitness, disabilities, persons suited to task.
Articles and equipment: inappropriate type and/or use, failure of equipment, insufficient training for use and repair, injury.
Substances (chemicals, plants, bio- hazards, waste): ill health - poisoning, infection, irritation, burns, cuts, eye-damage.
Manual handling: lifting, carrying, moving large or heavy items, physical unsuitability for task
If no hazard can be identified beyond those of everyday life, enter 'NONE'.

Give brief details of fieldwork activity: …Fieldwork will involve 1-1 interviews lasting approximately one hour with experienced therapists conducted either on NSPC premises or by telephone.
……….
……….
……….

1. LOCALITY/ROUTE	2. LAST VISIT	3. POTENTIAL HAZARDS
NSPC	Not yet visited due to location move	None beyond those accepted in everyday life.
My home (for telephone interviews)	Today	None beyond those accepted in everyday life.

The University Fieldwork code of Practice booklet provides practical advice that should be followed in planning and conducting fieldwork.

Risk Minimisation/Control Measures   **PLEASE READ VERY CAREFULLY**

For each hazard identified **(Col 3),** list the precautions/control measures in place or that will be taken **(Col 4)** to **"reduce the risk to acceptable levels",** and the safety equipment **(Col 6)** that will be employed.

Assuming the safety precautions/control methods that will be adopted **(Col. 4),** categorise the fieldwork risk for each location/route as negligible, low, moderate or high **(Col. 5).**

Risk increases with both the increasing likelihood of an accident and the increasing severity of the consequences of an accident.

An acceptable level of risk is: a risk which can be safely controlled by person taking part in the activity using the precautions and control measures noted including the necessary instructions, information and training relevant to that risk. The resultant risk should not be significantly higher than that encountered in everyday life.

Examples of control measures/precautions:

Providing adequate training, information & instructions on fieldwork tasks and the safe and correct use of any equipment, substances and personal protective equipment. Inspection and safety check of any equipment prior to use. Assessing individuals fitness and suitability to environment and tasks involved. Appropriate clothing, environmental information consulted and advice followed (weather conditions, tide times etc.). Seek advice on harmful plants, animals & substances that may be encountered, including information and instruction on safe procedures for handling hazardous substances. First aid provisions, inoculations, individual medical requirements, logging of location, route and expected return times of lone workers. Establish emergency procedures (means of raising an alarm, back up arrangements). Working with colleagues (pairs). **Lone working is not permitted where the risk of physical or verbal violence is a realistic possibility.** Training in interview techniques and avoiding /defusing conflict, following advice from local organisations, wearing of clothing unlikely to cause offence or unwanted attention. Interviews in neutral locations. Checks on Health and Safety standards

& welfare facilities of travel, accommodation and outside organisations. Seek information on social/cultural/political status of fieldwork area.

Examples of Safety Equipment: Hardhats, goggles, gloves, harness, waders, whistles, boots, mobile phone, ear protectors, bright fluorescent clothing (for roadside work), dust mask, etc.

If a proposed locality has not been visited previously, give your authority for the risk assessment stated or indicate that your visit will be preceded by a thorough risk assessment.

4. PRECAUTIONS/CONTROL MEASURES	5. RISK ASSESSMENT	6. EQUIPMENT
None required. Face to face interviews on NSPC premises will only be conducted when there are others present in the premises. As an existing professional and education centre, NSPC premises already conform to all health and safety requirements.		

PLEASE READ INFORMATION OVERLEAF AND SIGN AS APPROPRIATE

DECLARATION: The undersigned have assessed the activity and the associated risks and declare that there is no significant risk or that the risk will be controlled by the method(s) listed above/over. Those participating in the work have read the assessment and will put in place precautions/control measures identified.

NB: Risk should be constantly reassessed during the fieldwork period and additional precautions taken or fieldwork discontinued if the risk is seen to be unacceptable.

Date   ……Aug 12 2010……..

Signature of Fieldworker
(Student/Staff)

Signature of Student   ………………………………………………   Date   ……………………
Supervisor

APPROVAL: (ONE ONLY)
Signature of
Curriculum Leader   ………………………………………………   Date   ………………………..
(undergraduate students

only)

| Signature of Research Degree Co-ordinator or Masters Course Leader or Taught Masters Curriculum Leader | …………………………………………………………… | Date | ………………………… |

| Signature of Research Centre Head (for staff fieldworkers) | …………………………………………………………… | Date | ………………………… |

FIELDWORK CHECK LIST

Ensure that **all members** of the field party possess the following attributes (where relevant) at a level appropriate to the proposed activity and likely field conditions:

☑ Safety knowledge and training?

☑ Awareness of cultural, social and political differences?

☑ Physical and psychological fitness and disease immunity, protection and awareness?

☑ Personal clothing and safety equipment?

☑ Suitability of fieldworkers to proposed tasks?

2. Have all the necessary arrangements been made and information/instruction gained, and have the relevant authorities been consulted or informed with regard to:

☑ Visa, permits?

☑ Legal access to sites and/or persons?

☑ Political or military sensitivity of the proposed topic, its method or location?

☑ Weather conditions, tide times and ranges?

☑ Vaccinations and other health precautions?

☑ Civil unrest and terrorism?

☑ Arrival times after journeys?

☑ Safety equipment and protective clothing?

☑ Financial and insurance implications?

☑ Crime risk?

☑ Health insurance arrangements?

☑ Emergency procedures?

☑ Transport use?

☑ Travel and accommodation arrangements?

Important information for retaining evidence of completed risk assessments: Once the risk assessment is completed and approval gained the **supervisor** should retain this form and issue

a copy of it to the fieldworker participating on the field course/work. In addition the **approver** must keep a copy of this risk assessment in an appropriate Health and Safety file.

Appendix 4: Consent Form

New School of Psychotherapy and Psychology Department, Middlesex University School of
Health and Social Sciences
Research Consent Form

Project title: "When Passions Run High: A Phenomenological Exploration of
the Emotional Experience of the Therapeutic Relationship in Existential Psychotherapy".

I have understood the details of the research as explained to me by the researcher, and confirm
that I have consented to act as a participant.

I understand that my participation is entirely voluntary, the data collected during the research
will not be identifiable, and I have the right to withdraw from the project at any time without
any obligation to explain my reasons for doing so.

I further understand that the data I provide may be used for analysis and subsequent
publication in an anonymous form, and provide my consent that this might occur.

I understand that a recording is being made of this interview and will be securely stored until a
verbatim transcript has been made. The recording will be destroyed following approval of the
thesis.

Print name of participant   Participant's signature

Print name of researcher   Researcher's signature
Date

Appendix 5: Participant Information Form

New School of Psychotherapy and Counselling
Department of Psychology, Middlesex University
Town Hall, The Burroughs
Hendon, London NW4 4BT

Participant Information Sheet
Date: November 2010
Researcher: Victoria Brown

Study Title: "When Passions Run High: A Phenomenological Exploration of
the Emotional Experience of the Therapeutic Relationship in Existential Psychotherapy".

You are being invited to take part in a research study. Before you decide to participate, it is important for you to understand why the research is being done and what it will involve. Please take your time to read the following information carefully, and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take your time to decide whether or not you wish to take part.

Purpose of the study
The purpose of the study is to explore how experienced existential therapists conceptualize and work within the therapeutic relationship. In particular, the study will look at how they work with the emotional experience of the therapeutic relationship including their clients' experiences and expressions of affect and their own experience and use of emotion for therapeutic aims.

As an experienced existential therapist, your perspective is uniquely valuable for helping to explore this topic.

Understanding your involvement
If you agree to be involved, you will be asked to participate in one semi-structured interview with the researcher. The interview will last approximately 60 minutes, and can be conducted via telephone or on the premises of NSPC Ltd. in London, whichever is your preference. Travel expenses will be reimbursed.

The interview will cover your views of the therapeutic relationship in existential therapy and for examples of how you have experienced and worked with the emotional experience of the relationship. An interview guide will be sent in advance.

Potential risks
This research has been specifically designed to minimize any risks or disadvantages of participating. The interview will be scheduled to suit you to remove any disadvantages of lost work and your participation will be kept confidential and your data anonymized.

Sometimes, when people are recalling an emotional experience they can feel the same affect that they are recalling. Therefore, depending on what emotional experiences you may choose to convey (for example, a very difficult therapeutic relationship) there is a small potential for you to be emotionally impacted or distressed by participating in this research. If you feel this may be the case, you may prefer not to take part. In addition, I will share the interview guide in advance and you can withdraw your participation at any time.

Your consent
You will be given a copy of this information sheet and asked to sign a consent form prior to taking part in this research. Participation in this research is entirely voluntary. You do not have to take part if you do not want to. If you decide to take part you may withdraw from this research at any time without giving a reason. Your consent covers your consent to participating in the interview and the recording of the data as outlined below. Your participation will be kept confidential to the researcher.
The interview will be digitally recorded by the researcher. Your name will not be in the recording and a unique anonymous code will be assigned to each recording and transcript. The digital recording of the interview will be transcribed directly by the researcher and will be destroyed as soon as it has been transcribed. The full anonymized transcript will only be reviewed by the researcher and her supervisor, unless requested for inspection in the course of an institutional audit. The consent form you will be asked to sign gives you the option to request for your data not to be included in any institutional audit.
Short excerpts of the transcript may be published verbatim within the research as anonymous examples.

Data (the digital recording until transcribed, and the written transcripts) will be kept in a secure locked environment or stored on a computer with the password known only to the researcher.

The transcripts will be kept securely by the researcher until six months after graduation and will then be shredded and destroyed.

You can withdraw during the course of this study at any time. This includes before, during and after your interview. Should you withdraw your transcript will be immediately destroyed.

Organization & Funding of the Research
This research is being organized and funded by the researcher, with organizational support from the New School of Psychotherapy & Counselling Ltd.

Research Review
This study is being completed as part of the researcher's Doctorate in Counselling Psychology at the New School of Psychotherapy & Counselling. There is no external funding for this study. All proposals for research using human participants are reviewed by an Ethics Committee before they can proceed. The Middlesex Psychology Department's Ethics Committee have reviewed this proposal.

This research will conducted under supervision of a faculty member.

Further Information
If you would like further clarification or information before participating in this study, you may contact the researcher or supervisor in confidence.

Researcher:	Supervisor:
Victoria Brown	Jill Mytton
victoria.c.brown@gmail.com	jill.mytton@arthio.com
c/o New School of Psychotherapy & Counselling	New School of Psychotherapy & Counselling
254-256 Belsize Road	254-6 Belsize Road
London NW6 4BT	London NW6 4BT
Tel: +1.347.574.2097	

Appendix 6: Interview Guide

Interview Guide: "When Passions Run High: A Phenomenological Exploration of the Emotional Aspects of the Therapeutic Relationship in Existential Psychotherapy"

I am interested in the therapeutic relationship in existential psychotherapy, and in particular the emotional aspects of the relationship.

Before we look at the research topic, we'll start with just a couple of questions about you!

Can you briefly share your background with me?
How long have you been practising as an existential therapist?
What drew you to this approach?
Do you identify yourself with any particular kind of existential approach/position or author?

The therapeutic relationship in existential psychotherapy

Ok, let's move on to the therapeutic relationship. [We will start with your general experiences and then look at specific relationships.]

1. What is your experience of the therapeutic relationship in existential psychotherapy?

2. Is there anything unique about the therapeutic relationship in existentially informed psychotherapy?

3. Is there a metaphor that comes to mind that conveys something of the therapeutic relationship in existential psychotherapy?

Experiencing and working with emotions in the existential therapeutic relationship

4. What is your experience of the emotional dimensions of the relationship in existential psychotherapy? (this includes all emotional aspects- the therapists' feelings, how s/
he experiences the client's feelings and the emotional relationship
between you)

5. Can you describe your experience of a particular therapeutic relationship, session or moment where you and a client had an intense emotional connection together?

6. Can you describe an experience of where a *client* expressed strong emotions about you or your relationship together?

7. Can you describe an experience where *you* felt strong emotions about your client or your therapeutic relationship together?

Backup/further questions

What is your general view of the role of emotions in life or therapy?

What is your experience of your clients' experience and expression of emotions in the therapeutic relationship?

What is your experience of your own emotions in the therapeutic
relationship? (how you make sense of and work with these)

Appendix 7: Essential Statement of Results: A holistic statement of therapists' experience of the therapeutic relationship

Therapy is an emotional endeavour. Therapists experience their therapeutic relationships as emotionally impactful for them and even more so for their client. Many suggest this relationship *is* the therapy. While having many similarities to other kinds of relationship, including the possibility for any emotion to emerge that can exist in any relationship, there are some unique differences in the therapeutic relationship.

One is the therapist's focus on *being with* the client in a particular way. This includes not hiding behind theory or technique but attempting to foster a close, intimate relationship with the client that is mutually created and prizes equality. The therapist is there in service of the client, and the relationship, while mutual, is focused on them. This creates an atmosphere that can be seductive to the client.

The therapist's 'being with' also includes an acceptance of whatever the client brings creating a safe environment in which the client is increasingly able to open up to the therapist. In contrast to many other relationships, the dynamic and emotional currents between therapist and client are noticed and brought into the room to reflect on.

Emotions are embodied as well as verbal and the therapist is attending at multiple levels in the room: to their own embodied emotionality, deciding what to express of their own affective experience while also listening to the clients verbalized affective experiences and observing their embodied emotionality. We are always in some form of emotional 'mood' or attunement and so this is constantly present between therapist and client, although it may be very subtle. The emotions in the room are complex and dynamic. They may exist on several levels, for example an underlying stance of emotional relatedness toward the other may temporarily be overshadowed by a more powerful affective experience. Talking about and looking at an affective experience together changes its nature and so the emotional tone of the room may be constantly adjusting.

This is demanding work for the therapist and therapy may be seen as making heavy demands on emotional intelligence. Many therapists describe learning increased capability to be able to tolerate and attend to particular emotions, although many acknowledge that there are particular forms of emotional relatedness that are difficult for them. As well as attending to the client's emotions in the room, they are also working on holding the emotion between them and helping the client being able to tolerate staying with the emotion. At the same time, they

attempt to continue to hold themselves open as much as possible but in a boundaried way so that they are able to maintain a therapeutic stance.

By having the courage of being open to and present with the other in the here and now, therapist and client become increasingly emotionally connected through a dynamic dance in which they ebb and flow towards and then away from each other. With a number of clients, this dance includes moments of meeting or encounter – a powerful and acutely affective experience of the therapist and the client feeling fully connected to, seen with and open to the other that is hard to describe but pivotal in the therapeutic relationship. Through these encounters the therapist transcends the self feeling connected to both the client and humanity.

The therapist's openness to the other, their 'naked' presence in the room with no clothing of tools or techniques can make existential therapy challenging, very challenging at times. Therapists are truly touched by their clients- we cry, we laugh, we feel sick or traumatized, we feel love and loss. We are there with our whole selves, in a stance of emotional embodied relatedness. But this very openness is also what makes the experience very fulfilling – it is work we love.