Exploring the Therapeutic Relationship:

An Autoethnography

by

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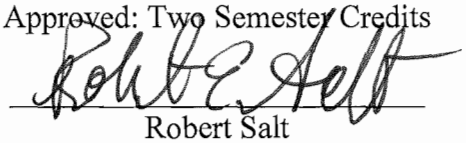

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ABSTRACT

A significant body of research on the therapeutic relationship confirms it as a vital contributor to high client treatment outcomes in psychotherapeutic clinical settings. Significant gaps in the research exist on specific elements that comprise the therapeutic relationship, factors contributing to its development, and what therapists can do to effectively establish and maintain quality relationships with clients. This study, conducted by a second year master's student in the marriage and family therapy program, consisted of journaling about experiences working with clients in a mental health setting over the course of a seven month period, and what factors, in her experience, both contributed to, and diminished the existence of therapeutic relationships. The study was conducted using a qualitative research methodology of autoethnography and was written in the form of personal narrative. The author's personal experiences of factors relating to the appearance of the therapeutic relationship are discussed and analyzed and extended to the broader context of the field of psychotherapy in a manner that is thought provoking and

evocative, and strives to elicit a personal response from the reader as well as an impetus for further discourse on the topic of the therapeutic relationship.

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Thank you to my family for believing in me, and for showing me what love is, by demonstrating it always.

Thank you Andy, for challenging and inspiring me daily. For being, so often, the impetus of creative spark. And for loving me for who I am. You make relationships fascinating.

And thank you to Bri for being the best friend I could ask for, throughout everything.

"It is not what the therapist does that is important—whether she interprets, reflects, confronts, disputes, or role-plays—but rather who she is. A therapist who is vibrant, inspirational, and charismatic; who is sincere, loving, and nurturing; and who is wise, confident, and self-disciplined will have a dramatic impact through the sheer force and power of her essence..."

–Jeffery Kottler

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Chapter I: Introduction

As I entered the second year of my master's program in marriage and family therapy, the notion of the "master's thesis" loomed on my academic horizon like a speck of incandescent light far off in the distance, projecting varying images, some bright and stirring, others dark and shadowy, shrouded in a mysterious intrigue each time I turned my gaze toward it. I knew I would write a thesis, because I wanted to stretch myself in as many ways possible throughout this master's program, but I also knew that the topic needed to be one that mattered and was intriguing to me, one that fascinated and excited me and would propel me through the process with enthusiasm and zeal, and also allow me to think and write in a variety of ways.

The second year of the program found me in the practicum year, where I would, along with the seven other members of my cohort, and under the supervision of my professors, begin to turn the skills and knowledge acquired during the academic year into therapy in a mental health clinic setting. As this practicum year unfolded, it occurred to me how relevant, fascinating, and unique my relationships with my colleagues and professors had become. Each was different and encompassed a unique repertoire of exchanges, ideas, feelings, and many of the relationships between my colleagues and I seemed grounded in a fascinating symbiosis. I became fascinated by the ways in which relationships with others in academic settings affect one's learning process, conception of ideas, personal growth, and intellectual maturation.

As I began to work more with clients this fascination with "relationships" quickly transferred to a fascination specifically focused on my relationships with them. The practice of psychotherapy, with all of the nuances that it carries, seems to have so much going on within it, that it is difficult to form an accurate conception of what about it is healing (a discussion at greater length on this topic occurs in following sessions). With my own clients, aside from the

perceived results from specific theories or techniques I utilized, there seemed to be something else that contributed significantly to the process, but what it was, I wasn't sure. Something that happened in the spaces between the words, a felt sensation as looks were exchanged, something about eyes locking and energy in the room when certain topics came up—what was that? What did it mean? Was it about me, them, or us? In what ways did it contribute to the relationship between myself and the client? In what ways is the relationship a part of the therapeutic process?

I knew, then, that I had my research topic. The light that had been far off on the horizon became a light that shined over me, consistently, for nine months—sometimes glowing and penetrative in rays of realization and personal insight, at other times dim and hazy, as the study tried to sort itself out and find itself, reexamine itself again and again under different lights, after pertinent discourse with others, while researching and scouring the literature—but mostly came into being via the commitment to a rigorous self-examination which strove to leave no relevant parts ignored, denied, or inconsequential.

What follows is an introduction to this study where its goals and research methodology are introduced. Following the introduction is a review of significant literature on the topic of the therapeutic relationship. The research methodology employed to conduct this study is described at length in chapter three. The study itself follows in chapter four, and chapter five discusses and describes conclusions of the study outlining areas needing further exploration.

Statement of the problem

The term "psychotherapy" elicits an abundance of controversy regarding origin, effectiveness, and even the principles contributing to practices that fall under the umbrella term "psychotherapy." For the purposes of this research paper, psychotherapy will be defined as "an interpersonal, relational intervention used by trained psychotherapists to aid clients in problems of living" (Frank, 1988). Efficacy research in the field of psychotherapy has determined that forty percent of client change throughout the course of treatment is related to extra-therapeutic influences; fifteen percent is due to expectancy (placebo effects); fifteen percent is due to specific techniques employed by clinicians, and the remaining thirty percent of factors contributing to client change is due to the establishment of a working therapeutic relationship between therapist and client (Lambert, 1992).

Recent studies in the field of psychotherapy indicate a high level of premature client dropout; one meta analysis of 125 studies concluded that the mean dropout was 46.86 percent (Geller, 2005). Prominent scholars in the field have suggested that high premature client dropout rates are due in part to a failure of establishing a working therapeutic relationship between therapist and client. The therapeutic relationship, also referred to as the therapeutic alliance, constitutes a multitude of varying definitions which will be discussed in greater depth in later sections of this paper. It can be loosely thought of, however, as a "measure of intimacy and mutuality between client and therapist" (Sexton, Littauer, Sexton, & Tommeras, 2005).

With alarmingly high levels of premature client dropout, scholars in the field of psychotherapy have suggested clinicians examine and improve upon existing therapeutic relationships with clients in their practices. But what elements comprise a "working" therapeutic relationship? What is it about the therapeutic relationship that is healing? How does a clinician

know if the therapeutic relationship is a good one? How does it develop, and how is it maintained? How does a therapist's personal opinion or the degree to which s/he likes the client impact the development and preservation of the therapeutic relationship? Given the importance of the therapeutic relationship as it relates to healing within therapeutic processes, these questions merit significant further examination and analysis.

Purpose of the Study/Methodology

While a substantial number of quantitative studies have sought to explain many of the intricacies surrounding the development and preservation of the therapeutic relationship, qualitative research methods such as autoethnography have rarely been used to explore this topic. The purpose of this study, then, is to examine one therapist's perception of the development, quality, and maintenance of the therapeutic relationship using an autoethnographic qualitative research methodology. According to Denzin (1997), autoethnography involves turning the "ethnographic gaze inward on the self (auto), while maintaining the outward gaze of ethnography, looking at the larger context where self experiences occur" (p. 227). The research methodology of autoethnography will serve as a unique method of studying the therapist (myself) as an active constituent in the context of the therapeutic relationship, and how I conceptualize its development, existence, maintenance, and effects on the therapeutic process.

Assumptions of the Study

This autoethnographic study will be conducted through the lens of a constructivist/interpretivist theoretical perspective. Constructivism is a theory that describes how learning occurs, and can be thought of as, "a relativistic point of view that emphasizes the subjective construction of reality" (Nichols, 2006). As a therapist practicing under a constructivist school of thought, it is my perspective that each and every client presents with a

unique repertoire of characteristics, including background, culture, values, and personality, which are to be encouraged, utilized, and celebrated for their unique complexity and worth.

It is my view that therapy should involve a creative interplay between therapist and client, where both objective and subjective points of view are expressed and meaning is constructed. The therapy environment should be designed to support and challenge the client's thinking, in hopes that he or she can arrive at his/her own conclusions. The therapeutic relationship, then, is a mechanism of change, consisting of two minds and souls alive and vitalized in the therapeutic setting, united by mutual care and concern for the other, both invested in the common goal of discovering and creating meaning specific to the client's reality, thereby affecting eventual second-order change. The use of autoethnographic methodology is an unusual and intriguing way of examining therapist thoughts, feelings, and behaviors that contribute to the creative dynamic between therapist and client. The research methodology of autoethnography is discussed at further length in chapter three. A review of the literature is next discussed in chapter two.

Chapter II: Literature Review

There is a substantial body of literature written on the topic of the therapeutic relationship and how it relates to the therapeutic process. The therapeutic relationship, as defined above, can be thought of as a "measure of intimacy and mutuality between client and therapist" (Sexton, et. al, 2005). There has been considerable debate over the last few decades regarding the therapeutic relationship and how vital it is to successful treatment outcomes, especially in comparison to specific therapeutic techniques employed throughout therapy. Several prominent theories about the relevance of the therapeutic relationship and specifically how it contributes to therapy will briefly be discussed.

One position is that a positive therapeutic relationship is necessary for the effectiveness of particular techniques but does very little in its own right to bring about change (Zuroff & Blatt, 2006). This is the belief of many contemporary cognitive-behavioral therapists. Carl Rogers poses a different view in his concepts of client-centered therapy, in that relationship conditions offered by the therapist, such as empathy, congruence, and unconditional positive regard are in and of themselves healing, and responsible for the effectiveness of therapy (Horvath, 2000).

Another view is that a positive relationship is neither necessary for change, nor a causal contributor to change. Therapeutic success is attributed solely to the specific effects of particular treatment procedures, for instance, directing the client to challenge her negative thoughts, giving homework assignments, etc. (Zuroff & Blatt, 2006). Finally, there is the perspective that effective therapeutic processes involve both a working therapeutic relationship *and* the implementing of specific techniques depending on client and presenting issue (Zuroff & Blatt, 2006).

An expansive review of the literature finds the therapeutic relationship an important contributor to client change in the therapeutic process: thirty percent of factors contributing to client change can be attributed to the establishment of a working therapeutic relationship between therapist and client (Lambert, 1992). The presence of a well-formed therapeutic relationship is indicative of future client success in therapy, including individual, couple, family and group therapies, (Horvath, 2000) and this correlation between the alliance and the results of treatment seem to hold constant across various treatments, clinical diagnoses, and client populations (Horvath, 2000). Additional research is needed to determine what exactly it is about the relationship that promotes healing. However, according to Erskine, a review of the psychotherapy literature reveals that the single most consistent concept throughout the history of psychotherapy is that of the therapeutic relationship, noting that there have been a sequence of prominent teachers, writers, and therapists who emphasize and epitomize "relationships," both in childhood as well as throughout adulthood as the basis through which an individual finds meaning and validation (1998).

Due to the subjective nature of the therapeutic relationship, and the fact that no two are exactly alike, it is difficult to pinpoint its effects with precision. It is often noted throughout the literature that it is the unique interchange between therapist and client, focused on the client's needs, that gives therapy the transformative effect in people's lives. Affirmation and validation experienced in the therapeutic relationship form a framework that allows for stronger self-acceptance and more effective communication with others. The therapeutic relationship, once established, becomes an involved interpersonal relationship through which the client learns to gain competence in facing life problems with flexibility and spontaneity, and also enhances the

client's interpersonal relationships outside of therapy, drawing on what he or she learned through the relationship with the therapist (Erskine, 1998).

According to the literature, one principle largely responsible for the development of the therapeutic relationship is the presence of a client-therapist emotional connection. This connection involves the client viewing the therapist as an important person in his or her life, a sense that the relationship is based on affiliation, trust, caring, and concern; that the therapist genuinely cares and "is there" for the client, that he or she is on the same wavelength with the therapist, and that the therapist's wisdom and expertise are valuable (Dunkle & Friedlander, 1996).

One noteworthy finding consistent throughout the literature on the therapeutic relationship is that the client-therapist emotional connection, as well as the therapeutic relationship itself, is generally developed in the first three sessions. By the third session, if a substantial relationship has not yet been established, clients are more likely to drop out of therapy prematurely. If they do continue in therapy, they are less likely to commit as fully to participating actively in the therapeutic process. According to Sexton clients in high-alliance therapies responded to their therapists with greater involvement than those in low-alliance therapies. High alliance sessions additionally had fewer topic changes, more therapist listening, and a greater degree of early client therapeutic work (2005). The research demonstrates that the severity of client's presenting problem in therapy does not impact the formation of a strong therapeutic relationship, nor does gender combination (different variations of client-therapist gender) or androgyny (Horvath, 2000).

Factors contributing to the development of the therapeutic relationship include client and therapist personality, quality of object relations, and pre-therapy interpersonal functioning. The

results of several quantitative studies measuring the existence of the therapeutic relationship and its contributions to therapeutic success in clinical settings reveal that it is the *client's* rating of the alliance more so than the therapist's perception of the alliance that most consistently predict outcome (Sexton, et. al, 2005). One study noted that less experienced therapists, particularly student therapists, are much more apt to misjudge the quality of the relationship than are better-trained clinicians. High treatment outcomes are only existent if the client perceives a strong therapeutic relationship (Horvath, 2000).

The literature summarizing the qualitative research on common factors in psychotherapy has shown that it is within the *therapist's* capacity to be involved in a therapeutic relationship, including creating the alliance and taking responsibility for repairing ruptures in the therapeutic process (Erskine, 1998). Ruptures pose a threat to both the therapeutic relationship and the therapeutic process itself, and merit immediate and careful attention. The literature notes that the resolution of these ruptures in the therapeutic relationship not only smoothes the course of therapy, but also may play a role in the direct resolution of some of the client's emotional difficulties. While ruptures or rifts in the relationship between therapist and client have been attributed to the client's act of transferring onto the therapist problems or situations reminiscent of other problems in the client's real-life relationships, empirical data indicates that a here-and-now discussion of ruptures in the therapeutic relationship is more likely to produce beneficial results than linking them to past experiences (Horvath, 2000).

The literature also indicates that another main component in the development of a sound therapeutic relationship involves therapist and client working from a collaborative framework, a partnership in which clients view themselves as active, esteemed constituents (Horvath, 2000). Therapists can validate and affirm clients' active roles in the partnership via attaining client

endorsement of activities which form the basis of therapy (for example, topics discussed, reflections, interpretation, homework, in-session exercises, etc.) (Horvath, 2000).

Several research studies have shown therapist activities that served to promote client-therapist connection building include active focused listening, keeping the topic largely centered on the client, providing a relaxed warmth in the session, allowing the client to become emotionally moved, avoiding the provision of too much information or advice, and not using a purely cognitive verbal style, a style that the client might perceive as indicating that the therapist was overly detached (Sexton, et. al, 2005). The literature also notes that according to one study, therapists with low amounts of anxiety were found better able to become personally involved with their clients, while highly anxious therapists exhibited more defensive reactions toward their clients. It is suggested, then, that less anxious therapists are better able to provide clients the space and freedom to express their feelings (McClure, 1987).

Another interesting piece of information in the literature discusses the notion of an attitude of "liking" or "disliking" clients in the relationship. Some theorists have posited that a therapist's attitude of extreme liking or disliking of a client is directly related to countertransference. Countertransference can be thought of as "the act of transferring onto the person of the client thoughts, feelings, and attitudes that are based on images from the therapist's internal psyche rather than those of the client" (McClure, p. 326, 1987). The literature suggests, then, that strong feelings of like toward a client are perhaps not necessarily as "genuine" as the therapist perceives, and may suggest that pieces of the client's personality or presenting issue are reminiscent of aspects of the therapist's own personality, memory, or past experiences.

According to the literature, therapist countertransference can pose significant effects on the therapeutic process. Therapists who feel a presence of strong, positive feelings toward

clients tend to give them higher prognoses; they also view them as more motivated and willing to embrace change. The converse is true for therapists who experience strong negative feelings toward a client. According to the literature, extreme feelings on either end of the spectrum may pose a detriment to therapy; over-identification results in rendering the therapist unable to separate from the client's material while disidentification leads to distancing behaviors on the part of the therapist. Overidentifying and disidentifying are two examples of "non-facilitative" countertransference, and both involve an appearance of "unresolved areas of the therapist's unconscious and result in misperceptions and inappropriate responses to the client based on those perceptions" (McClure, p. 326,1987). It is important to note that misperceiving a client's ideas, feelings, or needs by the therapist in and of itself is not countertransference. Countertransference occurs when the therapist as a result of this misperception *misresponds* to the client, deeming countertransference an active process. The literature suggests that therapists who are aware of strong feelings toward their clients need to be cognizant that distortions may be taking place; it also notes that further research is needed on the impact of the degree or intensity of liking or disliking on the therapeutic relationship (McClure, 1987).

Countertransference additionally can be "facilitative" and an enhancement to the therapeutic process. Facilitative countertransferences differ from nonfacilitative countertransferences in that they arise from resolved areas of the therapist's unconscious and create for better intuitive understanding of the client's experience (McClure, 1987). While "overidentifying" or "disidentifying" with the client can serve as a hindrance to the therapeutic process, and fall under the category of nonfacilitative countertransference, the literature states that therapist "identifying" with the client is an asset to both therapy and the therapeutic relationship, and actually a crucial component, because identification and empathy "go hand in

hand." Therapist identification with the client correlates highly with the client feeling understood. The literature states that it can be helpful to consider therapist identification as existing on a continuum where the midpoint and its surrounding areas can be thought of as optimal identification; extremes on either side (overidentification or disidentification) pose possible threat to the therapeutic process (McClure, 1987).

The goal with countertransference, then, it seems, is to first determine if the countertransference being experienced is facilitative or nonfacilitative, and then decide what to do with each. If the countertransference is nonfacilitative, the literature suggests supervision or personal therapy to recognize and resolve the nonfacilitative countertransference attitude or impulse (Kahn, 1997). The literature also suggests utilizing personality tests in therapy for the client, to better understand if therapist perception of the client is indeed accurate (McClure, 1987). If the countertransference is facilitative the therapist must find a way to utilize it in a manner that best fits the client's needs at that time in therapy, selecting a style to best convey the identification and empathy felt on the therapist's part toward the client. On the topic of countertransference, one prominent scholar and therapist writes, "The more gently vigilant we become about our attitudes, feelings, impulses, wishes, and fears, the more quickly we can turn the countertransference into something effective" (Kahn, p. 144, 1997).

There are definite gaps in the literature that this study will attempt to address. For instance, while it is posited that strong like or dislike toward a client suggests countertransference might be occurring, my review of the literature does not explore how this experience affects the therapeutic relationship. Is it plausible to suggest that a therapist experiencing extremely high regard for a client might perhaps be more motivated while

treatment planning and might also "show up" more fully for sessions? How does this impact the therapeutic relationship, and the client's prognosis for therapy? Conversely, what happens in the therapeutic relationship when therapist regard for the client is especially low? While the literature indicates that client gender and androgyny do not affect the formulation of a therapeutic relationship, what about other demographics? Do age, education, or perceived economic standing contribute in any manner? Do specific therapist personality types, (outgoing vs. reserved, for example) promote the therapeutic relationship in a smoother manner? What about the therapist's level of confidence and self-esteem? How do ruptures in the relationship actually affect the relationship, and if they *are* repaired, how is the relationship affected? How is the therapeutic relationship different when operating from a co-therapy dynamic? How does therapeutic style (directive, non-directive, affective, neutral, etc.) affect the formulation and existence of the therapeutic relationship? This qualitative research study will serve to expand upon findings already posed, while also addressing these additional queries.

An in depth exploration and discussion of the qualitative research methodology of autoethnography follows in the next chapter.

Chapter III: Methodology

The purpose of this study is to describe and examine my personal experiences of processes in the therapeutic setting as they relate to the therapeutic relationship and client change utilizing the research methodology of autoethnographic personal narrative. This portion of the research proposal will briefly introduce the research methodology of autoethnography and discuss subject selection and description, data collection procedures, data analysis, validity, reliability, generalizability, and limitations as they relate to the study.

An Introduction to Autoethnography

Autoethnography is an emerging qualitative research methodology that displays multiple layers of consciousness and connects the personal to the cultural through autobiography (Ellis & Bochner, 2000). It is often written in the first-person and utilizes a variety of written forms including journaling, poetry, photography, and personal narrative. This autoethnography is written in the form of a personal narrative, which involves, "tak[ing] on the dual identities of academic and personal selves to tell autobiographical stories about some aspect of...experience in daily life" (Ellis & Bochner, 2000, p. 740). Autoethnography differs largely from other research methodologies, such as studies that utilize the scientific method, for instance, in that it suggests that "We cannot know what to explore, until we have explored it" (Zuroff & Blatt 2006, p. 133). This method unlayers the field to readers, providing them with a deeper comprehension of not only the people being studied but the researcher as well. Autoethnography elicits a personal involvement and reflection from its reader, thereby instigating a dance of new thought and meaning that is mutual and interdependent. The intimacy, vulnerability, and subjectivity of autoethnography honors the feminist and constructivist post-modern perspectives that the observer influences the observed and that meaning is co-constructed, steeped richly in multi-

dimensional layers of culture, experiences, and values (Ellis & Bochner, 2000). In this autoethnography, it will be my goal to extend personal discovered truths and meanings to the reader and connect them to the field of psychotherapy.

Subject Selection and Description

As described previously, autoethnographies are an autobiography of one's own life experiences. Therefore, the participant in this study is myself. At the time of this study's beginning, in November 2008, I was a 27-year old female in my second year of graduate school in the marriage and family therapy program at UW-Stout. I had lived in Eau Claire, Wisconsin for approximately four months, having moved alone from Madison at the end of the previous summer. I was born in rural northern Wisconsin in the small logging town of Phillips, and subsequently spent much of adolescence and adulthood in Madison. My roots and upbringing have taught me to respect difference, and I have always been thirsty for new experiences that challenge personal perceptions and existing paradigms of thought. I chose to become a psychotherapist because I am fascinated by the depth and vagaries in the human mind, patterns and processes of human interaction, and the meanings people make by which to live and produce in the world. It is my wish to help individuals sort out the intricacies in their lives and form ideas and conceptions of themselves and the world that empower them to realize their own potentials and unique worth. I am also an advocate for social justice, and wish to be a voice for those marginalized by society who cannot speak for themselves. This research study will allow me the chance to understand myself in deeper, more complex forms so that I will be better able to accomplish these goals.

Data Collection Procedures

The data collection procedures for this autoethnographic research study involved keeping a journal of my personal experiences working with clients in therapy sessions over the course of a seven-month time period. I kept a running description of mainly self-observations made for seven months about therapeutic processes as they relate to the therapeutic relationship, making certain to write journal entries for the first three sessions whenever possible, because research indicates that the development of the therapeutic relationship typically occurs and is established by the third session (Sexton, et. al, 2005).

As noted previously, the research methodology of autoethnography specifies that the study is to be conducted in a manner that strives to better understand the self; therefore, the basis and primary focus of observation and journaling centers on *myself* and not clients. My personal experience with clients and all of the nuances involved in those interactions is encapsulated, in hopes to connect my personal experience to the culture and field of psychotherapy via autoethnography.

Journal entries did not serve as content-laden, behavioral descriptions of what occurred in sessions, but rather more so strove to capture the processes of interaction between the client and myself, focusing mainly on my thoughts, feelings, and reactions. For instance, when writing about an intake, I may have described how I felt in the therapy room, what I felt when introducing myself and discussing my vision of therapy. How do I feel it was received? Am I anxious? How do I feel making eye contact; is it comfortable or uncomfortable? Is the conversation natural and flowing or abrupt and choppy? Do I find myself easily articulate, or tripping over my words? How does my perceived opinion of how the client responds to me impact my perception of the developing therapeutic relationship? What does it feel like, both

physically and emotionally, when I make interpretive, reflective statements? How is the feeling different depending on the reception of these statements? Do I find myself liking the client initially? Why might that be? I did not focus too much on analyzing data in these journal entries, but recorded "flashes of ideas" or general speculations/hypotheses about the process. I also included accounts of previous episodes that were forgotten or went unnoticed, for instance, "Last time, felt very uneasy when client interrupted me several times and talked over me."

Data Analysis

The purpose of this research methodology is not to arrive at specific findings or absolute truths on the topic. Therefore, regarding the therapeutic relationship, the purpose is not aimed at providing proven results on components that add to or diminish the development, maintenance, and effects of the therapeutic relationship. The idea is to create significant meaning for myself and to readers that will also present as important to the field of psychotherapy.

The manner in which I analyzed data was specific, and deliberate. Near the end of the seven month journaling period, I began to read through the journal entries looking for the presence of recurrent or repetitive themes which either appeared in the literature and/or I personally deemed relevant to the therapeutic relationship, such as therapist self-confidence, performance anxiety, feeling urged to "deliver," countertransference, feelings of "like" toward a client, identifying with a client, etc. I also looked for relevant themes that occurred throughout the therapeutic process itself, such as ruptures in the relationship, discontinuation of therapy without notice, etc. As I analyzed this data, I found certain repetitive themes and patterns. The "clients" described in this study are based on actual clients but with distinguishing characteristics, features, and life situation significantly modified or changed to protect them. Some of the "clients" described are composite characters, amalgams of two or more actual

clients. Again, the primary focus of this study was myself, and what factors I perceive to be significant in the development, maintenance, and effects of the therapeutic relationship in therapeutic processes.

Validity

Validity poses the question as to whether or not a research study indeed measures what it intended to measure. The qualitative research methodology of autoethnography differs from quantitative studies in that validity cannot be obtained through objective analysis of data. According to Ellis and Bochner, "...validity means that our work seeks verisimilitude; it evokes in readers a feeling that the experience described is lifelike, believable, and possible...[one] might also judge validity by whether it helps readers communicate with others different from themselves, or offers a way to improve the lives of participants and readers or even your own" (2000, p. 751).

This study strove to uncover personal truths about factors that in my perception influence the existence of a therapeutic relationship in the context of therapeutic sessions. For the most part, this study involved me examining *myself* in an in-depth manner that was at all times challenging and often emotionally taxing. The nature of the subject matter suggested that it was imperative to the process and results that I was completely honest with myself and how I was feeling, at each step along the way, and that often painted my person in less than flattering lights. This study followed the autoethnographic ideology, "We cannot know what to explore, until we have explored it," (Zuroff & Blatt, 2006, p. 133) in that the data and prominent themes that arose along the way led to other investigations, topics, and ideas about myself and the therapeutic relationship which expanded and deepened the study. Interestingly, the findings that this study revealed on perceptions of a therapist (myself) in the therapeutic relationship were *vastly*

different than what I had expected during preliminary musings of what prominent themes *might* arise.

In order to honor the subject matter and proposed study, it seemed essential to the process that I dig as deeply within as possible to understand my internal processes and how they related to external processes occurring in therapy. The chosen subject matter itself placed me in a relatively vulnerable position, yet it was a position I was willing to accept because I believe the benefits of the study outweigh any probable effects of that vulnerability.

To the best of my knowledge the information in this study: thoughts, feelings, ideas, hypotheses, etc. can all be considered personal truths of the researcher. The effect this study has had on myself as therapist, a student, and a human being is enormous, and I find that I have an expanded wealth of understanding about my processes and how they fit into the context of my relationships with clients, supervisors, and colleagues, as well as a greater understanding about who I am and who I wish to be in the world. I attempted to write the study and its findings in a manner that was engaging, in-depth, thought provoking, vulnerable, and evocative, with the hope that readers will be able to extend it to the context of their own lives in a way that is personally meaningful to them. In my estimation if even one person who reads this narrative becomes stimulated by it in the sense that she thinks about and analyzes her own experience as a therapist (or any other avenue personally meaningful and relevant to her) and is provoked to some insight not previously realized, then the research study met and achieved its goals.

Reliability and Generalizability

A study is said to be reliable to the extent that its results can be consistently replicated. On the topic of reliability, Ellis & Bochner write, "Since we always create our personal narrative from a situated location, trying to make our present, imagined future, and remembered past

cohere, there's no such thing as orthodox reliability in autoethnographic research" (2000, p. 751). Ellis and Bochner also comment, though, that it is within the researcher's capacity to do "reliability checks." This might entail engaging in regular dialogue with an advisor or mentor, who knows the researcher well and understands the aims and complexities of the research study, and is thus in a position to offer comments, interpretations, and reflections on progress. I utilized this idea, deliberately selecting an advisor whom I trusted and felt both understood me as a person, as well as the aims of my study, and could comment on its reliability accordingly. This research project is to the best of my knowledge, a reliable expression of my experiences as student therapist.

With regard to generalizability in autoethnographic writing, Ellis & Bochner comment that, "A story's generalizability is constantly being tested by readers as they determine if it speaks to them about their experience or about the lives of others they know" (2000, p. 751). In this study it is my hope that the intimate nature through which I unravel my own personal process as a student actively pursuing therapeutic relationships will evoke in readers the feeling of having a vicarious experience themselves, and will speak to them in ways that can be foundational to their own meaning-making processes. While the personal truths expressed throughout this narrative should not be applied to others as a generalizable truth about what it means to be a therapist or specifically what it means to be a therapist involved in the therapeutic relationship, as a member of the psychotherapy field, my discovered truths are an opportunity to generate meaning and discourse on the topic of the therapeutic relationship for further thought and analysis.

Limitations

Autoethnographies are unable to provide absolute empirically proven truths. Therefore, nothing in this study can be generalized to the larger society, nor has been "proven" on the topic of the therapeutic relationship. With regard to my specific topic of the therapeutic relationship, it could be considered a limitation to not have the client's point of view throughout the study on the therapeutic relationship, especially considering the research noting that it is the client's perspective of the therapeutic relationship that actually defines and determines its utility (Zuroff & Blatt, 2006). Because autoethnographies study the self with the goal of extending one's experiences to the greater context of culture, having a client's input would not fit with the research procedures, yet it would be very interesting and provide a wider frame of reference.

Other limitations include the notion that as a human being alive and active within many social contexts, I cannot be separated from my personal worldview, perceptions and biases. This autoethnography's research subject is myself, about whom I could of course never be a completely objective observer. It should be recognized, however, that all research is impacted by some kind of belief or value system. While an autoethnography cannot provide generalizable results able to be replicated, it seems an especially appropriate research methodology to use when studying the therapeutic relationship because it is a chance to deeply investigate and uncover the nuanced and subjective human processes that exist within a therapist involved in therapeutic relationships. Relationships themselves, and what exactly it is that they consist of, are difficult to quantify, which is probably one reason the therapeutic relationship, what it consists of, and how to create one, is still considered a "gap in the literature."

It is has been an exciting and invaluable experience to study myself and unravel the many layers of my experience including thoughts, feelings, perceptions, ideas, theories, insight, and

introspection as I served as a therapist in therapeutic relationships. The personal truths I discovered have significantly impacted both my person and my self as a therapist and will, with hope, invite others to begin their own processes of self-examination and reflection. What follows is a description and analysis of therapy sessions following four "clients" between the time period of November 2008 and May 2009. A discussion of main findings, themes, patterns and discovered personal truths follows in chapter five.

Chapter IV: The Therapeutic Relationship

The air is thick, and smells heavy with cleaner, the industrial kind used in schools in late August when preparing for the big day. There's another essence to the air, though, aside from antiseptic, like something is hanging in it. That something feels weighty and unresolved, impervious to even the most industrial cleaning agent. I take a deep breath and try to sift through the heaviness for a clean, light, untouched air molecule. No luck. It's like trying to breathe in a sandstorm.

It's my first day of clinic as a student therapist completing the second year of my master's program in marriage and family therapy. Students get half of their practicum experience working in a student clinic that serves the local and surrounding communities by offering low-cost mental health counseling for individuals, couples and families. The first year of the master's program is all academic classwork, with smatterings of therapy role-play scenarios interspersed into the mix. Getting up in front of the class and "playing therapist" with student "clients," however, is a far cry from what I'm actually about to embark upon.

I am nervous. I think, if I actually think about how it's going to be in there with an actual client, and all the things that could, or might take place; all of the possible and probable scenarios that could very potentially unfold in about five minutes...I might have an anxiety attack myself. I think that my brain is not allowing me to "go there." So I'm just sitting here, breathing, and zoning in a way. Wish I could say I was meditating or finding chi or some kind of other inner blissful balance, but the fact of the matter is, I'm sort of freaking out. And the client is here! Deep breath—in I go—show time.

*The client's name is *Zach and he is tall, about my age, with a great posture—sort of a looming confidence about him as he follows us down the hall. We enter the little cubbyhole therapy room: four straight back chairs and a small table pushed against the wall, orange 70s-style carpeting and a fluorescent light that beams down on us in thin ghostly strands. The one-way mirror dominates the side wall, and I'm distracted by its immensity, and the images it projects. I glance at our little triangular configuration, my co-therapist and I seated next to one another with Zach at the point. We begin to get acquainted, "join," in therapy language. My co-therapist has been working with Zach for about five sessions; as a new therapist, I'm transitioning onto the case. When I begin to speak about myself, my tongue feels suddenly enlarged, with the consistency of sandpaper. I stutter a bit, and then do that thing where you're not sure if you should just start all over with the sentence, or try to soldier through the stilted syllabic starts that don't quite form words. I do the latter. Then start over anyway. We sit in silence shrouded by the heavy air.*

Zach speaks about his past few weeks, I exhale, relieved that he's going to fill up some space to take the spotlight off me. I steal a glance at Angela, my co-therapist. Wow, could she look more like a therapist? Brown cords, brown cardigan, hip glasses that still look professional. I look down at my own green knit top and white jeans, hair pulled back in a low ponytail. Why <u>am</u> I wearing white jeans?! I must look dressed for a summer day's walk in the park, not like a trusted and knowing professional, sage and seasoned, in whose company soul-bearers seek psychotherapeutic refuge. Angela's nodding at something Zach's saying, her expression the perfect mix of understanding and curious inquiry. I turn my gaze toward Zach and am stunned by the intensity of his eyes. Twin prisms refracting crystal threads of light that

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* All client/co-therapist names and distinguishing features have been changed

seem to emanate from a source deep within. This guy is intense. Looks like someone I would have dated. Our eyes connect. Oh! Did I just give him a look? Like a flirtatious look?! I glance at my reflection in the mirror. What do I look like? I don't look like a therapist to me. Zach is saying something about that this might be his last session, as he doesn't really feel like he's getting a whole lot out of his time here. My heart lurches. It must be me! He met me as his new therapist and now he's decided not to return. Wow. Okay. Angela's nodding again and saying that we're always here if he decides to come back. He looks at me. "What do you think about therapy?" he asks me. "What do you think works about it?" I freeze for a moment, then rattle something off about creating a space for exploration and having a witness there to listen and at times interpret and reflect. He nods. The air seems weightless for a moment. I look at him and see him truly as a client for the first time. Not a peer. Not someone I'd be friends with or harmlessly flirt with. A client. Coming in to a clinic for therapy.

That night I can't sleep. Events from the day flit through my mind in a seemingly endless montage of thoughts, feelings, interpretations, ideas and predictions. How did it go? How was I seen? Did the clients see me as a "real" therapist? Could they tell that I was nervous, almost shell-shocked at times? And what about how that client looked when I asked the question about his marriage. Was it too soon? Did I challenge him prematurely? Was I joined enough? Will Zach return? If not was it because of me? Or might he return because of me? Would that be because he thinks I could actually help? Did I "sell" therapy to him with my little speech?

When I really try to fall asleep I find that I cannot. I am consumed with thoughts about the day. The fact that I sat in rooms all day long and was invited into these people, strangers, really, invited into their lives, and in many cases ventured with them off the path of the chit chat

pleasantry and into the shadowy terrain of privately dark thoughts, fears, regrets and ruminations is incredible to me. I find myself picturing clients' lives at home, with their partners, their kids, what is it like there? What are their houses like? Their friends? What was it like for them when they grew up? Are they feeling content now? Lonely? Afraid? I start to begin thinking about possible interventions, but my mind won't stay focused. I feel weighted by the heaviness of what I was witness to, yet cannot relax. I fall into a half awake/half asleep trance-like state. My body physically feels like one big human-sized knot. There are so many possibilities of what could be tomorrow, and no way of predicting. Am I equipped to handle this?

Description and Analyses of Client Sessions 11/2008-5/2009

Part I

Description and Analysis of Client Sessions 11/2008-1/2009

Session(s) with "Alice"

I've met with client Alice, a single female around my age for three sessions so far with co-therapist Caitlyn. There is an undeniable chemistry between us. I believe, at this point, the chemistry lies in the triad, but I have a hunch if Alice and I met alone, the chemistry would continue, and perhaps even grow and deepen. The client is quite accommodating in that she creates and maintains incredible eye contact with *both* therapists providing for quite a balanced environment for therapy. I've noticed myself extremely influenced by the existence of this kind

of parity in the therapy room, and am put at ease when the client is able to balance eye contact and flow of conversation between both therapists.

I'm finding myself relating to Alice more and more with the subject matter she presents with. For instance, she talks about comparing herself to others, and wishing she could have things more 'figured out,' and feels uncomfortable, at times, for not meeting certain societal status quos. I find that I often relate strongly to the content of what she presents and struggles with. I also find that I like the way she utilizes therapy; she seems to desire to deeply explore, and get underneath what is going on. She speaks self-deprecatingly at times, and I struggle with how to respond. It seems a cheap and temporary solution to say, "Well, *I* don't see you that way at all," and yet I cannot stand to see her, basically seeing herself this way. Today I attempted a reframe as she was speaking disparagingly about how her tendency to 'over-analyze' gets in the way of fun and lightness in mind and heart, suggesting that perhaps being someone who *is able* to think so deeply and critically about the world has multitudes of possibilities that others might not, and the ability to contribute in special, unusual ways. She latched on to the reframe and seemed uplifted. Almost inspired. *I* felt inspired for her, and for me. In fact I felt like we as a duo were unstoppable—running hand in hand down a path toward enlightenment or self-actualization. As she was leaving she commented to Caitlyn and me that she gets a lot out of her time here, and is very pleased with how things are going in therapy. I felt like I had been awarded the gold medal in therapy-land.

Analysis

Several notable themes arise throughout this description of a therapy session with client Alice. It was very important for me to receive consistent eye contact throughout the session.

This suggests that I was feeling less than completely self-assured, as I needed an affirming boost to convince me that I was an important, prominent figure in the room. Of course, conversationally, it is simply easier to feel like one is involved in an engaging, meaningful, and mutual exchange when consistent eye-contact is present, but the amount of importance I placed on it and its consistent existence is suggestive that I wasn't feeling completely self-assured as a therapist at that time. By consistently looking to me, it showed that she placed value on what I thought and said, and that it was important to her that I was 'with her' and 'following;' I needed reassurance that I was important to her in the room. Retrospectively it seems somewhat arbitrary to have placed so much value on eye-contact; people have different conversational styles and it cannot be assumed that just because someone looks at you often it *means* they really care about what you have to say, and vice versa.

This consistent eye-contact was perhaps an ingredient that helped to create the "chemistry" between us I talked about, and it seems that natural chemistry with clients is a nice bonus that can speed up the joining process, and enhance the formation of the therapeutic relationship.

A significant amount of countertransference is evident in this description of therapy with Alice in that I found that I could relate deeply (in my perception) to the subject matter presented, including thoughts, feelings, fears, doubts, and even actual experiences. It was difficult at times to refrain from stating, "I've felt that exact same way!" Or, "I've been there!" The way you do with a peer when you're becoming friends or sharing intimate details. This identifying with my client seems to fall under the category of "facilitative countertransference," which, "arises from resolved areas of the therapist's unconscious and aid[s] the therapist's intuitive understanding of

the client" (McClure, 1987, pg. 326). I was able to identify with Alice's experiences, and I knew why; I was consciously aware of where the identification was coming from. I just didn't yet know how to implement this facilitative countertransference in a way that felt "therapeutic" to me. Additionally, it seems my instinct to refrain from pacifying Alice in the moment with regards to her self-deprecations was a decision some schools of thought, particularly neo-Freudians, would support: "The analysts believe...gratifications offered by the therapist merely prolong the illusion that the ultimate gratifier is out there somewhere, waiting to be found" (Kahn, 1997 pp. 14).

It is also important to consider and analyze the effect of Alice's comments at the end of the session about therapy being useful and worthwhile, and how good and affirmed they made me feel. Again, whenever someone gives a compliment, it seems natural to feel good, yet in this instance, I was placing *so much* stock in the client comments and affirmations, like my worth as a therapist was contingent upon whatever she did or didn't say. It speaks to my overall lack of confidence in myself at this stage as a therapist; I felt at the time, that, 'I *know* I've got good stuff to offer and that I will be a *really good therapist*, but I don't know how or when to communicate this stuff in a way that gets through.' So when Alice said, essentially, "It got through," I felt like rejoicing. That felt great. I just don't want it to matter to me quite as much.

Session(s) with client "Paul"

I had an intake today with Paul, a client court-ordered to attend therapy related to an incident of domestic abuse. The client possesses a strong, confident stature, and exhibits an aura of relaxed confidence as we settle into our chairs, suggesting he has been in situations like this

before. His dress and demeanor seem to imply he hails from a "rougher" environment where perhaps being tough was requisite for life. He emits a particular scent, perhaps a mixture of some kind of cologne and cigarette smoke that fills up the room.

As the session begins, I notice that I am very aware of this client's every movement and also very aware of my own. Every time I shift in my seat or push the hair from my eyes, it seems like it is happening in slow motion, and under a microscope. I cannot help but wonder what this client is thinking about my co-therapist and me, and what his time here will mean. Is it a joke for him? Is he laughing at us on the inside? He tells his story passionately, using evocative imagery and employing techniques such as pacing, build-up, and comic relief, suggesting that this is not the first time he's told his story. It doesn't seem scripted, though, and indeed I perceive a sincerity and perhaps a humility about him that is endearing. I am realizing that I am actually feeling very charmed by this client. I feel strong empathy for him and his struggle. But there is something else. Something about the combination of his demeanor, scent, facial expressions, and the way he speaks is reminiscent of *something* to me although I cannot pinpoint what. Indeed something about this client is evoking both a physiological and emotional response in me, by which I feel temporarily taken under the spell. I find that if I follow my impulses, I would have the urge to just sit there smiling and nodding with a particular gleam in my eye. Instead I do smile and do nod, but put the kibosh on the gleam. The session wraps up and the client reschedules, which is, of course, required of him. I wonder if that complex barrage of thoughts and feelings I was having during that session were remotely evident to Paul. I desperately wish I could have a *sense* of how that was for him. What he thought about us and the session. I try to think about how I "came off" as a therapist. I find that I cannot.

Analysis

This description of an intake with Paul describes a scenario where I experienced a significant amount of performance anxiety and self-doubt as to whether or not I was competent and professionally equipped to provide therapy to this client. In addition, a significant amount of 'nonfacilitative countertransference' is evident. Nonfacilitative countertransferences "arise from unresolved areas of the therapist's unconscious and result in misperceptions and inappropriate responses to the client based on those perceptions" (McClure, 1987, pg 326). The appearance of nonfacilitative countertransference is evident in the strong physiological and emotional responses I experienced during a session with Paul without a clear recognized explanation for their existence. In my estimation, the high incidence of countertransference present in this intake played a powerful role in my experience of both the client and of myself, in a sense diminishing my ability to be fully aware or present to the therapeutic process.

I also felt extremely insecure in my role as therapist or potential therapist to this client, probably due to the disparity between the life he described and his presenting problem and my *own* life experience. Unlike my experience with Alice, where nearly everything she spoke about was familiar to me, almost *nothing* that Paul described was familiar to me in a first-hand sense. This is not to say I held a belief that the therapist *must* relate to the content of what the client presents with, it is more a comment on my insecurities within my*self*, in that I wondered if he would take *me* seriously, or think I was too inexperienced or green.

This suggests that at the time of therapy with this client, I was struggling with not only if I "could" be a therapist to this client, but I was additionally experiencing uncertainties about my sense of identity as a therapist, and who that was—how much of my own self to bring into that

identity, and in what form. It seemed, at this point, that being a therapist meant choosing to expose and *utilize* certain parts of the persona, while not revealing others, and I was struggling to come to terms with what to show and what to conceal—keeping me quite occupied, and deeming it *very* difficult to predict how I would have been seen by a client.

Session(s) with clients "Henry and Liz"

Henry and Liz are a couple I think I could be friends with if they weren't my clients. We have a lot of interests in common, and I just get a *feeling* during sessions that we would connect in the real world, if we, say, met at a party somewhere. I haven't really had that feeling about any other clients so far this year, although I have liked many very much. Henry and Liz present for couple's therapy to work on issues in their marriage. They've had countless minor and one or two major attachment injuries, and have suffered a significant loss of trust in the marriage which causes a lot of intense verbal arguments, usually ending in one party slamming a door or sleeping on the couch.

When working with this couple I feel a significant amount of 'performance anxiety' and the urge to deliver. This couple is on the verge of a divorce, and it feels like things need to be happening *now*. There's no time to do a genogram or spend loads of time joining with Henry and Liz. Plus they've been to therapy in the past, and felt that the therapy they received was highly effective. While this might suggest they are good candidates for therapy now, it's only serving to amplify my performance anxiety. This couple is sharp and there is a lot of volatility between them. They seem to arrive almost swathed in a cape of dark, thick and stale emotions

that air out during session and attach to any positive energy in the room. I feel them attaching to my own energy field, and it seems to heighten my anxiety to an even heavier extent: "You must deliver." I'm working double-time when I'm in there with them and my heart is nearly always pounding. Sometimes my mouth gets dry and my voice shaky. But I'm always glad when I push and say something that feels like it should make an impact, provoke *some* insight. That's the thing with couples, though, they're so buried in their own problems; they're not exactly going to take time out to congratulate the therapist on a session well done or insight well-provided. That's the thing about this therapy stuff, in general—you just never *know* if you're doing a good job or not. Even if the client says you are, that could be about something else, them trying to get you to like them, or playing out some other transference. There are no absolutes, and no fail-proof test to know you're measuring up.

Analysis

My experience with this couple illuminates the strong amount of performance anxiety I experience during heated, high-intensity and volatile therapy situations. These clients needed help in an *immediate* sense, and came to me to get it. Of course as a therapist I am not expected nor have the power to "save a marriage," yet I still felt a tremendous amount of pressure to provide appropriate interventions tailored to address their specific patterns of negative interaction. My liking of Henry and Liz, and liking them as a couple, only served to intensify my desire to want to help them. In this sense, I do think that my liking of these clients encouraged me to work harder for them and possibly believe in them more, which correlates positively with the results of one study, positing that if a therapist likes a client, she tends to grant a more favorable prognosis (McClure, 1987).

I was not thoroughly satisfied with the level of joining that occurred in the first few sessions, and I worried that it would inhibit the ability for a strong therapeutic relationship to grow. It seemed very difficult, though, *to* join with them because of the intensity and immediacy of what they needed to talk about. I struggled to find creative ways to insert a piece of my personality into therapy, so they could get to know the person behind the therapist, but I do not believe I was particularly successful. I lacked confidence and the skill to know how to properly implement this, and effectively "manage" and balance those first few sessions. Thus, in lieu of spending the typically requisite first two sessions getting to know each other, we delved right into their issues and implemented therapy interventions right away, for the most part utilizing "emotion-focused therapy," which seemed exceptionally *difficult* to execute considering its emphasis on exploring and uncovering really deep, personal and complicated emotions, without the basis of a strong and trusting therapeutic relationship.

Interlude I: Description of Concurrent Internship Experience

The student clinic where I work utilizes a co-therapy dynamic when treating couples, individuals, and families. Therefore, for the most part students are always working with each other, and not alone, when seeing clients and completing necessary treatment planning, diagnosing, and case notes. This dynamic is intentional and allows for students to collaborate with their colleagues, and gain a more expansive breadth of knowledge around possibilities when treating clients. My experience of using co-therapy to treat clients has been overall a positive one, and I think it has allowed me the opportunity to gain much more insight and think about possibilities of what kind of therapist I want to be in a way that would not be possible if I were seeing clients alone from the beginning, and rarely, if ever, being observed or videotaped.

The drawback of always working with another therapist on a case for me has been that it makes it difficult, at times, to know what's working, and how much of it is has to do with what I'm providing, what my co-therapist is providing, or what we as a duo are providing. Most students see clients alone at the internships they report to on the days when they are not seeing clients at the student clinic. I have a rather unusual internship experience in the sense that I work with a licensed therapist in a behavioral health unit of a hospital, but I do not participate in treatment planning, case notes, or diagnosing. While the intention is to do "co-therapy" with clients, most clients view me as a student in training, and thus direct their attention and focus to the "real" therapist in the room. This makes sense to me, and I think if I were the client, I would probably do the same, unless the student therapist made aggressive efforts to assert her equality to the licensed therapist. I do not *feel* like I *am* equal to the therapist I work with, due to her status as a licensed therapist working in the field for ten years, and in addition it is simply not my nature to be highly assertive when I still have so much to learn. Due to all of this I am reluctant to "take the lead" regularly in the therapy room. Therefore, while my off-site practicum has privileged me with the ability to watch and learn from talented, seasoned therapists, it has done little to solidify confidence in my *own* ability to see and treat clients as a professional therapist working independently.

Since I do not get the opportunity to treat clients independently at my internship, I decided it was important for my growth as a therapist to find a way to see a client independently at the student clinic. I spoke to one of my professors about my situation, and proposed that I "take on" a client on my own. After giving it some thought, he agreed. The next intake that came in would be mine, and mine alone.

Session with client "Willa"

As it would happen, a client called for an intake that very afternoon. My professor presented me with the intake form. Willa, mid-fifties, former client, would like to be seen for "life issues she's dealing with." Hmm, I thought. This could be anything! How do I prepare for that? Plus, mid-fifties?! Without knowing it, I think I had been hoping for a client closer to my own age. Is she going to take *me* seriously? And, she has been treated here in the past...must mean whatever treatment she got was effective enough so that she would return. What am I up against? It would be so much easier if the first client I took on alone were someone who had never been to therapy before, and thus didn't know what to expect, versus someone who is possibly a 'therapy-pro' and looking for something specific...which I may or may not be able to provide!

On the afternoon of her scheduled intake, I am a tightly wound ball of nerves. I have reviewed her previous file, and cannot tell if I'm intrigued or terrified. I hope to be able to conduct the intake naturally, without having to refer to notes or questions, but I have a list of questions ready in case I blank. I feel like everything is riding on what becomes of this one session, which is ridiculous, I know, but I have had trouble building sound therapeutic confidence when I have as of yet never *known* if a client were coming back for me. It seems like everything I've been working on is going to either culminate in success or failure with the outcome of this one session. This will be my test.

My nervousness intensifies as the hour approaches. At about ten to I glance into the waiting room and see a very elegantly dressed woman with a hip haircut and stylish jacket filling out an intake form in the waiting room. My heart thunders in my chest and my insides squirm. I

was hoping she would be grandmotherly, not an intimidating woman-of-the-world type! Deep breath. *You can do this*, I tell myself. I open the door. "Willa?" I say. She looks up and smiles warmly at me. "Let's go back this way."

The session goes quite well. I don't use my notes. It feels natural and I feel like a "real" therapist for the most part. Her manner is calm and casual and her story is intriguing and easy to follow. My ear is so trained for process now that I feel like I'm already able to get underneath things and ask thought-provoking questions in this first session. I get a little tripped up when she asks me how old I am, because I'm not sure why she's asking (and assume she thinks I'm too young and lack the life experience needed to help her) and then not sure how to respond. So I just tell her. "Oh, my daughter is right around that age," she replies, to which I'm still not sure where the relevance lies. Is she trying to distance from me? Or possibly connect? I also feel uncomfortable when she compliments me rather emphatically on my appearance. Of course it feels nice, but I find that I don't know how to respond to it in this setting. I start to feel, like, who and what am I to you? She asks me a lot of questions near the end of the session about what I think she should do, and it's difficult to *not* give advice, even though I've decided that's not the kind of therapist I want to be. I feel uncomfortable *suggesting anything* when we just met and I barely know her. Again, at the end of the session she asks, "So is there anything I should be doing?" and I feel compelled to tell her something, as if it would solidify our roles as therapist and client, or make her trust or respect me more. But there *is* nothing I can think of for her to do, so I say, "No, we'll talk more about that next time," as confidently as I can muster. "Okay, great," she says, "can I pay for next session up front as well?"

Analysis

A lot was riding on this session for me, as I was viewing it as a personal "test" of sorts. Thus I was quite anxious, and cannot be certain that anxiety was not evident to the client. The literature indicates that a therapist's calm state can sometimes awaken regenerative states in otherwise "tense" individuals" (Geller, 2005) and therefore perhaps the converse is also true, causing her to sense my anxiety and become anxious herself. I struggled again with which parts of my "self" to bring into the session, meaning how much of my personality can I or should I bring into my therapy. Since this was my first client to myself, it was sort of my *first* chance to really explore what type of therapist I want to be. It felt a bit overwhelming, but also exciting, like learning a new dance. The thought of getting to learn a new dance for every single client felt exhilarating. Daunting, but exhilarating (exhausting?).

Should I tell her I can relate to her on that topic? Should I focus on just empathizing and validating a la Carl Rogers (Client-centered therapy); should I be neutral and somewhat detached like the neo-Freudians? Who do *I* want to be in the therapy room? And where should I lead the session? There are *so many* different possible routes one can take in this field, and how or when do you start to *know* which one to take? Evidently this is quite a common query for beginning therapists, according to the literature, "Before learning to speak in their own voice, some novice therapists are plagued by doubts about how to "best" implement their intentions" (Geller, 2005, pp 477).

During the session itself, I wasn't thinking about these things, and was just alive and present in the room and followed my intuition. It *seemed* to go okay. When I received validation from her at the end of the session that it was evidently feeling okay enough to

reschedule *and* pay ahead, I was understandably relieved, but would like to get to a point where confidence in myself as a therapist is strong enough that I don't place so much stock in client affirmation; it's simply not a strong enough or accurate enough barometer of how therapy and the therapeutic relationship are actually going.

Interlude II: Other Factors

My experiences outside the therapy room, and outside the various clinics I worked at all together did not find me basking in a carefree otherworld where thoughts about the clinic(s), my clients, and my performance were distant thoughts requiring memorandum to be recalled. Clinic experiences were, therefore, definitely not "out of sight out of mind." I think there are several possibilities for why I had a difficult time separating myself from the graduate program I was currently involved in. For one thing, I had just moved from a metropolis considered relatively cosmopolitan to a significantly smaller community, which though beautiful aesthetically, was located 90 plus miles from the nearest city and seemed to lack the thriving arts/culture scene that I was used to. This made for a rather isolated feeling. Also, I had moved alone. It was difficult for me to secure a large number of friends in my new town because I wasn't really affiliated with anything there; my university was in a neighboring community, through which I had made a number of friends in my program, who were, of course, other people learning to become therapists. Therefore, the majority of conversations with those friends revolved around therapy. What is it, how does it occur, who is feeling happy with how it's going for her, who is feeling unhappy, who is doing it all wrong, who is really shining, who read this article about this new style, who seems to be growing the fastest, who has the highest client load, etc. While I

benefited tremendously from these conversations, and enthusiastically chose to be actively involved in them, this also *was* my main social group at the time, and this is what we talked about. It was difficult, then, to feel particularly balanced with how I spent time with peers. The friends I made at my internship were also therapists. It seemed like there really was no getting away from it. Things were rocky with my partner and we were sort of on a "you do your thing I'll do mine" break. The few occasions when I did go home or had friends come to visit me *did* feel great, and it felt wonderfully restorative to connect around areas *besides therapy*, yet I also felt somewhat removed from their life happenings having simply just not been around. I also felt like they could not really understand this journey I had embarked upon, and the ways in which it really challenges a person's *entire self,* physically, emotionally, intellectually, *soulfully.* I discovered, to my dismay, that distance had crept in to spaces in my friendships that I thought had been airtight, and it felt alienating, and depressing. It makes sense, then, I think, why I focused *so heavily* on my experiences at the clinics where I worked. There was no option of 'not taking it home.' It *was* home.

Weekly supervision with professors on campus provided a much needed forum for me to staff cases and also granted me the opportunity to discuss my experiences of working at the student clinic, and how I was sort of handling everything. I expressed feeling overwhelmed at times with the sheer immensity of possible avenues one can take with clients in therapy, along with the multitudes of factors present within every single case that complicate things, and just when you feel like you took a route that felt promising, the client drops out or doesn't show up for three weeks or says everything's completely changed and your "way" feels irrelevant and you've got to start all over. When I expressed these confounding feelings with a professor one day, I'll never forget his response, something like, Yes, you've got a challenging, challenging

job here, you're working with the most sophisticated organism on the planet. You want an easy job, become a physicist.

I liked what he said. I think what I liked most about it was that someone who I respected immensely was validating my feelings on how difficult this actually was to succeed at, at least in the ways that I wish to. We have had many conversations in supervision about what kind of therapist I want to be, that I want to operate from a holistic standpoint, I want to have working knowledge and practice of pertinent theories, a library of current, relevant techniques and intervention methods; I want to possess the skill to know which technique to utilize at which time to best assist the client and facilitate change, and alter treatment as necessary. In addition to all of that, I want to truly connect with clients and have a *relationship* with them, to be utterly present to them and create a space in which they feel comfortable, at ease, non-judged, and *inspired* to think about and explore their experience in the company of a caring, stable agent who believes in them, never gives up on them, and is committed to their wellness. I want to utilize my heart and soul concurrent with my intellect when working with clients. I find the combination of all of this to be very challenging at this stage. When I expressed this to my professor he validated my goals and my struggle in integrating all of these parts to culminate in the kind of therapist I strive to be. He invited me to think less about "all" the possibilities sometimes, and follow my therapeutic instincts, noting that live observation of my sessions found me 'right on.' He also said he would like to see me speak even more in sessions, that any doubt on the client's part of my competence will be quickly ruled out once I began to speak (I had shared with him my fear that some clients might doubt my ability to help them due to my age, appearance or demeanor).

Think less, speak more. Hmmm. Why *do* I hesitate at times in session to speak up, I wondered. I'm always thinking and hypothesizing, but sometimes it *can be* a challenge to transmit those thoughts into words, and then speak them. After thinking about it for some time, I realized that this therapy pursuit has really been the first time in my entire life where I have placed myself in an "authority-type" position. Where I'm expected to speak up in a regular fashion, and expected, at times, to *"know"* things (psycho-education, for example) and share them in a manner that is clear, concise, and digestible, often to an audience that is less than thrilled to hear it. I'm the person now that people come "to see," often under the assumption that they will leave with answers, or advice, or direction with regard to seriously important life decisions—this is a tall order, and one that I take very seriously. This, combined with being a person with a rather reserved personality, who doesn't feel comfortable stating "I know," until I do (very, very rare), who isn't going to say "I can," before I have, makes for a therapist who is more likely to hold back until I feel confident that I've got the whole picture. In this program, with the co-therapy dynamic, it seems even more challenging but essential that I *do* speak up, because there are a lot of strong personalities that *will* fill up the space in the therapy room if I don't, and clients *won't* see that I am competent or be able to join with me if I don't make it happen. This is not a situation to which I can apply my typical *modus operandi* in life problems or situations—observe the entire situation, analyze each aspect thoroughly, think a great deal about options, select the best option, and *then* act. It seems that if I operate that way in this situation I'll be left in the dust.

I wondered how these revelations impacted the therapeutic process, and my relationships with clients. I decided in my second semester to show my confidence more, to speak up and be assertive more often in session, and to remember what my professor said: this *is* hard,

it *is* challenging—maybe by simply acknowledging that, my performance anxiety will start to wane a bit, and I can find a way to better integrate all of those important parts (heart, soul, and mind) into my therapy. With hope, an eventual integration of those parts can serve as an enhancement to the therapeutic relationship, and thus, the entire therapeutic process itself.

Part II

Description and Analysis of Client Sessions 1/2009-3/2009

Session(s) with client "Alice"

The therapeutic relationship between Alice, Caitlyn and me seems to be growing steadily. Working with Alice is somewhat unique in that I feel continually inspired *during every session* with interpretations and reflections that feel revelatory, and seem to reach her in a deep way and genuinely provoke a change in thought patterns on her part. She has acknowledged and confirmed this, and it is my sense that if something *weren't* going in a direction she found useful, she would let us know.

I had a session individually with Alice recently because Caitlyn was ill. I felt it would be time to test out my hunch that there is a strong therapeutic bond between Alice and me. The session we had together was not one I was all together satisfied with. It seemed messy and circuitous. I got lost. My interpretations felt esoteric and tangential. The problem was that I *relate to* what Alice is going through *so personally* that it is so difficult not to express that (or maybe keep it from getting in the way?). I need to remember that Alice is not me, and cannot do what I did to work through things or think about things differently. At one point in the session

Alice said, "I can tell I'm really challenging you, aren't I." Something in me snapped a little bit. I am working too hard for this client. I am working much harder than she is. I sat back a bit, and began asking more open-ended, general questions, and simply validated what she said instead of challenging it or setting her up to think about things in a different way. She seemed to sense my slight withdrawing and she seemed to withdraw as well. When she left that day, it felt very subtly like something had cooled between us.

In the next session, Alice seemed agitated and almost sullen. About ten minutes into the hour she abruptly announced that this was probably going to be her last session because she didn't think it was helping or that we were getting anywhere. My heart-rate quickened. *S*--- I thought. I should have checked in with her in the last session to see how she was feeling about her time here. Caitlyn and I both thanked her for being honest and feeling comfortable sharing how she was feeling. We took a break and conferred about what to do. I thought we should offer her a new direction in therapy which would possibly take us deeper under the surface of what was going on. We presented the idea to her and she accepted, nearly immediately, noting that we had to "promise" things were going to go deeper. We said we could not promise anything but that we would be happy to facilitate a new direction for Alice's therapy. When she left, I had mixed feelings. I felt relief that she had agreed to continue, both for her and for me. I *do* think therapy can help her. It was relieving that in the end she felt that way too; it bolstered my therapeutic confidence. Aside from the relief I felt other, more complicated feelings. I felt slightly manipulated or like I was being pushed or tested. I wondered what would have happened if we had simply said, "What do you think would help you feel like your time here is more productive?" Or even, "We're always here if you change your mind." It would be interesting to see how she would have answered those questions.

Analysis

These sessions with Alice describe an appearance of "overidentifying" with the client, which is a form of nonfacilitative countertransference that can become detrimental to the therapeutic process. Overidentifying occurs when the therapist is unable to remain separate from the client's material (McClure, 1987). My feeling that I had gone through 'exactly' what Alice had, and thus felt that I could understand it completely, even know what she should do, suggests I was overidentifying with her experience. The literature suggests that therapists need to be vigilant with regard to countertransferences of any kind, with the goal being to shorten the time it takes to recognize and resolve a countertransference attitude or impulse, often by means of seeking supervision (Kahn, 1997).

During my session alone with Alice, I did not feel the performance anxiety I experienced when treating Willa alone, most likely due to the existence of a relatively sound therapeutic relationship. I got a little flustered when she made the comment about "really challenging me" and thus withdrew slightly. In retrospect, I probably should have explored with her what she meant by that in order to keep our process collaborative and transparent instead of subtly withdrawing. She may have sensed my withdrawing, and felt abandoned. Yet, on the other hand, perhaps it was necessary for me to withdraw without explanation to win the 'battle for structure.' Again, it is difficult as a beginning therapist to *know* how to implement the correct interventions at the appropriate time to best reach the client. The literature corroborates this challenge for beginning therapists and suggests that students ground their decision making in the question, "What stylistic choices are required to individualize, as far as possible, the content of my communications?" (Geller, 2005)

It also seems that my desire to have Alice like me and believe in therapy caused me to make the hasty decision to offer a new therapeutic route in a manner that might have seemed almost like pleading. If my anxiety about Alice *not* returning and what that would do to my therapeutic self-esteem were at all evident to her, it would definitely interfere with the structure of her therapy and our relationship. While as Alice's therapist I genuinely *do* wish for her to stay in therapy and believe it is in her best interest to continue, and while I was actually feeling like therapy *should* take a different turn, my own issues of insecurities and fears of not being good enough definitely played a (slight) role in my decision to ask her to continue in that manner. Also, by suggesting we go a different way in therapy because the previous intervention route had been dissatisfying to her, I feared that we may be undermining the therapeutic process by enabling her to place responsibility for her getting better on other people, namely, her therapists, and not herself.

Session(s) with client "Paul"

Paul reports regularly for his sessions. It seems as though the joining process is coming about slowly, but feels as if it needs to happen gradually with this client. Thus "therapy" may or may not be occurring yet. It's more getting his story. The client's presence and scent still evoke physiological and emotional responses from me that I have learned to temper, by deliberately noticing this inner-reaction in the beginning of the session and choosing to center myself and not focus on it. Sometimes this is challenging because it evokes such strong feelings, and the feelings are stirring. If I were to focus on it, I'd get lost and I would not be doing my job.

In my perception, this client seems to have a tough exterior, but also a big heart and the ability to see his own mistakes and genuinely wish to do better in life. This makes me *really* like him in an authentic way (as opposed to in the beginning when I was just charmed by him with no substantive data yet) and it makes me believe in him as his therapist. Recently he reported to therapy and either no longer emitted that particular scent, or I was no longer affected or even cognizant of it. It was in this session, though, that Paul had his first big breakthrough after a particular line of questioning I was leading. I had felt apprehensive about "going there" because it often *feels* like Paul would really rather tell stories and chit chat than delve into anything far under the surface. After about fifteen minutes of this, I was antsy and had crossed and uncrossed my legs about a dozen times. *I want his time here to mean something.* I thought, well, I'll just tell him that, be transparent about it. So I did, and I said I think we need to focus more on some of the areas of your life that possibly led to you having to come here in the first place, and he said all right and barely flinched. So I started down a particular line of questioning that caused Paul to really think about and analyze his experience, and it ended with an emotional revelation. I felt overjoyed. I felt like we had *gotten* somewhere. Also, I felt like a therapist.

Analysis:

This excerpt demonstrates the ways in which a vigilant attitude towards countertransference allowed for therapy to continue, and even progress to a new level. It also illustrates my progression as a therapist in that I had the courage and belief in myself as this client's therapist to challenge him in a way it seemed he had not been before, yet felt intuitively like the right thing to do for his personal development. The reward, in this sense, was being able

to experience this client's breakthrough, and knowing that I was a factor in him reaching it, and it felt *much more* gratifying in an all-encompassing manner than when clients re-schedule or tell me they are getting a lot out of their time. Experiencing Paul's breakthrough was the greatest gift and reward as a therapist thus far.

Session(s) with clients "Henry and Liz"

Sessions continue to be heated, tense, action-packed hours that keep me clenched and on the edge of my seat. The couple's therapy is going well, considering their fixed positions when they presented some months ago. I do not feel all together comfortable with Henry and Liz, and I think it could be a result of not being joined enough with them. When they initially presented for therapy, they were in such a crisis-mode that it seemed impossible to spend the requisite first session joining and getting to know them, and letting them get to know us. It felt like we had to delve in immediately. The trouble with not being joined enough, I'm finding, is that it reduces the number of potential avenues to take therapeutically. I don't have the strong sense that they know and trust me and so I cannot feel as free to experiment and try different interventions with the confidence that if they do not culminate successfully, we as a unit can still sail on our relationship, and try something else. This makes for a rather constricted feeling in therapy. Ironically, of all my clients, I feel that Henry and Liz and I *could* and *would* be *friends* if we were in a different setting. They've shared a multitude of experiences and hobbies that I can relate to. I just haven't known how to relate to them that we have these things in common (as a means of joining) or perhaps felt that I would be creating an uncomfortable situation for my co-therapist, as though I was trying to bond with them excessively, leaving her on the outside.

At any rate, I begin to make deliberate efforts to join and share things about myself during session with Henry and Liz. This seems to have resulted in an enhanced therapeutic process all around. Not only is it strengthening and building our relationship as they learn parts about me that make me more of a person in addition to their therapist, but I have also been able to effectively employ it during excessively volatile times when tensions are high and everyone in the room could use some kind of relief.

I'm also finding that I can relate to a lot of what Liz says about what kind of relationship she wants, and the ways that Henry is not measuring up (in her perception). I have felt that same way in my own relationship, and have wished my own partner would do exactly the things she is saying. At times I wonder if I am covertly expressing this understanding to Liz. Sort of like a soft murmuring, *I get you. I understand. I'll help you.* At the same time, I also empathize *and* am impressed by Henry's commitment to Liz and willingness to really seem to look at himself in session to try to uncover what changes he would like to make. I am impressed by this because it's something I'd like my own partner to do more often when our relationship is in trouble. Henry's gaze at Liz during session seemed so intense, committed, trying, it was hard not to be affected by it, and drawn to *his* side. I wonder if my relating to or feeling for each of them sort of balances out in the end. Would it be better if I felt nothing for either of them besides unconditional positive regard?

Analysis

This excerpt describing my experience with Henry and Liz emphasizes the need for joining as a basis for the formation of the therapeutic relationship. Without a sound relationship, there are simply fewer avenues one can take therapeutically, and it seems to render advancement

in the therapeutic process extremely slow. Clients seem much less likely to be open to new and sometimes challenging interventions if they don't trust the therapist. I found with this couple that the co-therapy model at times seemed to hinder the growth of the therapeutic relationship. There was just too much going on in sessions for *all* of us to join well. So none of us really did, until I began to deliberately insert humor, anecdotes, and occasionally events from my own life into therapy. It seemed like the vibe relaxed a bit after that.

I also began to experience some countertransference with regards to some of the material the couple presented, in that it reminded me of my own relationship. I believe this incidence of countertransference would fall under the category of 'facilitative countertransference' because I was cognizant of its presence right away, and began to make vigilant efforts to not let it interfere with therapy. I identified with both partners at different times with the ways they were feeling and what they were presenting which seems to suggest a good prognosis for my therapy with them and the continued building of a strong therapeutic relationship. According to the literature this identification with them in conjunction with an unconditional positive regard actually enhances therapy: "The importance of counselor identification with the client has been emphasized as a crucial part of the therapy process, as a means to understand and empathize with the client's experiences" (McClure, 1987).

Session with client "Willa"

Willa, the client I see alone, has presented for a number of sessions now. I think the work we have done is good, although sometimes I wonder if she is simply looking for someone to vent to. That would be fine with me, because using session as a cathartic means to express pent up emotion can definitely be therapeutic in my view, and is necessary before real exploring

can take place. Lately, however, I've noticed a lull in our sessions, as though we are running out of things to talk about. She seems to not want to explore things in the way she did in the beginning, and we seem to have solved what she initially presented for. Today in the middle of her session, she suddenly said, "How are *you* doing?" I was sort of taken aback and didn't really know how to respond, so I answered briefly in a relatively general way. Still, it seemed like after that, our dynamic *definitely* shifted from a therapist-client dynamic to a, well, undefined dynamic. Peer-peer? Mother-daughter? Friend-friend? In retrospect, I really wish I would have responded to her question with something like, I'm fine, let's talk about why you're asking *me* how *I'm* doing, but I didn't have the presence of mind at the time in the session. For the remainder of the session it felt like I was dragging information out of her, "How's this going, how did that turn out, how's Joe, how's Jane, how are you doing handling blank?" It felt taxing, and I was getting the sense that she really didn't feel like talking anymore. So we ended the session. I asked if she wanted to book for next week and she said she would call. She didn't. I didn't see her again.

Analysis

This description of time with Willa highlights the need for transparency in the therapeutic relationship. When I sensed that the client did not feel like being in session, I should have asked her about it, or at the end of the session I could have inquired about how she was feeling about her time with me in a general way. I probably didn't ask because it felt awkward and because I was probably afraid that she would say something that would damage my self-esteem as a therapist. I still lacked confidence, and *especially* did not want the *one* client I was treating alone to not like me, or not think her time was meaningful and productive.

Of course there are *always* a multitude of reasons that a client discontinues therapy. With this particular case, it seemed like there was not exactly a strong need for her to be in long-term therapy, as she did not seem to have very much she wanted to talk about or explore. If she did discontinue therapy in part due to a problem in the therapeutic relationship, I cannot think of anything obvious suggesting why. I was respectful, curious, warm, empathic, present, and I tried to adjust my style to "fit" with her as much as possible. I was committed to her therapy and the meeting of her goals of which she endorsed. In the beginning few sessions I *was* anxious, and perhaps she picked up on that and it made her feel uncomfortable. Research indicates that if a strong therapeutic relationship is not established by the third session, clients are likely to drop out of therapy (Sexton, et al, 2005). A clinical trial studying the connection between therapist and client had findings which indicated that periods of time in which clients are engaged, talking about themselves, and emotionally involved correlate with a deepening connection between therapist and client. This deepening connection can be interrupted when the therapist appears disengaged with the client's material or speaks in a manner that is devoid of emotional content, or when the therapist provides general information or advice. To the best of my knowledge, I did *not* engage in any of these connection-interrupting activities.

Part III

Description and Analysis of Sessions: 3/2009-5/2009

Session(s) with client "Paul"

Rapport continues to build between Paul, Lara and me. It is a continual process, I'm beginning to understand, and not something that just occurs in the first couple of sessions and

then remains, formed but static. It is a *process*. I wonder if perhaps Paul has had few people in his life who have truly believed in him, both historically, and in the now. I also have gotten the impression that he's had few arenas to actually tell his story, at his own pace, to caring, non-judgmental people who truly believe in him and his ability to realize his own potential. I think it has been *essential* that we allow this client the time and space to open up to us. I think that alone has been therapeutic for him.

It seems that every session now only serves to strengthen the bond between therapists and client. Paul's presence inducing a physiological response for me is a distant, distant memory. I truly do not know if he no longer smells that way or I just "dealt with it" effectively enough to have it no longer show up on my radar.

I truly believe that the therapeutic space is alive and breathing and fertile for Paul with Lara and me as his therapists, and he will achieve great things for as long he wishes to attend therapy.

Analysis

This excerpt depicting sessions with Paul exemplifies a model of a well-formed, alive, and fully operative therapeutic relationship. It seems as though once a certain level of connection is reached between therapist and client, the windows of opportunities regarding possible avenues to take in therapy open up substantially. There are just so many possibilities when trust, connection, and unity are present in the relationship. In my estimation the management and vigilance applied to the countertransference I experienced early on was essential to the formation of the therapeutic relationship with Paul.

The literature corroborates the notion that the therapeutic relationship is not static, and its quality is not constant over time. Thus after initial establishment of a strong alliance, it is the therapist's obligation to manage the alliance, via successful resolving of potential rifts or ruptures in the relationship (Horvath, 2000). No ruptures had occurred in Paul's therapy at the time this document was written, but as his therapist, it is important to recognize that while a strong relationship may appear and exist, it is always subject to change.

Session(s) with clients "Henry and Liz"

The therapeutic relationship between Henry, Liz and me has continued to grow and strengthen weekly. I feel at ease with them and my performance anxiety has subsided tremendously. I feel comfortable naturally integrating little "joining" pieces from my own life into their therapy and it seems to further strengthen the bond between us. I'm not sure if my perception of the strengthened therapeutic bond between us correlates with the fact that I am now working with Henry and Liz alone, and have been for several weeks since my co-therapist graduated. Since this change, things have felt easier, more organized, and I have felt like I can be myself *and* be their therapist.

I have been much more innovative and spontaneous with my interventions in session, sometimes hopping up out of my chair to draw a diagram to illustrate a point, or turning the session "experiential" if I intuitively feel it would help the couple at that moment. I feel completely at ease being directive with them now, and saying something like, "Liz, can you turn toward Henry and tell *him* that you feel that way?" In my last session with them (they were moving), I took a risk and decided for the first time, to share with them what "I think." What I think they are each doing that is harmful to the relationship and what I think they could do

differently. Straight up. No frills. No dancing around. I *was* a little nervous to do this, to essentially transform into therapist-as-expert role (*not* my *modus operandi* or in my therapeutic value system for the most part), but I was kind of on a high from the dynamic nature of the session, the momentum was so strong, and I then had the intuitive drive to be direct with them in Brent Atkinson style (Atkinson, 2005) and tell them what I think. It seemed to go over well; they didn't look shocked and they kind of even agreed, and that meant admitting to hard stuff.

When they filled out their exit questionnaires I felt like it was another mini "test" of whether or not my impression of how things have gone matches how *they* feel. I have decided that in my opinion it is better to be a poor therapist and *know* that you are than to think you are really reaching and helping people and being this profound agent of change in their lives, only to have clients think precisely the opposite. In the first camp there is room for improvement. In the second camp, it seems you are missing a key, requisite quality for being a therapist in the first place, the quality of "perceptiveness."

At any rate, I felt (to a much lesser degree than I did with the "test" of whether Willa would return or not) that I was being tested again, or at least the value of me as a therapist was being tested, and it was—they were after all, filling out "evaluations" of the therapy. I felt differently though, as I waited for them to finish. Like what they said wasn't going to make or break me.

The evaluations were pretty much what I expected. Therapy did not solve all the problems in their marriage, but it did help. Would they return for our services again, yes. Would they recommend our services to a friend, yes. One partner commented that it seemed like it took

a while for therapy to "warm up" but once we got going, we really got going. They both rated "trust" in the therapist at the highest mark.

Analysis

This description of sessions with Henry and Liz illustrates the change and growth in me as a therapist in that I exhibited a great improvement in confidence, belief in my therapeutic impulses and intuitions, a decrease in performance anxiety, and place less overall stock in how the clients rate me at the end of their therapy; I care, tremendously, but am not going to quit the profession if the ratings aren't perfect.

In addition, it seems that the reconciliation of some of these inner-fears/worries/ruminations correlate highly with the building and maintenance of the therapeutic relationship, because the majority of therapist energy is being directed toward it, and not worrying about myself and how I am doing. My therapeutic identity seemed much more formed at this stage with these clients; I felt like I could be myself and also be a therapist, and there wasn't this guessing game about what to show and what to conceal in the ways I had felt in earlier sessions.

I was thrilled that they both rated "trust" so highly in their evaluations; it seemed to evidence the appearance and existence of a relatively strong and functional therapeutic relationship.

Session(s) with client "Alice"

Sessions with Alice following her decision to remain in therapy have been remarkable. The dynamic between Alice, Caitlyn and me epitomizes the well formed, joined, and balanced relationship between therapist and client, united by the common interest and goal: Alice's therapy. There is trust, there is belief in one another; in my estimation there is love. Truly, it feels as though from the moment the door from the outside hall swings shut, a certain magic takes over the therapy room, we enter into an energy field where inspirations are plentiful, and one inspiration seems to feed off the next in a seemingly endless array of possibilities and ideas. Each party in the room is integral to the process, for each brings a unique repertoire of thoughts, feelings, and intuitions that seem to join together in a symphony of ideas and novel possibility. Time seems to stop when we enter this realm and Caitlyn and I have had to make concerted efforts to *remember time*. Alice's therapy has become a transcendent experience which seems to encapsulate the nature of what true therapy strives to achieve. The therapeutic relationship is not an ingredient in this process, it *is* the process.

Analysis

This description of therapy with Alice seems to illuminate a therapeutic relationship that is functioning very well in all quadrants. There is trust, transparency, and collaboration. Ruptures in the relationship have occurred and been resolved, suggesting that they can and will be again. All parties seem comfortable and clear about who and what they are to one another. From a strictly personal point of view, I have a lot of confidence in myself as Alice's therapist, and rarely experience performance anxiety in the room. I have realized and dealt with countertransference issues that might have become a detriment to the process if they had not been recognized; the countertransference that exists at present seems fully facilitative.

With Alice I learned so much about therapy. It's come to my attention through working with her how much inherent value the therapeutic relationship can provide to a client, in the sense that the client learns that there is someone who is committed to her wellness, who is present, and curious, and fully desires just to understand her. It seemed to strengthen our relationship tremendously, to be just that to her, someone who sits and is present, and curious, and patient, who is non-judgmental and empathetic, validating *and* challenging, who communicates faith and belief in her both verbally and in affect, and who treats her like she is the only person in the world for those 50 minutes. These things all came naturally, and were not contrived, but they did take time and effort and analysis to come into being.

This concludes the description and analysis of therapy sessions utilized in this study on the therapeutic relationship. What follows in chapter five is a larger analysis on general findings and personal truths discovered throughout my experience in the context of the therapeutic relationship.

Chapter V: Results/Personal Truths

The end of the seven-month data collection period found me facing a mountain of journal entries depicting my thoughts and feelings while working with nearly a dozen clients, as well as pages and pages of scrawlings from various literature, conversations with others, and personal musings on the topic of the therapeutic relationship. As I began to sort through the massive amount of mostly un-quantifiable data, I started to observe several notable personal realizations about myself as a therapist navigating the therapeutic relationship. While the qualitative research methodology of autoethnography cannot provide proven, generalizable results, I believe that my own personal truths discovered throughout the course of this nine-month study are relevant to the field of psychotherapy and could generate a discourse on the therapeutic relationship and invite further meaning-making processes on the part of the readers of this study.

The single most consistent finding that held true across my experiences with all clients, transcending demographics, presenting problem, diagnosis, amount of time in therapy, and type of therapy presenting for (individual, couple, family, etc.) was that it is within the therapist's capacity to take responsibility for creating, maintaining, strengthening, and repairing the therapeutic relationship. This finding does correlate with much of the literature I reviewed on the therapeutic relationship. Further discussion on how, in my experience, the therapist accomplishes this feat will follow a bit later in this section. First, it is necessary to discuss some post-study thoughts on the therapeutic relationship and areas for potential further exploration.

As I was beginning my analysis following the conclusion of the study itself, it began to occur to me how unusual the therapeutic relationship really was in comparison to other close or intimate relationships I have experienced. In my perception, close friendships or partnerships

typically begin by having something in common, whether it be a shared interest or topic, or even a shared attraction. The relationship grows, expands, and deepens as parties feel more comfortable expressing personal feelings that leave them in a vulnerable state, but find that these feelings are welcomed, validated, and affirmed, and often *shared* by the other party. After significant repetition of sharing important, personal, vulnerable feelings, and having the other party affirm these truths, or at least not reject them, while also sharing his own personal, vulnerable feelings—a mutual trust forms, and the relationship deepens. The key factors in most intimate relationships (in my perception) then, seem to be mutual sharing and expression of important thoughts and feelings, coupled with mutual validation and affirmation of the other's experience.

What is different about a therapeutic relationship, is that it is one-sided. The therapist participates in the validation and affirmation arenas, but not in the mutual sharing. It is not a "two-way" street, at least not in the way typical relationships seem to form. Of course many relationships exist, and even close, deep relationships that are not founded on a mutual exchange of content and feelings (for example, a professor/student relationship). However, in the therapeutic relationship, the basis of content described and shared on the client's part seems to usually center around big, important, personal, complicated, and often very deep emotionally-charged feelings. The literature suggests that the basis of the therapeutic relationship is grounded in a deeply shared emotional connection between therapist and client. But how do you have the shared part, without the mutuality part that typically leads to a feeling of shared emotional connection in friendships/partnerships, etc. How do you bond without a two-way exchange of feelings?

I struggled with the reconciliation of these complexities in the therapeutic relationship, and I think it caused me to be unsure at times about what parts of myself to bring to session, and at what times, and also at times induced confusion on my part about "who and what I'm supposed to be to you" (with client "Willa," for example). I am still musing on this subject, how the therapeutic relationship differs from other personal relationships, and how to have the deep connection without the mutual sharing of experience, or, can *some* sharing occur on the therapist's part, and, if so, how much is prudent, and when does it begin to stray from the boundaries of the therapist/client dynamic and begin to look more like a friendship. It seems the ultimate therapeutic relationship would find the therapist understanding, affirming, and validating the client's experience outwardly, while also finding a way to communicate feelings of "identification" with the client's experience (if they exist) in a way that could ignite the "mutuality" spark that usually advances other deepening friendships or relationships to the next level of emotional connection. The therapist would have to find a way to acknowledge and communicate this identification in a manner that still preserves and enforces the "therapist/client" dynamic, and does not endanger the relationship by carrying it toward a friendship arena. It seems a delicate dance one must learn, and I certainly have not mastered it. How to connect without connecting too much. Relate, but not in a way that calls for commentary on the client's part of *your* experience.

The closest I came to achieving this multi-faceted connection described above, was throughout experiences in sessions with client "Alice." There were the requisite therapist activities of asking questions, reflection, interpretation, homework, empathy, validation, and affirmation—yet—there was something else. I did identify with much of what "Alice" presented, I did like "Alice" and I think I was able to communicate this in a way that proved

effective and enhanced the therapeutic relationship, while also maintaining the therapist/client connection and not bordering on friendship. How I achieved this, I cannot be sure. A lot of it, I think, was communicated via body language and affect. There are times when I think that the best way to form a therapeutic relationship is to simply be very present in the session with heart and mind, and communicate to the client in whatever way suits the therapist that you are simply trying to understand her and her experience, and it matters to you, and you will not give up trying to understand. With "Alice," I did that a lot. As the relationship deepened, it seemed I could show her I "identified" with her less, and was simply a presence that was "with her" and cared about her alongside the content of everything else that was occurring in the session. Perhaps expressed "identification" can serve as a bridge to achieving a more profound (and much more difficult to describe) connection between therapist and client.

Of course, with all of this said about my perception of the relationship with client "Alice" it is impossible to know how she felt about it. When I informed her that I would be leaving in a few sessions because of graduation, she seemed affected, and commented with something along the lines of, "What am I going to do now?" *I* felt a profound therapeutic connection with "Alice," but it is impossible to know with any certainty at all what her experience of the relationship actually was.

After conducting this study, the therapeutic relationship, then, in some ways still remains as elusive and enigmatic as ever, and still so difficult to explain, describe, and create. There were, however, certain more concrete personal truths which came to the surface during the analysis phase of the study that will now be discussed.

In my experience, confidence and belief in my abilities seemed a requisite component to the development of the relationship. In my perception, clients seek therapy expecting a service, and expect to be treated by a professional who knows what she's doing. Therefore it seems especially important to convey the inner confidence felt by the therapist, because otherwise what stock will the client place on therapist abilities, the relationship, etc.? As I described in a previous section, my typical *modus operandi* found me reluctant to say, "I know" until I do, or "I can" until I have and this seemed to require substantial revision for my pursuit in this field. It seems essential to trust one's therapeutic intuition at times, even without having "all" the information, because in what circumstance in this field would you ever have "all" the information? Additionally, it seemed that existing confidence and competence need to be shown early on, when the "selling" phase of therapy is still occurring, and with that basis formed, a therapist can bring more "I don't knows" into the session after the preliminary foundation has been established.

Another therapist quality that in my perception seemed to promote the therapeutic relationship was being "thick-skinned." In my experience, there are quite a lot of negative feelings expressed in therapeutic settings, and they were sometimes directed at me. I struggled with this a lot, probably because I am a sensitive person, and want people to like me, and can feel hurt if they do not. What I began to understand throughout this process, was that a lot of the time, the client's negativity toward me, in my perception, was not even actually about me at all. I think it is crucial for therapists to utilize client negativity and criticism in a manner that supports and enhances the client's process in therapy, and shows him a new way to be in a relationship that can be carried into real life. It seems imperative to not become outwardly defensive, although, I certainly felt defensive at times when clients criticized my performance.

What is fascinating, though, is that it seems like the better I got at not taking it personally, and focusing instead on how to utilize the clients' feelings to their own benefit, the deeper our relationship felt.

Another personal truth that may seem obvious at this point but I think needs to be made explicit is that the development of a sound therapeutic relationship, in my perception, is essential to the therapeutic process, and expands the level of possible avenues one can take in therapy tremendously. Time and time again I it seemed that without the trust and connection existent in a strong relationship, therapy felt constricting and one-dimensional. It seems essential to join with a client in whatever way feels most useful or possible during early sessions of therapy to create the bases for a sound therapeutic relationship.

On the topic of "joining" I did notice some trends personally throughout this study. I did find that significant age difference between myself and the client might have played a minor factor in the speed at which I was able to join. It seemed that often with clients closer to my own age I was better able to "identify" with them on something right away, and by making that known, we were able to join more quickly. This is not to say that I could not join with clients who were in a different age range than myself, it simply took longer in some cases. I also found that when working with couples involved in heterosexual relationships, I tended to be able to "identify" with the female at greater depth and immediacy. In my perception, socialization in this country sends different messages about what it means to be a boy or a girl growing up, and I found that in many cases, I was socialized in ways similar to the females I treated in heterosexual relationships, deeming it very easy to relate to them in a variety of relationship-based arenas. What I found seemed to work best was to convey that identification to the female right away,

subtly, but then form a personal vigilant attitude recognizing my predisposition to understanding the female probably easier and make sure to empathize and really work hard to understand and get underneath the man's experience. In some cases, it seemed like conveying my identification with the female right away, showed her that *I get you* and created a space for me to really focus on the man's experience. It is my personal opinion that the ways in which we are socialized in this country affect our wants, needs and abilities in relationships, and that we are unable to separate ourselves completely from this socialization. This socialization manifests in the therapy room no matter what we do. Keeping in check with these feelings and maintaining a vigilant attitude toward countertransferences of any kind seemed to be the best bet. In my perception, it seems that couples therapy with heterosexual couples might in some cases be enhanced with a male and female therapist operating from a co-therapy dynamic.

The appearance of therapist "liking" or "disliking" a client in therapy sessions and what the impact of that was on the therapeutic process was something that I initially wanted to explore and unpack prior to the study itself. I found, post-study, that significant liking or disliking of clients didn't arise too much throughout the course of this study. I honestly felt like I liked all of my clients, and the degree of liking did not impact my "showing up" for them, or treatment planning. Countertransference arose at times, and made my perception of the client hazy, and had to be dealt with and attended to, in order to have a more accurate conception of the client's person. In my experience, I mostly felt "positive regard" for my clients, and when feelings of like were extreme, (I never experienced extreme feelings of dislike in this study) countertransference seemed the most logical culprit for these *strong* feelings.

Two other very important variables in the construction of and maintenance of the therapeutic relationship in my estimation include a vigilance on the therapist's part to keep therapeutic processes transparent, in a sense operating from a collaborative standpoint, and also to take responsibility in addressing and repairing possible ruptures in the relationship. In my experience, as a young therapist, I struggled at times with the transparency variable. Sometimes clients would make offhand comments that seemed to have some bigger meaning or weight beneath them, that retrospectively I think should have been addressed and explored with greater immediacy. It seems best in the therapeutic relationship, to have processes occur in the open, and as little as possible "under the table" or implied about how therapy is going, or how the client is feeling about the therapist. In my experience, nearly every time I suppressed the urge to say to client, "Hold on for a minute, let's talk about this more. It seems like you're trying to tell me something important about the way you feel things are going," it ended up coming out anyway, later, and often in the form of a rupture or near-rupture situation.

Regarding ruptures, it seems best to address them in session, talk them out *in-depth* without glossing over parts due to therapist inability to tolerate awkward situations. Indeed, it seems especially important to allow the client the space to discuss ruptures to an open, receptive audience. In my experience, ruptures are a time for therapist-honesty, to show the person behind the therapist in order to repair the alliance. Therapist intolerance of awkward or tense situations is something I struggled with, but feel I have improved upon substantially, and it seems to have strengthened my relationships with clients. In my experience, once the relationship suffered a rupture but was able to be effectively repaired, the resulting relationship is one of significantly stronger depth and connection.

Recommendations

After spending nearly a year analyzing my self in the context of the therapeutic relationship, the largest recommendation I can conceive of for further research on the therapeutic relationship is to somehow include client perception and feedback into a study like this one. If this study had been exactly what it was with added feedback from the clients I was following, I think it would shed even more light on the therapeutic relationship and how it begins, is maintained, and flourishes. This recommendation is not said in a manner that intends to diminish the importance of the personal truths this study found, yet it would be quite interesting and relevant to existing literature on the therapeutic relationship to see if clients corroborated my sense of how things were going.

I was lucky enough to be involved in a therapist training program that emphasized the importance of joining with clients, and after this study, joining seems imperative to the therapeutic relationship and thus the therapeutic process in general, and in my opinion should be a part of many, if not all therapist training facilities. I think the reason behind the necessary joining period in therapy and how joining relates to the therapeutic relationship should be emphasized *even more* in academic training facilities.

Another recommendation I can conceive of would be to assign students a mini-autoethnography project much like this one to be carried out throughout their practicum year, where they could journal and explore their own experiences, and also have the opportunity to discuss their personal truths with classmates and professors. Throughout my practicum year, I often felt doubtful that I was excelling or "on the right track" and could have benefited from a consistent ongoing dialogue with other students and professors about my own fears and self-

doubts, as well as have the opportunity to hear from them and perhaps find connection and create personal meaning through these discussions. This might have quelled my fears of inadequacy at a faster rate so I could move out of the self-conscious stage in therapy at a more rapid speed and be able to concentrate all my energies— intellect, heart, and creative talents toward the client.

Chapter VI: Concluding Comments

As I sit amongst a nearly completed master's thesis encapsulating my personal experiences while navigating the therapeutic relationship throughout the course of one academic year, I feel a sense of satisfaction with the knowledge that the information provided throughout this research paper is a genuine, thoughtful, and heartfelt depiction of my experience as a young therapist.

While this section concludes the formal write-up of this study, it should be noted that, for me, the study is just beginning. That light that existed far off in the distance one year ago, and inspired me to conduct a study on the therapeutic relationship, is now a light that shines over me always, and it beckons me to keep searching, analyzing, thinking, learning, and taking risks in my (possibly) lifelong journey of becoming a therapist. While the personal conclusions detailed in this study were accurate representations of my thoughts and feelings on the therapeutic relationship, they are by no means static, cemented ideals existing in a vacuum that will not change. I hope they do change. I wrote this master's thesis after being "in the field" for less than one year. I hope when I look back upon it in years to come that I have grown in ways that will date this study as a representation of my experience when I was very new to the field. I will keep striving to find a way to incorporate heart, mind, and soul into my therapy and to uncover new, unique ways to connect and bond with clients therapeutically, ways in which I can bring and utilize my whole self in therapy.

I profoundly hope that this study can serve to generate a dialogue among its readers on the topic of the therapeutic relationship or therapy in general, even if it is connecting with others

out of vehement disagreement with the conclusions of my personal experience. I strongly feel that discourse with others about topics that we care about can broaden and deepen our understanding of both that topic and of ourselves, and can be the root of profound revelations and meanings under which we form a conception of ourselves and how we wish to live in the world.

I feel deeply honored to have been in a position where I had the means to conduct this study, and treasure the experience. I need to extend a deep gratitude to my clients for allowing me the priceless opportunity to learn so much from them. About relationships. About myself. About life.

References

Atkinson, B. (2005). *Emotional Intelligence in Couples Therapy.* New York: W. W. Norton & Company.

Denzin, N. K. (1997). Interpretive ethnography: Ethnographic practices for the 21st century. Thousand Oaks, CA: Sage. Erolin, K. S. (2008). Reliability, Validity, Quality, Trustworthiness. MFT 765 Class handout: University of Wisconsin-Stout.

Dunkle, J. H., & Friedlander, M. L. (1996). Contribution of therapist experience and personal characteristics to the working alliance. *Journal of Counseling Psychology, 43,* 456-460.

Ellis, C. & Bochner, A. P. (2000). Autoethnography, Personal Narrative, Reflexivity. In N. K. Denzin & Y. S. Lincoln (Eds.). *Handbook of Qualitative Research.* (pp. 733-767). Thousand Oaks, CA: Sage Publications, Inc.

Erskine, M. (1998). Psychotherapy in the USA: A manual of standardized techniques or a therapeutic relationship. *International Journal of Psychotherapy, 3* (3), 231-235.

Frank, J. (1988) [1979]. "What is psychotherapy?" In S. Bloch *(Ed.). An Introduction to the Psychotherapies (pp 1-2).* Oxford: Oxford University Press.

Geller, J. D. (2005). Style and its contribution to a patient-specific model of therapeutic technique. *Psychotherapy: Theory, Research, Practice, and Training, 42* (4), 469-482.

Horvath, A. O. (2000). The therapeutic relationship: From transference to alliance. *Psychotherapy in Practice, 56* (2), 163-173.

Kahn, Michael. (1997). *Between therapist and client.* New York: W. H. Freeman and Company.

Lambert, M. J. (1992). Implications of outcome research for psychotherapy integration. In J.C. Norcross & M. R. Goldfried (Eds.). *Handbook of Psychotherapy Integration* (pp. 94–129).

Lazarus, A.A, (1993). Tailoring the therapeutic relationship, or being an authentic chameleon. *Psychotherapy, 30* (3), 404-407.

McClure, B.A. (1987). Measuring countertransference and attitude in therapeutic relationships. *Psychotherapy, 24* (3), 325-335.

Nichols, M.P. and Schwartz, R.C. (2006). *Family Therapy Concepts and Methods* (7th Edition), Boston: Pearsons Educations, Inc. Allyn & Bacon.

Sexton, H., Littauer, H., Sexton, A., & Tommeras, E. (2005). Building an alliance: Early therapy process and the client – therapist connection. *Psychotherapy Research, 15* (1-2), 103-116.

Zuroff, D.C. & Blatt, S.J. (2006). The therapeutic relationship in the brief treatment of depression: Contributions to clinical improvement and enhanced adaptive capacities. *Journal of Consulting and Clinical Psychology, 74* (1), 130-140.