

An Exploration of Sustaining Empathy in the Therapeutic Relationship

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ABSTRACT

The purpose of this study is to examine a therapist's ability to sustain empathy in the therapeutic relationship. It acknowledges that empathy is a complex construct and examines its implications for the therapeutic practice. Despite being a term widely used across a variety of disciplines, studies into empathy have been sparse and inconsistent. More recent studies on the topic, however, have been informed by embodied psychotherapy and influenced by research on early development and neuroscience. In this study, the quality of empathic engagement is shown to emerge in the unique intersubjective experience of client and therapist. It is grounded in the shared embodiment of their humanity which is a dynamic complex construct, one which provides a useful framework for practice application. This exploration has demonstrated how the therapist's personal development and self-regulation are central to their ability to sustain and manage empathic engagement. The research was conducted as a qualitative study using a thematic analysis of the data. A number of themes were consistently raised by participants in the interview process. The findings were then discussed in relation to the therapist's view of sustaining empathy. They include aspects of the therapist / client relationship and the issue of reciprocity in therapy work. Interviewees discussed the bi-directional healing they have experienced in the therapeutic relationship. They spoke of the intersubjective experience and the relational depth in being able to create an empathic connection. However, despite what therapists' say they are getting from the work, this study found that it is virtually impossible to sustain empathy all the time in the therapeutic relationship. The research concluded that the re-emergence of participants' early developmental issues (like loss, separation, attachment) were significant blocks to their ability to sustain empathy. Along with difficulties, supports to the therapists' sustaining empathy were also explored. Finally, the study considered the implication for psychotherapy practice and pointed to possible directions for further research.

CHAPTER ONE

1.1 INTRODUCTION

Empathy describes the methods by which one comes to know how and why others feel as they do (Tuch, 1997, p. 3).

The psychologist Edward Titchener (1867-1927) introduced the term “empathy” in 1909 into English as a translation of the German *Einfühlung* (“feeling into”). In the 19th century, *Einfühlung* was used in German philosophical aesthetics and was understood as the ability to “feel into” works of arts and into nature (cited in Pigman, 1995, p. 2). Romantic thinkers, like Herder and Novalis, saw this ability as key while Coleridge vividly described the empathy of the artist but without giving it a name (Beres & Arlow, 1974; cited in Pigman, 1995). Robert Visser was the first to use *Einfühlung* in a more technical sense but it was Theodor Lipps (1851-1914) who developed it as the psychological concept we know today (Gerdes, et al, 2011). It was the particular concept developed by Lipps that Titchener had in mind in his translation of *Einfühlung* as “empathy”. The English word used was derived from the Greek *empathia*, from *en* (in) and *pathos* (passion or suffering) meaning “an especially intense state of feeling” (Depew, 2005). Over the years, the two therapeutic approaches that have focused most on empathy are psychoanalytic psychotherapy and person-centred therapy and it will be these two disciplines which will be referred to throughout this thesis.

1.2 AIMS & OBJECTIVES

This research is a qualitative study of therapists working in the field of psychotherapy: it aims to explore their perspective on how a therapist sustains empathy in the therapeutic relationship. By and large, psychotherapists listen to the words of clients in order to attempt

to understand their struggle and eventually relay this understanding through words. Buchholz (2006) argues that a successful relationship is dependent on mutual understanding rather than the one-sided conception of relations traditionally found in the conventional understanding of humanism and psychoanalysis (cited in Muth 2011). As Bohleber (2006) reminds us, speech and its understanding have its limits, however, therapists and clients do more than simply talk (cited in Muth 2011). The communication of empathy and empathic attunement is a major resource that exists between therapist and client. Together they create a world of sounds, words and silences, in the conscious and unconscious communication which exists in the interplay between therapist and client in the therapy room.

The overall aim in conducting this study is to explore the therapist's ability to sustain empathy in the therapeutic relationship and the specific objectives are as follows:

- To explore the person of the therapist in their ability to sustain empathy
- To explore what supports the therapist to sustain empathy
- To explore difficulties, if any, to sustaining empathy
- To explore insights, if any, for the future of humanistic and integrative psychotherapy

CHAPTER TWO

2.1 LITERATURE REVIEW

This literature review will initially focus on the contribution of psychoanalysis and (Rogerian) humanism to the understanding of empathy and will continue by examining contemporary research into empathy and its impact on the therapeutic relationship.

2.2 PSYCHOANALYTICAL CONCEPTION OF EMPATHY

It is suggested that Lipps (1903) was Freud's most probable source for the aesthetic and psychological discussion of the concept of empathy, as he had been an admirer of his for many years. It is evident from the literature that Freud's reference to empathy was somehow lost in translation. His conception of *Einfuhling* was first developed in *Jokes and their Relation to the Unconscious* (1905) where he viewed it as a process which allows us to put ourselves into the place of the other. Freud, in his work, never translated *Einfuhling* as empathy in a clinical context but he regarded it as essential for establishing the rapport between patient and analyst. He recognised it as part of the therapeutic process and regarded empathy as central to the interpretative process since it provided access to another's mental life (cited in Levy, 1985). In this sense, it helps the analyst to tune into the unconscious as well as into the conscious world.

Ferenczi (1928-1955), a devoted and talented follower of the psychoanalytic movement, found the technique after many years of working within the mode, to be less than successful with many of his patients. Rather than continuing to work in what he felt to be the remote and stern approach which prevailed in psychoanalysis in the late 1920s, he began to transform the emotional climate of his sessions into a responsive, warm and empathic process. He departed from the traditional use of the couch and was the first analyst to engage in face-to-face

contact with a patient. His approach had direct implications for the integration of empathy into the therapeutic context. He felt that rather than remain remote, the function of the analyst where “his mind swings continuously between empathy, self-observation and making judgement” was imperative in terms of the client being empathically understood (Clark, 2007, p. 94). It was not until many years later that his seminal role in the analytic treatment and the advancement of empathy as a critical function of the therapeutic process was acknowledged.

Between their final writings in the 1930s and the 1950s, Fenichel (1953) Fliss (1942) and Fromm-Reichman (1950) were among a small number of psychoanalytic writers who recognised the potential that empathy held for the advancement of the therapeutic relationship (cited in Clark, 2007, p. 99). It was almost three decades after Ferenczi that Heinz Kohut (1977), also a leading figure in psychoanalysis, affirmed the central role of empathy in psychoanalysis and introduced empathy as a pivotal construct in his treatment. Kohut defined empathy as a ‘*vicarious introspection*’ which enabled the therapist to feel into the inner life of another person. In this way, Kohut believed that a deeper understanding of the individual occurs through the sustained engagement of empathy and introspection. Both therapeutic processes provide essential means of acquiring a comprehensive clinical knowledge of a patient through an experience near modality. Kohut (1977) saw the ability to empathise as a basic one: “the empathic understanding of the experience of another human being is as basic an empowerment of man as his vision, hearing, touch, taste, smell” (1977,p. 144). Another significant development was Kohut’s (1984) discovery of empathic failure; he recognised that successive minor lapses in empathy enabled a client to negotiate separateness from their therapist. He recognised that minor empathic failure was important from a clinical perspective as it provided an opportunity for growth, enabling the client to tolerate the

inevitable misunderstandings that occur within the course of the therapeutic relationship (cited in Bohart & Greenberg, 1997).

2.3 INTER-SUBJECTIVITY

The concept of inter-subjectivity has become an important theme in psychoanalysis particularly since the shift from the drive / structure model to the relational / structure model. Stolorow, Atwood and Ross first introduced this concept into their work in 1978, they were later joined by Brandchaft and Orange (cited in Jaenicke, 2011). Together they developed the theory known as inter-subjectivity theory. The emphasis is on the mutual reciprocal interaction of the interrelating worlds of experience, between the subjective world of the therapist and that of the client. It involves interweaving their world of experiences (Stolorow, Atwood, Orange 2002). This concept is further illuminated by new research in the area of neurobiology.

2.4 HUMANISTIC CONCEPT OF EMPATHY

The original peak of interest in the role of empathy in humanistic psychotherapy came as a result of Carl Roger's (1969) hypothesis that there were six conditions of therapy; three of those come primarily from the therapist rather than through a mode of communication or specific actions. Humanist or client-centred qualities of attitude are: unconditional positive regard or acceptance of the client's experiences; congruence, a kind of whole-person authenticity and empathy, which sees the person's private world as if it were their own but without ever losing the "as if" quality. Empathy is defined as separate from the other qualities but all three together were considered necessary and sufficient for therapeutic change. Rogers basic premise was that there is an inherent need in each individual (as well as in all of nature) to reach his or her potentialities, which he called an *actualizing tendency*.

When a person experiences the core conditions from a significant other who is also experienced as genuine and human, the person develops unconditional positive self-regard (self-esteem), and the process of actualization is promoted. Within the therapeutic relationship, the link between the inner subjective world of the therapist and client has the power to heal. The quality of this type of therapeutic relationships in Rogers (1980, p.12) words “transcends itself” and becomes part of something larger, a deeply intensifying human experience. Conversely, this natural growth tendency is thwarted when the person experiences conditional acceptance or the absence of empathy.

The 1960s and the early 1970s saw a great deal of research activity on empathy within the humanist tradition. In the late 1970s, Charles Truax and his colleagues (Truax & Carkhuff, 1967; Truax & Mitchell, 1971) gathered evidence which suggested there were strong links between Rogers’ core conditions of empathy and genuineness, and the therapeutic outcome. However, a number of subsequent studies lead to inconsistencies: for instance Slone, Staples, Cristol, Yokston and Whipple (1975) found no relationship between the therapist’s empathy and client success. The second problem was the re-analysis of the data: the results were more inconsistent than previously claimed. A third problem was the methodology used by Truax and his colleagues to calculate the reliability of empathy measurements (Chinsky and Rappaport, 1970). It was found in the reanalysis that the relationship between empathy, in particular the therapeutic condition in general, was positive but weaker than originally thought (cited in Bohart & Greenberg, 1997).

Interestingly, there is a link between Rogers and psychoanalysis in his early training at Rochester, when he became familiar with the work of Otto Rank and several of Rank's students. This may account for how Stolorow’s (1976) in his work, draws a number of similarities between Rogers and Kohut’s work. Rogers himself was not especially interested

in transference however, Stolorows (1976) viewed Rogers's empathic reflection of feeling and his acceptant attitude, as central to Kohut's theory, which encouraged the development of mirror transference and unfolding grandiosity. The core conditions seem to provide the ideal climate to encourage the development of a narcissistically sustained mirroring transference. Through affirmation of the clients worth, significance and value the clients comes to experience themselves as prized, as the narcissistically disturbed client immersed in the mirror transference (cited in Kahn, Rachman, 2000).

2.5 EMPATHY IN CONTEMPORARY NEUROSCIENTIFIC RESEARCH

Research by the Italian neuroscientists, Giacomo Rizzolatti and Vittoria Gallese in the late 1990s on the behaviours in monkeys provides a new understanding of empathy (Gerdes *et al.* 2011). This research allowed neuroscientists to demonstrate that empathy can be empirically observed and quantified. During a break, one of the human researchers hungrily reached out to get a raisin for himself. Simultaneously, neurons in the monkey's brain fired. These newly-discovered connector cells were named "mirror neurons" because they appear to reflect the activity of another's brain cells. This research in neuroscience had a significant impact on the definition of interconnectedness, and changed our understanding of empathy forever (Rothschild, 2004). This research allowed researchers to demonstrate that empathy can be empirically observed and quantified (Gerdes *et al.*, 2011, p. 83). Neuroscience confirmed that when we see another person's actions, our bodies automatically respond as if we were the actor and not the observer (Jackson *et al.*, 2006). This phenomenon illustrated how the circuitry of the brain responsible for this is referred to as the mirror neuron system. According to Nakahara & Miyashiita (2005) "the astonishing properties of mirror neurons is that they point to a unique principle that our brains use to link self to non-self" (2005, p. 97).

Elliott et al (2011) propose that the discovery of mirror neurons has been crucial in illuminating the work of therapeutic empathy. When we hear people or watch their posture, gestures and facial expression, the neural networks in our brain are stimulated and a shared interpersonal representation is created. The result is an inner reflection or simulation of the experience of those we are observing (Gerdes *et al*, 2011). This new research further illuminates our understanding of empathy and demonstrates how inter- subjectivity influences the therapeutic relationship.

2.6 EMPATHY IN THE THERAPEUTIC RELATIONSHIP

Empathy “is one of the most delicate and powerful ways we have of using ourselves. In spite of all that has been written on this topic, empathy is rarely seen in full bloom in a relationship” (Bozarth, 1984, p. 131). The therapeutic setting is one place where the client can experience this type of relationship. In the humanist tradition, the therapist can offer this to the client, as being empathic. This is defined as being able

...to perceive the internal frame of reference of another with accuracy and with the emotional components and meanings which pertain thereto as if one were the person, but without ever losing the "as if" condition. Thus, it means to sense the hurt or the pleasure of another as he senses it and to perceive the causes thereof as he perceives them, but without ever losing the recognition that it is as if I were hurt or pleased and so forth (Rogers, 1959, p. 210)

According to Staemmler (2012), however, this traditional understanding of empathy can result in therapy being one-sided: where the clients are mainly viewed as objects rather than subjects. They are the object of empathic activity that comes from the therapist alone. This implies a very one-sided or imbalanced relationship. Commenting on Roger’s view, Bohart and Greenberg (1997) too, note how striking is the emphasis on separateness and the “as-if” quality of empathy. They observe how this understanding endeavours to distance the therapist from a state of identification with the client. Modern therapy has shifted its

emphasis to the interpersonal field of mutuality of influence. The therapist and the client are now seen as participating in an on-going feedback loop with each influencing the other.

Trop & Stolorow (1999) describe the working of empathy from the viewpoint of inter-subjectivity theory. In relational psychoanalysis, “empathy is understood as the co-created view of meaning that is a negotiated, moment-to-moment weaving of the fabric of a new relational experience” (cited in Preston *et al.*, 2002). It is a mutually regulated empathic understanding of sharing the struggle of one person trying to make themselves understood by the other. The therapist’s participation in the empathic dance shifts attention to the patient, back to themselves and then to the dyad. Instead of staying immersed in the patient’s meaning, they depart and focus on the client’s experience, the inter-perspective from which the dance is observed. Bohart and Greenberg (1997) suggest that empathy is a process of co-constructing symbols of experience. It is now recognised that the ability to relate at such an intimate level can provide the opportunity to learn from the client, making it a bi-directional give and take.

Kahn and Fromm (2008) suggest that in order to help a patient, the therapist must be able to tolerate vulnerability by identification: by acknowledging that “if it happened to the patient, it could happen to me” (2008,p,xi) The therapist has to be able to tolerate the sheer terror, the sadness, the pain, that comes with the client’s experience and to express caring for the patient despite what they know about them. The inter-subjective level of empathy is one within the experiential realm of the client (Spinelli, 2006). The therapist must first empathise with the client and their experience of themselves and then reflect how the person would experience this particular feeling. The therapist then has “to gain a sufficient sense of the experience in

relation to themselves and then consider if they were the person experiencing this difficulty, what would it be like for them” (Spinelli, 2006, p. 213).

According to Cooper (2007), the human experience is fundamentally embodied. This means that the therapist cannot know what the client’s experience is like without having some sense of what it feels like to be in the client’s body. While cognitive and affective ways of empathising may contribute to the therapist truly having an understanding, they must first experience the level of embodiment for themselves (cited in Haugh & Merry, 2001). This in-depth understanding of the client must also occur in a somatic way. Once the therapist has a sense of how the client feels in their body, they can experience something of the bodily sensations themselves. Figley (2005) noted that some would argue that it is wrong for a practitioner to have deep feelings of sorrow or sadness for their clients. Nevertheless, Figley and Nelson (1989) note that most of the systematic studies on the effectiveness of therapy point to the therapeutic alliance: to the therapist’s ability to deeply empathise with clients. The therapist’s need to recognise that empathy at this level is very unsettling. Without this level of contact, however, it is unlikely that therapy will take place

2.7 EMPATHY, SELF-AWARENESS AND SELF-REGULATION

According to Gerdes *et al.* (2011, p. 85), the “inclusion of self-awareness and emotional regulation as a component of empathy” is crucial. The concept of self-awareness and emotional regulation is an important companion for the therapist. In the therapeutic situation, it is the therapist’s task to use self-regulation in order not to expose themselves to defuse empathic states of excitation and to work in the way which is suitable to the client.

In 1990, Alice Miller suggested that only therapists who have had the opportunity to experience and work through their own traumatic past will be able to accompany patients (clients) on the path of truth about themselves and not to hinder them on their way. This is because they no longer fear the eruption in themselves of feelings stifled long ago and because they know from their own experience the healing power of these feelings (cited in Etherington, 2009).

According to Rothschild (2006), “it is our gift of empathy at full throttle felt and projected 100% present with our bodies, hearts, and minds that has its risks” (2006, p. 12). These risks were identified as “countertransference-based misapplication” which can be experienced as something such as loss of separateness and over-identification with a patient (Bohart & Greenberg, 1997, p. 25).

On the other hand, a lack of empathy and a dread of trial identification can lead to undue distance and insensitivity on the part of the therapist. According to Lang (1978), these failures are due to the therapist’s difficulties “in containing and metabolizing” projective identification which results in a misalliance in the treatment process (cited in Bourke *et al*, 1985, p. 4). The enormity of this pressure to understand cognitively, intuitively, and empathically, often leads to premature assumption and formulations of the patient on the part of the therapist. The pressure on the therapist can result in a failure to listen carefully to the patient. It is also worth noting that empathy begins with the person, and without the client’s ability to empathise, the therapist’s empathy cannot take effect (Gibbons, 2011).

The relational dimension of empathy in responding to the needs of an individual is vital in their search for being deeply understood. “To be empathic generally means to expose oneself

to the presence of the other: to be open to being touched existentially by another's reality, and to touch his or her reality. Thus there is always a readiness and the risk to change oneself" (Haugh and Merry, 2001, p. 48). According to Wilson (1994), listening empathically to trauma stories is taxing and stressful. To remain sensitive and finely tuned to these internal experiences of the individual's psychological injuries requires more than understanding that the event was traumatic; it requires skill and the capacity to use empathy "to access their inner scars of the psyche and organism" (Wilson, 1994, p.332). An empathic process of past trauma can be a difficult journey for both therapist and client and also "the greatest gift a therapist can give a client" (Kahn and Fromm, 2008, p. 109). In the words of Waskot (2011 p. 211):

...when someone tells of deeply anguishing, despairing or humiliating experiences they have undergone and may be relieved in my presence..... there comes a point where I cannot share their unique agony and when I sense that to attempt an empathic response in words would be futile and shallow.

In other words, to pretend to understand would be patronising and incongruent. To be truly congruent is likely to give rise to what Bozarth refers to as the "idiosyncratic forms of empathy – that are anchored in the clients experience rather than the counsellor's skill of reflection" (1984, p. 69). This occurs when the therapist is transparent in the relationship with the other person and where there is a person-to-person encounter in the relationship. This also strongly relies on the intuition of the therapist. While the therapist cannot always be sure of truly empathising with the clients, they can constantly strive to achieve congruence. This can be done by the therapist remaining open to the client while also remaining open to their own experience. As Lietaer remarked, "there can be no openness to the client's experience if there is no openness to one's own experience, and without openness there can be no empathy" (1993, p. 23).

2.8 COUNTER-TRANSFERENCE

According to Skovholt and Trotter – Mathison (2011), we are often called on to attach with our caring side or what is referred to as “the underside of the turtle and not the hard shell” (2011, p. 24). With the hard shell, we cannot get hurt; however, it is the softer side we must continually present if we are to attach to people. The countertransference within the therapeutic relationship is central to this openness. According to Hayes (2004), research and theory suggest that the therapist’s self-insight, self-integration, conceptual ability, empathy, and anxiety management facilitate management of counter-transference.

The therapist’s self-integration and self-insight, including cohesion of self, self-understanding, and differentiation of self from others, play an important role in managing counter-transference. Current research on the therapeutic relationship and how the work can impact on the therapist is well documented. Areas such as post-traumatic stress disorder, compassion fatigue, secondary trauma, vicarious traumatization, burnout, are some of the areas identified. Figley (1982) refers to the cost of caring for others in emotional pain. In this context, “it is reasonable to propose that the psychotherapeutic environment also creates opportunity for a vicarious resilience process” (Hernandez *et al.*, 2007, p. 232). The primary function of empathy in therapy is to provide a supportive setting for therapeutic work to take place.

To conclude in this review, there has been a focus on empathy in the literature of two disciplines, namely psychoanalysis and humanism from a Rogerian perspective. The review has looked at contemporary issues in the field of empathy, including its embodiment and the influence of neuroscience. Attention was given to the area of the therapeutic relationship and personal awareness of the therapist in sustaining empathy. A major gap in the literature is the lack of agreement among the experts in the field as to a definitive understanding of empathy.

CHAPTER 3

3.1 METHODOLOGY

“Methodology” is a term referring to the general way to research a topic while “method” is the specific technique(s) being employed (Langdridge, 2007). In doing this research, a qualitative method was chosen because it was thought that quantitative analysis would not capture and reflect the richness of the linguistic base data of the experiences of participants. Qualitative research can be defined as “a process of systemic inquiry into the meaning which people employ to make sense of their experience and guide their actions” (McLeod, 2003, p. 73). The aim of this research study is to explore how therapists sustain empathy in the therapeutic relationship. The fundamental goal of this type of investigation is to uncover and illuminate what things mean to people and is concerned with understanding individual perceptions (McLeod, 2003)

Aim of thesis:

The overall aim in conducting this study is to explore the therapist’s ability to sustain empathy in the therapeutic relationship.

Objectives of thesis:

- To explore the person of the therapist in their ability to sustain empathy
- To explore what supports the therapist to sustain empathy
- To explore difficulties, if any, to sustaining empathy.

To explore insights, if any, for the future of humanistic and integrative psychotherapy

3.2 RESEARCH SAMPLE

The chosen sample was therapists of the Irish Association of Counselling and Psychotherapy and the Irish Association of Humanistic and Integrative Psychotherapy. The research population consisted of four qualified psychotherapists: two male and two female. The participants had experience in clinical practice, a sum of thirty seven years between them. One male and one female had ten years' experience of working as psychotherapists; a third, a male, had seven years and the fourth, a female had five years' experience. Three of the participants were IAHIP supervisory-accredited. There were no exclusion criteria in the research sample. Three of the participants were self-employed and working in a private practice, seeing both clients and supervising therapists. One of the participants was working in a statutory organisation.

3.3 RECRUITMENT

The recruitment process involved randomly selecting and e-mailing twenty people from the IACP and IAHIP website who live in the County Wicklow and County Dublin geographical areas. In the e-mail, selected individuals were invited to participate in the research. An attachment outlines the purpose of the research and the nature of the thesis (Appendix A). After a week these emails were followed up by further emails. The lack of response demonstrated that the sampling strategy was ineffective. It was then decided to change strategy and a manager of a Family Support Service which employs a number of therapists was approached. Having explained the proposal, the researcher sought her assistance in accessing some of the therapists. The manager agreed to forward the research proposal to the therapists. Once again, there was no response. The researcher was feeling disillusioned and discussed with a colleague the difficulties in recruiting participants. This colleague offered to ask a therapist she knew to engage in the research. This was to result in using a sampling

technique known as “snowballing” (McLeod, 2003, p. 30): getting one interviewee through this colleague had a snowball effect in the sense that this first interviewee succeeded in getting two more interviewees. The final interviewee was targeted as a result of a journal article which the researcher read and in which this participant featured. There was a further reason for specifically targeting this interviewee as the researcher was trying to get a gender balance to the research. The researcher had successfully selected two males and two females. The first interview was set up and the venue was selected by the interviewee. The interview lasted 40-45 minutes. A further three interviews were conducted over the following three weeks at the interviewees’ convenience. The interview questions schedule, included as Appendix B, appeared to elicit a rich response.

3.4 METHOD OF COLLECTING DATA

The qualitative research approach is concerned with the subjective assessment of attitudes, opinions, and behaviours which provide the researcher with insight and impressions. McLeod defined qualitative research as a “process of systematic enquiry into the meaning which people employ to make sense of their experience and guide their actions” and stated that “the fundamental goal of qualitative investigation is to uncover and illuminate what things mean to people” (2003, p. 78). While there are many methods of gathering data “the goal of any qualitative research is to see the research topic from the perspective of the interviewee and to understand how and why they come to have the particular perspective” (Cassell & Symon, 2006, p. 11). According to Mason (2003), the qualitative interview is usually intended to refer to in-depth, semi-structured or loosely structured interviewing. The semi-structured or loosely structured research interview is a flexible way to gather data. In this study, a series of prompted questions were designed to encourage the participant to explore their experience of sustaining empathy in the therapeutic relationship. The face-to-

face interviews generated the richness and complexities of the interviewees' personal experience and the qualitative approach to the study gathers a more sensitive data (McLeod, 2003, p. 35). The reason for choosing this type of approach was that it offered the research a great deal of scope and allowed for an interactive interview. Adapting the informal approach of qualitative analysis creates a "non-hierarchical relationship between the interviewer and interviewee and the sense of encounter as a mutual inter-view is empathised" (McLeod, 2003, p. 76).

The interview was concentrated on themes rather than on rigid design. The interview sessions were tape-recorded which is useful to check wording or to quote statements afterwards. It also allowed the interviewer to maintain eye contact with the interviewee through the process (Bell, 2005). According to Mc Leod (2003), "the interview is a conversation where the people talk of a theme of interest to both parties. A well carried through qualitative interview may be a rare and enriching experience for the interviewee" (p. 75). Interestingly, one of the interviewees commented that the interview process provoked a lot of thought and stimulated them to carry out an exercise which helped to reflect more deeply on the questions posed by the researcher.

3.5 THEMATIC ANALYSIS

Having conducted the four interviews, with the two male and two female psychotherapists, the interviews were then transcribed; this lengthy process is well documented in research literature (Mc Leod 2003; Bell 2007; Langdrige 2007). The approach used to analyse the data was a thematic analysis: "a theme captures something important about the data in relation to the research question and represents some level of patterned response or meaning with the data set" (Braun & Clark, 2007, p. 82). Extracting the themes involved reading and

re-reading the data to find repeated patterns of meaning and familiarising myself with the material. Once the interview transcripts were read, they were placed horizontally on a flip-chart which allowed for two columns to the right of the transcript. The one to the immediate right of the transcript was where what was striking and relevant was coded. This process allowed for keeping track of the frequency of the codes featured in the interviews. This involved systematically colour-coding each of the questions in order to match the relevant codes with the relevant themes. In the second column to the right of the transcript, emerging themes were collated, again following through on the same colour code used in eliciting the code from the original transcript. The themes chosen were those which consistently appeared throughout the four interviews.

3.6 ETHICS

The ethical consideration made as part of the research was, drawing up an information sheet (Appendix A) outlining details of the researcher with her contact details; the topic of the study; where the studies are carried out; the area the research study would focus on and the length of the interview. The interviewees were encouraged to read the information sheet, and the participants were extended an invitation to ask any questions concerning any aspect of the study or the interview process. They were aware that they could withdraw from the study at any time; either before or during the research they were at liberty to do so. Confidentiality is an integral part of the research and the anonymity of the interviewees also needed consideration (Bell, 2005).

Prior to the interview, the participants were informed of how the transcripts from the interviews would be stored. The transcripts were stored in a locked filing cabinet. Each of

the interview transcripts were coded by numbers: the researcher was the only person who could identify the interviewees. Participants were aware that the audio recording of the interviews would be destroyed once they were transcribed. They were aware that vignettes from the interview could be used in the body of the research to support theoretical findings. The researcher included contact details of the thesis supervisor in the event they had any ethical concerns or any further questions. Each participant was asked to sign a consent form (Appendix B) stating that they had read the information leaflet and had had the opportunity to ask questions and that their participation was voluntary; that they could withdraw at any time; that they understood that as much as possible would be done to preserve their anonymity. The participants were informed that their identities would be protected both in the dissertation itself and in any publications arising from it. Participants were informed of the possibility that the outcome of this research would be disseminated through the IACP journal. It is worth noticing that the researcher recognised the duty of care towards participants of this study, which required awareness and sensitivity both during and after the interview (Bond, 2006)

3.7 LIMITATIONS

Due to practical and geographical limitations, this study is a small-scale qualitative study of four therapists living in the Dublin / Wicklow area. It is impossible to know how representative the findings of this study are of experienced therapists. A further limitation is that multiple authors describe empathy yet there is no definitive definition of what it is. There are instead similar ideals with similar language resulting in some variations around common themes.

CHAPTER 4

4 FINDINGS: INTRODUCTION

The people chosen for this research are accredited psychotherapists and selected from the IACP, IAHIP website. Three of the therapists are self-employed and work in their own private practice while one works within a statutory organisation. This chapter documents the four participants' accounts from the semi-structured interviews conducted with them in an effort to examine their perspective on how a therapist sustains empathy in the therapeutic relationship. The psychotherapists interviewed have between five and ten years' experience post-qualifying. Three of the therapists were self-directed in their commitment to their on-going professional development and three of them went on to become accredited supervisors. The fourth person undergoes in-house training as part of their on-going personal development. As detailed previously, four participants were interviewed and the transcripts of the interviews were coded thematically. Repeated reading and coding of the data yielded several different meaning units. These were reduced to three themes that contributed to the understanding of the participants' experience of how they sustain empathy in the therapeutic process.

These experiences are presented under the following general structural themes:

Theme A: The person of the therapist

The qualities of the therapist

Subjectivity and inter-subjectivity

Theme B: Potential Barriers and Defences against Sustaining Empathy

Theme C: Healing Power

Spirituality / Meaning – Making

Unspoken Understanding

4.1 THEME A: THE PERSON OF THE THERAPIST

The personal development, interpersonal style and life experiences of the therapist shape the emotional climate that a therapist offers when a client presents for treatment. Most of the participants saw the person of the therapist as being central to communicating the core conditions. This was reflected in their ability to connect empathically with clients in a way that revealed their authenticity. Communicating their trustworthiness, commitment, and dependability was of central importance to the participants; one of the participants discussed the significance of being transparent:

You can play pretend but you get caught out, that ... part of it, and empathy isn't something you can fake. To me empathy is not about nice words but it is being true to yourself and the person you're working with.

Wosket (1999) noted the challenge involved in the therapist dropping their professional mask: this releases them from the prison of their professional persona and shows their authentic self. Without exception, the participants felt a way of doing this was getting in touch with their own humanity and developing sensitivity towards themselves and their clients. For example, one participant stated:

I don't think you can have empathy without having acceptance of self and others, and I don't think you can have acceptance of self without having a deep understanding of yourself.

In somewhat similar findings, Oteiza et al (2010) found that the therapist relies on an understanding of their own internal world to gain a deeper understanding of themselves. The more in-depth the therapeutic work, the deeper the understanding the therapist needs of themselves.

Resilience in sustaining empathy involves taking risks, challenging others and allowing self to be challenged while at the same time remaining open to change. The participants felt that

knowing themselves allowed them build a self-confidence which was neither an arrogant nor a negative self-image; rather it was one of humility in their lives which in turn, translated into their practice. One of the participants described how he viewed this happening:

I think it's being in there with them and having much the same struggles myself in my own life as they are having - but not to the same extent; having that sort of connection with them rather than being the expert sitting with a sick person. I don't think I could work like that.

In this respect, the level of personal development is central to the provision of the therapeutic space for the client, as “the better integrated a therapist is, the higher the degree of empathy they exhibit” (Mearns and Thorne .2000, p. 148). The participants in this study felt that their chosen profession involved a life time of enquiry; and post-qualifying they all have “dipped in and out” of therapy when the need arose. This is not so much to “face the horrors of the unknown” (although that must be done) but rather to continue on a voyage of self-discovery, knowing that many of the most despicable places are yet to be visited” (Mearns & Thorne, 2000, p. 40).

The participants relied on a number of resources to assist this discovery. Apart from their own ability to self-reflect, they relied on the people around them to fulfil this function. Without exception, the valued role of family, friends, personal therapy and supervision were essential in the enrichment of the participants' lives. Through them, they could be alerted to changes in their own behaviour before they themselves were aware of such. One participant spoke of how this has been a process for her:

The only way I would know if I was losing my ability to be empathic is by someone else saying to me ‘you don't seem to be connecting with what is happening around you’.

Chamber-Christopher *et al.* (2010) found that therapists who bring conscious-awareness into their lives improved their relationship with themselves, increased their capacity to engage with others and enhanced their therapeutic work. The therapist has to be able to work with whatever developmental stage is present in the therapy room and then relate this through a thoughtful authentic and non-collusive manner to the client. This involves a high level of maturity in the therapist, coupled with the awareness and readiness to recognise and remedy any regression on their behalf (Gomez, 1997, p. 187). The participants in this study felt that self-awareness was central to this process. As stated by one participant:

I think its sustaining empathy with myself and awareness of myself and a connection with all of my own stuff - not just the bits I am comfortable with. I have to really challenge myself on a weekly basis to feel and be open to whatever feelings that are there - whether they are happy or sad. All this helps me to develop my intuition and trust my gut.

The participants recognised that, at times, there was a need to be selfish in the sense of attending to their own needs which were paramount to their self-care. One participant spoke of how important it was for him to put everything aside and focus on himself:

I need to switch off completely, getting out in nature, getting out with my friends avoiding a lot of the negativity that's on the news and stuff like that. I suppose really grounding myself in nature, through physical exercise and through my own interests and hobbies. Without doing this, I couldn't do the work.

This research finding is supported by Skovholt and Trotter–Mathison's (2011) who suggests that there are many aspects of self-care which are important to the therapist. He talks of how the therapist is made up of many parts and recognised that all of these parts need nourishment.

4.1.1 QUALITIES OF THE THERAPIST

The qualities of the therapist are central to the therapeutic process. These qualities are attitudes rooted in the therapist's belief system which are central to their own growth. The

participants in this study felt that holding the core conditions in the therapeutic setting was crucial to sustaining empathy. The communication of empathy may be conscious or unconscious in the therapy room; the therapist communicates empathy to clients through body language, maintaining eye contact or a warm smile which can often speak more than words. Rogers (1969) isolated the characteristics of three of the core conditions (namely unconditional positive regard, congruence and empathy) as the most important ingredients a therapist has.

Trust within the therapeutic relationship was central to developing an empathic environment. According to Rogers (1969), unconditional positive regard and mutual respect in the therapeutic relationship are essential in allowing trust to build. The participants in this study all stressed the importance of this trust in feeling accepted by their therapist and view it as a precursor to their self-acceptance and growth, thus echoing the findings of Daw and Joseph (2007). Participants perceived their own experience of personal therapy of considerable benefit both personally and professionally. Most of these participants reported that they strongly valued the experiential learning of personal therapy which they then brought into their professional practice.

This research found that the empathic presence of the therapist and the communication of empathy was one of the most important qualities of the therapist. It recognises that communication of empathy relies on the client's ability to accept what is offered by the therapist. Without the client's empathy, the therapist's empathy cannot take effect as the client has to be open to the process. Participants in this study said they experienced empathy and self-acceptance through their own experience of therapy. This allowed them to be more open and receptive to clients, as they had a deeper understanding and empathic openness.

The emphasis on accepting the clients where they were at in their lives was echoed in the research population:

I think if I can accept somebody as they are, who they are, and not endorsing their behaviour but see them as a human being in their entirety and try to work with them, it is quite interesting work.

This research found that this acceptance is also reflected in the work of Rogers (1969) who believed that human beings deserved our deepest respect, regardless of how worthless or inadequate the person feels about themselves. The ability to meet the client where they are at is a central belief of person-centred therapy and involves working with the client from their frame of reference. This study notes the difficulty one of the participants experienced in relation to this concept. This participant noted his lack of empathic connection when working with his own frame of reference and with his own process of change as he matured as a therapist.

I suppose the expectations at the beginning when I started working in the field were high of the client and low of myself. This has actually totally reversed. Now my expectation of me is that I maintain and sustain being good enough in a very holding way. But I am also more patient and tolerant with the client and more prepared to wait for the embryo of growth to take its time to develop.

What is evident from this study is the importance of fostering an environment where change can occur as change is central to the therapeutic process. Bion (1970) captures this well when he talks about the advantages of approaching a client “without memory, desire, or understanding” (1970, p. 52).

The communication of the core conditions to the clients is determined by the therapist’s own preference and way of communicating. The participants in this study discussed the significance of being congruent and the importance of not communicating contradictory

messages to clients. However they recognised that a more establishment relationship allowed for a more robust approach in communicating congruence. As stated by one participant:

It's not about nice words and all that. It's about being true to myself and the person I am working with and being straight with the person and not bullshitting them, and saying what I think are nice words. It's saying what I need to say and then allowing the clients to respond. It is where empathy is a barrier between being ethical and unorthodox. I think if I have the empathy and work out of that empathic place in myself and listening to myself, that's what keeps me ethical.

Clark (2007) argues that a therapist over a period of time can become open to a degree of communication and rapport within the therapeutic relationship. Through this long immersion with the client, the therapist develops a high rapport with the client in which empathic communication can be much more open. Spinelli (2006) questions this, suggesting that such an approach is open to philosophical naivety. This places the therapist in a position of willing collaborator in potential misuse and abuse of self-evaluating attitudes or behaviours the client may adopt.

The qualities of the therapist are possibly the most significant resource they have in the development of the therapeutic relationship. Research studies by Orlinsky and Howard (1986) found that it is not the theoretical orientation of the therapist which contributes to creating a therapeutic environment. It is, rather, the bond the therapist forms with the client, the therapist's ability to listen to the client, and to be with, and for the client. The attitudinal qualities of the therapist are an essential means of encouraging the client to recognise the same qualities in themselves.

4.1.2 SUBJECTIVITY AND INTER-SUBJECTIVITY

Rogers (1969) described three ways a therapist might develop empathic understanding: namely, from their subjective, objective and interpersonal experience. In our subjective

experience, there is no thought, no word, or action that a therapist takes with clients that is not highly subjective; everything the therapist touches is captured by their subjectivity and every individual experience is unique in its subjectivity. The personal reaction of the therapist illuminates how close the therapist is to understanding the client and interventions reflect this, or equally what the therapist is omitting to address with the client (Jaenicke, 2011).

Empathy acts as a key ingredient of the therapeutic process: the therapist imagines their way into another's experiences using his /her own subjective perspective to identify with a client. This identification must be transitory because the therapist must be in a position to objectively evaluate what he /she experiences in the subjective interaction with the client. Fliess (1942) referred to empathy in this context as "trial identification"; a momentary identification with the client through using their intuition, reaction, feeling, images, and experience of what it is like to be that client (cited in Casement, 1985). This study exemplifies how one participant's subjectivity became clouded around a client's difficulty and how counter-identifying with a client, however momentary, influences the therapy. As one of the participants acknowledged:

The biggest learning curve for me was making an intervention pre-empting what the client was going to say about his relationship with his partner, it turned out completely different. I kinda had to step back and look at myself and say 'God, you got that totally wrong' and not beat myself up.

Staemmler (2012) noted that healthy development can only occur when the therapist does, in fact, fail to empathise from time to time. Empathic failure is not only normal but welcome, in that it provides the opportunity for the therapist and the client to work through this disruption. This is also supported by Winnicott (1965): he noted a corrective therapeutic experience is never enough and it is the failures within the therapy, often quite small ones that enable a

client to bring their hate for the therapist into the transference. In this way, the failure succeeds in helping the client to develop (cited in Jacobs 1995).

The participants in this study talked of their own experiences of therapy and the importance of how their subjective experiences were honoured by the therapist. By working empathically from their frame of reference allowed them to discuss issues which previously had been unaddressed. One of the participants stated:

It allowed me to visit places of shame and core shame at my own centre and to actually evolve out of it, to acknowledge that I feel very shameful about certain episodes of my life and it is not unique to me.

In his work on subjectivity, Smail (2004) emphasises the uniqueness of each individual and also highlights the privacy, secrecy, and shame aspects of the subjective self. This uniqueness is, he argues, crucial, in the therapeutic process.

Participants in this study acknowledged that empathy is not something that exists in one person's subjectivity, either that of the therapist or that of the client. Rather it is something that exists between people. This unity in a therapeutic relationship forms a kind of *gestalt* which transcends and includes the two people involved. It is not just an intervention but a fundamental way of meeting a person from another experiential reality. Through this type of genuine meeting, a therapeutic intervention can be used. Recent understandings of subjectivity suggest that the joining of both the therapist's and the client's subjective worlds in therapy is fundamental to human development.

The mutual influence of the subjective world of both the therapist and the client and the deep process relating of subjective worlds offer the opportunity for both to be changed by the encounter. In this sense, healing is a bi-directional process. Participants in this study

acknowledged the challenge and the risk they felt that existed on leaving their own subjective world and entering into a co-created world of inter-subjectivity, which transcends and includes the people involved. One participant stated:

One of the gems of empathy is when a client you are working with touches off the unresolved piece within myself. It's when the light goes on and it starts flashing at you and saying 'oooooh' and as a therapist I am sitting there saying 'oh oh, don't go there' and then I move into the knowledge piece where you know you have to do it, to be fully in the relationship - that piece and I suppose that is the opportunity which therapy offers.

Thus, as argued by Orange *et al.* (2007), inter-subjectivity refers to the relational context in which all experience at whatever developmental level - linguistic, or prelinguistic, shared or solitary - takes place. Every action, thought and feeling is embedded in inter-subjective fields. From the moment we encounter one another, we are in a process of mutual regulation. As therapists, we not only meet a client; we meet a person who will change us as we seek to change them. Participants in this study recognised the power of the therapist-client relationship and the propensity it has to create change and to enhance their subjective view of the world; similarly, they recognised the capacity it had to alter their view of the world. As stated by one of the participants:

I suppose the depths of depression, the sadness and the trauma that are in most people that I would meet – can influence a lot of negativity that can come into the room with them on a daily basis. I find that I really have to manage so that it doesn't shape my view of the world and end up with the same view of the world as them – so to be really clear on my view which is constantly changing so it's hard enough to be clear on it but to be reasonably clear as to how I see the world.

This risk was recognised by Jaenicke (2011), who suggests that as soon as a client walks over the threshold of the therapy room, they can bring into the room an entire “trainload of misery, pain, longing, lost love, and buried longing as well as the vitality, joy, love, and hope” (p. 12). This is set in motion to collide with the therapist's own, if there is depth in the therapy work. Rasmussen (2005) recognises that without adequate support or professional

connections, working at this relational depth, trauma finds a home in the “invalidated unconscious” leaving the therapist unaware of the full impact of the treatment experience, which invariably impacts on the therapist’s ability to sustain empathy (2005,p. 23).

4.2 THEME B: POTENTIAL BARRIERS AND DEFENCES AGAINST SUSTAINING EMPATHY

This study found that participants used both barriers and defences which blocked them, as therapists, from sustaining empathy with their clients. Barriers involved the intrusion of the therapist’s own personal concerns being transposed into the therapy room and taking up a prominent position in the therapists attention during the therapy. The defences used by participants in this research included dissociation, over-identification and unresolved early attachment issues. These barriers and defences invariably impact on the ability of the therapist to sustain empathy in the therapeutic relationship.

Participants admitted that, despite their attempts to protect the client, their own internal turmoil at times took precedence over the needs of the client or the client–therapist dynamic. This research study found that most of the participants had a high awareness of how their personal life could intrude into the therapeutic space. One participant, for example, described how they became preoccupied with difficulties in their own life, difficulties which leaked into the therapeutic relationship and acted as a barrier to listening:

I am aware that it’s the client’s space and I try to be there for them but I am not always there 100% because I have too much on my mind. If I have left my sick child at home, this can keep intruding. But I make a huge effort to be there, even though my head is all over the place.

Mearns & Thorne (2000) noted that the inability of the therapist to listen to the client can be detrimental. The empathic presence of the therapist is essential for the client’s ability to hold

their experience without being traumatized. “It is as if the therapists hold the oxygen mask for the client who spends the rest of the week struggling to breathe” (Mearns & Thorne, 2000, p. 155).

Most participants agreed that it can be difficult to offer the core conditions to a client. One participant spoke of how she was particularly judgemental of people generally but felt less judgemental and more empathic of her clients:

I feel now there is an awful lot going on in the world right now and there is an awful lot going on in people’s lives and maybe that is why they are ‘acting out of proportion’ to what I might say.

The researcher sensed that there is “implicit judgment” here on the participant’s behalf. Without exception, participants were aware of how their own life experience has the potential to re-emerge in the therapy and disrupt the empathic process. The research uncovered a number of defences used by participants which caused such a disruption. When asked the research question “having overcome some of the difficulties in your own life, do you feel that it would help you in the work?” one participant stated:

I suppose the challenge for me is to overcome some of the... (long pause)... to understand my own feelings.

This lengthy pause in this participant’s response could be viewed as the therapist dissociating from what they were feeling. Wallin (2007) suggests that a lapse in discourse may reflect a person – in this case, the therapist participant in the research - having entered a different or dissociated state of consciousness.

Stalker (1987) argues that the relationship between empathy and counter-transference depends on counter-identification as well as identification with the client’s inner world. The impact of counter-transference in therapy can both enhance and diminish the client’s

experience of therapy. It is recognised that every clinician knows the experience of the wandering mind during therapy. This was substantiated by participants in this research study who found their mind wandered and that empathic process could be disrupted by boredom.

As expressed by one participant:

To be honest there are some clients that I find it difficult to stay with, when I hear the same thing every week. To be honest, I just get bored.

There are varying reasons for this response. Germer (2005) suggests that at times, it can be in response to “what is –or –is not” happening in the therapy (2005,p. 59).

When a client emotionally disengages, the therapist can simultaneously disengage and become bored.

I can think of two occasions - interestingly enough, that they were both males I felt it was going on and on.

Germer (2005) suggested a further reason why the therapist gets bored: it is when the client touches into the therapist’s own unresolved issues. This happens when the therapist’s own anxiety is activated by that of the client. The automatic response of the therapist is to tune out, become restless or otherwise become partially absent. In this respect, the psychotherapist needs to pay attention to their inner feelings and conflicts in order to differentiate between those which are evoked by a client, and the degree they belong to the therapist. The counter-identification process can be used to support the client:

I have been through it: not particularly their issue, but my own experiences help to give me a level of understanding of the client’s difficulties that I can use to support the client.

However this counter-identification can also work to the contrary. Participants in this research all agreed that there was a risk of over-identifying with the clients. However, one

participant gave an example of how the empathic process was interrupted by their inability to stay with the clients' process:

If someone was having an issue with their husband it may be something similar to what I would have as an issue and I would feel myself being drawn in. I have to remind myself it's not my story, this is someone else. Or I might feel a bit agitated, like 'come on fix it! Don't keep bringing the same issue up over and over. Move on'. I am aware it's about me and I get annoyed with myself when the same thing keeps coming up for me.

Sanderson (2006) describes the impact of the therapist's over-identifying with the client: where their boundaries become enmeshed or merged with the client's and the therapist has difficulty separating out their material from that of the client. This over-identification can have a significant impact on the therapy and the therapeutic relationship. It can manifest in the therapist taking on a persecutory role with the client. It can become noticeable in the therapist "becoming impatient and irritated with the client, or unconsciously adapting a punitive approach with them" (Sanderson, 2006, p. 131). Jacobs (2007) describes a further defence which was activated in this participant, unable to resolve their own difficulties. This results in them "turn against the self", which has a huge impact on their ability to sustain empathy in the therapy (Jacobs, 2004, p. 107). Interestingly enough, studies have found this is a defence mechanism used more commonly by women than men (Gremer & Carter, 1979; Ihilevic & Gleser, 1995; cited in Clark, 2007).

Thériault & Gazzola (2006) found that therapists with parallel painful experiences (either recent or distant) reported losing their way in the therapy. Many of the therapists reported being conscious of the dangers of working with clients whose issues were "too close for comfort" (Thériault & Gazzola, 2006, p. 324).

The re-awakening of early developmental wounds or childhood conflict can significantly impact on the therapeutic relationship and diminish the therapist's ability to provide an empathic environment for the client. Bowlby's (1993) research studies on early attachment have given significant insight into early attachment and how attachment patterns built in early life are carried as internalized working models into adult life. The understanding of early attachment and how therapists' own unresolved issues could impact on their ability to remain empathic in the therapeutic relationship was evident in this current research (cited in Holmes 1993).

Participants in this study demonstrated how attachment issues impact on the empathic process and their ability to sustain empathy. One of the participants was particularly interesting when he talked of his relationship with his supervisors and it would have been interesting to pursue this line of enquiry. However, as my role was that of researcher and not as therapist, I had to forgo my curiosity and hold the boundary. The participant was seriously inhibited about expressing his vulnerability to a female:

It is quite interesting. I have experiences of both male and female supervisors and I have to say I never once cried with my female supervisor but with the male supervisor I have found myself full of tears.

According to Main & Weston (1982), inhibition of emotional expression is a hallmark of avoidant attachment style. Research by Ainsworth (1978) found that a person with an avoidant attachment style does not show their distress. They can easily be misconstrued as calm, while in fact they can be extremely distressed underneath. Trauma as a result of separation and loss leaves them to conclude that their overtures for comfort and care would be of no use and in this sense they give up trying to find it, (cited in Wallin, 2007). It would

have been interesting to have pursued this particular defence in terms of how it would be translated into the therapy work.

This research study reflected further attachment difficulties from the participant population when they talked of the difficulty they experience in ending. As expressed by one participant:

I don't know how to naturally finish things. Unless the client says it to me, I can't finish and usually when the client finishes, I am always disappointed.

Ainsworth's studies on attachment identified the anxious-resistant who seek contact but are contact-resistant. In the hyper-activating strategy used in the anxious stage of this attachment style, there is intensity: 'a desire for fusion and closeness that manifests itself in worries about separation and abandonment' (cited in Dewitte *et al.*, 2008). Another aspect of this type of attachment style is that when the person pulls away, the deactivating strategy used by the therapist can have an equal impact on sustaining empathy in the therapeutic relationship. The hyper-activating and deactivating strategies used by the therapist can operate interdependently or in parallel. In the words of a participant:

Some of the clients that I wish would finish keep coming and coming.

Dewitte *et al.* (2008) found that a deactivating strategy is used to avoid attachment and dispel any thought of closeness and separation. Thoughts of developing closeness, separation, and abandonment are being suppressed to avoid intimacy and in this way, the therapist does not form any attachment to the client.

Olson *et al.* (2011) found that some mental function can be used defensively and some or all aspects of defences occurred out of an individual awareness. This is seen in this research study where a number of defences used by the participants were outside their awareness. This study shows how the challenge of a compromised empathic capacity can be

compounded by the participants' innate potential defensiveness in entering the shared experience of the clients. It recognises how barriers and defences impact on the therapist's ability to sustain empathy in the therapeutic relationship while at the same time acknowledging the humaneness and fallibility of the therapist.

4.3 THEME C: HEALING POWERS

For the participants, the factor which influenced the healing power of empathy was their experience of a deep psychological contact with their own therapist. This was acknowledged by all participants. One participant spoke of her desire for this type of connection with her own clients:

I find it nourishing when they are going deeper and deeper and when it is not there I struggle and I struggle with the empathy part as well and I am almost relieved when the hour is up.

Cooper (2005) found in his study that participants always reported an emotional charge if there was a relational depth in their therapy work, as opposed to lack of emotion and flatness. The study found that meeting a client at a relational depth is typically accompanied by a feeling of satisfaction. Participants usually describe the reciprocity they experience from this level of contact and refer to it as having a sense of rightness.

Participants in this study all spoke of how their own therapy influences their ability to develop empathy for themselves; this, in turn, enabled them to show empathy towards others. For some of the participants, however, beginning to work in the area of therapy opened up old wounds: wounds which had not been explored in depth prior to coming into the training and which only emerged through the therapeutic relationship. One participant acknowledged

underlying feelings outside of her awareness prior to starting her own therapy, this points to how the experience of empathy can have an inherent healing capacity in its own right:

It was through this relationship that I came to see myself as the person I am: I am actually a good person and I never realized I was a good person until I went into therapy.

According to Bohart & Greenberg (1997), once a person is able to symbolise their experience into their awareness, reorganising, exploring, explaining and creating a new meaning, this new understanding provides a new structure. This structure enables a person to reorganise their experience, symbolising it in a way that make sense to them. This is a form of healing process which leads to greater self-understanding. In this way, a person can become more compassionate and empathic with themselves.

Participants in this study had conflicting views on the ability to sustain empathy without having been through the process of their own therapy. Two of the participants began to see clients at the same time as they themselves went into therapy:

When I started my own journey, I went to therapy and I started to see clients as well. So I suppose I was still on my own journey, and I suppose we always are; like there isn't any time that we can say 'ok I'm healed'.

Two other participants considered it almost unthinkable to see clients without having attended to their own personal difficulties. They viewed the experience of personal therapy as “instrumental in healing the healer” (Corey, 2001, p.18).

As Corey (2001) warns, if a therapist is going to be empathic with a client, they need the willingness to identify emotionally; they also need a well-developed ability to regulate their emotions. Participants in this study felt that if the therapist is not actively involved in the pursuit of healing, it would create considerable difficulty for them “immersing oneself” into

the experiential world of the client (Bohart & Greenberg, 1997, p.5). One participant expressed strong views on the need for the therapist's own personal therapy to be well understood before seeing clients:

I think it's crucial for people. I would base that on my own experience of my journey in recovery and my journey in life and my journey to freedom. And I think if I hadn't dealt with a lot of the pain and suffering, the hurt and the rawness and the madness and that type of insanity that goes with it, that were there for me, if I hadn't done that I don't think I could sit down with somebody else and bear to be in the same bowl of pain as them and get that vicarious contact, it's bit like when you burn your hand then you rub it again off something else, it would be a bit like that, I think it's essential that people have their own therapy, without it I couldn't sit with someone else, and be empathic.

Yalom (2001) recognising the power of personal experience in the therapeutic setting, views the wounded healer as effective because, according to him such a person may be able to empathise with the wounds of their clients. In this way, they are capable of participating more deeply in the healing process.

The participants of this study acknowledged that being able to find acceptance of their life circumstances and resolved some of their own life experience for themselves, brought healing into their life. One of the participants stated for example:

I can accept that the world won't be as I want it. I can accept that I am inadequate and that I am very human and I can also accept that I am in a way very wounded and scarred by those things and they will never actually heal. The contents of the wound might heal but the scars will never actually heal and I think what healing has taught me is that I can learn not be inhibited by them.

Participants described the experience of accompanying the client on their journey. They described how the empathic communication of attunement allows access to previously unspoken aspects of their experience and helped them create new meaning:

I would never see me as being responsible for somebody else's growth. I would see them but I would see myself often as a privileged witness to that journey and to the growth of somebody else that struggles and watches them overcome adversity. It's so

hard to describe that feeling, being right in there with the client. It's a bit like a wondrous feeling really to me still. And as long as I have that, I think I will still be going around in the field of therapy for another while.

Skovholt and Trotter – Mathison's (2011) found that the therapist can experience what is viewed as a great gift in being able to solidify a connection with another human being. This allows for the on-going development of our species. The act of empowering growth, whether conscious or unconscious, can provide satisfaction and enormous meaning to the therapist.

One of the participants spoke of their own experience of healing and how it was instrumental in him going on to support and enable other people to find healing. However, he also recognised the limitations of his personal experience. As he explained:

It was out of respect to the people I was working with, that I needed more than my personal experience. That was one of the reasons I went on to train as a psychotherapist.

It was further acknowledged by participants that there was a parallel between what they were learning academically and how this filtered into their own growth process, how fundamentally important this was in their developing empathy. As stated by one participant:

It sounds odd to say this, but it was through the learning which I was getting, that allowed me to emphatically respond to myself, it gave me an understanding of why I might have done the things I done. If that hadn't been there I wouldn't have stayed studying and gotten what I wanted to get out of life because I wouldn't have known how.

Participants in this research explained how they themselves had received and absorbed empathy and that it was through this experience that they in turn were able to hold it with others. This shows how empathy can have an "intrinsic healing capacity in its own right" (Bohart & Greenberg, 1997, p. 10).

4.3.1 SPIRITUALITY / MEANING – MAKING

There are various understandings of spirituality but in this study, the term is understood as deriving from the human spirit. “Spirituality is viewed as an outward expression of the inner workings of the human spirit” (Swinton, 2001, p. 20). Participants in this research communicated the sense of spirituality in many different ways. They recognised the importance of the spiritual self. They acknowledged it was about valuing the spiritual aspect of life, not about the amount of spiritual knowledge they had as therapists; it was the former that was going to make them spiritually effective. Spirituality, in this sense, is viewed as the therapist’s ability to empathically enter imaginatively into a person’s experience which opens up their experience to be valued and understood. The interpersonal encounter between therapist and client, and the communication and existence of empathy, is seen as a potentially spiritual experience.

The participants of this research were unanimous in their agreement of how the spiritual aspect of empathic understanding in the therapeutic work has transformed their lives. As expressed by one participant:

If someone said to me ten years ago, you are about to embark on the most wondrous and mysterious journeys that any man has ever know, I would have said ‘you are mad’. But looking back, that’s what I really did, a journey into the unknown. To enter into a relationship with another person being open to the mystery of another person, it is wondrous.

According to Firman and Gila (2002), spiritual empathy is considered to be “one of the most profound intersubjective experiences” between therapist and client ((2002, p.6). However, it was also acknowledged that the level of experience of the therapist plays a role in this. According to Phelon (2001), the more advanced practitioners distinguished between integrated spirituality and unintegrated (ego driven) spirituality, and suggest that integrated

spiritual practice is more likely to provide a supportive context in which the therapist promotes healing.

Participants in this study recognised the importance of their own integration process. This study found that, without exception, participants' own personal experience of therapy and their experience of working with clients have all contributed to their spiritual development. Schreurs (2002) noted that therapy not only acts as a trigger to a spiritual awakening; rather, it also functions as a catalyst for further spiritual development. The participants spoke of how their therapeutic experience and their work provided them with the empathic environment to do this. In the words of one participant:

It's sort of like a balloon: when you blow it up first it is really tight – the more you blow, the easier it is to blow it up, the next time the rubber has expanded. That's the sort of way I see it: the more of personal experience I can integrate, the more my balloon is blown up, so to speak: it's not as tight.

According to Hernandez et al. (2010), the therapist can find as much healing as the client in the therapeutic relationship. The reciprocity opens up the possibility of appreciating, attending to, and making meaning out of the process where the therapists themselves are healed. It is in this type of relationship, which is mutually influencing, where there is a co-construct of meaning, where the therapist's state of consciousness comes into being by taking on an aspect of the other person's state of consciousness that their views combine into a joint construction of meaning comes into being. Through this experience compassion can develop. In this sense, compassion is used to connect to the mystery of the other person, which is not transmitted through other communication, channels, but by the empathic attunement of the therapist. The therapeutic relationship is central to its development. In this study, one participant highlighted the experience of compassionate empathy and explained how they experienced growth:

I would say that it has enhanced my degree of compassion towards my fellow man. It has given me a clearer understanding of the responsibility, I suppose to serve my community and to serve the people of the community and be honoured to serve them and to witness their journey. I have become far, far more compassionate towards people and I have become far more spiritual in a very existential way. I can feel that connection with the universe and am much more appreciative of what's around me.

This finding was supported in the work of Schreurs (2002) who noted that there was mutual growth opportunity from psychotherapy and spirituality. Specifically, growth through the process of psychotherapy would have a positive impact on spiritual growth, just as spiritual growth would have a positive impact on psychotherapy. Staemmler (2011) views it differently and his work questions the motives behind this level of compassion. He notes that the relationship between empathy and altruism has been the subject of much research. There was further discussion as to whether altruism springs from empathy or whether it is a defence against the discomfort this level of distress evoked. A further aspect of the argument is the apparent selflessness which can conceal self-centred or egotistical motives.

4.3.2 UNSPOKEN UNDERSTANDING

The unspoken understanding is a central part of the therapeutic process. It was illuminated in Freud's (1903) work on the unconscious and is probably one of the most significant moments in empathy and empathic understanding between therapist and client in the therapeutic process. From this work we have learnt that empathy does not require the participation of consciousness. Rather, it can, from beginning to end, proceed unconsciously. The importance of empathy in accessing unconscious communication was recognised by Freud. He believed that "it is only by empathy that we know existence of psychic life other than our own" (Freud, 1903, p.104, cited in Levy, 1985).

Studies into early attachments have been built on this understanding. Bowlby (1969) Ainsworth (1967) and Main (1991) illustrated the importance of early development and the development of empathy. Their studies found that the attunement of the care-giver is central to an infant being able to manage their own affective states, to manage difficult emotions. Through an unspoken understanding, in an attuned relationship, they learn to manage their emotions through affective regulation until they can modulate themselves (cited in Wallin, 2007). The work of Schore (2003) is built on this insight into early development. His studies found that the capacity to empathise was a function of the right brain, and that the development of the brain in the infant is dependent on their experience with the people around them. The attunement of the care-giver and a right brain-interaction between infant and care-giver is central to the infant's development (Gerhardt, 2004).

Beebe *et al.* (2003) compare pre-verbal communication documented in infant research to types of non-verbal communication in adult treatment. Further insight into the whole area of unspoken understanding was illuminated by research into neurobiology. In the 1990s, Rizzolati's work in the area of mirror neurons unveiled the neural mechanisms at the basis of this fundamental ingredient of inter-subjectivity. The mirror neuron systems in our brain mediate between the personal experiential knowledge we hold of our lived body, and the implicit certainties we simultaneously hold about others. This knowledge enables careful attunement with others, which in turn creates a shared understanding of inter-subjectivity (Gallese, 2001, 2003, 2005).

This research study found that the attunement of the therapist was an extremely important part of the therapeutic process and the unconscious communication to the client. As expressed by one participant:

When I feel that empathic connection, when I am picking up on their distress, I feel like just throwing my arm around their shoulder and saying 'it's ok, I'm here, I am with you, I have some sense of understanding. To me, it's like giving somebody a hug and an emotional hug without full expression. 'You know you're good enough'; letting them know you can hold them in a hug space. They don't have to do anything.

Casement (1985) found that a vital role of the therapist was to be able to hold the unconscious projected feelings and hold the unmanageability of the client's projection of acute distress. The projected identification, the feelings being communicated by the client, is being experienced by the therapist. In psychotherapy, the therapist is often subject to unspoken cries of a client. As with the mother, the therapist is able to listen to themselves and draw on their experience of the distress. The unconscious process may be the only way a client has of communicating their distress; otherwise, it remains unspoken. What is then needed is for the therapist to metabolise the client's feelings, and in this way make them manageable. They thereby become less frightening to the client. In time, the client can take back or own their own feelings.

This study found that participants recognised that early development can often leave a client with a deficit and a sense of hopelessness when faced with difficulties. They recognised that holding the hope for the client was central to their role; they could help create a new experience for the client. Empathic attunement is fundamental in the unspoken understanding of the client. As expressed by one participant:

As a therapist I hold the hope for the client, because I have been through it. While it may not be their particular issue, I have had healing through therapy and this has given me some understanding of the level of the client's distress and I can hold that for the clients until they can hold it for themselves.

These findings were supported by Winnicott (1990) who found the holding and containing crucial to the therapeutic process. The therapeutic holding involves providing the space,

“giving support, and keeping contact”, at whatever level is going on in or around the client (cited in Jacobs, 1995, p. 80).

This research study has shown the importance of the unspoken understanding in the therapeutic process. It has illustrated the important contribution of research into early development and neurobiology, which yields significant understanding of the unconscious communication process. This results in a new insight into the unspoken understanding of empathy within the therapeutic process.

CONCLUSIONS

This chapter presents a summary of the study's findings and offers conclusions with reference to the original research aim, namely to examine the therapist's ability to sustain empathy in the therapeutic relationship.

5.1 THE PERSON OF THE THERAPIST

This study was carried out as a qualitative research study using a thematic analysis, in order to examine the experience of four psychotherapists' perspective of sustaining empathy in the therapeutic relationship. This research found that the participants viewed their own personal development as integral to the process. Most of the participants felt that, as therapists, their authenticity was most important to them. Without feeling authentic, it would be impossible for them to communicate empathically. They believed that what contributed to this was their personal development and a deep understanding of themselves; in this way, it allowed them to feel connected to their feelings and what is going on for them. This coincides with Rogers (1969) reflections on his own authenticity. He believed that if he could form a helping relationship with himself, if he could become sensitively aware and accepting of his feelings the likelihood is that he could form a helping relationship towards another. He believed that if he was to facilitate the personal growth in another person, then he too must grow. Personal growth was an integral part of the process in being empathic. The therapist's conscious awareness of this was a central theme for the participants involved in this research.

5.2 QUALITIES OF THE THERAPIST

Participants in this study describe the attitudes of the therapist which are rooted in their belief system as important to their own growth. The mutual respect created by the effective use of

the core conditions is fundamental to the communication of empathy, thus helping them build a therapeutic relationship. Participants recognised that their own experience of therapy was of huge benefit to them and acted as a precursor to their own growth. Their own personal experience of therapy and the realness of the therapist that they experienced helped create a deeper understanding and empathic openness to the clients they work with. Similar findings were reflected in studies by Daw and Joseph (2007). In their research, they found that participants believed that their own experience of therapy or being in the client role yielded a deeper understanding and respect for the client. Most participants in this study felt it was important to accept and meet the client 'where they were at in their lives' or in an empathic way. There was a very strong sense of humility in most of the participants and an acknowledgment of their own humanity which helped them to see themselves in the clients; it was more a case of 'there, but for the grace of God, go I.' and an open-minded willingness of the participants to see themselves in the problems of the clients (May, 1989, p. 57)

5.3 SUBJECTIVITY AND INTER-SUBJECTIVITY

This research study found the subjectivity of the therapist as a significant factor in the therapeutic relationship and in the therapist's ability to sustain empathy. This research found that the therapist's values cannot be removed from the therapy room, and the dangers of doing so were presented in the findings. The results show how the participant in holding their own subjective view of the client's experience without checking out the client's subjectivity, can lead to an interruption in attunement and ultimately to empathic failure. This coincides with the literature on empathy which Clark (2007) acknowledges: a therapist's subjectivity may be based solely on factors which substantiate an initial impression, in the form of conformity bias. The majority of the participants recognised that empathy is not exclusive to the therapist and were very aware of the various ways in which empathy is

communicated in a therapeutic relationship. Participants in the study had found this intersubjective experience in the therapy quite powerful. This study also found that it is through this inter-subjective experience that the subjectivity of the therapist and that of the client come together in the therapeutic relationship. This co-creation of the therapeutic space can offer relational depth where this level of emotional meeting can be a powerful source of bidirectional healing. This research study also recognises the risks of this level of contact and the awareness of the participants of the propensity to alter their views of the world. There is therefore, a “cost of therapy”, there is “the impact of therapist’s work on their own emotional and physical lives” (Shaw, 2004, p. 282). In his study, participants reported bodily sensations in psychotherapy sessions that resulted in “considerable somatic discomfort” (Shaw, 2004, p. 283), suggesting that consciousness of one’s embodied presence is particularly vivid and memorable when these experiences are uncomfortable. Shaw furthermore suggested the possibility of the more general health implications for working as a psychotherapist and the importance of further exploration in this regard.

5.4 BARRIERS AND DEFENCES AGAINST SUSTAINING EMPATHY

For the most part, participants of this study were consciously aware of the barriers which arose in their ability to sustain empathy. For example, this research found participants experienced barriers to effective listening when concerns from their own personal life intruded upon their ability to attune to the client and impacted on their ability to sustain empathy in the therapeutic relationship. This study also found that the use of defences has a significant impact on the therapist’s ability to sustain empathy:

when the description of defences is being used ...[the subject] both knows and does not know that she sees, remembers and desires, believes, or feels something that she believes does or will involve her in a kind of dangerous situation , X . We cannot attribute the defences to her without attributing to her the knowledge (in some sense) that there is a danger to defend against. Further not only is it assumed that the subject

believes that because of X she is in danger or about to be, it is also assumed that she believes in the threat unconsciously and then she engages in the defence unconsciously (Scheafer 1992 as cited Davy and Cross, 2004,p.13)

The qualitative study demonstrated a number of defences used by participants which significantly impacted upon their ability to sustain empathy. The therapists mentioned the difficulty they have experienced with boredom in the therapy room. There were a number of reasons cited for this; the lack of relational depth was a significant factor in creating this ambiance; another area was the therapist's own unresolved personal material which resulted in the therapists' emotionally distancing themselves from what was being discussed. A further defence was the therapists' unresolved attachment issues and the impact of their attachment style in sustaining empathy by being over- or under-involved with clients. All the participants recognised the risk of over-identifying with the clients. This research study found the therapists' over-identification with clients seriously impeded the therapists' ability in sustaining empathy. The emergence of defensive strategies also emerged in the interview process, when a participant who was talking about his own experience engaged in a lengthy pause dislocating from the feeling which was emerging. These particular findings reveal the importance of on-going personal enquiry on behalf of the therapist working in the area of psychotherapy. Despite the participants' efforts to work on their own personal development, their unconscious process impacted on their ability to sustain empathy in the therapeutic relationship.

5.5 HEALING POWER

Participants in this study spoke of the nourishment they felt from the deep psychological contact that can exist in the therapeutic relationship. They spoke of the healing they received from their own therapy and how this strengthened their self-esteem. This research study

found that some of the participants' experience of personal therapy was parallel with their own way of working as a therapist. For other participants, it was unthinkable to see clients without having experienced their own healing from therapy and beyond their understanding as to how one could sustain empathy in therapy without it. Another factor which was found to have an influence on the healing process of therapy was the therapist's own personal experience - once the therapist found healing in their own life, they could pass it on and use this experience to participate more deeply with the client. Participants viewed the therapeutic relationship as a gift in the sense that it allowed them to be privileged witnesses to a person's journey. This is consistent with findings in Skovholt and Trotter – Mathison (2011) who found that participants in their study reflected a profound awareness of the pain and suffering of clients and their potential for growth.

5.6 SPIRITUALITY / MEANING-MAKING

This research study found that all the therapists identified the spiritual aspect of the work as important, to them at a personal level, and significant also in their spiritual development. They felt that building on their own personal awareness was crucial to their own spiritual development. The qualitative interviews indicated that the participants' spiritual life was a factor in their sustaining empathy in the therapeutic relationship. They found it difficult to describe the mystery of the other person and referred to the connection as 'wondrous and mysterious'. They spoke of their experience in terms of it being 'a journey into the unknown', a journey of finding a way into the client's experience. This study found that participants viewed empathy and the empathic process as life-changing. Therapists in this study mentioned how this type of relationship, which is mutually influencing, and where there is a co-construct of meaning, enhanced their degree of empathy, towards their fellow human beings. The inter-subjective experience of empathy provided a spiritual experience

with transcending qualities. For Skovholt and Trotter-Mathison (2011), the activities of a spiritual life can help the therapist search for meaning and understand better the pain of human living they are faced with on a daily basis.

5.7 UNSPOKEN UNDERSTANDING

The therapists in this study described the unspoken understanding within the therapeutic process as a fundamental means of communicating. In fact, the qualitative interviews found it to be one of the most subtle forms of communicating empathy in the therapeutic process. The therapists spoke for example of how important this process was in the therapeutic process; their views are informed by research into early development and attunement. This study found the therapists' understanding of projection and projective identification was key to their understanding of unconscious communication which is central to an unspoken understanding. The therapists reported the importance of being able to pick up on preverbal distress in the client and through this awareness; they hold hope for the client.

5.8 LIMITATIONS

The main limitation of this study was the small sample the researcher used in gathering the findings. The sample chosen was from a small geographical area. It would be more desirable to confirm if these findings would be similar in wider research sample. It is not the researcher's intention to generalise from the finding but mainly to explore a small sample and their view on empathy. There is, however, no obvious reason to expect these findings to be totally contradicted in a wider population of therapists. The findings of this research, in particular the defences used in the interruption of empathy, have their origin in the therapists' early psycho-pathology. There is currently a debate on the role of personal therapy in training (e.g. Daw and Joseph, 2007). Although this research study is not arguing that

personal therapy is the vehicle to the therapist sustaining empathy, it raised the question for therapists. This is all the more relevant and timely as there is a move towards greater regulation of talking therapies and a growing emphasis on the duty the profession holds towards the client.

5.9 FURTHER RESEARCH

This study found there was a significant difference in reciprocity experienced by the participants in this research sample. The participants who were self-employed reported a high level of reciprocity which supported them in sustaining empathy in their work. In contrast, the participant working in the statutory organisation experienced considerably more difficulty in sustaining empathy. In this respect, the researcher is recommending that a further study be carried out into the influence and impact an organisation has on the therapist's ability to sustain empathy.

Background research into this topic found that the discipline of neurobiology can potentially offer a fundamentally important means of understanding the communication of the empathic process. This could be explored further, given its significance in the therapeutic relationship both in terms of inter-subjectivity and the therapeutic relationship.

APPENDIX A - INFORMATION LEAFLET

Title:

An Exploration of Sustaining Empathy in the Therapeutic Relationship

Researcher's Name: Bernie Mc Grane

Researcher's Title: Trainee Psychotherapist

Telephone No. of Researcher: 087 6911684

Dated: 27th June, 2012

I am a student studying for an MA in Psychotherapy in Dublin Business School. I have chosen for my research study to explore Sustaining Empathy in the Therapeutic Relationship.

You are being invited to participate in this study by agreeing to a 30-45 minute taped interview. Before you decide whether or not you wish to take part, you should read the information provided below carefully. If you wish to ask questions please do so. You should clearly understand the risks and benefits of participating in this study so that you can make an informed decision.

You may change your mind at any time, (before the start of the interview or even after you have commenced with the interview) for whatever reason, without having to justify your decision.

WHY IS THIS STUDY BEING DONE?

The aim of the study is to explore the therapist's ability to sustain empathy in the therapeutic relationship. It focuses on the therapist's ability to sustain empathy and the supports and difficulties in doing so. It also considers the relevance of the findings for the future of humanistic and integrative psychotherapy.

WHO IS ORGANISING AND FUNDING THIS STUDY?

This study is part of a Masters Degree in Psychotherapy being undertaken at Dublin Business School.

HOW WILL IT BE CARRIED OUT?

If you choose to take part in this study, you will be invited to take part in a 30-45 minute taped interview with the researcher to obtain your views on the area of telephone counselling and/or long-term humanistic/integrative counselling.

WHAT WILL HAPPEN TO ME IF I AGREE TO TAKE PART?

If you agree to take part, you will meet with Bernie Mc Grane at your place of work or a venue which will suit you at a time of your convenience for a 30-45 minute taped semi-structured interview.

RISKS/BENEFITS

There are no known risks to you from taking part in this research. The results of the study will be made known to you and may benefit you in your work.

CONFIDENTIALITY ISSUES

All information obtained from you during the research will be kept confidential. Notes about the research will be stored in a locked file. Each person who participates in the research will be given a code number so that the researcher will be the only person who can identify who you are in the notes. The key to the code numbers will be kept in a separate locked file. The audio recordings of the sessions will only be accessible to the researcher and will be destroyed once transcripts have been made of the sessions.

IF YOU REQUIRE FURTHER INFORMATION

For additional information, now or at any future time, please contact: ***Bernie Mc Grane Tel: 087 6911684 or Grainne Donohue Thesis Supervisor at grainne.donohue@dbs.ie***

APPENDIX B - CONSENT FORM

Title:

An Exploration of Sustaining Empathy in the Therapeutic Relationship

PLEASE CIRCLE THE APPROPRIATE ANSWER

I confirm that I have read and understood the Information Leaflet dated 31st March, 2012 attached, and that I have had ample opportunity to ask questions, all of which have been satisfactorily answered. **Yes No**

I understand that my participation in this study is entirely voluntary and that I may withdraw at any time, without giving a reason. **Yes No**

I understand that my identity will remain confidential at all times. **Yes No**

I am aware of the potential risks of this research study. **Yes No**

I am aware that audio recordings will be made of sessions. **Yes No**

I have been given a copy of the Information Leaflet and this Consent Form for my records. **Yes No**

FUTURE USE OF ANONYMOUS DATA

I agree that I will restrict the use to which the results of this study may be put. I give my approval that unidentifiable data concerning my responses to this interview may be stored or electronically processed for the purpose of scientific research and may be used in related or other studies in the future. **Yes No**

Interviewee _____

Signature and Date

Name in Block Capitals

To be completed by the researcher or her nominee:

I, the undersigned, have taken the time to fully explain to the above interviewee the nature and purpose of this study in a manner that he/she could understand. I have explained the risks involved, the experimental nature of the treatment, as well as the possible benefits and have invited him/her to ask questions on any aspect of the study that concerned them.

_____	_____	_____	_____
Signature	Name in Block Capitals	Qualification	Date

APPENDIX C

Sample Questions

On the basis of a review of the literature, as well as reflecting on the researcher's own therapy and training experience, the following points will be used to encourage, expand and deepen the researcher's understanding of the participant's perspective on sustaining empathy in the work.

Please find below a copy of the interview schedule.

- What attracted you into the area of psychotherapy / Could you tell me a little bit about how you became a psychotherapist?
- Does working in the field of psychotherapy meet with your expectations?
- Is there a gap between your initial expectations and the actual experience of working in the field; has the gap impacted on your practice?
- Does the work impact on your views of the world or alter your views of life in any way?
- In what way positive /negative?
- Has working in the field enhanced or restricted your growth in any way.
- What supports you in your work?
- Do you feel your own personal experience of life gets in the way of your work
- Could you give me an example?
- What impact does your own healing have on the therapeutic relationship in being empathic?
- Does the therapist have to achieve healing from their own experience before they begin to work in the area?
- Do you have a sense that overcoming difficulties in your personal life influences the outcome of the work in any way?
- How does the therapist manage their own difficulties which may be parallel with those of their clients?
- Is there anything else that you would like to say - anything that hasn't been touched on in this interview?

To be completed by the researcher or her nominee:

I, the undersigned, have taken the time to fully explain to the above interviewee the nature and purpose of this study in a manner that he/she could understand. I have explained the risks involved, the experimental nature of the treatment, as well as the possible benefits and have invited him/her to ask questions on any aspect of the study that concerned them.

Signature

Name in Block Capitals

Qualification

Date

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