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The Therapist's Experience of Feeling in Too Deep with a Client: A Phenomenological Exploration

Deborah Lynn Weisshaar
Georgia State University

THE THERAPIST'S EXPERIENCE OF FEELING IN TOO DEEP WITH A CLIENT: A PHENOMENOLOGICAL EXPLORATION

by

DEBORAH LYNN WEISSHAAR

Under the Direction of Gregory J. Jurkovic

ABSTRACT

Research regarding the experience of the psychotherapist in the therapeutic interaction is uncommon in scientific literature and rarer still in the literature of the U.S. When Freud recognized the therapist's emotional experience in response to the client, he termed it countertransference and identified it as counterproductive to the analytic process. Later it was recognized as containing potentially useful information about the client. Despite a shift in academic concern away from the clinician's experience, outcome studies have demonstrated the importance of the therapeutic relationship. If the therapist's experience can help or hinder the relationship and, therefore, the process of therapy, it must continue to be explored. Some researchers have suggested that the field may be disproportionately populated by individuals who had excessive emotional demands placed on them as children (Miller, 1979/1990). Jurkovic (1997) proposed that, along with strengths endowed by this childhood responsibility, parentified therapists may find themselves more vulnerable to a sense of duty that they must help clients. Similarly, these therapists might feel compelled by their empathic concern to go above and beyond. The experience of a therapist in such a situation might be to "feel in too deep with a client" – the phenomenon of concern for this study.

Ten practicing, doctoral level psychologists were asked to describe a specific experience in which they felt in too deep with a client. Selection analysis and situational descriptions were reviewed with each participant. Four core themes emerged. They revealed the participants' experience of feeling in too deep as involving a variety of distressful thoughts and feelings. A specific cluster of feeling insecure, confused, or not in control was universal. The other three core themes were challenge in connection, altering personal style of therapy, and balancing the wants and needs of the different people in the therapy relationship. The unique experiences of participants relative to the core themes are discussed. Recent research on therapist-identified difficult situations provides a context for understanding these themes. Feeling in too deep is considered as a response to an ethical challenge.

INDEX WORDS: Therapist experience, Countertransference, Parentification, Phenomenology, Ethical

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DEBORAH LYNN WEISSHAAR

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DEBORAH LYNN WEISSHAAR

Major Professor:	Gregory J. Jurkovic
Committee:	Leslie C. Jackson
	Roderick J. Watts
	Marolyn C. Wells

Electronic Version Approved

Office of Graduate Studies
College of Arts and Sciences
Georgia State University
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CHAPTER ONE: REVIEW OF THE LITERATURE

Psychoanalysts discovered the power of the talking cure a century ago (Haynal & Falzeder, 1994). Since that time, the field of psychotherapy has become well-established. Nevertheless, it remains a field of constant exploration, theory development, and empirical research. Psychotherapy research is founded in the desire to better understand and serve clients. In the last thirty years, as psychologists continued to search for the most effective theoretical conceptualizations and interventions, most practicing therapists fell under the purview of managed care. In 1995, the American Psychological Association (APA) sought to counter society's growing perception of pharmacology as the panacea for mental health concerns (Westen, Novotny, Thompson-Brenner, 2004). The APA created a task force to identify psychotherapy treatment methods that had been demonstrated as effective through outcome studies. The treatments most amenable to clinical trials were cognitive and behavioral. For a few years, the power structure of the field turned away from the therapy relationship in favor of something quantifiable. Despite the good intentions of those psychologists who strove to align the field with a value of empiricism, the determination to be a science-based endeavor might have weakened the connection to one of the field's richest sources of information – therapists themselves.

In this literature review I will discuss the transition of psychology into an age of empiricism and how quantitative methods have been applied to the study of therapist experiences. The idea that therapists display aspects of themselves as persons in the

therapy setting was first raised in literature regarding countertransference. I will review the evolution of the construct. Because the idea of therapist personal reactions in therapy raises questions about previous personal experiences, theory and research on early caring roles will be discussed. Person of the therapist training models will also be presented. Finally, I will return to the question of existing research and theoretical literature on the experiences of therapists in the psychotherapeutic encounter.

The earliest writings on experiences of psychotherapy come from the era of Sigmund Freud. As the field evolved and the value for empirical work became more entrenched, the voice of the therapist became increasingly silenced. Researchers wrote less about their own qualitative experiences and more about the experiences of clients. Researchers also increased the use of objective measures for data collection. The purpose of research shifted from subjective experience to the objective and quantifiable. Larger and larger samples became the norm so that a single study involved a multitude of variables with data that are analyzed statistically to reveal relations. There is great value to repeated findings and broad associations that can be revealed by this type of research, such as treatment efficacy and patterns of comorbidity. However, fascination with large quantitative research is analogous to the generational experience of media and the continuity of culture. It seems inevitable that younger generations tend to favor new media, but societies that are rich in an oral history benefit from the wisdom of their elders. The wise persons in the field of psychotherapy are the practitioners who have knowledge to share other than what can fit neatly into statistical models.

Who is better prepared than the psychotherapist to share with emerging professionals and their peers what happens in the practice of psychotherapy? The

experience of the psychotherapist is complex, and though aspects of it can be revealed with objective measures, some depth and meaning are lost by an exclusive reliance on quantitative methods. Qualitative research offers another approach to consider the experience of the practitioner, such as during those times in the psychotherapeutic encounter that most challenge a therapist. Such a question may be difficult to ask, but the benefit of the shared knowledge it could generate would be of tremendous value for the professional development of practitioners at a variety of levels of training or practice.

There exists a body of literature on the broad experience of therapists in practice, and much of it focuses on extremely positive or negative experiences. On the positive end is research and writing about the personal satisfaction and transformative growth that therapists gain from their work (e.g., Burton, 1975; Guttman & Daniels, 2001; Shainberg, 1977; Sussman, 1992). Other literature focuses on the potential for experiences of extreme stress and the possibility of therapist burnout (e.g., Figley, 1995; Hellman**,** Morrison & Abramowitz, 1987; Horner, 1993; Sussman, 1995). These works inform us of the extreme range of personal experiences that therapists find to be part their work. Some employ quantitative methods; others are qualitative; and still others are personal accounts. These works also hint at a more nuanced and in-depth understanding of therapist experiences that do not fall on either pole of the continuum of broad satisfaction to burnout.

Empirical Research on the Experiences of Therapists

Researchers Orlinsky and Howard began their research with the Therapy Session Report (TSR) in 1965 in an effort to identify a range of in-session experiences for therapists. Researchers developed questionnaires for both clients and therapists to

complete immediately following a therapy session regarding their experiences in the therapy encounter. The authors explained that their intention was to devise "questions that were as purely descriptive and non-inferential – as close to the experienced 'surface' of events – as possible" (Orlinksy & Howard, 1986, p. 479). However, the items were developed by the researchers based on personal experiences as well as their academic knowledge. Thus, it is debatable whether participating clients and therapists would have chosen similar terms to describe their experiences. It could be argued that the TSR allows researchers to look at the therapy process through the lens of its creators.

An early publication about therapist responses to the TSR presented a list of 18 dimensions of therapist experience based on factor analysis (Hill, Howard & Orlinsky, 1970). Each of the dimensions is described by pairing a feeling or behavior of a therapist with that of the patient (as perceived by the therapist). Some of the dimensions clearly represent a sense of progress in the process and others imply more challenging circumstances, such as "resignation over impasse with a depressed narcissistic patient," "passive hostile detachment with intellectualizing patient," and "uneasy nurturant warmth with warm seductive patient" (p. 439). The authors offer a limited description of each factor in the text of the article, but do not provide readers with an opportunity to understand what these experiences are like for therapists and what they mean for the therapeutic progress of the client. Such depth of understanding is beyond the purpose of what these authors intended as they wrote that "the dimensions of therapist experience, while not exhaustive, do seem to represent a range of experiences that can be readily identified by the practicing therapist" (p. 450). The documentation of a range of experiences was a step toward self-awareness. The field will continue to grow as

practitioners more fully understand themselves as therapists, the experiences of peers, and particularly some of the challenging experiences that arise in the course of therapy work.

European and international research teams have continued to explore the experiences of therapists using both qualitative and quantitative methods. David Orlinsky, of the TSR research, along with an international research team, remains at the forefront of quantitative inquiry. European researchers have made contributions to qualitative literature, analyzing therapists' accounts of their experiences. The products of these lines of research are highlighted later in this literature review.

Countertransference

The unconscious process of the patient rather than the therapist was the focus of early analytic writing. The concept of transference explained how patients seemed to unconsciously respond to analysts in ways that revived old role relationships, especially those with parental figures. Freud's purpose in the pursuit of analysis was to uncover aspects of transference and other unconscious processes and explore the meanings they held for patients (Schachter, 2002). He proposed that the exploration should be objective and not hindered by the unconscious process, or countertransference (CT), of the analyst (Tyson, 1986). This value was demonstrated when he first addressed his peers on the issue in 1910.

> We have begun to consider the 'counter-transference' which arises in the physician as a result of the patient's influence on his unconscious feelings, and we have nearly come to the point of requiring the physician to recognize and overcome this counter-transference in himself (Freud, p. 19).

As others took up the discussion of CT from where Freud left off, its definition has varied from Freud's initial notion to any reaction to the patient. Other understandings of CT have

included: unconscious reactions specifically to the patient's transference, unconscious reactions from the therapist's previous relationship experiences to the patient, and ultimately any conscious or unconscious reaction of the therapist to the patient (Strean, 2001; Slakter, 1987; Tyson). Over time the question shifted from whether therapists experience emotional reactions to how therapists can integrate and manage those reactions in the best interest of the client.

Freud's 1910 statement about CT reflected his belief that CT was a threat to analytic progress. He first suggested that the practitioner engage in personal ***self-analysis*** to become aware of one's unconscious reactions, but by 1912 he had changed his suggestion to ***training analysis*** with a more senior analyst. The importance and complexity of attending to the person of the therapist and unconscious processes of the therapist will be discussed at more length later in this review. At this point, it is simply noteworthy that Freud suggested such measures and that his professed goal was to allow therapists to maintain a stance of analytic objective neutrality. It is now widely recognized, however, that Freud's own behavior contradicted his guidelines to others for maintaining objectivity. For example, Strean (2001) noted that Freud himself "lent money to patients, fed some, hugged others, gave advice to many, and even took some patients with him on vacation" (p. 4). The move toward a more moderate conception of the therapist in the interaction as a human being with certain boundaries was not made by Freud, but it was initiated by colleagues within his lifetime.

In 1919 Ferenczi criticized Freud's rigidity about the importance of conquering CT (Slakter, 1987). He emphasized that the therapist is first and foremost a human being in the therapy process and suggested that fighting the natural CT response might limit the

therapist's ability to develop an "empathic understanding" for the client (p. 11). Ferenczi was also the first analytic writer to consider what he called *objective* CT, which he defined as the therapist's emotional response, not to the client's transference, but to the true personality and interpersonal style of the client. Keisler (2001) recently reiterated Ferenczi's notion of objective CT and presented it as a counterpoint to a more classical view he called *subjective* CT in which the reactions of the therapist to the client are the manifestation of the therapist's own unresolved issues, perhaps dating back to his/her own family of origin interactions. Alongside the differentiation between subjective and objective CT, Keisler also asserted that while the therapist must bracket reactions that are subjective processes, objective reactions can provide useful information for confronting clients regarding dysfunctional behavior. Although Keisler's comments seem elementary to present day practitioners, the notion that CT could be beneficial to therapy, or at the very least a source of valuable information to the therapist, was not widely held until 1949 (Slakter).

After more than 50 years of theoretical discussion, the concept of CT continues to provoke contrasting opinions. Even the objective-subjective clarification made by Keisler can be critiqued as overly simplistic. Because the interpersonal encounter is necessarily complex, it is likely that a therapist's responses to the client's interpersonal style and transference behavior are intertwined with responses based on the therapist's own previous interactions. Thus, it seems more accurate to describe all reactions of the therapist as containing some element of objective CT and some element of subjective CT.

The voluminous literature on CT, and the ongoing controversies about it, lend support to the importance of therapist experience in the therapeutic encounter. A recent

study conducted with therapist-trainees found a correlation between CT management skills and therapeutic outcome (Gelso, Latts, Gomez, & Fassinger, 2002). Most notable in this research is that management of CT referred to much more than just defending against feelings. Therapist-trainees were evaluated for such skills as insight into elicited feelings, appreciation for the distinction between their own feelings and the feelings of their clients, containing their own anxiety in the presence of clients' anxiety, distinguishing between the inner experience of the client, and conceptualizing the dynamics of the therapeutic relationship. While this study was a preliminary investigation with relatively low power, findings suggested that positive therapeutic outcome is related to the ability of therapists to both understand the CT experience and to be in control of the reactions it might inspire in them.

The Importance of the Therapeutic Relationship

Most of the literature discussed in the present review thus far is from the psychoanalytic school, which emphasizes family of origin exploration and insight into the unconscious. Bernstein (1999) acknowledged that those therapists who now identify with an interpersonal orientation have humanized the analytic encounter. They also have refocused the work from the unveiling of the client's mind to understanding the dynamics in the therapy relationship, appreciating what those dynamics reveal about the client's functional and less functional past relationships, and creating a corrective experience in the therapeutic relationship. In order to accomplish this kind of work, it is imperative that therapists be much more than keen scientists. They must be empathic, warm, and capable of sustaining regard even with clients who do not yet trust them. The ability to form and sustain a relationship is critical so that clients can experience a model of a healthy and safe

relationship. Teyber (2000) described how therapists can use their relationships with clients to foster growth and healthy change. In fact, the importance of the therapeutic relationship was even acknowledged in the arena of cognitive-behavioral therapy, arguably the least interpersonal theoretical orientation. A thorough review of empirical research on relationship factors in cognitive-behavioral therapy found consistent support for the importance of the therapeutic alliance and the therapist's basic skills of empathy, genuineness, and unconditional positive regard (Keijsers, Schaap & Hoogduin, 2000). Thus, even those therapists most focused on psychoeducation and concrete skill-building demonstrated importance of relationship in effecting change with their clients. Productive therapeutic relationships require therapists to develop and maintain sensitivity to their own personal reactions while they tease apart objective versus subjective CT. Finally, a recent APA task force, motivated by the realization that too much emphasis on empirically supported treatments had diminished recognition of critical interpersonal variables, actually went as far as operationalizing key components of "empirically supported therapy relationships" (Norcross & Hill, 2003, p. 22).

If the ability of therapists to form and utilize relationships with clients is so critical to their work, and we know from the CT literature that therapist reactions may either help or hinder their relationships with clients, the question arises as to what more we know about these people who work as therapists, their personal histories, and their interpersonal skills. The CT literature has alluded to the fact that therapists may have their own unresolved role interactions that they transfer to the therapist-client relationship. Recall that subjective CT was defined as reactions to the client that derive from the therapist's psychological structure. Consider, however, that a given therapist might respond similarly

to all clients in some respects. Perhaps there is a reaction to the very interpersonal relationship structure that is the foundation of therapy. The desire even to seek the position of therapist might reflect a wish to indirectly achieve something through the therapeutic interaction. Sussman (1992) proposed a variety of underlying objectives that might inspire pursuit of the profession. Among motivations he considers are the desires to be idealized, to be a nurturer, to be in a dominant position, and to achieve safe intimacy. Although the considered propositions suggest diverse theoretical approaches, they share a suggestion that therapists themselves have experienced a trauma or deficit that they try to correct by taking on the role of therapist.

Parentification

The Theory of Alice Miller

Miller (1979/1990) provided the most heuristically powerful, groundbreaking, and complex theory on the development of the therapist as starting within the family of origin. Miller described how some children become burdened with the emotional needs of their parents. The process she described was later termed ***parentification*** (Jurkovic, 1997, Goldenthal, 1996). Miller's theory explained a path to parentification that originated with the mother's narcissistic wound, such that the needs of the mother for mirroring and empathy had not been met in her childhood. This mother then turns to her own children to meet her unmet need. Since Miller's publication, it has been acknowledged that there are other paths to parentification (Jurkovic). Any situation in which the parental system is compromised and the child realizes he or she is needed by parents is one which may initiate a cycle of parentification.

Miller recognized that certain children are more readily aware of the emotional needs in their environments. Once such children believe their parents are looking to them for support and care, they are quick to do all they can to provide the nurturing their parents need. The needs are beyond the child's capacity. Nevertheless, according to Miller, *the gifted child* strives to fulfill those needs. In the process, gifted children become especially attuned to the needs of others in their environment. At the same time as they hone the skill for being outwardly-focused, they experience an atrophy of their ability to be inwardly attuned. It is not that this ability is lost, but it is not reinforced and therefore under-practiced. Thus, Miller's gifted child develops special skills for being aware of the emotional experience of others but loses strength in the ability to be in tune with his or her own emotional experience. For Miller this situation is the beginning, not of an illness, but of a tragedy in which people lose contact with their true selves and, thus, the "authentic sense of being truly alive" (Miller, 1990, p. xxi).

Miller's writing is based on her theorizing and her experience in clinical practice with psychoanalytic trainees. She described these individuals as entering training analysis with confidence that they had protected and happy childhoods. They have been overachievers, prized for their success, but have a sense of emptiness and self-alienation within. They are susceptible to an overpowering sense of shame if they ever fail to live up to some ideal image they hold for themselves. When discussing their childhoods with her, these people seemed detached or unsympathetic for the emotional experience of the children they once were. In place of sensitivity for themselves, they have an exquisite ability to empathize and feel for others. Miller asserted that she has seen a common significant childhood history in all candidates for the psychoanalytic profession with whom

she has had contact. They all had mothers who were emotionally insecure and who depended on them, as children, to behave in a certain way. The children all had "an amazing ability to perceive and respond intuitively . . . to take on the role that had unconsciously been assigned" (Miller, 1990, p. 8). Finally, Miller, believed that the "[parentified] role secured 'love' for the child. . . . He could sense that he was needed and this, he felt, guaranteed him a measure of existential security" (p. 8). Miller then described the trajectory from this childhood history to the role of mental health professional.

> This ability is then extended and perfected. Later these children not only become mothers (confidantes, comforters, advisers, supporters) of their own mothers, but also take over the responsibility for their siblings and eventually develop ***a special sensitivity to the unconscious signals manifesting the needs of others***. No wonder that they often choose the psychoanalytic profession later on. Who else, without this previous history, would muster sufficient interest to spend the whole day trying to discover what is happening in the other person's unconscious? (p. 8-9).

Research on Parentification Histories of Therapists

Empirical studies conducted since Miller's book was released have demonstrated, with some inconsistency, the association between psychotherapy as a profession and a history of parentification. In one study, Lackie (1983) evaluated the descriptors that 1,577 social workers used to describe their families of origin, and found that over two-thirds described themselves with terms such as "the parentified child, the overresponsible member, the mediator or go-between, the 'good' child, the burden bearer" (p. 310). Another study comparing the personal experiences of psychotherapists and physicists found therapists reported more childhood trauma and emotional deprivation, more caretaking of parents during childhood, and more ambiguous communication in the family of origin (Fussell & Bonney, 1990). More recently a study evaluated the attachment of

psychotherapists, and found that while a brief measure indicated 70% reported secure adult attachment style, the sample also scored highest on compulsive caregiving as their current insecure attachment pattern (Leiper & Casares, 2000). Although this study did not directly address parentification, there is an implication that the security of attachment styles in adulthood reflects the reliability and consistency of parenting received in childhood. Finally, a more recent study of parentification and therapists compared early histories of graduate students in art and counseling psychology (DiCaccavo, 2002). Limitations of the DiCaccavo study included a small sample size, minimizing power to detect differences, and the possibility of a poorly chosen contrast group. While DiCaccavo did not find a statistically significant difference in the histories of these two groups, it is notable that the research question remains of interest in the field.

Theoretical Implications of Parentification

In addition to empirical research, theoretical work has further explored early histories of psychologists. In 1995, Glickauf-Hughes and Mehlman articulated their perspective on the narcissistic issues of therapists, giving considerable reference to Miller's writings. Like their theoretical predecessor, Glickauf-Hughes and Mehlman also based their work on experiences with trainees and therapists undergoing their own therapy. Jurkovic (1997) contributed to the discussion with a chapter titled "Wounded Healer" as part of his text on parentification. Like others, Jurkovic based his work on contact with professionals. There is considerable overlap between the emphases of these two works. Both identify that the process of parentification may endow certain persons with natural skills that are particularly valuable to the practice of psychotherapy. Jurkovic

described four areas of strength that parentified therapists bring to the therapy room. The first strength is ***dedicated empathic caring*** in which parentified therapists can draw upon their own painful family experiences to be authentically empathic with clients. Jurkovic noted that the therapists who are able to turn their experience into a therapeutic strength are the ones who have given critical thought to their own experiences and have been able to differentiate themselves as persons apart from the needs of their family members. The second strength is ***humanness*** whereby parentified therapists may appear less inhibited than their peers in the therapy setting because of their years of familiarity with the role. Thus, when they sit with clients as caring listeners they can present themselves more naturally. ***Resourcefulness*** is another strength, which is again founded on years of experience in developing strategies to solve interpersonal problems and family crises. Finally, ***clinical range*** is described as a strength which indicates that, because of familiarity with situations of distress, many parentified therapists are willing to work with a wide range of cases of personal and family dysfunction.

The recent theoretical discussions on parentification also have discussed the potential challenges that these therapists may encounter (Jurkovic, 1997, Glickauf-Hughes & Mehlman, 1995). The two main themes of potential challenges are boundary difficulties and narcissistic struggles. Boundary difficulties surface when the parentified therapist heeds the call from within to rescue the client, creating an imbalance of effort. The therapist may be more accommodating, such as with missed appointments or unpaid fees, or overly accessible, such as with telephone contact. Although each therapist must determine his/her own style for these boundary decisions, the danger of parentified therapists' inclination emerges when they recognize their discomfort with the imbalance.

At that point the therapist may attempt to re-establish boundaries, but they risk being experienced as rejecting by the client. The narcissistic struggle for parentified therapists is related to their childhood experiences of trying to be appreciated for their helpfulness. As Miller (1990) described, the gifted child becomes aware of the need in his/her environment, initiates a child's effort to meet the need, and thus begins a cycle of trying to tackle problems beyond the scope of his/her abilities. In an effort to attain narcissistic validation, parentified children develop impossible perfectionistic ideals. Later as therapists, they transfer desire for admiration from their parents to their clients and supervisors and may find it difficult to regulate self-esteem without validation from others (Jurkovic). Therapists may find themselves maintaining an unhealthy hierarchy in therapy to retain a position of being needed. They may also subtly discourage the client's expression of negative feelings toward them (Glickauf-Hughes & Mehlman). According to these discussions about the personal experiences common to these therapists, it appears particularly important for parentified therapists to carefully attend to their personal sense of boundaries in therapy and any tendency to find gratification for personal esteem needs through the therapy relationship.

Training for Person-of-the-Therapist Issues

The admonitions for therapists that are implied in the parentification literature are generalizations. Nevertheless, they highlight the importance of being aware of the person of the therapist, the sensitivities that each therapist brings to therapy as a result of his/her own personal experience in the world, and particularly in his/her family of origin. This issue seems like a return to Freud's early calls for training analysis and the many subsequent reiterations of the call, such as that of Dub, who in 1947 wrote "The

psychotherapist can understand and help his patient to the degree that he can understand and help himself" (p. 29). Now that there is an established value for therapists to understand themselves in relation to their therapy work, the question is raised about where such exploration should take place. The challenge is that neither training nor personal psychotherapy can be undertaken without elements of the other interwoven. The field is thus tasked to address personal issues in training and to find a way to manage the inevitable dual relationships that will emerge (Aponte, 1994; Watson, 1993). In a training model described by Aponte, trainees use genograms, interviews with family members, and live supervision to explore personal history. The interaction with supervisors is meant to be therapeutic but not therapy, and trainees are encouraged to use the training as an opportunity to become aware of their issues and begin a process of working through them. After gaining an awareness of unresolved issues, trainees bring those to individual therapy for further exploration.

Whether the person of the therapist is explored in training, supervision, or personal therapy, the process of experiential exploration has come to be regarded as an implicit aspect of the development of the therapist (Deacon, 1996). The therapists who appreciate themselves as persons are more able to relate authentically with clients. Assuming therapy is a relational experience, it will be qualitatively different for clients whose therapists have undertaken a journey of self exploration than for those clients whose therapists are less aware of their own dynamics within the therapeutic relationship. Critics of the movement encouraging therapists to undertake personal exploration have alleged that it is unduly *deficit-based* and that a focus on deficits in the family of origin overshadows exploration of personal values and beliefs about life in general and the process of therapy (Carlson &

Erickson, 1999, p. 58). It does seem a valid argument that the more therapists are aware of their beliefs and values, the more they are able to understand their experiences when conducting therapy, and thus, the more able they are to be calm and effective while working with clients. More data about the challenging experiences of practice is needed to help guide person-of-the-therapist training in the most effective and least pejorative manner possible.

Research and Writing on Therapist Experiences

The existing literature about the experience of the therapist is limited. The work of Orlinsky and Howard (1986) with the TSR involved parallel data from clients and therapists. However, the data on clients appears to have been a greater focus of analysis. Moreover, the information garnered was limited by the closed-answer format of the questions. Factor analysis of therapists' responses generated 18 categories of experiences, although the researchers did not conduct a qualitative exploration of them. Thus, the TSR research is more helpful when examining breadth but not the depth of therapist experiences.

In 1987 a group of British psychologists analyzed their own accounts of difficulties in psychotherapy work and developed a taxonomy of such situations (Davis et al.,1987). Each researcher contributed to a pool of difficult situations, which they collectively sorted into similar groups. Davis and colleagues then reduced the groups to ten categories of difficult situations. Two limitations of the study are notable. Like the quantitative TSR research, this qualitative research focused on breadth and not depth of experiences. Detail about the different experiences is absent. Also, generalizability was diminished because the second pool of items, used to demonstrate the reliability of the categories, came from

among the same researchers who had developed the original taxonomy and who would sort the new data.

Although not yet published when the present research was initiated, a large-scale international study of psychotherapists (Orlinsky & Rønnestad, 2005) provides information about a variety of professional experiences. Nearly 5,000 psychotherapists from four countries and three continents participated. Among the instruments used in this study was one based on the Davis et al. (1987) qualitative research. Factor analysis revealed three broad dimensions of therapist difficulties: self-doubt, the frustrating case, and negative reactions to clients. The Orlinsky and Rønnestad study also identified different strategies used by therapists to cope with such difficult experiences.

The most recent contribution to this line of research was offered by Dutch researchers, Smith, Kleijn & Hutschemaekers (2007). The researchers created categories of therapist reactions based on therapist interview data of difficult experiences. Among the most commonly identified reactions were were: feeling anxious or threatened, being impacted by the intensity of the client's feelings, and struggling with shock, confusion, and helplessness. Smith et al. also delineated three types of difficult situations which they termed *traumatic, interactional,* and *situational*. They identified patterns of therapist responses to the different situations. Therapists reacting to traumatic situations demonstrated such responses as shock, anxiety, feeling overwhelmed and feeling destabilized. Those reacting to interactionally difficult situations demonstrated a higher than usual level of emotional investment along with feelings of helplessness and being manipulated. Therapists reacting to existentially difficult situations demonstrated a heightened rumination style and increased sense of responsibility.

Compared to peer-reviewed literature in other countries and research from international cooperation, the literature generated in the United States reflects a paucity of research or writing on the experiences of therapists during the psychotherapeutic encounter. As noted previously in this review, general discussions about the role of the therapist have involved focus on either satisfaction and personal benefits which accompany the work or the possibility for stress and burnout. Qualitative work, such as phenomenology, which could elucidate specific experiences of therapists, is almost exclusively limited to doctoral dissertations (e.g., Barry 1992; Basson, 1997; Kahane, 2002). It is to the detriment of the field that none of this work has entered the professional discourse as part of the peer-reviewed literature. A search of American psychological literature in the past 30 years revealed only one peer-reviewed article using qualitative methods to investigate the experiences of therapists; "An exploration of psychotherapeutic resonance" Larson (1987). The methodology of this work is notable for selecting participants who reported via initial questionnaire that they had experienced resonance in terms that fit with the researcher's own experiences. Thus, the ability of the research to explore the different meanings of the resonance experience was limited by the initial participant selection criteria. Aside from the Larson article, it appears that American psychologists are generally not publishing peer-reviewed qualitative research about the experiences, difficult or otherwise, of therapists conducting psychotherapy.

One retrospective piece was offered by Basescu (1987) in which he explored his thoughts and feelings in the course of analytic sessions. Rather than explore a single experience in depth, Basescu drew from a broad range of salient experiences as a psychoanalyst. His comments are complemented by anecdotes and description. Basescu's

article opens with a description of the process by which he concurrently listens to clients and listens to the stream of associations and reflections that run through his own mind. At times, he utilized these experiences as information which he offered to the client for them both to consider. Basescu's words, first composed as a lecture, lure readers because they reveal the person behind the role of the analyst. Quite unlike the objective or neutral analytic persona that Freud advised, Basescu acknowledged his subjective, affective experiences of being a psychoanalyst, such as feeling anxious when clients appeared desperate for progress.

Another published work by a therapist regarding his perspective in the therapy encounter is that of Yalom in the text, *Love's Executioner & Other Tales of Psychotherapy* (1989). The book offers ten fictionalized accounts of psychotherapy work as told by the renowned master-therapist, based on Yalom's actual cases. Like Basescu's, Yalom's writing is both very personal and introspective. He recounts thoughts and feelings as difficult therapeutic processes played out in his room. The title work to the compilation is a case in which the therapist believed that his responsibility to illuminate reality to an infatuated septuagenarian forced him to destroy her belief in a hopeless and unrequited love. Yalom shared a range of very human emotions as he and his client trudged through what seemed to be hopeless work. By the time Yalom wrote *Love's Executioner*, he had practiced as a psychotherapist for over 30 years and become an icon in his field. That he was already so established before exposing his less confident moments raises an interesting question about how comfortable therapists are with fully revealing themselves. In today's highly litigious atmosphere, practitioners might feel threatened to speak candidly with researchers about their feelings, faults, or possible therapeutic errors. Nevertheless, it is

humanness that many experienced therapists recognize as being so helpful. If therapy relationships and the authentic feelings that define them are such an integral part of therapist effectiveness, it is truly incumbent upon the field to strive to understand these relationships and feelings.

Another text based on first-hand accounts of therapist experiences is *The Intimate Hour: Love and Sex in Psychotherapy*, (Baur, 1997). Stepping into an arena dominated by ethical grandstanding and reports of flagrant abuse, Baur explored the possibility of authentic feelings of love that therapists can develop for clients. Baur searched for a consideration of attraction to clients that was as sufficiently complex as the topic merits. She found that the experience had not been adequately discussed in the literature.

> Rather than telling all these clinicians to be on guard against these feelings and to stifle them as quickly as possible, which is what the politically correct attitude tends to do, I think we should pay more attention to these warning signals…. Sexual attraction is an occupational hazard for therapists – a legitimate, serious problem – and, as we often tell our patients, it is not wise to solve serious problems quickly. It is often more instructive to stand under a problem and experience the uncomfortable ambiguity it brings to us. (p. 7).

Interestingly, Baur's desire for practitioners to thoughtfully explore the meaning of love experiences, rather than simply reject them, mirrors the re-conceptualization of countertransference as a source of information about clients and self. Part of the book presents Baur's integration of information she gathered by discussing the topic with practitioners. She suggests that therapists should acknowledge the reality that the therapeutic interaction is inherently intimate; that they must not to succumb to political pressure to deny that reality; and that mental health professionals should use their skills and their colleagues to explore it.

Research by Pope and Tabachnick (1993) and Stout (1993) attest to the reality that psychologists are not immune to developing sexual feelings for clients, although discussion of this reality is considered taboo. In their national survey of 285 therapists Pope and Tabachnick found approximately 95% of male therapists and 76% of female therapists identified having felt sexual attraction for a client. Of those, 63% had felt guilty, confused, or anxious as a result of such an attraction. In their study, 9% of professionals were found to have had some kind of sexual involvement in therapy to include a range of behaviors such as nudity, sharing sexual fantasies, or sexual contact. Stout's oral history research with over 40 psychiatrists and psychologists also demonstrated a range of therapists' experience with regard to sexuality and their work. Many participants discussed experiences of sexual attraction and one identified having had sexual contact with clients.

Closing Thoughts

If the voices of therapists are silenced, it becomes impossible to learn from their experiences. The CT literature demonstrated a transition from an initial rejection of the notion that therapists have feelings to embracing the feelings as sources of valuable information. Practitioners should learn from the experiences of colleagues. Understanding the experiences of therapists requires some awareness of the personal histories of the people who serve in this capacity. Thus, the literature on family of origin issues helps to contextualize the person of the therapist. It is also crucial to understand how therapists can grow to appreciate the selves that they bring to the therapy room. Finally, it must be acknowledged that qualitative work which could allow for therapist expression, especially about challenging experiences, is now the exception rather than the rule of American peer-reviewed literature.

CHAPTER TWO: INTRODUCTION TO THE PRESENT STUDY

Theoretical and Empirical Foundations

That therapists are human beings who can be deeply touched by the process of their work is generally an accepted truth within the profession of psychotherapy today. Most also agree that the psychotherapy process is influenced by the way the therapist experiences the work. In spite of these two realities, there is a paucity of research on the experiences of therapists in the peer-reviewed literature of the field. It is especially lacking in the American literature. The present study focuses on therapists' experiences of "feeling in too deep" with clients. If therapists have been generally reluctant to pursue research on their own experiences, the phenomenon presently under consideration might be particularly aversive. It suggests that there are times when the psychotherapy process might feel uncomfortable for the professional and that there may be times when professionals feel some loss of control regarding the way they experience psychotherapy with clients. Such assumptions about what it means to feel in too deep with clients are, however, just assumptions. It requires careful research with therapists themselves to better understand what the experience is truly like for them, what is happening clinically when they feel in too deep, how they navigate the experience to a resolution, and what thoughts and feelings are associated with this phenomenon.

It can be argued that the appropriate methodology to answer such questions is qualitative rather than quantitative, as qualitative inquiry is better equipped to explore new ideas and meanings than is the tradition of hypothesis-driven quantitative

methodology (Miles & Huberman, 1994). Once ideas have been sufficiently explored, the knowledge from qualitative research can be applied to quantitative studies to explore aspects of the phenomenon, such as under which circumstances it is most likely to occur. Qualitative research can lay the foundation for an understanding that is later furthered by quantitative research.

The voices of therapists are of critical value in any research effort that aims to understand their experiences. As participant-researchers, therapists can provide a description of their experience in an interview and then consult in the process of understanding the data (van Manen, 1990). Such research, emphasizing the active participation of the data sources, is the exception, rather than the norm, of modern-day research. When early psychoanalysts like Sigmund Freud wrote about their experiences, the voice of the professional was implicitly part of the discussion. As the field of psychotherapy became increasingly empirical, however, the voice of the therapist became increasingly de-emphasized. Rather than writing about their own experiences as therapists, researchers reported statistically significant findings based on objective measures. Data could come from therapists, clients, or third party observers, but the cachet was in the quantification of complex constructs. This approach allows for the study of relations among many variables and the elucidation of trends. However, quantitative and qualitative research traditions are best considered as compliments to each other, not as competitors for our research interests. To better understand important trends, we need qualitative research. For exploration of new ideas and nuances, we turn to qualitative approaches. Quantitative work can be particularly illuminating when it is based on the findings of qualitative research. Quantitative research might also elicit a finding that can be further

explored qualitatively. Unfortunately, funding and publication realities tend to push researchers toward exclusive use of quantitative methods. In the context of research regarding the experiences of therapists, the wise voices of practitioners reflecting on their own experiences are threatened. The loss to the profession carries with it enduring and significant consequences.

The earliest written works on the experiences of therapists were part of the psychoanalytic tradition with the recognition of CT. Transference had been understood as a process by which patients unconsciously revived family-of-origin relationships with analysts, and analysis was intended to uncover the meanings of this in-session experience (Schachter, 2002). In 1910, Freud acknowledged that analysts themselves might have unconscious responses to their patients. He asserted that such experiences must be overcome and not allowed to interfere with the objective exploration of the patient (see also, Tyson, 1986). In time, Freud suggested that analysts explore their CT through self-analysis or training analysis in order to maintain neutrality with patients (Strean, 2001). Critics like Ferenczi, however, soon countered that fighting the natural CT response could inhibit the therapist from developing an “empathic understanding” for the client (Slakter, 1987, p. 11). Like Ferenczi, modern day proponents of an interpersonal approach to psychotherapy embrace the experience of the therapist as a resource that provides rich data on the interpersonal style of the client (Teyber, 2000). Going far beyond what Freud would have proposed, advocates of an interpersonal theoretical orientation also emphasize the therapeutic possibilities of a human encounter between therapist and client (Norcross & Hill, 2003; Teyber).

The recognition of therapy as a process of relating between two persons suggests that the experience of both participants can influence its outcome. If mental health professionals seek to provide a therapeutic experience for their clients, it is incumbent upon them to also be mindful of their own experiences in the therapy encounter. Despite the value of self-exploration, modern contributions to a literature on the experiences of therapists in practice are limited and mostly focused on either extremely positive or negative experiences. Many therapists have written broadly about the personal satisfaction and transformative growth that they gain from their work (e.g., Burton, 1975; Guttman & Daniels, 2001; Kottler, 1993; Shainberg, 1977; Sussman, 1992). Others have written about the risks for burnout and stress that accompany the practice of psychotherapy (e.g., Figley, 1995; Hellman et al.,1987; Horner, 1993; Sussman, 1995). Such works attest to the range of personal experiences that therapists find to be part of their work, and most provide some element of authentic personal account. These works are important contributions toward an understanding of the experiences of therapists. However, they do not offer a detailed examination of a more nuanced therapist experience which does not fall on either pole of the continuum of experiences from broad satisfaction to burnout.

Research on specific experiences from the therapy encounter was conducted by a team of therapist-researchers who sought self-report information from clients and therapists. The TSR was developed to access this information with items the authors intended to be "purely descriptive and noninferential – as close to the experienced 'surface' of events – as possible" (Orlinsky & Howard, 1986, p. 479). Despite this intention, the authors based TSR items on their own experiences as professionals and educators in the field, leaving open the question of whether their participants would have

used such terms if asked to describe their experiences in their own words. Also, although the authors gathered data from therapists and clients alike, much more was published about the experiences of clients than those of therapists. One publication that addressed the experiences of therapists (Hill et al.,1970) developed a list of 18 dimensions of therapist experiences, pairing a feeling or behavior of the therapist with that of the client (as perceived by the therapist). Some of the dimensions allude to challenging experiences, such as "resignation over impasse with a depressed narcissistic patient," "passive hostile detachment with intellectualizing patient," and "uneasy nurturant warmth with warm seductive patient" (p. 439). However, the depth of description for each factor is limited, and the authors recognized that depth of understanding was beyond the purpose of their research. In closing they wrote, "the dimensions of therapist experience, while not exhaustive, do seem to represent a range of experiences that can be readily identified by the practicing therapist" (p. 450). While it is of some value to recognize that therapists have a range of experiences in sessions, the field will not achieve greater understanding unless researchers and practitioners more fully explore some of the challenging experiences inherent in the therapy process.

Other researchers have utilized qualitative methods to look broadly at therapist-described difficult situations (e.g., Davis et al., 1987; Smith, Kleijn & Hutschemaekers, 2007). Because the Davis et al. researchers conducted a self-study method, the generalizability of their taxonomy of therapist difficulties is limited. And, like the TSR research, the intent of researchers was to capture breath, not depth. Nevertheless, Davis et al. ultimately identified 10 categories of therapist responses in what appears to be the first effort to use a qualitative method to consider this topic. Smith et al. accessed interview

data for therapists who selected various difficult experiences to discuss. Again, the goal was to reveal categories and patterns but not to explore a specific experience in depth. Among the most commonly identified reactions were: feeling anxious or threatened, being impacted by the intensity of the client's feelings, as well as struggling with shock, confusion, and helplessness.

The most recent quantitative research on therapist experiences is from Orlinsky and Rønnestad's (2005) large-scale international study of psychotherapists. In collaboration with researchers from the Davis et al. team (1987), Orlinsky and Rønnestad developed questions to inquire about difficult experiences as well as coping strategies. Nearly 5,000 psychotherapists from four countries and three continents participated. Factor analysis of their responses revealed three dimensions of therapist difficulties: self-doubt, the frustrating case, and negative reactions to clients.

As was suggested by the literature on CT, the way in which therapists experience the therapeutic engagement with their clients may be due, at least in part, to their own personal histories. If so, common experiences of therapists may be linked to common personal histories. Sussman (1992) suggested that there are certain common motivations behind the pursuit of the profession. These include desires to be idealized, to be a nurturer, to be in a dominant position, and to achieve safe intimacy. Miller's (1979/1990) theory about the development of the therapist as beginning with experiences in the family of origin was particularly groundbreaking. Originally published in German in 1979, Miller's revised and translated text (1990) described how some children become burdened with the emotional needs of their parents. She identified the *gifted child* as one who is readily aware of the need in his or her environment. These children develop special skills for being

aware of the emotional experience of others, do their best with limited skills to meet the emotional needs of parents, but in the process lose familiarity with their own inner experiences. Miller found this pattern to be common among psychoanalytic trainees and associated their professional pursuit with their unique sensitivity to the inner experience and needs of others.

Interest in the association between childhood experiences and the profession of psychotherapy has spawned research that has largely supported Miller's (1979/1990) theory. Lackie's (1983) impressive study with 1,577 social workers found that over two-thirds self-described as "the parentified child, the overresponsible member, the mediator, or go-between, the 'good' child, the burden bearer" (p. 310). Another study compared family-of-origin experiences of psychotherapists and physicists and found therapists reported more caretaking of parents in childhood (Fussell & Bonney, 1990). The most recent study along these lines (DiCaccavo, 2002) did not find a difference in early histories of graduate students in art and counseling. However, considerable limitations in this study included a very limited sample size and arguably a poorly chosen contrast group in that artists may also be inspired by difficult personal experiences.

As this shared personal history has been identified for at least a substantial group of therapy professionals, some therapist-theorists have begun to explore how this legacy might impact the work of psychotherapists (Glickauf-Hughes & Mehlman, 1995; Jurkovic, 1997). For example, Jurkovic's writing about the ***wounded healer*** highlights both strengths and challenges that may result from a history of parentification. Among the strengths are a natural empathy, an ability to be at ease in the therapeutic role, and creativity in managing complex interpersonal problems. Potential challenges can also result

from a dedication and commitment to the work. Parentified therapists are particularly at risk for boundary difficulties when they heed the call from within to rescue the client and consequently create an imbalance of effort.

Development of the Present Research

Because qualitative research acknowledges that the person of the researcher impacts the research, the meaning and interest in the topic should be explicated. The question of interest for the present study evolved from an awareness that many therapists struggle with inclinations to become overly invested in the client's situation, and an appreciation of theory which may link such experiences to the therapist's role in the family of origin. I recognized my own personal experience of parentification and my inclination to align empathically with clients. The possibility of a more difficult experience arising from my concern for clients intrigued and daunted me as an emerging professional. In discussing these ideas with more experienced therapists, I developed an awareness of how little I understood the phenomenon of feeling in too deep with clients. As seasoned professionals reflected on their own familiarity with this phenomenon, it became clear that the experience was probably a challenging one, and one that had yet to be explored.

It is worth noting that the question in this study (i.e., the experience of feeling in too deep with a client) was determined with careful consideration. This language was first proposed by one very experienced therapist (A. G. Weiss, personal communication, June 14, 2004) and was later corroborated as a meaningful experience by another (G. J. Jurkovic, personal communication, June 16, 2004). As I brought the idea to still more experienced therapists, I began to hear different ways of relating to the experience. Nevertheless, it seemed to be a recognizable phenomenon to most experienced

practitioners. I was initially concerned about the wording of the question; specifically I worried that the use of the word “too” would suggest a pejorative connotation. I believed that therapists could at times experience an extreme empathic alliance with clients, perhaps driven in part by their own caretaking tendencies or family history. I also believed that this could create a unique experience in the therapeutic process; however, I did not believe that it was necessarily bad. I did presume that the therapist would recognize the experience as more intense in some way, and that it could actually be part of tremendous therapeutic progress.

Nevertheless, the wording concerned me, and I raised my concern with others. One consultant resonated with the experience but also noted that in today’s litigious atmosphere, it is difficult for therapists to admit any experience other than confidence in their process, thus making it difficult for participants to own feeling in too deep for the purpose of my study (R. Lester, personal communication, January 27, 2005). Another implored me not to over think the process, rather to let the data speak for themselves (A. Weiss, personal communication, January 18, 2005). Finally, I consulted with Wendy J. Austin, a faculty member in the Department of Nursing at the University of Alberta who holds a Ph.D. in counseling, and has done considerable research using qualitative methods in psychiatric nursing. My discussion with Austin convinced me that the research should move ahead with the original question. Together, we could not identify a better phrase to capture the experience that was not too wordy, vague, or apologetic. Austin also reiterated the importance of being open to one’s findings in exploratory work. She noted that stories shared by participants in her own study of the experience of moral distress for psychiatric nurses did not include the example that inspired her to do the study, but the

stories did help her understand their experiences of the phenomenon (see Austin, Bergum, & Goldberg, 2003). Thus, the present study was undertaken with an expectation that feeling in too deep will be described differently by different therapists.

Theoretical Basis for Qualitative Methodology

It was quickly determined that a qualitative methodology would be most appropriate for this research because the experience of the therapist when feeling in too deep is an exploratory interest. Although some knowledge of the parentification literature led to the consideration of this phenomenon as an important one, the focus of the study is not the relation between a parentification experience and a later professional one, which could be investigated with a quantitative method. Rather, the focus of the present research is on the adult, professional experience of feeling in too deep with a client. While qualitative methodologies do not allow for a rigorous examination of the relations between variables, they are most appropriate for this research as they allow a rich exploration of the data, for multiple meanings to surface, and for new areas to be examined (Miles & Huberman, 1994).

For the aims of this study, the phenomenological tradition seemed most appropriate because this method is designed to explore the phenomenon of human experience (Creswell, 1998). Generally, the approach involves the analysis of multiple descriptions of the phenomenon and the determination of any meaning that underlies it. This has been described as “the essential, invariant structure (or essence)” (Cresswell, p. 52). For the purpose of the present research, however, the common meaning structure was not the only goal. It also is important to consider how individuals may have different meaning structures around the experience. The experience of feeling in too deep with

clients could be considered a nodal point around which a narrative of experience will be described. The different ways therapists navigate the experience are all considered valuable to understanding it.

After conceptualizing the experience of interest as a narrative, it was incumbent upon me to consider a narrative research approach. The narrative tradition in psychotherapy emphasizes the constructivist tendencies of human beings to create meaningful narratives from our experiences (Polkinghorne, 2004). A particular advantage to performing qualitative research with therapists is that they are, by training, meaning-makers and well-practiced at verbal communication. Although narrative research methods would emphasize meaning-making and personal stories, they are most intended for form or content analysis (Lieblich, Tuval-Mashiach & Zilber, 1998). While the form of interview data is not the interest of the present study, exploration of content is relevant. Content analysis, however, reflects a goal-directed process in which investigators quantify different representations of certain pre-planned themes. With regard to the current study, the meaning behind therapists' experiences of feeling in too deep with clients is exploratory and not a confirmation of ***a priori*** assumptions.

The Blending of Phenomenological Traditions

Any brief consideration of phenomenological methods will reveal the vast diversity within the tradition. Many researchers identify as phenomonologists but differ in their application of the method. The general practice of phenomenology can be traced to the pioneering work of Edmund Husserl (Husserl, 1970). Those who have adhered more closely to his approach emphasize that phenomenology is a descriptive science (Osborne, 1990) and strive to be true to the data by letting it speak for itself. Such work is well-

represented by existential and empirical traditions such as Moustakas (1994), Wertz (1984), and Collaizi (1978).

The tradition of hermeneutic phenomenology as practiced today is traced back to the work of Heidegger, a student of Husserl who broke away from his teacher over their approaches to phenomenology (Heidegger, 1981; see also Hopkins, 2001 & Sheehan, 1997). In an article comparing empirical and hermeneutic approaches, Hein and Austin (2001) demonstrated how similar the content of the products are and yet how different the forms can be. The ultimate product of a hermeneutic study is a rich document, filled with colorful examples and literary exposition (W. J. Austin, personal communication, February 1, 2001). As compared with traditional Husserlian phenomenology, hermeneutic work is more tangible and less distant. The reader of a hermeneutic description of a phenomenon, is moved by its poignancy and precision (van Manen, 1990). According to van Manen, the hermeneutic description "awakens our basic experience of the phenomenon it describes, and in such a manner that we experience the more foundational grounds of the experience" (p. 122). Austin's text *First Love: The Adolescent's Experience of Amour* (2003) is an example of how rich, literary, and personally involved the final product of hermeneutic research can be. Like hermeneutic phenomenology, the heuristic tradition is less rigid than the empirical and existential traditions. Moustakas described the heuristic phenomenologist as a "scientist-artist" who employs both contemplation and imagination in weaving a "creative synthesis" out of the essences that have been revealed (2001, p. 273).

The blending of qualitative methods and traditions in the present research is both a function of the fact that they have much in common, and that some of the best descriptions

of how to approach phenomenological work in the field of psychology come from the more traditional empirical and existential schools. According to van Manen (1990), hermeneutic phenomenology pairs its two components. Phenomenologically, it strives to be true to the appearance of the phenomenon, and hermeneutically, it recognizes that any attempt to capture the essence of a phenomenon involves interpretation. In contradiction to the Husserlian rigidity of limiting phenomenology to pure description, hermeneutic phenomenologists welcome the element of interpretation that is inherent in one's experience of a given phenomenon. According to von Eckartsberg (1998) the hermeneutic phenomenologist seeks to "do justice to the integrity, complexity, and essential being of the phenomenon. We become spokespersons and messengers for the meanings that demand to be articulated" (p. 50).

According to some estimates, more than 20 unique kinds of phenomenology exist (W. J. Austin, personal communication, February 1, 2005). Given the inconsistency of meanings behind named traditions, and the necessity to craft methodology to meet research demands, it is important to verify the actual methodological practices of a given study. One commonly held tenet across traditions is that good phenomenological methodology must be idiosyncratically crafted for each investigation (Colaizzi, 1978; Moustakas, 1994, Osborne; 1990; van Manen, 1990).

Phenomenological Tradition Applied to the Current Study

A few key points about the process of phenomenology, as it will be applied in the present study, deserve brief comment. These points include: how previous beliefs are managed, how to focus interviews, how participants become involved beyond the initial interview, and how methodological rigor is addressed.

Addressing Pre-Understandings

It must be noted that all people, whether human science researchers or not, approach discussions of lived experience with some notions of their own. In the context of phenomenology, these preconceived ideas are not brought by the researcher to the participants. Nevertheless, in order to best explore the lived experience descriptions of others, phenomenological researchers must become aware of their pre-understandings. The traditional phenomenological requirement is a certain suspension of pre-understandings, a process Husserl termed ***bracketing*** (Creswell, 1998, p. 52; Osborne, 1990, p. 81; van Manen, 1990, p. 47). Although this term has become standard in the field, its original definition of setting aside pre-judgments may be misleading. van Manen noted that the most effective way to manage pre-judgments is to make them explicit and then not to attempt to forget them forever, but rather to be aware that they are being held aside to allow other data to enter.

For the present study, it is important to be explicit about pre-judgments associated with the parentification and wounded healer literature. One assumption from this literature is that the experience of feeling in too deep may be tied to a nurturing and empathizing instinct learned in childhood. Another assumption is that feeling in too deep with clients can be an aversive experience, one that perhaps re-activates the early experience of feeling responsible for problems that were beyond the capabilities of the child to fulfill. In order to allow participant voices to become the data of this research, it is important that these pre-judgments be acknowledged and held aside. Should certain of these themes be revealed in interviews, they will be explicated by participants and not by the researcher's perspective that the professional experience could be related to a childhood one.

Enhanced Role of Participants

In the present study, the primary data were collected via in-depth interviewing, but the role of the participant extended beyond the initial interview. In the first interview, participants were asked to describe one instance in which they felt in too deep with a client. It was important to start with a specific recollection of the participant and then to examine fully that instance of the experience rather than explore general reflections. Participants were encouraged to discuss the experience broadly, incorporating the visceral experience, the narrative of how it started and was resolved, and the cognitive thought processes that accompanied it. However, they were also held to a specific incident, and asked again about the specific example if it appeared they were generalizing (van Manen, 1990). Having fully explored their experience, participants have completed their initial task of providing data. They were later brought back into the project during data analysis (Moustakas, 2001; Osborne, 1990; van Manen, 1990). Before the second meeting, the researcher transcribed the interview, analyzed it for preliminary themes, and condensed the data into the form of an individual situational description. In the second meeting, the participant assessed the accuracy of the analysis and engaged in a "collaborative hermeneutic conversation" in order to delve more deeply into the meaning of the themes that arose (van Manen, p. 99). Although the process of returning to discuss themes with selected participants could be repeated multiple times, practical and logistical considerations limited participant contact to an initial interview and a single follow-up interview consultation.

Essence and Difference

Finally, it is notable that the processes of hermeneutic or heuristic phenomenological studies pose somewhat of a contradiction. The goal of traditional phenomenology is to explore lived experience so as to reveal its "essential invariant structure (or essence)…recognizing that a single unifying meaning of the experience exists" (Creswell, 1998, p. 55). Hermeneutic phenomenology, however, emphasizes that human experience is always more complex than an essence. In 1990, van Manen wrote that "To do hermeneutic phenomenology is to attempt to accomplish the impossible: to construct a full interpretive description of some aspect of the lifeworld, and yet to remain aware that lived life is always more complex than any explication of meaning can reveal" (p. 18). Thus, if there is an essence to be found by this process, there may always be another description which captures other elements of the phenomenon. Moustakas (2001) described the composite description developed by the heuristic researcher as capturing "all of the core meanings of the phenomenon as experienced by the individual participants and by the group as a whole" (p. 271). Similarly, the purpose of the present study was to explore a multiplicity of meanings for the experience of feeling in too deep with clients and to notice whether some meanings are true for all participants. Instead of only searching for a single essence to be revealed, this study was designed to respect the most profound meanings offered by each of the participants.

Methodological Rigor

A discussion regarding methodological rigor was raised during the proposal of this research. At issue was the fact that a qualitative methodology necessitates a different approach to rigor than does a traditional quantitative methodology (Choudhuri, Glauser &

Peregoy, 2004). Quantitative research relies on demonstrations of reliability and validity to represent measurement rigor. In very simple terms, validity asks whether an instrument is measuring what it was intended it to measure, and reliability indicates that the measurements can be made consistently. These constructs can not be directly applied to phenomenological work (Lemon & Taylor, 1997; Yonge & Stewin, 1988). The very idea that a phenomenologist measures a phenomenon contradicts the ideal of interpretation that is central to the hermeneutic approach. Rather than reducing an experience to simplified component parts, a hermeneutic phenomenologist seeks to illuminate the complexity and mystery of an experience and ultimately to "construct a *possible* interpretation" as to the nature of that experience (van Manen, 1990, p. 41). If a phenomenological goal is to carefully illuminate a possibility, it can be expected that one researcher's possible interpretation will differ from that of another researcher, yet both will hold meaning. Ultimately, reliability and validity fail as constructs for phenomenology because they were developed with an assumption that there exists a singular truth to be found and measured consistently.

Although it is arguable that the concepts of reliability and validity would be misapplied to this work, they are considered foundational to modern science. Therefore, it is important to explore what these terms mean to the present work and what other concepts of rigor might be more helpful. Unlike most quantitative research, or content-analyzed narrative data, there is no *a priori* question guiding a hermeneutic phenomenology and thus no pre-planned coding scheme to be completed in a reliable fashion. The researcher begins to analyze material and embraces the task of interpretation, not just description (van Manen, 1990). Were the task simply to describe the elements of a

data set, as believed by strict followers of Husserl's model, it would be easier to measure similarity or reliability between different raters. Instead, by embracing interpretation, hermeneutics "implies the acknowledgement of a distortion" (van Manen, p. 26) and a tolerance of uncertainty (Yonge & Stewin, 1988). Because hermeneutic phenomenology celebrates the complexity of experience, practitioners do not claim to exhaust all possible meanings for an experience. As such, no two hermeneutic phenomenologists are expected to respond in an identical fashion even as they attempt to illuminate the same phenomenon based on the same external data.

The construct of validity also can be misapplied to hermeneutic phenomenology. Validity traditionally asks whether we are measuring what we intend to, but hermeneutic interviews do not provide an objective standard against which to verify validity. For this reason, the participants in this study were enlisted as co-researchers. In the follow-up consultation they had the opportunity to review selections of their transcripts along with preliminary analyses provided by the researcher. At that time, participants could assess the accuracy of the researcher's interpretation as a reflection of their experience. By reflecting on the analysis early in the process, participants helped address what many qualitative researchers describe as credibility. If critical data are missing or misinterpreted in the initial analysis or mistaken about it, the researcher has an opportunity to integrate the correction into the ongoing data analysis. Lincoln and Guba (1985) consider the technique of returning data and analysis to the participants for review to be the most important feature of methodological rigor in qualitative study.

Although some researchers have attempted to re-define terms of rigor such as reliability and validity so the language would be more applicable to qualitative research

(Le Compte & Goetz, 1982), others have expressed concern that their methodology will be misunderstood by the appropriation of positivist terms (Yonge & Stewin, 1988). Among the terms that some qualitative researchers have suggested as more applicable to their work are: verification, trustworthiness, confirmability, and credibility. Although these terms overlap in meaning, they all address a level of confidence in data and analysis as would be established for quantitative research through discussions of reliability and validity. Creswell (1998) summarized eight practices that could contribute to trustworthiness and credibility. Of these, the three that are applicable to interview-based hermeneutic phenomenological research are: clarification of researcher bias, participant review of analysis, and review of procedures and product by an external consultant. See Methods section for details on the application of these practices to the current study. Despite the appearance of similarity between external review and inter-rater reliability, for hermeneutic phenomenology an audit by an external consultant is not intended to demonstrate that different researchers will create an identical product. Instead, the processes of analysis and writing are considered intimately connected in the exploration of a human experience (van Manen, 1990). As such, it is inevitable that the person of the researcher will be expressed through the discourse, and again, no two researchers could create the identical product. Rather, a consultant should be familiar with the process of phenomenology, and if possible, the unique style in which it is being applied to the present study. The consultant can then review a selection of data and analysis to corroborate that the analysis and themes revealed were appropriate for the data. The themes themselves provide structure around which the phenomenological discussion is written. While the discourse of different researchers should not be expected to be identical, Churchill,

Lowery, McNally, and Rao (1998) showed convergence between the themes that emerged in three different analyses of the experience of date rape conducted by three phenomenologists using the same narrative data. These researchers demonstrated how their unique perspectives were interwoven into narrative interpretation and that embracing the reality of interpretation is considered a defining feature of the hermeneutic-phenomenological method.

CHAPTER THREE: METHODS

Interviewing and Developing Analysis

Given that the present study is exploratory and examines a phenomenon that has yet to be described in the literature, it was expected that procedures would evolve over the course of interviewing and analysis. Among anticipated adjustments were questions for the interview and steps in the analysis process. It was also understood in advance that the format of the interview would differ somewhat for each participant; the interviews were conversations, not structured processes. The researcher inevitably learns about the phenomenon as the research process unfolds. Change is expected during the course of data collection as the purpose of hermeneutic phenomenology is to move toward a fuller understanding of the phenomenon rather than to rigidly compare participant reports (W. J. Austin, personal communication, February 1, 2005).

Participants

As noted earlier, participants in this study were considered co-researchers. They both contributed data in the form of an extensive interview, and were consulted in the interpretation of the data. Despite their increased role, selection criteria were minimal. Unlike hypothesis-testing projects in which participants must be both representative and of sufficient number to provide statistical power, participants in phenomenological studies must meet only one criterion. They must have experience with the phenomenon of interest (Creswell, 1998). In the present study, ten currently practicing psychologists were recruited. Creswell estimates that phenomenologies usually involve interviewing up to ten

people. In the current study sample size was not guided by saturation, defined as the recognition of redundancy in cases and an awareness that no new data are emerging with additional participants (Tucket, 2004). Because the participants of this study described very different experiences, each revealed unique components of the experience of feeling in too deep. Strict adherence to a rule of saturation would not have effectively delimited the sample. Nevertheless, recurrent aspects of the experience across participants became clear after only a few interviews were conducted and continued to the completion of ten interviews.

One sampling technique that was not planned but emerged in the sample was the negative case (Lincoln & Guba, 1985). After agreeing to participate via phone contact and beginning the interview, one participant re-evaluated hers as an experience of feeling in deep, but not in too deep. This participant's data offered some contrast to the other participants, indicating what might differentiate the two experiences.

Although not a formal requirement of the phenomenological method, diversity was sought across a range of demographics, such as experience, training background, personal background, and theoretical orientation. Prospective participants were contacted by phone and asked for 10 minutes to consider the research proposal. The text that guided telephone contacts is presented in Appendix B. The text of an informed consent document is provided in Appendix C.

An additional consent was considered for participants' clients, however it was determined to be unnecessary, logistically complex, and possibly detrimental to the well being of the client. Although participants were assured that full transcripts would not be included and that the focus of analysis and quotation would be on the therapist's

experience, rather than the clients, all participants were asked to disguise client information in their interviews. As psychologists, all participants are also bound by professional ethics not to reveal identifying information about clients. Obtaining consent from clients would have also presented a logistical obstacle because participants mostly spoke about their work with clients who had since ended treatment. Reactivating clients' concerns after they had already experienced therapeutic closure was considered an undue risk to their emotional well being. Similarly, informing clients that the therapist felt in too deep may not be psychologically appropriate for certain vulnerable clients. Without knowledge of their psychological status this information could not be shared responsibly.

Attempts were made to contact 18 other psychologists for this study. Ten of those were never successfully reached by phone. Three were either uncertain of the construct or did not relate with having experienced it. Four cited work and personal time demands that prohibited participation. One of those who declined to participate commented that being in deep is an important part of his therapeutic style and therefore it never feels too much. Another prospective participant who declined for reasons of personal demands explained that the phenomenon had been experienced, but expressed concern that it would be too emotionally taxing to review at the present time.

The participants of this study were 10 psychologists with counseling or clinical doctorate degrees currently seeing psychotherapy clients. Of the 10, two were Psy.D. clinical psychologists, five were Ph.D. clinical psychologists, and three were Ph.D. counseling psychologists. Only one was previously acquainted with the researcher. Four were recommended by committee members. Two were recommended by other participants. Two were identified by the researcher in a search of practicing psychologists

listed on an internet recommendation source. Nine participants were licensed, one was completing post-doctoral work for licensure. The amount of time post-doctorate ranged from less than 1 year to 17 years. Participants were asked if they could offer any words to describe their therapeutic orientation and among the responses were: cross-cultural, family systems, aesthetic, narrative, dynamic, self psychology, object relations, interpersonal use-of-self, experiential, existential, and feminist. The participants were also asked to offer words to describe themselves personally and they were found to be heterogeneous in the following other self-identified categories: race, ethnicity, religion, and sexual orientation. These sample description data are presented in Table 1. Names of participants and demographic attributes of participants and clients have been changed in the remainder of the document to protect anonymity.

Data Collection

Participants were asked to dedicate one hour for interviews which were held in their offices. They were not asked to prepare a written response before this meeting. Although a prepared description could have reduced the time needed for the researcher to become acquainted with the experience that the participants shared, there remains a serious drawback to asking participants to write about their experience. The purpose of the initial interview was to elicit a description from the participant of his/her own experience of feeling in too deep with a client, as he/she lived it. Although any recollection will incorporate some reflection, it was the aim of the interview to obtain as pre-reflective a statement as possible. According to van Manen (1990), “writing forces the person into a reflective attitude – in contrast to face-to-face conversation in which people are much more immediately involved” (p. 64). Thus, the data in this study were

Table 1.

Participant Demographics.

Category	Participants Responses	
Gender	7 Female 3 Male	
Race	7 Caucasian/White, 3 African-American/Black	
Sexual Orientation	8 No Comment 1 Gay 1 Lesbian	
Religious Affiliation	5 No Comment 4 Christian 1 Buddhist	
Degree	5 Clinical Ph.D. 3 Counseling Ph.D. 2 Clinical Psy.D.	
Theoretical Orientation & Practice Style	5 psychodynamic 2 eclectic/integrative 2 cross/multi-cultural 1 object relations 1 interpersonal 1 narrative/aesthetic,	2 family systems 2 feminist 2 experiential 1 self-psychology 1 existential 1 use-of-self
Years since degree	mean: 10.3 years 2 participants, 1-5 years 2 participants, 6-9 years 4 participants, 10 years 2 participants, 16-20 years	

Note: Terms used in this table were based on participant-generated labels and therefore do not always fit clearly into categories. Most participants responded with multiple labels for theoretical orientation and practice style.

obtained strictly through dialogical contact with participants. Because the course of each interview was determined by the content that the participant shared, each was unique. Interviews were minimally structured and more conversational than formal (W. J. Austin, personal communication, February 1, 2005). A list of questions was generated to guide the interviews, to the extent necessary (see Appendix D). In many cases, the participants spontaneously addressed the questions without being asked directly. The interviews were digitally audio-recorded for later transcription, to allow the researcher to be maximally present during the interview itself. The researcher maintained a stance of curiosity and empathy (Alvesson and Sköldberg, 2000) and utilized non-directive questions and those from Appendix D to encourage a complete description by the participant.

Data Analysis

Interviews were transcribed verbatim from recorded interviews to create each participant's protocol. The researcher executed all transcription to be fully re-familiarized with the interview. It is at this point that the methodology becomes less obvious. Even academics specializing in this methodology recognize that there is significant heterogeneity in data analysis and interpretation methods (Alvesson & Skölderberg, 2000; Osborne, 1990; van Manen, 1990). The analysis plan for the present study was based on the works of Alvesson & Skölderberg; Creswell (1998); Colaizzi (1978); Moustakas (2001); Osborne; van Manen; and Wertz (1984).

Before analyzing across participants, a selection-analysis procedure was conducted and a situational description was written for each individual protocol. The interview was read in its entirety by the researcher in order to become reacquainted with the whole of the report as well as its details. The researcher then began a search for ***thematic aspects*** using

van Manen's (1990) *selective* approach of identifying salient sections and highlighting them. This is similar to Colaizzi's (1978) process of *extracting significant statements.* The interview protocol was printed with line numbers. The researcher then slowly read the interview to identify sections that seemed to address an aspect of the participant's experience. These sections were copied and printed alongside their page and line numbers. The researcher then made an initial effort to understand each thematic aspect by attempting to identify the participant's intended meaning, a step Colaizzi termed *formulating meanings.* It is at this point that the researcher was challenged with the task of using creativity and familiarity with the protocol to uncover meanings that were consistent with the report, but may not be explicitly stated in it. When the entire protocol had been read for thematic aspects which had been identified and interpreted preliminarily, the researcher read through all selections again and attempted to re-interpret them so as to focus more on the lived experience of the therapist-participant and less on the unique details of the situation or client presentation. Thus, the selections of the interview protocol were analyzed, then re-analyzed. The researcher then composed an individual situational description of the protocol to capture a rich account of both concrete experiences and meanings (Moustakas, 1994). This final step also was completed with at least one revision to allow the researcher to focus on the meaning of the lived experience rather than situational details.

At this point the researcher scheduled a second meeting with the participant to review data analysis. Participants first reviewed the final selection-analysis, carefully noting anything that did or did not correspond to their intended meaning. Next, participants were presented with the situational description which they also evaluated for

accuracy. If indicated, the individual structural description or selection-analysis was revised following the consultation process. Most changes initiated by participants were minimal involving clarification of experience and word choice. The most extreme was the elimination of a description of the client's anger. The participant's word "rapid" was misunderstood as "rabid" which overemphasized his sense of threat. It is important to note that the involvement of participants was not intended to authorize an end point of the analysis, but rather to provide the researcher with feedback about the accuracy of preliminary interpretations and descriptions.

During the research process the consultation meetings became more structured with participants asked to first review selection-analysis and then the situational description. The intention was to allow participants to respond to the experience on both levels. Selection analysis functioned as micro analysis and the situational description served as a snapshot macro perspective of the experience.

Once all interviews had been analyzed to the point of follow-up consultation by most participants, the researcher began the process of between-participant analysis. At this point the researcher read over all individual descriptions to propose essential themes which could become topics for the last stage of the final follow-up consultations.

Credibility Audit

Audit meetings were held in response to comment during proposal that this research should involve credibility procedures in addition to the follow-up consultation with participants. Auditors were two doctoral-level clinical psychology students also working on qualitative dissertation research. They met with the researcher once together and then individually two more times. Each of the five meetings provided an opportunity

to review data and analysis for one participant prior to the follow-up consultation. The auditors read the complete interview, noted their thoughts about how it reflected the participant's experience, and then described this to the researcher. In each case the auditor's comments seemed to align with the interpretations of the researcher. Auditors were then presented with the selection analysis and situational description for the given interview. Auditors were asked to note if any of the researcher's interpretations did not seem to correspond with their own or did not seem to be based in the data. In all five cases, the auditors reflected a similar understanding of participant's experience.

CHAPTER FOUR: RESULTS

The results of this study are presented in two sections. Situational descriptions are presented first for each of the 10 participants. The second section of results is an elucidation of the core themes that emerged from all participants.

Situational Descriptions

Sally

Sally described feeling *in deep* when working with a client, but was not comfortable calling the experience *in too deep*. At first the idea of feeling in too deep raised thoughts of having her own personal reactions interfere in the work, struggling with the extent of her power and influence as a therapist, or being challenged by not knowing something that is critical for her client. Although she did not describe personal reactions as interfering in this case, she did speak of strong personal reactions and of struggling with influence and the unknown.

The clinical work she described was with a client who was working on a gender/sexuality issue that Sally had not worked with before, but the client believed she was expert in. Sally felt it was important to be clear about the limits of her knowledge at the outset of the work and to pursue expert supervision. Her concerns about being able to provide the best care were quelled by an expert supervisor. Sally eventually realized that her client was also newly understanding his issues, which helped her to be comfortable with the fact that she could not develop a quick understanding of him and that they would

need to proceed slowly. As the client revealed his sense of entrapment, pain, and fear of loss, Sally felt those feelings with him in a very real way. She also worked with the client and his spouse together developing a sense of awe for their genuine love and commitment. She allowed the client to see her feelings and know how much she cared during their work, and she credited his awareness of her caring with his ability to accomplish so much in therapy.

However, when the client moved and they ended their therapy relationship she found it difficult to enforce the boundary between them that she believed they each needed. It was painful not to be able to give her client the care and support that had sustained him during their years of work. She had to balance her own interest and care for him, his desire for contact with her, her professional opinion that he needed more support than she could provide long-distance, and her experience that his needs for ongoing contact after termination could be overwhelming to her.

During their work, she recognized how important it was to both of them for her to remain hopeful even as her client struggled with what she believed were the most emotionally hurtful experiences. When her client spoke of not being accepted for who he was, Sally identified with her personal knowledge of oppression and being invalidated as a person. Sally also realized that, while she was comfortable expressing some emotion during their work, she felt a responsibility to contain her emotional expression when they were ending so she could model an ability to move on and be better able to do so herself. Sally herself was personally very deeply touched by their work. Between sessions, without prompting, she found herself thinking about her client. It was sobering to be reminded of how people can use faith to explain being exclusionary and she wanted so much to be a

better representative of a person of faith for her client. This experience continues to inspire her actions to live as a good Christian, mindful of the need to 'love thy neighbor.' Professionally, it taught her how to address indirect expressions of suicidality with her judgment about when clients need, and are safe enough to take, space to work through emotions without being rescued too soon.

Terrence

Terrence described his experience of working with a client who he liked very much, but with whom his central experience was feeling in too deep. Unlike other times he had felt this way, this experience was unresolved. He was left feeling that he could no longer work with his client. Their work lasted four months during which time Terrence worried that they were experiencing their interaction very differently. She trusted him implicitly, whereas he did not yet feel that their relationship was sufficiently developed for either of them to feel safe when she disappeared into her painful past. When she did so, he felt unable to be present with her, as though she had gone into the past and was not really in the room with him anymore. Terrence felt confused about his client's mental experience. He felt disoriented; unsure of where she was and where they were going. He felt scared and alone, and desperately wanted companionship in this process. Mostly, he didn't even feel the presence of his client and he longed for someone else to know what was happening in their sessions, someone who could understand her in ways that he could not.

Terrence regularly discussed his sessions with colleagues to get practical advice on how to slow the client down and help her stay more present. His consultations also soothed his sense of being alone and confused. Ultimately, Terrence was forced to call the

authorities when his client was imminently suicidal and revealed that she had been prepared to suicide violently in his office during their last few sessions had he angered her sufficiently. Knowing that she had concealed a weapon during sessions felt like a violation to Terrence. He felt badly about the repercussions of her scuffle with authorities. However, Terrence also realized how unsafe he felt with this client and how this reaction would inhibit his ability to give her the help that she needed. It was sad and painful to him that he could not offer her the support and care that she needed. Terrence also felt that he had misled his client by assuring her that she could express the range of her feelings toward him, even anger. He had focused on his commitment to their relationship, but he could not continue that relationship when he felt so unsafe with her.

Like the client, Terrence's father had displayed an unpredictable anger that was dangerously directed at him. Although when working with his client Terrence was not thinking of this early personal experience, he believes that the fear of unexpected violence would have felt familiar to him upon learning of her intentions. Terrence's faith in people's universal ability to recover from trauma was shaken by this client. He no longer assumes that recovery is always possible and has since worked to accept that some clients will never recover and he can only offer them his help in improving their lives. Terrence also learned from this case to trust his instinct when he feels that he and his client are not yet ready to delve into the past. Terrence noted that because he felt so endeared to this client and he admired her strengths, he overlooked the extent of her difficulties and was not firm enough with his instinct to stop uncomfortable explorations into her past.

Amelia

Amelia described feeling in too deep with a client who was in an ongoing abusive relationship, and who came erratically to therapy. Amelia experienced their work as crisis driven which kept her from being as reflective as she likes to be. In fact, this interview seemed to clarify for Amelia the degree to which their power struggle over structure paralleled her client's struggle to have control over his own life. Also, now that she is out of that work, Amelia believes she has grown as a therapist and has developed sensitivity to her own feelings as "red flags" for the sense of responsibility that she can come to feel for a client.

Listening to this client's story, Amelia felt viscerally distressed but feared that her own horrified reaction could cause her client to feel shame. Amelia felt honored to be chosen as the only person the client trusted to share with, but burdened by being her client's only safe outlet. She also felt overwhelmed with horrific information and desperately needed to share with colleagues and supervisors in order be cleansed. At the same time as Amelia challenged herself to meet this client's monumental needs, she doubted her competence as a therapist, whether she had enough resources to meet her client's needs, and whether she herself could tolerate this work. Amelia was inclined to bend her own practice rules, such as termination after missed sessions, to accommodate this client's crisis needs. She felt sad and frustrated that she could not offer more to her client, so Amelia could not bring herself to be unavailable to him.

Amelia's personal values as a mother and family member were activated by this client's situation. She also attributed her instinctive protectiveness and sense of responsibility to having been the oldest sibling. Ultimately, the therapy relationship was

severed when Amelia attempted an involuntary commitment after a reported suicide attempt. She hoped that in some deep place, her client understood that her effort was an act of love and caring and a demonstration that Amelia was really listening to him. Amelia herself felt serenity and clarity when she knew how she had to respond to the suicide threat. The experience of feeling in too deep with this client taught Amelia how emotionally draining such an interaction is and how reluctant she is to take on such a responsibility again. Nevertheless, Amelia passionately described how personal connection between client and therapist is integral to good therapy. For her, the determination of the appropriate level of connectedness and disclosure has to be made individually, based in part on the needs of the client and the resources of the therapist.

Linda

Linda described an experience of feeling in too deep with an adolescent child of a client system. When she became extremely concerned that the system was dangerous to the girl, Linda failed to determine objectively whether the girl herself was actually experiencing severe psychopathology (early psychosis). She experienced the client as small and needing protection, and even recollected her during this interview as much younger than she really was. To Linda, the child also seemed in need of an emotional advocate, since the parents seemed unsympathetic to how sad and lonely she was. Linda's own values about raising children made it hard for her to see how this family might be functioning in a culturally appropriate way.

By becoming so much the child's advocate, Linda was soon defending the client against her parents and battling for the child's freedoms. At some point this role became uncomfortable and Linda questioned her actions and her motives. She considered the ethics of

the role she was taking and whether it felt right to her. She also wondered if she was driving the parents away by siding with the girl regarding adolescent freedoms and emotions, but not addressing their concern about the girl's mental stability. At this point Linda decided she was in too deep and she responded by dramatically shifting her approach. She became much more objective and addressed the possibility of a more serious diagnoses. Linda had been so connected to the girl, that, until that point, she had not been able to objectively evaluate the girl's pathology. However, by validating the parents' worry with a potential diagnosis and psychiatric referral, she lost the client system. It was particularly painful for her when they did not return again for therapy or termination.

For Linda it was sad that she would not be able to make more progress with her client and that the parents did not recognize the progress that was being made. Moreover, she seemed to be disappointed in herself that she had lost objectivity. Linda suggested that she could personally identify with this client's experience of not having her worldview understood, and this point of connection might have inspired her to become too quickly aligned with the girl. Also, getting involved in the lives of others as an advocate was a role she had taken in her family since childhood. As a professional, Linda believes that being in deep is central to providing good therapy because it means really understanding a client's experience. This particular professional experience is one that she returns to whenever faced with a parent system that seems not to understand the child's emotional needs. Thinking back, she is inspired to push herself to consider the parents' perspective more carefully and to look for ways in which the system might actually be functioning.

Yvette

Yvette described feeling in too deep with a client who was working on traumatic memories. She expressed a disconnection between the minimal level of expressed emotion from her client and her own internal experience of profound emotions. As she listened to her client flatly recalling trauma, Yvette felt that she became stuck in her client's world of experience. During this work, memories of Yvette's own trauma experience were triggered. She re-experienced feeling powerless and frightened as she had before. She also felt anxiety, apprehension, and a lack of control in the present. She actively processed these feelings in an intellectualized effort to make sense of her own personal emotions. She wondered if she was feeling the emotions that her client was not yet safe enough to feel. Yvette felt trapped in her own feelings and her client's story. She worked hard to be free and able to provide her client with therapy. When sessions ended and Yvette had time to herself, she would sit with her feelings, processing them, and possibly dissociating. But when the time came to work, she would put this intense process away and attend to her other clients.

She was aware of a depth that she avoided with this one particular client. Yvette monitored her own emotional experience. She worried that it could interfere with her work with this client, so she kept discussion of her feelings out of the explicit therapy work despite her standard treatment model of incorporating them integrally into the work. There was an urgency in her need to avoid her own scary, deep, emotional places with this client. To do so, she focused on tolerating, managing, and containing her own emotions.

When she gave her client validating messages about how hard her experience was, Yvette may have also been validating herself about her own experience. She worked with her client on a theme of uncertainty to which she also related. The feelings inspired by this

experience caused Yvette to consider resuming her own therapy. In relaying this experience, Yvette also shared how details of her work with this client are missing from her memory, possibly the result of dissociation during her post-session process or possibly from an effort to stay above the depth of difficult memories.

Edward

Edward discussed his experience of feeling in too deep when a client idealized him and therefore misperceived him and misrepresented him to others. Particularly troubling for Edward was his belief that he and his client had to continue to avoid dealing directly with this core issue because confronting these beliefs would have destabilized the client. Edward had agreed to do long-distance work with this client who, after moving away, felt a need to continue the work they had begun. Ultimately, however, this client's situation deteriorated to the point that she felt in crisis. She revealed that she had been hiding the severity of her symptoms and Edward felt betrayed that his client had lied to him.

Edward also felt some guilt that he had unwittingly participated in his client's unhealthy beliefs by agreeing to do long distance work, and then he felt a conflict between giving the client the contact that she wanted and realizing that he could not provide sufficient care. He felt caught between a sense of responsibility for the worsened situation and resentment for being lured into a position of responsibility for a crisis that he believed was unnecessary. Edward frequently questioned the scope of his responsibility as a professional. These questions inspired a sense of insecurity and reminded Edward of being the responsible child who had to do his best in everything or risk disappointing someone. In this case, Edward felt that the parents of his client held him at fault for their daughter's

condition and expected Edward to be able to fix the crisis. Edward was relieved when the parents were later able to accurately understand him.

Edward was disappointed that he had not recognized how emotionally challenged the client was. He was saddened by the prospect of the client's future struggles. Edward felt better about the situation when he considered theoretically why his client needed these misperceptions, and when he decided that he as a therapist needed to accept how his client functions. It was also helpful for Edward to consider similar situations in which he was able to eventually discuss client misperceptions. Peers helped Edward manage concerns about responsibility and appreciate why he would feel discomfort. This experience has inspired Edward to be more careful about accepting a client request for long-distance work. It has also provided another experience for him to consider and value his own style as a professional.

Howard

Howard described working with a client who became confused about their relationship. The experience of feeling in too deep with her was a sense of panic that he had done something wrong to create her misperception, and a fear of disciplinary repercussion. Toward the end of this experience, Howard began to recognize that his style of being exceedingly caring and nurturing had fed her confusion.

Howard had been accessible to her by phone between sessions, and even late at night. He had changed their routine by adding hugs in response to her request. It made him uncomfortable to make her uncomfortable, so he did not push difficult conversations. But in the process, he led his client to experience interactions with him as easy, so idealizing him became natural, and getting confused about their relationship was more

likely. Their relationship, and how she pushed the limits of it, were among the topics they avoided. When the client canceled sessions, Howard took the initiative to call her to check on her, rather than allow her to take responsibility to get back in touch with him. Later he identified these behaviors as being her "rescuer," but at the time he simply felt it was his job to be responsible for her.

When she became confused about the meaning of their hugs and the possibility of a sexual nature to their relationship, Howard panicked. The situation was complex and frightening. He realized that he had been unable to steer his client's emotional experience with him and felt a loss of control. He worried that he had overlooked how troubled she was and that his supervisor would blame him for her confusion. His fear of criticism by his supervisor was profound and almost childlike, as though he had done something on the order of a violation and would be punished. He was able to consult with colleagues and was relieved to be able to explain the situation from his perspective. His romantic partner was also a colleague and consulting with her comforted him because it reminded him of who he was personally. Howard coordinated for his client to meet with his supervisor for a few sessions, who framed the client's feelings about Howard as understandable given her personal history. Howard felt regret that he was somehow responsible for her difficulty, but he did not want to blame either of them, so in speaking with the client he focused on the confusing nature of the therapy relationship.

Being the responsible one who takes care of others is a role Howard knows well, as he identified the pattern since a childhood role of helping both parents with emotional needs. Howard found that feeling in too deep was helpful in that it forced him and the client to finally have the difficult discussions that each of them had been avoiding – he

because he wanted to keep their work feeling safe and comfortable, and the client because she wanted to be taken care of. He learned through this experience that he needs to balance his caring way with limits, opportunities for clients to take responsibility for themselves, and for them both to clarify the relationship. He also learned that intense relationship work can be confusing for some clients. That Howard had been unaware of his client's confusion taught him that, in addition to what is said, he needed to listen more carefully for what topics are avoided.

Tammy

Tammy experienced feeling in too deep with a client who revealed a history of perpetrating a particular kind of violence that was of unique concern for Tammy at that time due to her own personal life circumstances. She felt extremely connected to the client from many years of work and was committed to providing him with the best therapy she could. With her client's revelation, Tammy suddenly lost clarity in how to proceed and worried that her therapeutic instinct could be clouded by reactions stemming from her own family life circumstance.

Tammy did not want her issues to interfere in her client's work. Tammy noticed that she held back for a few sessions to get a better sense of what was going on for her client and inside of her. When she chose to speak, her concerns inspired her to evaluate her therapeutic choices even more carefully than she normally would. Tammy also had to decide how to cope with the client's need to discuss violent content. She felt a sense of dread when anticipating this client's sessions, but also believed that her client needed to work through this material.

Tammy altered her traditional style of work in order to balance her own need to protect her personal life with her client's need to process. She put some limits on the extent to which they would explore the client's angry and violent ideas. It was not easy for Tammy to restrain processing in this way, but, because she felt she and her family were the direct targets of her client's rage, she could only feel safe in the work if she instituted some speed bumps. Colleagues helped her accept this decision and consider how to proceed given that the extreme and uncomfortable personal reaction she felt was a new experience. Tammy used meditative techniques to prepare for sessions and distance from the negative affect when they were over.

Tammy's reaction to this work extended outside of the therapy room. She found herself troubled outside of session by her client's revelation. The fact that she had not suspected her client was capable of such acts also led her to question her judgment about people in general and her sense of safety in the world. Tammy experienced a range of discordant emotions tied to this work. She struggled with feeling connected to her client but also being repulsed by her client's past actions. Tammy was angry and frustrated with her client for having complicated some of her personal life decisions so dramatically, but she also understood how much he was struggling. Finally, an added layer of discomfort for Tammy was her discomfort with having such negative feelings about a client. This experience was an inspiration for Tammy's later efforts to reach out to persons who may be navigating employment in the midst of the same family life circumstance that complicated this work for her.

Max

Max spoke about his work with a client who came to him confused and suicidal. His experience of feeling in too deep with her was about an uncomfortable level of responsibility for her well being, his fear that he could not keep her safe, and his awareness that he did not have specific expertise regarding the issue that was creating the client's distress – a very specific experience of gender and sexuality. Max had been drawn to this client's sense of need because she had no other resource options. He knew that he did not have specialty experience, and made a conscious choice to be honest about his skills and limitations and still offer his services. Early in their work, Max felt he was exerting considerable effort to draw his client toward him because she seemed stuck and so pained by her secret. Max felt added pressure because he could sense how much his client valued therapy by her conscientiousness and punctuality. Despite all of their work, and her consistent attendance, the client was unable to say very much in session. This was very scary for Max because the client could not talk to form the bond with him that he believed could keep her safer from suicide. The client was also unwilling to involve a psychiatrist, or tell anyone else about her situation, so Max felt totally alone with the responsibility for her well being.

Max also felt like the container for her secret and all of her pain. He consulted with a gender specialist, and yet he consistently felt that he was not providing enough to meet his client's need. Max also sought consultation to help him with the sadness and frustration of working with such a pained client who was so inaccessible. Max felt stuck on the outside of her experience and wanted desperately to get to where he could help. In time, Max gained a sense of effectiveness when the client could communicate with him

through her writing. The pressure to do more was reduced when consultation helped him acknowledge how much he was already providing her by sharing information, listening, and not rejecting her.

In consultation, Max also worked on re-conceptualizing his role so his level of responsibility was more manageable. He felt somewhat relieved of being alone with her secret when the client was able to confide in a few friends and a religious leader he had contacted on her behalf. Max's spirituality and his family's values drew him to want to help this client. Ultimately, Max's faith also helped him navigate feeling in too deep. He realized that he did not have to be his client's savior, but was just a part of her healing. He coped with his own sense of responsibility using prayer and imagery.

Eventually, the client needed to share her secret with her family. Even though the client's suicidality had passed, Max feared that she could be devastated by her family's rejection to the point of self-harm. He carried a sense of responsibility for her throughout the process of reunion with her family and the transfer of her care to a specialist. Max recognized that his client got better care because he could acknowledge that he was dealing with more than he was comfortable with and because he was willing to seek support and resources. Nevertheless, the work was emotionally draining for Max and he realized that it would not be fair to himself, his other clients, or his family if he were to have more than one situation like this in his caseload at a time.

Ronald

Ronald shared his experience of feeling in too deep when working with a client who was suicidal. Feeling in too deep was a painful and scary experience which was not a consistent part of their work together; it was not even consistent during suicidal times. It

was a worry that he did not have what his client needed and he could not bring in another professional, such as by transferring the client. Ronald realized that his fear was lessened when he sensed that his client was able to hold onto their relationship to stay safer from suicide. One of the struggles of this case was feeling that he could not use hospitalization as a last resort because he believed his client would suicide upon release. Ronald was impressed by this client's charm and style, but in part because of his client's savvy, Ronald had less power and fewer options as a therapist.

At first he acted on instinct to assess the suicide risk, but learned that by doing so his client could no longer feel their connection, which Ronald believed was most likely to keep him safe. So Ronald fought his instinctive response to do objective assessments of suicidality when he felt fear for the client's safety, and rather worked hard to stay relationally present with his client. Ronald had to overcome his fear for his client, relax his instinct to control the situation with standard practices, and trust that their relationship was what would be most helpful to his client. He came to a spiritual belief that there was a larger force guiding them in the relationship work which relieved him of the burden of being alone with the responsibility for keeping his client safe.

Ronald also worked to accept that the decision to live or die was his client's and not his to make. This was a difficult reality that Ronald worked on with a supervisor, but he gained some relief from his fear for his client when he could remember. It was painful to worry that he could give all of his best efforts and his client might still choose death. Ronald knew that he was putting in more efforts to engage his client than is considered standard practice, but he felt that this client needed more. Ronald also believes that he

became more involved with this client's emotional journey because the client needed to feel the security of his presence.

Ronald's own personal experiences of suicide and mental illness among loved ones were activated by this work. These experiences were the foundation of his knowledge that there is much in the lives of others that he does not have the power to make better. Ronald also recalled his own consideration of suicide and shared something of that time with his client when the client asked. He generally shared more about his feelings with this client because he believed the client needed that to help articulate and validate his own feelings.

Core Themes

Four core themes emerged which were represented in the data from each of the 10 participants: thoughts and feelings of distress, challenge in connection, altering personal style of practice, and balancing. Although each therapist shared different stories with varied clinical and personal issues, these themes were consistent elements of each therapist's experience of feeling in too deep. In this section I will discuss each of the core themes with more detail about how each was meaningful to different participants. Throughout the presentation of these results I will also indicate how themes and sub-themes appear to be interrelated.

Thoughts and Feelings of Distress

The core theme, ***thoughts and feelings of distress,*** is, perhaps, implicit in the phenomenon under investigation – distress being implied by the word *too* in the phrase ***in too deep***. Nevertheless, it emerged as a theme slowly over the course of this analysis. Participants expressed or implied a range of feelings, which were noted in thematic analysis. Even during the course of interviewing I was moved by the weight of the

emotional experience in the stories of my participants. When analyzing across participants, the repetition of certain emotions became apparent. I recalled that one therapist declined to participate because she expected that it would be too emotionally taxing. It is also notable that three of the participants became tearful during our interview. With the broad preliminary theme "emotional" I reviewed my previous analyses for each participant, extracting the different emotions expressed. Upon review, the negative valence and cognitive component of these experiences emerged and the theme was renamed to reflect those aspects. I then returned to the analysis and data for each participant to re-familiarize myself with the context of these thoughts and feelings of distress and developed a charting method to explore patterns across participants (see Table 2).

Universal Cluster: Insecurity, Confusion, Not in Control

While some kind of powerful thought or feeling of distress was common to all participants, the nature of these experiences varied from insecurity to fear to guilt and more. The only distress cluster that was common across all participants was feeling insecure, confused, or not in control. In the following pages I will explore this cluster of feelings and will show the association to other experiences of distress. It is also important to recognize that these were personal feelings of the participants, not feelings for their clients. For example, sad, scared, or threatened are listed because the therapists personally felt those emotions. In some way, the sadness or sense of threat was for themselves not their clients.

Table 2

Clusters of Distress Thoughts and Feelings

Distress Cluster	Participants E	Te	A	H	L	Ta	M	R	Y	S
insecure confused not in control	x	x	x	X	x	X	x	x	X	x
guilty self-critical disappointed in self	x	x	x	X	x	x			x	
craving support need to not be alone	x	x	x	x		x	x	x		
frustrated	x	x	x		X		X	x		
scared threatened fearful under attack		X		x		X		x	X	
pain in ending feeling unresolved	x	x	x		x					x
drained exhausted overwhelmed		X	X				X		x	
anxiety		x		X		x			X	
sad		X			X					X
misunderstood	x	x		x						
too responsible hyper-responsible	x		X				X			
mad, angry	X					X				
dread						X				
horrified			X							
revulsion						X				

Note: Lowercase x indicates that the cluster was implied by participant, capital X indicates that one of the words or phrases in the cluster was stated verbatim by participant.

The least to emphasize. It is notable that Sally, the one participant who identified as feeling in deep rather than in too deep, described the least experiences of distress. She was also the participant who least emphasized feelings from the universal cluster of insecurity, confusion or feeling not in control. Sally spoke of discomfort in the beginning of her work as a result of her lack of familiarity with the issue her client presented. It took longer than usual for her to have a sense of what he was really dealing with. She said,

> It was a process of being comfortable with going slow enough. Because I didn't – a month into this I couldn't have said, 'I know what this is. I know what the diagnosis is. I know what the dynamics are.' I couldn't say that and I think I was floored at the beginning.

Sally questioned if she knew enough to do this work and even considered transferring the client to someone more expert. The differences between Sally's experience of insecurity and that reflected by other participants were the duration of the feeling and its intensity. For Sally, this was a feeling she associated with the initial stage of the therapy relationship, but it did not pervade her sense of being with the client later in their work. Sally also did not describe the feeling as being so intense or distressing as other participants did. Finally, because this feeling of insecurity was a more circumscribed experience for Sally, it was not related to her experience of other thoughts or feelings of distress.

For the remaining nine participants, feeling insecure, confused or not in control was something that either emerged well after a working relationship had been established or was a feeling that persisted during the work and was often linked to other kinds of distress.

Client misperceptions. Edward and Howard were both distressed by feeling unable to control the clients' misperceptions of them. Each discussed having been idealized by his client when he didn't realize it was happening and then finding himself unable to control his client's skewed thoughts. In addition to feeling misunderstood, Edward felt a lack of control due to the long distance nature of his work. He acknowledged that by agreeing to phone therapy, he limited his access to information that would have helped him know that his client's health was crumbling. When his client finally told Edward the truth about her condition, she was in need of more extensive intervention. Edward described how his sense of not having control was amplified by geographic realities and the expectations of his client's parents,

> The drama with her family. Here she is out of state, upset parents, mad at me in another state, calling me in another state, "What do we do? Where do we put her in treatment?" She's barely functioning. And dealing with my own, what is my responsibility? People wanting me to fix it and then my own voice of 'What have I done that it got this crazy?'

Edward also described his sense of confusion about his client's thought processes. Over time he began to realize how much his client was distorting his communication into what she wanted to hear. As that realization solidified, Edward also grew to accept that his client depended on this idealization and Edward believed it would not be in his client's best interest to deconstruct it. He said,

> For me one of the things that makes it too deep is what's happening is not articulated between me and the client. It's almost like something is getting enacted and when I start to get some clues about what's going on, this drama that I've been participating in, and I'm uncomfortable [with]. And even if I do have and idea of what could be going on, the other thing that makes it feel too deep is I'm not sure how really helpful it would be to lay it out to this person here and now.

Howard also felt a lack of control based on his client's misunderstanding of him. This experience grew from the startling realization that his client was confused about whether there was a romantic nature in the relationship. He had added hugs to their routine at her request and years later she questioned what the routine implied. Unlike Edward who experienced frustration because he could not clarify the misperception with his client, Howard felt it was imperative that the misunderstanding did not persist. He described himself as "panicked." He feared that his supervisor would think he had done something wrong, and he was anxious about repercussions.

Realization of client instability. The sense of being insecure or having lost control of the situation for many of the therapists involved a realization that the client was far more psychologically or emotionally challenged than they previously recognized. Many of the therapists expressed some guilt or disappointment about not having appreciated the extent of the client's difficulties. This was true for both Edward and Howard. Edward described his thought process, "Wow, she's that young inside! Uggh! Why hadn't I picked up on this before now?" Howard shared a similar realization, "I knew that she was a lot more unstable than I had imagined her." Linda described feeling uncomfortable in general and she questioned herself for being aligned with the child so much more than the parents. She told me, "I think I lost some objectivity about whether she was really sick." When Linda recognized the imbalance, she changed course dramatically by validating the mother's concern. This acknowledgement led to a rupture of treatment when the family ceased coming. Linda expressed a sense of disappointment that she had some responsibility for the abrupt termination. She also expressed sadness not just for her client's situation, but also on some level for herself. "It was really hard. It was hard for

her. It was hard for me to see her go. It was hard to see that the parents couldn't see she was making progress."

Like these other therapists, Tammy's sense of confusion and feeling not in control coincided with being surprised about the extent of the client's problems. After years of intense work, Tammy's client unleashed a torrent of violent thoughts and feelings about her, and disclosed a history of possibly perpetrating abuse. Tammy said, "I felt confused. I felt that I wasn't responding completely objectively. There were a few sessions where I mostly sat quietly and didn't respond a lot because I didn't trust that I could untangle everything going on in the room." Linked to her sense of confusion was a sense of threat, because Tammy believed that her client needed to process these violent thoughts with her. Tammy approached those sessions with a feeling of dread and noticed that she also felt angry with her client, who made these revelations at a time when he knew Tammy's sensitivity to the abuse was heightened given her personal life circumstances, of which her client was well-aware.

Client inconsistency. For Amelia and Ronald, insecurity revolved around not knowing whether their clients would return. Neither could count on a consistent therapy schedule despite the life-threatening circumstances of their clients. Both expressed a painful realization that they had no control over whether their clients would return and they both accepted that the continuation of treatment was a decision only the client could make. Ronald struggled with the knowledge that if his client did not feel connected to him, he was at greater risk for suicide. So if the session ended without the sense of relationship strongly established, Ronald would worry, "He could walk out and not come back. The best of me could not be enough." Ronald expressed a sense of "powerlessness" in relation

to his client's life and confusion about his ability to influence in his role as therapist, "There was a moment where it made me question 'what the hell am I doing anyway?' It made me question my profession some. I think sometimes we get insulated and think we are more powerful than we are." Ronald spoke about how he ultimately accepted the reality that his client would choose whether to live or die. However, he felt sure that the one variable he could impact was his client's sense of connectedness to him. As long as their relationship was strong, he felt he was in a position to help his client stay safer from suicide. Ronald described how standard strategies to maintain his client's safety, like suicide risk assessment questions, backfired because when he attempted them his client "felt dropped in the moment" and the sense of connection between them was weakened. He also believed that he could not hospitalize involuntarily because he knew his client would be able to control the appearance of risk enough to be released and then he would be free to suicide, and would no longer have the relationship with Ronald to protect him. With a perception that strategies like risk assessment and involuntary hospitalization were not possible for his client, Ronald felt more insecure in his work and less in control of therapeutic outcomes. Another distressful feeling that Ronald described was being scared about what would happen to his client, not just for his client but also for himself. He told me, "I knew I'd be forever changed if he suicided. In a – in big ways."

Like Ronald, Amelia struggled with her client's decision to come or not come to therapy. Also like Ronald, Amelia expressed a sense of frustration in her interview; however, Amelia's insecurity contained a self-critical questioning about her professional adequacy.

> I didn't know if he'd ever come back. And he didn't know if he'd come back either. I don't mean to sound like he was manipulative but that game of 'Am I going to come back or not?' and what does that mean? What does that mean about me as a therapist? What does that mean about my being able to be in the room with him?

Amelia maintained a strong sense of responsibility for her client's well being. In her words she felt, "too responsible" which made her sense of insecurity and lack of control over the therapy so much more wrenching. Amelia indicated that she only developed a sense of peace when she was forced to attempt an involuntary hospitalization. Although it ended their therapy relationship, Amelia was hopeful that her action was experienced by her client as a loving gesture. Overall, Amelia described this work, including the dramatic ending, as "exhausting" and "draining."

Personal emotions. Unlike many of the other participants, Yvette's sense of feeling not in control was more about her own experience rather than the therapy interactions or the behaviors of her client. Yvette found herself relating to the traumatic memories that her client was processing which aroused a set of unpleasant feelings that she felt she could not control. She said, "I just remember feeling kind of anxious, apprehensive, fearful probably. That powerless, 'I'm not in control' feeling. Just old feelings for me." Even though her style of practice usually involves utilization of her own reactions as a therapeutic tool, Yvette felt her emotions to be unsafe and she believed that she could not use them to benefit her client. She described how the emotions seemed to take over and she fought to regain her sense of control. "I was aware that what I was trying to do was contain. I couldn't allow myself to be sinking any more deeply into that place. I needed to get out of that place pretty quickly." In a way, Yvette also indicated some disappointment in herself or self-criticism as she pushed herself to change her emotional experience. She

told herself, “You’ve got to get a grip, you’ve got to contain this.” There was a sense of desperation in Yvette’s attempt to regain control of her emotions, for both herself and her client. Yvette also recollected that she considered resuming her own therapy during that time.

Most profound experience of insecurity. Of all the participants, feelings of insecurity, confusion and feeling not in control were most profound for Terrence. In his words, “The feeling of being in too deep really permeated a big section of our being together.” Also, whereas other therapists, like Linda and Edward, expressed regret about having to end work with so much that was not yet resolved, Terrence’s lack of resolution involved a sense of guilt and a lingering confusion. He told me, “She really fell apart very quickly in ways that I still don’t understand.” Like Edward and Howard, Terrence felt that he could not control the way his client misperceived him. He believed that she trusted him in a very rapid and implicit way indicating that she was probably not really relating to him at all. He said,

> I think there are a lot of ways that I had a lot of other people's faces superimposed on mine, and that was what she was feeling connected with, as opposed to really feeling connected in our actual relationship. And I think that was what felt really disconcerting and disorienting for me.

He described how he tried to slow her process so that they could wait with her exploration of the past until they had developed more of a connection, but he found himself unable to stop her and he felt confused about what was happening. He described the experience as “feeling kind of scared and a little disoriented, and thinking, ‘I am just not sure what exactly is happening here.’” Terrence noticed that his sense of confusion was more intense than he had ever experienced before,

> I felt like I didn't understand. With other clients I felt like I might not know where we're going, but I kind of know what path we're on. I didn't have a sense for what path we were on – she and I.

The extent to which Terrence felt confused and insecure in this work was underscored by his desperate desire not to be alone with the content of their sessions. Other participants also discussed the sense that they needed to share their experiences with colleagues in order to seek consultation and support. Terrence, like Amelia, experienced this need very immediately after client contact. He described regular calls to a colleague following sessions to debrief. Whereas Amelia was looking to cleanse herself of the "horror" of her client's story, Terrence needed to process not just the client's story, but also how confused he was about their interaction.

> There were many, many times when I got my officemate on the phone and would process with her what had happened in session and I remember talking with her a lot about my feelings of being disoriented and not being sure of what was going on.

Ultimately, Terrence's work with this client ended when his sense of confusion was eclipsed by his feeling of being unsafe. After learning, in the course of his client's suicide attempt, that she had come to his office many times with a concealed weapon, Terrence was unable to feel safe enough to resume his work with her. In many ways, this realization represented the apex of Terrence's insecurity, confusion and feeling not in control. He did not know what would have provoked his client to use the weapon and therefore he had no control over either of their safety in the room together. This feeling was too much for him to tolerate and he knew that he could not feel comfortable enough with her to provide her with the care that she needed. Because of his sense of insecurity,

Terrence did something that he had never before and has never since done; he declined to continue to treat the client.

Other Thoughts and Feelings of Distress

In the preceding section I presented the experiences of participants regarding feelings of insecurity, confusion or lack of control, and attempted to show how that cluster connected to other thoughts and feelings of distress. It would be impossible to provide detailed exploration of the variety of different aspects of distress expressed, but a few points are worth noting. Two other clusters that were nearly universal were feeling self-critical and craving support. Often these feelings were closely connected to feeling insecure, confused, or not in control as has been noted above. Other times, self-critical feelings or a desire for support did not seem directly connected to insecurity.

Self-critical. Linda and Terrence both felt disappointed in themselves about the way treatment terminated. Terrence said, "the whole thing just felt so bad and part of [it] was this sense that I had betrayed her, that I had let her down. Because ultimately I couldn't continue to be with her." Even though his need to terminate with this client was the result of his extreme sense of insecurity, Terrence struggled with self-reproach for not being able to satisfy his client's need for a consistent relationship that could withstand her anger. Terrence was essentially judging himself for feeling threatened. Yvette also seemed to judge herself for her feelings. When her own trauma memories and emotions flooded back during work with a client she chastised herself, saying "You've got to get a grip."

Edward described a sense of guilt when his client revealed how poorly she was actually functioning. In the midst of high emotions from client and parents, Edward

questioned himself. He said, “[there was] my own voice of ‘What have I done that it got this crazy?’” Later, as Edward came to believe that his client was idealizing him and their therapy relationship, he again felt an uncomfortable sense of responsibility. He said, “there is a way in which I collaborated with her, like ‘There is nobody else as special as me.’” The collaboration that Edward was referring to was his decision to make special arrangements for long-distance counseling. Edward felt a sense of guilt that he had encouraged his client to feel as though Edward were the only therapist with whom she could do good therapy work.

Like Edward, Howard’s sense of guilt involved his availability to his client, but it started with a chilling fear that he would be held responsible for something he had not done. Howard had experienced a panic when the client revealed her confusion that the relationship could be romantic. He said,

> I had some fear that I had done something wrong and I was going to get into trouble. A primitive, unrelated to reality sort of thing, like my mother's going to put me in time-out, or I'm going to be punished for something I did wrong that I'm not aware of. It’s very primitive and panicky.

Howard knew intellectually that there had never been sexual or interpersonal impropriety, but the question of it created a firestorm of worry in him. Although he was not “guilty” of the behavior his client was implying, Howard developed a sense of responsibility for the misperception which contributed to her confusion. He said,

> Somehow she's got this thing all really confused and it's going to make it look like I did something wrong – like I misled her. It's like a guilty conscience. And, in some ways I did mislead her. I did say through my behavior that I would take care of her, that I would be there at 2 o'clock in the morning, that I would make it all better. You know, she wasn't accountable. Life with me was easy.

Desire for support. The craving of support from colleagues and supervisors was also often linked to the feeling of insecurity. When Ronald discussed his process of accepting the reality that his client may leave and commit suicide he expressed frustration that he did not have the control to keep his client safe. In his words, "I had to let that be okay. That he could go and not come back. And I would call my supervisor and go 'HELP!'." Howard actually involved his supervisor to help resolve the confusion, however, he also expressed the emotional importance of communicating with other therapists. "I remember feeling good about being able to tell my side of the story," he said.

Other therapists expressed their need to not feel alone with secrets or horrifying information. Amelia spoke of debriefing with supervisors and colleagues. "It almost felt like I had to cleanse myself because what he was talking about was so horrible and it was about a current situation." Max consulted with a colleague to help him cope with the burden of being the only witness to his client's sadness, especially early on when he had not yet found a way to connect with her. He described himself, before coordinating this ongoing support as "isolated with the information, just like [my client] was isolated with her secret."

Terrence's experience of contacting his officemate immediately after sessions is another example of a therapist who was desperate not to be alone with a disconcerting clinical situation. He recalled this as a distinct part of his experience.

> I remember feeling such a strong need to have other people with me in this. That was part of what led me to consult as much as I did. For a while after almost every session I got with my officemate. Because I just felt like I needed somebody with me.

Like many of the other participants, Terrence's consultation had both practical and emotional purposes. He sought guidance from colleagues about methods to address his client's dissociation, but he also sought a very basic sense of comfort and companionship for himself.

Tammy told me she "did a lot of consultation with colleagues" which served to address her confusion about her client's behavior as well as her own emotional responses. She processed feelings of "anger," "revulsion," and "disgust" for her client. She said, "These are not feelings I enjoy having about a client." Colleagues provided "support around the intensity of my responses to him." Tammy was upset and disoriented by her feelings. She was particularly troubled that, in order to tolerate the work, she would have to introduce limits to how much she would listen. She found support from colleagues around this change in her practice style which was an effort to balance her client's needs and her own.

Thoughts and Feelings of Distress: Summary.

The thoughts and feelings of distress that arose in therapists as part of feeling in too deep ranged considerably. The one universal cluster of emotion was feeling insecure, confused, or not in control. At some point, each of the participants expressed one or more of the emotions from this cluster. Sally, who self-described as feeling ***in deep*** but not ***in too deep,*** is the participant whose experience of this cluster was the most circumscribed and time-limited, early in the work. All of the other participants experienced these feelings after already establishing a working relationship. The triggering experiences ranged from recognizing that clients were misperceiving therapists, to the recognition that clients were more emotionally challenged than therapists had previously appreciated, to not

understanding what was happening when a client expressed extreme violence, and not being able to stop the client from dissociating. Other experiences of insecurity included the reality that therapists had no control over the consistency of the client coming to therapy, and having to proceed in high-risk situations without standard strategies that the client seemed unable to tolerate. One therapist actually ended the therapy relationship because he felt insecure about his safety with the client. Another therapist was confronting confusing emotions that she related to her own past trauma. All of these experiences elicited confusion, insecurity or a sense of not being in control for the participants. Many other distressing experiences were associated with feeling in too deep. Two nearly universal feelings were guilt or self-criticism and craving support or the need to not be alone with the situation. Other clusters of distress that at least four of the participants identified with included feeling frustrated, anxious, overwhelmed or drained, unresolved about termination, and the cluster of scared, threatened, fearful or under attack.

Challenge in Connection

The second core theme which was found in the data from all participants was the theme of challenge in connection. Like the theme of thoughts and feelings of distress, challenge in connection emerged over the course of analysis. It began with the awareness that the sense of connectedness between therapist and client was central to the story each participant told about feeling in too deep. Reviewing each analysis, I summarized each participant's experience of connection in this therapy work and later I selected representative quotes. When I refocused on the summaries and quotes to identify patterns in the experience, I noticed the universality of a sense of challenge or struggle that corresponded to the experience of connection.

Some participants (Terrence, Edward, Linda, Howard) revealed how their work was beset by challenges in forming a genuine connection. Others (Sally, Amelia) spoke of the challenge of letting it go. Still other participants (Max, Ronald) expressed how their work depended on the formation of connection. Tammy shared her struggle to maintain connection and how the strong connection already established with her client made it so much harder to manage the change in their work. Finally, Yvette described responses to her own feelings that likely limited her relational connection to the client. Table 3 presents how different participants experienced different challenges in connection.

Table 3

Challenge in Connection

	Participants									
Challenge	E	Te	A	H	L	Ta	M	R	Y	S
Missing or Flawed	x	x		x	x					
Sacrifice			x							x
Need to Affirm or Achieve							x	x		
Struggle to Maintain						x				
Inhibition									x	

Like emotions, it seems intuitive that a theme relating to connection would result from this study. Therapy is essentially an interaction between at least two people and the relationship between therapist and client(s) is an important part of their work. In the present study, connection is considered to be a healthy, caring, and meaningful bond between therapist and client. The word evokes commitment, respect, and mutuality. I

chose to represent this theme with the word “connection” rather than “relationship” very consciously. I noticed that, although not exclusively, connection was the word more often chosen by participants when describing their experience. I also considered the meaning of the alternative word, relationship, within the field of psychotherapy. Although there is nothing wrong with the word itself, it could connote prescriptive role relationships, such as when clients play the role of client and therapists play the role of therapists. In that situation a therapy relationship could be mistaken as something that must fit a certain mold to be appropriate. My interest was to capture the meaning of my participants. Their words most emphasized the quality of the connection that they felt rather than the appropriateness of the relationship using external criteria. It is also worth noting that I did not consider the term alliance. Although therapists frequently use this related term in professional circles to denote an achievement in the therapy work, it is more descriptive of the productivity of the work rather than the human experience of the interaction. The term alliance was also used by only one of my participants and only once in his interview.

Missing or Flawed Connection

Four of the participants described a connection with clients which was in some way flawed or missing. Traditionally phenomenology focuses on eliciting the lived-experience of participants, thus, I questioned whether participant awareness about this flaw was part of their experience or whether it developed later, upon reflection. One of the particular challenges of exploring human experience is that it does not exist with clear boundaries. It is not easy to know what delineates therapists’ experiences of feeling in too deep from their responses to feeling in too deep. However, it seemed that all of four of these participants recognized the existence of a problem in their connection with the client.

Three (Terrence, Edward, and Linda) seemed to gain an awareness of what the problem was during the experience, whereas Howard developed his understanding of what the problem was later, upon reflection.

Of these my participants, Terrence addressed the theme of connection most directly. He described it as what was missing in the work with his client. When he sensed that his client trusted him completely and very quickly, he questioned whether she was, in fact, relating to him. He wanted to slow down their work to give themselves time to establish a strong connection which he felt was necessary to keep them grounded when she explored painful memories. In explaining the value of the connection, Terrence said, "It feels like that connection sort of undergirds or supports what could be pretty scary work, difficult work, or intense work. And it felt like I didn't have that with this client." Without the foundation of connection, Terrence felt distanced from his client and unable to help her as she increasingly dissociated in sessions. He also was clear to state that the experience of connection was not only needed to support the client, but also to support him during the work.

Like Terrence, Edward's experience was of a missing connection. He realized during this therapy work that his client had concealed her symptoms, idealized him, and distorted much of what he said in sessions. Edward recounted thoughts he had, "I've had a relationship with this person and she's been lying to me. Why? Why would she do that?" Given the time-limited nature of their work, Edward decided that it was not in his client's interest for him to strip away the misconceptions wrapped up in the idealized relationship. He theorized that, for some reason, his client needed the connection to the idealization at that time, rather than to experience the real relationship. Despite his own discomfort with

being misunderstood, Edward accepted the limits this need placed on the connection that he and his client could have.

Linda also experienced a flawed connection with her clients. She was working with a family and recalled a change in her own behavior when they first met. “I had already formed an allegiance, an alliance in some way, with the girl – and had formed an assumption that this mother was missing the boat with her.” Linda recognized that she had changed her own practice style by becoming committed to one client above the others. Her connection with the girl was so strong and sudden that, according to Linda, she lost objectivity and the ability to recognize pathology in the child. Whereas Terrence experienced the lack of connection because his client assumed the relationship without developing it, in Linda’s case, it was the therapist who assumed relationship. She described how she appreciated that the child was experiencing an invalidation of her worldview. Linda said, “I think at some level I kind of identify with her and that may have spurred my eagerness to latch on and protect her.” When Linda recognized that she had lost objectivity she sought to quickly reestablish equilibrium, but by that time she had lost the opportunity to form connection with the parents.

Howard also experienced a flaw in the connection between therapist and client. He felt a great deal of responsibility for her and had gone to great lengths to be available to her. He took late night calls and even added hugs when she asked for them to be part of their routine. It is likely that Howard did not sense the problem in his connection with the client until it became apparent that she was confused about the nature of their relationship and the meaning of the hugs. It was then that Howard panicked and sought support of colleagues and his supervisor to clarify the situation. Howard suggested that, at the time

of the work, he believed his client needed him to take responsibility for her. However, he later came to believe that his behavior created an imbalance in the relationship. Eventually he recognized that a healthier connection required more balance. Rather than managing all of his client's needs, he should actually hold her accountable for her behavior in their relationship.

Sacrifice of Connection

For both Sally and Amelia a considerable part of the experience of feeling in too deep had to do with the drama involved in needing to sacrifice connection. Both therapists identified as being a solid, consistent, caring relationship in their clients' lives and for very different reasons they both needed to end the connection. Sally's client was leaving the area and she believed that he needed to establish a new therapy relationship in his new location. She didn't believe he could engage in the kind of treatment that he needed if he continued to have contact with her, and despite the great deal that she cared for her client, she knew that the ongoing contact could become overwhelming to her. She said, "What's really hard about that was really being the one who had to insist on the goodbye part." Sally explained that it was not her style to be so firm about an ending. Moreover, it was particularly difficult to completely terminate such a powerful connection. In fact, she struggled in discussing this case as feeling in too deep in part because she believed that the connection itself, and the client's awareness of her caring, is what allowed for so much growth to take place.

Amelia also felt that she had to take an action which would end her connection with the client. Due to the client's need to work only in crisis, Amelia and he had never established a regular routine. Nevertheless, Amelia knew that she was the only person who

knew of his "horrific" secrets. She felt honored to be trusted and quickly developed a powerful "protective" and "nurturing" response to the client. It could be argued that Amelia's connection was unbalanced like Howard's. They worked according to the client's crisis needs and Amelia could never say no, even after she would have normally terminated the client for missed sessions. Ultimately, Amelia was faced with the very difficult challenge of showing her caring by taking an action that she expected would alienate the client and destroy their connection. Her client reported suicidality, intent, plan, and a failed attempt with expectations to try again. Amelia explained why, in addition to her ethical responsibility to report, she felt she needed to attempt hospitalization at that point,

> When it came to him, it was part of the corrective relationship that needed to happen. He had been not listened to and ignored in the past. There's no way I could listen to this and not do what any caring, loving, connected person would do for another person. There was no way. He could not see me for ever, for the rest of his life. But I kind of hold onto something inside of me that says, he knows on a deeper level that that was done out of love. That was done out of care and concern for him.

Need to Affirm or Achieve Connection

Two of the participants emphasized that their experience of feeling in too deep involved a tremendous need to establish or re-affirm their connectedness with clients. Both Max and Ronald worked to keep their clients safe from suicide and both spoke about the sense of connection and relationship as their most powerful tool to do so. In fact, Ronald believed that standard options of risk assessment and involuntary hospitalization were not options for him because they interfered with his client's sense of connection and relationship with him. He said, "there were time where the connection with me was what he was holding onto and I knew it." So it was when Ronald felt the sense of connection

slipping that he became most frightened, and he found himself needing to fight his instinct to use the standard practices which he found could push his client away from him emotionally. “It taught me not to armor myself when I'm scared. And not to step back from people just because I'm scared. That it is important for people to know that they have an impact on you.” Another dimension to Ronald’s experience of connection with this client was his belief that the client needed to see and feel more of an effort from Ronald to trust enough to begin to expose his own emotions. With that understanding, Ronald was willing to put forth more of the effort in the relationship than he normally would so that his client could begin to form connection with him.

Like Ronald, Max also found himself most frightened when he realized that he was working with suicidality and not feeling the sense of connection with his client. Like Amelia, Ronald, and Sally, when Max started the work he knew that his client had no other resource in which to trust. He made an extra effort to form connection with her due to her need, and yet, for a long time Max struggled. For weeks his client was unable to verbalize her sorrow and desolation. Max knew she was considering suicide and he felt desperate to form a connection with her that he could use to help her stay safe. He explained,

> It’s the suicidal and won’t connect that makes me panic, because I don’t have a way in and I don’t have any idea how I can help them. And so that’s when I start feeling hyper-responsible. Like I better figure out something quick. I better not let this person leave my office knowing they want to die and not having made a connection.

Struggle to maintain connection

The challenge regarding connection in Tammy’s experience of feeling in too deep was twofold. The client’s violent content made it hard for her to maintain connection, but

she also found that the closeness they had already developed created a more intense situation for them to navigate. After working intensively with a client for many years, Tammy found herself caught off guard when the client both disclosed previous behavior that bordered on abusive, and became passionate in his need to process angry and violent thoughts about his therapist. Tammy struggled to continue her sense of connection while processing the client's revelations and "rageful fantasies." She minimized her responses to the client while she took time to determine what was happening. Tammy said, "I did not lose empathy for his position, but that sat alongside moments of revulsion. Is that too strong? That may be too strong. Anger? I don't know, some set of emotions that weren't positive." Although these distressing feelings challenged her connection, Tammy worked to maintain it. As she said,

> It mattered very much for me to be there for him. Somebody I had known for a very long time, that I cared about, that I felt we had done good work together, and I didn't want that to get derailed. And I don't think that it did, but it could have.

Tammy also recognized that she and her client were experiencing a powerful and painful interaction that actually could be considered the result of having such a close relationship. The client became aware of a change in the personal life circumstances of his therapist and became "furious." According to Tammy, "My history with him, and the length and intensity of that, and the closeness, there was certainly a connection that perhaps if I hadn't been so connected with another client it maybe wouldn't have had the same impact."

Inhibition of Connection

The participant whose experience of feeling in too deep seemed to least involve connection was Yvette. She did not use the words "connection" or "relationship" in her

interview. She discussed a case that involved a trauma history reminiscent of her own, which evoked painful emotional memories. Yvette felt the need to "contain" her emotions in order to be present with the client. By doing so, however, she was unable to utilize her emotional responses to inform the therapy as was her practice. She said, "I just kind of went with the flow and you know, did therapy, but without my experience being with her. Whereas, if it had been someone else, maybe I would have done that." Although Yvette did not explicitly raise the issue of connection in her interview, it appears likely that her need to distance emotionally could have created an obstacle to forming a close connection between them.

Challenge in Connection: Summary

A second core theme of the experience of feeling in too deep was challenge in connection. Nine of the ten participants discussed their sense of connection directly. The one participant who didn't, explained a need to limit her own emotional experience which could have inhibited a sense of connection between client and therapist. Some participants struggled with a sense that there was a flaw in the relationship. Three of those therapists explained a feeling that clients idealized them or trusted too quickly which led to a sense that the connection was empty or false. One therapist herself "aligned" too quickly and lost objectivity. Two therapists decided that they had to sacrifice the connection because of the client's needs. Two other therapists, working with suicidal clients, experienced a desperation to establish or re-affirm connection. Finally, one therapist recognized that the strong sense of connection already established contributed to her emotional stress in managing new violent content and maintaining her sense of connection alongside very powerful feelings of distress.

Although there was a sense of challenge or struggle related to all of the therapists' experiences of connection in these cases, connection itself was by no means a universally negative experience. In fact, Sally found it difficult to denote this case one of feeling in too deep precisely because the connection which was painful to sacrifice had been such a powerful healing element for her client. She said, "I felt more progress was made in the therapy. That there is something about the connection - that I cared about them and really had their best interest in mind is what made the difference for them." Similarly, Amelia said,

> That is the crux of it for me. For me the best therapy is when you are friggen' connected with the client. I mean, that's just a complicated thing. Where do you draw the line on being connected or becoming too close.

Altering Personal Style of Practice

A third core theme represented by all participants was altering the personal style of practice. In some fashion each of the therapists described this work in which they felt in too deep as involving something that was new for them. Most of the therapists spoke about the decision to take a particular action as a conscious choice so it appears that most were aware that they were working in a different fashion than would be their norm. Because the participants conveyed awareness of the newness during their work, the theme of altering personal style of practice is about their lived experience rather than a similarity of circumstances. There was diversity among participants about what kind of change they were making in their style of practice. The categories that emerged within this theme were: new issue, termination, limiting, client request, and connection. As was noted about other core themes, it is difficult to determine the boundaries of the experience of feeling in too deep and thus it could be argued that changes in practice style preceded the

experience, were prompted by it, or both. Focusing more on the experience of the participant and less on the chronology of actual events, all participants seemed aware of the newness of a practice behavior that they connected to the experience of feeling in too deep. In the following paragraphs I will highlight the five categories of this theme, touching on how altering personal style of practice was experienced by each of the participants. I will also note connections between this core theme and the other three as appropriate. Table 4 identifies which participants experienced which categories of this core theme.

Table 4

Changes in Style of Practice

	Participants									
Changes	E	Te	A	H	L	Ta	M	R	Y	S
New Issue							x			x
Termination		x	x							x
Limiting	x					x			x	
Client Request	x			x						
Connection					x			x		

New Therapeutic Issue

Addressing a new therapeutic issue was central to the experience of both Max and Sally. In fact, both felt the need to seek expert consultation because the clinical situation of the client was so unfamiliar. Also, both therapists addressed their limited previous knowledge directly with their clients. As Sally told her client, “This isn’t work

that I typically do. I'm learning with you." For both Max and Sally, taking on these clients led to feelings of insecurity in that they did not rely on a familiar treatment approach. Max took on his client because he felt certain that she was isolated with her problem and did not have the resources for treatment elsewhere. He said, "I took her anyway, even though I had a hunch from the beginning that I'm going to be in too deep here. I don't know enough. I took her knowing that I was going to need consultation, was going to have to read."

While both Max and Sally emphasized the newness of the clinical experience, however, as the interview proceeded it became clear that more powerful feelings were linked to other aspects of the work. For Max it was the frustration early on of not being able to create a connection with his suicidal client, and never feeling "out of the woods" throughout the work. For Sally it was the need to sacrifice connection and be the one to "insist on goodbye." As described previously and as will be noted again in reference to the core theme of balancing, Sally approached the end of therapy with this client differently than she had with others by being more firm about boundaries.

Termination

Like Sally, two other participants sensed a change in their own practice style related to therapy termination. Terrence also enforced an ending; however, unlike Sally's client who wanted informal ongoing contact, Terrence's client wanted to resume therapy. The extent of his feelings of insecurity after her revelation about violent intentions made that impossible for Terrence. It was painful for him to deny her the connection with him, but he knew that he could no longer provide the treatment she needed. Terrence had to balance his own need for security with her need for a resilient therapy connection. He said,

"She actually wanted to continue to work with me when she got out [of the hospital] and I wasn't willing to do it. It is the only time that I've made that decision." This change in behavior for Terrence was linked to his feeling of insecurity, but also to the resulting self-critical feeling that he had "betrayed" his client.

Amelia also recognized a change in her therapy practice regarding endings; however, the first difference for her was that, for much of their work, she did not enforce the ending. Her client had a need to come in crisis and, because Amelia was so drawn by the needs of this client, she was never willing to enforce her center's rules about missed sessions and therapy termination. She told me,

> that's another thing that I wasn't used to. I never said when he called, 'I'm sorry. We're finished. You had a certain number of times and you didn't show up and now my caseload is full.' I never did that. I never could say that. I never could say that.

Amelia spoke of how the client's crisis style meant that their work was intermittent, which was not her norm. It also distracted her from working on their interaction itself as a therapeutic issue as she normally would have. However, she noted that she was not consciously aware of the process issues that she was not addressing during their work. In fact, the realization was not made until speaking about their dynamics at the time of our interview.

Amelia did ultimately initiate the ending with her client by taking an action that she had never taken before, attempting to hospitalize. She described that dramatic ending as very difficult, but also very clearly what she believed her client needed. By sacrificing their connection, she hoped her client would experience how much she cared. If the hospitalization attempt is understood, as in Amelia's words, to be "part of the corrective

relationship that needed to happen" it was in line with her style of practice to show her client that she cared. The specific actions she took to do so in this case, however, had never been previously required of Amelia.

Client Request

Two of the participants, Edward and Howard, changed their personal style of practice by adding something new at their client's request. Edward resumed therapy with a client who contacted him and requested to continue their therapy work by phone after she had moved away. They agreed about the need to switch to a local provider if certain symptoms re-emerged. Things spun out of control after the client withheld information about her functioning and Edward was left to coordinate her move back to the local area for intensive treatment of her primary symptom issue. During that work, Edward recognized how much his client had distorted their interaction in an effort to "idealize" and "protect" the relationship. Edward said, "I'm going to think a lot harder before agreeing to do phone sessions with someone who's out-of-state. I don't know that I would, except under time-limited circumstances."

Like Edward, Howard changed an aspect of his therapy practice style at the client's request. Also like Edward, it was later in his work with that client that he felt in too deep. Howard's client told him about a friend whose therapist gave her hugs. He told me, "Somehow she was making the case that it would be good for me to hug her. So we started doing that. Kind of a therapist hug at the end of sessions." Years later this client became confused about the nature of their relationship and the significance of the hugs. Her insinuation of a sexual dynamic caused Howard to feel confused and panicked. Howard arranged for the client to meet with another therapist and his supervisor to

process her confusion. Although Howard did not explicitly state that having a client meet with his supervisor was a change from his style of practice it is very likely that this was another change in practice style for him.

Limits

Three of the participants, Edward, Yvette and Tammy, changed their practice style by introducing limits in the therapy work. As described previously, Edward had altered his practice of therapy by agreeing to phone therapy. Another change in practice style for Edward was his decision not to discuss the relationship issues with his client. This could be seen as a limiting behavior, but unlike Yvette and Tammy, it was not intended to create more comfort for the therapist. In fact, it is Edward's preference to address interpersonal dynamics with clients, but he decided that he could not do so in this case and still address the therapeutic needs of his client who needed to focus on brief work and then prepare to move away again.

Yvette found herself identifying with her client's traumatic experience and reliving her own. As described in a previous section, Yvette felt a lack of control with emotions that were confusing and frightening. She fought to minimize the extent of her own experience and, contrary to her normal practice style, she kept her experience out of the therapy process. She said, "I didn't use those feelings in session. Since I was trained in [that] model, it's what I use, but I didn't do any of that." While it is clear that Yvette was uncomfortable with the feelings aroused by this work and felt a need to contain them for her own emotional safety, she also believed that they could also be detrimental to the client.

Tammy also introduced a change in her practice style to limit her own exposure and feelings. Like Yvette, her personal life was activated by the client's content. However, whereas Yvette was identifying with the client as a trauma survivor, Tammy was being forced to see her client as a possible abuser. Given Tammy's personal life circumstances, this content was particularly disturbing for her. The client also expressed "rageful fantasies" about the therapist and her family. Tammy worked through her feelings and responses with colleagues. She described her decision to change her style as setting "a boundary that was somewhat uncomfortable for me; an internal limit on how much I was going to explore with him about his reaction to my [family]." She explained the change, "Normally, if a client brings anything to me, grist for the mill, as they say. I think a client should be free to bring in anything and I'm there to sort of work through it." However, during this work Tammy felt that she needed to impose some limits to contain how personally threatening the content could become. It was a difficult decision to make and she sought consultation, in part, to accept her decision to strike a balance between the exploring that her client needed to do and the limits that she needed for herself.

Connection

The two therapists who altered their personal style of practice with regard to therapist-client connection were Linda and Ronald. As described above, Linda became quickly aligned with one member of a system. She recalled being aware of her instant allegiance "The intake is when I noticed that I was going to be in a little deeper." Later she said, "I saw myself starting to take sides, starting to advocate on behalf for her own individual freedoms, and for her independence. So I think I got in way deep." Linda

credited the imbalance of her alliance with a sense of confusion and loss of objectivity regarding client pathology.

Ronald also changed his practice style by increasing his connectedness with a client. He found himself working with a suicidal client who he believed needed their sense of connection desperately. Moreover, whenever Ronald enacted standard risk assessments for suicidality his client lost the sense of their relationship. Ronald said,

> You know when someone's really, really suicidal, of course we all click into our automatic questions, and our automatic questions cover our ass, but they're not in relationship anymore. And so he felt dropped in the moment. And he was. So I learned a lot about – about not letting my fear guide me.

Because Ronald believed that his client's best chance at healing and survival from suicidality rested on the strength of their connection, Ronald was challenged not to rely on standard resources and his typical approach. He said, "I really needed to not retreat from him. As scary as that was, I needed to just trust that there was something bigger – that our work together was something we could rely on." While approaching someone's threat of suicide with relationship was new and frightening to Ronald, he truly believed that it was their only option.

Altering Style: Summary

The ways in which the ten therapists of this study altered their personal style of therapy ranged considerably, but all were clearly aware that something about their approach to the work was new. Moreover, they were all aware of changes in style during the course of the work, making it part of their lived experience. One change was as simple as taking on a new therapeutic issue and it was highlighted by the therapists who did it, even though those therapists also expressed more emotion regarding other aspects of the

work. All other changes in personal style seemed more central to the emotional experience of feeling in too deep. Two therapists utilized a different approach to connection with clients, which seemed necessary to the therapists, but was also associated with their sense of insecurity or lack of control in the work. Two therapists added an element to therapy based on client request and later related those behaviors to client misperceptions which they could not control. One of those therapists also noted the change of not addressing interpersonal dynamics with the client. Two therapists added limits on their work to minimize the impact of threatening content. Three therapists addressed therapy termination in ways they had never before. One of the three both bent her setting's rules about termination and eventually enforced one, all of which she found to be emotionally draining. The other two participants also enforced an ending and expressed considerable sadness for how the clients were impacted.

Balancing

The final core theme is balancing. All of the participants expressed some way in which this case forced them to weigh different needs or goals. Most participants needed to balance the client's needs against their own. At times balancing was required in terms of considering the different needs of the therapist, or different therapeutic strategies. Like the three other core themes, balancing conflicting needs or goals was part of the conscious, lived experience of these therapists. Nearly all of the issues that therapists were balancing have been touched on in previous sections as they related to other core themes. Therefore, this section will only reiterate the way in which the different therapists in this study found themselves balancing as part of their experience of feeling in too deep. Table 5 identifies which participants experienced which aspects of balancing as part of feeling in too deep.

Table 5

Balancing

Aspect	Participants E	Te	A	H	L	Ta	M	R	Y	S
Therapist Safety		x				x			x	
Sacrificing Preference	x						x	x		x
Therapist Support							x			
System Members					x					
Caretaking & Client Accountability				x						

Therapist Safety

For 8 of the 10 therapists balancing involved a sense of having to choose between the needs of the client and those of the therapist. Three participants (Terrence, Yvette, and Tammy) found that they ultimately had to choose to protect their own safety. Their experiences provide an interesting range regarding perceived threat. Tammy's client revealed violent fantasies about Tammy and her family which made her particularly uncomfortable. Yvette found herself re-experiencing her own trauma through a similarity with her client's trauma history. Terrence learned that his client had brought a concealed weapon to his office and had been prepared to use it on herself. All of these therapists struggled to honor their own need for safety as well as their client's need for healing. The most difficult challenge was when the very things which could help them feel safe did not seem to be the best for the client.

Tammy recalled that she approached her sessions with a "heaviness of knowing that I was going to have to sit and listen to more of this." She thought, "We've got to process through this. I can't shut this door; this has to be talked about." However, she also realized that she had a lower tolerance for this particular violent content at this time in her life and ultimately decided to limit her exposure. She told herself, "I'm setting this boundary and I don't know if this is optimally therapeutic or not, but this is where I'm comfortable – there is only so far I will go."

Yvette also decided to enact a limit that was not her norm, however, for her it was how much of herself she brought into the session. Yvette was trying to minimize how much of her feelings she shared because she was feeling entirely too much. Her own traumatic history was so similar to her client's and her in-session emotion felt powerful and dangerous. She pleaded with herself to "get a grip," and reminded herself "to be contained and managed." It was Yvette's therapeutic approach to use her feelings to help clients understand their own, but given how destabilizing her own feelings were, she felt she could become lost in them. On some level she also believed that her feelings could compromise her ability to help her client, so limiting them was both a choice to protect herself and to do the best that she could for her client.

Terrence's experience of balancing was similar to Yvette and Tammy in that he was forced to choose between his own safety and what he believed was best for his client. All of these participants actually spoke of their decision as being ultimately the best that they could offer for their clients. Whereas Yvette and Tammy imposed limits to protect themselves, Terrence chose to end the therapy relationship altogether. Part of their work had included Terrence encouraging the client to feel safe enough to express her anger with

him, while assuring her that he would not leave her because of it. However, after learning of her preparedness for violence, Terrence felt too unsafe to continue. He said,

> Ultimately, there is a way in which I couldn't be with her in her anger, in which it was overwhelming for me, in which it did keep me from being with her. And I don't think there was any way around that, but the whole thing just felt so bad.

Like Yvette who worried whether she could be helpful to her client if the trauma memories became too vivid, Terrence worried whether he could be helpful to his client while feeling so unsafe with her. His decision to end the therapy relationship was therefore both about his need to take care of himself, as well as his belief that he could no longer provide the therapy relationship that his client needed.

Sacrificing Preference

Five participants (Edward, Ronald, Amelia, Sally, and Max) experienced balancing as having to sacrifice their preferences or comfort in order to honor their client's needs. Edward, for example, struggled to tolerate being misperceived and misrepresented by his client. After coordinating for the client to return to the area for temporary, specialty treatment, Edward recognized how much of their interaction was being misconstrued by the client. He told himself, "She's carrying a person who's not me with her." Edward felt "entangled" and wanted to process this dynamic and help his client experience the relationship more realistically. However, because their work was time-limited and the client was focusing on a separate presenting issue, Edward sacrificed his own preference and did not challenge his client's misconceptions. As he told me "Idealizing me helps her hold it together and gives her something that she's felt like she's needed, and I need to respect that. So it helped me pull back."

Like Edward, Ronald also believed that his client could not tolerate the frank discussion that he wanted to have, so he decided it would be in his client's interest to sacrifice that goal. Ronald's client was suicidal and felt "dropped" whenever Ronald sought to assess for risk. Ronald would have preferred to clarify his client's intentions, but simply asking the questions created a sense of emotional distance between them that he believed his client could not tolerate. Ronald also believed that "If I ever forced the hospitalization, he'd be out of there in 10 minutes because he knew how to. He's smooth." Moreover, the trust and connection that they had built would be destroyed and Ronald knew that their relationship was his best tool to keep the client safe. Consequently, Ronald gave up the expectation that he could use risk assessment or involuntary hospitalization as tools for managing this client's suicidality.

Amelia balanced her own preference and her client's needs regarding structure. Amelia's client was in a complex and ongoing abuse situation. Therapy was so painful for him that he only came when he was desperate. Amelia said, "There was a lot of struggle with him coming or not coming, and he only wanted to come in crisis. Well, it's not my norm and it's not most clients' norm either." Nevertheless, Amelia found herself resuming work with the client when he surfaced after multiple missed sessions. As her client's only confidant, Amelia refused to turn him away and therefore decided implicitly that she would work around her client's crisis needs.

Sally also struggled to balance her own preference and her client's needs regarding structure. For them, it was the structure of termination that presented the challenge. When the client had to relocate, Sally believed that he needed to establish a therapy relationship in his new setting and she felt certain that ongoing contact with her would make it

impossible for her client to commit to something new. She would have preferred to allow him the flexibility to contact her about his progress and for her to be able to continue to show him that she cared. With other clients she could leave the door a bit more ajar, but with him she believed she had to be firm. She said, “I think it was trying to figure out what he needed. Some of it was what I needed too, because I didn’t feel comfortable with continuing a connection that felt too much like blurring the boundaries.” The more this client pulled for ongoing contact the more Sally recognized the importance of closing loopholes. She ultimately closed her email account because her client was so eager to continue sharing articles and thoughts. What makes the balancing in Sally’s case unique is that both therapist and client actually wanted the same thing, but the therapist decided they both really needed the opposite. Both wanted contact, but Sally knew that gratifying his desire even a bit led to him wanting so much more. It could easily become overwhelming for her and it would not have allowed the client to separate enough to connect to a new therapist.

Therapist Need for Support

Max’s balancing arose twice in this case. Primarily Max spoke of balancing two different needs that both arose in him as the therapist. However, (like Sally, Edward, Amelia, and Ronald) Max also sacrificed some of his own comfort and preferences to accommodate his client’s needs. When this client first presented at Max’s center, she described a very complex issue of sexuality in which Max did not have expertise. However, Max knew that the client was suicidal, and referral to an outside provider involved risk that she would not get treatment. Her resource limitations were considerable and Max’s center was the client’s most reliable access to mental health care. So, for Max,

even taking the case was the result of balancing her needs and his comfort. The thought of working with a client in crisis without sufficient expertise about the presenting issue made Max uncomfortable, but her need for help outweighed his insecurity.

During this work, Max had to balance his own need for support. As he expected, he felt the need for consultation with a specialist to provide him with information, educational materials and an understanding of the process his client was experiencing. Despite the support, however, Max felt stuck. He said, "Nothing would catch me up fast enough, I thought, to be what I thought this person needed." In addition to technical support about sexuality, Max felt that he needed support for himself about working with a client who was so deeply depressed. He said, "I was looking for something concrete and tangible to hand her and so the information came first. Then I needed to address being with her, and taking care of the instrument of myself in terms of being with her." Max knew that his client was isolated with her secret, but he herself was also feeling isolated as the only person who knew her secret and the person who witnessed her pain. So in addition to honoring the client's need for treatment over his sense of discomfort by agreeing to take him as a client, Max was challenged to balance his own needs for both specialty and emotional support as he proceeded in the work.

Different Members of a System

While working with a client system, Linda found herself balancing her own perceptions of need within it and therefore her own alignment to the members. When she started working with this family, Linda was so quickly drawn to the child that she questioned whether the parents had any sense of their child's needs. However, by quickly aligning with this child against the parents, Linda lost her ability to appreciate their

perspective. In time, she grew to question her own position and asked herself, “What are you doing? What’s going on? Why are you defending your client in this way, against her parents? Are you her advocate really? You know, this is a whole family system, are you alienating the system?” Linda actually shared his struggle regarding balance with the mother when she said to her, “I find myself in that bind with her, whether to advocate on her behalf or sit here with what you want me to do, and whether that’s in her best interest.” She recalled that she was initially critical of anything the parents said, “then I recoiled. As I saw myself get in too deep I sprung back out and became ultra-objective.” Linda validated their belief that a psychiatric consultation would be appropriate. She explained thought disorders, which had been the parents’ concern, but they had already been alienated and they never returned to therapy. In this case, Linda was presented with the challenge of connecting with all members of the system. Her focus was imbalanced when she became so drawn to the child and, although she tried to rectify the situation later by validating the parent’s concern, she was not able to connect with them enough to keep them engaged in the therapy.

Caretaking and Client Accountability

If Linda recognized the importance of balancing during her work, Howard seemed to appreciate it as a lesson learned somewhat in the moment, but more fully in retrospect. Because of that, balancing was less a part of his lived experience of feeling in too deep, although he did identify a sense of not being balanced during the work. For Howard the issue was about balancing his caring and caretaking behaviors with the degree to which he held the client accountable for her behavior in the therapy relationship. Howard’s style was to take a great deal of responsibility for clients. He called clients to follow up on

scheduling changes and was accessible for calls in the middle of the night. He also allowed this client to avoid difficult conversations, such as processing her use of crisis phone calls. Howard told me that he struggled because,

> It feels good to rescue. It feels worse to hold people accountable. It's certainly harder on them, and therefore physiologically harder on me because I assume that I'm feeling their struggle and some part of me that brought me to this work wanted to make people's lives easier rather than richer [by] letting them suffer with whatever the moment's about.

However, this case taught Howard that his pattern of "rescuing" encourages clients to idealize him and misperceive their relationship, such as this client eventually did regarding hugs. Howard said, "I was doing too much and some of my caring was actually destructive or counter-productive. I honestly think I'll be working on that until the day I die – figuring out how to be nurturing, but also hold people accountable."

Balancing: Summary

The theme of balancing emerged for all of the participants as part of their experience of feeling in too deep. Overall, balancing refers to prioritizing needs wants or preferences of the different people involved in the relationship – the therapist and client or clients. Eight of the ten participants described a clear conflict between their own needs and those they perceived for the clients. Three of those participants decided to prioritize their own physical or emotional safety. The other five sacrificed their preferences given the extent of client need. One of these therapists sacrificed her preference for support within her own work environment in order to ensure this client would get treatment, and then described how she also needed to address balance in the outside consultation she sought. One therapist found that she had to balance the needs and wants of different members of a

family. Finally, one therapist recognized how his client's desire for caretaking and his instinct to provide care needed to be balanced by an expectation of client accountability.

CHAPTER FIVE: DISCUSSION

The present study was undertaken to explore a critical experience that psychologists may have in their work as psychotherapists. Ten practicing doctoral level psychologists discussed a time in which they felt in too deep with a client. The previous section presented individual situational descriptions for each participant as well as an explication of four core themes that emerged universally for all participants. One core theme of feeling in too deep was distress. Many therapists described their lived experience as involving self-criticism, a yearning for support, frustration, anxiety, or a sense of being overwhelmed. All participants experienced a universal distress cluster; feeling insecure, confused, or not in control. A second core theme was the challenge in connection within the therapy relationship. Some therapists struggled to form a connection that could keep a suicidal client safe. One found it difficult to maintain a close connection when disturbing information has been revealed. Others negotiated the difficult decision to sacrifice connection when it was deemed in the best interest of the client. A third core theme was the alteration of personal style of therapy. All therapists work in a certain comfort zone and it seems that, when they feel in too deep, the therapeutic style expands beyond that zone. Participants altered their manner of connecting to clients, added rituals or arrangements based on client request, imposed limits, and even took different approaches to termination. The final core theme, balancing, may be what makes feeling in too deep such a difficult and intense experience. All of the participants made difficult decisions about how to prioritize the wants, needs, or preferences of the different people involved in

the therapy relationship. Often, the client's needs conflicted with the needs or preferences of the therapist.

Despite the emergence of these core themes, the experience of feeling in too deep did not appear to follow a unified pattern for all participants. Because of the variability regarding how the four core themes took shape across different participants, a general structure for the phenomenon was not developed. Rather, what seemed to unify the experiences of participants was an ethical issue that emerged primarily in the core theme of balancing. The ethical issue also fueled aspects of the other three core themes.

Ethical Considerations.

The phenomenon of feeling in too deep with a client appears to be a profound clinical experience for therapists involving some awareness of a need to balance care for self and client, a challenge in the therapeutic connection, a sense of distress, and some change in practice style. Reflection on the specific experiences shared by participants and these core themes reveals that feeling in too deep may be a response to an ethical challenge presented by the clinical situation. There is an ethical timbre to the stories that participants shared. In no way do I wish to imply that any participant's behavior was professionally unethical. Rather, they seemed to find themselves in ethically challenging situations that were not easily resolved. Perhaps participants felt in too deep when working in a high stakes clinical situation in which a single, ethical, best practice was not apparent or did not seem possible.

Although participants were not formally queried about client diagnosis during the interviews, they all relayed information regarding clinical presentation as context for their experiences. It would be fair to state that, universally, the participants were working on

high stakes clinical situations. The imminent safety of clients was frequently uncertain. Five of the clients experienced active suicidal ideation and two of those clients attempted suicide. Other clinical issues included: complex matters of sexuality, ongoing abuse, PTSD symptoms, acute eating disorder, violent fantasies about the therapist and therapist's family, borderline dynamics, and adolescent thought disorder. Abuse histories were prevalent among clients. It follows intuitively that as dysfunction and safety risk increases, ethical concerns become more salient.

Only three participants actually used the word *ethic* in the data collection interview. Amelia spoke of her ethical responsibility to attempt hospitalization and her own personal ethics of demonstrating how much she cared. Linda questioned if advocating for the child against parents was ethically appropriate. Sally spoke of the ethics behind her decision to work honestly with a client who believed she was an expert and later to terminate with him. On closer inspection, even those who did not use the word still implied ethical concerns. Howard worried about misperception of their relationship as inappropriate. Max explained his decision to provide services for a suicidal individual when his expertise was limited, but the client's access to other services was extremely unlikely. Terrence feared that he betrayed his client. Ronald worried about the implications of breaking confidentiality due to suicide risk. Tammy sought to be optimally therapeutic given the limitations in what violent content she could tolerate. Edward questioned the scope of his responsibility when a client misrepresented her health then became very unstable. Yvette feared her own emotions could harm her client.

Most of the concerns expressed above overlap with the more complex and nuanced issues considered for each participant regarding the core theme of balancing. As

described previously, the needs or preferences of eight participants conflicted with the needs or preferences of the clients. In all of the cases, the needs or wants of different people in therapy relationships came into conflict and the therapists were challenged with the task of resolving the differences as responsibly as they could.

The established ethics of our profession offer little precise guide for what should be done in these cases (APA, 2002). Terrence could apply standard 10.10b when he chose to terminate a therapy relationship after experiencing a safety threat from his client. Max and Sally could both refer to standard 2.01d in choosing to accept clients requiring a new area of competence for which they sought consultation. Max's case is particularly fitting as the client may not have been able to access any services had he not been willing to stretch his own comfort and competence. All of the other dilemmas had to be approached creatively, keeping in mind standard 3.04 to avoid or minimize harm to clients, and general principle A of beneficence and nonmaleficence.

The general principles which begin the APA ethics document are "aspirational in nature" (APA, 2002, p.3). They are set forth as guides for professional behavior, not rules to be enforced. Principle A of beneficence and nonmaleficence actually refers to the potential for the therapist to experience conflict, "When conflicts occur among psychologists' obligations or concerns, they attempt to resolve these conflicts in a responsible fashion that avoids or minimizes harm" (APA, p.3). While this statement is broad and non-specific, the language seems to refer to various obligations that the therapist makes to others. Therapists must be attentive to responsibilities toward clients, students, employers, and professional organizations. However, the preponderance of therapists in the present study actually experienced a much more personal conflict

regarding their own needs and those of clients. Feeling in too deep with a client involves an internal struggle of balancing care for self and care for client, and honoring the conflict of interests that can emerge. The therapist's ethical dilemma is how to at once provide the best care for the client while also maintaining the needs and safety of the self.

The four core themes represent aspects of the experience of feeling in too deep that were common in the awareness of all participants. All therapists in the present study were aware of some conflict they had to manage. They were also aware of altering an aspect of their personal style of practice, having a challenge in connection, and experiencing feelings of distress. When asked about sharing anything about the experience with their clients, the majority of therapists responded that they did not discuss the meta-level of feeling in too deep. Some implied that their clients could not have tolerated such information. Now that the core themes of therapist experiences have been identified, the question must be considered again: could it be useful to share something about these experiences with clients? Are there instances in which being made aware of the therapist's experience, relative to one or more of the core themes, could be helpful to clients and to the therapeutic process? Therapists who are influenced by the theory of contextual therapy may recognize as a therapy goal the client's ability to become considerate of the needs of others (Goldenthal, 1996). With this in mind, it may be growth-promoting for clients to be exposed to the needs and boundaries of the therapist, especially when the therapist's needs appear to be in conflict with the needs or wants of clients.

Recent Literature on Therapist Experiences

Difficult Experiences

The proposition of being explicit with the client can be considered in light of the findings from the Orlinsky and Rønnestad study of clinical practice and professional development (2005). Researchers gathered questionnaire data from nearly 5,000 therapists from four countries and used factor analysis methods to identify therapist perceived difficulties and coping strategies. One of the identified constructive coping strategies was a cluster called *problem solving with a patient* in which,

> Therapists gave themselves permission to experience their difficult or disturbing feelings, shared their experience of the difficulty with the patient, and attempted to work jointly with their patients to deal with the difficulty. (p. 52)

It appears that this core coping strategy may have been generally deemed a clinical impossibility by the participants of the present study who sensed risk in the lives of their clients. It may also be true that such disclosure is simply not part of the professional style for some therapists, and thus the possibility of expressing their conflict was not considered.

Many of the instruments used in Orlinsky and Rønnestad's (2005) quantitative international research were based on qualitative work by collaborators, such as Davis et al. (1987) who evaluated self-generated instances of therapist difficulty. The products of the Davis et al. research were ten categories that comprised a *taxonomy of therapist difficulty*. A brief review of these categories reveals considerable overlap with the phenomenological experience of participants in the present study who described feeling in too deep. The Davis et al. categories included: judging one's performance as inadequate, fear of harming the client, being unsure how to proceed, feeling a need to protect oneself from the client,

feeling unable to form a relationship with the client, when therapist personal issues interfere in the work, feeling stuck at an impasse in the work, feeling undermined by a client's purposeful behavior, having awareness of a painful reality, and experiencing an ethical dilemma. Using these ten difficulties as a lens through which to view the experiences shared by participants in the present study, it appears that most participants in the present study actually struggled with multiple overlapping difficulties in the course of feeling in too deep.

Findings from the large-scale, international, quantitative study also correspond with core themes from the present study. Questionnaire items based on the Davis et al. (1987) categories were generated and responses of the nearly 5000 participants were factor analyzed to reveal three broad dimensions of therapist difficulty: *professional self-doubt, frustrating treatment case,* and *negative personal reactions* (Orlinsky & Rønnestad, 2005). All three of these dimensions involve distressing feelings. Professional self-doubt most overlaps with the universal distress experience of insecurity in the present study. This dimension refers to being unsure of what to do, questioning one's ability to benefit the client, feeling a lack of momentum and an inability to access the root of the client's problem. The second broad dimension, having a frustrating treatment case, resonates with the core theme of balancing from the current study. It refers to distress over a sense of powerlessness to impact the client's tragic circumstances, being stuck in a static and unproductive therapeutic relationship, frustration over obstacles in the client's life and "feeling conflicted about how to reconcile obligations to a patient with equivalent obligations to others" (p.51). Participants of the present study mostly experienced a conflict between obligations to self and to client. Orlinsky and Rønnestad's third

dimension is negative personal reaction to a client which overlaps with both the core themes of distress and challenge in connection. Negative personal reactions from the Orlinsky and Rønnestad study include frustration with emotional neediness, difficulty generating empathy, finding personal values interfere in one's attitude toward the client, and inability to identify something to like or respect about the client. Altering personal style of practice is the only core theme from the present study not reflected by one of the dimensions of difficulty identified by Orlinsky and Rønnestad.

Aspects of feeling in too deep that were illuminated in the present study also overlap with a more recent study of reactions in therapist identified difficult situations (Smith et al., 2007). These researchers used an exploratory interview and qualitative analysis to identify categories of therapist reactions. It is notable that nearly all of their identified categories of therapist reactions were also represented in the narratives of the present study's participants. Many of the categories are reminiscent of thoughts and feelings from the core theme of distress. Both studies reported therapist confusion, anxiety, needing to talk, exhaustion, hyper-responsibility, anger, frustration or irritation, and somatic reactions like revulsion or feeling horrified. Some of the distress experiences from the present study that were not reported by Smith et al. may begin to distinguish what makes a therapist identified experience of feeling in too deep different from an identified difficult situation. These include: self-critical, scared or under attack, pain in ending, and misunderstood. Smith et al. reported a category of shock and confusion, however, it is not clear how much that category overlaps with the present study's universal distress cluster of insecurity, confusion, or feeling not in control. Three of the Smith et al. therapist reactions may be similar to the present study's core theme of altering

personal style of practice: “being more outreaching than usual”, “avoidance of the client”, “setting limits for the client” (p. 37). One of those items and two others also allude to the present study’s core theme of challenge in connection: “avoidance of the client,” “consciously regulating therapist empathy level,” and “not being able to empathize, feeling a great distance” (p. 37). None of the Smith et al. categories appear related to the present study’s core theme of balance in which therapists are at once attending to the needs and wants of client(s) and self. Also, none of the Smith et al. categories, including the overlapping distress items, were represented in their own sample universally. Thus, although many similar feelings, thoughts, and experiences were identified between these studies, the universality of the four core themes differentiates feeling in too deep from a therapist identified difficult experience.

Sexuality, What Was Not Said

The absence of reference to sexuality by participants is another parallel between the present research and previous research on therapist identified difficult experiences (Davis et al., 1987; Orlinsky & Rønnestad, 2005; Smith et al. 2007). When initially contacted for the present study, potential participants were asked to discuss an experience of feeling in too deep with a client. When we met, I heard the stories that they offered to share with me. As noted above, a variety of high stakes issues were discussed, but in no way can this contextual information represent an exhaustive list of the clinical or therapeutic issues in which a therapist might feel in too deep. It is notable that none of the participants revealed sexual intimacy with a client or any allusion to their own thoughts or feelings of sexual attraction. While the actual rate of sexual boundary violation by mental health professionals is extremely low, research indicates that the vast majority of therapists

have felt attracted to a client (Pope & Tabachnick, 1993). Given the emotional intimacy of the therapeutic encounter, it is logical that therapists would experience sexual thoughts and feelings regarding clients and simply never act on them. One might imagine that the professional who has any such experiences might feel in too deep with the client.

In my data, the closest reference to a sexual issue was a client becoming confused about the possibility of sexual implications from the routine of an end-of-session hug that she had requested years before. In qualitative research the absence of a finding is also considered a finding (R. Watts, personal communication, January 12, 2007). Pope, Sonne, and Greene (2006) address the therapist's sexual thoughts and feelings toward clients as a taboo topic. It is both a disservice to clients and to therapists themselves to be unwilling to explore this domain. In his candid interviews with psychologists and psychiatrists, Stout (1993) found many reports of attraction and some reference to actual sexual contact. One of his participants reported having sexual relations with clients after therapy termination, and many reported being told of the therapist-client contact of other professionals. The fact that the participants in the present study did not relate sexual contact with clients is likely because it has not happened. Since previous research (Pope & Tabachnick, 1993) demonstrated that the rate of attraction is quite high, that it did not emerge as part of the present data could indicate that therapists are still silenced by the taboo of the topic. They may have decided that any degree of confidentiality provided was insufficient to admit to sexual fantasy. Similarly, the sample might have self-selected for participants with more socially and professionally acceptable experiences to share. Another possibility is that the participants have had sexual thoughts regarding clients, but that these thoughts do not make them feel in too deep. As one of Stout's participants commented, feelings of

intimacy are natural, especially when you are working as an empathic, compassionate witness to another person's emotional pain.

Multicultural issues were also minimally raised by participants, and may be considered taboo by therapists. The risks of overlooking cultural issues in therapy have motivated the American Psychological Association (2002) to include appropriate consideration of them part of the profession's ethical guidelines. In the present study, one participant, Linda, actually suggested that cultural assumptions may have interfered with her understanding of the client system. Two other participants, Max and Ronald, also commented on culture as a part of their understanding of the client's experience. Given that this topic was not pursued in the present study, it would not be appropriate to comment on whether or not participants overlooked this issue. Nevertheless, culture is an issue that we do ourselves and our clients a disservice by avoiding. Like sexuality, we also might find ourselves feeling in too deep when we avoid rather than explore culture. Therapists who hold culture as a taboo may not be aware of internalized stereotypes or cultural norms. Strain in the therapeutic relationship may arise when therapists act on their own discomfort with difference and project that onto the client, assuming that the client would be made uncomfortable by such topics. The result is the therapist's avoidance discussions of difference whether cultural, racial, sexual-orientation, or class. Pseudo-familiarity, or instant intimacy may arise from the therapist's attempt to create a relationship by denying his or her own discomfort. In addition to the loss of an opportunity to explore these areas, therapists may also fail to recognize the client's awareness of their discomfort and avoidance.

Participant Lessons

All of the participating therapists were asked how the experience of feeling in too deep was helpful to their client's therapy and/or their own professional development. Although reflective questions like these do not fall within the purview of traditional phenomenology, it seemed a great potential for lost learning not to ask. As a rule, mental health professionals probably explore the meaning in personal and professional life experiences more instinctively than others do. If it is human nature to create a narrative of experience, therapists are even more natural meaning-makers. When participants were asked to comment on any positive impact of their feeling in too deep, their responses were as varied and intriguing as the clinical situations in which they found themselves. Many spoke about what they learned. Quotes referencing the lessons identified by participants are presented in Appendix A.

Overall, the professional lessons learned were insights that can be categorized as statements about the benefit of acting similarly or differently in the future. Four of the participants spoke of insights from the experience of feeling in too deep that indicate a level of satisfaction with their work and an intention to act similarly in the future. These include thoughts about the critical value of consultation; the need to slow down and carefully conceptualize one's impact on the client, the importance of not allowing fear to impede the maintenance of relational connectedness; and musings on the power that we have as therapists and how we must be very responsible with our influence.

Six of the participants offered insights from the experience of feeling in too deep that indicate lessons learned and an intention to do something differently in the future. These include thoughts about how allowing the client to avoid difficult topics created a

more difficult and complex experience for both; the need to sufficiently establish a therapeutic connection before addressing trauma; how to recognize protectiveness as an indicator for feeling in too deep; that it may actually be a benefit and not obstacle to allow oneself to feel painful, scary feeling in session; and the importance of carefully building rapport broadly in client systems.

Participants also commented on how feeling in too deep provided insights about themselves: a loss of faith in universal resilience; growth of awareness of professional style and strengths; and the desire to never again take on a crisis case that could necessitate an emotionally exhausting and risky corrective experience that ends the therapy relationship.

Participant Selection and Generalizability

The generalizability of findings is an important consideration whenever convenience or small samples are accessed for research. Participants for the present study were identified through recommendation, participant suggestion, and blind contact. Because inclusion criteria for phenomenology are simply experience and willingness to participate, sample description cannot be diagnostic. However, it may provide some clues as to who is likely to have the experience. Participant demographics are provided in Table 1. Most interesting are the multiple terms that therapists used to describe their theoretical orientation and practice style. The most frequent identification was psychodynamic. Other terms were integrative, feminist, family systems, multi-cultural, experiential, object relations, self-psychology, interpersonal, existential, narrative, aesthetic, and use-of-self. The absence of cognitive or behavioral styles and the preponderance of dynamic and person-focused styles may tell us something about who is more likely to experience feeling in too deep with clients. It follows logically that a more personal and affectively engaged

therapy style could create more vulnerability to feeling in too deep. However, this finding may also be an artifact of the non-random sampling style. Nevertheless, the question is raised as to what personal variables may predispose the therapy professional to the experience.

Interest in the preponderance of parentification histories among therapists led to the identification of the present research topic. Although participants were not asked directly about parentification experiences, it is notable that four participants referenced that history without prompting. The possibility for a complex interaction exists. An example might be that personal history, such as parentification, impacts both choice of theoretical orientation and therapeutic style, and all three could impact vulnerability for feeling in too deep. Future research could investigate these potential relations.

Limitations

The limitations of this study will be discussed as pertaining to two broad categories: conceptual and methodological. Conceptual limitations include the intangibility and chronology of the experience under investigation. Methodological limitations relate to general issues with qualitative and phenomenological research as well as specific difficulties encountered by the novice qualitative researcher regarding credibility procedures, data collection consistency, and the balance of depth and breadth of the sample.

Conceptual Limitations

Researching a human experience poses challenges that physical science researchers do not encounter. How can we be assured that we actually have an appropriate sample of the experience under investigation? If an experience were tangible, a test could

demonstrate that it had certain properties to qualify for inclusion. If an experience were a gem, it could be viewed under a microscope for purity or it could be tested for interaction with another substance. Because none of this is possible with the intangible, phenomenologists ask potential participants if they identify with an experience. If they do, we proceed to ask them about it. Still, our ability to select a specific experience is limited by our language and any tangible boundaries that may be used as guides.

The present research was an attempt to understand a completely intangible experience. Therapists were asked about any experience of feeling in too deep with clients. They were not limited to discussion about the experience in a specific clinical context or after having had a measurable external experience. Some examples of other phenomenological dissertation research might help make this distinction more clear. A similarly unbounded study is *The experience of feeling really understood in psychotherapy* (Grote, 2006). A more tangibly bounded study of human experience is one about the death of a partner in unmarried couples, *The widow who wasn't a bride: A phenomenological study of loss in cohabitating couples* (Shatz, 2006). The difference between the bounded and unbounded phenomenon is context. An unbounded experience is an idea, whereas a bounded experience is defined by tangible circumstances. Because feeling in too deep is an unbounded, intangible experience, the data were extremely diverse. Participant stories were disparate and did not fit a uniform chronology that could be mapped. Participants met criteria to participate simply by identifying with the experience of feeling in too deep with a client, which is arguably more a cognition than an emotion.

Time boundaries for the experience pose another limitation related to intangibility. This issue was raised in the explication of the core themes. Because feeling in too deep is non-specific, there is no clarity as to when it begins and when it ends. It is difficult to distinguish between antecedents of the experience, the experience itself, and responses to it. Of course, such delineations are artificial. Feelings and thoughts develop over time and can remain over time. There may be a point at which the therapist recognizes feeling in too deep. The therapist may have various thoughts and feelings of distress in response and these experiences may persist. The therapist may be responding to the quality of the connection between therapist and client. Therapists may alter their style of therapy to manage feeling in too deep, or perhaps a change of style preceded the feeling, or both. Finally, the experience of feeling in too deep is likely going to require the therapist's careful attention to balancing client and therapist needs. Or perhaps it is when those needs seem most in conflict that feeling in too deep arises to begin with. The preceding statements represent the various ways the core themes may relate chronologically within the experience of feeling in too deep.

Methodological Limitations

Qualitative research is fraught with empirical limitations when judged by the criteria of a positivist, quantitative paradigm. As discussed in the introduction to this work, typical evaluations of measurement rigor such as validity and reliability cannot be directly applied to qualitative research, which is an exercise in exploration and explication, not measurement. Conversely, given its limitations, qualitative research cannot claim to represent the totality of a topic being studied. Phenomenology, for example, is an exercise in understanding a given experience, and does not provide information on the manner in

which that experience might interact with other variables, or how prevalent the experience is in a population. Hermeneutic phenomenologists, in particular, seek to illuminate a human experience, and accept that the truths uncovered by one researcher might vary from the truths uncovered by another. These limitations simply reflect the differences between this form of qualitative research and standard quantitative research.

In order to address issues of rigor, a credibility procedure was added to this research with peer consultants and raw data from five participants. Overall, the procedure could have been more standardized, universal, and structured. If more time and resources had been available, peer consultants could have completed the same written analysis process as the researcher and the products could have been compared by a third party evaluator for consistency. Also, if credibility procedures were introduced earlier in the research, they could have been conducted on interview data from all participants, rather than just five. A limited emphasis on inter-judge consistency, however, is consistent with the theory of hermeneutic phenomenology which seeks to explore and illuminate meanings, not find a single verifiable truth.

Data collection procedures evolved over the course of this research, which is appropriate for this methodology (W. J. Austin, personal communication, February 1, 2005). The analysis and consultation plans were constantly being evaluated for effectiveness as this study was conducted. The general procedure did not change, but some refinements were made as described previously, and some unintended irregularities occurred. Although universal procedures are not as imperative to qualitative studies as quantitative research, changes in procedure that impacted participant contact should be noted. For example before the sequence of the follow-up consultation became

standardized, the first few participants attended more to either the selection analysis or the situational description. Over the course of analyzing more interviews, more context of selected quotes and more detailed interpretation were included in the selection analysis document, which impacted the follow-up consultation. Later in the process, participants were handed a pen and encouraged to write on the documents during consultation. Early on, one participant did so spontaneously, but most simply affirmed the analysis and continued a discussion about certain points of importance. Finally, the first few descriptions were later revised to eliminate quotes and excessive detail that could compromise client and therapist anonymity.

Efforts to balance depth and breadth in the sample also created a limitation. Due to suggestions from the advisory committee, the sample size was increased from 5 to 10 at the time of proposal. It could be considered a limitation that saturation did not guide sample size, but given the intangibility of the experience and the diverse nature of the data, such a guide was probably not feasible. The increase to 10 participants meant more breadth in the sample. Similar research with fewer participants, may have permitted more depth to the analysis, such as with additional follow-up consultations.

Future Research

One potential avenue for future research has already been considered regarding the personal qualities of therapists that might identify who is more likely to experience feeling in too deep with a client. The following additional thoughts about future research are offered in light of related research and the core themes of the present study.

One avenue for future research would apply Orlinsky and Rønnestad's concept of *constructive coping* to the present study (2005). If participants would be amenable to a

third interview, they could comment on the degree to which they felt able to communicate and problem solve with clients. Conversely, participants could also comment on degree to which they felt constrained from doing explicit problem solving. It seems likely that the perception of client frailty inhibited participants from being as open with clients. It would be interesting to ask participants what, in retrospect, they could have shared with clients and how they believe that could have altered their experience of feeling in too deep with the client as well as the client's experience of therapy. If constructive coping is a strategy that is often utilized by therapists, not having it as an option could contribute to the distress experience of feeling in too deep.

Other research should specifically address the core theme of balance. It is the one core theme that was not at all reflected in most recent study of therapist reactions to difficult situations (Smith et al., 2007). Future research could explore experiences in which therapists decide to make their experience of conflict part of the therapy discussion. What is involved in the decision to do so? What are the outcomes? Are there contextual differences between circumstances in which therapists engage in a dialog about their need to balance and the circumstances in which they manage the conflict silently?

Further research might also explore the therapists' choice to alter personal style of practice. This was the one theme not alluded to in Orlinsky and Rønnestad's (2005) three dimensions of difficult experience. Participants in the present study were found to have an awareness of altering their personal style of therapy during this work. Some appeared to do so as an antecedent, and perhaps cause, of feeling in too deep. Others appeared to do so as a coping strategy for the experience. Pope et al., (2006) recognize that changes in therapy style could signal attempts to constructively address a therapy need. However, the

authors also caution that the more extreme the departure from a therapist's norm the more carefully it should be considered. Future study could explore when therapists choose to alter their style of therapy and their reasons for doing so. Research with paired therapists and clients could inquire about changes in therapy and could assess the mutual awareness of both parties. Questions for therapists could include if and how they discussed therapy changes with clients, how successful that change was, and how communication between therapist and client was a part of the therapy change. Any study that included clients as participants will involve an ethical limitation. It could not involve clients whose stability posed a safety risk. Nevertheless, an understanding of how therapists consider change in personal style of therapy could complement discussion of how such change is applied to high-risk client situations.

Finally, further research should be conducted on the therapist's experience of challenge in connection. Additional qualitative study with therapists could explore when they experience challenge in connection with and without feeling in too deep. Another question is the way in which challenge in connection may precipitate the various thoughts and feelings of distress that were identified. Because the art of psychotherapy rests in the therapeutic relationship, it seems likely that therapists who find themselves unable to form the necessary connection may feel a sense of confusion, insecurity or powerlessness. These feelings comprised the universal cluster of distress of this study.

Closing Comment

Ten practicing doctoral-level psychologists spoke about the experience of feeling in too deep with a client as meaningful in their own therapy practice. One participant later clarified that she felt in deep, but not in *too* deep. Only future study can demonstrate whether this phenomenon has wider resonance among professionals in the field. Assuming it continues to prove meaningful, we as scientists, scholars, educators, and professionals must apply the knowledge gained about the experience to our work. Feeling in too deep should not be another experience that therapists ***don't talk about*** (Pope et al., 2006). Rather, discussions and lessons about this experience should be integrated into our formal graduate training programs as well as our ongoing professional development. If we can learn from the experiences of our peers who have felt in too deep with clients, the struggles that await us in our own work may be less distressing for us as therapists and more productive for our clients.

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APPENDICES

Appendix A: Participant Comments on Professional Development

Howard

. . . doing what's temporarily easiest has long-term negative consequences, which is a lifetime learning thing. Like it is temporarily easiest to support, and not confront. I don't want to say confront, but bring stuff up, talk about the things that are hard to talk about. Because keeping things a little light got me in too deep. By going into some of these things as we went, I would have had more – I would have been safer. Part of my avoidance was avoiding the feeling – it is from a desire to stay safe in the moment. It's safer to avoid this conversation, because it makes her uneasy, it makes me uneasy, her uneasy, me uneasy, we're just going to stay uneasy. But ultimately, it creates safety to bring these things up. To be able to talk about them.

Max

Well, she got better care because I knew I was in too deep. She got much better care because I knew it and I knew what to do about it. In that I knew I needed a consultant for my head and then a couple weeks later I knew I was needing a consultant for my heart. And so I think my own awareness of myself gave her better care.

Well, I'm going back to the head and the heart again. In the head I got a lot more knowledge [on this issue] than I'd had, a lot more than I ever got in grad school. I had a compelling reason to do it because it mattered to this person. And unfortunately, it hadn't been personal to me. So once there was a personal reason to do it, I did that.

So the heart place, I guess it's always good to be aware of how sitting with that much pain impacts me. It's always good to just monitor that and to realize that I can consult with someone about that – that experience of sitting with depression and someone

wanting not to live. That was helpful in my development too. It wasn't the first time that I've done that, but it seems that every time that I do it, it goes to a different layer.

When someone is not wanting to live and they're silent, the impact on me is that I, inside, sometimes start to panic. Like, "I've got to do something to make sure this person does not die." And I start feeling hyper-responsible for them. I'm not a brand new therapist saying I feel that panic. But when I know that someone wants to die, I do feel really responsible. So the consultation helped me figure out what parts I'm responsible for and what parts I'm not. And when that happened it felt more manageable to me so that was good professional development.

It's not when someone is suicidal. I should clarify that. It's when someone is suicidal and not communicative. Because suicidal I deal with every week of my career. It's the suicidal and won't connect that makes me panic.

Terrence

I have a tendency to err on the side of missing psychopathology. I'm much more careful since this client. I'm much more careful with somebody who has a really traumatic history.

I think that that's the biggest thing. I no longer make the assumption that somebody with a severe, severe traumatic history has worked through it and is put together. Even if they seem that way. I tend to assume that there's stuff there, even if I'm not seeing it. And I tend to be very cautious about getting in too deep too quickly with a client like that.

The difference is that with her I was more willing to go with her pacing in a way. Even though I did a lot of grounding, I think I was more willing to go with her pacing than I would be now. I think I would do a lot more, stop. Not just let's get grounded or let's make sure that you're put back together before you leave.

Before this happened to me, I had a lot more universal faith in people's resilience. And that got shaken a bit by this client. I think that I had a sense, it was never really articulated, but I had a sense that anybody could recover from anything. And I don't quite believe that anymore. And I've had several clients since then [about whom] I've had the feeling – that I've had the sense that there may be ways to make their life easier, but they're not going to get out of this; they're not going to be ok. That I can help them, help their lives work better, but they're not going to be ok.

Amelia

It helps me really clearly. I have locked in me red flags. I have a red flag for anything that pulls on my protectiveness. That's something that comes from me being a mother and probably oldest.

The thing about getting in too deep or getting too close is that you have the sensation of too close, too invested early on. I've got to tell you the truth, I don't want to be involved with taking something so that it has that kind of ending, regardless of the corrective whatever. It's too exhausting!

Yvette

…you know just tolerating. The thing that I learned from her about myself is needing to be challenged in terms of how I tolerate when this stuff comes up for me, and knowing when – like telling myself its ok to feel, like there's nothing wrong with feeling stuff . And learning to not have that be an obstacle in the work. Trying to find a balance with that.

Linda

It continues to help me. I think I conjure up this experience often times when I'm sitting in a parent meeting with their child with the child as the IP, and I'm listening to what the child says and what the parents say and my internal consultant/supervisor starts talking and saying "These parents are missing the boat with the kid." And the very next thing my internal supervisor says is, "Well remember that one kid you said that about? Give them

another chance. Give them a second. Let's inquire about their experience. Let's find out about their experience as parents. Let's also find out about the kid. Let's see how they mesh." It continues to help me.

It allows me to be more immediate in the process of this being "in and out." I think I'm much more aware of when it's occurring. And I can in conscious moments negotiate where I want to be in terms of how far out and I can be critical in terms of being too far out, as well. And sit back and look at it: "Is this where you want to be with this parent, with this child? What are you likely to lose? What are you likely to sacrifice in terms of rapport? Is that worth sacrificing for the sake of providing some harsh information? How many poker chips are you going to give up by doing that?" And I can make some more critical decisions about that.

Edward

I think it's been part of a process too for me, just in general. I'm in one of those phases where I am pulling back and looking at how I work. And what is that? What do I do well as a therapist? How do I understand that? How do I articulate it? That there's lots of different ways to do therapy, but I continue to get more comfortable with who I am and what I feel like my strengths are.

Sally

It also makes me really look again at, what role do we play? As therapists we have an incredible amount of power, and what do we do with it? And also recognizing what power we don't have and, can we be ok with that? You know that we can't – You can't decide for a person what they're going to do. They don't always decide what you want. Just that whole thing of – the power you do have, and how do you use it and the responsibility you have to be responsible with it and accountable for what you do. And at the same time balancing that with what you don't have power to do.

Tammy

I think any moment that makes us slow down and examine ourselves more fully sharpens us, makes us grow and expand. And it expanded me, it challenged me a great deal - it challenged me a great deal and it made me think really hard about what I was doing and how and why, and what it meant and how to conceptualize it all. And that all is expansive, in terms of . . . the container that is me in the therapy room, the hold that I provide. In terms of just intellectually, how I'm conceptualizing and thinking about what's going on and how I'm responding to it. So I found it very helpful and now looking back on that time I still understand it that way.

Ronald

It taught me not to armor myself when I'm scared. And not to step back from people just because I'm scared. That it is important for people to know that they have an impact on you. You don't have to go to some objective, "you don't impact me" place. Especially when someone's at that kind of risk. So yeah, he taught me not to armor myself when I'm scared. And he taught me to go beyond neutrality. He taught me to let go. He taught me humility. There was a big piece of humble pie with that. And letting go would be allowing something bigger than me to help me. Of getting the ego that is mine out of the way.

Appendix B: Recruitment Call Guide:

I am calling to request your participation in my dissertation research. Your name was selected with the assistance of my dissertation committee members Greg Jurkovic, Marolyn Wells, Leslie Jackson, and Rod Watts as an accomplished psychotherapist in the Atlanta area.

My research focuses on an experience that therapists may have when conducting psychotherapy. It was described to me by one experienced therapist as feeling in too deep with a client. Having explored the literature, I find that descriptions of therapist experiences are limited and tend to reflect polar extremes of either being personally enriched by the work or becoming burned out by it. It is my contention that there exist many more nuances to the personal reactions of psychotherapists and that the idea of feeling in too deep with a client might reflect a much more complex experience. As a therapist-in-training with some clinical experience, I have some idea what this might mean. However, I would like to use the opportunity of my dissertation work to gain a better understanding of the phenomenon from experienced psychotherapists.

I have decided to approach this exploratory research with a phenomenological research design. I will be attempting to interview 10 therapists in the Atlanta area regarding a specific experience in which they felt in too deep with a client. We will conduct an initial interview together and then follow-up with a consultation at a later date. The purpose of the interview is to allow participants to describe a specific experience in detail and to assist me in understanding what the experience was like for them. The purpose of the later consultation is to review my analysis of your description for accurate reflection of meaning.

My goal in using a phenomenological research design is to capture the essence of the experience of feeling in too deep with clients, as well as to respect the most profound individual meanings offered by each of the participants.

I would like to thank you in advance for your consideration of my research. I realize that it is not easy for practicing therapists to involve themselves or their clients in research. I can assure you that your participation will be met with the highest level of confidentiality and respect.

Appendix C: Informed Consent Form

Georgia State University
Department of Psychology
Informed Consent Form

Title:	A Phenomenology of the Therapist's Experience of Feeling in too deep with Clients
Principal Investigator:	Deborah Weisshaar, M. A.
Faculty Supervisor:	Gregory Jurkovic, Ph. D.

You are being asked to participate in a research project designed to gain a better understanding of a personal reaction of feeling in too deep with clients that therapists may experience while conducting psychotherapy. If you accept, participation will include an initial interview which will last between 60 and 90 minutes, and a follow-up consultation lasting 30 to 60 minutes to review findings and interview material at a later date. Meetings will be held in your private professional office at a time convenient to your schedule.

The purpose of the interview is to allow participants to describe a specific experience in detail and to assist the researcher in understanding what the experience was like for them. The purpose of the later consultation is to review the researcher's analysis of the description for accurate reflection of meaning. A digital recorder will be used in both meetings to facilitate an accurate record of our discussions.

Records will be kept private to the extent allowed by law. Our conversation will be transcribed and the original recordings will be destroyed upon completion of the project. During the course of the research all materials will be stored in a locked file cabinet within a locked office in the GSU Psychology Clinic for Therapy, Assessment and Research. Electronic copies of recordings and transcriptions will be kept on password and firewall protected computers. All study transcripts and materials will be de-identified such that you and other participants will only be identified by first name aliases rather than real names. There will be a total of 10 participants. Neither your name, nor any clinical material threatening the confidentiality of your client, will be included in transcripts for dissertation publication.

There are no obvious risks of participation, except that the discussion may cause participants to recall professionally challenging experiences which may inspire you to debrief with a colleague. Participation, however, will benefit our profession's appreciation for the experiences of therapists.

Finally, participation in this study is given on a voluntary basis and you may choose to withdraw at any time.

Call Deborah Weisshaar, M. A. at 404-550-8460 or Gregory Jurkovic, Ph. D. at 404-651-3271 if you have questions about this study.

If you have questions or concerns about your rights as a participant in this research study, you may contact the Institutional Review Board (IRB) which oversees the protection of human research participants. Susan Vogtner in the office of research compliance can be reached at 404-463-0674.

You will be given a copy of this consent to keep.

If you are willing to participate in this research, please sign below.

_____ _____

Participant Date

_____ _____

Principal Investigator Date

Date Consent Form was approved by GSU IRB: 06/02/05

Date Consent Form no longer will be in effect: 06/02/06

Appendix D: Question Guide for Participant Interview

1. Describe a specific experience you had in which you felt in too deep with a client?
2. Please share your recollection as to what was happening clinically at that time.
3. At what point did you sense you felt in too deep?
4. What other thoughts or feelings do you recall from that time?
5. What was that like for you?
6. How did you navigate that experience to a resolution?
7. Did you seek any consultation?
8. In what way, if at all, did you share your experience with your client?
9. Did that experience bring to mind other experiences from your personal history?
10. Did that experience bring to mind other experiences from your professional life?
11. In what ways did you experience that process as helpful to your client's therapy?
12. In what ways did you experience that process as helpful in your own professional development?
13. Personal/Professional Background questions:
    a. Training background (Ph.D./Psy.D., orientation of training settings?)
    b. Therapeutic theoretical orientation
    c. Years of experience post doctorate
    d. Ethnic, cultural, religious, other