Therapists' Internalised Representations of their Therapist: An Interpretative Phenomenological Analysis

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pp. 285-287: **Paper for publication.** Cover letter and Author's agreement checklist.

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City University Declaration

Section A: Preface

Overview

This preface will outline the different components of this Portfolio that embody my work. Each component was undertaken and completed during my time at City University London, which represents my learning and core competence skills as a trainee Counselling Psychologist. The portfolio ties together the different sections that relate to the form and function of the therapist's own therapist representations[1]. The important contributions of these internalised therapist representations and their relevance to Counselling Psychology are linked throughout.

The phenomenon of internalising one's own therapist from the experience of personal therapy has shown similar patterns of behaviour. Therapists' descriptions of their own therapist's representations and clients' or patients' descriptions of their therapists' representations demonstrate the many different forms of representations. Representations such as, feeling a sense of one's therapist (felt-sense)[2] or having an imagined dialogue with one's therapist in the absence of the therapist (felt-presence)[3] are presented. These therapist representations are manifested in different modes such as identification, introjection and incorporation that seem to offer meaningful introspections for the participants. The overarching theme that pervades the portfolio is the topic of identification with these internalised therapist representations. This piece of work is pertinent to Counselling Psychology given the increasing awareness of transference and

[1] "Representations are externally unobservable mental activities, such as autobiographical memories, images, thoughts, expectations, plans and fantasies" (Geller et al., 2011, p.21).

[2] The term 'felt-sense' (Gendlin, 1978) describes clients' accounts of their feeling a bodily-sense of their therapist's presence.

[3] The term 'felt-presence' (Dorpat, 1974) describes client's evocation of images and words of their therapist outside of therapy. Felt-presence and felt-sense are terms that are used interchangeably.

countertransference within the therapeutic alliance. The portfolio upholds the idea that a therapist[4] through the intersubjective perspective[5] with their personal therapist may form internalised representations of their therapist. The same processes occur within the therapist-client/patient[6] relationship and impact upon the intersession experience and final outcome experiences in therapy.

This portfolio also acknowledges the tension between a phenomenological method in exploring consciousness and the psychodynamic perspective which is viewed primarily as an unconscious process. Qualitative psychology methods do have a tradition of incorporating psychodynamic ideas and paying attention to the emotional aspects of the interview can enrich the analysis (Midgley, 2006). Therefore in understanding the experiences of internalised representations, connections between conscious experiences with unconscious psychodynamic aspects are reviewed. For the purpose of resolving this epistemological tension this study will discuss intersubjectivity and how it contains a relational aspect between the client-therapist. Intersubjectivity is about two minds interfacing with one another (Lyons-Ruth, 1999) and it is in itself a pluralistic paradigm integrating the intrapsychic and the interpersonal worlds (Jimenez, 2006). It is through relational intersubjectivity clients can absorb feelings of the therapist becoming a like-subject that operates at a conscious and unconscious level (Benjamin, 2010) or what Cooper and McLeod (2011) distinguished between what is knowing and what is not knowing in this pluralistic paradigm.

[4] The term 'therapist' will be used interchangeably throughout to refer to psychologists, psychotherapists and counsellors.

[5] The 'intersubjective perspective'… "are grasped not as products of intrapsychic mechanisms originating within the interior of the patients isolated mind, but as taking form at the interface of the interacting experiential worlds of patient and therapist" (Stolorow, 2000, p.149).

[6] The terms 'client' and 'patient' will be used interchangeably throughout.

The research

The research components of this portfolio begin with a critical literature review focusing on the effects of internalising one's therapist representations and the topic of the therapeutic alliance is introduced. The therapeutic alliance is an important and broad aspect in Counselling Psychology. Therefore the literature review begins by highlighting the implication of the therapeutic relationship in the formation of internalised therapist representations. The majority of the studies reviewed are of participants who themselves are therapists; it is this information that provides a rich source of content with regard to therapist representations. The literature review explores the participants' experiences of their therapist's representations post-therapy. This portfolio includes novel research that explores therapists' experiences of their internalised therapists' representations.

My interest in conducting this research stemmed from my personal and professional use of my internalised therapist representations. I wondered if other psychologists, psychotherapists or counsellors used their own therapist's representations, as I had done, in their personal lives and while conducting therapy. This study examines participants who have already formed representations of their therapist; thus it includes research on the experience of the phenomenon of internalised therapist representations. The relevance of this research to Counselling Psychology includes many aspects, such as the importance of a sound therapeutic alliance, the post-therapeutic benefits of therapist representations and the therapists appropriate matching to one's therapist and indeed therapy itself. Eight participants - three psychologists and five psychotherapists - were interviewed about their experiences of internalisation of their therapist. All participants had a minimum of one year of personal therapy with the same therapist. Utilising semi-structured interviews, data was collected and analysed according to the principles of Interpretative Phenomenological Analysis (IPA) as outlined by Smith, Larkin, and Flowers (2009). Three master themes

emerged from within the data: 1) ***letting the therapist in, 2) identifying with the therapist*** *and* ***3) the changes within.*** Implications, applications and limitations of the research are further outlined in this study.

Professional practice

This psychodynamic case study examines my work with a client who seemingly experienced poor early object-relations which may have impacted his current interpersonal relationships. The client's early object-relations in combination with current significant relationships including the wider social network are explored in a therapeutic context to assist in the formulation of the client's current difficulties. This case study is a reflection of the content and process of therapeutic work using Brief Dynamic Interpersonal therapy (DIT) (Lemma, Target, & Fonagy, 2011). The client had little feeling of connection to others and this appeared to be synonymous with harmful internalised representations which likely led to his emotional distress. The case study emphasises the impact of poor interpersonal relationships and the demarcation line between love and hate of others. In particular, the case study demonstrates a client who may have experienced early introjection of harmful intra-psychic objects which he subsequently projected into current relationships. The client's experience of his self and object representations are explored to identify the clients Interpersonal Affective Focus (IPAF) (Lemma et al., 2011).The IPAF is designed to examine a client's defensive functioning in relationships with others (Lemma et al., 2011). The goal of the work was to provide a space for my client to explore his interpersonal relating to others, especially to his mother. In presenting this case study my aim is to demonstrate my development as a trainee Counselling Psychologist over the three years of my training.

Journal article

This section presents a paper which will be submitted for publication to the Journal of Counseling Psychology. The development of internalised representations may play a role in

one's interpersonal relating in adult-life. Taking this into consideration this paper focuses on how the therapeutic alliance in the client-therapist relationship may be an important concept in the formation of therapist representations. Moreover consideration is given to the functional use of these representations to improve one's interrelationships and their interpersonal relationships. The article entails a summary of the main research findings and the implications of these findings from a Counselling Psychology perspective.

The connections within the doctoral portfolio

There is evidence that a dysfunction in forming inner representations may lead to a difficulty in how a person experiences themselves in relation to others. Conversely, where there are positively formed representations, there is evidence of improved relations to self and others. From a Counselling Psychology perspective I sense that my positive intersubjective relatedness has helped me professionally to develop solid interpersonal relationships with my clients, in turn strengthening the therapeutic alliance. This in turn may improve my client's relations with themselves and others; this has informed my epistemological and personal reflection of my work as a trainee Counselling Psychologist. As Stern (2002) contends in his multiple-self theory, the intrapsychic relationship is shaped by the relational experience. Therefore, the overall theme that threads through this doctoral portfolio is the ***'interpersonal relational field'***, in the context of the '***therapeutic alliance'.*** This theme is intrinsically linked to each of the sections which holds relevance to the practice of Counselling Psychology, but is also connected to me in a personal capacity. I will outline these thematic connections below.

The qualitative research in this study examines the in-depth lived experience of therapists' internalised representations of their therapist, that is, their tendency in using these representations with others in the post-therapy experience. Participants' self and object

representations come under the influence of new ways of relating as they come into contact with others in the world. This suggests the participants' may be impacted by these newly formed representations which in turn may influence their form of relatedness in the physical presence of others. Consequently, the client and the therapist bring their own individual personalities, their personal histories, to create the analytical third (Ogden, 1994) or the intersubjective thirdness (Benjamin, 2004), a dyad co-creation in the clinical practice.

My experience of a sound therapeutic alliance with my therapist over three years of professional development has led to a recognisable change in my own inter-relationships and interpersonal relationships. I developed the ability to hone in on my therapist representations whereas other times they came to me voluntarily. I noticed that the positive change of experiencing my therapist representations was welcoming and helpful in improving how I interacted with others personally. Moreover I often experienced my therapist representations that were present when I was working with my clients. Furthermore, I am acutely aware that the presence of my therapist representations may interface in a professional relational capacity with my clients' which can potentially enhance the therapeutic working alliance.

The case study was in part an exploration of early object-relations and in part an exploration of adult interpersonal relating. The client demonstrated the persistence of distorted views of interpersonal relating with others and with me in the therapy sessions. Due to the complexity of this client, I found myself attempting to use a similar psychodynamic style to that of my personal therapist, particularly in difficult moments with my client. For instance, I found it helpful to occasionally have an imaginary dialogue outside of the session with my therapist to calmly see what he would say or do with this client. I noticed that I would also, in my relating to this client, remain calm and focused on improving trust with the end goal of

developing a solid therapeutic alliance. It was apparent to me even from the first session with my client that I was leaning on my therapist representations which were now being used constructively to actively engage with this client. The client who had experienced his mother as a persecutory object seemed to have internalised this persecution which he may have also experienced in his relations with others. I believe that I may have experienced a sense of therapeutic presence[7] in the sessions with my client. Moreover, in therapy it was important to reflect on my own way of intersubjective relatedness.

The journal article focuses on two main themes which have relevance to the importance of the therapeutic alliance. The first theme relates to Counselling Psychology practice and the formation of constructive internalised therapist representations through relational intersubjectivity, that is the dyad between the client and therapist. The second theme relates to the influence of the formed representations with others and the effects of these changes.

[7] The term 'therapeutic presence' describes the therapists feeling and use of their bodily sensations of their clients experiencing (Geller & Greenberg, 2002).

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Section B: The Research

Therapists' Internalised Representations of their Therapist: An Interpretative Phenomenological Analysis.

Supervised by Dr. Susan Strauss

Abstract

Research investigating clients' internalised representations of their therapists has shown that developed therapist representations can be evoked by clients both within therapy and post-therapy. Clients can use their therapist representations to problem-solve, to self-soothe and to introspect. However, research suggests that clients may experience difficulty in forming representations of their therapists where there is either an absence of a therapeutic alliance or therapy relationship. Given that most therapists have engaged in therapy as clients themselves it is likely they also can potentially form representations of their therapists. From a Counselling Psychology perspective, therapists who can form representations of their therapists may be able to use these for personal and professional development. Considering the implications of therapists possibly using their therapist representations, it would seem relevant to investigate therapists' experiencing of this phenomenon. Therefore, this qualitative study aims to explore how therapists experience their therapist representations. Semi-structured interviews were conducted with eight participants, -three psychologists and five psychotherapists, - all of whom were therapists and had completed a minimum of one ended year of personal therapy with the same therapist. Using Interpretative Phenomenological Analysis (IPA) the transcripts were analysed which indicated three master themes: 1) ***letting the therapist in, 2) identifying with the therapist, 3) the changes within.*** It was found that the participants seemed to have experienced a felt-presence of the representations of their therapists either alongside them or inside of them. They seemed to experience their therapist representations as holding. These representations may have had a reparative function of early object-relations thus improving current interpersonal relationships. The participants experienced imagined dialogue almost as a mentor-mentee style relationship. Interpretations of the participants' descriptions of their experiences appeared to make the process of internalised representations more explicit. The implications, applications and limitations of this qualitative study are addressed from a Counselling Psychology perspective.

Introduction

Opening statement

This study explores the phenomenon of internalised therapist representations. Knox, Goldberg, Woodhouse, and Hill (1999) suggested there was limited experiential research on the specific topic of internalised representations. Therefore, this study uses a phenomenological approach to unearth therapists' experiences of their therapist representations following personal therapy. Interpretative Phenomenological Analysis (IPA) (Smith, Larkin, & Flowers, 2009) is the chosen qualitative approach, to explore the participant's experiences. IPA was chosen as it is considered the most appropriate method, in line with my epistemological position and my primary research question: how do therapists experience their therapist representations?

The concept of therapist representations

Clients' internal representations of their therapist can be defined more specifically as the "client bringing to awareness the internalized image, occurring in visual, auditory, felt presence or combined forms of their therapists when not actually with them in session" (Knox et al., 1999, p. 244). These internalised visual images according to Horowitz (1972), enables the process of continued information-processing, allowing new meanings to be reconfigured, by what he called "thought by trial perception" (p. 799). Given then that clients may internalise their therapist representations it could be considered that they are likely to use these to experiment and subsequently experience the world differently in their day-to-day functioning. Geller, Cooley, and Hartley (1981) explained that the image representation or imagistic mode of representation is just one form of representation; the haptic or touch representation and the conceptual or lexical word representations can also be evoked.

The leading authors who pioneered the studies on representations stated, "the concept of representation encompasses memories and expectations, habits and skills, images and

fantasies, thoughts and symbols. Representations may be concrete or abstract, realistic or unrealistic, and may infer to things past, present or future" (Orlinsky, Geller, Tarragona, & Faber, 1993, p. 425). This may suggest that therapist representations are a challenging and a complex phenomenon for a client to first identify with and may require some intentional focusing for this phenomenon to actually occur in one's mental and sensory modes. More recently representations were defined as, "externally unobservable mental activities, such as autobiographical memories, images, thoughts, expectations, plans and fantasies" (Geller et al., 2011a, p. 21). It is likely then that a therapist representation is a phenomenon of internalisation whereby a client has some awareness of their interpersonal relationship with their therapist that is experienced in the client's present consciousness and subsequently felt in their immediate sensory modalities.

The origins of representations

Freud (1915/1957d), in discussing the unconscious, noted in his psychological diagram of word presentation, that infants move from a motor image to a sound image to an object association whereby "the object presentation itself is once again a complex of associations made up of the greatest variety of visual, acoustic, tactile, kinaesthetic and other presentations" (p. 213). Beres and Joseph (1970) further explained that mental representations are largely "unconscious psychic organizations" evoked consciously as images, fantasies and thoughts (p. 2); these typically develop through mother and infant interaction (Harpaz-Rotem & Blatt, 2009) and within the infants environment such as motor and memory reflexes (Horowitz, 1972). Therefore with primary care, intersubjective relations can be transformed into intra-subjective ones (Laplanche & Pontalis, 1973, p. 226). It is these early primary identifications (Braddock, 2011), that enable the representations to become the imprint for thinking and imagining which are evoked in one's schema (Orlinsky et al., 1993). These early representations also promote superego formation (Sandler & Rosenblatt, 1962) and mental functioning (Bion, 1959). Bion asserted in his paper

The Psychoanalytic Study of Thinking that, “thinking has to be called into existence to cope with thoughts” (Bion, 1962a, p. 306). Without this proper mental functioning between infant and mother, conflicts can arise for the child’s represented inner world resulting in disturbances in the child’s capacity for representation (Lafarge, 2004), resulting in emotional difficulties in adulthood (Blatt, Wein, Chevron, & Quinlan, 1979).

Freud (1940/1964) suggested, as did Hartman and Loewenstein (1962), that the process of internalisation has an organising function in shaping an individual through growth and change in one’s ego as the object representations and images of the external world are internalised. This makes sense when you consider Freud’s description of the internal world whereby, “a portion of the external world has (…) been taken into the ego and thus become an integral part of the internal world” (Freud, 1940/1964, p. 205). This external identification may lead to the beginning of object relations whereby there is a libidinal bond that resides within one’s internal ego (Bain, 2011). However, Sandler, Holder, and Meer (1963) interestingly argued the opposite in that they said “it is one of the functions of the ego to create and organise the representational world” (p. 151). Taking these two theoretical constructs together this may suggest there is a mutual relational interaction between the ego structures and the external object representations in the creation of one’s representational world. This would seem to occur in the original mother-infant bond that continues in all subsequent relations (Loewald, 1980). This begs the question of whether a similar relational aspect occurs in therapy where the client introjects the therapist representations in the intersubjective encounter.

The phenomenon of internalisation

Roy Schafer, a founding theorist on the topic of internalisation, defined it as, “all those processes by which the subject transforms real or imagined regulatory interactions with his environment, and real or imagined characteristics of his environment, into inner regulations and

characteristics" (1968, p. 9). Schafer (1972) later asserted that his theory on internalisation referred "to a fantasy, not a process" (p. 434), as it was more concretely linked to the term incorporation, taking fantasy objects into the body. More recently in describing the phenomenon of internalisation, some recent dictionary meanings explain some of the many alternative formulations and epistemological positions. For example, *The Counselling Dictionary: Concise Definitions of Frequently Used Terms* says it is, "the process of taking in thoughts and behaviors from others and making them one's own and the process of incorporating the norms from one's culture and making them one's own" (Gladding, 2001, p. 65). *A Dictionary of Psychotherapy* says "it becomes synonymous with introjection, incorporation and identification which involve the making internal of what has been expressed as external through permanent mental representation in the internal world" (Walrond-Skinner, 1986, p. 186).

These dictionary meanings seem to indicate that internalisation is a process where the outer or external objects are intra-psychically introjected inside as internal objects. Freud had touched on this point and so had developed the early framework; for instance, in *Instincts and Their Vicissitudes*, Freud (1915/1957a) described how the external world objects were incorporated into the ego as pleasurable love objects. His later work in *Group Psychology,* Freud (1921/1955) distinguished between normal identifications (the Oedipus complex) and abnormal identifications (symptom formations). He summarised that "identification is the original form of emotional tie with an object, secondly, in a regressive way it becomes a substitute for a libidinal object tie" (Freud, 1921/1955, pp. 107-108). Although Freud did begin the topic of identification and incorporation, today internalisation is viewed simply as a process whereby the outer becomes inner, a generic psychological term closely related to inside or internality (Wallis & Poulton, 2001). The process of internalisation would seem therefore an ongoing active regulatory activity that may have no boundaries considering the extent of our likely introjections and projections. Contemporary theory according to Moore, Fine, and American Psychoanalytic

Association (1990) said internalisation happens “by three principal modes: incorporation, introjection and identification” (p.102). Therefore the term internalisation is a broad umbrella term and covers the concepts of introjection, incorporation, and identification (Chessick, 1993; Meissner, 1981; Schafer, 1968; Wallis & Poulton, 2001). Identification is when one person behaves like another in terms of characteristics, attitudes where there exists a fantasy to “take the place” of the other (Hartman & Loewenstein, 1962, p. 49), or a form of imitation becoming like another (Chessick, 1993). However, “in identification one takes on only certain aspects of the desired person, whereas in introjection there is a total incorporation, in a cannibalistic fantasy of both the good and the bad“ (Chessick, 1974, p. 45). For this reason, Kernberg (1966) stated, “introjection is the earliest most primitive and basic level in the organization of internalization processes” (p. 241).

The identification and experiences with therapist representations

Hueso (2012) explained that clients regularly feel pressure in experiencing projections from their therapists to conform to thinking, feeling and acting in accordance with these projections. Reviewing Reik’s (1956) autobiographical extract illuminates his internalised therapist representations which he could recall vividly. Reik whom had known Sigmund Freud for 30 years and was in personal therapy with Freud for many years wrote about his reminiscences:

> These reminiscences varied in character, sometimes they were clear recollections of things he said. The perception frequently was accompanied by the visual image of Freud sitting at his desk across from me (….) Now and then his voice was recalled, its timbre, the intonations and inflections, the modulation of a sentence even the clearing of his throat. (Reik, 1956, p. 20)

Reik's experience was seemingly very vivid in the manner he could recall both Freud's verbal language "things he said" and non-verbal "an apt smile he had used" (p. 21). The representations Reik experienced were most prominent in working with clients which offered him some meaning-making but he had expressed his risk of over identification to his master when he said, "*suddenly [I] became aware that it was my voice that spoke but that he [Freud] had said this same thing in a conversation"* (p. 21). This would seem to suggest that Reik may have been experiencing conscious representations (i.e., Freud's words) that had been previously internalised by way of his identification and relationship with Freud. Fleischer and Wissler (1985) pointed out the special goal of treatment of therapists is to enhance their intra and inter-psychic lives but cautioned that, "patients should develop a freedom to internalize the valued and useful aspects of their therapy experience without being blindly enslaved to model themselves after their therapists" (Fleischer & Wissler, 1985, p. 593).

Object relations theory in the development of client-therapist representations

Object relation theorists emphasise that early relationships with caregivers organise internal dynamics (part or whole objects) whereas interpersonal-relational theorists emphasise development of social relationships (real or imagined) (Aron, 1996). Object relations theorists focus on lasting impressions of early life and argue these residues of early life shape interpersonal relations (St Clair, 1986). In this section, I will link how object relations may play a part role in the development of therapist representations. The primary mechanism by which therapist representations are formed may be through the relational intersubjectivity field (i.e., between the client/therapist dyad therapy relationship) of which object relations may play only an ancillary role. Due to the immensity of this topic, I have decided to focus on the British school of object relations theorists, namely Melanie Klein, Michael Fairbairn and Donald Winnicott. As

these theorists all have a common theme, they do nonetheless have distinctions which I will address. I will also briefly outline the more contemporary view of object relations theory.

Bacal (1987) says there is no universal theory of object relations. However as Odgen (1983) stated the British object relations theorists did have a common theory of internalising internal objects. In this regard object relations is about a person's unconscious relationship to internal objects that interface in one's interpersonal experiences. Bacal (1987) in distinguishing the main British object relations theorists' emphasised that Klein's (1935) object relations theory upholds that an infant's ego is motivated by instincts or drives and introjects good and bad objects which are generated by unconscious phantasy as an internal phenomenon. For example, Klein (1946) emphasised that the beginning of object-relations occurred when the infant introjected the "good gratifying" and projected the "bad frustrating" breast (p. 99). Bacal highlighted that Fairbairn's (1949) object relations theory disagreed with Klein's theory, instead believing the ego was not driven by instincts, but rather the ego with its own energy is motivated by object-seeking relationships with others. Fairbairn favoured that it was not mere unconscious phantasied objects that were internalised but the real object relationship as an active dynamic agency capable of feeling and thinking (Odgen, 1983). Greenberg and Mitchell (1983) described this object-seeking in relationships as the relational social model. This was a step towards the dynamic psychic organisation that was considered largely conscious and relational in a social context (Scharff, 1996). Therefore Fairbairn began the move away from the one-person psychology to the beginning of two-person psychology (Kibel, 2005). In this regard the British middle school began to explore the inner and outer worlds with real-life relationships moving away from Freud's and Klein's biological mechanistic drive reductionist model to a more mind-body relational structural model (Elisha, 2011). Winnicott (1951) added to this new object relation model with his theory of a physical holding and object-usage of transitional objects in one's actual experience (Greenberg & Mitchell, 1983). Implicit in Winnicott's texts is an infant's

internal world being met with the experience of the external world at a conscious and unconscious relational level (Odgen, 2001). Object relations would seem to place the human connection and the primacy of the real-life relationship in the sphere of internal and external thus likely playing an important role in the development of representations.

The more contemporary object relations theory addresses the intrapsychic and interpersonal effects in relationships to include unconscious internal objects in relation to external objects (Ogden, 2002). Kernberg (1976) stated, “Object relations theory may refer to the general theory of structures in the mind which preserve interpersonal experiences and the mutual influences between the intrapsychic structures and the overall vicissitudes of expression of instinctual needs in the psychosocial environment” (p. 56). Therefore Kernberg’s (1976) theory of object relations moves away from the classical meta-psychological polarities of intrapsychic and interpsychic to a pluralistic style of interpersonal relational aspect in a form of experiential reality with the conscious and unconscious external world. In this respect the unconscious is a function of the interpersonal view (Cavell, 1988).

Mitchell (1988) explains that to overcome any confusion in the dichotomy between object relations and interpersonal relations, the term “relational matrix” is more appropriate in understanding how these two different relations may overlap (p. 9). In summary, object relations established in early infant-caregiver’s interaction may develop into mental representations that are generalised with other interactions (Silverman, 1991). Considering that these internalised representations and one’s object relations are likely to be individually unique as clients themselves and indeed therapists, it may be the case that clients and therapists enter into an intersubjective field each carrying their own historical self and object representations that shape

the interpersonal experience. Thus the internalised early object relations or 'past unconscious'[8] (Sandler & Sandler, 1987, p. 281) likely interact in the present relational intersubjective encounter, forming what Davies (1996) referred to as "internalized dyadic representations" (p. 565) in the "internalized self-other dyad" (p. 562). Given this interaction (i.e., object relations with interpersonal relations), the formation of therapist representations may encompass the pluralism of the intrapsychic and interpersonal worlds rather than object relations in itself.

Relational intersubjectivity model: Conscious and unconscious experience

Freud (1915/1957d) remarked that the unconscious of one human being likely reacted upon another passing through consciousness (Cited in Gerson, 2004, p.82). In this section I will delve further into the relational intersubjective model as Freud barely touched on this topic. I will explain how this model may be the primary mechanism in the formation of therapist representations. I will also introduce how intersubjective theory acts as a bridge between the conscious and unconscious experience. To begin with, Bucci (2001) explained that the inner experiences of the conscious and unconscious are unobservable and as such they require a theoretical framework. For example, from a psychosocial level according to Sclater (2003) we are not just inside ourselves but we are mostly in relation to others, real and imagined which occurs at a conscious and unconscious level. In this context Sclater explains through language and presence humans develop an embodiment and unconscious fantasy to the other, "it is a way of integrating the inner and the outer" (Sclater, 2003, p. 372). As Bradfield (2013) emphasised the subjective self is found within the intersubjective world through relating in a relational dialogue and not through the classical theory of an autonomous ego. "Most interpersonal relations are in fact a mixture of I-Thou and I-It" (Bradfield, 2013, p.125), and this includes the client-therapist identification with its organising ego activity (Loewald, 1960). From

[8] "The past infantile unconscious represents in a sense, what can be referred to as the 'child within'. We can think of it as having been formed and structured during the course of the child's early development" (Sandler & Sandler, 1987, p. 334).

this relational and interpersonal perspective, therapy is about a meeting of two differing subjectivities (Rasmussen, 2005), and as such is a co-creation of subjectivities (Silverman, 1996a). Therefore the intersubjective integrates the interpersonal with the intrapsychic at conscious and unconscious levels (Gerhardt, Sweetnam, & Borton, 2003). As Benjamin (1998) put it, there is a double-sidedness with the intra and inter in that one cannot be eliminated without the other which is why the intersubjective theory bridges a synthesis between the two perspectives. As the unconscious is regarded as a fluid state in this intersubjective experience information may move freely from the unconscious to the conscious mind (Stolorow & Atwood, 1992).

Lyons-Ruth (1999) explained that psychodynamic theory has moved more to a relational intersubjective perspective which is a social constructivist stance. She explains that the intersubjective meeting in therapy results in a way of being with the others space where both the client and the therapist become agents to each other, leading to the formation of new representations. She explains that relational experience comes about from implicit procedural or enactive representations that are unconscious, that is not dynamically unconscious. Thus Lyons-Ruth (1999) seems to suggest that the representations formed by way of the relational intersubjective encounter are not subject to '*primal repression' or 'repression proper'* as Freud (1915/1957c, p.148) postulated but instead remain outside awareness thereby existing in a form of implicit relational knowing which is internalised in therapy. This according to Lyons-Ruth (1998) defines the real therapy relationship. Stern (1998) agrees with this idea, saying that a client and a therapist can be together in an intersubjective state in that they share implicit relational knowing in non-verbal representations. "These implicit representations are unconscious but not necessarily under any form of repression, in psychodynamic terms they are descriptively unconscious but not dynamically unconscious" (Stern, 1998, p.304). For this reason the shared implicit unconscious memory of information can be brought into

consciousness (Dienes & Perner, 1999; Jimenez, 2006). The effect is that unconscious thoughts and affect become conscious in a new form of 'intersubjective consciousness' (Spezzano, 1995, p. 24). From this theoretical positioning it could be the case that any developed representations from the intersubjective experience may remain situated in a 'descriptive unconscious'[9] or 'preconscious'[10] which may be expressed consciously as participants bring their awareness to their therapist representations. As Stern (2002) outlines, a person's self is intersubjectively constituted which is internalised as a pre-symbolically represented experience referred to as the "intersubjective self" (p. 698). Over time this new 'intersubjective self' is therefore likely to be experienced consciously which can be symbolised through speech and thought in the relational interaction.

One-person psychology versus two-person psychology: A pluralistic approach.

Grotstein (1997) emphasises that today there is a shift from one-person psychology to a two-person psychology, a shift from internal reality to external reality in the development of relationism, interactionism, and intersubjectivity. This according to Grotstein is a move away from the classical Freudian model of psychic determinism that drives were the main force of motivation. Therefore Grotstein (1997) acknowledges the tension between the psychic intrasubjective reality and the objective intersubjective reality where there exists an "exploratory drive" in a shared world view of reality (p. 414). Stolorow (1997a) referred to this reality as "intersubjective systems" which are the reciprocal interplay between worlds of experience between a client and a therapist or more simply put, two humans between two subjective worlds (p. 338). Stolorow's argument is similar to Grotstein's (1997) and Orange (2000) that the one-person psychology is today curtailed considering that a person's intrapsychic organisation is

[9] The 'descriptive unconscious' denotes that mental events are not dynamically unconscious [ie., repressed] but rather are merely out of consciousness which are accessible to consciousness (Tubert-Oklander, 2006).

[10] "The preconscious refers to content that are unconscious in the descriptive sense of the term but they differ from the contents of the unconscious system in that they are still in principle accessible to consciousness" (Lapanche & Pontalis, 1973, p. 325).

incorporated into the 'intersubjective system' where inner experience (unconscious intrapsychic) is mutually constituted with the outer experience (interpersonal conscious reality). In this regard a person does not have a Cartesian authoritarian isolated mind but has an intersubjective viewpoint from the interface and interaction in the experiential world which is continually shifting (Stolorow, 2000). For Stolorow (2000) therapy is therefore about a dialogue of exploration between the client's and therapist's experiential worlds in their relatedness to each other in the intersubjective space. Furthermore it would appear that the conscious and unconscious processes are parallel as clients hold subjects not objects in the 'relational unconscious'[11] (Harris, 2004). The 'relational unconscious' concept (Davies, 1996), brings the intrapsychic and intersubjective perspectives into interconnectedness, being the fundamental property in the interpersonal relation (Gerson, 2004), and it is considered not destructive but instead creative and generative (Safran, 2006). More recently Bromberg (2009) stated that the interpersonal interaction in therapy and the 'relational unconscious' leads to a "therapeutic internalisation of the otherness" through client and therapist intersubjectitives exercised in a kind of communion (p. 357). This two-person relational intersubjective theory lends itself to a more pluralistic dynamic paradigm than Freud's idea of a repression barrier of the intrapsychic. Thus according to Stolorow (2013), the 'intersubjective systems' theory states that the unconscious is constituted in relational contexts. Gerson (2004) explained Stolorow and Atwood's (1992) theory that an individual's unconscious interfaces in the external intersubjective experience with another's capable of fluidly entering into consciousness.

So far, I have outlined that within the relational experience between a client and a therapist it is likely a descriptive unconscious exists, that is not structurally repressed, but one that can potentially engage in moving implicit procedural pre-conscious thoughts to the forefront in the explicit relational knowing. Evidence documents this knowledge, that unconscious memory is

[11] The 'relational unconscious' is not a static unconscious in the Freudian sense but instead refers to an unconscious that has its content constructed in the interpersonal relationship (Weinberg, 2015).

closely linked to implicit memory (Schacter, 1987). IPA's hermeneutical phenomenology acknowledges the tension between the pre-conscious and conscious state. Therefore in this context information moving from the pre-conscious state to consciousness is a cognitive event not a dynamic one (Stern, 1989). I have also acknowledged that the intersubjective aspect of the client-therapist 'relational unconscious' links conscious and unconscious experience. It is likely then, any developed or developing therapist representations may be situated in the 'descriptive unconscious' and preconscious organisation that may be given symbolic meaning.

The contemporary relational intersubjective model

Today there is an acknowledgment of the "mind-relationship split" that is, between the intrapsychic and the interpersonal (Wolson, 2012, p. 209). Relational theory suggests a shift from one-person psychology to a two-person psychology with an emphasis on mutuality and reciprocity, in that information is generated not solely from an unconscious phantasy but from a "meeting of minds" (Aron, 1996, p. xii). Stolorow (1997b) states that this 'meeting of minds' can refer to "an abstract idea of the psychological system constituted by the intersection of interacting subjectivities" (p. 862). Stolorow therefore concurs with Aron's mutual influences and mutual regulations within intersubjectivity as the basis of relational theory, but prefers the term "unfree associations" in the analytical dialogue (p. 861). Yeatman (2015) noted that although Winnicott (1951) moved forward from one-person psychology to a two-person psychology, it is really Jessica Benjamin who pursues the intersubjective subject-to-subject relationship. Benjamin (2004) defines intersubjectivty as "a relationship of mutual recognition and a relation in which each person experiences the other as a like-subject" (p. 5) and indeed as "two-way streets" (Benjamin, 2006, p.116). She compares her intersubjective thirdness to Winnicott's (1951) transitional space which is "the intermediate area of experience" (p. 230). Benjamin (2004) speculates that this space is created by letting go of the self to take in the others reality, yet at the same time accepts a distinct separateness to the others differences. Her theoretical

perspective is therefore a two-way directionality; it is not solely about mental processes but more about interactive patterning and mirroring the relationship which suggests a conscious and unconscious process. Benjamin (2009) favours the relational theory in therapy moving away from the orthodox thinking of polarities and more about hearing multiple voices as part of one self. She believes in the "shared third" or "moral third" where there is no one doing to the other, rather it is about multiplicity and bi-directionality in the client-therapist dyad (p. 442). Benjamin (2013) in reviewing her work believed she translated the mother-infant intersubjectivity in the therapy room where there exists two subjects in one relationship. Even more elaborately put, Benjamin (2010) suggests intersubjectivity is not about a path to self-consciousness but more about mutual recognition in a shared project in the dyad relationship. Along the same lines, Orange (2009) in her analysis of intersubjectivity stated, "we join the other in the intersubjective space time" in that client and therapist meet in the exchange of their conscious and unconscious relations (p. 245). In this regard, "there is no subject except for another" (Green, 2000, p. 8). The function of this dyad relationship is often to engage in a dialogical empathic understanding to create a "developmental second chance" for those whose previous experience is in need of reparation (Orange, 2009, p. 243).

Critical literature review

In earlier research, internalisation as a general phenomenon has been written about in important books such as *Aspects of Internalization* (Schafer, 1968), *Internalization in Psychoanalysis* (Meissner, 1981) and two pioneering papers, *Introjection and the Castration Complex* (Fenichel, 1931), and *Internalization, Separation, Mourning and the Superego* (Loewald, 1962). Representations such as dreaming of one's therapist has been written about by principal psychoanalytical authors Harris (1962) and Rosenbaum (1965), however dreaming is just one of the many ways therapist representations may appear to oneself. The various

different forms of representations are documented within this review citing empirical research with participant examples.

The empirical research specifically, therapist representations have been written about in many doctoral dissertations (Barchat, 1988; Bender, 1996; Blatt, Auerbach, & Levy, 1997; Derby, 1989; Epstein, 1989; Green, 2007; Honig, 1989; Roy, 2007; Tarragona, 1989; Wzontek, Geller, & Farber, 1995). Studies within the Journal of Counseling Psychology by Knox et al. (1999) and Quintana and Meara (1990) discussed clients' internalised representations of their therapists. Conversely, there is evidence of therapists who have representations of their clients (Geller, Lehman, & Farber, 2002; Lehman, 1991; Schröder, Wiseman, & Orlinsky, 2009). Some of these studies along with more contemporary studies will be outlined in this critical literature review. For organisational purposes this literature review will encompass three areas within the field of internalised representations.

First the review will start by introducing the different and broad aspects of the therapeutic alliance and therapy relationship, both of which are important themes to this thesis and Counselling Psychology. The extant empirical research will begin by grouping the important scholars and their pioneering Therapist Representation Inventory (TRI) studies which began two decades ago on the topic of representations encompassing the client-therapist dyad. In doing so, the review of these series of TRI studies aims to illustrate the first important findings between the client-therapist representations and client-therapist alliance. Although the TRI studies are quantitative with some mixed methods, their relevance to the present qualitative study are worthy of attention due to their suggested findings which remain salient today. The middle part of this review will include contemporary empirical qualitative research to provide a deeper focus on clients' inner experiences of the formed representations of their therapists. As this study is qualitative in design and as all of the therapists in this study had ended therapy, this

middle aspect of the research has important relevance to review. In the final part, a summary of the literature and the relevance of this topic for Counselling Psychology will draw an end to the review. It is necessary to highlight that the literature review that follows contains mostly related studies on clients' or patients' representations of their therapists. However, as these clients or patients within these studies were themselves therapists (i.e., therapist-patients), these studies are relevant to review therapists' experience of their internalised representations of their therapist.

The therapeutic alliance in the client-therapist relationship

Freud (1905 /1953) using his therapeutic procedures began and explained the journey of working-through with clients' unconscious material. Later Freud (1912/1958) referred to "*positive transference*", as affectionate feelings but he never used the term alliance (p.105). Historically the term '*alliance'* has been recognised as the "*we*" in the relationship between the clients' and therapists' egos (Sterba, 1934, p.121); however, as Zetzel (1956) explained, a failure in ego development could potentially prevent a "*therapeutic alliance"* forming (p. 372). Greenson (1965) adapted Zetzel's therapeutic alliance and coined the term "*working alliance"* to refer to non-neurotic clients who had the ability to work and maintain a functioning relationship with their therapists (p.155). These early pioneers helped develop the concept of alliance, however the term was later interpreted less as a psychoanalytic construct, and more so as having a conscious relational aspect in psychotherapy. For instance, Bordin (1979) referred to the client-therapist relationship as a collaborative bond that was determined by the "closeness to fit" of the client and therapist within the therapy (p. 253). By Bordin referring to the therapy relationship as a mutual bond, it brought forward the idea that the therapeutic relationship asserted more a positioning of equality instead of the traditional method of analysed and analyst or subject-object relationship.

Horvath and Luborsky (1993) stated that the term ‘alliance’ could be considered a general term that referred to three similar aspects in therapy: the therapeutic alliance, the working alliance and the helping alliance. Research suggests that the alliance is a predictor of therapy outcome (Falkenström, Granström, & Holmqvist, 2013; Horvath & Symonds, 1991; Horvath, Del Re, Flückiger, & Symonds, 2011; Jordan, 2003; Marmarosh et al., 2009; Xu & Tracey, 2015). Furthermore there seems to be a connection between early drop-out and a poor or weakened alliance (Sharf, Primavera, & Diener, 2010; Tryon & Kane, 1993). Thus repairing alliance ruptures is related to a positive therapy experience lowering risk of drop-out (Richards, 2011; Safran, Muran, & Eubanks-Carter, 2011; Swank & Wittenborn, 2013). Drawing these findings together, this suggests that the therapeutic alliance may be a common factor in therapy success. It may also hint that without a sound alliance, therapist representations may never have the opportunity to develop with early termination. Early client drop-out from therapy occurs frequently ranging from 20-30% (Connell, Grant, & Mullin, 2006; Saxon, Ricketts, & Heywood, 2010; Swift & Greenberg, 2012). Due to early termination of therapy, the client-therapist relationship bond is potentially not only missed, but there may be a further risk of the client and therapist carrying away harmful representations within this group of early drop-out population.

Gender differences have also proven to play a role in representations and alliance that extend a similar pattern. For example, from the descriptions of those experiencing their therapist representations, female clients in comparison to male clients are reported to engage more in imaginary therapeutic dialogue (Tarragona, 1989), think more of their therapist and therapy (Perry, 1992), daydream and plan more for the next session (Farber & Geller, 1994) and have less interpersonal distance to their therapists (Arnold, Farber, & Geller, 2000).

From a Counselling Psychology perspective working to avoid potential drop-out and monitoring gender differences may have implications in therapist-client alliance and relations. As Cooper (2010) explained, the alliance contains a relational context in that the therapeutic encounter is

something emerging between the client and therapist interaction leading to a positive outcome. Cooper and Ikemi's (2012) dialogue on relational perspectives further revealed Cooper's sense of alliance in psychotherapy, as he debated that the client and therapist engage in a "dialogical process" (p. 128). Similarly, Mearns and Cooper (2005) implied that Roger's (1961) core conditions may have been too holistic, instead they stated, "it is actually the therapeutic alliance between therapist and client that is generally a better predictor of positive therapeutic outcomes" (p. 14). McLeod's (2003a) also found that the therapeutic relational encounter was considered a process, one of emotional warmth and acceptance. The alliance within the therapy relationship therefore may be considered something that is created by a mutual connection; however, consideration should be given to avoid early termination and understanding gender differences for therapist representations to form.

The Therapist Representation Inventory (TRI) studies: Forming alliances

Geller et al.'s (1981) original study is important to review as it developed a methodology to better understand and assess therapist representations. Before reviewing this first empirical study, it is necessary to explain the Therapist Representation Inventory (TRI; Geller et al., 1981), as it was used in this study and the other related TRI studies that follow. The TRI is a self-report questionnaire containing four subscales: 1) The Therapist Embodiment Scale (TES), a 12-item nine-point Likert-type scale to assess the different forms and vividness of the therapist representations the client takes hold (e.g., "I imagine my therapist dressed in a certain way"), 2) The Therapist Involvement Scale (TIS), a 38-item nine-point Likert-type scale designed to assess clients thoughts of their therapist (e.g., "I imagine being held by my therapist"), 3) an open-ended question (e.g., "please describe your therapist") and 4) the final part of the TRI includes a nine-point rating scale from worse (1), to marked improvement (9), to show changes in therapy outcome.

Geller et al. (1981) further formulated three factors within the TES based on Bruner (1964) and Horowitz (1978) three modalities of inner schemas (imagistic, enactive and lexical). These included: 1) image representations or the imagistic mode were found to enable conscious reality and fantasy thoughts (e.g., “I picture a specific expression on my therapists face”) 2) tactile-kinesthetic representations or the haptic mode were found to enable perceptual presence (e.g., “I imagine my therapist and myself in physical contact”) and 3) vocal representations or the conceptual mode were found to enable processing beyond the therapy itself (e.g., “I imagine a particular quality to the sound of my therapists voice”). Based on factor analysis, six sub-items were developed within the TIS scale to identify conscious thoughts, feelings and functions about the therapist relationship, these included: 1) sexual and aggressive involvement (e.g., “I imagine being my therapists child”) 2) the wish for reciprocity (e.g., “I wonder if my therapist ever thinks about me”) 3) continuing the therapeutic dialogue (e.g., “when I am having a problem I try to work it out with my therapist in my mind”) 4) failures of benign internalisation (e.g., “I feel as though I were never in therapy”) 5) the effort to create a therapist introject (e.g., “I daydream about my therapist”) and 6) mourning (e.g., “I miss my therapist”).

Geller et al.’s (1981) methodology using the TRI, served the purpose of identifying the forms of the representations [their appearance into conscious awareness] and their content [frequency, duration, vividness] of these mental representations of one’s therapist. The TRI was designed therefore to examine the different ways that clients constructed, made sense of and functioned with their mental representations of their therapists and the therapy process within and post-therapy. Geller et al. (1981) recruited 206 (120 men and 86 women) psychotherapy volunteers from the Yale Department of Psychiatry, The Connecticut Society of Clinical Social Workers and from the Society for Psychotherapy Research. The sample was split between those who had ended therapy (140) who had over three years of therapy and those currently in therapy (66) who had 31 months of therapy. Participants were asked by mail the type of therapy they had

received, the frequency and duration of therapy, the time elapsed since ending therapy, their own therapy orientation and years of work experience, and other demographics to include age and gender. The self-report TRI was administered and a dimensions manual was created to help assess the criteria in assigning scoring to the Likert-rating. The participants' written descriptions of their therapists were rated by three psychologists and three psychiatrists using the Conceptual Level Scale (CLC; Blatt et al., 1979) to distinguish the different levels of representations according to the participants experiences.

Geller et al. (1981) found that their data was positively skewed, which they said indicated their participants had internalised their therapist representations. In particular, they found that the participants could evoke experiencing kinesthetic and lexical representations thereby knowing, sensing, and recognising "words, pictures, sounds, odors and bodily sensations" of their therapists (p. 137). They found significant correlations between the scores on the TES Factor 1 (image representations) and self-perceived therapy improved outcome. They also found significant correlations between the scores on Factor 2 (tactile-kinesthetic representations) and self-perceived therapy improved outcome. However, there were no significant correlation between scores on the TES Factor 3 (vocal representations) with improved outcome. The improved outcomes included lowered painful emotions associated in areas such as subjective distress, interpersonal relations, self-esteem, work performance and general satisfaction. Overall there was reduced anxiety, depression, loneliness and feelings of loss. The most common representation was the wish for therapist reciprocity. This may suggest that the participants had developed positive relational aspects with their therapists which aided the development of the therapeutic alliance, in turn internalising benign therapist representations which lead to improved outcome.

Although Geller and his colleagues developed a substantial move forward in understanding representations, their study made the assumption that their sample groups of trainee therapists were expert witnesses to introspection. However, they did not take into account possible disturbances or neurotic levels of personality in their participants at the pre-treatment or post-treatment phase. As a result, it could be argued this may have influenced the results. For example, Blatt (1991) assumed that different types of psychopathology were due in part to impaired cognitive-schema structures of the representational world. If this were the case within this study's sample group, then the self-reported TRI findings may be questionable. Even though the authors reported that the sample group did show clustering indicating the presence of internalised representations, this may have been attributed to expectancy effects outcome which is a common phenomenon (Tambling, 2012). Another drawback of this study was that it tended to focus only on the forms and functions of the clients' therapist representations. In doing so it may have omitted two important aspects: 1) how the clients experienced these representations developing over the course of therapy and 2) how the clients experienced these changes occurring. A final consideration this study may have omitted was the absence of reporting any findings on gender differences. Research had shown during the time of conducting this study in 1981 that women were better than men in self-disclosure of interpersonal information (Rubin & Shenker, 1978). This finding is still consistent today showing that differences in gender self-disclosure begins in boys and girls' early development (Rose & Rudolph, 2006). Assuming women were better at revealing their therapist representations compared to the men in this study, it may have altered the clustering of the original findings which had grouped women and men together.

Orlinsky et al. (1993) used Geller et al.'s (1981) original data participant group, but expanded the initial research to see if clients retrieved and used their internalised therapist representations in-between sessions when their therapists' were not physically present. This time the

participants' descriptions of their therapists were scored using the Conceptual Level of Object Representations Scale (CORS; Blatt, Chevron, Quinlan, Schaffer, & Wein, 1988). This nine-point scale was used to assess the participants' cognitive development of their therapist representations based on Piaget's (1950) model to include: 1) the sensorimotor-preoperational level (schemas or mental thoughts), 2) the concrete pre-conceptual level (logical thoughts) and 3) the conceptual or formal operational level (integrative internal and external abstract thinking). A second instrument, the Intersession Experience Questionnaire (IEQ; Orlinsky & Tarragona, 1989), a 42-item measure, was employed to examine the frequency, context, content and feelings evoked with the therapist representations between therapy sessions. Most of the participants reported a higher intensity of their therapist representations prior to the beginning of their sessions and immediately after their sessions. The researchers also reported that 25% of the respondents were thinking about their therapist and therapy a lot on other occasions as well. Using factor-analysis the most significant dimension showed patients recreating imaginary therapeutic conversation with their therapists consistent with Geller et al.'s (1981) findings. These formed representations seemed to have a noticeable function, that was to create a desire to identify with their therapists subjectivity. For example, as a result of the intersubjective encounter, one participant commented "I try to solve my problems in the way my therapist and I worked on them in psychotherapy" (Orlinsky et al., 1993, p. 603). Orlinsky et al.'s (1993) model assumed that within a benign cycle, where the patient and therapist had a positive schema formation such as support in emotional distress, the patients experienced positive representations of their therapist and therapy. In contrast, within the disruptive cycle, where there was evidence of a lack of therapist support and holding, the patients experienced higher negative therapist representations. This suggests the therapy relationship and the therapeutic alliance may be crucial to the formation of benign therapists' representations.

There were two main limitations to their research. Firstly, Orlinsky et al.'s (1993) model may have over simplified their definition of representations. For example, they delineated that representations existed more to conscious mental introspection than unconscious mental introspection thus they may have discounted underlying representations. Recent research shows that unconscious representations are the first form of processing due to their evolutionarily capacity (Augusto & Augusto, 2014). Secondly, they assumed that therapists' representations were formed as a by-product of the activation of the schemata function of organised working-memory. However working-memory is regarded as a system to store information only in the short-term (Marchetti, Benedetti, & Broadway, 2014) and is subject to forgetting (Baddeley, 2001). This then suggests the participants' memories may not have been accurate to their recalled therapist representations. However recent research indicates that conducting working-memory training enhances working-memory capacity (Shipstead, Redick, & Engle, 2012). Thus a client with training in working memory could possibly have the potential to internalise more of their therapist representations. However as Orlinsky et al. (1993) did not carry out any pre or post working-memory assessments in their study or conduct working memory training, no definitive conclusion can be drawn regarding internalisation of representations through clients' organised working memory as they had suggested.

Geller and Farber (1993) also used the Geller et al. (1981) client/patient participant data, but this time their study seemed to report more qualitative aspects specifically into two aspects of clients' therapist representations: 1) their different uses and 2) their association to time. To establish when the therapist representations were activated they focused on the data research responses to one of the original questions, "under what circumstances do you actively evoke images of your psychotherapist in his or hers physical absence" (pp. 171-172). Their findings identified five circumstances whereby all clients did evoke their therapist's representations, such as sadness, painful affect, conflict, anxiety and depression. In particular, clients had a felt-

presence of their therapist when they attempted to resolve their personal problems discussed in therapy. Thus the representations seemed to be evoked when there was a need for connection to their therapist. Geller and Farber (1993) revealed in their study and consistent with Epstein (1989) that for both current and former clients, the greater the number of sessions the more likely these representations manifested themselves. Moreover the higher number of sessions there seemed to be a tendency to use less of a visual representation [i.e., an image of the therapist] and a higher usage in hearing conversational conceptual modes [i.e., the voice of the therapist]. Rosenzweig, Farber, and Geller (1996) partly contradicted these findings in their investigation of clients' felt-presences, as they found that clients in the later phases of therapy (12-36 months) had more active visual representations of their therapist compared to those at the beginning of therapy (0-12 months); Rosenzweig et al. (1996) however cautioned this result, saying it was likely the word representations would give over in the longer run. However both studies agreed that these imaginary therapeutic dialogues were used to fantasise about therapist reciprocal relationships, self-soothe and offer comfort to clients. They were also found to exist more in current clients as opposed to past clients. Furthermore, with more sessions, clients could bring more awareness to their bodies with enactive representations [i.e., felt-presences] typically lasting from a few seconds to one minute and could express their therapist's kinesthetically felt-presences, as "lived bodily experiences" that were with them (p. 177). Based on the above findings, it is likely therefore there is an association between the client-therapist relationship and the formation of representations. For example, research by Arnold, Farber, and Geller (2004) reported that the more the therapist was viewed as helpful or seen as a "positive ideal" (p. 305) the more the therapeutic dialogue could continue post-termination of therapy which Wzontek et al. (1995) found was to serve the function of maintaining an enduring relationship with the therapist. In a similar vein, a study by Geller, Farber, and Schaffer (2010) found utilising the Supervisory Representation Inventory (SRI), a model of the TRI, supervisees could evoke their supervisors' words, vocal qualities and their

felt-presences. They also found that the supervisee's internal dialogue was used to improve their clinical interventions, for example "what do you think the patient meant when she said that?" (p. 218). Geller et al. (2011b) suggested that the therapeutic dialogue evokes past therapy memories facilitating changes in clients' implicit or procedural memory to build new schemas. Combining these findings and given that both clients and supervisees seem to share common factors by using internal dialogue [more often in difficult situations] and felt-presences [more often to attain therapist affirmation], it is likely that this phenomenon has implications for all mental health workers.

A drawback to Geller and Farber's (1993) study may be the accuracy of their findings, showing only 15-18% of the therapists-participants had conscious representations of their own therapists while working with their own clients. Although their study did not explore the experience of those representations while actually conducting therapy with their own clients, they may have made an erroneous assumption. For example, they assumed that this lower percentage was associated to the participants increased years of experience and as such had less reliance on their therapist representations. However it is worth noting the same data from the original Geller et al. (1981) study, was used which showed that almost one third of the 140 of the total 206 participants had ended therapy over 10 years previously. Those within therapy have more access to and use more of their therapist representations compared to those who have already ended therapy. Taking this into consideration it may be that the therapist-participants were simply not engaged in on-going development thus lowering their opportunity to attain new therapist representations.

Contemporary qualitative research studies

Knox et al. (1999) carried out a valuable qualitative study on clients' internal representations of their therapists. This study set out to explore in particular how clients experienced and used

their therapist representations and how they may have influenced the therapeutic relationship. The inclusion criteria were that the participants should have had a minimum of 15 sessions or 6 months with the same therapist. Knox et al. (1999) recruited 13 participants (7 women and 6 men), most of whom had been in long-term individual therapy between 6 to 42 months with an average of 82 sessions with the same therapist. Basic demographic information was collected to include: age, gender, race, therapy history, and information on the therapy itself included; length of time in therapy, number of sessions, and their therapist's orientation style. In the first interview the participants were asked, if they heard their therapist's voice or words or felt a presence of their therapist or evoked an image of their therapist. Those who responded confirming they had experienced these forms of representations were invited to continue with the interview. Those who did not experience these forms of therapist representations were not given any further questions and the interview was ended. A second follow-up interview was conducted after two weeks with the participants who were included in the study to explore any new thoughts on their therapist representations. In this second meeting they also completed the Client Satisfaction Questionnaire-8 (CSQ-8; Larsen, Attkisson, Hargreaves, & Nguyen, 1979) to assess their satisfaction with their therapy. Following the interviews the data was transcribed and sent to several of the participants for corrections or amendments. The Consensual Qualitative Research (CQR; Hill, Thompson, & Williams, 1997) methodology was used in this study to analyse the data. The CQR uses a consensual group process where team members examine and describe the data from a small group of participants so that interpretations of the data are reached inductively within the team. Knox et al. (1999) found that clients experienced representations of their therapist positively and across different modalities such as auditory, visual and felt-presence, that appeared to enable them to recreate the therapy setting in a real life experience. It seemed the participants were able to use their therapist representations to overcome anxiety and fears and reinforce what had been discussed in therapy. However, they could also evoke their therapist representations when they were contented. It appeared the

clients could evoke the representations frequently, 2-3 times a day and they could occur anywhere lasting from a few seconds to less than a minute, always with affect. Knox et al. (1999) believed the clients were using these representations to continue the reflexive work of therapy itself. The clients seemed to have used their therapist representations such as internal imaginary conversations to introspect and move the therapy and therapy relationship forward between sessions simultaneously developing an alliance to their therapists. The representations were found to increase in frequency and intensity something Knox et al. (1999) believed was related to their "active agentic roles" allowing them to be called upon when desired (p. 252). Some participants spoke of "non-internal representations" which they described as thinking of their therapy and their therapist but did not experience any concrete internal representations (p. 254). Knox and her colleagues considered that these clients may have misunderstood the distinction between a representation and a thought which they believed to be a limitation of their study. Although this study was extensive in providing an inside experience of the therapist representations, there may be other limitations the authors may not have considered.

The CQR used in the Knox et al. (1999) study did successfully reach a consensus to construct and interpret themes. This consensual qualitative method is considered a useful qualitative method for problem-solving (Sundstrom, Busby, & Bobrow, 1997). However, there may be some problems in using this methodology. Although Knox et al. (1999) did explore their own expectation-biases, it is still questionable if a team can truly reach consensus without bias. For example, working in a team can resort to "evaluative influence" which is a way of thinking about the effect of a body of evidence to shape practice (Herbert, 2014, p. 388) and in a related vein 'group-think' within a team who are guided by similar values and beliefs can result in pre-conceived notions (Macek, 2012). Even though the researchers did use a form of member-checking with their participant's data, there is an added concern about "in-group power" (Dijke & Poppe, 2004, p. 22) considering that the team may not have relied on the participant feedback.

Furthermore there is a risk of social interpersonal power where one person can enforce their views over another's within the 'in-group' (Sturm & Antonakis, 2015) possibly distorting the interpretation of the data. Given this series of drawbacks related to the nature of the consensual methodology used in the Knox et al. (1999) study, perhaps it would have been better to conduct this research using a lone researcher which McLeod (1999) suggested has the advantage of total immersion and familiarity in one's research in comparison to team research. Another drawback of Knox et al. (1999) study was that there was no mention about the levels of experience in the three judges who were used to reach consensus on the data. The limitation here is the possibility that the individual judges may not have had the skill to make interpretations of the participants' data to capture the essence of the experiences thus affecting the validity of the study. A related concern is the auditor used in this study as Knox et al. (1999) did not confirm if they used an internal or external auditor. Internal auditors are likely to have some over-involvement in the research and may result in missing out on seeing a different perspective of the data analysis (Hill et al. 2005). Lastly there were no pilot interviews which could have checked if anything was left out (McLeod, 2003a).

Green (2007) carried out a mixed methods analysis to examine clients' conscious and unconscious post-therapy experiences. They investigated, if clients' retrospective representations of their therapy experience had indicated they had internalised the therapeutic experience. Green (2007) recruited 10 participants from the database of ongoing research at the Institute for Psychoanalytic Training and Research (IPTAR). The sample group had 6 to 25 months of therapy and had ended therapy between one and two years. Semi-structured interviews were conducted using the STR (Geller et al., 2004), a 12-question interview format designed to evoke working memory experiences of the therapy and therapist. Thematic content analysis was carried out on the STR transcribed interviews and coded using the Relationship Therapeutic Dialogue (RTD; Geller et al., 2004). The qualitative analysis of the therapy and

therapist identified six superordinate themes: 1) client felt secure, 2) client used the therapy as a resource to teach her/him how to function better in daily living, 3) client did not really get heavily emotionally, 4) client was angry about aspects of my treatment or my therapist, 5) client representations contained examples of Pfeffer Phenomenon (Pfeffer, 1963, 1993) and 6) client failed to become actively engaged in the therapeutic process. Some of the participants transcribed narrative experiences seemed to capture the essence of their therapy, for example, Case 243 remarked, “I felt cleansed” (p. 77) and Case 89 said, “I don’t remember any individual moment (...) it’s all a big blur” (p. 80). Others experienced inhibited introjection where they struggled to recall their therapist dialogues post-therapy; Case 284 commented that she, “didn’t want to like, blend into somebody else” (p. 75). However for most participants they were able to recall and use their therapist’s dialogue. For example, Case 13 said “I can talk them out with myself [therapist words] even if times are very bad, I will be able to cope with them” (p. 65). Green (2007) believed that some clients experienced their representations as positive affect; however others experienced negative affect towards their therapist and therapy, particularly to specific communication exchanges and nonverbal interactions. More recently Mosher, Goldsmith, Stiles, and Greenberg (2008) and Mosher and Stiles (2009) were able to identify that there seemed to be a developmental continuum in respect of how therapists were experiencing their therapist voices being assimilated. These positions started with the lower level of assimilation of therapists voices such as “I would like, repeat a behavior that he would talk about” (p. 439) to the more advanced assimilation “there was nothing more for me to really learn from therapy, like, I realised that I had it [my therapist voice] within me” (Mosher & Stiles, 2009, p. 443).

In a related study, Roy (2007) also used the STR (Geller et al., 2004) and conducted two hour narrative semi-structured interviews with 10 client/patients, two years post therapy. Roy (2007) also recruited from IPTAR and also used the RTD (Geller et al., 2004) to code the transcripts.

However, in this study, unlike Green (2007), Roy used the Effectiveness Questionnaire (EQ; Seligman, 1995) to determine patients' satisfaction of therapy. Roy's (2007) findings showed that the participants who found their therapy was more effective seemed to have more imagined dialogues with their therapist in the post-therapy experiences compared to those who found therapy less effective. In addition, those who had more global connectivity with their therapy had more positive words to say about their therapy; this seemed to lead to more positive descriptions of their therapists compared to those with less connectivity who had more negative words leading to less positive descriptions of their therapists. Positive words used included: safe, dependable, challenging, parental, close and warm; some negative words used included, distant, mistrustful, awkward, unequal and unsatisfactory.

In both of these studies, Green (2007) and Roy (2007) in their analysis found the presence of conscious therapist representations which were brought to life by the participants' descriptions. Their findings were echoed in that their participants' ongoing therapeutic dialogue with their therapists seemed to have continued even in the absence of therapy. This imagined dialogue was related to those who viewed their therapist and the therapy (including the therapy environment) as a positive experience. The findings of these studies would seem to suggest that internalised therapist representations may develop when there is a therapeutic alliance founded on a sound client-therapist relationship and improved therapy outcome including therapy satisfaction.

Although Green (2007) and Roy (2007) did successfully answer their research questions there were some limitations: 1) Thematic content analysis may be superficial at the manifest level and difficult to make interpretations at the latent level (Crowe, Inder, & Porter, 2015). Perhaps IPA would have been a preferred method of analysis which Willig (2008) suggested is one of the best methods to attain mean-making of one's experiences; 2) many of the 12 questions in the

STR seemed too suggestive (e.g. question 11 asked, “do you remember any dreams in therapy especially ones where your therapist appeared”). Perhaps a more open-style interview format would have enabled the participants to attain deeper experiences of their representations; 3) the studies were conducted one to two years post-therapy and not during active therapy which may have influenced the accuracy of the recalled representations; 4) the original data population used in Roy’s (2007) study was generated by Seligman’s (1995) survey who asked 26 questions about mental health professionals distributed in a supplementary consumers report questionnaire on mental health. Current research showed that data from mental health surveys is generated from self-observation and is limited to drawing causal inferences (Korn & Graubard, 1999). This could suggest Roy’s (2007) data collection is open to doubt.

Summary of literature review

The studies found that clients seem to evoke their therapist representations, primarily as emotional responses, such as sadness but also with positive emotions of hopefulness and confidence. The evoked representations seem to be more frequently used as a means to problem-solve in social and work environments. The therapist representations appeared to be more active in current clients as opposed to clients who had ended therapy. They are also evoked by therapists while conducting therapy. The existing research however did not illuminate the experience of how these representations are used to solve problems which paves part of my interest in choosing my research question. For instance, is it the case that the therapist representations are experienced as a kind of working tool that is easily accessible while conducting therapy? Does the experiencing of the therapist representations facilitate the process of problem-solving in one’s personal and professional lives? In what situations do therapists experience their therapist representations and where do they manifest themselves more vividly?

The research so far has also found that representations seem to form when there are a greater number of sessions with one's therapist. These representations subsequently manifest initially as visualisations of the therapists moving later to a form of imaginary therapeutic dialogue and felt-presences. These fantasied imagined conversations and felt-presences can be used in-between sessions to maintain an ongoing relationship to the therapist and can be used for self-soothing, introspection and solving problems. In doing so, it is almost as if the representations transform themselves from a continuum of sight to inner sound so they are held for longer within. Yet it remains unknown if the experience of these therapist visualisations and imagined dialogues can be controlled and held in mind for longer periods of time or are they fleeting moments as the research suggests. There is another bigger gap in the literature that remains unanswered: how do therapists experience their therapist's representations as a felt-presence? My research question may attempt to highlight a more in-depth understanding of this experience.

The research also found that clients who had more positive relations with their therapists had more benefit post-therapy than those who had poorer relations with their therapists with less benefit post-therapy. Therefore it would appear that a positive therapy relationship and an active therapeutic alliance maybe essential to the process of forming representations as opposed to a negative therapy relationship and a passive alliance. The development of a positive alliance also appeared to show the enduring quality of their therapist representations. This topic needs expanding in the research to explore if it is the experiencing of the therapy relationship and subsequent alliance that forms the representations or the experiencing of the representations that develops the therapy relationship and alliance. It was also generally found that the therapists' representations were evoked more frequently just immediately after the session or just before the session with their therapist. On one hand this could suggest that the therapy

relationship and alliance were strongest at these time points. On the other hand, it may simply suggest the representations at these times are being used to prepare and end sessions. One of the challenging points of personal therapy is the cross-over between teaching and healing in providing personal therapy to therapists (Geller, 2013). My research question will aim to identify these gaps in the research in particular to find out what the experience may be like for those who do not form a sound alliance with their therapist.

Relevance of this study to Counselling Psychology

I am interested to explore therapists' experiences of their therapist representations which is the primary research question. I will attempt to link the effectiveness of therapists knowing about their therapist representations with Counselling Psychology. Research has shown that clients generally show improvements where they can internalise and evoke positive auditory and visual representations of their therapists, especially as therapy develops after one year (Rosenzweig et al.,1996). In conducting this study it may become relevant that therapists' representations of their therapists may play a more significant role than previously conceived. For example, the possible formation of the therapist representations and the use of these representations may be dependent on the quality of the therapy relationship and the therapeutic alliance. Furthermore therapist representations may provide a reparative function to both trainees and qualified therapists' development. Thus trainee and qualified therapists self-monitoring their evocation of their therapist representations may offer assistance while conducting therapy especially in difficult situations. This has relevance for Counselling Psychology as the monitoring of the quality of the therapy relationship and alliance between therapists with their personal therapists could potentially signal an end to therapy if these components are missing. Some therapists

may have the ability to develop a genuine 'real relationship'[12] with their clients which is also perceived by clients as authentic, leading to better progress of therapy (Kivlighan, Gelso, Ain, Hummel, & Markin, 2015). Even the therapeutic presence of the therapist is considered crucial to effective therapy (Geller & Greenberg, 2002) and can even improve a therapist's listening and attunement skills (Geller, Greenberg, & Watson, 2010). It has also been found that therapists who can intentionally enhance their own emotional mental representations for their clients can improve empathy performance (Gibbons, 2012). Current research suggests that therapist effects are more important than therapist methods (Ronnestad & Skovholt, 2012).

The American Psychological Association *Handbook of Counselling Psychology* explains that there is an increasing level of pressure for Counselling Psychologists faced with work-to-family and family-to-work challenges (Whiston, Campbell, & Maffini, 2012). Counselling Psychologists often demonstrate their inner state of anxiety by taking home client conflicts and sometimes personal therapy conflicts. When therapists' can engage in self-care such as mindfulness meditation it can improve the quality of their self-awareness helping them professionally and personally (Keane, 2014). If therapists could become more aware of their own therapist's representations they may be able to use these to continue the ongoing work of conflict resolution; they may also be able to distinguish between their own and their clients' representations and lower the risk of bringing their therapy work home. Pope and Vasquez (2011) stated that therapists have an ethical responsibility "that requires continuous awareness to prevent compromised performance especially during difficult or challenging periods" (p. 65) and the American Psychological Association (APA, 2010) guidelines recommend therapists seek consultation should they become aware of their personal or work problems. One of the risk factors is therapist's burnout and one important antecedents of burnout is client over-

[12] The term 'real relationship' may be defined as "the personal relationship existing between two or more persons as reflected in the degree to which each is genuine with the other and perceives the other in ways that befit the other" (Gelso, 2011, pp 12-13).

involvement (Lee, Lim, Yang, & Lee, 2011), possibly due to poor self-awareness. However, being self-reflective may improve clinical competence and prevent burnout at work (Urdang, 2009). Therefore therapists should protect their own mental health by monitoring their self-awareness and having the ability to self-separate professionally (Trotter-Mathison, 2010). They may be able to do this by focusing on their mental internalised representations.

Fromm-Reichman (1950) argued that personal therapy gives insight to interpersonal problems in order that the person can handle them on their own. As Orlinsky, Schofield, Schroder, and Kazantzis (2011) pointed out, the idea of 'once trained always competent' is not the practice, as continuing professional development is more of the norm. All 75 organisations of the UK Council for Psychotherapy require trainee therapists to partake in personal therapy (Macran & Shapiro, 1998) but do not outline minimum hours, with the exception of the British Psychological Society (BPS) who stipulate 40 hours of personal therapy (Daw & Joseph, 2007) and the United Kingdom Council for Psychotherapy (UKCP) and the British Psychoanalytic Council (BPC) [formerly British Confederation of Psychotherapists, BCP] who stipulate personal therapy for the duration of training (Szymanska & Palmer, 2002). This means that many therapists may miss the opportunity for developing useful representations from their therapists which could be potentially used to alleviate their own and their client's distress. Studies on therapists undergoing personal therapy, has been found to improve personal growth (Daw & Joseph, 2007; Timm, 1999), professionalism (Rake, 2009), and personal wisdom (Martin, 2011) that can potentially protect clients from their therapist's own failings. Furthermore personal therapy helps in working with our own clients (Wigg, Cushway, & Neal, 2011), in that it allows the therapist as patient experience "being in the other chair" (Kumari, 2011, p. 220). Bike, Norcross, and Schatz (2009) concluded that personal therapy is central for therapists' self-renewal. Therapists should consider focusing more attention to their personal therapy so that the opportunity for therapist representations may form. This may seem important given that therapist's therapists are

considered role models who can possibly influence how their therapist clients/patients conduct themselves as practitioners (Geller, Norcorss, & Orlinsky, 2005).

The literature review found that internalised representations seem to develop better the longer a person is in therapy. This finding could also potentially impact therapist training by extending the minimum number of hours of personal therapy required. Furthermore as representations are more enduring the longer a person is in therapy with the same therapist, the trainee therapist may need to consider this point and avoiding switching therapists unnecessarily. The studies also showed that representations are measurable and adaptable to change in therapy and help in lowering symptoms. Thus reflexivity of one's therapist representations may also be important to allow therapists to successfully filter out hostile internalisations that may hinder their working with clients. Jennings (2005) in the Journal of Mental Health Counselling found master therapists were those that engaged in continuous self-awareness and self-knowledge. Representations appear to present themselves as a phenomenon in therapy between a therapist and a client where there exists a meaningful relationship. Thus "the central interest in existentialism is being" (O'Hara, 2014, p. 67), however as Spinelli (2014) commented, one cannot make sense of themselves or 'being' without some inter-relational context. The present study is specific to therapists' reflective experience of their therapist representations and so I believe this research is timely, meaningful and has the potential to provide fertility for additional research.

Methodology

Chapter outline

This chapter starts by introducing my study, the research strategy, aims and design. It begins by reviewing my rationale for choosing a qualitative research method in conducting this study, but in particular my reasoning of adopting an IPA approach (Smith et al., 2009). This chapter will outline the theoretical paradigms of my work and consider my philosophical, ontological and epistemological positioning. Consideration will be given to the epistemological tensions between IPA and psychodynamic theory. I will describe how I ensured the rigour and trustworthiness of the study. Highlighting procedures in respect of sampling, recruitment, interviewing and analysis are given before concluding with information on ethical issues considered in this study. This chapter presents a complete overview of the methodology of the present study, chosen to examine how internalised representations are experienced.

Rationale and overview of the study

IPA was used to analyse participants' transcripts for the purpose of identifying core overarching superordinate themes as to the experience of their internalised therapist representations. My phenomenological approach aimed to offer insight to therapists' experiences of their therapist representations as accurately as possible, through a rich descriptive account. These descriptions included a textual and structural account of the representations experienced to provide information on the context in which they occur and have occurred. The descriptions will follow the steps outlined by Smith et al. (2009) to systematically analyse the experiential experiences starting with a more comprehensive level to the smallest units of experiences. The analysis will start with the exploration on an idiographic approach and later develop convergence and divergence among all participants. More importantly the study will give a detailed description of the range of experiences as opposed to the average experiences to

improve internal and external validity (Krefting 1991). This approach will therefore offer a more counter-balanced approach to the data.

Research aims and design

This study proposes to enhance the understanding of the internal working model of internalised therapist representations. Using interviews with psychologists and psychotherapists who have all completed therapy, this study explores their formed representations of their therapists. The purpose of this phenomenological study is to describe the essence of the participants' experiences of the phenomenon, rather than testing any hypotheses and so will include the following primary research question: how do therapists' experience the inner representations of their therapists?

Rationale for adopting a qualitative approach

The debate on qualitative versus quantitative is considered resolved as both research methods are valuable (Patton, 2002) however, I will outline my rationale for choosing a qualitative approach for this study. Ritchie, Lewis, McNaughton, and Ormston (2014) asserted that qualitative research contributes to social theory of individuals by inductively exploring the different perspectives of our participants, or what Flick (1998) called the "pluralization of life worlds" (p.12). Qualitative research is contextual and collects real-life data studying perceptions and themes in how people act (Gray, 2004). More specifically, qualitative research in Counselling Psychology according to McLeod (2011) is about enhancing knowledge to identify what is effective or ineffective in practice. He stated, "the primary aim of qualitative research is to develop an understanding of how the social world is constructed" (McLeod, 2011, p. 3). Taking these together, in the present study I have chosen a qualitative research method as opposed to a quantitative research method, as I believe it can derive a better understanding of my participants' descriptive experiences of their therapist's representations within a social context.

Elliott, Fischer, and Rennie (1999) defined that the aim of good qualitative research is to explore interactions of others in a live context which is consistent with Denzin and Lincoln (2011) who identified that qualitative work is interpretative in natural settings. Therefore I sense that my leaning towards a qualitative approach "allows researchers to get at the inner experience of participants" (Corbin & Strauss, 2008, p. 16). I am therefore opposing the more positivist form of working within quantitative methods to find objective scientific truths and so my focus is to research at the humanistic level using qualitative methods. Qualitative research or qualitative inquiry as McLeod (2011) explained is a way of learning for both the researcher and those within the research; consideration of this fact to further understand internalised representations and its usefulness in Counselling Psychology was another rationale for my choosing a qualitative approach. In further consideration in choosing a qualitative approach I believe it to be the most appropriate method in line with my epistemological position that mental representations may exist in the 'descriptive unconscious' (Stern, 1998) that potentially can be dialogically extrapolated into consciousness. From this perspective I subscribe to Finlay's (2011) form of qualitative psychology that gives voice to the participants allowing them to witness their experiences.

It is also worth highlighting that the research so far on the topic of internalised representations has been mostly quantitative using the TRI and the SRI (Bender et al., 2003; Honig, 1989; Lehman, 1991; Renschler, 2006; Romei, 2003; Tarragona, 1989; Weinman, 2001) with some mixed methods studies (Epstein, 1989; Green, 2007; Roy, 2007). Although this quantitative research is a valuable source of knowledge on the topic of internalised representations, Knox et al. (1999) highlighted that the TRI used in some of these quantitative studies did not provide an inside view of clients' experiences of their therapist representations. This study aims to report

new findings and expand the knowledge of this topic using a purely qualitative phenomenological approach.

Rationale for IPA

In my quest to explore therapists' experiences of their internalised therapist representations, IPA was my preferred method to make sense of these experiences. IPA is about approaching the data to understand the participants' world at both a descriptive and interpretative level (Larkin, Watts, & Clifton, 2006). This offers the possibility of analysing data from a person in context of the phenomenon, such as their lifeworld. As Eatough and Smith (2006) outlined, the use of IPA is best suited to this idiographic approach of hermeneutic enquiry as it provides a rich contextual analysis of a phenomenon. It also looks at a person's subjective lifeworld experiences giving meaning through interpretation. As Smith et al. (2009) added, IPA is appropriate for the participant in making sense of their experience and in turn the researcher making sense of the participant's sense-making, hence the "double hermeneutic principle" (p. 3). Defined more broadly, "IPA offers an established, systematic, and phenomenologically focused approach, which is committed to understanding the first-person perspective from the third-person position, so as far is possible, through intersubjective inquiry and analysis" (Larkin, Eatough, & Osborn, 2011, p. 321). In this iterative and circular process of interviewing and interpreting my participants' experiences, I chose IPA as the most appropriate research method to answer my research question. IPA therefore allows me to interpret at the underlying conceptual level enlightening participants' life world experiences.

As a trainee Counselling Psychologist my developing pluralistic style of thinking helped me to explore alternative ways to examine my participants' experiences. I will explain how I viewed narrative analysis and grounded theory as possible alternatives. Narrative analysis is a useful method of inquiry into a person's retrospective self-understandings which are woven into

experiences (Freeman, 2015). Narrative analysis can be considered a better alternative than the use of structured interviews which can fragment an individual's experience (Elliott, 2005). Although much can be gained from narrative analysis, Bruner (1987) first asserted that narrative accounts were reflexive narratives and constructions of one's autobiographical unstable stories. More recently, Esin, Fathi, and Squire (2014) stated that narrative analysis tends to focus on self-generated meanings and is not interested in the internal states of the narratives accounts. Furthermore as Carranza (2015) explained, due to an individual's difference between their "internal" and "external" story, it is likely the narrator will produce a more reasoned story in their interpretation of their experience (p. 67). In contrast, IPA allows me as the researcher the opportunity of a preferred method of micro-analysis of understanding the lived experience of participants' descriptions especially to what becomes known during the interview process. Moreover IPA format will include me situating my participants within a contextual frame of reference of therapists personal therapy which I could not easily manage using a narrative analysis approach. Nevertheless I am conscious that at some level my participants will endeavour to tell me stories about their therapist representations and so I will keep in mind the strengths and limitations of the narrative analysis approach.

I had also examined grounded theory (Glazer & Strauss, 1967), an inductive research approach with the aim of developing a new theory about internalised representations. Grounded theory is a rigorous research method that has little requirement in forming hypothesis and conjectures (Bryant & Charmaz, 2007) and because of its dynamic nature of discovery, new and unanticipated theory may arise; it also is in line with the constructivist-interpretative epistemological viewpoint (Charmaz & Henwood, 2008). Woolley, Butler, and Wampler (2000) advised that although grounded theory is a creative, holistic and a sound inductive oriented approach to theory building research, it is more appropriate where little is known of the phenomenon under investigation. Following my own reading of the literature on the topic of

internalised representations, I found that this theoretical phenomenon had already been developed and so instead my focus shifted from one of development of a theory to knowing more about the existing experience in itself. I ascribe to Popper's (1972, 1983) paradigm that previous theories and phenomena can be refuted to highlight new experiences. Perhaps using IPA this may be achieved with its characteristic features to include, an idiographic approach, an inductive approach and an interrogative approach (Smith, 2004).

Smith and Eatough (2007) asserted that IPA is a humanistic and holistic model that can link the participant and the researcher together at various cognitive, linguistic, affective and physical levels. Smith et al. (2009) detailed some of the skills best suited in their IPA approach so that the researcher could identify the different kinds of reflections from the participants' experiences; these included pre-reflective reflexivity, reflective glancing, attentive reflexing, and deliberate reflection. As these qualities are key principles in my training as a Counselling Psychologist, it facilitated my personal interest in conducting an IPA study using semi-structured interviews to gain first-person experience. These first-person experiences are what Dilthey (1976) believed were real and the starting point of research of complex human beings; the polar opposite of what he described as artificial laboratory responses. Thus IPA is about the examination of a person's individual experiencing and the micro understanding, interpretative and meaning-making of this experiencing.

Limitations of IPA

Even though IPA is my preferred methodology for this study, it does have limitations. I am aware of the ongoing challenge in keeping an open mind in my interviews with my participants. To overcome this task, I will attempt to follow Giorgi's (1997, 2008) Duquesne Phenomenological Research Method (DPRM) principles by bracketing or putting aside my understanding of the research phenomenon to enable a deeper exploration of how the

phenomenon is lived; understanding that language relies on constructs and therefore may limit direct access of experience. Dor (1998) explained that as soon as a person is inhabited by language they can unwillingly alienate and conceal themselves by the actual “order of language” (p. 127); this he referred to as the “splitting of the object” (p. 136). Dor (1998) emphasised because of the unconscious structure and subjectivity of language a person may say something different from what they believe they are actually speaking as the unconscious evades one’s speech. From this perspective Willig and Stainton-Rogers (2008) may be correct when they said, “an interview transcript or a diary entry tells us more about the ways in which an individual talks about a particular experience, within a particular context than about the experience itself” (p. 67). This suggests that my participants who are bound by language may be restricted to tap into their inner experiences.

I earlier acknowledged in the introduction that the intersubjective relational aspect in the client-therapist relationship upholds tension between unconscious and conscious experience. Interestingly the intersubjective dynamics between the client and therapist can also apply between the researcher and the researched (Hollway & Jefferson, 2000). Hollway and Jefferson (2000) suggest that the researcher and the participants are porous with unconscious material derived from each other’s internal fantasies from significant relationships that can be accessed by tuning into emotional feelings of the participants. Finlay (2005) similarly refers to “reflexive embodied empathy” which is the researcher’s intersubjective embodied relationship with the participants in the process of the hermeneutic reflection (p. 272). This reflexive embodied empathy is a central construct in combining psychodynamic with hermeneutic phenomenology (Bradfield, 2013). According to Bradfield an individual’s subjectivity is influenced by the exchange of intersubjectivity between the researcher and the participants; there is an overlap between the psychodynamic and the phenomenological hermeneutics in the relational history

from which the analysis grows. And so, I now acknowledge that a controversial tension also exists between the researcher and the researched in exploring a psychoanalytical concept within a phenomenological framework. This tension can be largely resolved by the premise that I am speaking primarily of a 'descriptive unconscious' (Stern, 1998; Tubert-Oklander, 2006) that may enable therapist representations to potentially reach the participants' self-awareness. This concept of a 'descriptive unconscious' is analogous to Mancia's "non-repressed unconscious[13]" (2003, p. 946) or "unrepressed unconscious" (2006, p. 83). Taking all of these factors into account and having considered alternative forms of inquiry, it is likely the 'descriptive unconscious' and indeed the relational "co-unconscious" (Weinberg, 2015, p. 195) would appear to link the unconscious aspect with consciousness. In this respect IPA allows a form of convergence between the two perspectives (psychodynamic and phenomenological). For this reason I believe IPA is the most suitable research method to capture real-time experiences at a humanistic level.

Theoretical paradigms and philosophical perspectives

Schmidt (2006) defined hermeneutics as the "art of understanding" (p. 10) and Finlay (2013) defined phenomenology as, "a way of seeing how things appear to us through experience" (p. 173). This study's theoretical underpinnings will employ primarily these hermeneutical and phenomenologist positions. By adopting the phenomenological paradigms of Heidegger (1962) and Gadamer (1975) my study will focus on the nature of the hermeneutic process. Heidegger (1962) kept an open mind by asking, "what is it that phenomenology is to let us see? And what is it that must be called a phenomenon?" (p. 59). From this perspective, I am interested in how my participants experienced their therapist internalised representations. Merleau-Ponty (1962) explained that spoken and written words had meaning; he said, "we find here beneath the

[13] "In the analytical relationship this unconscious [non-repressed unconscious, the unconscious nucleus of the self] part can emerge essentially through certain modes of communication (tone of voice, rhythm...) which could be called the musical dimension of the transference and through dream representations" (Mancia, 2003, p. 945).

conceptual meaning of the words an existential meaning which is not only rendered by them, but which inhabits them and is inseparable from them" (p.182). More recently, in collectively speaking about the importance of phenomenologists namely Heidegger and Merleau-Ponty, Finlay (2011) stated, "they argue that we all have an embodied sense of self which is always in relation to others which our consciousness is shared with others through language, discourse, culture and history" (p.19).

My philosophical understanding is similar to the reading of Smith and Sparkes (2006) in that I also depart from the traditional Cartesian view of self as seen as a thing separate to one's body. We are likely embodied beings whereby our narrative in our story telling is a case of our identity and vice versa in how we make sense of the world. From these theoretical perspectives and being mindful that my understanding of another person's experiences may come with my own prejudices and beliefs, I will adopt an open interpretative position that draws on the theory of hermeneutics in the meaning-making of my participants' lifeworld experiences.

In this study, my overall theoretical and philosophical perspectives will adopt an eclectic development, or a phenomenological, hermeneutic and idiographic approach. From this perspective I adopt the constructivism-interpretivism paradigm. More specifically, my phenomenological perspectives within my IPA study will aim to make sense by interpreting my participants' perceptions: their conscious lived remembered experiences. Thus my paradigm will follow a set of beliefs of enquiry to provide understanding of my participants' world. These beliefs are according to Langdridge (2007), are the basic principles underpinning research in the social sciences.

Ontological and epistemological pluralism

Spezzano (1995) highlighted the challenge of the modern ontological assumption of the relationship between the unconscious and conscious and the epistemological assumption that unconscious knowledge is mediated through one's conscious mind. Clarke et al. (2015) explain that there are three different kinds of analytical pluralism, 1) multiple methods of analysis, 2) multiple theoretical frameworks and 3) multiple data sources. In this section I will address the degree of commensurability of the disparate sources of epistemology used in the present study (i.e., conscious versus unconscious). I will examine this clashing epistemology and ontological diversity in researching one's experience of representations. As a researcher I ascribe to the hermeneutics of faith and restoration by decoding meanings of the participants' communication with as little distortion as possible (Josselson, 2004). The hermeneutics of faith or restoration according to Josselson is linked to the phenomenology of experience to attain understanding of one's subjectivity and intersubjectivity. Ricoeur (1970) spoke of the crisis in the art of interpretation which he described as a war of hermeneutics between the interpretation of restoration (restoration of conscious meaning) and interpretation of suspicion (illusions of consciousness). Ricoeur proposed a dialectical form of relationship that integrated both kinds of interpretation to resolve this conflict between true and false consciousness. Ricoeur (1970) stated, "At the outset the quality of being unconscious is still understood in relation to consciousness… the enigmas of consciousness no longer serve as signs of the unconscious" (pp. 118-119). Ricoeur warned against Freud's idea of a concrete hierarchical topography of the conscious, unconscious and preconscious epistemology favouring more convergence between them when he said, "the invisible and visible are in a reciprocal relation" (p. 386). He advocated the theme of intersubjectivity as a means of convergence of phenomenology and psychoanalysis believing relationships are centered in this dimension. This study follows Ricoeur's theory of convergence; I believe therefore that the data derived from the conscious and descriptive unconscious are commensurable due to the underpinning of this intersubjective

theoretical perspective. You could say I am adopting a narrative bricoleurs interpretative stance in knowledge production which is grounded in the domain of human complexity (Kincheloe, 2005).

Ontology and epistemological positions

Ontology has no precise definition but it is generally accepted as the existence of one's reality or their "science of being" from their interaction with their social and cultural environment (Busse et al., 2015, p. 29). Ponterotto (2005) suggests ontology is about the nature of one's reality and what can be known from this reality. In studying the phenomenon of internalised representations, I believe that each person may bring their own subjective experiences to form an intersubjective client-therapist dyad experience. For example, Orange (2009) explained that the 'intersubjective systems' are about two personal worlds that emerge. For Orange development is the interplay between child and caregiver, client and therapist which is rooted in phenomenology and hermeneutics, and individuals cannot be separated from these systems.

In acknowledging that the realities of internalised representations seem to exist, it may be that these intersubjective experiences play a central role in their development. Therefore my ontology and epistemological positions are derived from the phenomenology of individual consciousness that may be linked to the relational unconscious experiences. Willig (2008) commented, "there are potentially as many experiential worlds as there are individuals, a researcher who attempts to generate this type of knowledge asks, what is the world like for this participant?" (p.16). Stolorow (2013) says that 'intersubjective systems' theory is based upon phenomenological contextualism as it explores different worlds and their meanings that develop in the therapy situation where emotional and relational experiences are organised. "Such organising principles are unconscious, not in the sense of being repressed but in being pre-reflective" (Stolorow, 2013, p. 383). And so for Stolorow (2013) the relational perspective is

about bringing pre-reflective activity into reflective awareness. This he asserts moves out of the Freudian psychoanalytic objectivist epistemology of the therapist making objective observations and interpretations to a perspectivalist epistemology shaped through intersubjectivity. He does not however negate exploring the unconscious but is more concerned with pre-reflective mind in the phenomenological inquiry as this he believes organises conscious experiences. I deduce therefore that there is reality to my participants' individual experiences but this may be more complex due to the suggestion by Denzin and Lincoln (2011) that there are multiple constructed realities. Koppe (2012) elaborated and defined three levels of realities: 1) the physical level (time and space), 2) the psychical level (intersubjectivity) and 3) the societal level (relational). I will explore how the phenomenon of representations exist and are experienced within these different contexts in which they may appear to existence, particularly the intersubjective epistemology using a constructivist interpretivist paradigm.

Hoffman (1991) says that the "social constructivist paradigm" or "participant-constructivist" are more appropriate terms in discussing relational aspects in the intersubjective encounter as there is an ongoing construction in the social exchange in therapy (p. 78). Hoffman (1991) states, "for the theory of intersubjectivity to be consistent with the social constructivist paradigm, it must encompass interaction on multiple levels of psychological organisation and consciousness. Any divorcing of the intrapsychic and the interpersonal is unacceptable in this model" (p. 82). Aron (1990), Hoffman (1991) and Mitchell (1988) principally differ with other relational intersubjective theorists, particularly Benjamin (2010, 2013) in that they do not separate out the significance of the individual's intrapsychic in the two-person's psychology acknowledging a more rational form of asymmetrical relational theory. This suggests that the traditional meta-psychological intrapsychic drive theory should not be ignored in the relational contextual intersubjective perspective (Aron, 1990). However despite the differences between the relational intersubjective theorists the general consensus is that relational theory cites the therapist's personality in the

relationship is equally as important as the interpretative technique (Kernberg, 2011). Even though different therapist therapeutic approaches do not play a significant role in therapy outcome (Tschuschke et al., 2014), therapists with a constructivist epistemological style have a tendency to have a greater degree of closeness and engagement with clients in therapy compared to those therapists with a rationalist epistemological style who are more distant and less engaged (Lee, Neimeyer, & Rice, 2013).

Cacioppo, Semin, and Berntson (2004) explained that positivism, a branch of scientific realism, believed that theoretical constructs or psychological phenomena could be analysed to find deductive truths similar to physics and chemistry. I do not assert this positivist paradigm but rather, in paraphrasing Ponterotto (2005), I hold the belief that the nature of constructivism is a co-construction of meaning-making of reality through dialogue and interpretation (p. 129). Ponterotto (2005) suggested therefore that, “the constructivist or interpretivist paradigm can be perceived as an alternative to the received view or positivist paradigm” (p. 129). This fits in with Kirman’s (1998) idea that within the hermeneutic social constructivism model, knowledge is constructed with others in a social context in this intersubjective field and not from a Gods-eye perspective; as such it is an open system rather than a closed system of subject-object interpretations. This suggests that the constructivist approach to research is more pluralistic in that there is no searching for a single objective reality or truth. Therefore this study will employ a constructivism-interpretivism epistemological paradigm to explore what is revealed in my participants constructed realities with respect to their individual personal experiences to their representations of their therapists. However as Hansen (2004) explained constructivism has its limitations due to solipsism, in that a person may not have the capability to fully separate out or transcend their own mind to understand the phenomenon of which they may experience or research. In this study I will focus on the mean-making of individual minds and their internal cognitions, however I do appreciate that social constructionism, that is the collective meaning-

making shaped by language and social processes (Schwandt, 1994) may influence the participants' descriptions of their internal world. As Gergen (1985) explained, social constructionism is, "the way people come to describe, explain or otherwise account for the world including themselves in which they live" (p. 266). Therefore although this study will primarily work from a constructivist viewpoint, [i.e., how one's personal knowledge is internally constructed], I believe that I cannot disregard intentionally the social constructionist perspective in my quest to obtain my participants internal knowledge. In this sense, I form the opinion that both perspectives may be intrinsically linked in this study.

According to Piaget (1971), epistemology is the theory of valid knowledge. More recently, Coyle (2007) stated, "the term epistemology refers to a branch of philosophy that is concerned with the theory of knowledge and that tries to answer questions about how we can know and what can we know" (p. 11). Relating this to my own study, I am interested in this concept of knowing using qualitative research methods developed by Husserl (1964) in studying consciousness and first-person experiences. These experiences according to Wertz (2005), are Husserl's collective terms known as epoche's, the first being the "epoche of the natural science" or "natural attitude" whereby the researcher becomes free from bias, preconceptions and influences (p. 168). Husserl's second epoche outlined by Wertz (2005) is "the phenomenological psychological reduction" where the researcher delves into the psychological world of the participant from their personal experiences (p. 168). As Dodd (2004) put it, also referring to Husserl's (1964) work, "reduction is the means whereby we orient ourselves in order to be able see what there is to see is such a place" (p. 188). Thus reductionism is the only true access to inner experience (Moran, 2000) consistent with Finlay (2008) who regarded Husserl's reduction as the method when the researcher as a philosopher avoids the world of objective scientific knowledge in order to see the phenomenon in its essence.

My epistemological stance is that a phenomenon is best understood adopting these principles of natural enquiry and phenomenological psychological reduction through the lived experience of such phenomenon. In this study, I am particularly interested in finding out more about the concept of eidetic reduction or intuition of essences; by doing so, according to Wertz (2005), "it enables the researcher to grasp what something is" (p.168). Therefore my epistemological position is developed primarily, although not exclusively, from this phenomenologist standpoint. By this I mean that my epistemological reductionist position will not pursue the pure form or structure of the essence of the phenomenon itself per se, but rather, my reduction will be more about exploring my participants' experiencing of the phenomenon. In this study, I will therefore explore the essences of the participants' experiences of their internal representations so as to "attend to the experience itself" (Ashworth & Ashworth, 2003, p. 186). As phenomenology is about the things themselves and being open to interpretation into the lived experience, this study will focus specifically on the phenomenon of therapists' internalised representations of their therapist's. Ashworth (2003) referred to this lived experience as the fundamental structure of human experience that can be understood by addressing the phenomenon of something or the "eidos of the life-world" (p. 147).

Giorgi (1997) remarked, one cannot speak about anything or refer to anything without some degree of consciousness. Laverty (2003) further detailed this point in explaining Heidegger's perspective more clearly, saying that one cannot entirely step outside pre-understandings as understandings exist due to our 'being' in the world (p. 14). More recently, Willig and Stainton-Rogers (2008) stated, "phenomenology is concerned with the phenomena that appear in our consciousness as we engage with the world around us (...) it makes no sense to think of the world of objects and subjects as separate from our experience of it" (p. 52). For these reasons I believe that it is likely that my own lifeworld experiences may be engaged and linked in the lifeworld of my participants' descriptions of their experiences through a form of shared

understanding thus circling my study back to my constructivist approach in the research process. Finlay (2008) stressed the importance in being open to the other's experience, being interested in a kind of "relational context" (p. 3). This relational concept first discussed by Giorgi (1997) suggested that there exists a subject-object intentional relationship, the essence of consciousness that needs to be understood in phenomenology. Therefore I do acknowledge that it is likely my presence in this study may come with some pre-understandings that exist in a relational context. Thus my bracketing on complete neutrality will be a challenging position, if not impossible and an ongoing process in my study. Bearing this in mind, I will adopt the principle of Finlay (2009) by attending to the embodied meaning of the phenomenon as it is lived, being responsive to the interconnection between myself and those being researched. This meaning can only be achieved by providing a rich description of the lifeworld of my participants and keeping an open phenomenological attitude.

In summary, my epistemological position, in situating my study, will work between the descriptive empirical Husserlian tradition and the Heidegger/Gadamer hermeneutic interpretative approach. My relativist ontology position and ontological pluralism questions what is out there to be found in studying the phenomenon of therapist representations. However I am aware that a post-modernist position, a form of relativism argues that due to multiple interpretations a researcher could favour one over another (Hansen, 2014). As my constructivist-interpretivism epistemology believes that knowledge is socially constructed with more than one way of knowing (Smith & Sparkes, 2006), I will adopt a neo-pragmatic approach in that truth does not have to be found in one over another as either will do (Hansen, 2014). Thus this study will adopt a constructivism-interpretivism epistemological paradigm due to the dialectic nature of my methodology, to find what becomes knowing in the course of interaction or relatedness with my participants individual experiences. In doing so, I will adopt a critical relativist position in this research believing there is no singular absolute truth; rather there are

multiple realties with multiple meanings. Thus I will explore my participants' individual experiences of their representations of their therapists in context. As Larkin et al. (2011) stated, "Heidegger's view of the person as always and indelibly a person in context and the phenomenological concept of intersubjectivity, are both central here" (p. 324).

My epistemological position acknowledges the tension between the conscious and unconscious experience in the intersubjective context. Silverman (1996b) says that the two-person psychology is an extension of the hermeneutic social constructivist position which is interactively created. Silverman's view is that clients generate an internalised object relational perspective that is intersubjectively organised and separate to one's own self-organisation. Orange (1992) agrees with Silverman (1996b) but goes a step further suggesting that this social constructivist position is not only relationally generated but usually relationally maintained. According to Stolorow, Atwood, and Orange (1999) phenomenology today is contextual in a relational system and comes through understanding the intersubjective field; it is no longer intrapsychic Cartesian model built on an objectivist epistemology. Ultimately, "for relational theorists all meaning is generated in relation" (Mitchell, 1988, p.61). Meaning is therefore generated from a pluralistic and constructivist perspective as we understand each other through experiencing one another (St Clair, 1986), particularly within a social constructivist paradigm instead of an objectivist paradigm (Hoffman, 1992).

I hope to offer the reader a rich description and an enmeshed element of my participants' narrative experiences, which Ponterotto (2005) described as the essence of the constructivism-Interpretivism, or the capturing of the "Erlebnis", 'the lived experience' (p. 131). As a social science researcher, I am aware of my primary position which Lyons (2007) said is twofold. Firstly, I am putting myself in the place of the participant and secondly, I am asking critical questions about my participants' worlds. These form the crux of my epistemological positioning;

hence different interpretative stances are possible as IPA combines empathic hermeneutics with questioning hermeneutics (Smith & Osborn, 2008).

Reflexivity

According to Riessman (2015), reflexivity involves entering a “hall of mirrors” so that the researcher can enter the phenomenon being investigated (p. 221). Qualitative research therefore acknowledges that the researcher may influence and shape the research process. Reflexivity is important in qualitative research because it encourages us to foreground and reflect upon the ways in which the person of the researcher is implicated in the research and its findings (Willig, 2008). Finlay (2002) explained that reflexivity has moved even further beyond introspection to now include intersubjective reflection, mutual collaboration, social critique and discourse deconstruction. More recently, Finlay (2011) stated that reflexivity is “a process of continually reflecting upon our interpretations of both our experience and the phenomenon being studied” (p. 79).

First I would like to say something about my personal reflexivity and explain what directed me to this research. In my search for a therapist, I seemed to struggle in finding an alliance with several different therapists and more often I did not continue beyond the fourth session. During this period of therapist switching I was intrigued reading a book by Professor Ivor Brown, a renowned clinical psychologist in Ireland in the 70’s and 80’s. I discovered we had been neighbours which I had observed by the picture of himself on the front cover of his book. His personal story touched me, in particular his enduring stories of some of his male clients who he had seen over the years. A few months after reading his book, sitting in my local coffee store he entered and sat alongside me and so I struck up a conversation about his book. During this conversation, I inquired if he could possibly recommend a therapist considering that I wished to explore aspects of my relationship to my father. He suggested a male therapist may be

preferable to a female therapist to challenge my thoughts and feelings surrounding my father-son relationship. Soon after, my long therapy journey began with a male clinical psychologist whom also was a counselling psychologist.

In therapy with this same therapist, I noticed over time that in my day-to-day I seemed to have adopted some of my therapist's behaviours. Reflexivity, according to Finlay (2003), is "where researchers turn a critical gaze towards themselves especially their emotional investment" (p. 3). At some point in the process of my change, it felt that I had internalised some of my therapist's habits and behaviours. In my self-reflection, my therapist representations did not occur immediately, but I observed after a few months in therapy I had become more assertive in greeting others with a more welcoming voice and a smile. I had more direct eye contact and I noticed my posture was different, sitting more like my therapist in a upright position. In addition, I found I was listening more attentively. One year later with my same therapist, I noticed the impact of my therapist representations whilst working with my own clients. It was at this junction that I had further observed myself leaning on my therapist representations especially during difficult and stuck moments with clients. My research therefore had been motivated by the impact of my own reflexivity, where I discovered the extent and functioning of my own internalised therapist representations in my personal and professional life.

Smith (2003) advocated the use of intra-personal and inter-personal levels of reflexivity. Therefore the introspective recording of my personal reflexivity was a starting point for my rationale in this research project. As a trainee Counselling Psychologist, I am aware of my own pre-suppositions coming into this study and how these can impact on my study. As Shaw (2010) remarked, "the challenge of reflexivity for an experiential qualitative researcher is to first identify these fore-understandings" (p. 238). Shinebourne (2011) commented, "the researchers point of access to participants' experience is through their accounts and through the researchers own

fore-conception" (p. 5). Having experienced and observed my own therapist representations and having undertaken some literature review I began with some fore-understandings on this topic. Starting out, I became aware that internalisation seemed to occur the longer one was in therapy with the same therapist and that the representations could be verbal and non-verbal. The representations could also include both thinking and behaving similar to one's therapist. I had to bracket these fore-understandings or at the very least suppress my subjectivity. But my bracketing was not about disavowing from my consciousness all of my knowledge. Morse, Swanson, and Kuzel (2001) said that all good researchers should learn about their topic before inquiry but avoid using this knowledge to frame their study.

From the beginning of this research, I asked myself why I internalised my therapist and whether I could learn more about this phenomenon. I wondered was it because I had a male therapist or perhaps it was my fondness for his therapy environment. Looking back I sense that I had an excellent interpersonal relationship with my therapist. According to Benjamin (2010) the phenomenology perspective is when the dyad moves towards authentically connecting with others in shared meanings and shared procedural knowledge which is the shared third which creates a felt experience to the other. The client and therapist by bringing in their subjective world experiences involve a process of understanding together in this hermeneutic process (Orange, Stolorow, & Atwood, 1998). Reeder (1998) in discussing hermeneutics in the psychoanalytical environment suggests one should explore the analytic relationship from an intersubjective dimension of the matrix of communication which is holistic. This he advocates is not about static terms of manifest conscious or latent unconscious but instead as "something on its way, not a possession but a process embedded in the intersubjective dialectic of interpreting" (p. 66).

Finlay (2002) commented that reflexivity is constituted as a joint process between the researcher and the participants'. Finlay (2002) went further and suggested this intersubjectivity is one aspect that falls within the epistemological positioning of constructivism. As an example I recall one of my participants stating, "I never experienced any internalisation with my therapist A [pause]". I found this response as a shocking revelation, so much so, I shifted in my seat and felt I had looked at my participant in disbelief. I believe my surprised reaction had the effect of shining a light on my ideologies and assumptions and may have impacted on the next part of my participant's reply, "but I did with therapist B". Once I had reflected on my behaviour I adopted a more neutral position. As Finlay (2002) remarked, "being preoccupied by one's own emotions and experiences, however, can skew findings in undesirable directions" (p. 541). I had to acknowledge my mistake and realise that I had not on this occasion bracketed my investigator bias and thus I may have missed out on a new understanding of the phenomenon in that exchange.

In my reflexivity I had a keen interest to keep a part of my reflexivity engaged in a form of Gadamer's (1975) style spirit of openness as I suspected that by conducting the research, in a form of lived worldly experience, it could evoke new personal constructs in understanding both my participants and my own representations. McLeod (2011) said this was a kind of conceptual encounter. This joint approach of researcher-participant mutuality was theoretically a part of the constructivism-interpretivism paradigm in my study that may have had some influence in my data collection which Finlay (2002) explained is central in research. I was intrigued whenever such an experience was jointly constituted in real time between us. I can once give an example with participant, Jack. We were discussing the appearance of his therapist wearing cardigans, when suddenly, Jack discovered how he too had been wearing cardigans; Jack became emotional in this moment and I sensed possibly his experiencing of loss of his therapist. Finlay (2008) explained that these forms of researcher/participant reductions are intertwined with

reflexivity as a form of dance weaving among the natural attitude of meaning-making within the exchange itself of the interview. Here I had observed that my own fore-understandings had shifted; as Smith (2007) noted, one needs to consider going from the thing [phenomenon] to the fore-understanding and not always from the fore-understanding to the phenomenon. He stated, “while fore-structure may ontologically precede encounter with the (things), understanding may work the other way from the thing to the fore-structure” (Smith, 2007, p. 6). I was very conscious that my reading of the text could also potentially have the same effect. Gadamer (1975) also emphasised this similar perspective, in that one reads a text by projecting meaning which is revised as new text emerges creating a new understanding with the text as a whole.

I maintained my own reflexive journal diary of my therapist’s representations and also a separate ongoing research journal to allow a rich source of data from multiple positions. In a meta-analysis on researchers reflexivity, Ritola (2011) found that researchers have the privileged position of being able to be reflexive across different roles, the investigator, the expert, the decision maker, the participant recruiter, the insider and the outsider. According to Krefting (1991), reflexivity is a form of increasing creditability or internal validity in qualitative studies. Reflexivity in research improves validity in being “critically self-aware” (Finlay, 2006, p. 319) and is considered a procedure in the validity of methodological research (Schwandt, 2007). I was aware at the beginning of this research that my reflexivity would continue to be an ongoing shifting process. This awareness of reflexivity being a process as opposed to a state allowed me to bracket off any new bias or pre-conceived assumptions of internalisation so as to keep a neutralised perspective, as far possible.

Wertz (2005) explained that one of the most important concepts within phenomenological research is using Husserl's concept of intentionality[14] being conscious of consciousness. In my study I adopted this central theme of intentionality as I engaged relationally in understanding lived experiences on emotional, perceptual, linguistically and bodily levels. My years of reflexivity in personal counselling provided me with the necessary skills to adopt this varied analytical attitude. I kept in mind Ashworth and Chung's (2006) suggestion, to attend to William James's (1890) concept of personal stream of consciousness which is itself an ongoing process. I maintained a stance of this consciousness which Giorgi (2008) suggested was about allowing the participant to choose the situation and avoiding defining the phenomenon.

Smith (1995) suggested that researchers should ask whether they kept good practice and principles within the interview process. I followed the guidelines of Hefferon and Gil-Rodriguez (2011) that more is not always more, and so from the beginning I included fewer questions within my interview schedule sheet and allowed my participants to speak freely about their experiences. I also thought about my preconceptions and motivations to my research question (Finlay & Gough, 2003). Lastly by using myself as the sole researcher in the analysing process of my participants' data, I could attain more maintainability in the validation of my work.

Quality and validity

In ensuring my study's quality and validity, I familiarised myself with Yardley's (2000) qualitative research principles of validity, sensitivity, rigour and transparency although I primarily followed the qualitative guiding principles of the paradigm-specific criteria developed by Morrow (2005). Morrow's (2005) validity criteria were the most suitable to my own study's ontological and epistemological positions. She explained that qualitative research, in particular the

[14]The term 'intentionality' is borrowed from philosophy, a feature of some, but not all internal or cognitive states in that they are focused outward at objects, events, and states of affairs in the real world (Reber, Allen, & Reber, 2009).

contructivism-interpretivism approach, requires authenticity with one's participants and with the research itself. Morrow (2005) further clarified the importance of understanding participants' meaning in context, culture and rapport which she referred to as "constructions of meanings" (p. 253). However Morrow (2005) explained that fairness and bracketing were also paramount in assisting researcher validity. I will outline some of these in more detail and emphasise how each of these criteria improved my study's validity providing some participant examples to illustrate my points.

Culture

This is about understanding the background behind different cultures and being open to specific meanings within participants' cultures. According to Eleftheriadou (1999), "at all times the therapist's reaction will be a result of an interaction of their own psychology, family and culture" (p. 228). Thus as a researcher I was aware of the risk of drawing a similar parallel to this therapist's style of thinking and attempted to avoid assumptions and stereotyping cultures. In my study, Sarah had described that although she had not seen her mother for many years in person, she did not mind at all, she explained, it was part of her culture to move forward independently of the family home and make her own way in life. My own culture of maintaining close ties to the family of origin was something I had to put aside keeping an open phenomenological attitude to her experience.

Fairness

This role of fairness in research was a criteria that Reicher (2000) reported was important and later supported by Morrow (2005) as an essential component to improve validity in qualitative research. This means that the researcher should give detailed viewpoints from a broad range of participants. I did this twofold; firstly, in my study of understanding how therapists' experienced their therapist representations, I invited psychologists, psychotherapists and counsellors, which I

believed to be fair and sound representativeness of the therapist population (see Tables section 1). Secondly, in writing up my analysis I offered a range of descriptions from all of my participants' transcribed narratives included in this study.

Kvale (1999) notes that within any research interview one cannot adopt a neutral position due to the human unconscious emotional interaction and suggests therefore there is the existence of a social construction of psychological knowledge from a conscious and unconscious perspective. However Kvale (1999) highlights there is an ethical argument that researchers should not go beyond interviewees' interpretations as the participants never asked for this level of enquiry. Frosh and Emerson (2005) ask what is allowable and what is not in the intersubjective encounter; they also caution researchers not to make over interpretations not grounded in the text. Although Hollway and Jefferson (2000) believe in paying attention to the psychodynamic in qualitative research, Midgley (2006) criticises Hollway and Jefferson's model for lacking validity and reliability believing it to be too theoretically driven and not grounded enough in the data. As Midgley (2006) rightfully asks, does a qualitative researcher have the right to point out contradictions and self-understandings of our participants? Taking all of the above into account I acknowledge the pull between knowledge generated between the conscious and unconscious experience but I feel it is important for ethical and methodological reasons to decidedly stay close to the participants' text in the analysis.

Bracketing

Due to my personal interest in the phenomenon of internalisation in my study, it was necessary to bracket my assumptions, to improve my internal validity. Morrow (2005) commented that this was for the purposes, "of making one's implicit assumptions and biases overt to self and others" (p. 254). She also suggested it is better for a researcher to ground themselves in the literature

so as the researcher can see the phenomenon from multiple perspectives. Morse et al. (2001) suggested this offered some protection against investigator bias.

Verification

According to Morse, Barrett, Mayan, Olson, and Spiers (2002), researchers should focus on the verification process or constructive process during the study as opposed to a kind of post hoc evaluative process when the study is completed. Without this ongoing verification, errors will be missed and threats of validity may go unnoticed. Therefore, "verification is the process of checking, confirming, making sure, and being certain (…) ensuring reliability and validity and, thus, the rigor of a study" (Morse et al., 2002, pp. 9–10). To manage this verification process I conducted triangulation to improve the quality and validity of my study using three methods: 1) I presented my first findings of my themes to my research supervisor to ensure transparency and bring forward new perspectives in exploring my initial findings; 2) I engaged with an external IPA expert who conducted an analysis on one of my participant's transcripts and 3) I utilised a personal diary for reflexivity recommended by Smith (1999a) and Smith (1999b).

Rigour

The core strategies to ensure rigour and ongoing self-correction according to Morse et al. (2002) are investigator responsiveness, methodological coherence, theoretical sampling, sampling adequacy, an active analytic stance, and saturation. This is a process that is never linear but rather to and fro. In this study, as suggested by Elliott et al. (1999), I provided sound examples from the transcripts and themes that illustrated the analytical procedures thus grounding the study. To keep a balanced view of my study, I did what Morrow (2005) advised regarding maintaining adequacy of data by documenting adequate descriptive material of sufficient disconfirming evidence in my analysis instead of exclusively focusing from a confirming position thereby increasing trust in the data interpretations.

Procedures

Sampling and participants

Eight participants were selected for this study who had all undergone individual personal therapy for a minimum period of one year. As these participants had completed a measure that indicated the concrete presence of their formed therapist representations, they were purposefully chosen as the most appropriate to provide rich data on the actual phenomenon of representations internalised. My sample population (7 females and 1 male) included three psychologists and five psychotherapists all working as therapists thus ensuring a more homogenous sample that is necessary to understand a particular group in depth. Some participants chose to identify themselves as both psychotherapists and counsellors. The mean age of participants was 46 years with a range from 34-59 years. The mean total of years of personal therapy with the same therapist was 3.5 years with a range from 1.0 year to 6.4 years. The mean number of hours spent with the same therapist was 147 hours with a range from 50 hours to 400 hours. The mean number of sessions attending personal therapy was 3.5 sessions per month with a range of 2-4 sessions per month. The mean time since termination of their therapy was 1.5 years with a range from 1 week to 6 years. Finally, there were three participants working in the voluntary sector, four participants in the public sector and just one in the private sector. The sample size is not regarded as small (1-3) but an appropriate sample size (4-8) for this phenomenological study (Smith, 2011). Those who showed an interest in the advertised study were given the opportunity to find out more about the study either on the phone and those who agreed to participate were posted a copy or emailed my cover letter. I aimed to describe this event as a unique opportunity in exploring their personal experience of therapy though not therapy per se. An additional one person was recruited through an advertisement for the purpose of a pilot interview that was later incorporated into the main body of the study. A gift book voucher to the value of 25 pounds sterling or 30 Euro was offered for participation in this

study and handed out at the end of the interview. Demographic details relevant to this study can be found in the Tables section 1.

Recruitment

Participants were recruited in Ireland through a designed poster distributed in therapist centres throughout Dublin City and County that offered individual personal therapy to adults (see Appendix A). Participants were also recruited in the UK through an advertisement placed within The Psychologist (see Appendix B). The same advertisement was used in Ireland within The Irish Psychologist magazine (see Appendix C). Those who contacted me by phone and thus had expressed initial interest in the study were emailed invitations to participate which included a cover letter (see Appendix D) and a screening tool, the Therapist Embodiment Scale (TES) (see Appendix E). The TES was used to determine participants' existing internalised representations of their therapist. The TES is a subscale of the TRI (Geller et al., 1981) that measures the degree of sensory modalities evoked by therapist representations. Demographic details were collected from those who returned materials by post and had passed the screening tool for formed therapist representations (see Appendix F). In addition, to explain the study, a detailed information sheet was sent out with the cover letter (see Appendix G), along with a consent form (see Appendix H).

Inclusion criteria

Participants were required to be either psychologists accredited by the British Psychological Society (BPS) or the Psychological Society of Ireland (PSI) or psychotherapists or counsellors accredited by the British Association for Counselling Psychotherapy (BACP) or the Irish Association for Counselling and Psychotherapy (IACP). This ensured that the participants were of standard professional competency with recognised accreditation reciprocity. To be eligible in this study, one needed to have had regular one-to-one counselling with the same therapist and not currently be in therapy. To be eligible to participate in this study, it was a requirement that

the participants had completed 40-50 hours of personal therapy with the same therapist, were currently qualified and were in a work setting. The reason for this inclusion criterion is that research has shown that clients' internalised representations of their therapists are more developed and stable after a period of one year (Rosenzweig et al., 1996). This was considered important so that the participant data would be of rich content to the phenomenon of internalised representations.

Pilot study

A pilot study was conducted with one participant for the purposes of examining the quality and rigour of my interview questions, but also with the intention of practicing the layout of my interview procedure. Smith et al. (2009) explained that a poor interview often contains closed questions along with an unresponsive interviewing style. The data from the pilot study was fully transcribed and coded to explore the richness of the data collected. As this pilot study had met all of the requirements and the richness of the data was illuminating in how therapists experienced their therapist representations this pilot data was included within the main study.

Interview procedure

My methodological approach to explore and evoke therapists' descriptive experiential internalised mental representations of their therapists made use of semi-structured interviews. Before commencing, I clarified the previously collected demographic information with my participants and outlined my confidentiality agreements with them. I then outlined my own personal interests in the study so they were aware that the research aim was of mutual interest, a co-construction of inquiry in this event. I advised my participants that there were no right or wrong answers and that it was alright to be reflective and take their time. I also explained that the schedule was flexible and that our meeting did not include interpretation or a clinical analysis. I advised them that I would debrief them at the end of the interview which would also include contact details for psychological resources and my own contact details. I recorded the

interviews simultaneously using two Olympus digital voice recorders, models VN 6800PC one as a backup in the event of lost or inaudible data recordings. I began with open questions to allow the participants a more descriptive account of their experience funnelling to more specific style questions (see Appendix I). Using guidelines of Smith et al. (2009), I attempted to design questions using IPA's inductive epistemology to promote a focused discussion of their experiences of the phenomenon. My interview design was inspired by Geller (2011) who undertook a qualitative study to review the autobiographical narrative accounts of six clinical therapists of their personal therapy experiences.

Transcription

Due to time constraints the transaction was carried out by a transcription agency and they signed a confidentially agreement (see Appendix J). The transcripts included a rhythmic content as in conversational analysis standard in IPA research (Smith et al., 2009). Transcriptions of interviews were not carried out in chronological order but in the order of which I found most engaging and comprehensive to the richness in data. Each interviewed participant was given a number and a pseudonym name to protect their privacy. In addition, all transcriptions were sensitive to maintain anonymity, and so places or other identifying content was changed by me.

Analysis

As recommended by Smith (2004), and Smith and Osborn (2008) the first stage of my analysis began within-case analysis before progressing to a cross-case analysis. Analysis began with my interpretations of the transcripts following IPA protocol of reading and rereading the text. According to Smith et al. (2009) an IPA study is accepted where there exists a positioning between Ricoeur's (1970) 'hermeneutics of empathy' and 'hermeneutics of suspicion'. I incorporated the use of IPA analysis to identify the core categories and themes by which my participants made sense of their representations. The interpretation process was to

contextualise my participant's narratives to find the essences of their experiences (Shinebourne & Smith, 2009).

According to Finlay (2009) the research analysis starts out with concrete descriptions of the participant's first-person lived experiences. This involves reflecting on the material in an ideographical approach and later synthesising by forming themes within the essence of the phenomenon and "reading between the lines" (p. 10). In analysis, Smith (2004) suggested analysis is non-linear, and that, to understand the part you look to the whole and to understand the whole you examine the parts often described as the hermeneutic circle. He suggested our analysis should involve moving from the language to the person and from the person to the language, again a form of hermeneutic circle. McLeod (2003b) stated, "the incompleteness of interpretation has been labeled the hermeneutic circle; every interpretation can in turn be interpreted by someone else" (p. 87). According to Wertz (2005) analysis requires an attitude of wonder entering into the world of the other, focusing on meaning as it is presented by the participant. This he asserted, means reflecting on the psychological processes of "bodily, perceptual, emotional, imaginative, linguistic, social and behavioural" activity (p. 172). I used excerpts from my participants' descriptions of their experiences to give the reader some understanding on an empathetic level. My subjective analysis was an iterative process at how I interpreted my participants interpretations of their experiences, the "double hermeneutic" (Smith et al., 2009, p. 3). I mapped out briefly how I conducted this idiographic process of analysis through a series of stages which I will now outline.

In this first stage, I immersed myself in my participants' data by several repeated readings and listening to the transcription material to locate my underlining first impressions. Smith (1995) explained that analysis is an iterative process where text has to be read many times as each time throws up new themes and meanings. As Ricoeur (1970) said referring to the 'hermeneutic

field', "a symbol is a double-meaning linguistic expression that requires an interpretation (…) that aims at deciphering symbols" (pp. 8-9). The readings helped me to feel the mood, the style and flow of description and engage in the interpretative relationship with the transcript (Smith & Osborn, 2008). In my initial reading, anything interesting that sprung to mind I noted within my descriptions section on the transcripts, for instance, the non-verbal language, defenses or incongruence of my participant. This allowed me to go beyond the explicit text where my analysis included inquiry at the implicit level.

The second stage was an active process of hovering on the semantic content in a kind of free association style yet simultaneously concentrating on the explicit phenomenological underpinning of my participants' lived world. At this detailed level of analysis, I wrote my initial comments in a column to the right of the original transcript. According to Smith et al. (2009) this initial exploratory work should separate out discrete focuses into: 1) descriptive comments, in other word's what was said, at face value in the dialogue (noted in black text); 2) linguistic comments or specific use of language such as metaphors, pronouns, tone of speech, pauses and sighing or laughing (noted in blue); and 3) conceptual comments at the inquisitive level, interpretation beyond my personal frame of reference, within the participants' explicit lived world (noted as red underlined) (see Appendix K).

The third stage now involved going beyond the initial analysing of local comments, and extracting the developing emerging themes from across the exploratory comments and notes including transcripts. These emerging themes were more concrete in capturing my understandings in a more coherent fashion. Smith and Osborn (2008) commented that this stage is a much higher level of abstraction using mostly psychological terms and it is a process of linking the terms to the actual text within the transcript. Once I had completed this process I

created a list of the emergent themes in advance of my clustering of these themes (see Appendix L).

The fourth stage involved bringing it all together and organising connections between the themes making sense among them. I conducted this as recommended by Smith (1995) by printing each theme on paper and cutting them out separately. In doing so, I could form clusters by moving them about, noting similarities or dissimilarities among the themes. This process enabled me to move themes about from one cluster to another always going back to the main transcript text to verify its suitability to my newly formed master theme. Smith and Osborn (2008) commented that "as a researcher one is drawing on one's interpretative resources to make sense of what the person is saying, but at the same time one is constantly checking one's own sense making against what the person actually said" (p. 72). Through a process of abstraction, polarisation, contextualisation and numeration analysis, newly formed subordinate themes from these clusters emerged to form superordinate themes. I noted the page number and line number as identifiers (see Appendix M).

As a further step in reduction I collapsed my new subordinate themes noting the page and line number with relevant quotes so they could be easily traced back to the original transcript. For further collapsing of themes (see Appendix N). In the final stage of analysis I listed by page number and line number the quotes for each of the emergent themes (see Appendix O). On completion, the whole process restarted with the second participant until all participants were analysed and a final master table of themes was created. I presented within the subtheme quotes showing divergence and convergence to demonstrate the range of lived experiences and to attend to the essence of the experience.

Timetable

The study began from the research proposal stage in February 2014. The process of finding participants was very challenging however the first participants were recruited in September 2014. The interviews were conducted between September 2014 and November 2014. The analysis of the first participant took place in February 2015 and all analysis were completed by April 2015.

Ethics and permission

My study was grounded by the standard codes of conduct and ethics outlined by the British Psychological Society (BPS, 2009), the Psychological Society of Ireland (PSI, 2011) and the Health and Care Professions Council (HCPC, 2015). This study had ethical approval from the Department of Psychology Research Ethics Committee at City University London (see Appendix P). For this study I engaged the services of Howden group for professional civil liability insurance cover (see Appendix Q). Data was collected using one-to-one semi-structured interviews in a private room within public college buildings that had personnel at reception who could be called in the case of any unforeseeable circumstances. Pseudonyms were used throughout the study to ensure anonymity and all files were coded to protect anonymity. Participants were posted a copy of the study's information sheet in advance of the interview that explained their participation was voluntary and the reasons for the study. Written consent was obtained prior to participation in the interviews and again following interviews for permission to use the material (see Appendix H). Participants were made aware their data including recording material would be secured in a lock and key cabinet in my home office and would be destroyed after five years though they could request me to destroy this anytime during this period. Before beginning the interview, participants were given an outline of the interview procedure and I again explained their rights as participants, in particular to confidentially and withdrawal.

All participants received a copy of my debriefing form as part of the post-interview process. This post debriefing form contained the full contact details of the leading psychological organisations in both the UK and Ireland. My full contact details were also included (see Appendix R and S). I did not expect any greater risk of either physical or mental harm to my participants that would occur in ordinary life. As my participants were also practicing therapists, I did not foresee any difficulties of a hierarchal imbalance of power other than a risk of my participants' possible enthusiasm in providing me with data that might be more relevant to my study. Willig (2008) outlined that good ethics should include: 1) informed consent, 2) no deception, 3) right to withdraw, 4) debriefing and 5) confidentially. I believe I followed these important guiding principles in my study.

Analysis

The Interpretative Phenomenological Analysis (IPA) of the eight participants' interviews revealed three master themes related to the research question. A summary below provides an overview of the superordinate and subordinate themes. For an illustration of the main participant recurrent themes (see Table 2 in the tables section).

Superordinate theme one	**Subtheme**	**no**
Letting the therapist in	The yearning for the therapist	1
	The feeling of connection to the therapist	2
	The therapist's navigating voice	3
Superordinate theme two	**Subtheme**	
Identifying with the therapist	The modeling of self to the idealised therapist	1
	The visualising image of the therapist's support	2
	The emotional containment of the therapist	3
Superordinate theme three	**Subtheme**	
The changes within	The growing experience of change within	1
	The internalised loss of the therapist	2

Table 1 Superordinate and subthemes

Summary of the main superordinate and subthemes

The analysis aims to show connections across the participants so that the individual cases are represented within the higher order concepts of the superordinate and subthemes (Smith et al., 2009).

Analysis of the transcripts yielded interesting data covering a range of internalised representations by the participants. This section aims to introduce and discuss some of the emergent themes within the three superordinate themes: **(letting the therapist in), (identifying with the therapist), and (the changes within).** For each theme, quotes are used from the participants to illustrate the lived experience of that theme.

The first superordinate theme titled, (**letting the therapist in)**, concerns the participants' experience of the presence of their therapist representations in relation to themselves and their lifeworld, especially to the mother fantasy and internal dialogue with their therapist.

The second superordinate theme titled, **(identifying with the therapist),** presents an account of the participants' identification with their therapists which manifested most frequently with the visualisation of their therapists. The representations of their therapists were often also experienced as supportive and holding in their personal lifeworld but also within their professional lifeworld.

The third superordinate theme, **(the changes within),** examines the main agents of change within their lifeworld impacted as a result of their therapy and therapist representations. This superordinate theme also explores the participants' internalised loss of their therapist.

Superordinate theme one: Letting the therapist in

The yearning for the therapist

Most of the participants seemed to have experienced some kind of parental fantasy in that they experienced their therapist primarily as their mother and other times their father. Within the participants' extracts this relational parental fantasy of internalised feelings for the therapist as mother and father appeared to contain a child-like tone. There seemed to be a sense of the

participants yearning a symbolic parent in therapy, almost in a way to offer them something new, possibly something supplementary in the relationship. In this first extract, Jack described a dream he had about his therapist.

> *Yeah, well she was older than me and I dreamed about talking with her on a bench in a kind of park. Then when, then I started having sexual counter-transference during this but it felt funny that she said, "well, this is normal, you know, to have this feeling. It's almost like a little boy would have for his mother or something wouldn't it?" and I was like "Oh God" but yeah, it was just kind of simple Freudian, you know, oedipal stuff.*
>
> Jack: 23-24, 683-696

Dreaming is one way representations of one's therapist are expressed. Jack's extract can be interpreted on many different levels. Firstly, the dream figure is someone older and possibly wiser than himself; he is attempting to form a bond with this woman in the dream. He dreams of "*talking with her*", which has seemingly gone beyond the therapeutic space of the therapy room. In a sense, it seems to be an experience felt by Jack where his therapist has become a parent-like figure in holding him. Secondly, the experience of the dream makes you wonder the content of their conversation as there is a certain intimacy and closeness in this sitting *"on a bench*". There appears a level of romanticism in their proximity, akin to a mother and child in this park environment. Thirdly, there is a level of grounding and solidness in the image of the bench where the bench resembles a level of holding; it could be seen as a metaphor of a strong structure of four legs as with the unity of mother and child. Further evidence of this unity was evident when Jack said: "*she allowed me to, she invited me to project my mother onto her and I remember that".* (20, 590-593)

Furthermore, Jack's park bench dream contains a degree of warmth as he seems to experience his therapist as very accepting of him where she was not bothered about his seemingly sexual

feelings towards her. Jack acknowledges his child-like attraction to his therapist as he experiences himself as the little boy in his likely fantasy to be with his mother. Jack felt this experience as "*funny",* not funny in the comical sense but in the odd sense of feeling a little strange and embarrassed. In his language the funny feeling is described as, "*It felt funny*" instead of *"I felt funny*" as Jack seems to experience this peculiar feeling as something outside of himself. 'It' is an object, an abstract piece, and so it may be that Jack found it difficult to put the experience into words. However other evidence of Jack's mother fantasy is expressed differently, he states:

> *I wasn't told what was happening or why it was happening so this time it was a very concrete feeling of moving my mother out and moving Alice [in] (pseudonym name for therapist), almost like a way to view the world.*
>
> Jack: 18, 508-513

Therefore Jack's experience of feeling his therapist as a mother figure is at times intangible while other times it is experienced as more real.

The following extract once again portrays a child-like fantasy to the mother, Nadia remarks:

> *I think with my childhood I don't really get on with my mother. We just have a very bad relationship so I kind of feel that I lack a mother figure, a proper one. In a way I'm consciously I suppose you know, have a desire of a mother in my therapist.*
>
> Nadia: 8, 208-214

Nadia describes her conflict she had with her mother. In this extract, one interpretation is that she was not afforded the protection as a child and now clings to her therapist for a psychical

holding and containment in the mother-fantasy. Nadia also commented, "*I suppose in a way what I was trying to do was protect myself as in getting a nice mother image*" (30, 890-892). She seems to be longing no ordinary mother but a "*nice mother*", a good enough mother who could protect her as a little child. But there is something more; Nadia seems to try to go further and embody her therapist as "*the mother image*". She seemingly is looking for a holding, a psychic picture, something that she can keep forever that can be non-fleeting and long-lasting. In a sense she may be attempting to imprint in her mind the nice mother image as she later confirms in this brief extract.

> *I feel that now I kind of have internalised her in a way.*
>
> Nadia: 31, 913-916

She seems to experience a sensory element where she can *"feel*" the mother-therapist inside of her. This may refer to an emotional element as if she is in touch with her own body. Nadia later communicated:

> *He would be like [big time] my mother-figure kind of thing in psychoanalytical terms.*
>
> Nadia: 55, 1642-1644

On one level this fantasy of letting the therapist in as the internalised mother is a significant event described as "*big time*". On another level and possibly more compelling is that Nadia has a male therapist yet she has identified him as a mother figure. In that sense, it would seem she experiences a greater longing to a missing mother and not her father with whom she already had a good relationship. Her fantasy is relational and evidence is provided in Nadia's remark, she says:

> *He said that I was the daughter he never had.*
>
> Nadia: 54, 1588-1595

This single sentence is very powerful as it seems to suggest a relational parent-like experience with her therapist. It would seem both Nadia and her male therapist are on some interpersonal experience of mother-daughter relationship. The therapist is experiencing Nadia as someone he too is longing for, the daughter possibly "*he never had*". He seems to experience a bond of parental love for his client as a daughter and thereafter it was perhaps a shared experience of fantasy.

The parental fantasy representation may also have been experienced in this next extract, Kaelyn says:

> *I think with my first therapist it was connected to my parent's death, you know. Both of them. Because they both died when I was quite young you know. So they were profound moments actually, you know, making connections and you know, just really (…) they shifted me hugely and I can't even explain to you because it's quite personal.*
>
> Kaelyn: 20, 575-583

For Kaelyn the experience of connection to her therapist reminds her of her own parents, in particular to the loss of her parents. On one hand her experience seems to be unlike Jack's and Nadia's, both of whom only described experiencing their therapist as "*mother*" whereas Kaelyn seemingly experiences her therapist as both mother and father as they "*both died*". For Kaelyn the experience seems almost unreal, a feeling of mystery, one that cannot be signified, "*I can't even explain*". On the other hand you do sense her experience is similar to Jack and Nadia as she too has a need, a demand to fill the space and maintain a form of parental image lived

through the therapist relationship. There is a feeling that Kaelyn was trying to weave it all together *"making connections*" but struggled as the connections were fleeting and hard to grasp as they were only "*moments*". It is as if the experience is felt by her as a momentous event, it seems to hold deep personal meaning, in a kind of seismic way, "*they shifted me"* almost a shifting of her ground and her world with her parental fantasy. To this point the analysis has focused primarily on the attachment to a parental fantasy however this next extract confirms a polar viewpoint.

Sarah comments:

> I kind of find it difficult maybe to relate, you know, to him in that scope of, you know, like being my parents, you know. [Laughs]. Maybe also because he is the man, you know, they say in my culture (…) in terms of, he is like a father figure or a mother figure, you know. So I would say (…) I think it is more father (…) My relationship with my father has been always close, you know. But also because my father passed away again I missed [him] a lot, you know, of my father. I never seen that, seen him, you know, in that…you know.
>
> Sarah: 16-17, 458-490

Sarah seems to be experiencing difficulty in connecting to her therapist in the mother-father fantasy. She makes a possible identification to him as father, but is rather uncertain as she feels the connection is more culturally specific. Although her father has died and she does experience this loss she does not appear to have a need to fill her loss with a substituted fantasy of letting her therapist in as father. Explicit in her statement and rather matter-of-fact about determining her parental fantasy she told me, "*I kind of find it difficult maybe to relate, you know, to him in that scope"*. Although Sarah says she was not looking for a parent in her therapist, there may be something implicit in her use of the word "*scope".* Possibly she may have been looking for her

father in her therapist through the "*scope*" but within her horizon her current therapist could not been seen.

Another participant who struggled with the parental fantasy was Sharron. However her perspective differs to Sarah in that Sharron seemingly did attain it; she says, *"I suppose you know she became the mother figure for me very strongly*" (25, 729-731), however unfortunately Sharron seemed to have experienced rejection by her therapist.

> *Oh it was one session certainly with this woman, the one I was with for nine years. I spent one session; I didn't talk through the whole session, I just sat and cried. And I meant there was a lot of anger that I felt you know playing out. I suppose of transferences that she was not like my parents, not helping me basically and not giving me any help, that I was expected to do it for myself.*
>
> Sharron: 19, 549-561

In this extract, Sharron seems to experience a very deep emotional sadness. The sadness seems to relate to her therapist not becoming that all-loving mother or father. In one sense she seems to express a lot of frustration, "*a lot of anger*" that her therapist may not have "*played out*" the role model of the parent she was longing. This underlying anger may be evident in her addressing her therapist nameless as "*this woman*", thus perhaps implying unrelatedness. In another sense, it could also be interpreted that Sharron was in therapy behaving like a spoilt child "*playing out*", acting out in a regressed state in the hope she would be lifted and symbolically put into the arms of her therapist. This holding and containment was not felt by Sharron, as she says in this extract:

> *I think, you know, there was far more substantive stuff that we dealt with and I really did have this massive internal transference to go through, you know, massive. So I think even though that was worked through and we became more relational, as I said at the end, it still was that piece of really – And I think because my piece was maternal abandonment, even though we worked it through, when I stopped with her, that piece came back in again then and I just had to process that again, you know.*
>
> Sharron: 49, 1445-1550

As Sharron repeatedly used the word "*massive*" she seems to experience the work of transference as a monumental piece of work. In a sense she seems to regard it [transference] as *worked-through* however in reality it would appear it may not have been fully worked through, as "*that piece came back in again*". Sharron seems to indicate it is her unresolved *"maternal abandonment*" that was not worked through and so it would appear her therapist may never have accompanied Sharron in her likely experience as a child in therapy. Perhaps her therapist did recognise her maternal desire, but did not want to become the fantasy parent who would someday end therapy, creating another abandonment. Either way the interpretation seems to be a feeling of annoyance and a form of protest as it is Sharron that ended, "*I stopped with her*".

Summary

Most of the participants seemed to experience a sense of connection to their therapist and seemed to use their therapist as the fantasised object parent. It appeared that the participants absorbed the parts from their therapist's they may have missed in their primary care development. Many of the participants seemed to experience their parental fantasies as a kind of wonderful connection which they often struggled to put into words. In contrast, there was also some annoyance and frustration present in those who, although they did experience their

therapist as mother, they may also have experienced their therapist as rejecting, as not becoming enough of a mother or father.

The feeling of connection to the therapist

Most participants seemed to experience having their therapist living within. They often expressed it as something that was just there, simply felt. It was felt as a form of presence, a physical attachment that was either alongside them or even inside of them. For the most part, it seemed the participants could identify with this presence and recalled it as something akin to a conscious mystical experience. The felt-sense or felt-presence connection manifested itself in day-to-day life, but mostly it was felt where there was a conflict or a feeling of being stuck. The felt-sense seemed to make sense to the participants and understood by them as a shared experience between themselves and their therapist's. The presence of one's therapist was experienced in different ways.

> *I do have a sense of her a lot of the time but it's more that she is with me or beside me.*
>
> Janice: 23, 670-673

> *I suppose sometimes she is with me, she is with me more than I actually thought. I suppose it's something I will always remember.*
>
> Helen: 43, 1278-1284

From these extracts, it could be interpreted the experience of the felt-sense or the feeling the presence of one's therapist is experienced consciously. It would seem Janice and Helen experience the presence of their therapist's on a temporal level, *"a lot of the time"* and "*always remember".* In a sense, both Janice and Helen seem to share comparable experiences in that their felt-presences of their therapist's are alongside them, "*she is with me".* Their experiences

seem to be felt without any doubt that their therapists are with them, holding them. It seems to be experienced as having some effect, some other value that they hold dearly like a friend that is with them and understands them.

In contrast to the felt-sense experiencing, Sarah remarks:

> *Well I suppose it's really within you, it's inside not outside. Obviously and flexibility is you have the boundary as well, you set the boundary.*
>
> Sarah: 29, 840-863

Sarah experiences her therapist presence as something within, "*inside"* of her, "*really within*" that is, "*not outside*" as with the previous extracts where there seemed to be more of an experiencing of a togetherness and along-sidedness. She uses the term *"it"* to describe her therapist felt-presence so in a way it may imply a degree of distance even though she feels it is still something internal. Possibly Sarah's felt-presence is something she controls by her setting *"the boundary*"; in other words, she sets the perimeter of the therapist presence, so ultimately it may be her decision whether to experience this felt-sense within her body or not.

In stark contrast, Janice says:

> *I think I feel a sense of her but it's not an embodiment. It's not something that's in me, Em, it's more someone that's with me.*
>
> Janice: 28, 814-818

Here Janice seems to imply there is a sense of feeling her therapist presence outside of her body. It does not seem to be experienced as something incorporated inside. Of interest is how Janice increases her felt-sense as she moves from describing "*it""* as an object to "*someone*",

therefore she seemingly experiences another person alongside her [i.e., her therapist]. The felt-sense is thus experienced as a kind of animated object as opposed to an inanimate object. Life may be brought into the felt-sense, a human attitude that is internalised in different ways. Let us take a look at two extracts below to illustrate this point:

> *I was a bit embarrassed like God I'm really imitating her voice now. It was only imitating her voice or her mannerism or even her accent you know.*
>
> Nadia: 24, 709-717

Nadia acknowledges that the presence of her therapist manifests itself in her mimicking of her therapist accent. She seems to experience it in the "*now"* as she notices her manner and tone moving towards her therapist. She also seems to experience this mimicking as shocking, almost in a sense of disbelief in this feeling. Her feeling "*embarrassed"* may suggest she has gone too far impersonating her therapist.

Jack also experiences this level of self-awareness regarding his therapist but it is observed in his style of dress, as he commented:

> *I started wearing cardigans because she wore cardigans all the time. I remember yeah, so there was almost identification in that kind.*
>
> Jack: 19, 538-566

Jack describes how he had a dream of his therapist becoming his mother in theme one and here now Jack gets a sense of his therapist by wearing clothes like her. The cardigan seems to offer him warmth and comfort on his body.

In contrast to Jack who appears to hold an object of touch as his representation of felt-sense, Helen has a different experience:

> *In the sense of self-disclosure she would not self-disclose. So in a sense of knowing her I don't know her at all. But at the same time I feel as if I do know her, you know, I really feel as if we have connected at very, very deep levels. And that […] It's just a connection. It's just – it's there, you can't see, you can feel it without physical touch or anything, you know. It's just the contact, you know, the erm – the eye contact, the posture and just the softness of her presence.*
>
> Helen: 1-2, 20-36

There are several points of interest in this extract. First, Helen describes not knowing her therapist *"I don't know her at all*", yet paradoxically she has the experience of attachment to her therapist, as she emphasises "*really"* feeling connected, and so she appears to be very ambivalent in her felt-sense experiencing. Second, her connection is felt as a mutual collaborative event as she describes the connection in the context of two persons "*we"*, therefore it seems her connection has shifted from an *"I"* to a "*we*" connection. Thirdly, the connection is felt at *"very very deep levels*" which could be interpreted that she feels her therapist presence at deep unconscious levels. She had earlier stated she did not know her therapist at all, so perhaps the connection is only felt by her at some intersubjective unconscious level or at an interpersonal psychic level, "it's there, *you can't see it".* This could also be interpreted as something that is almost unattainable, untouchable and most likely therefore unreachable to the physical hold, yet it still emerges as a "*presence"* in the therapist presence of body movement. In the next extract Helen seems to balance her understanding of the phenomenon of feeling her therapist presence:

> *No, no I felt it very much. Even when - often times when I would, I suppose … when you would go through therapy and you might work though things that are difficult, you know. Sometimes you might isolate yourself a little bit more or you might not feel like engaging as much with people. Erm… on the opposite side of that when I would be engaging I might have a little chuckle and say 'Oh, if she could see me now' like, you know, or this is so different to like seven years ago when things weren't so good. She would be happy for those things, you know, so it's a feeling of "Oh it's a moment", it's almost a moment shared together even though we are not together.*
>
> Helen: 21, 601-619

Helen describes her possible two scenarios of experiencing the felt-sense, the positive and the negative, however in both experiences the felt-sense would appear fleeting, "*it's a moment*" something coming and going in an instant. She seems to believe the felt-sense of her experience is also felt by her therapist simultaneously. From this it could be interpreted that she has taken in a part of her therapist which may explain her feeling of oneness and unity of a"*shared together*" experience. She provides further evidence of these feelings: "*yeah though as if yeah, as if she knows me without me having to explain a lot, she gets it, she understands me*" (3, 64-66) and *"I just knew her by her presence, I could you know, she understood (pauses) you know, it meant more to her like*" (9, 264-267).

An important and final narrative that weaves throughout the participants' descriptions of their feeling of connection is how it can manifest itself while working with clients. When the participants were asked about their felt-sense of their therapists, some remarked:

> *Sometimes I do when I'm with my clients, I do sometimes I have thought about that and I do think I'm trying to [...] I take on being like her yeah.*

Jackie: 11, 318-323

I think it's only whenever I am with clients that was the time that it will happen you know, like kind of dawn to me.

Sarah: 21, 613-617

Yeah certainly I would. I would of her even around, when it comes into certain aspects of a piece with a client she would come to my mind.

Kaelyn: 12, 341-356

It is interesting in that these above extracts all seem to indicate the participants experiencing a form of awakening to their senses of thinking about their therapists'. Using words such as "*dawn to me*" or "*come to my mind*" may provide a clue into how they were experiencing their therapist representations. Furthermore the apparent presence of these representations seems to hint at the use of these representations in particular as a possible helping apparatus with their own clients struggling and problem-solving.

Summary

The participants often spoke of a felt-sense of their therapist which they experienced as a feeling of their therapist representations as either being beside them or alongside them. For others, the experience was felt more as having incorporated their therapist inside of them. The experience was sometimes consciously felt, but more often it was an experience that was something hard to put into words and therefore may only have been felt unconsciously. The participants' felt-sense of their therapists was not only present in their private lives but also while they were themselves conducting therapy.

The therapist's navigating voice

The participants often had experiences of internal imagined dialogues with their therapists. In most occurrences the participants could visualise their therapists in conjunction with these virtual conversations. These experiences were regarded as positive connections in their lives, felt both personally and professionally. The internal voices seemed to be experienced consciously. In that sense, the internal dialogue may have been experienced not as self-talk, but instead a two-way relational experience suggesting an internal boundary between the self and the therapist. The dialogue had significant meaning and value and there was an importance placed on taking in and listening to the internal voice of their therapist as a form of possible guidance. Introducing this first extract has a particular potency as it links back to theme one, the parental fantasy. Jack remarks:

> *Yeah, definitely yeah internal voice and then later became almost an internalised, unconscious model...Like, you know, they talked, I never understood it until I experienced the internal working models of parents. So she kind of replaced my mother and became more of a positive filter to the world inside me in the female sense rather than…Then my Dad was the male sense of the two.*
>
> Jack: 26, 762-755

On one level Jack explicitly lets us know that he has the experience of his therapist voice, the internal voice. What is interesting about this extract is that for Jack the experience seems to be developmental, for instance he describes how the voice "*became".* In a sense it feels that the voice grew inside of him, starting out small and flourishing into his deep unconscious state, almost becoming a part of his existential self that developed *"later".* Jack also says the voice became *"a model*", perhaps a kind of navigating role model like a parental caregiver for him. One could interpret that Jack was therefore using his therapist representation as the internal

voice to substitute the voice of his mother. Another level of interpretation is Jack's use of the metaphor "*filter".* What could Jack be filtering? What is he attempting to clean out? Filters in the generic sense are there to provide a function of ciphering out dirt, thus it could mean that Jack was using the internal voice as a way of providing fresh oxygen and freedom to breathe in his life. He describes how the voice is a female filtered voice which possibly relates back to his mother fantasy in his therapist, however we now capture for the first time that the voice has a male impact too.

This sense of internal voice is also captured by Jackie who experiences the voice of her therapist, as she comments:

> *And that has kind of stuck in my head, this mantra – what is the worst that could happen when you're feeling stressed or anxious? And I've kind of said it to a friend of mine and he said – oh, that's really good, I say that to myself now. So it's kind of weird how that sort of stuck in my head, yeah.*
>
> Jackie: 5, 119-128

In this extract there are again multiple interpretations. First, Jackie describes the voice in her head as a "*mantra*", and so you get the sense the voice contains a spiritual element and, typical of any mantra, it is repetitive. She would appear to experience vividly this mantra [her therapist voice] as it somehow embedded inside of her, "***stuck in my head",*** which ironically she does repeat twice, in the opening sentence and the last sentence in her extract, almost mantra-like. It almost feels she cannot escape from her therapist voice. Looking specifically at the repeated mantra, "*what is the worst that can happen when you're feeling stressed or anxious*?", Jackie appears to use the mantra when she needs the support of her therapist. There is a level of therapist empathy and understanding in that this mantra seems to be navigating for her as it

was for Jack's internal navigating working model. Her mantra also seems to offer her a soothing element, for example, she comments:

> *Yeah I would think so maybe yeah in work situations or relationships with people, you know, I'd think what she says you know, that mantra, that mindfulness.*
>
> Jackie: 16, 450-454

There is therefore a sense of the internal dialogue that is ongoing, the helping therapist. Janice also experiences her therapist's voice as a form of internal dialogue and helping as she remarks:

> *If I am thinking about something and getting quite upset or if I am going into a tricky situation or something or I am dealing with something I'd rather not be dealing with, then I'd kind of think, 'ok what would she do?'.*
>
> Janice: 24, 706-716

There is a sense of continuous supportive holding in this internal dialogue. As Janice describes "*that inner dialogue would go on for quite a while"* (27, 782-784). Therefore we get some insight that the dialogue may have a temporal quality and as such it is something that appears at times where she has a need for support. There is also a philosophical attitude when she says, *"I'd be thinking what would she say*" (27, 784-785), as she may be attempting to use the internal representation to get inside the head of her therapist just as her therapist is inside her head, a meeting of minds so to speak.

This philosophical thinking was also evident in Sharron's extract:

> *And I am aware sometimes too that I would be kind of thinking you know what would she have said to me now in this situation?*
>
> Sharron: 38, 1137-1140

For the most part, so far, there is an element of day-dreaming the imagined dialogue of the therapist representations and thinking about one's therapist in a personal capacity. However there is good reason to assume these representations are used while conducting therapy: Jack describes his imaginary dialogue with his therapist.

> When I'm lost in therapy with patients or clients sometimes I get completely lost, and she comes into my head "Slow it down Jack. Just take a breath and go back into your breath and, you know, just really calm yourself". What she will often say is, you know "Don't worry if you've missed something if it's important it will come back. It's like a hook in the sky, it's like a balloon".
>
> Jack: 28, 821-835

Jack's therapist's voice seems to come to him when he is lost and so in one sense you can capture his sense of being lost without his mother. Perhaps he uses the voice to reach out to his therapist for reassurance and guidance. This extract seems to bring an embodied dimension to the voice as he says the voice comes "*into my head*", just as it was for Jackie "*stuck in her head".* For Jack however the voice seems to be a more free-floating experience *"it's like a balloon*", coming to him almost uninvited but nevertheless a welcomed experience. Interestingly, Jackie and Jack describe their experiences of their voices as being inside their "*heads*" and not their minds. This may suggest again an embodied dimension of the therapist representations and an awareness of separation.

Summary

The internal navigating voice and imagined dialogue with one's own therapist demonstrate how the therapist representations are experienced on both a personal and professional level. For some they appear to be friendly reaching out as a supportive and caring role. For others, they also appear to arrive unexpectedly, especially in difficult situations and mostly while working with clients, but not exclusively.

Superordinate theme two: Identifying with the therapist

The modelling of self to the idealised therapist

This theme reflects how participants identify with their therapist, which takes different forms - verbally in using their therapist's language and non-verbally through identification with the therapists' body language, such as body-posturing. Most participants reported these identifications, especially to the likeable parts of their therapist. There were mostly instances of the participants mimicking their therapists. There were noticeable identifications with their therapists professionally, in that most of the participants had aspired to identify with their therapist's professional work practice whilst working with their own clients. In general the therapist identifications were experienced as a positive and a valuable resource in their own therapist roles. The following extracts share a common narrative whereby each participant seems to identify with the therapist's verbal language. For example, Janice says:

> *I think from her.*
>
> Janice: 14, 416

> *I would have said things to clients that she has said to me, so I would use her language.*
>
> Janice: 39, 1152-1154

It is interesting that she does not say I would use her words rather "*her language"*, and so it could be interpreted that she may mimic her therapist instead of selecting specific words.

Sarah goes a little further when she remarks:

> *I think the use of the language so you learn from your therapist the words that they always use…Certain phrases that they always use, you know, and yeah, even their body language, you know, how they kind of approach you in that way.*
>
> Sarah: 23, 667-677

Sarah describes using her therapist's words but seems to capture the imagination of what it is like to be in therapy with her own clients. It is as if she experiences having her therapist inside of her as she uses her "*body"* as the vessel to transmit her therapist's language and phrases. These phrases appear to be open and helpful and could be experienced by her as holding.

In contrast, Nadia describes the opposite experience:

> I was too much, kind of, I suppose, thinking about her. Or, you know, trying to speak like her that I didn't know where I was for a minute maybe, you know. I was kind of lost in that a little bit, not too much because I felt safe with her but it was on my side, it wasn't on her side.
>
> Nadia: 26, 756-765

Nadia describes herself as feeling *"kind of lost*" in the likely identification with her therapist's language. She is perhaps describing a sense of loss of her self-concept, where her real self is shadowed out as she attempts to adopt and model her therapist's language by mimicking her therapist's voice. She goes on to explain further, "*her accent was really really nice, a very*

*London accent, I really like her accen*t" (23, 667-668) and "y*eah like really professional, kind of it's not just the dressing bit, it's just the whole package you know*" (10, 288-290). She may therefore experience herself becoming almost invisible and worse becoming a witness to this potential loss of self-identity.

The participants also described a form of idealising the therapist's body. Sarah already touched on this however it is Sharron that points to her use of her therapist's body language more concretely.

> *I think the last one I had five years ago was very inclined to lean forward, you know, when we really were catching something and I think I tend to do that too. You know, to lean forward.*
>
> Sharron: 36, 1069-1081

In one sense Sharron has a conscious recall in how she mimics her therapist. It could be interpreted that Sharron shifts her posture when metaphorically she is leaning on her therapist for support. She does not confirm what the "*something*" is they are "*catching"* but you do get a sense it may have considerable importance to catch it.

Nadia also seems to have the capacity of identification.

> *Well again like say if I were to behave like her which I didn't do today on purpose, I suppose if I really want to get really into it, I suppose I will wear a ponytail or a suit. I just (…) I paint a character.*
>
> Nadia: 22, 635-641

Nadia appears to outline the mood of getting into "*character*", perhaps her therapist's character, by being able to dress in her therapist's image. We know from her earlier extracts in theme one that she attempts to sound like her therapist, and so she seems to fully embrace her therapist

identity. Her language suggests that she experiences her therapist identification as a piece of art, as if to "*paint a character*" which has a feeling of life and enthusiasm. She may also experience a desire "*to get really into*" the picture of her therapist's character. Of course paintings have a frame and thus it could also be considered that she uses and identifies her therapist's character as holding and keeping within the therapeutic framework. The extracts in this theme from Nadia and Sharron presented seemed to indicate how their own bodily identifications were entwined with their therapists'. In one sense Nadia and Sharron do bear witness to their therapist identifications but perhaps there is more of a mirroring experience of their posturing where there is a meeting on an unconscious bodily level.

Identification with the therapist is also experienced by the participants while they are working with their own clients, as Helen describes:

> *I suppose I would do what my therapist probably did with me and try and help my clients be more assertive for themselves.*
>
> Helen: 32, 928-932

Jackie also communicates her conscious decision in identifying with her therapist.

> *I have I suppose taken, I do take on her style, I know that when I'm with clients. I don't think there's any specific sort of situation but I just know I take on that style.*
>
> Jackie: 21, 610-619

Jackie begins by saying, she takes on "*her style*" but ends her sentence to say "*that style*" and so she may be experiencing some confusion and enmeshment of her therapist's style and her own style. Or perhaps she has the ability to try out different styles within therapy.

Sarah also comments on her experience:

> *I suppose it's a reflection, you know, that sometimes when I see some of my clients. I have seen so many clients, you know, the situation then I will tend to turn the table over. I become my therapist and I can adopt that approach, you know, of him and apply the same way.*
>
> Sarah: 21, 620-627

Firstly, this extract is particularly revealing as it extends a narrative that is found also within the other extracts from Helen and Jackie where they all in some way become the therapist. For instance, Sarah seems to experience her therapist's representations as looking in the mirror, "*a reflection"* of her therapist looking back at her or being with her. Secondly, she uses the pronoun *"I*" several times within this extract which could be interpreted as meaning that these identifications belong to her; thereby it is her choice "*to turn the table over"* and not her therapist, which may signal a form of independence from her therapist. Furthermore her table metaphor may also illuminate her experiencing herself as being the top surface of the table; the underside of the table her therapist. Perhaps then she experiences an element of safety in turning the table over, thus protecting herself by allowing her therapist metaphorically come to the front. Perhaps she may even experience this turning-over as a kind of lying down and surrendering to her therapist's identification.

Summary

The therapist's representations seemed to be felt by the participants through the identification of the therapist within both verbal and non-verbal language. The representations were mostly experienced by the participants as bringing in a sense of their therapists' style even though they

were felt as something unreal at times. The representations were found by most participants as very useful especially at times when working with their own clients. It is during these times the participants may have experienced identifying themselves with their idealised therapist's.

The visualising image of the therapist's support

The participants reported thinking like their therapists. These experiences went further than the internal dialogue of imagined conversations in that they seemed to be able to recreate an accurate image in their minds of their therapists. The images were often vivid and long-lasting and seemed to be used to act as fundamental support, working in conjunction with the internal voices.

Within these first extracts it appears that the image of the therapist is quite real and accessible. For example:

> *Yeah, she had shoulder length hair and she was very glamorous in her fifties at the time I imagine, yeah and she always wore scarves that's what I remember about her and very you know nicely dressed.*
>
> Kaelyn: 3, 59-65

> *The first thing I always think of when I think of her is her clothes, always her clothes. And what really struck me and which made it very easy, easing and comfortable for me and comforting was that she wore the same clothes every week.*
>
> Helen: 4, 94-100

> *I still remember her really well. The one thing that always stuck out I suppose is that she always wears a ponytail, always.*
>
> Nadia: 12, 328-336

In these extracts the three participants can all visualise their therapists' appearances which seems to be the "*first thing*" when their therapist images are evoked. In a sense the clothes and overall appearance are possibly experienced as a form of boundary of the therapy and therapist. They may have felt the clothes provided a kind of therapy uniform or perhaps there was an experiencing a sense of comfort in the consistency in their therapist's appearance.
In contrast, Janice has a different narrative when she comments:

> *I suppose the first thing that comes to mind when I think about her is her face and her smile.*
>
> Janice: 2, 48-54

Here we see again the theme of the "*first thing*" but this time instead of clothes the image is the therapist's face, an accepting smile, almost a photo image of this therapist representation.

Similarly Nadia remarks:

> *I have not seen this therapist in three years but I still have her image in my head.*
>
> Nadia: 40, 1178-1195

This extract is illuminating in that it shows that the image of her therapist may be embedded and deep-rooted. She says the image is "*her image*" as opposed to "*my image*", which could suggest the image is not something that is created superficially but was instead projected into her by her therapist. In this next extract Helen experiences her therapist's image as an image beside her. She says:

I would close my eyes and see her. So it was as if she was with me. I would actually even, you know, it was a very difficult time so I would be like Ok. I would imagine she was sitting beside me. I would imagine she was with me.

Helen: 18, 527-533

There are several levels of interpretation in Helen's experience of her representations of her therapist. Starting out, she states that she sees an image of herself alongside her therapist in dialogue. She seems to experience the visualisation as a form of meditation, "*close my eyes*", so as to enter into the therapeutic world. She seems also to visualise the therapist environment and her own presence within this space which gives her a feeling of greater proximity compared to some of the other participants who can only visualise their therapist's image. It seems that for Helen there is a kind of mirror image of her therapist "*beside her"* as she repeats this narrative.

In the analysis earlier in theme one, Jack, in his dreaming of his therapist had a visualisation of "*talking with her on a bench".* He expresses the benefits of this visualisation:

> Yeah, well it was a calming sense and it was moving […] if I was getting upset I almost like internalised, how would you say it, erm […] the feeling I had in the room with her would be internalised into myself and I would go 'OK, what would happen here?' that kind of virtual conversation but she would be embodied within me in that way.
>
> Jack: 18, 522-534

It would appear that Jack uses the visualization of his therapist as a means of self-soothing, where he can project his vulnerability to his therapist as a mother figure. Or perhaps he does not need his therapist's physical presence, preferring instead his internal image of his therapist.

A difference of opinion is expressed by Sharron, as she says:

> *I would never have dreamt about her. I would have thought about her a lot outside sessions but I think that's a fairly common piece.*
>
> Sharron: 22, 636-657

Sharron, in contrast to some of the other participants, struggles to visualise her therapist.

Summary

In this theme it appeared that for most of the participants the image of the therapist was concrete and easily attainable, particularly in situations when the participant needed help and advice. For many of the participants they could experience these representations inside and outside the therapy room.

The emotional containment of the therapist

Many of the participants could identify with their therapist's support and holding which they regarded as a feeling of warmth and professionalism. The experience of this support was an emotional support in personal difficulties in their day-to-day lives. The support was experienced face-to-face but was also in a form of imaginative dialogue with their therapist in the absence of their therapist. Jack describes how this warmth was a guiding presence:

> *I wanted, kind of guidance, you know, it was almost like not able to do, that things channel, but I am now going to cross the Pacific Ocean in a little boat, I need a bit of help here. So navigation yeah I think that's the sense of not being lost.*
>
> Jack: 12-13, 362-368

In his description of his therapist's support his language is broken and his sentences are incomplete suggesting he may need support in putting things together. He says he is in a "*little boat"* crossing the vast "*Pacific Ocean"* or perhaps an open "*Channel"* which may indicate he feels lost without "*navigation"* of his therapist to guide him and hold him. He also says he needs a "*bit of help"* which may suggest that Jack does not want to be completely rescued from his lost feeling but rather he may need a helping or holding hand. He may even have a desire to keep his independence at sea but needs some emotional support to make the crossing ahead.

This safety theme of holding is also evident in an extract from Helen, as she says:

> *There were times that I would bring her with me and she would be with me and I would be saying, Oh, if she was here now she would be saying you're ok Helen, you will be safe, you can do this.*
>
> Helen: 41, 1220-1225

Helen may be experiencing a kind of journey like Jack but her experience is different, as her holding is felt more within imagined dialogue of her therapist alongside her "*bring her with me".* This may suggest Helen's support is about encouragement as her therapist voice says "*you can do this"* and "*you're ok Helen*" suggesting she leans on her therapist as a kind of personal instructor. Her therapist holding seems to bring a personal dimension and loving support to the containment. There is also something very encouraging in her therapist's message, almost parent-like, "*you will be safe".*

Janice in this next extract is more explicit about this emotional parental holding as she refers to her therapist:

> *Like you draw on someone in a support network or you might draw on a parent, you kind of say a partner and say you know, I know that they are always there.*
>
> Janice: 28, 822-828

Janice says she is extending out to someone and this someone is comparable to a "*parent".* In her experience she emphasises the word *"draw"* twice, as if she may be attempting to sketch out this support network. This may imply also a social network she seeks from her therapist, therefore going beyond the professional boundaries thus becoming a kind of friend "*always there*" for her. Janice uses the word "*parent"* as opposed to parents which may hint that she was seeking out a parent in her therapist. From the above extracts, it appeared that Jack, Helen and Janice seemingly experienced a yearning for holding that was not present with immediacy. Kaelyn has a different experience:

> *I'm just thinking when I look at both of them… I mean my more recent therapist who I have gone to over a number of, you know, she is so wise, she is just so wise and she is so holding and so warm and yet she also is professional, there is warmth about her.*
>
> Kaelyn: 25, 741-747

Kaelyn can also experience the professionalism in the holding as being caring as she makes a comparison between both of her therapists. It is her experience of warmth in therapy that distinguishes between the holding and the non-holding therapist. She refers to her most recent therapist's warmth almost as a form of safety.

Nadia expresses a similar theme:

Empathy, big time, professionalism, the body language you know the positive the whole time so I felt welcome, I felt that I was in good hands.

Nadia: 18, 535-537

She too experiences her therapist as holding and warm but also professional and she seems to feel the holding more permanently "*whole time"* as opposed to a fleeting feeling. Nadia may regard her sense of holding as something united, just as she conjures the image of a pair of hands, no ordinary hands, but "*good hands*". This metaphor is very meaningful as it may imply that Nadia experiences being held by her therapist in a safe therapeutic manner. Furthermore, she may also experience her therapist as strong knowing she will not be dropped in therapy as she is being held in both hands.

Janice also communicates this felt-sense of reassurance:

I suppose when my therapist seen that side to me she would talk about, you know, almost by way of reassurance like that core is quite steel.

Janice: 40, 1170-1182

She expanded upon this further: "*She would always say things like you know if you're distressed or whatever she'd always say you know, if you want to contact me between sessions, phone m*e" (12, 347-355). Her support then and holding may be experienced by Janice as "*steely*" at its "*core*" almost like solid rock.

As a point of divergence Sharron comments:

> *I might be angry with her because again that piece about feeling she wasn't doing enough for me or she wasn't being enough for me.*
>
> Sharron: 23, 686-690

Sharron seemed to imply her therapist was not "*doing enough"* or "*being enough",* possibly in not becoming her mother-figure in therapy. She seems to experience anguish and frustration of not having this fantasy and being held by her therapist.

Summary

Most participants felt a sense of holding by their therapist. For some it was imaginary dialogue, for example, "what would she say?", whereas for others it was more of a concrete holding, offering additional support even beyond the therapeutic hour. The holding was mostly felt as their therapists being professional, and they experienced the holding as an emotional warming presence.

Superordinate theme three: The changes within

The growing experience of change within

The participants mostly reported that they had experienced some change in their personalities, such as becoming more assertive, in their personal and professional lives, which impacted on their learning and self-beliefs. The changes were experienced twofold: some participants felt their changes occurred because of the therapeutic relationship itself; others attributed their changes to changes they had made themselves.

In these first two extracts both Janice and Helen let us know of their change in assertiveness within themselves:

> *I feel more self-assured in doing that* [being assertive].

Janice: 34, 1003-1004

> *I am more assertive but it's in a softer way and [my friends] didn't see that. They would have been used to me being more like, maybe opinionated, and maybe use more a firm tone of voice to be assertive in the past. So I have changed my way of being assertive I suppose.*

Helen: 34, 989-1006

It appears they experience the change within their internal self differently, more "*self-assured"* as in Janice's experience and in "*a softer way"* for Helen. Even though their experiencing of change are unique to them, they both agree that the experience of change started from their experience with their therapist.

Jackie echoes these feelings of change of self, however she emphasises that the changes are due to the impact of both her therapist and therapy:

> *I just think I am becoming more mindful of myself and, you know, how I behave with other people, how I interact. I mean it's probably part of me studying, doing the counselling course but she's definitely part of my learning experience, most definitely, yes, yeah.*

Jackie: 19, 542-550

Thus she attributes this change of self to her therapist's behaviour. Nadia shares a similar experience:

> *I suppose in a way yeah I think she has changed me now I'm trying to think. Erm… she made me believe in myself that I have a future in my field that, you know, I could be a good professional.*

Nadia: 32, 939-948

Nadia like Jackie seems to suggest the change in self-belief in her professional role is down to her therapist and not so much in herself. There is a sense of an external attribution where the therapist is the catalyst of change. There is also an experience of an external locus of control where the change comes from the outside as opposed to the inside.

Interestingly Sarah experiences a divergence as her therapist had a more challenging role in making change. She says:

> *We are always very respectful towards you know, our teachers, our elder, you know, including the therapist. I would never have this feeling of anger, you know, to express anger - I think he had a huge difficult time trying to get me to unravel that part of me.*
>
> Sarah: 18, 527-537

Sarah describes how her therapist had difficulty in helping her to make changes to her own self.

> *I think as time goes by you realise that you will have changed. So, there is a certain way of seeing things that you were so strongly, you know, kind of some people said. This is what I believe, what I used to believe but this is how I now [believe] you know.*
>
> Sarah: 34, 991-1017

In a sense the change for Sarah may have resulted in a change of self-belief as it did for Nadia which allows her to think outside of herself. It seems she experiences the change within as a movement from inside to the outside "*what I used to believe but this is now how I [believe]"* whereby possibly the changes inside of therapy brought about changes in herself outside of therapy.

This feeling of movement is echoed in a small extract from Sharron.

She said after a certain length of time that I had shifted.

Sharron: 8, 222-237

The changes experienced by Sarah and Sharron may indicate a temporal quality, for example for Sarah she experiences changes "*as time goes by"* and for Sharron "*after a certain length of time*". This may suggest then that the changes for both Sarah and Sharron were experienced as a gradual process in the course of therapy with their therapists.

Helen also gives an account of this temporal dimension.

Nothing in the therapeutic way kind of changed. Probably I felt a little bit more connected in a way to her as well because it was, it's ok to change nearly, is kind of a message or, you know, things change. It was nearly as if there was an evolvement, a natural evolvement happening.

Helen: 29, 840-848

Helen describes her change as an "*evolvement*" and so in a sense it is, as if she experiences something growing, something "*happening"* to her, a sense of change within, that was transmitted in a "*message".* She seems almost to view her therapist as the ingredients of her change.

Sharron has a similar understanding as she describes her experience of changes:

I saw her as someone who'd have the answers for me but someone who was giving me a different view of myself, because each therapist I've worked with has given me a different

> *view of myself. You know, a different slice of myself, or an awareness of a different part of myself.*
>
> Sharron: 18, 519-527

Sharron describes her therapist as the one with the *"answers*", like Helen's "*messages"* that show her a different perspective of herself. Her experience of change comes about by her therapist offering something different, a "*different view*", a "*different slice",* and a "*different part*", of herself. Her therapist by offering these different perspectives may be viewed by Sharron as possible gifts her therapist was "*giving her*" enabling her to change within herself. It may also be the case that Sharron experienced herself as becoming integrated with the different therapist perspectives. Although Sharron and Helen seem to share similar perspectives on change within, for Sharron her experience is somewhat more confusing as she comments: "*I think also what she did changed [me] and I'm not sure whether that was because I might have moved from an I-it to an I-thou relationship"* (3, 72-85). Sharron now describes the shift in change which may have occurred the other way around and so she seems uncertain who is actually responsible for the change in herself.

As a way of divergence, Sarah has a different perspective on her changes:

> *Well to a certain extent yes but not completely I mean certainly there are times it's up to you how you are, who you are, you know, you can't say that the therapist would change your personality entirely.*
>
> Sarah: 43, 1264-1270

Unlike Helen and Sharron who seem to regard their therapists as being responsible for their changes, Sarah acknowledges that it is not the responsibility of the therapist alone for her entire change within herself. Thus for Sarah the therapist is only partly responsible.

Finally Jack comments:

> *Yeah and to be intrigued and curious about fears and things instead of kind of frozen with anxiety and fear and the other critic is gone. I think some people would like the other critic back but it's a very freeing experience. But it can be isolating as well because I find that you are different then to other people who have those things. You have dislodged this overly bearing kind of superego structure.*
>
> Jack: 43, 1265-1276

He describes an internal change of self, a shift in movement where there is an experience of being dislodged. In a sense Jack, as with the others, finds an experience of freedom in his change of self.

Summary

A sense of change was experienced by most participants. The change was felt as a form of evolvement, a kind of shift and a movement in the direction of their therapist becoming a part of themselves. For many of the participants this change of self was believed to have occurred due to their experiencing of their therapist representations. However for others the impact of change was more blurred which was believed to have occurred due to the mutual relational aspect and thus not exclusively because of their therapists influences.

The internalised loss of the therapist

Most of the participants reported an experience of missing their therapist which seemed to be felt as a withdrawal of support. For others it was a deeper sense of loss almost as a form of grief and mourning. There were some difficulties in the active separation from their therapist and in

some instances a longing to return into the cusp of their therapist for support and holding. The quotes, from Sharron and Jack, illuminate the experience of loss:

> *I finished the nine years, afterwards I really, after about three months, I'd a real feeling of grief and then I was starting therapy again because I was in training so I had to work that through then.*
>
> Sharron: 49, 1463-1467

> *Oh [ending therapy] was very sad, yeah it was big. I was going around; whenever I got near to the street [where my therapist was working] I would be yearning and mourning.*
>
> Jack: 37, 1095-1097

Both Sharron and Jack seemed to have experienced the loss of their therapists as a form of pain expressed as a "*real feeling of grief" and* "*yearning and mourning".* It seemed they experienced their sense of loss as significant events. However, it seemed unclear whether it was the physical loss of the actual therapist's presence or perhaps the loss of the therapeutic outcome that was being mourned. Jack may have experienced his loss as a form of losing his parental fantasy he was holding that was evident from theme one. Sharron due to her perception of her therapist not doing enough or being a good enough mother may have experienced her loss as a missed opportunity which she grieved post-therapy. Therefore as Jack and Sharron had a mother fantasy with their therapists it seemed they both may have coped with their loss through the internalisation of their therapist's representations.

Nadia echoes a similar experience; she also seems to miss her therapist as her mother figure:

> *I miss her so much, you know, so I was like 'Oh I wish she was my mother' and fantasising a bit like 'Oh God you're my mother, you're a normal person' because my own mother is so screwed up.*
>
> Nadia: 27, 784-793

Nadia seemed to have internalised her therapist as a mother holding figure, what she described as a normal mother experience. Nadia also seems to express a wish-fulfillment, almost a dream-like state to have her therapist back again. She emphasises in her tone the depth of this loss and it feels almost a sense of despair and longing.

Sarah shares a similar experience to Nadia of this wish-fulfillment:

> *I suppose I had to get used to it. It's just I feel like I was on my own wishing I could talk to him, you know, I could bring this issue, you know, to someone to discuss about it because that's what he was there for me, you know, for the three years*
>
> Sarah: 40, 1180-1194

Sarah's experience is more of a sense of abandonment, "*on my own",* where she struggles to fantasise her therapist, unlike Nadia who can access her therapist in fantasy. Sharron also articulates her abandonment of her therapist:

> *I've really missed her and I've felt abandoned which would have been my piece again, even though I had known it was coming, but I found it hard I mean.*
>
> Sharron: 25, 731-747

There is a sense from Sharron's description that she may feel annoyed at the loss of her therapist. She seems to almost feel this loss is one of abandonment just as she had

experienced a sense of a similar abandonment evident in the earlier theme one when her therapist did not take up the position as mother in therapy. Combining both of her losses may have compounded her loss with even greater intensity as she "*found it hard"* to cope with the loss.

In Jackie's loss experience, it is one of feeling lost:

> *It is quite positive and I suppose in a way that you do lean on them because, you know, even though I'm finished my therapy now I'm kind of thinking, 'Oh a little bit lost', you know, because she's not there. You know. And I think – well I might have to go back.*
>
> Jackie: 25, 731-747.

Jackie experiences her therapist as absent, "*not there*". She seemed to be like the other participants in that she too was struggling with the actual loss or the acknowledgment of the loss. It is as if she was experiencing mixed feelings: the positive side of having had her therapist support and the negative side of missing this therapist support.

Some participants like Jack experienced the loss of the therapist as a form of stricken grief. Others like Sharron and Jackie seemed to experience their loss as abandonment. It is only Sarah as a point of divergence who says that she did not miss her therapist.

> *I was actually quite happy [laughs] when my therapist was away on holidays. I think he has a problem with me because like I say I am not really a clingy person, I am quite independent.*
>
> Sarah: 39, 1158-1162

Although Sarah expressed that she did not miss her therapist, she did earlier say she had a wish to talk to her therapist and so it could be interpreted that she only has to cope with the loss of her therapist on holidays, knowing he would return. Therefore it could be suggested that Sarah, unlike the other participants may have had a better ability to use her likely formed therapist representations to maintain a bond to therapist and avoid any pain in missing her therapist temporarily.

Summary

The participants loss seemed to be felt as a form of abandonment of their therapist and to cope with this loss most participants fantasied their therapists as a supporting mother. The loss seemed to be felt at times as a deep sense of grief and mourning and for some it may have been experienced as persecutory. Overall the participants seemed to have a wish-fulfillment to be close to their therapist; they did so by having an imagined dialogue with their therapist to cope with their loss.

Discussion

Introduction

This study explored how Counselling Psychologists experienced their therapist representations post-therapy within their day-to-day lives. The interviews produced rich data, and from the analysis three master themes emerged: 1) **letting the therapist in, 2) identifying with the therapist self and 3) the changes within.** In this chapter, the results of the analysis are related to existing literature and psychological theory. For example, intersubjectivity theory suggests clients give an account of their conscious lived experiences using discourse generated by the unconscious within the interview enquiry (Frosh, Phoenix, & Pattman, 2003). In the current study's research interview process, participants' seemed to freely reflect consciously on their unconscious formed therapist representations. I earlier explained that I am speaking about a fluid state unconscious which is not dynamically repressed, but merely descriptively unconscious (Lyons-Ruth, 1999; Stern, 1998; Tubert-Oklander, 2006) and a relational unconscious generated in the intersubjective therapy relationship (Gerson, 2004; Harris, 2004) capable in reaching consciousness. In this regard I explain how it seemed likely the participants could access their therapists' representations and simultaneously I dissolve some of the tension between the unconscious and conscious perspectives. The implications of this research from a Counselling Psychology perspective and clinical practice are considered. Strengths and limitations of this research will also be outlined and suggestions for future research will be explored. A final summary will provide a synthesis of the key findings.

Interpretation of findings from master themes

Master Theme One: Letting the therapist in

The analysis and interpretation of this theme highlighted the participants' acceptance of their therapists to become a part of their private and professional lives. The participants seemed to

engage with their therapist in a way that was inviting and playful. However, managing the feelings of connection to their therapists was challenging as participants had to grasp what was either an imaginary or a real experience. A main finding in this study was the participant's depth of experiencing their therapist as the mother figure which seemed to offer them insight and was viewed as being helpful within the therapeutic relationship. This theme will now be broken down further into three subthemes: 1) the yearning for the therapist, 2) the feeling of connection to the therapist, and 3) the therapist's navigating voice.

The yearning for the therapist

Bollas (1987) highlighted that good analytic work in therapy involved the therapist becoming the transitional object. Nolan (2012) explained that clients often find transitional objects or "not me possessions" in the potential space in therapy which helps to mediate internal and external reality (p. 62). In the present study, it appeared that the participants may have experienced their therapists as parental transitional objects in therapy supporting Bollas and Nolan's findings. The participants seemed to experience more mother-object representations. It is likely then there may have been some reenactment in therapy of the participants maternal internal working model which Bowlby (1969) defined as the "partnership" that continued post-therapy (p. 268). These early attachment relationships or partnerships according to Ainsworth (1989) continued as "affectional bonds" (p. 711). Therefore these likely maternal bonds that were encountered within the participants' relationships with their therapists suggested there may have been a sound therapeutic 'working alliance' and a 'real relationship' (Marmarosh et al., 2009, p. 347) to enable the formation of their therapist representations.

In considering Klein's (1946) theory on introjection of the mother object, the development of the mother representations found to exist in the present study seemed to point to the importance of the relational encounter. As Levin put it in 1996, the primary drives Klein spoke of, were not

simply biological or libidinal but had relational gratifications. Relating Klein's (1946) developmental theory to the participants themselves, it seemed that the process of therapy mirrored these relational experiences, a process most likely facilitated through the transference and countertransference experiences in therapy. Transference is the carrying over of past relationships that the client displaces onto the therapist in the present (Gelso, Pérez Rojas, & Marmarosh, 2014) and countertransference is the therapist's emotional response to their client (Millon & Halewood, 2015). As Thomas Ogden commented this is, "enacted interpersonally by means of a projective identification in which the internalized good-enough mother is in fantasy embodied" (1992, p. 79). Thus with the participants having possibly embodied their therapists as mother in the internalisation process it may have enabled the participants to use these experiences to further contribute to the therapist-mother attunement post-therapy. It appeared that the conscious mother fantasies were experienced by the participants in imaginative conversations with their therapists and the unconscious mother phantasies were experienced in dreaming about their therapists, thus allowing the representations of the therapist in.

Participants appeared to have a desire to be loved and metaphorically held by their therapists during therapy. For the most part, their mother representations were gratifying which seemed to resemble Winnicott's 'good-enough' mother meeting the "omnipotence of the infant" (Winnicott, 1960, p. 145). Only one participant found they were frustrated when their therapist did not become the counter-transference mother-object, thereby not becoming the good-enough mother-therapist. Winnicott (1955) explained that fantasy or fantasising enables a child to internalise their inner experience of their external reality in a good-enough mother-relating. It could be suggested that this process of attunement most likely occurred between the participants and their therapist, this is turn may have facilitated regulatory or corrective functioning in their lives. It was almost as if the participants were yearning for this reparative

quest by seeking out the mother within the context of the therapeutic relationship. In essence the experience seemed to indicate a yearning for good-enough mothering.

The participants may have had a yearning for their therapist as mother, but what was it that facilitated this process to happen? We know from Stern (1977) and Gomez (1997) that an infant is attuned to staring at their mother's face, so that the infant can turn its attention to other objects slightly reducing the early caregiver's capacity to hold. Kohut and the Institute of Psychoanalysis (1971) and Kohut (1977) explained the mirror metaphor; that through the mothers gaze the child can become what he or she wishes to become in their self-development (Malin, 2011). It is also accepted that the maternal gaze contains oedipal content and jouisance for both mother and infant (Gambaudo, 2012), and it is used in the medical model, particularly nursing as a form of active engagement with patients (Ellefsen, Kim, & Ja-Han, 2007). However even though gazing in therapy mostly leads to a positive outcome, it can be experienced by clients as forms of attack, hate, anger and criticism (Roth, 2014). From this theoretical positioning and given that the participants were in long-term therapy with the same therapist, it seems plausible to suggest that the therapeutic interpersonal relationship may have been a powerful mechanism whereby the yearning for the therapist first developed due to the reenactment of the transference and countertransference mother-gaze. In other words, perhaps the gazing/mirroring in therapy was a prelude to Klein's (1946) projective identification; this seemed to play a role in the internalisation of the therapist as a mother object representation that also seemed to have had an enduring effect post-therapy. However it is worth highlighting that not all therapists are available to become the parent attachment figure (Farber, Lippert, & Nevas, 1995).

The feeling of connection to the therapist

In the fantasy of 'letting the therapist in', participants in this study reported having a felt-sense of their therapist presence even in their physical absence. This felt-sense or felt-presence was experienced as a physical attachment that was either alongside them or incorporated inside of them that was sometimes felt and used in conducting therapy with others. These findings are consistent with those of Geller et al. (1981) in that their psychotherapy participants had experienced bodily connections as a felt-presence of their therapists in therapy with their own clients. Chessick (1993) referred to this as keeping something inside of oneself, however more recently, Kriegel (2014) philosophically explained that emotions felt are intrinsically linked to bodily sensations or "somatic phenomenology" (p. 421). Kriegel's (2014) "new feeling theory" suggested that internal feelings are directed internally to one's body sensations (p. 420). This may suggest that the participants' emotions stirred up in therapy reemerged and were subsequently kinetically felt through their experiencing of their therapist representations as inner bodily sensations post-therapy. This seemed to allow them to experience their therapist in the 'here and now'.

In this study it was noticeable how the participants who were qualified therapists seemed to experience and use their therapist representations to problem-solve during times when they were most challenged by their own clients. Again this finding is consistent with Tarragona (1989) and later supported by Orlinsky et al. (1993), that the evoking of the therapist representations occurred more often when participants needed support and solutions to problems. In the present study, this may suggest the participants' connection to their therapists were experienced not only bodily but emotively. Given that client-therapist attachment develops where there are many sessions (Parish & Eagle, 2003) and therapist emotional warmth is also associated with more secure client attachment to the therapist (Woodhouse, Lauer, Beeney, & Cassidy, 2015), it seems reasonable to assume the participants had developed good

therapeutic relationships over their long-term therapy. It appeared then that the participants may have captured Buber's (1958) “I-Thou” mutuality by using their therapist’s representations to maintain this supportive relational bond and as a means of working-through their self-development (p. 15). In doing so, they may have been continuing the process of their own personal healing even in the absence of their therapists’ physical presence by using their therapist representations. If so, this would be an important finding going beyond the existing research that suggests representations are primarily used for challenging situations or when reassurance is needed.

From the participants’ descriptions it appeared that they had experienced connection to their therapist representations that seemed reasonably accessible to their consciousness. Due to their conscious presence of their therapist auditory, visual and sensory representations, it is likely the participants had developed the capacity for reflective functioning or mentalisation. According to Fonagy, Gergely, Jurist, and Target (2004) this allows an individual to distinguish between their intrapersonal mental representations and their interpersonal communications with others. As Holmes (2014) further suggested, a person who has been mentalised is also likely to have formed a secure attachment with the capacity to mentalise others. Recent research found that secure attachments have a tendency to evoke more positive therapist representations compared to insecure attachments who have a tendency to evoke more negative therapist representations (Geller & Farber, 2015). From these theoretical perspectives and given the participants in the present study described more positive words than negative words about their connection to their therapists, it is probable that they had secure attachment styles. Secure attachment styles are associated with improved therapeutic alliances (Diener & Monroe, 2011; Mallinckrodt & Jeong, 2015) and better therapy outcome (Lilliengren, Falkenström, Sandell, Mothander, & Werbart, 2015). However there is still the concern of the direction of causality as a therapist’s own anxious attachment can result in a poor alliance (Degnan, Seymour-Hyde,

Harris, & Berry, 2014). Overall however, it would appear that the participants had secure attachments and possibly their therapists did as well which may have enabled the development of quality therapy relationships with sound therapeutic alliances. With these likely relational alliances the participants possibly could form and subsequently evoke their therapist representations to feel connection to their therapists. Their experiencing of their therapist representations seemed especially transparent while working with clients which seemed to suggest a form of hermeneutic circle.

An alternative but still speculative reason for experiencing vivid therapist representations when working with clients may have been the participants desire to gain a sense of organisation of their practices in their therapy room. Therapists do this when they introject their supervisor's representations (Kaplan, 1994; Romei, 2003). For example, Kaplan (1994) found where there existed positive transference in the supervisor-supervisee relationship there was more intensity in the level of internalisation process. Conversely those supervisees who experienced their supervisors as less supportive and holding, in other words less collaborative in the relationship had lower levels of supervisor internalised representations. Even though therapist-supervisor relationships are mostly covered within the phenomenon of 'reflection process' (Searles, 1955) and 'parallel processing' (Ekstein & Wallerstein, 1958), perhaps the participants were able to engage in a similar process of parallel processing to evoke their therapist representations. As such, the participants may have felt empowered to draw upon their therapist representations possibly allowing their own internal therapist supervisor with them in the room. Parallel process allows therapists to improve interactions with their clients by trying out new methods (Hinkle, 2008) and is an unconscious replication of the therapy relationship (Morrissey & Tribe, 2001). This may further suggest that the participants in the present study actively used their therapist representations to manage their clients' difficulties and in turn manage their own anxieties as therapists. It could even be suggested they may have had the ability to switch between using

their self-representations and their therapist representations. Perhaps this may have been an experience of affective regulation, “a balance between positive and negative effect” whilst working as therapists (Fonagy et al., 2004, p. 92). The participants’ agility to seemingly alternate rapidly between both their self and their therapist representations to possibly enhance their own abilities is a new idea and may contribute to the knowledge of how therapists experience their therapist representations. It further suggests the importance of understanding the supervisory role in the context of forming representations within supervisees especially given that therapists’ use their representations in providing psychological therapies.

The therapists navigating voice

In this study the therapist voice representations were often experienced by the participants as a form of imagined dialogue with their therapist. In these situations, participants described having a virtual conversation with their therapist, again in the therapist’s physical absence. Hearing voices and experiencing hallucinations contain form (objective reality) and content (life experiences) (Singh, Sharan, & Kulhara, 2003) and have been considered to be psycho-pathological (Evrard, 2014). The participants in the present study however did not appear to experience hearing their therapist’s voice as a form of paranormal activity; instead they regarded them as a method of meaning-making and a positive experience. The therapist voices were therefore considered not objective reality as in the case of pathological disturbances but these auditory experiences seemed to be accepted as soothing and useful in working with their own clients. It is likely therefore the therapist’s voice representations were used as a form of building and assimilation to help them in moving from a position of uncertainty to understanding (Mosher & Stiles, 2009).

Therapists have been previously found to engage in this process of imagined conversations with their clients which manages therapist anxiety (Arnd-Caddigan, 2013). Again consistent with

research from Rober, Elliott, Buysse, Loots, and De Corte (2008), they showed therapists have a “dialogical self” where the therapist-client can listen to their own inner voice and engage in a form of inner conversation (p. 413). Clients over time may form a cognitive emotional schema of their representations of both therapy and therapist. Once formed into the schema clients may use the representations to create a virtual conversational dialogue with their therapist (Hartmann, Orlinsky, & Zeeck, 2011). Similarly in the present study it did seem that all of the participants could hear the voice of their therapists speaking to them in an advisory capacity such as a mentor-mentee style of relating. They were apparently able to listen to their therapist voice and effectively use the communication to assist in times that required a second opinion. As Bridges in (1993) had pointed out, “therapists treating therapist-patients must remain aware of the ever present and silent power of the mentoring relationship” (p. 44). This appears to resemble the results from the Therapist Intersession Experiences Questionnaire (T-IEQ; Lundy & Orlinsky, 1987), which suggested that therapists “form mental representations, cognitive schemas or working models of particular others when they engage in relationships in this case of their patients” (Schröder et al., 2009, p. 50). In the present study the participants found they evoked their therapists’ voice representations in a personal and in a work-related capacity, again representing the hermeneutic principle. Consistent with Tarragona (1989) study, the participants frequently observed their vocal representations when they faced challenges with their clients and when the therapist representations could lend support in working through and coping with difficulties. Schafer (2002) commented this psychical presence of the therapist is felt as the object lives on internally as a form of support; this phenomenon seems to have been the essence of the participants experience in the present study.

What was striking from the participants’ narratives and analysis was the level of identification in their use of their therapists’ word-representations. It seemed they used these to learn and grow within themselves and improve their interpersonal relations with others. It appeared the

participants were unconsciously asserting themselves with similar qualities and characteristics of their therapists through the process of identification, much in the way a child might mimic their caregiver. This is consistent with research by Geller et al. (2010), who investigated how therapists in training used their formed representations from supervision to aid their own professional development. Geller et al. (2010) found that supervisees could evoke representations of their supervisors' words which they were able to use as a form of imagined dialogue. The supervisees were able to use this imagined dialogue within their own professional working practice as a means of clinical intervention. They noticed in particular the flexibility in recalling their supervisors' word representations whenever they encountered difficult and painful emotions within their patients. Furthermore Geller et al. (2010) surmised that the representations were stored within the long-term memory of the supervisees which they used as "dialogic partners" in working with clients (p. 218). Thus Geller and his colleagues postulated that there was a form of continuing supervisor-supervisee dialogue. In the current study the participants seemed to have enacted a similar experience with the likely presence of these 'dialogic partners' to possibly overcome blind spots in their practice. It was almost as if they could experience their therapist within, something Ogden (1994) explained existed in the therapeutic framework as the "analytic third", a co-creation of the therapist and client (p. 17). It is likely then that a similar joint creation occurred between the participants' existing self-representations and their therapists' self-representations to form another third layer of newly formed 'other' representations that may have been carried beyond the therapy environment. This could be considered a new finding in the research advocating that the formation of representations is one of co-construction that offers meaning-making; as Buber (1958) remarked, "relation is mutual, my Thou affects me as I affect It" (p. 30).

Master Theme Two: Identifying with the therapist

In this second theme, participants appeared to use their therapist representations as a form of imitation of their therapist which they identified as a welcoming and open experience. It was also an experience that involved the participants positioning their therapist representations within, thus using these to model and act as a form of guidance in their lives. This guidance seemed to be experienced as a 'holding function' (Winnicott, 1963, p. 240) and as a form of 'container ♀ - contained ♂' (Bion, 1962b, p. 90). The identifying with the therapist seemed to be regarded as an important component of their new formed identity; however they did not feel they had entirely lost their personal identity of self. This theme will now be broken down further into three subthemes: 1) the modelling of self to the idealised therapist, 2) the visualising image of the therapist's support and 3) the emotional containment of the therapist.

The modelling of self to the idealised therapist

Participants made identifications to the likeable parts of their therapists which took different forms. Most frequently used by the participants were the linguistically formed identifications, the voices of their therapists, thereby sounding like and speaking like their therapist. However the mimicking of the therapists' body language such as body-posturing was also very prominent across the participants' descriptions and considered to be a positive and a valuable resource. Recently, Rake and Paley (2009) found that therapists discovered their personal therapy had professional benefits to model themselves on becoming a therapist. Similar findings were reported by Ciclitira, Starr, Marzano, Brunswick, and Costa (2012) but this time it was about being a good therapist. Although the present study did not take into account the participants' frequency of use in their therapist representations or their number of years in practice, it seemed evident from the analysis that there was some dependency upon the use of their therapist representations to model their therapist and become a better therapist. This may

suggest that the participants in the current study were less experienced and needed to model themselves after their own therapists to compensate.

Evidence of modelling after the therapist and the manifesting of the therapists representations may be due more to the establishment of a strong working alliance (Bender, 1996; Davis, 1996). As Bordin (1979) commented, the “strength of alliance will be a function of the goodness of fit of the respective personalities of patient and therapist” (p. 252). As the participants mostly spoke of their therapists within a positive framework it suggests they may have developed within their long-term therapy this positive alliance. Perhaps more telling were the participants’ descriptions of imitating the body movements and language of their therapists whilst working with their own clients possibly providing further evidence of this alliance. For example, Rizzolatti, Fogassi, and Gallese (2001) explained that neurophysiological experiments and theory such as the “direct-matching hypothesis” (p. 661) suggest that humans map their visual representations of a direct action of another to their motor representations to: 1) understand the other and 2) organise future behaviours. Rizzolatti et al. (2001) added a similar process occurs in imitation of speech patterns but in both situations there needs to be sufficient gaze of the other. In the present study therefore, it could be considered that the participants and their therapists’ gazing and mirror-neuron activity facilitated the development of their therapist’s representations which they experienced as a form of modelling their therapist through body movement and speech intonations.

This modelling of the therapist has a striking parallel to Bandura's (1977) social learning theory. In the social learning theory there exists the imitation of behaviour and identification of personality, both of which are treated synonymously (Bandura, Ross, & Ross, 1963). In this regard it seems probable that not only had participants modelled their therapist’s voice and body gesturing, such as hand movements but that they also encompassed some parts of their

therapist's personality traits. If this were the case, it would suggest that there was a fundamental change in the way the participants were 'being' in the world with themselves and others. Taber, Leibert, and Agaskar (2011) found an association between congruence in client-therapist personalities and bonding in therapy. Participants in the present study seemed to have experienced noticeable changes in their personality but even more interesting was that their friends and families also noticed these changes in their personality traits, in particular to higher levels of openness and lower levels of defence in their daily lives.

In this study, participants seemed to have a desire to become the master therapist or ideal therapist, and they seemed to do this by using their therapist representations. Master therapists or ideal therapists have a tendency to learn and grow (Crisp, 2014) and have an ability to be sensitive to clients' needs (Sullivan, Skovholt, & Jennings, 2005). These findings raise the possibility that the participants, all of whom were therapists themselves, may have been experiencing this internalised form of growth and sensitivity which led to their change in personality traits. Furthermore, it could be suggested that they may have wished to incorporate only the best parts from their therapists or, perhaps, it was the therapist who projected only the good parts, "a therapist may unconsciously wish to prove, *I can be a better parent than the patient's own parents*" (Carsky & Yeomans, 2012, p. 79). We know from the participant narratives in this study that they did experience the therapist as both the mother and father. Perhaps therefore the therapists projected unconsciously to the participants what they believed the participants were missing from their parenting which the participants introjected.

Regardless of the direction in which these positive internalised representations were formed, it is of interest how the participants did not describe having identified with any negative aspects of their therapist representations. This is an interesting finding as it raises the question of why and how this may have happened. A possible explanation for the exclusion of any negative

representations may be because positively formed representations are more durable and therefore also more accessible to consciousness. It may also be that the participants did introject both positive and negative therapist representations, but they had the ability to separate out these two kinds of representations. Klein's (1946) two-fold concept of splitting suggests it is a defense against anxiety and it is a part of normal development. This is also consistent with Hamilton (1990) who found, that splitting in therapy does occur in normal adult personality structures and aids personal growth and change. As Savvopoulos, Manolopoulos, and Beratis (2011) put it, "splitting and repression are two central mechanisms of psychic organization" (p. 77). Therefore the participants in the present study could have formed negative therapist representations but they were able to either unconsciously repress them or split from them to avoid conjuring any negative feelings about their therapists with whom they had formed a positive alliance and a 'real relationship'.

The visualising image of the therapist's support

In this study participants seemed to identify with their therapists style using an internal dialogue or imagined conversation, but they could also use visual cues to recreate an accurate image in their minds of their therapist. These visual images were easily accessible, concrete, often enduring and were used as a form of holding especially when the participants were in need of emotional support and advice. In this study it was found and consistent with Rosenzweig et al. (1996) that the formation and use of the visual therapist representations seemed to develop as the therapeutic alliance was sealed. Geller et al. (2002) found participants' use of their visual and lexical therapist representations allowed greater understanding and planning of clinical interventions.

Current research in counselling and psychotherapy by Mozdzierz, Peluso, and Lisiecki (2013) explained that one of the important tasks of a therapist is "confronting" which is the process of

directing someone's attention to something they may be avoiding (p. 320). In the present study the participants in experiencing visualisations of their therapists may have allowed them this opportunity to look at themselves, challenge their old thoughts or schemas and develop new ways of working. Or perhaps the visual representations were a first step towards self-reliance and independence from their therapists. Principally, representations help with continued separation-individuation which is achieved through the progressive internalisation of images to aid personal growth (Behrends & Blatt, 1985). Yet paradoxically in the present study the participants' by evoking the visual therapist representations seemed to have anchored themselves to their therapists, influencing their thought patterns. If this were the case it may be likely the participants experienced their therapist representations as a form of inner conflict between independence and dependence upon their therapists.

It was particularly noticeable how some participants felt an embodied sense whenever they had a visualisation of their therapist whereas others did not. Geller et al. (2002) found that the more experienced therapists could evoke bodily representations such as "bodily focused sensations, rhythmic patterns, and odors and scents" compared to the less experienced therapists (p. 742). In the present study, some participants used these non-verbal or body representations of their therapists whenever they visualised their therapist and vice-versa. They used statements such as, "it was just a feeling, a moment, it was almost a moment shared together" or "she became almost this kind of intense voice to me". Conversely Geller et al. (2002) found that the less experienced therapists were more likely to evoke cognitive experiences, such as lexical modes of representations. Although it was notable in the present study that participants in visualising their therapists did evoke more bodily representations compared to lexical representations, it remains unclear if this could be attributed to therapist experience or therapist orientation alone.

Perhaps other psychological constructs can explain the increased bodily sensations. For example, in normal mourning, Kernberg (2010) highlighted that an internalised object relationship develops in the ego where there is an experience of a lost object. This is consistent with Freud's (1923/1961) original assertion that "the ego is first and foremost a bodily ego" (p. 26). This may suggest the participants missed their therapists and they intentionally evoked mental images of their therapists which subsequently manifested in comforting bodily identifications. This likely enabled them to cope better with their emotions in missing their therapist support whilst maintaining a connection to their therapist post-therapy.

From a neurological perspective, Bucci (2002) proposed memory schema is predominately constructed of sensory and bodily representations following repeated interactions [i.e., in therapy with one's therapist]. More simply put, Bucci (2002) suggested there is a linear system whereby emotions move into the body thereafter creating non-verbal symbolic experiences such as visual images. Moreover Mark (2009) explained that these spontaneous images are rich symbols that alter relatedness between the client and therapist, "to be imaginatively called into being" (p. 414). Furthermore the spontaneous mental imagery are also believed to be a co-created imagery phenomenon between the client and therapist: it is also understood by clients as an experience of transference and is found to be a positive therapeutic experience (McGown, 2015). In the present study, it was noticeable how the participants would gesture a smile and show fondness when they were asked to evoke an image of their therapist with me in the interview process. It seemed they had the ability to quickly conjure a visual image of their therapist suggesting an embodied positive emotion connected to the visual image, possibly supporting Bucci's (2002) theoretical position. Taking together this current research including the present study's findings it is likely the participants were better able to experience more bodily representations of their therapists due to their long-term connections with their therapists positive experiences.

Although the participants' experienced visual therapist representations, it seemed overall that there was more reliance on their internal conversational dialogues with their therapist and less on their visual representations of their therapists. This is consistent with the original study of Geller et al. (1981) which found therapists reported more use of imaginary dialogue with more sessions; however they did not explain how this may have developed. This may be explained using Piaget's (1954) cognitive developmental theory.

The emotional containment of the therapist

Participants seemed to experience emotional holding, as a form of warmth and professionalism which they were able to experience beyond the therapeutic session. The analysis suggested it was more the holding metaphor which drew parallels between maternal care and client-therapist relationship (Slochower, 2011). This maternal holding was used to draw upon emotional responses and memories so as to provide reassurance in difficult situations. Similar to Epstein's (1989) study, the participants in the present study likely used the presences of the internalised representations of their therapists as an emotional container or helper and as a form of wisdom, that may have been experienced as a level of caring from within. Thus this holding metaphor appeared to be a '*holding space'* between the therapist and client which may have allowed a kind of safe zone between them (Slochower, 2013). Even though the participants never experienced their therapists' physical holding, they did seem to experience an embodied dimension as earlier explained. This is consistent with current research by Glenberg (2015) who suggested we are embodied and are bodily experiences are interconnected to our thoughts through interactions in social environments.

The participants' seemed to experience emotionally a caring therapist within the therapy relationship that appears to go beyond the active agency of the professional therapeutic

alliance. In the present study some concrete instances of this relational aspect were found throughout. For example, Janice confirmed that her therapist would contact her in-between sessions to check if she was alright, Sarah acknowledged how flexible her therapist was in giving her 50% discount on her fees, Helen warmly recalled how her therapist would walk up three flights of stairs each time she needed a glass of water and Nadia commented that her therapist once offered her tea and cake when she arrived hungry after a long journey to the session. These are just a few of the many situations that the participants fondly spoke of that they believed improved their therapy relationship. This relational human element suggests a form of the intersubjective field as people engage at an interpersonal level. This interactionalism relational continuum encounter may be the core component in the development of therapist representations which promotes the development of a sound therapeutic alliance.

Some participants had feelings of insecurity about making important decisions, and as such there seemed to be evidence of over-reliance on their therapist's representational holding in guiding their personal and professional lives. This seemed to indicate that the participants were lacking in their own internal resources for holding, relying on their therapist representations to support them. This may be one of the reasons they stayed with the same therapist to ensure there was a strong enough foundation for independence or perhaps they may have been avoiding the actual loss of holding. According to Ogden (2004), Bion's (1962b) container-contained concept was a process where an infant's unprocessed thoughts or (B-elements) were transformed by the parent into processed elements of experience (A-elements). From this theoretical position it could be considered that through transference and countertransference the participants experienced their therapists' as the mother object representation which enabled them to understand their own unconscious thought processes. In other words, the participants may have been using the representations of their therapist's mother image as a form of self-reflection to analyse and organise their own thoughts, to make sense of them. Moreover they

may have also used them to experience a sense of containment, being held mentally, and then drawing upon the representations to organise their conflicting and stuck thoughts. According to Lemma (2003), the therapeutic frame or holding environment anchors the therapy in reality, itself being a container and helps the client and the therapist to cope with the anxieties.

From the analysis, participants seemed to have experienced a psychological journeying of becoming more open to new experiences possibly using their therapist representations as a support during this change process. Winnicott's (1960) work with clients in therapy believed "the false self is represented by the whole organization of the polite and mannered social attitude, (a not wearing the heart on the sleeve)" (p. 143). As Ogden (1992) observed, it is through a safe and controlling management of the client's regression from false self towards true self, that the client can let go of their false self and defenses. This, according to Balint (1968) and Ogden (1992), allows the therapist to become the role of the caretaker, thus providing the facilitating environment that may have been otherwise missing. This may allow clients to find their true self or "to be what he truly is" (Rogers, 1961, p. 64). In the present study it is probable, as with most long-term therapy, that there was a shift in the participants' sense of self which altered their belief systems, exposing their vulnerability of true self. This theme expands the existing literature in that participants may have experienced and used their therapist representations not only to cope with difficult situations but they may also have used their representations to cope with their anxiety of revealing their true self in therapy.

Master Theme Three: The changes within

Participants appeared to use their therapist representations to actively engage in a process of change. The predominant changes appeared two fold; a movement towards an ideal-self, and a shift in self-concept, both of which were embraced positively. In this study, participants also had to learn to cope with the loss of their therapist. For some this provided the opportunity to grow

as they managed to survive this loss. For others the missing of their therapist seemed to be a painful experience. Participants seemingly used their therapist representations to provide some solace in times of feeling vulnerable and to help with the physical detachment from their therapist. This theme will now be broken down further into two subthemes: 1) the growing experience of change within and 2) the internalised loss of the therapist.

The growing experience of change within

Participants seemed to have experienced a change in their self-concepts, in that they experienced a change in their way of being in the world post-therapy. For most the changes were experienced as behavioural, such as new assertiveness and newfound connections with others. From the participants' descriptions they attributed these observable changes of self to the representations of their therapists having impacted upon them or within them. It is likely therefore that the sufficient conditions of congruence, empathy and unconditional positive regard were met in the participants therapeutic relationship to construct "psychotherapeutic change" or "constructive personality change" (Rogers, 1992, p. 827). Blatt and Auerbach (2001) found the importance of mental representations of self and others was crucial in clients' psychological functioning post-therapy that offered a less fragmented self. In the present study, although the participants did find changes in their personality, they did not entirely feel the loss of their personal self and their experience seemed to indicate more of a growth towards authenticity or ideal self.

It was apparent in the present study that a change in the participants self may have occurred through the work of their therapy and their therapy relationship. Some spoke of having the ability to do things differently such as getting their points across in a softer way or being better able to interact in the world. For example Janice said, "*I have changed my pattern quite significantly (…) I'll move more into areas of discomfort in my life"* (35, 1028-1043), and Helen remarked, *"I*

think I have evolved because of my therapy and my therapist" (32, 952-956). With this heightened sense of self-awareness, there seemed to be a level of change in the participants' use of self. This new use of self seemed to give the participants an expression of freedom, more assertion, almost in a way dislodging their superego structures. They described more often how their inner critic was gone which afforded them the sense of moving into new experiences. The current study suggests that the participants experiencing and using their therapist representations may have facilitated these changes in self which reinforced their strength in growth. It appeared therefore that the therapist representations were functioning as a form of transitioning of the other. Participants seemed to experience the internalised representations of their therapists as expediting the process of insight, and enabling improvements in their daily functioning. Overall the analysis indicated this sense of shifting from a position of more closed thoughts and feelings to one of openness and growth.

The analysis revealed that there appeared to be a change in the participants' self-concept through their therapist representations. Some notable comments included *"I think less of inside the box and more outside the box" (Sarah: 45, 1336-1346), and "I am becoming more mindful in how I behave with other people" (Jackie: 19, 542-550)*. The participants' positive self evaluations of these changes were linked to their more socially adjusted way of being in the world. These changes led to reported feelings of higher satisfaction and general well-being and most likely led to a strengthened sense of self (Akın, Demirci, & Yildiz, 2015). This is consistent with research showing that changes in self-concept at the termination of psychotherapy result in reduction in neurotic personality traits (Styla, 2012). It seems likely that through the process of internalisation of the therapist representations the participants experienced an improved perception in their sense of self. Taking this a step further it could be suggested that they also experienced congruence between their self-image and their ideal-self leading to improved self-actualisation. This is consistent with Toukmanian, Jadaa, and Armstrong (2010) who found

participants had a gain in their perceptual congruence and depth in experiencing of mental operations due to their personal therapy interpersonal interaction.

Another finding in the present study was the participants' experience of improved self-esteem, which was likely to have had a relation to the change in their improved self-concept. These two theoretical constructs are closely linked which is possibly why there was a consensus in experiencing a comfort in their therapist representations. The representations did not appear to be viewed as a threat to their self-concept but perhaps more experienced as a way of changing within to grow as a person. However reaching this point of change for some participants seemed difficult. For example, Kaelyn commented; "*she challenged me quite a bit and she moved me (…) she would come in and give me a different way to look at [life]*" (4, 93-108). Therefore, although the changes were mostly identified as a positive experience, participants at times may have felt like they were being directed by their therapists.

The internalised loss of the therapist

Most of the participants spoke of having missed their therapist, physically and emotionally, experiencing a sense of loss in the form of grief and mourning when therapy ended. They experienced challenges in separating out from their therapist; more often they had a yearning and a longing for their therapist. Clients seemed to introject their therapist through internalisation to enable the process of mourning their therapist (Loewald, 1988). In the present study, these loss experiences seemed to be felt as forms of abandonment, and to compensate their loss most participants experienced fantasising their therapists as the all-supporting mother. This appeared to help the participants keep an alliance to their therapists by dreaming of their therapist or by engaging in imagined dialogue with their therapist that appeared to be a form of wish-fulfillment. In this respect the therapeutic encounter contained a transference element where possible feelings of loss or affection were experienced through the attachment bond to

the therapist. With any normal loss such as a death of the other there is mostly a grief reaction and emotional distress knowing they cannot see the person again (Boelen, 2010). Bowlby's (1969) description of loss involving yearning and searching for the lost attachment figure did not seem to be the likely experience of the participants. Rather the loss experienced internally by the participants seemed to replicate Freud's (1915/1957b) description in *Mourning and Melancholia* that, "the object has not perhaps actually died but has been lost as an object of love" (p. 245). In this context it is believed that in the current study the participants used and experienced their therapist representations to keep a libidinal tie to their therapist or more contemporarily put, to maintain a bond (Silverman, 2013).

In this study the participants seemed to experience feelings of loss, and had some difficulty in working through them which was evident in their high frequency of thinking about their therapist. Those who reported missing their therapist the most seemed to dream and fantasise more of their therapist. In a sense this dreaming seemed to give the participants a way of reengaging in the therapy through this active imagination. Rohde, Geller, and Farber (1992) found that therapists reported dreaming of their therapists which contained ambivalent themes of protectiveness-responsiveness versus separation-rejection. Day-dreaming of one's therapist was also found to contain elements of anger and sexual content (Pope & Tabachnick, 1994). Current research by Hill et al. (2014) reported two main findings into dreaming of one's therapist: 1) anxious clients with fears of abandonment dreamed of their therapists and 2) those who wished to be close emotionally had fear of rejection. In the present study the participants experiencing dreaming of their therapists seemed more about the wish-fulfillment of being held and identifying with their therapist and less about fear of rejection. However, it is important to point out that the participants feelings of loss, their persistent thinking and dreaming of their therapists may not have been considered unusual but instead a process of normal management of their loss. Bergstein (2013) posited that dreaming allows the working through of emotional

experiences in the unconscious so they do not have to appear in one's external conscious reality. It could be considered therefore the participants in the present study were possibly working through their loss by dreaming of their therapists post-therapy. For this reason, and in line with the work of Klein (1940), participants may have used their experience of their unconscious therapist representations as a form of inner growth to keep the object within. By doing so, they may have been comforted in using these representations in times of missing their therapists.

In particular from the analysis it also seemed that the participants missed the physical presence of their therapist. The body is an unconscious carrier of meanings (Gubb, 2013). This would suggest that the absence of their therapists' bodily presence may have interfered with their intersubjective experiencing and prohibited meaning-making. Perhaps this is why they may have used their felt presences of their therapists to continue this meaning-making process. A possible scenario here, is that the participants may have missed seeing their therapist, reading the therapist's body language to gain an unconscious understanding of experience. In essence therefore the loss may have been experienced as a destruction of the projective identification which is used as a tool for understanding one's state of mind (Buckingham, 2012). If this were true, it is likely the loss of the projective identification experience in therapy may have been compensated by the participants' use of their therapist representations.

Implications for Counselling Psychology

Although the limitations of this study and potential future research are highlighted in the sections that follow, the current study findings will hopefully have promising implications for future Counselling Psychologists. This research has emphasised the importance and the impact of the therapist's role in the formation of clients' internalised representations of their therapists. From

the findings some possible suggestions for Counselling Psychology professionals are now outlined below.

Current research shows that positive client-therapist relationships are paramount to the establishment of a strong working alliance leading to positive therapeutic outcomes (Flückiger, Del Re, Wampold, Symonds, & Horvath, 2012; Horvath & Greenberg, 1989; Horvath et al., 2011; Schauenburg et al., 2010) and a poor alliance can lead to early drop out (Sharf et al., 2010). The results of the present study found that participants did appear to have a strong working alliance with their therapists and it is likely they also experienced a good therapy relationship that seemed to help the formation of therapist representations. In particular a new finding in this study was the significance of the participants' use of their therapist representations to self-reflect and grow in their personal and professional lives. As this study also found internal therapist representations could influence and impact post-therapy development, it may be important that consideration is given to ensure therapist representations form in the first instance. A key component to this process of developing therapist representations is personal therapy, for example, therapists therapy is important for therapeutic learning which is an ongoing process (Orlinsky et al., 2011). More recently it has been found that therapists who rated a higher alliance with their own therapists found that in conducting therapy their own clients there was an overall improved client outcome (Gold, Hilsenroth, Kuutmann, & Owen, 2015). It can be suggested that in the absence of a positive working alliance and a quality therapy relationship in ongoing therapy, the opportunity to form internalised representations may be missed. The findings of this study recommend that trainee Counselling Psychologists should regularly monitor their working alliance and the quality of their therapy relationship. This would seem important given the knowledge that a positive working alliance can result in more positive constructed therapist representations (Atzil-Slonim, Tishby, & Shefler, 2014; Orlinsky et al., 1993), in turn leading to an improvement in the client's ego

(Dorpat, 1974). Thus it would seem central for therapists that this likely common factor is highlighted to promote the development of inner representations to further personal growth. It would also seem appropriate that therapists in personal therapy should explore and repair ruptures in the alliance that may impact the real therapy relationship and any likely developing therapist representations, especially as they can use these while conducting therapy themselves. It may even be favourable to have the therapist and the client openly discuss their self and object representations, which could also yield interesting results towards a healthy intersubjective relationship and working alliance. By identifying each other's concrete representations, it could further enhance the development of new self and object representations.

It is accepted that clients' use of their therapist representations have several functional abilities such as self-soothing, problem-solving, coping mechanisms which can be used in both personal and professional lives (Geller, 2006). However a new finding in this study seemed to identify that participants experienced changes in their personality characteristics which they understood to be the derivatives of their interactions with their therapist and self representations. These changes allowed them to approach and see life situations from different perspectives. The unique contribution of this finding for Counselling Psychology is the implication that Counselling Psychologists may be able to influence the formation and change in their clients' behaviours by their self-representations. Therefore it would seem relevant that therapists promote self-awareness and reach out to their clients in relational depth experiencing (Mearns & Cooper, 2005). Moreover Counselling Psychologists should also consider encouraging their clients to engage in a self-reflective process where they can acknowledge and use more of their therapists representations during and after therapy has ended so that clients can learn and further develop.

Geller et al. (2005) said that therapists' own therapy or therapist-patients come with more knowledge and self-awareness to the therapy room than lay patients. The present study found that the participants all of whom were therapists themselves used their therapists' representations while conducting therapy with their own clients. They used their therapist representations not only as personal therapy but also as a form of supervision or mentoring in particular as a means of solution-focused therapy with their own clients. This resembles the parallel coaching context of supervisors with their supervisees (Crowe, Oades, Deane, Ciarrochi, & Williams, 2011). The implication for Counselling Psychologists is to now consider personal therapy as having the ability to provide this double hermeneutical concept. Oteiza (2010) understood that personal therapy allows one to experience the world as a client and their therapist as a model. Therefore the present study's findings may show that personal therapy has a more far-reaching element to helping others than previously conceived especially given the knowledge that therapist representations may be evoked in difficult situations and are mostly a positive experience. However more consideration should be given to the quality of the alliance as it is associated with positive therapy outcome (Lambert, 2013), and also to the potency of interpersonal 'relating' in the therapeutic relationship as it is affiliated to growth (Mearns & Cooper, 2005, p.161).

Strengths and limitations

A strength of this study is that it demonstrated that using a phenomenological method to research how therapists experienced their therapist representations reveals rich data. Using this qualitative approach, it was found that therapist representations may play a more active role than was previously understood. For example, the present study found that the participants seemed to experience using their therapist representations as a tool in correcting past relationships which were identified in the good-enough mother representations. They also appeared to be able to use the therapist representations to lower their anxiety in their personal

and professional lives using a form of mentor-mentee style relationship. Furthermore the participants seemed to experience their therapist representations as a real presence or felt-presence alongside them or inside of them; this ultimately offered an experience of a continued bond to their therapist and had the effect of enhancing positive characteristics of their personalities. Taking all of these findings into account it may seem important that Counselling Psychologists become more aware that their self representations are likely to be influential mechanisms of change in therapy. It is further suggested that the findings may demonstrate the importance of matching of trainee Counselling Psychologists and their personal therapists to ensure the passage of a quality therapy relationship and a positive alliance to promote the development of benign therapist representations, especially given the findings in the present study that therapists seemed to use their therapist representations in an advisory manner with their clients. The quality and the rigour of this study were conducted in line with the methodology proposed which further enhanced the validity of these new findings.

It is necessary, however, to point to the limitations of this research. The selected sample was purposively chosen, small in size, and restricted to therapists; therefore cannot be regarded as representative of the entire population or indeed of therapists generally. The aim of this study was not to generalise, but to give more depth to an area in which little is known. It was deemed important to find and recruit participants in this study that had already formed representations of their therapists. However in doing so, it is possible this group may have over-stated their positive representations because of their likely positive transference. Positive transference tends to present where there are feelings of liking, trust, and fondness to one's therapist (Chessick, 2002). Thus perhaps the data in this study may not have included a broad range of therapist experiences. The participants in this study may also have reported and interpreted their experiences to me from a psychological perspective portraying themselves professionally

and may have intellectualised their retrospective reflections, possibly omitting sharing their personal in-depth feelings in this study.

Although the study research was open to both male and female participants, the actual sample consisted of seven female participants and one male participant. Having more women represented within this study may nonetheless have limited the range of experiences in understanding therapist representations. For example, earlier research by Faber and Geller (1994) suggested that women patients used their therapist representations more often, kept their therapists in mind for longer and missed their therapists more often than male patients. Recent neurological evidence shows that women have a higher functioning in assessing their episodic memories compared to men (Lundervold, Wollschläger, & Wehling, 2014). As the episodic memory or autobiographical memory is grounded in experience (Cheng & Werning, 2015), this may suggest that the women in the present study were better able to recall their experiences of their therapist representations compared to the male participant. On one hand this could be viewed as a benefit to this study to investigate the phenomenon at a deep level however, on the other hand this study could be considered heterogeneous. Preferably a more balanced ratio of gender selection within my inclusion criterion may have proved beneficial to understanding a broader range of therapists experiencing their therapist representations especially given the fact there are both female and male therapists.

In the present study, some of the participants spoke of their descriptions of their yearning for the therapist. For example, some notable comments included "*moving mother out*" (Jack: 18, 508-513), "*lack of a mother figure*" (Nadia: 8, 208-214) and "*my piece was abandonment*" (Sharron: 49, 1448-1550). The conscious interpretations explicit in these accounts of their mother-figures point to likely feelings of maternal negation, however at an unconscious level the participants'

descriptions of their mother-relations could be interpreted much differently. Therefore this study had to manage the challenge of avoiding interpreting the 'repressed unconscious'. The repressed unconscious I speak of in this context is what Davies (1996) referred to as the 'classical unconscious' centred on a repression based model (p. 561). It may have seemed plausible to bring together the conscious and the classical repressed unconscious interpretations but this was avoided for ethical and methodological reasons. The exception was my interpreting the participants descriptive accounts likely derived from their 'descriptive unconscious' and 'relational unconscious' which seemed to present themselves into the participants' consciousness. Thus in the present study, it was often challenging to stay to the close reading of the text as many alternative interpretations could potentially have been included. Therefore I acknowledge that one of the main limitations in this study was the epistemological tension between the IPA research methodology and the psychoanalytical psychodynamic theory. This tension was largely resolved by distinguishing between a 'repressed unconscious' (Freud, 1915/1957d) and a 'descriptive unconscious' (stern, 1998) that developed relationally in the intersubjective encounter as a 'relational unconscious' (Davies, 1996; Harris, 2004) which itself is regarded as a concept that links the intrapsychic and intersubjective perspectives which can reach consciousness (Gerson, 2004). The value of the relational unconscious emphasises the dynamic fluidness interwoven between the conscious and unconscious emerging in the intersubjective co-constructed 'real relationship' (Zeddies, 2000), where two subjectivities mix (Gerson, 2006).

Future research

This study was limited to working with those who had ended therapy and therefore did not address the development of representations during actual therapy. Even though the IEQ (Orlinsky & Tarragona, 1989) can reveal clients' use and experience of their therapist representations between therapy sessions (Perry, 1992; Tarragona, 1989; Zeeck, Hartmann, &

Orlinsky, 2006), these are still post-examinations. Given the nature of post-examinations, the therapist representations may be limited to recall due to forgetting. Instead it may prove more beneficial to examine the formation and the use of therapist representations during therapy itself. This methodology would likely incur using the 'therapist immediacy technique' [i.e., how the therapist is feeling about the client] developed by Hill (2004) and Hill et al. (2008), in conjunction with the 'therapeutic immediacy' technique [i.e., the on-going therapist-client disclosures in the here and now] developed by Kuutmann and Hilsenroth (2012) and Mayotte-Blum et al. (2012). This methodology would seem likely to provide more accurate feedback on the client-therapist representations in-session. This is also supported by evidence based research on real-time collection feedback from clients which appears to be more stable (Norcross & Lambert, 2011). Using these immediacy techniques they could also be used to identify the alliance and the effect on the developing representations. Therefore future research exploring participants' in-session experiences of their therapist representations at various stages of therapy may enhance an improved and sophisticated understanding of the phenomenon.

It is necessary to signpost that there was a sense of internalised loss experienced by many of the participants within this study as they had all ended personal therapy. Clients' sense of loss and mourning the therapist and therapy has been long documented (Balint, 1950). More recently, Fragkiadaki and Strauss (2012) even found that therapists also have to work through termination. It was interesting to find that the internalised loss was at times felt as persecutory. Given that the participants used their therapist representations such as imagined dialogue to overcome their feelings of loss, it may be worth considering examining whether the loss impacts upon the benign representations. It could be the case that the positive representations are neutralised by any negative representations; if so, this may have important implications to the developing of coping strategies to endure the experience of the loss of the therapist, "perhaps if

we can focus more on what actually happens in the process of termination the lore of termination as loss will fade as new theories emerge" (Weil, 2014, p.108). In this regard the termination of therapy also needs greater research to avoid the internalisation of the experience of excessive post-therapy pain in loss and missing the therapist.

Orlinsky et al. (1993) asserted that when clients had positive schema formations and good rapport with their therapists, they could experience positive representations of their therapists and therapy. In the present study it is likely the participants had formed mostly positive representations of their therapists and therapy, indicating they may have experienced a sound therapeutic alliance and a quality therapy relationship with their therapists. Future qualitative research may benefit from examining clients' therapist representations where there is an absence of a therapeutic alliance or where there is evidence of poor intersubjective relations to explore if therapist representations manifest in participants experiences and in what form. Therapists can be trained specifically to improve alliances (Crits-Christoph et al. 2006; Hilsenroth, Kivlighan, & Slavin-Mulford, 2015). Monitoring the client-therapist alliance can begin after the first session (Kokotovic & Tracey, 1990), or even before with client-therapist expectations (Rennie, 1998). This could be done by using the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989), a post session-to-session evaluation, or alternatively using the method of moment-to-moment observation (Coutinho, Ribeiro, Sousa, & Safran, 2014). Given that the internalisation of mental representations would appear to be influenced by therapeutic bonds, it would also seem timely to conduct further research, on appropriate matching of clients and therapists. The therapist seems to have a significant impact on the type and degree of representations formed by the client. In this regard more focused research on the therapist style and tone could prove rewarding. It may also be worthwhile to explore gender differences on representations in respect to alliances; it appears that female clients experience a greater sense of relatedness to their therapists, whereas male clients' descriptions of their representations

included more interpersonal distance to their therapists (Arnold et al., 2000). Furthermore male clients seem to need longer periods of therapy to have the same changes in affect compared to female clients. These findings suggest a greater understanding is needed to take into account gender difference as it is likely to impact the formation of representations.

Although this study did not explore the participants' attachment style, there did appear to be an overarching theme of mother-infant bond relationship in the narrative between client and therapist. This is interesting as it points back in the direction of the parallels between attachment style and working alliance. Research indicates that secure attachment styles may be linked to therapeutic alliance and are considered to be a predictor of therapeutic outcome (Smith, Msetfi, & Golding, 2010), however other research, contradicts this finding showing secure attachments were not found to have a connection to therapeutic outcome (Bucci, Seymour-Hyde, Harris, & Berry, 2015). Therefore future research could examine participants' experiences of their formed representations using a mixed-methods approach and by identifying therapists across the various attachment styles using the Adult Attachment Interview (George, Kaplan, & Main, 1985). Perhaps also the role of therapists attachment styles (Rizq & Target, 2010) may have implications on how representations develop and are experienced as loss. However as attachment is not viewed as a static trait or even a fixed probability, but rather a product of the interaction between an infant and its caregiver (Sroufe & Waters, 1977), caution should prevail in making any rigid assumptions to participants attachment style.

Summary

Participants' experiencing their therapist representations as the mother figure was a main finding in this study. Participants seemed to use these mother representations to reconstruct and improve relationships with others. There were little negative representations revealed which was aligned with the fact that there seemed to be a strong working alliance and a good quality

therapy relationship between the participants and their therapists. However it was suggested there may have been defensive mechanisms in use such as splitting and repression to foreclose any negative representations. The representations appeared to have a double function; participants used them to problem-solve but also seemed to use them as a form of mentoring in an advisory capacity. A unique finding indicated how the participants' long-term use of their therapist representations resulted in a softening of their superego structure. This seemed to have the effect in changing some of the participants' characteristics and traits of their personality including their self-concept and their way of viewing their lifeworld. The participants used their therapist representations in combination with their own self-representations to self-reflect, often experiencing these as a form of dialogical voice or bodily representations. The contributions of these findings pinpoint the important influence a personal therapist may have on one's personal and professional development. Of real interest is the creation of a continued bond to one's therapist by using the internalised representations to keep the therapist within. This therapist representational bond could be considered a valuable component to further enhancing growth in individuals' lives in the absence of the therapist. The study highlighted certain strengths and limitations and directions for future research.

Conclusion

It is suggested that a sound working or therapeutic alliance, is just one component of the therapy relationship (Gelso, 2011). I now suggest the alliance may also be just one component to the development of therapist representations. I further suggest that although object-relations play an important role in the relational interface encounter, it would seem that these internalised object-relations are just another component to the formation of therapist representations. Therefore this study's results suggest that it would seem more likely that it is the collective aspect of the relational social intersubjective experiences within the therapy relationship, (particularly long-term therapy with the same therapist) and the client's and therapist's entwining

object-relations (they each bring into therapy) that create therapist representations. Alternatively it could even be suggested that a tripartite model may exist, that is, the therapeutic alliance, the object relations and the real interpersonal client-therapist relationship that form therapist representations. Thus through this interpersonal perspective using Descartes cogito, “I interact therefore I am” a person may become “larger than oneself” (Tronick, 1998, p. 296). As mental representations seem to influence human behaviour (Renschler, 2006), the implications for Counselling Psychologists to explore these inner representations may need more attention to research and practice. As a final comment I would like to acknowledge that for a variety of behavioural and psychological reasons a person’s self may be subject to change over time which could impact the therapy relationship; it is therefore likely that the participants’ accounts of their therapist representations in this study may have an entirely different outcome at another point in time.

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Appendices

Appendix A: Recruitment poster/flyer

Participants needed!

What's this about?

In conducting this research, I am looking for volunteers to take part in a study to find out about how you interacted with your personal therapist. In particular, this research aims to explore your experience of your conscious internalised mental or bodily representations of your therapist. Representations of your therapist may be experienced consciously (for example, thinking of your therapist, behaving like your therapist, or recognising words, sounds, and sensations of your therapist).The representations of your therapist can take form in different ways and vary from person to person. This study wants to find out more about this interesting phenomenon.

Who's invited?

You are invited to take part in this study, if you are a qualified Psychologist, Psychotherapist or Counsellor. If you are working towards your accreditation you are also invited. You should also be currently in a work setting (e.g., voluntary, public or private practice) and have completed 40-50 hours of one-to-one counselling with the same therapist. However, for this study, you should not be currently in therapy. This topic is very much a central part of self-awareness and therefore has a special interest in the everyday lives of counselling professionals and indeed conducting therapy with others. Practicing therapists are those that engage in on-going self-knowledge and self-reflection.

What's involved?

You will be asked to *participate in a single session, a 60 minute audio-recorded one-to-one interview in Trinity College Dublin or in DBS College.* Your participation will be voluntary and you will have the right to withdraw at any time. Your recorded interview will be transcribed and analyzed under Interpretative Phenomenological Analysis (IPA) style. Your recording will be kept confidential. You will not be identifiable so your anonymity is protected. You will receive a summary of the study's main findings.

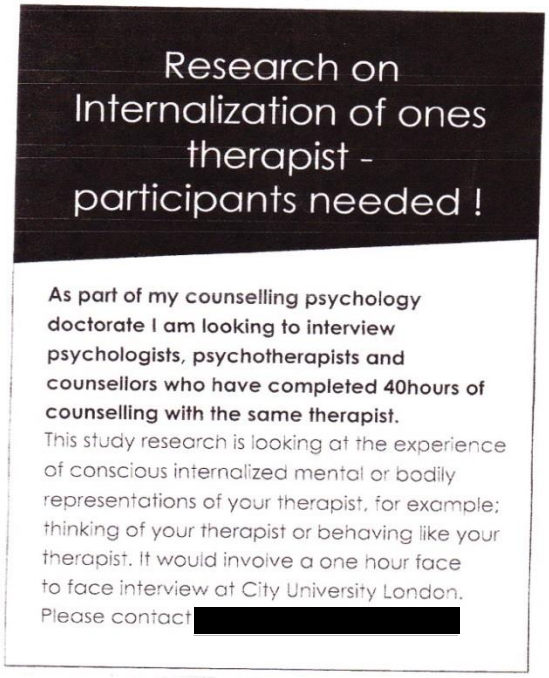
Thank you. For more detailed information about this study, or to take part, please contact me directly, *Ronan O Neill:* Email: [redacted]

The study is supervised by Dr Susan Strauss at City University London: [redacted]

This study has been reviewed and has received ethics clearance
through, the Psychology Department Research Ethics Committee, City University London.

Appendix B: Recruitment advertisement UK

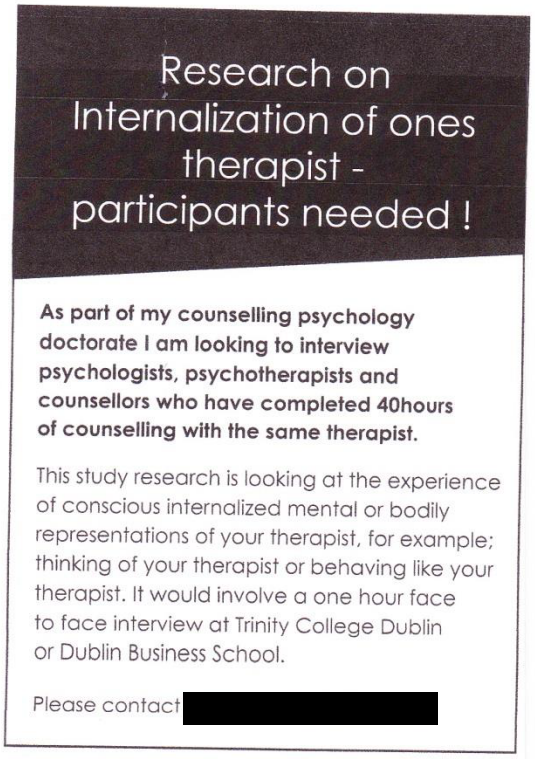
Appendix B:



the psychologist
vol 27 no 9 | september 2014

Appendix C: Recruitment advertisement IRE

Appendix C



Research on Internalization of ones therapist - participants needed !

As part of my counselling psychology doctorate I am looking to interview psychologists, psychotherapists and counsellors who have completed 40hours of counselling with the same therapist.

This study research is looking at the experience of conscious internalized mental or bodily representations of your therapist, for example; thinking of your therapist or behaving like your therapist. It would involve a one hour face to face interview at Trinity College Dublin or Dublin Business School.

Please contact [redacted]

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Appendix D: Cover letter

Cover letter

Sept 2014

Dear

Thank you for your time in considering participating in this research project.
This study is about how you experience representations of your therapist. For the purpose of this study, I am interested to know how you may have experienced imagining engaging in a dialogue with your therapist, or having experienced a felt-sense of your therapist. If you are a qualified psychologist, psychotherapist or counsellor and currently working in a counselling setting, then this study could be of interest to you. However, for the purpose of this study, you should not be currently in personal therapy. I have attached an information sheet that provides more detail as to the structure of the research. In particular the information sheet will outline more information on the purpose of the study, why you have been invited, details on confidentially and anonymity, the procedures should you participate, and the benefits in taking part. The information sheet also contains details regarding ethical approval of the research. I have also included the demographic sheet which should be completed and returned to me along with the signed consent form at your earliest convenience.

Thank you very much and I do hope you will choose to take part in this research.

Kind regards

Ronan O Neill

Appendix E: Screening tool

The Therapist Embodiment Scale (TES) The internal experience of your therapist may consist, in varying proportions, of words, pictures, sounds, bodily sensations, and so on. When you actively call forth the felt presence of your therapist in his or her physical absence, what is typically characteristic of you? Use the following 9-point rating scale in answering the questions. Please write the number corresponding to your answer in the space before each question.

1	2	3	4	5	6	7	8	9
Not at all characteristic		**slightly characteristic**		**moderately characteristic**		**quite characteristic**		**highly characteristic**

_____ 1. I imagine my therapist sitting in his or her office.

_____2. I picture a specific expression on my therapist's face.

_____3. I see my therapist gesturing.

_____ 4. My image is limited to my therapist's head and face.

_____ 5. My therapist is wearing a particular type of clothing.

_____ 6. I imagine a particular quality to the sound of my therapist's voice.

_____ 7. I think of my therapist as making a specific statement(s) to me.

_____ 8. I experience in myself certain characteristic bodily sensations.

_____ 9. I think of the odours in his or her office.

_____ 10. My image of my therapist is not tied to a specific place or time.

_____ 11. I imagine my therapist and myself in physical contact.

_____ 12. I am aware of a particular emotional atmosphere which gives me the sense that my therapist is "with me".

Appendix F: Demographic sheet

For the purpose of gaining some background information on those participating in this study, please can you complete this form. The information you supply will be kept confidential and will not be used to identify you in this research.

1) What is your age _____

2) Are you male or female? circle either, Male or Female

3) How long were you in therapy with the same therapist?

Years _____ and months _____

4) How many hours (approx.) of personal therapy did you complete with the same therapist? No. of Hours completed _____

5) How often did you attend therapy?
No of times per week ____ No of times per month _____

6) How long has it been since you ended therapy with your therapist?
Years _____ Months _____ weeks _____

7) Are you a qualified? Please circle Psychologist, Psychotherapist, Counsellor

8) What service are you currently working in? circle, Voluntary, public, private

Appendix G: Study information sheet

Therapists' Internalised Representations of their Therapists:

Interpretative Phenomenological Analysis.

I would like to invite you to take part in my research study. Before you decide whether you would like to take part, it is important that you understand why the research is being carried out and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information and once again thank you for considering taking part.

What is the purpose of the study?

This study will look at Psychologists, Psychotherapists or Counsellors who have internalised their therapists' representations after completion of their own therapy. You are being asked to participate in a study that explores the experience of this phenomenon. The primary aim is to closely examine the experience of your description of your formed representations of your therapist. This study is being conducted as part of my doctoral dissertation at City University London where I am currently a trainee counselling psychologist. The study is expected to be completed towards the end of 2015.

Why have I been invited?

To be eligible in this study, you should have completed 40-50 hours of personal therapy with the same therapist, currently qualified and in a work setting. The reason for this inclusion criterion is that research has shown the phenomenon of internalisation is more stable after one year with the same therapist. Please note however, you should not be currently in therapy.

Do I have to take part?

Participation in this study is voluntary and participants will have the right to withdraw at any time. Should you choose not to answer a particular question, there will be no impact on you and you have the right to choose which questions to answer. It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. However, even if you consent to take part, you are still free to withdraw at any time and without giving a reason.

What will happen if I take part?

You will need to complete a one page demographic information sheet and read and sign the consent forms and return these to me should you participate. The research method is mainly descriptive in nature and so I will be interested in your experiences. Your

direct involvement will only last for the duration of the interview, which will be a one-off 60-80 minute one-to-one meeting sometime in July 2014.

Where will the interviews take place?

If you choose to participate in this study, you will be asked to attend a semi-structured interview, in the Social Sciences Building in City University London. This will offer a professional atmosphere with refreshments in place and the area will be private to ensure confidentially. The first 10 minutes will give you the opportunity to settle in and ensure you are clear with the procedure of the interview. You will be able to ask me any questions before we commence. Once the interview is complete, there will be a final 10 minutes to allow you the opportunity to ask me any other questions about my study and discuss how the interview experience was for you.

What do I have to do?

To participate in this study you should complete the relevant demographic information and return it to me along with the signed consent forms. On doing so, you will be asked to attend for an interview where you will have the option, agree to a suitable time that is convenient to you. If you need to cancel or postpone after agreeing a date and time, please contact me and I will reschedule for you.

What are the possible disadvantages and risks of taking part?

Discussing this topic may cause some anxiety, however I do not expect any greater risk of either physical or mental harm to you than would occur in ordinary life.

What are the possible benefits of taking part?

Therapists own therapy improves professional robustness and enhances working relationships with clients. Therapists' regardless of who they are can benefit from their own therapy to facilitate personal growth. Master therapists' are seen as those that engage in continuous self-awareness and self-knowledge. Placing a higher order of importance of one's reflexivity, such as your conscious awareness of the representations of your therapist is part of this process. I believe this research is timely, meaningful and important to the counselling profession as personal self-awareness is essential. The research will continue to advance the theoretical assumptions of this most interesting meta-psychological phenomenon that is often scant in research and often difficult to define.

What will happen when the research study stops?

The audio-taped interviews and journals will be labelled and coded and stored in a locked secure storage cabinet. However, should this study be stopped for any reason, then the information stored will be completely destroyed immediately.

Will my taking part in the study be kept confidential?

Yes, all your information will be kept in the strictest confidence. As the primary researcher, I will be the only person who will have access to your information. If I have to seek assistance from my supervisor then you will not be identified, as each participant will be given a separate code and/or pseudonym. I will seek the assistance of transcription services due to the large content of the material in this study, but again your identity will not be compromised due to stable password protected folders. It is intended that the data collected from this study will be kept for a period of 5 years, thereafter, the data will be destroyed in full.

Reward for participating.

I will give you a gift book voucher to the value of 25 stg at end of our meeting as a token gesture for taking part in my study.

What will happen to the results of the research study?

It is expected that the results of this study will be made available firstly to the City University Library and to other academic publishers that show an interest in the results. In accordance with the principles of confidentially you as a research participant in this study will not be identifiable in any of the published materials. As a valued participant, should you choose to join in on this research, you will be sent a summary of the main findings if you tick your acceptance.

What will happen if I don't want to carry on with the study?

Should you wish not to continue with the study, then you will have the option to cancel out completely your participation, even if you have already signed the consent form.

What if there is a problem?

If you would like to complain about any aspect of the study, City University London has established a complaints procedure via the Secretary to the University's Senate Research Ethics Committee. To complain about the study, you need to phone [redacted]. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is ***Therapists' Internalised Representations of their Therapists: Interpretative Phenomenological Analysis****.*

You could also write to the Secretary at:
Anna Ramberg
Secretary to Senate Research Ethics Committee
Research Office, E214
City University London
Northampton Square
London
EC1V 0HB
Email: [redacted]

Who has reviewed the study?
This study has been approved by City University London Psychology Department Research Ethics Committee, approval number *[insert approval number here]*

Appendix H: Consent form

Consent form

Research Project: Therapists' Internalised Representations of their Therapists: An Interpretative Phenomenological Analysis.

Ethics Approval number _____

I agree to participate in this research project about understanding the experiences of the phenomena of internalisation which is being conducted by Ronan O Neill, a doctoral student in Counselling Psychology at City University London, where this study has been ethically approved. I understand that my participation will involve me attending an audio recorded interview at the Social Sciences Building at City University London and that my audio-taped interview will be transcribed. I understand that what I say, or write, is confidential and no information will lead to my identification or anyone else I refer to in this project. The audio recordings will be kept for a period of 5 years in a locked cabinet, and then destroyed after this period. I also understand the results of this study will be made available, firstly, to the City University of London and may be made available to future academic media publications.The information will not contain any identifiable personal data. I understand that my participation is voluntary, and that I can choose to withdraw at any stage from this project, without giving a reason, and without being disadvantaged even if I have signed this consent. In such a situation my recordings will be destroyed immediately. There are no known risks to me and that safeguards will be taken to minimize any potential risks if I choose to participate.
I can confirm that I have read and understood the study information sheet and that I have been given the opportunity to ask questions.

_____	_____	_____
Name of Researcher	Signature	Date
_____	_____	_____
Name of Participant	Signature	Date

When completed, I would like to receive a summary of the findings of the research. Circle YES / NO

Appendix I: Interview schedule

1) Can you describe your therapist? *Prompts:* personality / appearance / gestures / voice & speech tone / statements / mannerism / the setting / active- passive / turn-taking in talking

2) How did you choose your therapist and what kept you with this same therapist?
Prompts: likes – dislikes / caring – not caring / skills / understands you sometimes-all the time.

3) Can you describe if you have ever experienced a felt-sense of your therapist?
Prompts: agreement or disagreement/ first time or most recent time / positive or negative / remembered conversations / a dialogue / a dream / with a client / physical contact.

4) In what circumstances might you think of your therapist?
Prompts: where would you be, at home / work / with clients, how often would it occur / how long for / vividness / feelings – sad- happy and emotions felt / when- day time or night time.

5) Can you describe a situation where you feel you have done something different as a result of your interaction with your therapist?
Prompts: At work / with a friend / with a family member / on your own perhaps.

6) Can you describe a situation in which you experienced your therapist while working with your own clients?
Prompts: when it occurred /where were you/ why then/ what was replayed/what words/things that happened between you / doing something your therapist suggested / remembering something said between you / sound like / act like / move like / gesture like / laugh like / gaze like / touch like.

7) How would you detect if your therapist has influenced or impacted you ever in some way? *Prompts*: did you notice it / did someone else notice it / did you sense it or feel it / is it clear or fuzzy/ therapist on holiday / you on holiday / due to work or sickness/ things you noticed or a friend or

8) Is there anything else that comes to your mind now after talking about your therapist today? *Prompts:* That you may not have thought about before now / or just today perhaps

Appendix J: Confidentiality agreement

APPENDIX J

Confidentiality agreement

Doctoral Research Project: Practitioners' Internalized Representations of their Therapists: An Interpretative Phenomenological Analysis.

I agree to engage in the transcription process for a project about understanding the experiences of the phenomenon of internalization which is being conducted by Ronan O Neill, a doctoral student in Counselling Psychology at City University London, where this study has been ethically approved. I understand that the audio recorded interviews will be transcribed by me and that I understand that what I write is confidential and no information will pass to anyone else other than to Ronan O Neill as the primary researcher responsible for this study. The audio recordings will be kept for the duration of the study and will be destroyed on completion of the study. I understand that Ronan will advise me as to when the study has been completed.

I can confirm that I have read and understood this confidentiality sheet.

[redacted] [redacted] [redacted]

Name of Transcription Agent | Signature | Date

Leah Foley

[redacted] [redacted] [redacted]

Name of Researcher | Signature | Date

Ronan O Neill

Appendix K: Sample of transcript analysis

238		
239		
240	**R: ...in your therapist? Like what's the setting like...emm?**	
241		
242	J: Hmm. It's a small...it's a small little room, smaller than this room. She rents...a space in like a...kind of commercial unit or whatever.	
243		
244		
245		
246	**R: Yes, OK.**	
247		
248	J: Emm. So it's a smaller space than this. Eh. It's got a little stove... that's not a real fire but it's like a plug-in stove with pretend flames...em...	
249		
250		
251		
252		
253	**R: OK. OK.**	
254		
255	J: which is it's quite nice. Makes you...pretend...makes you think there's a fire going.	
256		
257		
258		
259	**R: Yeah, yeah, gives a nice warm atmosphere as well.**	
260		
261		
262	J: Yeah, absolutely. Emm...she always has an oil burner burning with a nice kind of lemony... citronella kind of...ehh... oil so that it always smells...	
263		
264		
265		
266		
267		

The Therapy Atmosphere. The Therapy Room. The Therapist's Stuff. The Therapy smells. The Therapist's space!	as soon as you walk through the main doors of the building you can smell the smell, emm.. which is one of the first things I think about actually when I think about the space. Em. And then she just has a bookshelf with loads of books that I always find myself kind of staring at. And… she has… **R: She has a lot in the room for a small room.** J: Yeah, yeah she does, yeah…. **R: And the smell, that's interesting, you like the smell of the building.** J: Mmm **R: Is there anything you *don't* like about the atmosphere and setting in the therapist's room, with your current therapist?** J: ....Emm. No, nothing… **R: OK that's good, that's very, very**	I used to recall the smell & it was a nice smell. & it was the first thing I noticed when I arrived, & it's the smell that makes me associate with room. I also would spot my therapist's stuff lying about like books & often I would be drawn to the books. Strong agreement that there is a lot in the room... (The space) = neutral position: The smell - was emphasised & it seemed she enjoyed the smell. Thinking of negative thoughts of the therapist & room I could not recall anything at all.

Prompting. & Helping.	**good.**	My Questions & my prompt not so leading in this position with my use of the word caring. I should have asked. Can you say something else about made you choose your therapist.
	J: Mmm.	
	R: And overall then you told me why you chose your therapist…	
	J: Mmm.	
Type of Therapy.	**R: …emm…would you consider your therapist caring..**	
	J: Yeah, caring.	I was cautious at the start with my therapist but I had a gut feeling from the beginning that I had a therapist that was caring. I was sure from the start.
Care of Therapist.	**R: ..or non-caring? Why would you consider them caring? Why would you consider *her* caring, I mean, your therapist? What jumps to…what springs to your mind when you say… you said caring straight away to me there..**	
	J: Yeah	
	R: ..so I was just curious, you obviously straight away you know her to be caring…	
	J: Yeah, very much so.	

328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357	Time in therapy with therapist. The Boundaries of my therapist. Flexibility of therapist. Feelings of being held by therapist. Support of therapist	**R: Why so?** J: I suppose because when I have had times where things were kind of difficult, em, she would have... very much kind of checked-in around, I suppose, self-care between sessions. Eh, we upped sessions to twice a week for a period of time. Em. And in that she did reduced fee, eh, without me asking. Em. So I think I went to pay her...em... and she said something along the lines... she basically halved the fee. **R: OK, that's very nice.** J: When she was seeing me twice a week, yeah. And she would always say thing like, you know, if you're distressed or whatever she'd always say, you know – if you, if you want to contact me between sessions...emm... or if you're going to... whatever situation you're... whatever, phone...you know, phone me if it would be helpful to get some phone support, em, or whatever.	Times - Suggest Temporal dimension. I was feeling that she took good care of me when I was feeling life harden + difficult. She held me. My therapist went beyond the normal borders by lowering the fee. My therapist showed great flexibility with me. The Boundaries were loose with my therapist & I really felt so cared because of the loose boundaries which is something that stick with me.

Excitement in shifting boundaries of therapist?	**R: That's really going, let's say, against the real traditional boundaries.**	Excitement in the shifting of boundaries, and a degree of certainty of core so these shift in boundaries.
	J: ..boundaries…absolutely.	
	R: So she kind of went beyond those boundaries. I can understand now why you felt very held there.	Still a feeling of being held even though the boundaries were loose and moved in between sessions.
loose boundaries	J: Yeah.	
	R: So how was that… or was that a comfortable experience or an uncomfortable experience for you?	When I compared my own training to hers I thought it a little strange.
Self-comparison to therapist.	J: I f…	I noticed myself making comparisons to my therapist.
	R: The fact that she did that.	
	J: Yeah, I found it a bit weird at first I must say because of course because my own training was like – oh wow, that's just…that's just so not how… like… that's so outside the boundaries or whatever. But I do find that… I don't know, I suppose I find in my	A sense of shock at shift in boundaries. And a feeling of a [illegible] of excitement in the change.

388	Influence into Physical work.	own work that I do that now a little more in my own work. Obviously not giving out my personal number but I would say to my clients at work – "if you're struggling, ring me". You know, there's no guarantees and I'm very kind of specific with them around that and say, you know, "I'm not always in the office and I'm split between two sites and that kind of thing so I can't get back to you straight away and obviously if you're in crisis phone your Care Doc or whatever. But if you want to check in during the week or f there's something you're not sure about..."	I too have copied his loose boundaried relationship in my own work. I find that I can clearly write of Physical things I do now myself in taking with clients.
389			
390			
391			
392			
393			
394			
395			
396			
397	Physical use of language.		He works to reassure a strong closeness of that of his Physical words.
398			
399			
400			
401			
402			
403			
404	Verbalization of Physical.		=> use of Physical dialogue & choice of language that is Physical.
405			
406			
407			
408			
409			
410	Copying my Physical.	**R: And how do your clients find that?**	I feel I was appreciated by my clients when I/ Phoned me, & I do think it come from his ability & copy my Physical language
411			
412		J: People would say kind of thank you very much – and...	
413			
414		**R: OK, where do you think you got that from then? That, that confidence...**	
415			
416		J: I think from her.	
417			

Concious insufficiency of my therapist.	**R: to do that?** J: I think from her. **R: Because it does take a lot of confidence…** J: Yeah. **R: …to be able to do that, that's great.**	Strong identification of a concious identification of the therapist. Very engaged. Yeah = with strong conscious affirmation to therapist feelings.
Wish to be my therapist. Keeping the therapist	J: Yeah. Em, but my supervisor would be very much like that as well, you know, at work. I mean I've spoken to her about clients who I feel are in distress and I would say – "Jeanie, I think he could do with maybe two sessions a week - and not the full hour but just… if you're his only… if you're the only conversation he's having with anybody, someone with severe social anxiety for example or something like that." Just to keep that kind of maintenance going. **R: It is generally about the relationship, isn't it?**	I often would feel I am doing this kind of internalising my supervisor similar to that of my therapist as I often say similar things to her. I often feel I could do as my therapist does & offer some extra sessions for needy clients in times of depression. I often wish to be my the therapist.

Appendix L: Chronological list of emergent themes

EMERGENT THEMES CHRONOLOGICAL LIST – JANICE

Thinking of therapist 1: 1-27

Visual warmth 2: 51-56

Visualization of therapist 2: 48-54

Personality characteristics 3: 59 – 65

Emotionality of therapist 3: 75-77

Non-verbal communication 3: 80 – 85

Linguistically warm 4: 88-91

Presence of therapist 4: 93-108

Choice of sex of therapist 5: 128-152

Work identification 6: 156-185

Positivity of therapist 7: 199-205

Type of therapy 8: 209-214

The therapy setting 9: 239-245

Space of therapy 9: 249-253

Scent and Smells therapy 9/10:263-272

Caring of therapist 11: 307-327

Feelings of being held 12 331-336

Boundaries of therapist 12: 336-344

Support and trust 12: 347-357

Work boundaries 13: 381-386

Work identification 14: 388-404

Identification with therapist 14: 415-424

Wishing / holding therapist 15: 430-444

Use of therapy relations 16: 449-477

Struggle in recalling 17: 483-500

Incorporation of therapist 18: 509-516

Releasing and reassurance 18: 515-524

Accepting responses 18: 528-533

Non-judgmental feelings 19: 538-543

Positive therapist 19: 554-561

Therapists exercises 20: 568-585

Challenging and difficulty 20: 586-597

Defiance of therapist 21: 598-610

Forcing of therapist 21: 620-627

Remembrance of therapy 22: 628-637

Therapist's presence 23: 661-668

Body-mind presences 23: 669-677

Positioning of therapist: 24: 691-704

Compassion identification 24: 706-715

Therapists support 25: 720-747

Therapists recall 26: 759-763

Fantasy of therapist and identity 27: 780-781

Along sidedness of therapist 28: 813-818

Holding of therapist 28: 822-829

Recalling of therapy 29:864-867

Reliance identification 31: 900-914

Ego change of self 32: 928-957

Use of personal self 33: 958-977

Use of professional self 33: 980-987

Personality change 34: 988-997

Assertiveness of self 34:1000- 1005

Pattern of ego change 35: 1028-1039

Freedom of self: 35: 1040-1047

Confidence in identity 36: 1048-1052

Language identification 37: 1086-1099

Working with clients 38: 1112-1136

Imagining of therapist 39: 1151-1154

Memory reassurances 40: 1168-1181

Therapist's language 41: 1198-1205

Work parallels 41:1207-1214

Methods of therapist 42: 1255-1257

Profound moments 43: 1258-1274

Impact of therapist 43: 1278-1285

Therapists affect 44: 1293-1297

Holding visualization 45: 1324-1332

Identification of self 45: 1336-1345

Control of therapist 46: 1350-1354

Kindness of therapists 47: 1387- 1388

Fantasy of therapist 49- 2030-2045

Appendix M: Summary table of clustered themes

SUMMARY TABLE OF CLUSTERING OF THEMES – JANICE

THEME	SUB THEME	PAGE	LINE NUMBER
Identification	Thinking of therapist	1	1-27
	Working identification	6	156-185
	Work Identification	13/14	388-404
	Identification with therapist	14	415-424
	Incorporation of therapist	18	509-516
	Along sidedness of therapist	28	822-829
	Reliance identification	31	900-914
	Working with clients	38	1112-1136
	Imagining of therapist	39	1151-1154
	Work parallels	41	1198-1205
	Therapists language	41	1198-1205
Fantasy	Visualization of therapist	2	48-54
	Wishing holding of therapist	15	430-444
	Therapists presence	23	661-668
	Positioning of therapist	24	691-704
	Compassion identification	24	706-715
	Therapists recall	26	759-763
	Fantasy of therapist identity	27	780-781
	Recalling of therapy	29	864-867
	Language identification	37	1086-1099
	Therapists affect	44	1293-1297
	Fantasy of therapist	49	2030-2045
Change of Self	Ego change of self	32	928-957

	Use of personal self	33	958-977
	Use of professional self	33	980-987
	Assertiveness of self	34	1000-1005
	Personality of change	34	988-997
	Pattern of ego changes	35	1028-1039
	Freedom of self	35	1040-1047
	Confidence in identity	36	1048-1052
	Identification of self	45	1336-1345
Holding	Feelings of being held	12	331-336
	Releasing and reassurance	18	515-524
	Holding of therapist	28	822-829
	Memory reassurances	40	1168-1181
	Holding visualization	45	1336-1345
Challenges	Work boundaries	13	380-386
	Therapists exercise	20	568-585
	Challenging and difficulty	20	586-597
	Defiance of therapist	21	598-610
	Forcing of therapist	21	620-627
	Profound moments	43	1258-1274
	Control of therapist	46	1350-1354
Warmth	Visual warmth	2	51-56
	Personality characteristics	3	59-65
	Linguistically warm	4	88-91
	Caring of therapist	11	307-327
	Support and trust	12	347-357
	Accepting responses	18	528-533
	Non-judgemental feelings	19	538-543

	Positive therapist	19	554-561
	Therapists support	25	720-747
	Kindness	47	1387-1388
Atmosphere	Emotionality of therapist	3	75-77
	Non-verbal communication	3	80-85
	Presence of therapist	4	93-108
	Positive of the therapist	7	199-205
	Type of therapy	8	209-214
	Setting	9	239-245
	Space of therapy	9	249-253
	Scent and smells	9/10	263-272
	Boundaries of therapist	12	336-344
	Methods of therapist	42	1255-1257
	Impact of therapist	43	1278-1285
	Personality	45	1342-1347

Appendix N: Collapsing of subthemes

FURTHER COLLAPSING OF SUBTHEMES - JANICE

THEME	NEW SUB Theme	PAGE No	LINE No	Quote
Identification	Cognitive identifications	14	416	I think from her.
	linguistic Identification	39	1152-1154	I would have said things to clients that she has said to me. So I would use her language.
	Body identification	6	156-185	I wanted to have therapy with her because I had trained & I had done a lot of yoga training
Fantasy	Intra-self	27	782-783	that inner dialogue would go on for quite a while.
	Inter-self	23	670-673	I do have a sense of her a lot of the time but it's more that she is with me or beside me.
Change of Self	Intra-change	34	1028-1332	I feel more self-assured in doing that *(being assertive).*
	Inter-change	35	1028-1037	And I suppose in lots of different situations not just romantic relationships
Holding	The good-enough	28	822-828	Like you draw (referring to therapist) on someone in a support network or you might draw on a parent, you kind of say a partner and say you know, I know that they are always there.
Challenges	Control	46	1350-1355	on a cognitive level sometimes I am thinking, was she just very directive there? (*referring to therapist)*
Warmth	Gestalt warmth	12	347-357	She would always say things like, you know, if your re distressed or whatever she'd always say you know, if you want to contact me between sessions…phone me if it would be helpful to get some phone support.
	Role model of therapist	18	529-532	She models this kind of really accepting response to pretty much whatever you bring which is nice.
Atmosphere	Mood			

Appendix O: Emergent themes with subtheme quotes

EMERGENT THEMES AND SUBTHEME QUOTES – JANICE

Theme 1 – Identification / with Therapist:

Page No	Line No.	Quote
6	156-185	I wanted to have therapy with her because I had trained & I had done a lot of yoga training ..I might be able to bring that stuff into my work someday as well.
13/14	386-393	I suppose I find in my own work that I do now a little more in my own work, (*working with loose boundaries*)..I would say to my clients at work , if you're struggling ring me".
14	416	I think from her.
18	513-517	I will talk to her about something that I've been storing up or whatever and then we'll kind of process it and I always find her response is just very kind of reassuring.
28	814-818	I think I feel a sense of her but it's not an embodiment. It's not something that's in me, Em, It's more someone that's with me.
31	900-912	Some days you feel more resilient than others and its more that I would either draw on her or on other people in my life at the times when I am less resilient, I suppose that your re kind of like, fuck, I can't do this on my own.
39	1152-1154	I would have said things to clients that she has said to me. So I would use her language.
41	1206-1215	I communicate what I am feeling about them (*clients)* or thinking about them if I think it's going to be helpful in a more open way because I know that I found it helpful myself *(in therapy)* whereas it's not really something that's in our manuals .. it's not really trained into you.

Theme 2 – Fantasy.

Page No	Line No	Quote
2	48-54	I suppose the first thing that comes to mind when I think about her is her face and her smile.
23	670-673	I do have a sense of her a lot of the time but it's more that she is with me or beside me.
24	706-716	If I am thinking about something and getting quite upset or If I am going

		into a tricky situation or something or I am dealing with something I'd rather not be dealing with then I'd kind of think OK, what would she do (*her therapist)*
26	759-761	(*thinking of therapist)* It could be ten minutes or half an hour.
27	780-789	I suppose because I would be thinking about what would she say, so that would kind of, that inner dialogue would go on for quite a while where I'd be thinking" what would she say and what did she say the last time when we talked about something similar"
37	1092-1099	So in between sessions you're the one that's actually taking it so she would put it more down to that I am running with what she's giving me whereas I would be thinking it's probably both. *(her and my own impact)*
44	1294-1297	It's interesting, I can feel my palms sweating when I think about *. (her working with me)*
49	2030-3045	She's amazing, she's absolutely amazing *(ref to her therapist) I* went on Monday and slept for fourteen hours afterwards.

Theme 3 – Change of Self.

Page no	Line no	Quote
32	948-957	The way I interact with the course, the teaching staff on the course is very different as a result of my therapy… I suppose I feel more self-assured in kind of saying when I am not ok with something and yeah and I suppose just articulating that and saying I am not OK and that's not OK.
33	968	Much more assertive.
34	1003-1004	I feel more self-assured in doing that *(being assertive)*
35	1028-1037	I suppose with romantic relationships, I suppose the pattern, I've changed my pattern quite significantly as a result of therapy. And I suppose in lots of different situations not just romantic relationships.
45	1328-1332	I suppose the more I see her (therapist) the more relaxed I am with her. So I wouldn't kind of hold to stuff as much.

Theme 4 - Holding.

Page No.	Line no.	Quote.
12	331-335	I suppose because when I have had times where things were kind of difficult, she would have very much kind of checked in around, I suppose self-care between sessions. We upped sessions to twice a week for a period of time and in that she did reduced fee.

18	514-516	I always find her response is just very kind of reassuring.
28	822-828	Like you draw (referring to therapist) on someone in a support network or you might draw on a parent, you kind of say a partner and say you know, I know that they are always there.
40	1170-1182	I suppose when my therapist seen that side to me she would talk about, you know, almost by way of reassurance like that the core is quite steel.

Theme 5 – Challenges.

Page no	Line no	Quote
13	381-387	Yeah I found it a bit weird at first (*movement of boundaries by therapist)* I must say because of course because my own training was like wow.. that's so outside the boundaries or whatever.
19	556-562	There are some exercises that she's asked me to do that I haven't really kind of fully understood.
20	586-597	I found it really difficult at first (*working with embodiment with my therapist)* I felt quite self-conscious doing it.
21	621-627	And the therapist was saying you know, I am going to sit as you would so I'm you in this scenario. And I was like, I don't want to talk to you.
46	1350-1355	Yeah I do, I do, I suppose on an emotional level I do but then on a cognitive level sometimes I am thinking, was she just very directive there? (*referring to therapist)*

Theme 6 – Warmth

Page no	Line no	Quote
2	51-54	She always looks very kind of warm in her face.
3	75-76	She crack the odd joke
4	88-90	Her language is quite relaxed, she doesn't use a lot of jargon with me.
12	347-357	She would always say things like, you know, if your re distressed or whatever she'd always say you know, if you want to contact me between sessions…phone me if it would be helpful to get some phone support.
18	529-532	She models this kind of really accepting response to pretty much whatever you bring which is nice.
19	538-542	I certainly haven't felt judged. I feel she's very supportive, very supportive.
19	555	Mostly a positive experience (*referring to therapist relations)*

47	1388	Just warmth really *(thinking of therapist)*

Theme 7 - Atmosphere / Ambience

Page no.	Line no.	Quote.
3	76-77	She'd crack the odd joke
3	82-85	Her body language is always quite relaxed when she sits down.
8	213-214	Its talkative (r*eferring to therapists style).*
9	242-246	It's a small little room, smaller than this room.
9	263-267	She always has an oil burner burning with a nice kind of lemony citronella kind of oil that it always smells as soon as you walk through the main doors of the building you can smell the smell which is one of the first things I think about actually when I think about the space
12	340-344	So I think I went to pay her and she said something along the lines, she basically halved the fee.
45	1327-1335	Yeah she is quite funny, like I feel I suppose the more I see her the more relaxed I am with her.

Appendix P: Ethics release form

All students planning to undertake any research activity in the School of Arts and Social Sciences are required to complete this Ethics Release Form and to submit it to their Research Supervisor**, together with their research proposal clearly stating aims and methodology**, prior to commencing their research work. If you are proposing multiple studies within your research project, you are required to submit a separate ethical release form for each study.

This form should be completed in the context of the following information:

- An understanding of ethical considerations is central to planning and conducting research.
- Approval to carry out research by the Department or the Schools does not exempt you from Ethics Committee approval from institutions within which you may be planning to conduct the research, e.g.: Hospitals, NHS Trusts, HM Prisons Service, etc.
- The published ethical guidelines of the British Psychological Society (2009) Guidelines for minimum standards of ethical approval in psychological research (BPS: Leicester) should be referred to when planning your research.
- **Students are not permitted to begin their research work until approval has been received and this form has been signed by Research Supervisor and the Department's Ethics Representative.**

Section A: To be completed by the student

Please indicate the degree that the proposed research project pertains to:

BSc ↑ M.Phil ↑ M.Sc ↑ **D.Psych** ✓ ↑ n/a ↑

Please answer all of the following questions, circling yes or no where appropriate:

1. Title of project.

Therapists Internalised Representations of their Therapists:

An Interpretative Phenomenological Analysis.

2. Name of student researcher (please include contact address and telephone number)

Ronan O' Neill: [redacted]

3. Name of research supervisor

Dr Susan Strauss

4. Is a research proposal appended to this ethics release form? Yes ✓

5. Does the research involve the use of human subjects/participants Yes ✓

If yes,

a. Approximately how many are planned to be involved? 8-10

b. How will you recruit them?

Posters/email-lists/advertisements in Counselling & Psychotherapists Centers, and journals BPS & IPA.

c. What are your recruitment criteria?

(*Please append your recruitment material/advertisement/flyer)*

If you are a qualified Psychologist, Psychotherapist or Counsellor or a Psychotherapist or Counsellor working toward accreditation and currently in a work setting, (i.e., voluntary, public or private) and have completed 40-50 hours of one-to-one counselling with the same therapist, you are invited to take part in this study. However, for this study, you should not be currently in therapy.

d. Will the research involve the participation of minors (under 18 years of age) or vulnerable adults or those unable to give informed consent? No ✓

d1. If yes, will signed parental/carer consent be obtained? N/A

d2. If yes, has a CRB check been obtained? N/A

(*Please append a copy of your CRB check*)

6. What will be required of each subject/participant (e.g. time commitment, task/activity)? *(If psychometric instruments are to be employed, please state who will be supervising their use and their relevant qualification).*

Participants will have to complete a single page 12-item screening tool, the Therapist Embodiment Scale (TES), a subscale of the Therapist Representation Inventory (TRI). Each participant will attend an interview (60-80 minute approx.). Also a single page demographic sheet will be administered in advance of any interview. They will be required to read the study information sheet, ask questions about the study if they wish and sign the consent form in advance of the interview.

7. Is there any risk of physical or psychological harm to the subjects/participants? yes ✓

If yes,

a. Please detail the possible harm?

b. The study will may involve the participants speaking about their experiences of their therapists, their therapy and their clients. This could possibly cause some anxiety. However, in conducting this study, I do not expect any greater risk of either physical or mental harm to my participants that would occur in ordinary life.

The group of participants I am recruiting will either be qualified Psychologists, Psychotherapists, or Counsellors and therefore I believe these individuals would have the appropriate training and skills to be self-reflective. Any anxiety that may arise, I would foresee only lasting the duration of the interview. Also participants will be in safe public environment with services available. The start and ending of the meeting will involve notification to the reception.

c. What precautions are you taking to address the risks posed?

I will only recruit qualified psychologists, psychotherapists and counsellors for this study. I will only recruit those who have completed 40-50 hours of personal therapy. I will only recruit those who have ended therapy and by doing so I hope to avoid any risk of contamination of their personal therapy.

Each participant will receive a completed information study pack including a list of contacts of psychological services in the community. My full contacts and my supervisor contacts will be made available. My own personal care will involve ongoing therapy for the duration of the study.

8. Will all subjects/participants and/or their parents/carers receive an information sheet describing the aims, procedure and possible risks of the research, as well as providing researcher and supervisor contact details? Yes ✓

(*Please append the information sheet which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)*

9. Will any person's treatment/care be in any way be compromised if they choose not to participate in the research? No ✓

10. Will all subjects/participants be required to sign a consent form, stating that they fully understand the purpose, procedure and possible risks of the research? Yes ✓

If no, please justify

If yes please append the informed consent form which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

11. What records will you be keeping of your subjects/participants? (e.g. research notes, computer records, tape/video recordings)?

I will keep audio-taped voice recordings, written transcripts of these recordings, computer notes on the analysis and demographic information plus a chronological audit trail of the study.

12. What provision will there be for the safe-keeping of these records?

All print hard copies and audio tape recordings will be under lock and key in a secure metal cabinet in my home office. Computer anti-virus software and pass worded ID denying access to everyone other than myself on PC.

13. What will happen to the records at the end of the project?

The recordings will be kept for a period of 5 years where upon they will be destroyed.

14. How will you protect the anonymity of the subjects/participants?

Participants will be issued with pseudonyms to protect their anonymity and any names or references to places will be changed also protecting identity.

15. What provision for post research de-brief or psychological support will be available should subjects/participants require?

A completed list of resources within the community including addresses and full contacts to include phone, email and web addresses in a debriefing form. My contact details will also be available in the event they need further assistance to guide them in the correct direction of seeking further assistance. The debrief will be both verbal and in print. I will also allow time for participants to ask questions before and after the study to reduce any possible anxiety

(*Please append any de-brief information sheets or resource lists detailing possible support options)*

If you have circled an item in **underlined bold** print or wish to provide additional details of the research please provide further explanation here:

I will conduct a pilot study using two or three participants for the purposes of examining the quality and rigor of my interview questions, but also with the intention of practicing the layout of my interview procedure. I will conduct a pilot study in the hope that I can adapt my methods to higher standards in this iterative process, making the process more professional and less anxiety-provoking for the participants.

The pre interview period of 15 minutes will aim to relax my participants, check relevant data for verification purposes and allow me to go through the procedures once more. The post interview period allowing 15 minutes will give the participants the opportunity to reflect on the experience of the interview process and any negative impact the interview may have upon them. Participants will be debriefed verbally and in written format detailing information to include their right of withdrawal

Signature of student researcher [redacted]

---------- Date -- [redacted]

CHECKLIST: the following forms should be appended unless justified otherwise

Research Proposal
Recruitment Material
Information Sheet
Consent Form
De-brief Information

Section B: Risks to the Researcher

1. Is there any risk of physical or psychological harm to yourself? Yes ✓

If yes,

a. Please detail possible harm?

I will be meeting a group of people whom I do not know and as such it carries some risk although small as I will be working with professional therapists.

b. How can this be justified?

The fact that I will be recruiting qualified therapists who have had personal therapy, it is expected there would be appropriate self-awareness to their own physical and psychological self-care.

c. What precautions are to be taken to address the risks posed?

I will advise the reception area of my starting times and ending times of each meeting.

Section C: To be completed by the research supervisor

(Please pay particular attention to any suggested research activity involving minors or vulnerable adults. Approval requires a currently valid CRB check to be appended to this form. If in any doubt, please refer to the Research Committee.)

Please mark the appropriate box below:

Ethical approval granted

Refer to the Department's Research and Ethics Committee

Refer to the School's Research and Ethics Committee

Signature [redacted] ---------- Date [redacted]

Section D: To be completed by the 2nd Departmental staff member *(Please read this ethics release form fully and pay particular attention to any answers on the form where **underlined bold** items have been circled and any relevant appendices.)*

I agree with the decision of the research supervisor as indicated above

Signature [redacted] ---------- Date [redacted]

Appendix Q: Insurance form

Researcher(s) Names(s)	Ronan O Neill
Supervisor(s) Name(s)	Dr Susan Strauss
Degree Programme	Dsych programme in counselling psychology
Project Title	Therapists' Internalised Representations of their therapists, An interpretative phenomenological analysis
Abstract (maximum 100 words)	This study proposes to explore therapists' experience of their therapists' representations. A qualitative study will be carried out to make sense of the lived experience of therapists' internalised representations. The Interpretative Phenomenological Analysis (IPA) is my chosen qualitative approach. This study aims to explore therapists' experiences of the representations of their therapists that may have been internalised. The study seeks to find out how in what circumstances they experienced their therapists' representations and what actually occurs to these representations.
Brief descriptions of method of recruitment, procedures and participants	Posters and email directly to centre's employing qualified Psychologists, Psychotherapists and Counsellors.
Expected end date of project	End 2015
Will the research involved involves children or vulnerable groups?	NO
Will the research take place abroad?	Part of it will be conducted in Ireland

For office use only

Application reference	Insurance form
Application submission date	
Application approval date	
Approving body	
External ethical approval sought?	YES / NO
	Body (e.g. NRES):

Appendix R: Debriefing form: UK

Debriefing form

Therapists' Internalised Representations of their Therapists:

An Interpretative Phenomenological Analysis.

Thank you for taking part in this study.

The study proposes to enhance the understanding of the internal working model of internalised therapist representations in therapists. The study will also enhance experiences of therapists' external behaviours from their therapists' representations. This study will employ a review of the content of the therapist's descriptions of their therapists' representations, but will also pay deliberate attention to the form of these representations, in other words their experience of them entering into their conscious awareness. Although today's interview was not a therapy session, I understand that some material discussed in this meeting may have evoked some thoughts or concerns. If you do feel concerns regarding anything that has arisen today, a full list of contacts are available through The British Psychological Society (BPS) London Office: 30 Tabernacle Street, London EC2A 4UE Telephone: +44 (0) 207 330 0890 E-mail: london@bps.org.uk or the British Association for Counselling & Psychotherapy BACP House, 15 St John's Business Park, Lutterworth LE17 4HB Tel: 01455 883300.

If for any reason, however you find that the services provided here are not sufficient to meet your needs, please do not hesitate to contact me to discuss further recommendations.

Once again thank you for your participation and I look forward to sharing some feedback to you in the near future.

Yours sincerely,

Ronan O' Neill [redacted] [redacted]

Appendix S: Debriefing form: IRE

Debriefing form

Therapists' Internalised Representations of their Therapists:

An Interpretative Phenomenological Analysis.

Thank you for taking part in this study.

The study proposes to enhance the understanding of the internal working model of internalised therapist representations in therapists. The study will also enhance experiences of therapists' external behaviours from their therapists' representations. This study will employ a review of the content of the therapist's descriptions of their therapists' representations, but will also pay deliberate attention to the form of these representations, in other words their experience of them entering into their conscious awareness. Although today's interview was not a therapy session, I understand that some material discussed in this meeting may have evoked some thoughts or concerns. If you do feel concerns regarding anything that has arisen today, a full list of contacts are available through, The Psychological Society of Ireland (PSI), floor 2 Grantham House, Gratham Street, Dublin 2. Tel 01-4720105

If for any reason, however you find that the services provided here are not sufficient to meet your needs, please do not hesitate to contact me to discuss further recommendations.

Once again thank you for your participation and I look forward to sharing some feedback to you in the near future.

Yours sincerely,

Ronan O' Neill [redacted] [redacted]

List of Tables

Table 1: Summary of participants' demographics

Participant	Age	Years in therapy	Hours in therapy	Sessions per MTh	Ended therapy	Type of therapist	Work position
Sharron	57	5.9	400	4	1 year	Psychotherapist	Voluntary
Sarah	40	3.0	120	4	1 year	Psychotherapist	Voluntary
Janice	34	1.0	50	3	1 year	Psychotherapist	Public
Helen	42	6.4	200	4	4 MThs	Psychotherapist	Voluntary
Jackie	55	2.0	50	2	1 week	Psychologist	Public
Nadia	38	3.3	150	4	2 years	Psychologist	Public
Kaelyn	59	2.5	84	4	1 year	Psychotherapist	Private
Jack	44	4	120	2	6 years	Psychologist	Public

All names have been changed to protect participants' anonymity.

Table 2: Participant recurrent themes

participants	Jack	Helen	Kaelyn	Jackie	Sarah	Nadia	Janice	Sharron
Parent fantasy	✓		✓			✓		✓
Internal voice	✓	✓		✓	✓		✓	✓
Internal dialog	✓	✓					✓	✓
Client work	✓	✓	✓				✓	✓
Visual image		✓	✓				✓	
identification	✓	✓	✓	✓	✓	✓	✓	
Active therapy			✓	✓		✓	✓	✓
Felt sense	✓	✓	✓	✓		✓		
visualization	✓	✓	✓		✓		✓	
Loss	✓			✓	✓			✓
Self-change	✓	✓	✓		✓	✓	✓	
containment	✓	✓	✓	✓	✓	✓	✓	

Table 2. Main recurrent themes across participants

Section C: Professional practice: Advanced case study

Client case study:

_____

Short term psychodynamic treatment of a client in the context of love and hate:

_____

Section D: Paper for publication

The internalised representations of one's therapist: An Interpretative Phenomenological Analysis.

Abstract

This study examined how therapists experience their own therapist's representations. Semi-structured interviews were conducted with eight participants, all of whom were therapists themselves and had completed a minimum of one ended year of personal therapy with the same therapist. Using Interpretative Phenomenological Analysis (IPA) the transcripts were analysed and indicated three master themes: 1) ***letting the therapist in, 2) identifying with the therapist, and 3) the changes within.*** This paper focuses on the most significant findings from superordinate theme one. The findings provided a sense of understanding the participants' experiences of knowing the form and function of their therapist's internalised representations. The study found that participants seemed to experience their therapist representations as mother-object representations. It appeared the participants experienced these representations almost as a 'holding function' (Winnicott, 1963, p. 240). In particular, the participants experienced this metaphorical holding as a concrete felt-sense of their therapist, incorporated either alongside them or inside of them. They could also engage in visualisation and imagined dialogue of their therapist as a means to overcome difficult therapy and personal situations. These sensory representations manifested in a form of imitating one's therapist and seemed to be used in an advisory capacity in a mentor-mentee style relationship. This relationship seemed to enable a continuing bond to the therapist which the participants appeared to use to manage anxiety. The participants' experiences are explored to make the process of internalised representations more explicit. The implications, applications and limitations of this qualitative study are addressed from a Counselling Psychology perspective.

Keywords: representation, internalisation,