The therapeutic relationship in psychodynamic psychotherapy: An exploration of patients' and therapists' experiences in the South African context

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Abstract

The therapeutic relationship has been a cornerstone of the theory and practice of psychotherapy since it first emerged as a healing modality. Research has extensively reported on the therapeutic relationship and its role in the outcomes of psychotherapy. Despite the vast research on the therapeutic relationship, little qualitative exploration has focused on both patient and therapist lived experience. Using a hermeneutic phenomenological qualitative methodology, this study examined the lived experiences of both patients and therapists, within the same therapeutic relationship in a South African context. Three patients and three therapists (i.e. 3 patient-therapist dyads) were interviewed using in-depth semi-structured individual interviews (six interviews in total) to explore their experience of the relationship they developed during therapy, and the meanings that have been made of this. Through thematic analysis, using interpretation to deepen the analysis, several themes and subthemes were identified.

Both patients' and therapists' lived experiences of the therapeutic relationship in psychodynamic psychotherapy clustered around three major and somewhat similar themes, with various sub-themes. Patients' lived experiences of the therapeutic relationship centred around the following themes and sub-themes: therapist's therapeutic approach (holding the patient in mind—knowing them; non-judgmental stance; providing an objective presence—perspective; and a consistent presence), facilitating therapeutic factors (mutuality; and therapist self-disclosure), and process within the relationship (describing the relationship—a lifeline; moment of meeting; change; and the relationship over time). Whilst therapist-participants' experiences of the therapeutic relationship held somewhat similar themes with subtle differences, namely, patient qualities, facilitating therapeutic factors (holding and containing; theoretical orientation; use of technique; and supportive factors for therapists), and process within the relationship (describing the relationship—intimate yet formal; moment of meeting; change; and the relationship over time). Similarities and differences between patient and therapist experiences are examined that may influence the therapeutic relationship. Conclusions are discussed with a consideration of the limitations of the study as well as implications for future research, practice, and training.

Key Words: Therapeutic Relationship; Therapeutic Alliance, Psychodynamic Psychotherapy; Patient and Therapist Lived Experience, South Africa

Compulsory Declaration

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution and quotation in this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

Signature: Date: 29/08/2018

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Table of Contents

List of Tables

List of Figures

List of Appendices

CHAPTER ONE: INTRODUCTION

In this qualitative study, the purpose is to explore the experience of the therapeutic relationship in psychodynamic psychotherapy from both the perspective of the patient and therapist. My interest in the therapeutic relationship is important and guided my choice of study. The way in which I work, as a training clinical psychologist, largely makes use of the relationship formed with my patient during therapy. I place enormous value and confidence in the connection formed with my patient and use this connection to venture into their subjective world and experience, which essentially allows me, together with my patient, to enable change and instil hope.

As a training psychologist, I have been taught, and learned through experience, about the importance of the therapeutic relationship in working with patients. In my very first encounter of therapy with a patient I remember my lecturers and supervisors easing my anxiety by encouraging me to focus on the relationship and connecting with my patient, and not concerning myself too much with technical factors and interpretations. Although this greatly eased my anxiety and removed the pressure of performing some outstanding technical work in the first session, I was still unsure of what forming a relationship explicitly meant.

Often, I found these connections were formed on an intuitive basis, and I would find myself seeking a language that could describe for me what was happening within the therapeutic exchange. I was also interested in thinking about how the patient experiences the therapeutic relationship and what it meant for them. In my early stages of training I struggled to think and understand what the relationship and connection was offering my patients. Therefore, my own interests and perhaps unanswered questions encouraged my choice of study.

In this chapter, the background of the study is introduced. Thereafter the context, motivation and purpose of the study is explored. Following this, a brief methodological overview and the definition of the term "therapeutic relationship" is provided. Lastly, a summary for each chapter is given.

Background of Problem

Psychotherapy research (Cooper, 2008; Horvath, Del Re, Flückiger & Symonds, 2011; Lambert, 2013; Lambert & Ogles, 2004; Wampold, 2001) and neuroscience research (Fosha, Siegel & Solomon, 2009; McKenzie, 2011; Schore, 2012) have provided extensive support for the benefits and positive change psychotherapeutic interventions offer. Widespread research has identified the therapeutic relationship as central to treatment success (Castonguay &

Beutler, 2006; Constantino, Castonguay, & Schut, 2002; Hill & Knox, 2009; Horvath et al., 2011; Martin, Garske, & Davis, 2000; Ribeiro, 2009; Safran & Muran, 2000). This finding is often noted irrespective of the theoretical stance of the therapy process (Horvath & Bedi, 2002; Horvath et al., 2011; Hubble, Duncan, Miller, & Wampold, 2010; Martin et al., 2000; Naidu & Behari, 2010; Norcross, 2002; Wampold, 2001).

However, several arguments have been put forward speaking to the limitations of outcome research and encouraging a more qualitative, in-depth approach. For instance, the therapeutic relationship has been shown to be important in treatment success but how the relationship achieves this is largely unknown (Castonguay, Constantino, & Holtforth, 2006). Others have argued that outcome-based research situates the researcher's understanding of the relationship within the measures used to assess it (for example, Horvath's Working Alliance Inventory) which does not necessarily account for the patients' and therapists' actual lived experience of the relationship during therapy (Nath, Alexander, & Solomon, 2012). A further critique proposes that due to the copious amounts of outcome-focused research on the therapeutic relationship, definitions and understandings of the construct are too diverse, global, and conflicting due to the varied theoretical approaches and methodologies (Campbell & Simmonds, 2011). Therefore, an approach to understanding the phenomenology of the therapeutic relationship is needed.

In line with this, Horvath (2005) argues for increased theoretical engagement around the relationship between patient and therapist. Charura and Paul (2014) document how different theoretical modalities influence how the therapeutic relationship is understood, valued, and carried out. Moreover, one's philosophical or epistemological worldview is important in how the therapeutic relationship is conceptualised, what interventions are chosen, one's therapeutic style, and how the relationship is formed and valued (Charura & Paul, 2014; Lee, Neimeyer, & Rice, 2013). An exploration of the complex and contextually intertwined nature of the therapeutic relationship seems to align more comfortably with a qualitative approach, which provides a richer understanding of the phenomenon. Discovering how patients and therapists experience, make sense of, and engage with, the therapeutic endeavour may offer greater clinical relevance to the study in general and particularly from a South African perspective (Rice & Greenberg, 1984). The present study seeks to understand the therapeutic relationship from a psychodynamic approach, which focuses on the relationship between patient and therapist and the patient's past and present patterns of relating.

Another important consideration when it comes to the therapeutic relationship includes patient and therapist characteristics and experiences (Summers & Barber, 2003). For instance,

both patients and therapists hold positive and negative characteristics that can either aid or hamper the development and maintenance of the therapeutic relationship as well as treatment progress (Ackerman & Hilsenroth, 2001; Ackerman & Hilsenroth, 2003; Audet & Everall, 2010; Bedi, Davis, & Williams, 2005; Castonguay et al., 2006; Nezu, 2010; Norcross & Wampold, 2011). The experience of both parties in the therapeutic encounter is also crucial as their views, although similar on some matters, may differ importantly in terms of how each perceives the therapeutic relationship and its strengths and weaknesses (Accurso & Garland, 2015; Bachelor, 1991; Bachelor, 2013; Errázuriz, Constantino, & Calvo, 2015; Horvath et al., 2011).

In summary, the present study fully acknowledges and holds the therapeutic relationship as the most crucial element in the therapeutic endeavour, however, theoretical underpinnings are important in how the relationship is conceptualised and valued, and how therapists approach the psychotherapy.

Context, Motivation and Purpose

South Africa demonstrates high rates of mental health disorders. For example, Seedat and colleagues, in their large scale nationally representative South African study, found that 30.3% of their participants met the DSM-IV criteria for a lifetime prevalence of any disorder (Seedat et al., 2009). The most common disorders that participants in this study met criteria for were anxiety disorders (15.8%), substance use disorders (13.3%), and mood disorders (9.8%). Apart from HIV/AIDS and other infectious diseases, neuropsychiatric disorders are the most common conditions in South Africa (Bradshaw, Norman, & Schneider, 2007). These rates of psychopathology in the South African population underscore the need for psychological and psychiatric services to address these issues meaningfully. The need for psychotherapeutic interventions is further highlighted through South Africa's high prevalence of childhood sexual abuse and traumatic experiences which inevitably leave "psychological scars" (Waumsley & Swartz, 2011, p. 281).

Another significant concern is that even among those people suffering from mental health problems who do seek treatment, early termination of therapy can be common and may threaten the individual's capacity to recover. One study found that the therapeutic relationship significantly contributed to dropout rates of patients, where patients who dropped out of therapy scored lower on a therapeutic relationship rating scale compared to patients who completed therapy (de Haan, Boon, de Jong, Geluk, & Vermeiren, 2014). Similarly, studies have identified the therapeutic relationship as a contributing factor to early termination and as

predictive of therapy outcome, specifically poor therapeutic relationships (Constantino et al., 2002). Reasons associated with early termination in terms of the therapeutic relationship may include *inter alia* the patient's negative views towards the therapist and negative transferences. For example, one study found that African American populations may hold negative perceptions towards their therapist and a feeling of disconnect between patient and therapist may be apparent, which resulted in early drop-out (Palmer, Murphy, Piselli, & Ball, 2009). Therefore, forming a strong therapeutic relationship may facilitate treatment compliance and outcomes.

There have been relatively few studies investigating the patient's experience of the process of counselling (McLeod, 2013; Oliveira, Sousa, & Pires, 2012). Therefore, this study aims to explore the experience of the therapeutic relationship from the perspective of the South African patient and their respective therapist. To my knowledge this is the first study of this nature carried out in South Africa that specifically explores both patients' and therapists' perspectives regarding the therapeutic relationship in psychodynamic psychotherapy. Although some research on psychotherapy in the South African context exists (Eagle, Haynes & Long, 2007; Langley & Klopper, 2005; Victor & Nel, 2016), research examining the experience of the therapeutic relationship from both patient and therapist is limited compared to other contexts (Accurso & Garland, 2015; Bachelor, 1991; Bachelor, 2013; Castonguay et al., 2006; Constantino et al., 2002; Errázuriz et al., 2015; Horvath et al., 2011; Martin et al., 2000; Naidu & Behari, 2010; Wampold, 2001).

Purpose of the Study

The purpose of this study was to qualitatively explore the experiences of the therapeutic relationship in psychodynamic psychotherapy from the perspective of both the patient and therapist. This study extends previous research by incorporating both therapy participants (patients and therapists) and gaining a phenomenological understanding of their experience. The literature has highlighted the importance of exploring the therapeutic relationship within a context as dynamic as South Africa. The therapeutic relationship has been linked to both therapeutic outcome (Horvath et al., 2011; Naidu & Behari, 2010; Safran & Muran, 1995; Wampold, 2001) and premature endings (Safran, Muran, & Proskurov, 2008; Swift, Greenberg, Whipple, & Kominiak, 2012). Therefore, this study aims to contribute towards the understanding of the therapeutic relationship in a South African context by gaining the unique experiences of both patient and therapist of the relationship during psychodynamic psychotherapy. This research may contribute to the knowledge in this area and potentially

inform practitioners in clinical practice (Leach, 2005) and ultimately facilitate the formulation of improved treatment strategies and patient-therapist relationships for therapists working in a South African context.

These aims were achieved through investigating the following research question:

1. What are patients' and therapists' experiences of the therapeutic relationship during psychodynamically-oriented psychotherapy in a South African context?

Research Methodology Overview

An exploratory qualitative design was chosen to gain a rich interpretative understanding of both patients' and therapists' experiences of the therapeutic relationship. A hermeneutic phenomenological paradigm was adopted which strives for interpretation and understanding as well as examining the human experience of being in the world. A purposive sample of 3 patient-therapist dyads participated in the present study. Semi-structured interviews were utilised to explore and understand the participants' experiences of the relationship during therapy. A thematic analytic approach—outlined by Braun and Clarke (2006)—was conducted to reveal and highlight important and relevant themes that emerged from the data. Interpretations were used to facilitate and deepen the data analytic strategy (Alhojailan, 2012). Trustworthiness of the data and methodological approach was ensured through rigorous reporting and use of research, as well as the self-reflective stance I adopted as the researcher and incorporating the context of therapy participants (Koch, 1996).

Use of the Term 'Therapeutic Relationship'

Green (2006, p. 426) observed that "the therapeutic alliance is an umbrella term for a variety of patient-therapist interactions and relational factors operating in the delivery of treatment". The psychoanalytic/psychodynamic tradition has a long history regarding the therapeutic relationship. Over the years, however, the therapeutic relationship has been understood within a variety of psychotherapeutic approaches and various terms have been used to describe the relationship, namely, the working alliance, the therapeutic alliance, therapeutic bond, and helping alliance (Horvath et al., 2011). This study will use the term 'therapeutic relationship' when referring to the concept. A general definition describes the therapeutic relationship as "the feelings and attitudes that therapist and client have toward one another, and the manner in which these are expressed" (Norcross & Lambert, 2011, p. 5).

Outline of dissertation

This dissertation consists of six chapters. **Chapter One** provides a background for the study in terms of the importance of the therapeutic relationship, past and current research, the

context, motivation and aims of the study. Furthermore, this chapter identifies important study research questions and research methodology.

Chapter Two introduces theoretical understandings and approaches to the therapeutic relationship in a brief overview, leading to a more detailed account of a psychodynamic approach. Thereafter, this chapter outlines the importance of psychotherapy, in general, which—due to the central role of the therapeutic relationship in psychotherapy—necessitates also a discussion of the therapeutic relationship in terms of the current literature on the factors influencing the therapeutic relationship. The therapeutic relationship is placed in the context of South Africa in terms of both research and practice.

Chapter Three describes the methodological approach adopted for this study and provides a rationale for the theoretical and paradigmatic point of departure. The choice of research procedures and materials used to collect data are also discussed in detail. Lastly, an account of the data analytic strategy is described along with a discussion of the trustworthiness of the data and ethical considerations for the present study.

Chapter Four presents tables, quotations and excerpts from the qualitative data to illustrate the findings of this study in accordance with the study's aims and objectives. Analyses have been collated and findings pertaining to the research questions presented according to the themes and subthemes that emerged from the data.

Chapter Five presents an examination and discussion of similarities or differences essential to patient- and therapist-participants' experiences of the therapeutic relationship. Previous study findings and theoretical understandings of the therapeutic relationship have then been used to understand the current study findings.

Chapter Six concludes the study's major findings. Thereafter study limitations are explored. Following this, my reflexive commentary as researcher is offered.

Conclusion

This chapter has provided some insight into the current situation of the therapeutic relationship both internationally and within a South African environment. An overview of the context, motivation, and purpose of the study has been provided. The following chapter will cover the current empirical literature on the therapeutic relationship.

CHAPTER TWO: LITERATURE REVIEW

This chapter is presented in two parts. The first part of the chapter outlines the therapeutic relationship in terms of its history and definition, the theoretical discourse surrounding the concept, and also engages with a conceptualisation of the therapeutic relationship in terms of a psychodynamic perspective. The second part introduces a brief understanding of psychotherapeutic interventions and the importance thereof. Thereafter, it engages with outcome and qualitative research as it relates to the therapeutic relationship, as well as South African research related to the subject matter. This includes patient and therapist perspectives of the therapeutic relationship, as well as various contributing factors.

The Therapeutic Relationship from a Theoretical Standpoint

This section focusses on the theoretical background of the therapeutic relationship, by first describing its definition and historical journey and then locating the therapeutic relationship within a psychodynamic paradigm.

Definition and historical journey. The psychoanalytic/psychodynamic tradition has a long history regarding the therapeutic relationship. Over the years, however, the understanding of the therapeutic relationship has expanded to include within its ambit a variety of psychotherapeutic approaches. By examining the history of the therapeutic relationship, it is revealed how diverse definitional concepts have arisen. It becomes important to map such developments in history, to locate the present study's approach and definition of the therapeutic relationship, which takes on a psychodynamically oriented perspective.

Although Charcot and Janet were the first to investigate the relationship between doctor and the hysterical patient during the 1880s (Friedman & Schustack, 2016), Freud (1913) was the first to conceptualise the therapeutic relationship in terms of transference and how it manifests between patient and therapist. Traditionally, little importance was given to the interpersonal relationship during the therapeutic encounter and the therapist would be perceived as the expert equipped to analyse the patient (Charura & Paul, 2014). However, Freud did refer to the relationship and highlighted the importance of developing rapport, having transference that was effective, and a pact within the analysis, if the patient were to hear the analyst's interpretations (Byerly, 1993; Freud, 1912, 1937). Repetition compulsion was a term coined by Freud which proposed that an individual has an innate drive to repeat a significant and problematic early relationship in their adult life. Freud noted that patients seemed to recreate, in the therapeutic encounter, these problematic dilemmas experienced in their early relationships in order—unconsciously—to make sense of the pain and distress. The analyst observes and links these enactments in the therapeutic space to the patient's past thus allowing

the patient to work through such events and make sense of their experiences. Thus, from very early on, theories incorporated relational phenomena (i.e., therapeutic relationship) between patient and therapist.

Various terms for the therapeutic relationship have been adopted since the use by early analytic approaches of the *ego-alliance* between patient and analyst which was regarded as necessary to generate insight and resolve defences and transferences (Freud, 1912; Greenson, 1965; Zetzel, 1956). For example, Fenichel (1941) renamed effective transference as *rational transference*, which is defined as "a positive rational relationship coinciding with irrational aspects of the transference" and was recognised as necessary for analysis (Campbell & Simmonds, 2011, p.196). Alternatives, however, have included *therapeutic alliance* (Zetzel, 1956), *mature transference* (Stone, 1961), and the *working alliance* (Greenson, 1965; Horvath et al., 2011).

Despite the various manifestations of the term, interest in the concept of the therapeutic relationship and its therapeutic impact emerged strongly only in the 1970s which saw the emergence of research focussing on the impact of the therapeutic relationship on the outcomes of psychotherapy. It was at this point that the therapeutic relationship began to be considered as a pan-theoretical factor associated with positive treatment outcomes (Horvath & Symonds, 1991; Martin et al., 2000). It is also around this time that Bordin (1979) offered a pan-theoretical description of the therapeutic relationship in which he highlights three important elements of the construct—bonds, goals, and tasks. Bonds describe the affective relationship between therapists and their patients and holds empathy, genuineness, and acceptance at its core. Goals generally describe therapy aims decided upon by both the patient and therapist. Lastly, tasks include the actions and processes implemented during therapy (Bordin, 1979, 1994). Bordin defines the alliance as "the patient seeking change and the therapist offering to act as a change agent" (Bordin, 1994, p.13). He further emphasises that the shared experience between patient and therapist results in bonding during the therapeutic relationship. The formation of goals and tasks are done through "bonds of mutuality", which allows for the relationship between patient and therapist to be strong enough to tolerate the difficult process of change (Anderson & Levitt, 2015, p.280). Bordin (1979) also argued that the power of the therapeutic relationship may be influenced by how well patient and therapist "fit" with one another.

Later research builds upon Bordin's work (see, for example, Constantino et al., 2002; Castonguay et al., 2006; Martin et al., 2000) and describes the therapeutic relationship as the positive regard between therapist and patient (bond/attachment) which is collaborative in

nature. Naidu and Behari (2010) extend this further and describe the therapeutic relationship as "complex attachments and shared understandings formed, and activities undertaken by psychotherapists as they attempt to help patients manage psychological issues" (p.42). Thus, the collaborative nature that these later works describe is similar to Bordin's concept of goals within the therapeutic encounter. Not only has Bordin's work offered a pan-theoretical approach towards the therapeutic relationship, it has provided a multi-dimensional approach towards the construct. Previous research has been one dimensional in nature and limited in describing and capturing the complex experience the therapeutic relationship offers both patients and therapists, which prompted further research to explore this complexity (Gelso & Hayes, 1998; Gelso & Samstag, 2008).

For instance, while the various terms used to refer to the therapeutic relationship have been regarded as interchangeable, Horvath and colleagues have differentiated between the therapeutic *relationship* and the therapeutic *alliance* (Horvath et al., 2011). In their contention, the former is made up of various "interlocking elements" (such as empathy, rapport, trust and so forth), while the latter is the conceptualisation of what the relationship may achieve using the elements successfully (Horvath et al., 2011, p.56). Therefore, the therapeutic relationship consists of important elements that are necessary to achieve the therapeutic alliance. Horvath and Bedi (2000) understand the therapeutic alliance as an aspect of the relationship. They are inextricably linked and the patient may have an experience of both the therapeutic relationship and the alliance, where the therapeutic relationship impacts upon the alliance. In this study, I will be considering both terms, but I continue to use the term 'therapeutic relationship', which may also include elements of the therapeutic alliance.

Another multi-dimensional approach to the therapeutic relationship is described by Gelso and colleagues who draw on the work of Greenson (1965) who holds psychoanalytic roots. They suggest that the relationship is made up of three components—the working alliance (WA), the transference-countertransference configuration, and the real relationship (RR) (Gelso, 2009; Gelso & Hayes, 1998; Gelso & Samstag, 2008). The WA has been most empirically researched and linked with treatment outcomes (Horvath, 2006). The transference-countertransference configuration, has also been linked with treatment process and outcomes, whilst the RR—"the personal relationship existing between two or more people as reflected in the degree to which each is genuine with the other and perceives and experiences the other in ways that befit the other" (Gelso, 2009 p.254-255)—is less researched. Gelso (2009) argues that the RR is implicit within the therapeutic encounter, in the background of clinician's work, and therefore not at the focus of research. Genuineness (participants' degree of authenticity

with each other) and realism (experiences and perceptions that befit the other, rather than inaccurate or distorted perceptions that may be because of unresolved conflicts) lie at the core of the RR. The RR holds similarities to the working alliance, yet differs in terms of the work collaboration, which in the RR is independent of the work of therapy and instead is reflective of the personal connection between therapist and patient (Gelso, 2009). Thus, the RR as described by Gelso and colleagues is what the present study is essentially seeking to explore— both patients' and therapists' experience and subjective reality of the therapeutic relationship.

Extensive research places the relationship at the core of therapeutic change and treatment outcome (Castonguay & Beutler, 2006; Constantino et al., 2002; Hill & Knox, 2009; Horvath et al., 2011; Martin et al., 2000; Ribeiro, 2009; Safran & Muran, 2000), over and above therapeutic paradigm (Horvath & Bedi, 2002; Horvath et al., 2011; Hubble et al., 2010; Martin et al., 2000; Naidu & Behari, 2010; Norcross, 2002; Wampold, 2001). Horvath (2005, p.4) suggests that there should be a heightened "theoretical debate about the construct of relationship". He argues that Bordin's pan-theoretical construct of the therapeutic relationship sparked "the development of measuring procedures that in practice defined the construct for research that followed" and therefore created little opportunity to critically investigate limitations and implications of Bordin's original concept (Horvath, 2005, p. 4). Additionally, the shift from a context steeped in psychodynamic thought to a pan-theoretical conceptualisation detached the therapeutic relationship from being defined in terms of the framework of therapy and change related to one broad theoretical approach (Horvath, 2005). This has meant that the nature of the research on the therapeutic relationship and how the concept has been operationalised over the years appears to be disembodied and fragmented resulting possibly in a loss of nuance and meaning. Thus, increased theoretical discourse and debate may bring together this apparent gap and fragmentation. It is important to reiterate that the present study fully acknowledges and holds the therapeutic relationship as a crucial element in the therapeutic endeavour. However, theoretical underpinnings are important in how the relationship is conceptualised and valued, and how therapists approach the therapeutic endeavour.

Theoretical discourse. Psychotherapeutic interventions include numerous orientations and history seems to demonstrate an emergence of various models of the therapeutic relationship reflecting different theoretical underpinnings (Charura & Paul, 2014; Knox & Cooper, 2015). Although beyond the scope of the current research study, it is important to comment on how the major approaches in psychotherapy understand the therapy relationship. For example, a cognitive-behavioural therapist may view the relationship as "a close

partnership, agreeing on particular aims and tasks with the patient" (Knox & Cooper, 2015, p. IV). The classic analytic approach takes a stance of a neutral analyst who allows the patient room to engage with their past and present, specifically looking at their thoughts and feelings and few interventions being conducted. Whilst the psychodynamic approach encourages transference and countertransference processes and makes connections with early experiences and how it maps onto current experience and onto the therapeutic relationship (Knox & Cooper, 2015) working, therefore, with the relationship in the here-and-now. Person-centred and experiential—existential, gestalt or humanistic—therapists, on the other hand, while also working with the here-and-now focus specifically on encouraging individual responsibility and self-determination rather than on unconscious dynamics (Paul & Charura, 2014). However, all therapists require a depth of relating in their own way.

Paul and Charura (2014, p.16) represent the context of the therapeutic relationship in enveloped concentric circles.

Meeting the other in relationship

The model: The practice of therapy

Psychology: The therapist's understanding of human nature

Philosophy: The therapist's worldview

Socio-cultural setting
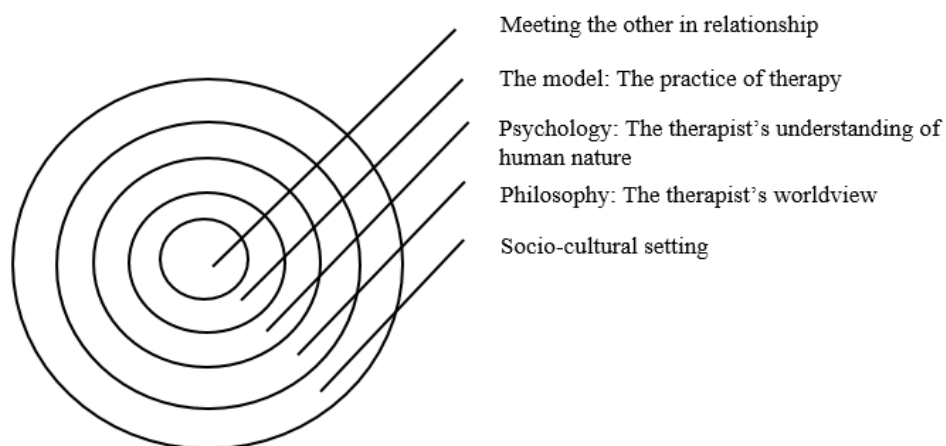
Figure 1. The therapeutic relationship. This figure illustrates various contexts that influence the therapeutic relationship.

Therefore, although the therapeutic relationship is at the core in the potential of human change, the different approach/theoretical model as well as one's philosophical views and socio-cultural setting influences how the therapeutic relationship is seen, understood and valued.

A psychodynamic approach. As research has emphasised that the therapist's own worldviews and theoretical preferences influence how one conceptualises and uses the therapeutic relationship (Lee et al., 2013; Charura & Paul, 2014), I have chosen to approach the conceptualisation of the therapeutic relationship from a psychodynamic perspective. Personally, this is the approach within which I practice/train and it resonates with my own

philosophical worldviews regarding human nature. Moreover, the relational emphasis of this approach seems to align well with the concept itself—the therapeutic relationship.

Previously, the classical analytic approach has focused on patient transferences in the relationship based on the patient's past experience of relating. The patient engages with free association to allow inner conflicts to surface. The expert therapist subsequently interprets the meaning behind the patient's behaviour as connected with their past forms of relating and experiencing others, resulting in patient insight and awareness. There has been much movement and development from this classical analytic approach to a more relational approach in the field of psychodynamic therapy (Charura & Paul, 2014; Paul & Charura, 2014). This section introduces an overview of the psychodynamic and relational approach to the therapeutic relationship.

Object Relations Theory. Important object relational theorists such as Rank, Fairbairn, Klein and Winnicott evolved from the more classical Freudian approach and each of them hold the understanding that we are relation-seeking beings (Charura & Paul, 2014). The basic premise of the object relations theory is that infants primarily seek relationship with an 'other'. Through being in relationship with others, one can develop a sense of themselves and their personality. Less focus is placed on instinctual (libidinal), sexual or aggressive drives, with greater emphasis placed on the patient's relational capacity. During adulthood, individuals relate to others and situations largely based on early relational experiences with primary objects. McWilliams (1994, p. 51) describes objects as "key figures in childhood and their internalized representations". The therapist concentrates on transference and countertransference themes that emerge in the relationship with the patient, as well as connecting behaviour with past experiences. One of the main assumptions in object relations theory is that a reparative relationship is possible. Through the formation of the therapeutic relationship and the supportive role of the therapist a new way of relating can emerge.

Nolan (2012, p.65) makes use of Winnicott's (1971) understanding of play in the therapeutic space, highlighting that creativity is key to finding a fuller sense of self, and identifying this as an "element of therapy as we help our clients find, recover or repair their feeling of a true and vital self". A space is offered where a patient's capacity for creativity, spontaneity and growth is encouraged. However, such a space is only created "if the client as an infant could rely on an attentive loving caregiver" (Nolan, 2012, p. XIX). An infant, needs to feel secure in relationships in order to reach out to the other, and only in security can a space for play be created. With play comes a sense of self in relation to others. The therapeutic relationship therefore provides the vehicle for a different relational experience and offers an

opportunity and potential for the patient (i.e. the theoretical infant) to relate in a different way with their therapist (i.e. the theoretical caregiver). Through the sense of safety experienced by the patient within the therapeutic relationship an opportunity is generated for play and creativity to develop. The relationship between therapist and patient is therefore key to the process of change and growth in psychotherapy.

Essential also to therapeutic processes are the concepts of holding and containment (Stadter, 2012). Often the therapeutic relationship is linked, in a metaphoric sense, with the mother-child relationship as alluded to above (Brandell & Ringel, 2004; Nolan, 2012; Schore, 1994). The child grows and develops through, and in, relationship with his/her mother; as such, patients grow and develop in relationship with the therapist. This is, however, not simply a unidirectional process and, like the mother influences the baby, so the baby influences the mother and in terms of the therapeutic relationship, the patient influences the therapist. Both relationships, which have obvious and important differences, also have similarities which include authenticity, empathy, gratification, frustration and goals of growth. The concept of holding, attributed to Winnicott, focuses largely on the external environment (although does extend beyond this) between patient and therapist, whereby containment—as conceptualised by Bion—speaks to a more internal process (Stadter, 2012). Winnicott coined the term holding and related it to a mother holding and soothing her baby, rocking back and forth until he/she settles (Winnicott, 1960). Thus, the physical environment provides holding for the infant, while in therapy the consistency of the hour, the office, respectful presence and empathic interpretations of the therapist provides holding for the patient. Containment on the other hand describes being with or in reverie with the infant and includes the mother's capacity to tolerate and process her infant's distress (such as anxiety and frustration) (Bion, 1962; Bion, 2008). The mother's internalised version of the infant's experience is given back to the infant in a more digested and processed form, which feels less destructive to the infant who is then more able to tolerate these affects and thus feels contained. This intersubjective exchange between mother and infant is ultimately internalised as the infant grows and becomes more mature in its capacity to self-contain. During the distressing and intolerable affective experiences of a person, the other who experiences the person identifies on some level with this affective experience but is able to contain the feeling within themselves and remains empathically attuned to the distressed person and most importantly remains in the relationship (Stadter, 2012).

Containment, however, is not necessarily about action, but is rather about authentically being and staying connected. Therapists often hold a lot of difficulty and distress, and it takes

time for patients to be able to take back the digested experience. As Stadter (2012, p.98) states, "sometimes, just being with the patient and serving the function of containing rage, anxiety and hopelessness without avoiding the pain, without allowing oneself to be abused and without being attacking—just being there with the patient—is what's needed". Therefore, as we look closer into what constitutes a therapeutic relationship, concepts like holding and containment provide a safe and relational atmosphere and in essence form part of the therapeutic relationship (Brandell & Ringel, 2004).

The relational and intersubjective approaches. A combination of social factors and research findings has led to the development of a more holistic approach to theory and practice to therapy (Paul & Charura, 2014). Since the 1980s, a new therapeutic paradigm has emerged that takes the relationship as the key concept in the theory and practice of therapy. The main philosophy of the relational approach states that "our sense of self is developed through relationship and that we maintain and perpetuate this sense of self through relationship" (Charura & Paul, 2014, p.87). Therefore, it can be argued that transformation within therapy occurs through a therapeutic relationship where the patient's sense of self can become established, affirmed and accepted in how they relate to the world.

Relational theorists and clinicians draw upon infant research and observation, linking this to the experience of the therapeutic endeavour between patient and therapist. It is now known that the development of an infant's brain is influenced by the caregiver-infant relationship and the brain, like the infant, cannot develop optimally without the relationship (Schore, 2012). Nolan (2012) pays particular attention to how the therapeutic relationship is formed from a relational perspective. A new model is put forward which considers non-verbal communication and the use of the body within the therapeutic setting and links it with infants' preverbal communications and the importance thereof. This includes human interactions involving reciprocity, rhythmic coupling, turn taking, matching, vitality affects, attuning, and switching modes of expression (Nolan, 2012). Much like the relationship between caregiver and baby, these modes of expression also mature and develop within the therapeutic relationship between patient and therapist (Nolan, 2012). Therefore, a non-verbal and implicit way of relating is recognised as significant, and meaning is sought from explicit expressions of mind and body which aids the therapist in meeting the patient in a real, and useful manner. The therapist is also interested in the meaning the patient gives to their experience and enters into a potential real human-to-human relationship (Stadter, 2012). Change happens in relationship as the therapist provides a more nourishing experience of self-with-other, which is part of the therapeutic process.

A key tenet of intersubjective theory is that a separate, independent mind does not exist. Instead, the mind develops as a function of the relationship with another—in the intersubjective field. The therapeutic relationship therefore is created together between patient and therapist. This reflects the highly interpersonal quality within the therapeutic relationship that has been described as "an interactive process of reciprocal mutual influence" (Stolorow & Atwood, 1992, p.18).

The encounter during therapy involves the here-and-now interaction between patient and therapist as well as each party's own experience of their existence (Paul & Charura, 2014). A therapist can only be helpful to the patient if they are able to fully enter the therapeutic relationship, thus providing a valuable therapeutic presence using the self (Paul & Charura, 2014). The relational approach holds a strong appreciation for seeking meaning, connectedness, co-construction, recognition, responsiveness and empathic attunement, most of which are essential in understanding the therapeutic relationship within psychodynamic frameworks. This approach is concerned with "interaction, enactment, spontaneity, mutuality, and authenticity" (Mitchell, 1997, p. IX)

It has been said that relational therapists have created a more open space to discuss the therapist's experience of therapy with any given patient, and have encouraged a warmer and more authentic milieu within the therapeutic process using terms like co-construction, mutuality, enactments, self-disclosure and flexibility of the frame (Paul & Charura, 2014). Therefore, the patient is not the only participant within the therapeutic endeavour. Both the patient and therapist are active participants and influence one other. The discussion now turns to Part 2 of this chapter, which addresses research on psychotherapeutic interventions and the therapeutic relationship.

Psychotherapeutic Interventions and the Therapeutic Relationship: Research

Psychotherapy has been demonstrated as a valuable activity for improving problem outcomes and the mental health of patients (Horvath et al., 2011; Joyce, Wolfaardt, Sribney, & Aylwin, 2006;). Typically, psychotherapy approaches aim to implement various psychological strategies to treat mental and emotional problems (McLeod, 2013). Although each approach/orientation may deviate in relation to specific strategies and focus, overall main goals seem uniform across orientations. For example, psychotherapy aims to provide symptom relief, induce behavioural change and improve social functioning and personal growth (McLeod, 2013). Therapists work collaboratively with patients to encourage and support how they relate

to themselves and their tolerance for intimacy and interpersonal relatedness (Safran & Muran, 2000).

Much research has centred around demonstrating the effectiveness and efficacy of therapy. It is now widely supported that psychotherapy is, in fact, successful (Cooper, 2008; Lambert, 2013). This is reflected in the findings of a meta-analysis, which included twenty-three studies (11 randomised controlled trials and 12 observational studies) and involved 1053 patients with complex mental disorders. The findings demonstrated significantly higher outcomes for "overall effectiveness, target problems, and personality functioning" for long term psychodynamic therapy as compared to shorter forms of psychotherapy (Leichsenring & Rabung, 2008, p.1551).

Moreover, advancements in neuroscience research have allowed for previous theories of therapeutic change to be supported (Fosha, et al., 2009; McKenzie, 2011; Schore, 2012). Various psychotherapeutic approaches have been shown to have positive effects on brain neural functioning through the use of cognitive, emotional and behavioural strategies that form part of clinical practice (McKenzie, 2011). Neural development from birth is crucial for establishing emotional maturity in humans and the consequences of traumatic, abusive and inconsistent experiences have been identified as greatly impinging on one's neural network development (Fosha et al., 2009). What has previously been only anecdotally understood and 'known' by psychotherapists based on clinical experience and judgement is now supported by an increasing body of neuroscience research (McKenzie, 2011). For example, Cozolino (2006) identified three sequential neuron areas that become activated in the brain in response to human experience. The brain structures have been observed to change on a structural level in response to human experience. Therefore, change experienced during psychotherapy has been linked with structural changes within the brain.

As previously mentioned, a large body of research has identified the therapeutic relationship as a critical element for all forms of psychotherapy (e.g., Arnow et al, 2013; Castonguay & Beutler, 2006; Hill & Knox, 2009), regardless of theoretical underpinnings or technique (Horvath et al., 2011; Naidu & Behari, 2010; Wampold, 2001) or the type of presenting problems (Bachelor, 1991; Safran & Wallner, 1991). For example, one meta-analysis (Horvath et al., 2011) revealed a positive association between the therapeutic relationship and treatment outcome (ES of r = .275). Although this finding is modest in proportion to the total variance, this is the strongest effect found for the correlation between the therapeutic relationship and treatment outcome. Another study examined patient-rated working alliance for chronically depressed patients receiving two different treatment

approaches (brief supportive psychotherapy and cognitive behavioural analysis system of psychotherapy) and results revealed the therapeutic relationship role as a predictor of treatment success irrespective of orientation (Arnow et al, 2013). Evidence suggests therefore that the therapeutic relationship is key to the efficacy of psychotherapy in treating psychological conditions.

      Argument for a qualitative approach. Although outcome research has presented extensive evidence for the role of the therapeutic relationship in positive treatment success and change regardless of theoretical orientation, the nature of the association between the therapeutic relationship and treatment outcomes is less well understood (Castonguay et al., 2006). Therefore, what constitutes a fruitful therapeutic relationship and how such a connection is formed is largely unexplored, empirically. Although quantitative research has been useful in illuminating this association, Nath and colleagues argue that quantitative outcome research on the therapeutic relationship—by simply examining constructs such as dimensions of bonding and collaboration—does not capture adequately the vicissitudes and nuances of the relationship in context (Nath et al., 2012). For example, some researchers have questioned the measure-based outcome research, arguing that measures/constructs and events in therapy are constructed by researchers' perceptions and their definitions of such events, which patients may not necessarily naturally produce themselves (Elliot, 1989; Patton & Jackson, 1991). In support of this, Horvath (2009) argues that researchers who examine the therapeutic relationship should transcend from the more global understanding and perspectives of the therapeutic relationship and provide more specific and contextualised understandings.

      Another argument suggests that the consequence of the vast empirical evidence and copious research studies examining the therapeutic relationship resulted in the diversity of definitional and measurement approaches to the construct (Gaston 1990; Kokotovic & Tracey, 1990). Therefore, different studies may have measured different aspects of the therapeutic relationship thus making it difficult to make overarching statements or conclusions about the nature thereof. Horvath and Symonds (1991) recognise how empirical research, making use of outcome variables based on relevant theory, has proved useful in theories and hypotheses that have been generated. However, they further argue that little information exists regarding the distinct experience of the therapeutic relationship.

      Moreover, philosophical commitments and attitudes have also been found to be important when examining therapeutic constructs and events. Lee et al. (2013) explore the epistemological approaches to counselling and psychotherapy and are interested in therapists' different views/perspectives towards human change and how individuals make sense of life.

This links with their different philosophical attitudes, which in turn affects the approach and intervention they adopt in therapy and their understanding towards how people live, operate and change. Moreover, one's epistemic attitude connects with one's therapeutic style, choice of interventions and, most importantly, how the therapeutic relationship is structured and valued (Paul & Charura, 2014). Therefore, by qualitatively exploring the therapeutic relationship it allows for greater depth of investigation and recognition that philosophy and hence all psychology is located, socioculturally and historically.

Qualitative research exploring psychotherapy has been on the increase and aims to introduce depth and understanding as it pertains to the therapeutic processes, therapeutic techniques, the therapeutic relationship and patient factors (Maione & Chenail, 1999). Research in counselling and psychotherapy has increasingly considered how patients and therapists perceive the therapeutic endeavour (Elliott, 1989; Gelso & Carter, 1985; Patton & Jackson, 1991; Rice & Greenberg, 1984). The aim of such research is to understand how patients and therapists generate, make sense of and engage with their behaviour in therapy. Choudhuri (2003) explains that clinicians themselves use qualitative methodology in their everyday practice of seeking to understand their patient's worldview, and so "it makes an elegant equation to do in counselling research what is done in counselling practice" (Choudhuri, 2003, p. 272). Similarly, empirically based outcome studies may be useful in establishing the effects of medicine, however when it comes to psychotherapy processes individual patient needs are essential to each encounter and practitioner clinical judgment should be preferred (Paul & Charura, 2014). Therefore, by considering the complexity and contextual relatedness of significant events as they naturally occur from the perspective of the involved therapy partners, data obtained through qualitative methods may offer a richer understanding of these events as well as provide greater clinical relevance than interpretations imposed on the clinical situation from the outside (Elliott, 1989; Rice & Greenberg, 1984).

Perspectives on the therapeutic relationship. The discussion now turns to the examination of the therapeutic relationship from both the perspective of the patient and therapist. Ackerman and Hilsenroth (2003), discussing the therapeutic relationship, state that "future researchers should work toward integrating quantitative and qualitative analyses of the interactions between patients and therapists to present a clinically meaningful picture of the data" (p.29). Therefore, key quantitative studies outlining important hypotheses are discussed, with qualitative studies elaborated upon to expand and deepen the understanding of the therapeutic relationship from both the perspective of the patient and the therapist.

Monitoring the therapeutic relationship closely during psychotherapy has been found to be a significant matter. A mismatch may arise where patients' and therapists' perceptions of the relationship may not correspond (i.e., the therapist believing that the relationship is in good shape when the patient does not share this perception) and could potentially dilute the impact of the intervention (Horvath et al., 2011; Bachelor, 1991; Bachelor, 2013). Therefore, by exploring patients' and therapists' experiences of the therapeutic relationship, rich meaning and understanding can be gained from a unique contextual perspective and can play a role in facilitating how that relationship functions to produce positive therapeutic change.

In a quantitative study, Bachelor (2013) examined how patients' and therapists' perspectives of the therapeutic relationship were similar and/or different. For patients, the therapeutic relationship was facilitated through collaboration and working with their therapist on common goals. Patients were more aware of what therapists offered the therapeutic relationship in terms of their positive, accepting and understanding attitude which aided the relationship, as compared to therapists' perspectives regarding their contribution to the relationship. Additionally, patients were more alert to negative elements within the relationship compared to therapists. Lastly, therapists placed greater emphasis on patients' contributions within the therapeutic relationship including, their "active participation… commitment to the work… and willingness to disclose information about self" (Bachelor, 2013, p.132). It appears that both study participants (patient and therapist) seemed to value, appreciate, and reflect more freely on their therapy partner's contribution and what they brought to the therapeutic relationship, rather than their own contribution.

Another study revealed that children and caregivers leaned towards a higher therapeutic relationship rating and were consistent over time compared to therapists who rated weaker relationships and weakening over time (Accurso & Garland, 2015). This indicates further disparities in how the relationship may be perceived and experienced by patients and therapists, respectively. Several hypotheses have been proposed for this finding, namely, that therapists may "underestimate the extent to which families feel allied to them", may be more sensitive to the breaches in the relationship compared to patients, or may hold higher expectations (Accurso & Garland, 2015, p.350). Lastly, Errázuriz et al (2015) conclude that consideration should be given to different perspectives regarding the therapeutic relationship and propose that therapists should not rely solely on their own perspective as this places them at risk for challenges and difficulties that may exist in the relationship. Therefore, investigating the experiences of the therapeutic relationship from both the perspective of the patient and therapist appears crucial. The discussion now explores various factors that contribute to the therapeutic relationship with

specific attention paid to similarities and differences in the experience for both patients and therapists.

The therapeutic relationship from the patient's perspective. A rich and direct source of information about the therapeutic relationship is the patient who can account for their experience as a crucial 'actor' in the therapeutic process (Sackett & Lawson, 2016). Patient experiences of psychotherapy are, however, often not the focus of counselling research, despite patients identifying the therapeutic relationship as the most important factor during psychotherapy (Oliveira et al., 2012). One study examined 40 patients' perspectives of the factors that fostered the development of the relationship with their therapist (Bedi et al., 2005). Findings revealed that patients rarely mentioned their own contributions and felt the therapist was the main contributor to the relationship. Active listening or sensitive nonverbal communication as well as techniques or exercises facilitated the relationship according to the patients. Furthermore, the therapy room, the characteristics of the therapist (e.g. well-groomed) and the therapist's willingness to go the extra mile (e.g. call anytime) played an important role in the development of the relationship.

In line with this, Nezu (2010, p.172) expressed that the behaviourist approach to psychotherapy is aware of various therapist characteristics ("gender, race, age, weight, height, dress, hairstyle and office décor") and the manner in which they may "be interpreted correctly or incorrectly by a client", thus influencing their experience of the therapist and possibly the therapeutic relationship. Qualitative studies have also highlighted therapist characteristics that are supportive elements within the therapeutic relationship including, empathy, caring, acceptance, competence, support and being personable (Bischoff & McBride, 1996; Kuehl, Newfield, & Joanning, 1990; McCollum & Trepper, 1995)

Ackerman and Hilsenroth (2003), in their comprehensive review of 25 studies investigating therapist factors that facilitate the therapeutic relationship, found several personal attributes and techniques of therapists conducive to building a positive relationship with patients as outlined in Figure 2 below.

Personal attributes	Technique
Flexible	Exploration
Experienced	Depth
Honest	Reflection
Respectful	Supportive
Trustworthy	Notes past therapy success
Confident	Accurate interpretation
Interested	Facilitates expression of affect
Alert	Active
Friendly	Affirming
Warm	Understanding
Open	Attends to patient's experience

Figure 2. A Summary of Therapist's attributes and techniques found to contribute positively to the alliance (Ackerman & Hilsenroth, 2003, p.28).

These findings highlight the therapists' personable characteristics and techniques that strengthen the therapeutic relationship. Furthermore, research suggests an empathic and non-judgmental attitude on behalf of the therapist creates an open and responsive atmosphere, which in turn allows the therapist to adapt treatment to the needs of the patient thus facilitating the therapeutic relationship (Watson & Gellar, 2005).

In a qualitative study, Audet and Everall (2010) examined therapist self-disclosure and its influence on the therapeutic relationship. Both positive and negative themes were identified and are presented in Figure 3 below.

Higher order themes	'Facilitation' themes	'Hindering' themes
Early connection with therapist	• Comfort • Egalitarianism	• Role confusion/ uncertainty • Role devaluation/reversal
Therapist presence	• Attunement • Feeling understood/not judged	• Feeling misunderstood
Engagement in therapy	• Taking risks • Closeness	• Feeling overwhelmed • Impeding involvement

Figure 3. Summary of Facilitating and Hindering Themes Towards the Therapeutic Relationship (Audet & Everall, 2010, p.333).

The above summary of Audet and Everall's (2010) findings show that therapist self-disclosure contains both facilitating and hindering aspects with regards to the therapeutic relationship. Considering both the facilitative and hindering aspects of therapist self-disclosure captures the complexity of such phenomena and promotes a reflective stance around the use of this technique wherein therapists are encouraged, but also cautioned. Similarly, Hill and Knox (2009), in their review study, noted that therapist self-disclosure is a facilitating factor in respect of the therapeutic relationship. They further describe how therapist trainees should be guided in the benefits and appropriate use of self-disclosure in order to facilitate the impact of the therapeutic relationship.

Change is also an important factor when considering the therapeutic relationship. For example, in a qualitative meta-analysis of seven different qualitative studies Timulak (2007) found that factors regarded by patients as helpful in therapy included awareness, insight, self-understanding, behavioural change and problem solution, empowerment, relief, exploring feelings and emotional experiencing, feeling understood, patient involvement, reassurance,

support, and safety. Thus, patients identified the above-mentioned factors as being useful and valued within the therapeutic relationship with their therapists and ultimately leading toward change.

Inasmuch as there are a number of factors that may positively impact the therapeutic relationship, there are others that may render the therapeutic relationship ineffective, or damaging. Norcross and Wampold (2011) have highlighted a number of such factors that are equally as important to consider. These elements all relate to negative therapist behaviours and processes, which encompass hostile, critical, pejorative, and blaming stances (Lambert & Barley, 2002); using a confrontational style (Miller, Wilbourne, & Hettema, 2003); making unverified assumptions (Lambert & Shimokawa, 2011); therapist rigidity; inappropriate self-disclosure; criticalness; over-structuring of sessions (Ackerman & Hilsenroth, 2001); and employing a one-size-fits-all approach to all patients (Norcross & Wampold, 2011).

A further factor that may play an important role in how the patient experiences the therapeutic relationship is that of the patient's internal object relational world. Errázuriz and colleagues note that a patient's sense of the therapeutic relationship may be indicative of their object relational patterns (Errázuriz et al., 2015). For example, many studies have been interested in examining how personality and object relations are congruent with the therapist-patient dynamic and is therefore associated with the therapeutic relationship (Errázuriz et al., 2015; Taber, Leibert & Agaskar, 2011). Relationships—both adaptive and problematic—allow one's self to develop alongside the internalised representations of others. This starts early on in life and impacts our thoughts, feelings and actions towards both ourselves and others (Blatt & Auerbach, 2003; Bowlby 1969). Constantino et al (2010) argue that difficult interpersonal patterns stemming from problematic early relational experiences may be overcome by the therapist adapting appropriately to the individual patient's presentation in the therapeutic process. It is important to note that although the patient enters the therapeutic process with their long history and patterns of relating to themselves and others and how they think, feel and behave, so too does the therapist in terms of how they approach the therapeutic endeavour (Arthur, 2001; Topolinski & Hertel, 2007). At this point the discussion turns to the therapist's experience of the therapeutic relationship, according to the literature.

The therapeutic relationship from the therapist's perspective. Inasmuch as it is important to understand patients' experiences of the therapeutic relationship, it is equally as important to explore therapists' experiences as the second 'actor' in the relational space. As discussed previously it is well known that poor therapeutic relationships can result in early

drop-out rate (Constantino et al., 2002) and it is thus very important for the focus to be on the relationship from the moment of meeting and address ruptures as they arise.

The therapist's theoretical understanding and knowledge of various personality dynamics and problems is likely to provide a supportive and scaffolding function, aiding their therapeutic work with patients. Patient factors often impact in various ways and to varying degrees upon the formation of the therapeutic relationship. By engaging their theoretical support system therapists are assisted in their ability to predict which patients may have an easier or more difficult time forming a therapeutic bond thus allowing for adjustments to be made to their approach that may better suit the patient at hand (Castonguay et al., 2006; Safran, Muran, Samstag & Stevens, 2001). The therapist's theoretical toolkit therefore goes beyond just academic knowledge and can play a role in the experience and nature of the therapeutic relationship with patients.

When thinking about therapist experiences and reflections of the therapeutic relationship with their patients, patient qualities and characteristics that may be helpful/ hindering in forming the therapeutic relationship becomes an important consideration. A study by Castonguay et al (2006) found that positive therapeutic change was linked with the patient's desire and expectation for change, their object relations, and their psychological mindedness, whilst impingements to change was associated with difficulties with relationships, avoidant behaviour, and negative cognitions, according to therapists. Somewhat similarly, Accurso and Garland (2015) noted that gender, diagnosis, and race/ethnicity influenced the therapeutic relationship when examined from child, caregiver and therapist reported experience. Therapists reported that the relationship improved over time with girl children compared to boy children as well as children with anxiety disorders compared with other disorders. Whereas, non-Hispanic White caregivers reported the relationship starting strong and improving less over time compared to caregivers of other races/ethnicity where they reported the relationship starting lower and improving over time. Paivio and Bahr (1998) found that patients who displayed attitudes of self-loathing and self-rejection had more difficulty forming a therapeutic relationship than patients who had positive beliefs about themselves. Another study reported that high levels of perfectionism interfered with patients' ability to have a positive therapy relationship (Zuroff et al, 2000).

In addition to patient qualities (as perceived by the therapist), it is equally as important to examine therapist qualities that may aid or hamper the process of forming a therapeutic relationship. One study, for example, found that therapists who felt hostility towards themselves were counterproductive in the therapeutic endeavour (Henry, Strupp, Butler,

Schacht, & Binder, 1993). Therapists negative self-views may therefore impact their work with patients.

In line with this, material brought to the surface during therapeutic work with the patient may tap into the therapist's own unresolved issues which may result in a problematic dynamic (Rosenberger & Hayes, 2002). For example, Rosenberger and Hayes (2002) found therapists' unresolved personal problems may negatively impact the therapeutic relationship by them not adequately addressing countertransference moments or by reacting on this countertransference in a way that threatens objectivity (Rosenberger & Hayes, 2002). Therefore, these characteristics may play important roles when attempting to engage therapeutically with patients and are important for therapists to be cognisant of during therapeutic processes.

A number of authors (e.g. Norcross, 2000; McWilliams, 2004) have discussed, at length, the importance of psychotherapists' supportive structures and self-care practices. Factors herein include self-awareness and recognising one's personal experience. Commitment to personal therapy as a practising psychotherapist is an important self-care practice that also promotes self-awareness. Previous studies have stressed the importance of therapists' personal insights into their own family relationships, negative beliefs, and interpersonal patterns, as these factors have been found to have a significant impact on patient relationships (Constantino et al., 2010).

A qualitative study exploring alliance ruptures and impasses found that when such instances occur the practice of rigidly keeping to specific techniques may worsen the rupture rather than facilitate repair due perhaps to a neglect of the impact of these moments on the here-and-now therapeutic relationship (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Piper, Azim, Joyce, & McCallum, 1999). Thus, dealing transparently with powerful and sometimes negative reactions on the part of the therapist in therapy is important. For example, a study on patients in long-term therapy demonstrated that these participants revealed more satisfaction with the therapist's self-disclosure when this was done in the context of congruent anger compared to if this was done with a neutral reaction (Dalenberg, 2004). This speaks perhaps to the genuineness of the therapist in the room, and the feeling from the patient that the therapist is open and engaged in the relationship. This reflects the call for therapists to employ metacommunication skills[1] (Safran & Muran, 2000) or to explore the rupture directly and

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[1] Kiesler (1988, p. 29) describes metacommunication as "any instance in which the therapist provides to the client verbal feedback that targets the central, recurrent, and thematic relationship issues occurring between them in their therapy sessions".

openly with the patient, and recognise their own contribution to the alliance rupture (Burns, 1990) in a transparent manner. McLeod (2013) notes that the therapeutic relationship may fluctuate throughout the therapeutic process because of various factors (such as, for example, transference and misinterpretations). However, if these disruptions are adequately attended to, reparations are possible and the positive relationship is sustained (McLeod, 2013). In line with this, Safran and colleagues suggest that the collaborative working through of ruptures in the therapeutic relationship in a non-defensive way leads to positive outcomes (Safran et al., 2001). Similarly, a 'rupture-repair sequence' during the therapeutic process may be linked with better therapy outcomes (Stiles et al., 2004). Thus, therapists should be aware of ruptures within the therapeutic relationship and their meaning and act in an authentic and appropriate manner in response to the rupture which then contributes toward repair within the therapeutic relationship.

The therapeutic relationship in South Africa. In general, psychotherapy research—both qualitative and quantitative—conducted in South Africa is sparse compared to international contexts, with some exceptions (see Aspoas, 2012; Cartwright & Gardner, 2016; Victor & Nel, 2016; Waumsley & Swartz, 2011). One quantitative South African study investigating the clinical practice at the Child Guidance Clinic at the University of Cape Town found that most of the patients ended therapy with positive outcomes despite the traumatic histories of a large proportion of cases seen (Waumsley & Swartz, 2011). This is suggestive of the value and importance of psychotherapy in a South African context. Despite this, there is a lack of qualitative research exploring the experience of the therapeutic relationship from both the perspective of the patient and therapist. There is, however, research examining patients' and therapists' experiences, separately, with more research reporting on therapists' experiences during psychotherapy (Cartwright & Gardner, 2016; Eagle et al., 2007).

South African psychologists may face a number of challenges in their therapeutic work given the divergences related to race, culture and context between therapist and patient (Eagle et al., 2007). Therefore, exploring the therapeutic relationship from the therapist's perspective may elucidate important additional information that may not be available if exploring only the experience of the patient. Furthermore, a qualitative exploration of these experiences of the therapeutic process and relationship within a South African context is important as it may highlight context specific experiences.

For example, one South African study by Cartwright and Gardner (2016) revealed a number of themes from 18 counselling and clinical trainee psychologists in a phenomenological study on their experiences of engaging patients in a therapeutic encounter. These themes included "difficulties with personal material; difficulties with certainty, control,

and idealized intentions; frustrations with the patient's presentation; difficulty in becoming the focus of attention; reactions triggered by perceived exclusion; anxieties about difference; and interpersonal strategies to manage intense emotions" (Cartwright & Gardner, 2016, p.1).

Another study explored experiences of 6 practicing psychodynamic therapists in non-traditional settings (i.e., community settings) within the South African context (Oosthuysen, 2015). One of the findings revealed how theoretical understanding offered a protective, comforting and buffering factor for therapists who were exposed to harrowing recollections of patients' experiences. Therefore, exploring therapist experiences in engaging patients therapeutically may serve to highlight strengths and difficulties, which is a gap this study hopes to address.

Patients' experiences during psychotherapy are equally as important and provide rich insight into how therapists' efforts are received and valued or disliked. For example, a South African study explored caregivers' experiences of a parent-infant project in Alexandra township, Johannesburg—The Baby Mat Project (Aspoas, 2012). Findings revealed that caregivers felt hopeful and not alone in their problems after experiencing the project. However, concerns around disclosing abuse and the actions that may occur as a result caused considerable anxiety. Many caregivers experienced frustration when their perceived expectations were not met. The study highlights the importance of exploring therapy-participants' experiences of therapeutic interventions which could aid in future intervention endeavours. However, this research may only be peripherally relevant given the different dynamic involved during the triad interaction part of parent-infant psychotherapy, compared with the dyadic engagement in individual psychotherapy.

Another qualitative study explored how 15 self-identified lesbian, gay, and bisexual people experienced their individual psychotherapy (Victor & Nel, 2016). Findings revealed positive therapy experiences linked with unconditional positive regard, acceptance, and non-judgement on the part of the therapist and in relation to patients' sexual orientation, whilst negative therapy experiences occurred when patients experienced their therapist as "being disaffirming" regarding their sexual orientation (Victor & Nel, 2016, p.1). This study, however, did not explore in any depth the therapeutic relationship and the experiences thereof of either therapist, or patient, or both.

Langley and Klopper (2005) explored the concept of trust in treating patients with borderline personality disorder, using individual interviews and focus groups of 10 mental health care workers (psychiatrists, nurses, psychologists, and social workers) and 6 patients. This study did not specifically focus on the therapeutic relationship, rather it examined helpful

experiences identified by patients and mental health care workers. Despite the sole focus of the study not relating to the therapeutic relationship, trust was the first theme identified for both patients and mental health care workers in forming and maintaining the therapeutic relationship. Thus, for both patients and therapist trust is a crucial component in forming a therapeutic relationship.

This chapter has outlined the historical trajectory of the therapeutic relationship, providing a brief theoretical discourse surrounding the concept, with a specific focus on psychodynamic approaches. Moreover, outcome and qualitative research has been discussed; including, South African research and therapist and patient perspectives of the therapeutic relationship.

CHAPTER THREE: METHODOLOGY

This chapter provides a description of the research process. First a summary of the purpose of the study is offered with special attention afforded to the research methodology. Thereafter, the research design is explored and then a theoretical discussion will introduce this study's paradigmatic point of departure. Of significance in this chapter are issues of sampling, method of data collection and method of analysis which will be discussed in depth. Thereafter issues of quality and rigor will be discussed. Finally, ethical considerations will be put forward.

Purpose of the Study

The present study sought to understand the experiences of the therapeutic relationship from both the perspective of the patient and therapist in a South African setting. Therefore, a qualitative design using a hermeneutic phenomenological paradigmatic approach was chosen to guide and uncover a near-lived experience, core content and essential features of how both patients and therapists experience the therapeutic relationship and how these may converge and differ. The ontological and epistemological assumptions are presented below which guide the research methodology for this study. Lastly, thematic analysis was employed to uncover meanings and interpretations of participants' experiences.

This study asks the following research question:

What are patients' and therapists' experiences of the therapeutic relationship during psychodynamically-oriented psychotherapy in a South African context?

Research Design

The purpose of this study was to understand patients' and therapists' experiences of the therapeutic relationship during psychodynamic psychotherapy in a South African context. Therefore, an exploratory qualitative research design was chosen, which seeks discovery and offers new insights into phenomena and illuminates unique narratives and authentic experiences of all those participating in the research (McLeod, 2011). Therefore, the patients' and therapists' experiences of the therapeutic relationship will be studied using rich descriptions, interpretations, context and, the meanings thereof (Carlo & Gelo, 2012; Denzin & Lincoln, 2008). As the researcher, I aimed to understand the therapeutic relationship from the participants' perspectives (patient and therapist) where their own words and use of language were used to capture the experiences of the therapeutic relationship (Taylor, Bogdan & DeVault, 2016).

McLeod (2011) states that when thinking about applying a research methodology it is important to consider one's beliefs or assumptions regarding ontology (nature of reality and

being) and epistemology (theory of knowledge) prior to deciding upon methodology, thus clarifying what the researcher understands to be known. Ontology asks the questions: "what is the form and nature of reality?", and "what can be known about that reality?" (McLeod, 2011, p.55). This study encompasses a constructivist–interpretivist approach, whereby there exists multiple, constructed realities (known as the relativist position), rather than a single true reality. Reality, according to the constructivist position, is subjective and influenced by the context of the situation, namely the individual's experience and perceptions, the social environment, and the interaction between the individual and the researcher. Epistemology, on the other hand, refers to the "study of knowledge, the acquisition of knowledge, and the relationship between the knower (research participant) and would-be knower (the researcher)" (Ponterotto, 2005, p.127). Epistemologically, the study is located within constructivism–interpretivism, whereby a transactional and subjectivist stance is advocated and maintains that reality is socially constructed and, therefore, the dynamic interaction between researcher and participant is central to capturing and describing the 'lived experience' of the participant.

Additionally, research has emphasised the use of qualitative methodologies when aiming to understand patient experiences (Levitt, Butler, & Hill, 2006) and, more specifically, phenomenological studies (Oliveira et al., 2012). Qualitative methods are best suited when the phenomenon is not clearly understood (Hsieh & Shannon, 2005). Although research investigating the therapeutic relationship may be vast in developed contexts, the understandings and meanings of this phenomenon in a South African context is extremely limited. Therefore, the exploratory qualitative design is a valuable and fitting approach for this study that offers rich detail of participants' lived experiences.

Paradigmatic Point of Departure

To explore patients' and their therapists' experiences of the therapeutic relationship during psychodynamic psychotherapy, a hermeneutic phenomenological paradigm was used (Finlay, 2003; Heidegger, 1962; Laverty, 2003) . Hermeneutic phenomenology stems from the philosophy of hermeneutics, which has interpretation and understanding at its core (Annells, 1996). Martin Heidegger contributed to the understanding of hermeneutic phenomenology departing somewhat from the descriptive phenomenological approach originally developed by Edmund Husserl (1980). Essentially, hermeneutic phenomenology examines human lived experience—much like Husserl's approach—but highlights the importance and role of the social, historical and cultural backgrounds of individuals and the inability to separate this from experience (Laverty, 2003). In essence, hermeneutics strives towards interpretation and

understanding, while phenomenology examines human experience and being-in-the-world (Annells, 1996). For example, hermeneutics involves perspective and, as such, one's "pre-understandings or prejudices" are always tied to interpretation (McLeod, 2011, p.4). Phenomenology on the other hand attempts to develop a detailed and in-depth account of the phenomena under question, separating the assumptions, pre-understandings or prejudices underpinning the phenomenon (McLeod, 2011). The process involves a thoughtful, reflective stance and immersion in the phenomenon until the meaning and truth becomes known. Thus, Martin Heidegger fused phenomenology and hermeneutics, aware of their limitations as standalone approaches and drawing on each of their strengths to create something new and in essence "move easily back and forth between interpretation and description as necessary" (McLeod, 2011, p.62).

Furthermore, this type of phenomenology stems from the interpretivist paradigm (Dowling, 2007) which proposes that one's lived experience cannot be sought without interpretation (Kafle, 2013). Heidegger was against the concept of 'bracketing' and argued that by acknowledging assumptions, research allows these perspectives to become explicit. Reflexivity on behalf of the researcher is essential and continuous throughout the research process (Laverty, 2003; Sloan & Bowe, 2014). Therefore, in order to capture a close account of both patients' and therapists' experiences of the therapeutic relationship a hermeneutic phenomenological approach allows us to understand their experience and take into account social, historical and cultural backgrounds as well as the researcher's own assumptions and how it intersects.

Participants

Three patient-therapist dyads (6 participants in total) were recruited to take part in this study (see Table 1 below) using non-probability, purposive sampling. A purposeful sample, also known as a judgment sample, is a common technique in qualitative studies and is observed as a more "intellectual strategy" (Marshall, 1996, p.523). Thus, participants with specific characteristics—outlined below in the inclusion criteria—could be identified that would allow for the research question to be answered. This allowed me, as the researcher, to directly source therapists via the supervisor's professional network. In addition, snowball sampling was used to supplement the purposive sampling to identify other participants via the therapists who had already agreed to participate in the study. Therefore, clinical and counselling psychologists in private practice were approached alongside their respective patients who attended psychotherapy.

The following inclusion criteria applied:

1. Patients have attended psychotherapy for a minimum of 6 months.
2. Patients are currently engaged in psychotherapy.
3. Patients are over the age of 18 years.
4. Therapists were requested to identify patients who are not acutely psychologically vulnerable or unstable, and/or who do not present as actively psychotic at the time of the study.
5. Therapists were clinical/counselling psychologists in private practice who have been registered with the Health Professions Council of South Africa as "Independent Practice" for at least 3 years.

While patients' diagnoses/presenting problem, number of sessions or type of therapy received have been identified in the literature as factors that do not influence the therapeutic relationship in a significant manner, these were recorded in order to provide context (Horvath et al., 2011; Naidu & Behari, 2010; Safran & Wallner, 1991; Wampold, 2001).

Table 1. Summary of Participant Relevant Information

Dyad	Pseudonym	Gender, Race, Home Language		Position	Additional
1	Tessa	Female, Afrikaans	White,	Patient	8-year therapy process, Major Depressive Disorder & Borderline Personality Disorder
	Therapist 1	Female, Afrikaans	White,	Clinical Psychologist	16 years private practice, Psychodynamic Therapy
2	Kathy	Female, Afrikaans	White,	Patient	8-year therapy process, Major Depressive Disorder & Borderline Personality Disorder
	Therapist 2	Female, Afrikaans	White,	Counselling Psychologist	16 years private practice, Psychodynamic Therapy
3	Lisa	Female, Afrikaans	White,	Patient	10-year therapy process, Borderline Personality Disorder

Therapist 3	Female, Afrikaans	White,	Clinical Psychologist	15 years private practice, Psychodynamic Therapy

After ethics approval had been granted the researcher invited private practice therapists to be part of the research through telephonic communication. Initial contact with potential private practice therapists was carried out through the efforts of the study's supervisor. As a clinical psychologist, the supervisor of the study is part of a professional network consisting of other HPCSA-registered psychologists in private practice in the Pretoria and Johannesburg regions. Initial contact was made with potential therapist-participants through this network via the supervisor by way of an advertisement circulated by email which contained a brief description of the study and the researcher's contact details. Any interested parties were requested to make direct contact with the researcher. The supervisor was therefore not aware of the identities of those who responded to the request. Thereafter the researcher made further contact with the parties who had indicated their interest in participating. Following their agreement to participate, therapists were asked to identify a patient whom they thought may be interested in the study and who met the inclusion criteria. The therapist first established the patient's interest in the study and gained their consent to disclose their contact details. Thereafter, the researcher made contact telephonically with respective patients and gauged their willingness to participate and provided a brief introduction to the study and what participation entailed.

Data Collection

Mode of data collection. In-depth semi-structured interviews were employed as the method of data collection for this study. This type of interview creates a basis for engaging with participants to gauge a deeper and clear depiction of their lived experience. According to Smith and Osborn (2008) semi-structured interviews provide a flexible approach, whereby the interview structure may be adapted according to participants' responses. Similarly, Galletta (2013) argues that this type of interview has a certain framework designed using theory that allows for the research question to be specifically addressed, whilst providing an opportunity to gain new insights. Therefore, important topics that potentially surface may be further investigated and the participant is able to give their narrative in a more open manner.

The interviews for this study were informed by an interview schedule with themes and topics gleaned from the literature and clinical experience (see Appendix C & F for provisional schedules for patient and therapist). The interview allowed for sufficient flexibility for the

participant, allowing them to guide the process and to provide an experience-near indication of the therapeutic relationship being studied. A broad initial question ("Can you tell me about your experience of therapy?") was asked to stimulate the participants' narratives. Thereafter, specific experiences of the therapeutic relationship and how they experienced the 'other' was explored through prompts and probes as guided by the interview schedule. The interviews ranged from 60-90 minutes in duration and were audio-recorded with consent from the participants using a digital voice recorder. This method is useful when using a hermeneutic phenomenological perspective because by asking open questions and allowing the participant to mostly guide the process a close depiction of the participants' lived experience is elicited (Laverty, 2003).

Data collection procedures. Once patients agreed to take part, arrangements for a time, date and venue convenient for the patient was agreed upon for the interview to take place. Written and verbal informed consent procedures took place prior to the interview (see Appendix A and B). Patients' respective therapists were contacted informing them of their patient's acceptance and participation in the study and thereby arranging a convenient time to meet and interview therapists, separately. Written and verbal informed consent (see Appendix D and E) procedures took place prior to the interview and included consent for the interview to be recorded. Once the interviews had been conducted, interviews were transcribed verbatim by the researcher who subsequently conducted the analysis as described in detail below.

Data Analysis

Using thematic analysis—according to the guidelines outlined by Braun and Clarke (2006)—the aim was to identify, through their lived experiences, the meaning and reality that the therapeutic relationship had for the patient-participants and therapist-participants. Both patient-participant accounts and therapist-participant accounts were analysed and the findings have been captured in Chapter 4, illuminating major themes and their respective sub-themes. Thereafter, the discussion section (Chapter 5) brings together, comparatively, both patient-participants' and therapist-participants' lived experiences and meanings held in relation to the therapeutic relationship.

Braun and Clarke (2006) describe thematic analysis as a "flexible and useful research tool, which can potentially provide a rich and detailed, yet complex, account of data" (p. 78). The following steps were involved:

1. Becoming familiar with the data: As the researcher I transcribed the data verbatim and became 'immersed' in the data by re-reading and re-listening to the data.

2. Identifying codes within the data: I began to identify and highlight important phrases that captured the research objective

3. Searching for themes from the codes identified: Important phrases were grouped under common themes

4. Refining these themes: By re-examining the themes, changes/ sub-themes emerged that best described/ fit the data

5. Providing names for the themes: Simple names that described the 'essence' were given

6. Extracting quotes from data that described the essence of each theme was carried out

The above-mentioned guidelines do not need to be performed directly in this order but may fluctuate back and forth, iteratively (Braun & Clarke, 2006). Furthermore, this approach provides a standard framework not linked with a specific theoretical perspective and has been used in similar research (Audet & Everall, 2010). While thematic analysis allows for rich description of the data, Alhojailan (2012) states that this analytic approach can move beyond description to encompass, additionally, interpretation of data. Therefore, this study moved beyond the descriptive use of thematic analysis and incorporated interpretations in the data analytic strategy. Thus, while thematic analysis was used as the specific strategy to guide and scaffold the analysis, interpretation was used to reinforce and deepen the analysis and occurred throughout the analytic process. Lastly, this approach to thematic analysis is inductive in nature, meaning the data began with specific content and moved towards broader 'patterns' through increasing levels of abstraction of the data. Such an approach to thematic analysis aligns well with the hermeneutic phenomenological positioning. For example, Braun and Clarke (2006) argue that this process is at the semantic level and extends from simply describing the data, by arranging similar content, summarising, interpreting, and finding meaning in the patterns.

Trustworthiness of the data.

Koch (1996) explores issues of trustworthiness and rigour from a hermeneutic phenomenological perspective and suggests that each researcher determines the criteria for trustworthiness and rigour that are most applicable to their research. For this study, the trustworthiness of the data was ensured by the rigorous reporting of the research and its findings, including theoretical, philosophical, and methodological issues (Koch, 1996). Another concept is transferability which describes the "degree of similarity between the two contexts" (Koch, 1996, p.179). Therefore, enough contextual information was included so that other readers are able to make decisions about how the findings of the present study may

transfer over to their own contexts. However, qualitative interpretative research is more interested in interviewing a small number of participants and the theory that governs data analysis suggests that multiple meanings of a phenomenon can be gathered in the minds of people who experience it as well as multiple interpretations. The aim, therefore, is not to come to a single truth nor is it deemed necessary for a different researcher to come to the same themes/conclusions—the aim is therefore not for replication, but for engagement with the applicability and relevance of the findings. Rigor is judged based on 'thick description' that captures the themes and participants responses and allows for transparency of the researcher's interpretation (Ponterotto, 2005).

As the researcher, I also made use of a reflective journal in order to note observations, contextual issues and my personal responses. The reflections were consulted during the analysis process to facilitate interpretations and understandings. Multiple sources of data were used in the study, for example, journal entries, conversations, observations and interviews. Therefore, a rich account of participants' experiences, including contextual and situational issues and the participants' backgrounds and histories, as well as my own background and history is provided (Koch, 1996). Overall, dependability was enhanced by providing quotations and using tables to structure the data to highlight similarities and differences (Alhojailan, 2012). An extract of the study findings have been structured in a table format and can be found in Appendix G. Additionally, the study's supervisor assisted the process of data analysis by reviewing the data, and examining themes in the beginning and near the end process of data analysis, which contributed to the overall dependability of the study (Alhojailan, 2012). This enabled a second opinion regarding the transferability of the research rather than the specific themes that were reached.

Ethical Considerations

Ethics clearance was granted by the Faculty of Humanities Research Ethics Committee at the University of Pretoria on the 22/05/2017 (REF: GW20170107HS). The UP Code of Ethics for Research Involving Human Participants provided a guideline for this research study (Humanities Research Ethics Guidebook[2]).

Participants were required to give both written and verbal consent for their participation. Participants' permission for the interview to be recorded was also obtained (Wassenaar, 2006). Part of the consent process ensured that participants understood that participation was voluntary and they may decide not to participate or may withdraw from the

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[2] http://www.humanities.uct.ac.za/sites/default/files/image_tool/images/2/HumEthicsGuide.UL-28.08.13%5B1%5D.pdf

study at any stage without consequence (Creswell, 2013; Halai, 2006; Wassenaar 2006). For patient-participants it was explicitly communicated that by the researcher talking to their therapist the focus was not on the content of their therapy, but simply how they experienced one another and how they experienced the therapeutic *process*— not on what was discussed in therapy. It was emphasised that the therapist would not be required to disclose to the researcher anything that the patient spoke to them about in therapy without first discussing this with them and obtaining their consent to do so. Confidentiality between the therapist and patient was therefore held in place and helped to put the patient at ease (Halai, 2006). Patient-participants were, however, open to voluntarily disclosing therapeutic moments of their own volition if they felt this was necessary to convey or illustrate a particular point during interviews. Participants were informed that the researcher would be the only person aware of the identities of the participants. Although anonymity was not possible owing to the qualitative nature of the research and contact with the researcher, confidentiality was guaranteed. Pseudonyms were used during the write-up of the report, and in any subsequent scholarly publications or presentations to protect the identities of the participants (Halai, 2006). Furthermore, identifying particulars, like race, gender, and age were carefully dealt with in the report to further protect confidentiality of both the patient and therapist. Participants were also informed that the data produced by the interviews may be used for the purposes of future research. Due to the sharing of names and personal identifying details during the interviews, audio recordings have been retained only by the researcher in a secure electronic format to which only the researcher has access. Disguised and anonymised verbatim interview transcripts have, however, been stored electronically on a USB disc and kept securely in the Department of Psychology at the University of Pretoria and will be archived for a period of 15 years. Moreover, as a student clinical psychologist, I adhered to the Health Professions Council of South Africa code of professional conduct for psychologists throughout the research process. Lastly, while potential harm to participants was unlikely, counselling and support services were made available for the participants although none of the participants made use of the services.

CHAPTER FOUR: FINDINGS

This chapter presents the findings of the present study. Thematic analysis was used to highlight the essential themes derived from the interview data collected with the aim of gaining a rich account of patients' and therapists' experiences of the therapeutic relationship. As mentioned in *Chapter 3*, this study incorporated interpretations in the data analytic strategy to reinforce and deepen the analysis. Patient-participant accounts and therapist-participant accounts were analysed separately in this chapter, whilst *Chapter 5* draws on the similarities and differences between patient-participant and therapist-participant accounts. Table 2 below outlines the themes and sub-themes accordingly.

Table 2. Summary of Patient-Participant and Therapist-Participant Main Themes and Sub-themes.

Main Themes	Patient Participants	Therapist Participants
Theme 1	**The Therapist's Therapeutic Approach** • Holding the patient in mind- knowing them • Non-judgmental • Providing an objective experience- perspective • Consistent presence	**Patient Qualities**
Theme 2	**Factors Facilitating Therapy** • Mutuality • Therapist self-disclosure	**Factors Facilitating Therapy** • Holding & consistency • Theoretical understanding • Understanding patient dynamic • Technique • Supportive factors for therapists
Theme 3	**Process within the Therapeutic Relationship** • Describing the relationship: Lifeline • Moment of meeting • Change • Time	**Process in the Therapeutic Relationship** • Describing the relationship: Intimate[3] yet formal • Moment of meeting • Change • Time

Three major themes were found to capture the essence of the patient-participant data, namely, the therapists' therapeutic approach, factors facilitating therapy, and process within the therapeutic relationship. The three major themes also comprise of various subthemes.

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[3] The use of the word intimate is used to describe a close connection/ relationship with another and does not imply any sexual references.

Similarly, three themes (including subthemes) comprised the therapist-participant data, namely, patient qualities, factors facilitating therapy, and process within the therapeutic relationship. The themes and sub-themes presented in this chapter assist in detangling the complex nature of the therapeutic relationship. However, many of the themes and sub-themes do not have sharp borders and often merge and overlap with other therapeutic factors.

Patient-Participant Themes

Three major themes were identified for the patient-participants' data, each with their own sub-themes. The first theme describes the therapist's approach within the therapeutic relationship. Theme 2 involved factors facilitating therapy according to the patient. The last main theme for patient-participants highlights the process within the therapeutic relationship.

Theme 1: The therapists' therapeutic approach. The therapists approach during therapy is one of the major themes which captures the essence and experience of the patient-participants in the study. The following sub-themes were found within this theme: holding the patient in mind—knowing them; a non-judgmental stance; providing an objective experience—perspective; and a consistent presence on part of the therapist.

Sub-theme 1: Holding the patient in mind—knowing them. For many of the patient-participants, part of the experience of the therapeutic relationship was related to the associated experience of being held in mind by their therapists. Both Lisa and Tessa explained how their therapist knows them very well.

> *I used to have a ball and then I would throw the ball against the wall and I don't want to talk to her and then she knows if I walk in with a ball, then I don't want to talk to her. She knows. She knows, and I ask her "how can she knows me so well?", she never lived with me, she just sees me once a week for 45 minutes (Lisa)*

For Lisa, she is surprised by how well Therapist 1 knows her when she only sees her once a week and reiterates this by repeating how her therapist "knows". There is also a sense of intimacy described in her words ("she doesn't live with me") yet her therapist is able to hold Lisa in mind and have a deep understanding of her. From Lisa's descriptions there is a sense that Therapist 3 can read her mind. This experience seems different compared with her other relationships. Tessa experiences the feeling of being held in a similar way by her therapist and she describes appreciation for her therapist's ability to keep her in mind and understand her. She also describes how she is not able to get away with what she ordinarily could get away with because of this understanding on behalf of her therapist.

Um, I, she knows everything about me. I know nothing about her because she's got the boundary thing going on. And, um, it's actually nice to have somebody that knows you that well, because I can't sit here and bullshit my way out of anything because she knows me and she knows why I do stuff and why I don't do stuff and why I say stuff. So, um, I, I just, ya, I just think it's great (Tessa)

Tessa's words "she knows why I do stuff…" is noteworthy and seems to capture the therapist's knowledge and understanding of Tessa in a meaningful way. The therapeutic context and relationship offers something different compared to other contexts and relationships. Therapist 1 seems to understand and know Tessa deeply and therefore understands the reasons behind her behaviour and experience, which leaves Tessa feeling "caught out" and unable to get away with things—she feels known. It must also be highlighted that Tessa seems to hold some uncertainty around the disparity between them (therapist and patient) knowing each other. There seems to be a disproportionate experience of her therapist knowing her so intimately, yet Tessa does not know her therapist in the same capacity and perhaps she holds anxieties and feelings of vulnerability in relation to this distinction. However, Tessa's description of knowing appears to capture something different. Her anxiety seems centred around a wish for more self-disclosed information on the part of her therapist which is discussed in a later theme, rather than a more implicit way of knowing her therapist. For example, Lisa's description of her therapist understanding and knowing her is illustrated in her description of entering therapy with a ball. In this example, there appears to be an implicit relational quality of knowing another person, rather than information disclosed although both illustrate an element of knowing the other in the context of the therapeutic relationship.

Sub-theme 2: Non-judgmental stance. Patient-participants emphasised the importance of a non-judgmental stance on the part of the therapist and described this as facilitating the therapeutic relationship. Kathy described Therapist 2's non-judgmental stance and explained how there was an understanding and knowing between the two of them.

So, when I was looking. When I was sitting in front of her, I just knew she didn't judge me. She understood that there's a- you come from a certain place – when, when ooooo when, when stuff happens to you and a certain way, you react in life, it's because of stuff that happens to you and reasons that happen to you – its (mumble) better (Kathy)

The therapist knows and understands Kathy and Kathy implicitly feels her therapist's feelings towards her. This is linked with the previous sub-theme, whereby the patient also holds an implicit knowing within the therapeutic relationship regarding the acceptance felt on behalf of the therapist. Acceptance seems to facilitate a knowing within the relationship and vice

versa. In Kathy's experience there is a sense of acceptance and understanding on the part of the therapist. The therapist can empathise with the patient's experience taking into consideration their roots and therefore offers a whole-hearted and implicitly felt form of acceptance. Lisa also highlights the concept of a non-judgmental and accepting approach adopted by her therapist (Therapist 3).

> *Ya, I think overall the best thing for me was. It's like if I wanted to hit, throw my ball against the wall, and talk to her I was allowed to do it. If I want to go sit in the corner- I was allowed to do it. Um, some people think there is the psychologist chair and there is the psychologist chair. So, you don't cross that boundary…Because, isn't it that when you there that you have to be you and if you want to cry- you have to cry, you're not going to be afraid you gonna cry and your psychologist is going to 'ah no you're a cry baby and all that nonsense' (Lisa)*

In Lisa's description, she relays a human experience of being completely accepted for who she is. Her words go against a more traditional therapeutic understanding of 'what should be allowed in the process'. Lisa enters fully into the relationship, by simply being, and feels reassured by the safe presence of her therapist, who demonstrates acceptance and understanding without judgment. However, in Lisa's other comments and accounts of her experience within the therapeutic relationship she relays her fears of potentially being judged or not accepted, speaking about her struggle in adapting to Therapist 3's approach which required immense focus on herself.

> *I don't talk- I am not a talker…OK I don't think I really want people to know me- because it's me. People are not, mos, supposed to know me (Lisa)*

This speaks to the deep shame that patients may feel about revealing their inner most thoughts, experiences, memories and desires and the fear that these will not be tolerated or accepted by others. This also links with the above sub-theme (holding in mind—knowing them) and illustrates how being known by the therapist may also be an uncomfortable position. However, Lisa also describes how she feels her perception of psychologists has changed over the years.

> *So, with Therapist 3 a lot of things changed and I think my feeling about psychologists also changed. Actually, now, I can watch movies about psychologists without feeling – they gonna attack me now (Lisa)*

There is something important revealed in Lisa's experience and fear of being judged or not accepted. It appears to be ingrained in her being and perhaps takes much longer to feel safe enough to open up within the therapeutic relationship, despite the presence of an accepting

therapist. Lisa's use of the word "attack" illustrates how assaulted she can feel when her sense of self and being are rejected, condemned or judged. However, through the therapeutic relationship—by being accepted and known—Lisa's sense and fear of judgment has lessened considerably. It appears that, over time, Lisa has been able to become more comfortable with the experience of being known by her therapist.

Sub-theme 3: Providing an objective experience—perspective. Most patient-participants described how their therapist provided an objective presence in terms of gaining perspective. Below Tessa describes her experience of how Therapist 1 provides her with a different perspective compared with her own self-deprecating stance, which provided Tessa with a sense of normality. She relates how her therapist offers her an opportunity to stand back and how her therapist introduces an objective reality that counters her internal world that is perhaps more critical and harsh.

> *Um, ya so I really uh, I think it's very good to get an, an objective opinion. I think it's quite, uh, quite nice, ya… She actually had a reason for doing or telling me whatever-so – ya, and just to have someone else's opinion. Because I tend to blame myself for everything…I take it personally, like it's me and I'm not good enough- so if I hear her side… from someone normal, ya- sometimes I just need a reality check (Tessa)*

Kathy similarly described how Therapist 2 allowed for another mind to help her talk and therefore gain perspective and not over react.

> *Mostly by talking, mostly about talking about things and, um, not, help me to not over react on everything that happens to me. That was one of the biggest things… (Kathy)*

There is a sense for these patient-participants that having another mind helps them to think and bring perspective, instead of thinking on their own and relying only on their—potentially distorted—internal dynamics and understanding. The therapeutic relationship therefore offers a supportive presence that can think with the patient in their most difficult and terrifying experiences and allow these thoughts and experiences to become thinkable, tolerable, and manageable.

Sub-theme 4: Consistent presence. Therapists' consistent presence was found to be an important sub-theme within the therapist's therapeutic approach for patient-participants. They experienced their therapists as 'being with' them during the sessions. Kathy relays her experience of being devastated and crying and Therapist 2 being fully present and with her in that moment of need. Not only does this demonstrate to Kathy that her therapist cares, but it shows her that her needs are important and should be acknowledged and recognised.

Ya, you know what also makes Therapist 2 also great at her job- you know when you sitting there and you crying your heart out and you are devastated for whatever reason- she doesn't go (mimics typing on her cell phone) ...She is really with you, really with you... (Kathy)

Lisa talks about the consistent presence of Therapist 3, in terms of her therapist never ending the therapeutic relationship despite Lisa acknowledging how difficult she could be at times and how her therapist survived her testing behaviour.

If I told Therapist 3 I didn't want to see her anymore, she was still there the next day and I tested her. In every possible way, I tested her and she was there. And she would never leave and she never left (Lisa)

Lisa further illustrates how Therapist 3 stayed with her, in a somewhat denigrating manner by describing her therapist as a fungus.

Mmmm, Therapist 3 is like a fungus (laugh). Grows on you, more and more, you are trying to wash it off and beat it off—but nothing, it's just growing and growing (Laugh) (Lisa)

Although this may seem to come across as quite a negative statement, taken with the understanding of Lisa's own dynamic, it can be viewed positively. For example, Lisa's dynamic seems to include severe acting-out behaviours in an attempt to push the other person away and thereby manifest/acknowledge her own sense of unworthiness in the relationship. However, no matter how hard Lisa tried to "beat" off the relationship and push Therapist 3 away, her therapist remained consistently present and thereby changed Lisa's previously held notion that people will always leave and perhaps her feelings of unworthiness in the context of relational experiences. Moreover, the analogy Lisa uses to describe the therapeutic relationship and the powerful imagery that comes with this, also speaks to the complexity and, at times, ambivalence of the therapist as being needed, but the process not being particularly pleasant or comfortable.

Theme 2: Factors facilitating therapy. Factors facilitating therapy is another main theme found to enhance the experience of the therapeutic relationship for patient-participants in the study. The following sub-themes were found within this theme: mutuality, and therapist self-disclosure. It is acknowledged that Theme 1 could also be regarded as a factor facilitating therapy and is not necessarily a mutually exclusive phenomenon. However, given the nature of the data it was felt that what is described in this theme was substantive and warranted a main theme on its own—describing the atmosphere the therapist provides within the therapeutic setting.

Sub-theme 1: Mutuality. Patient-participants spoke of mutuality within the therapeutic relationship and the importance thereof. Kathy describes this in terms of mutual collaboration in relationship with her therapist. Kathy highlighted how she and Therapist 2 had worked together in order to bring about change for Kathy.

> *…She would come back and she would give me feedback and she would say, "At this conference I have learnt this and I think we should implement this"…And I would also go. I didn't just make it her problem … Like she must do all the work… I will Google it and go on You Tube and watch videos…I will also say, "Therapist 2 what do you think about that?" and she would say, "Yes, let's try it" … But you can have the best therapist in the world and if the patient is not willing to work on it and you and, and, it's like a business, you have to be teachable (Kathy)*

Kathy has describes an openness on both the part of the therapist and the patient in their collaborative work during therapy and within the relationship. The pair has ostensibly come to an understanding that the relationship consists of both parties and therefore the two of them work together. Kathy also strongly identifies with the patient's responsibility within the therapeutic relationship and how the patient should be willing and open to work or "be teachable", as she says. However, it is also important to understand Kathy's dynamic, whereby she openly discussed with me during the interview that she considers herself to be "into personal development". Kathy is someone who appreciates learning and growth and seems to like teaching others. This became evident in our interview, as Kathy suggested and emailed me two books that would help me in my work. She also said once I have read the books, "you'll tell me, Kathy, this is good advice you gave me". Thus, she seems to value receiving help and learning, but she also values teaching others and giving. For instance, she said, "For me it's all about serving people- that's just my personality—neh."

Other patient-participants emphasised mutuality within the therapeutic relationship in terms of honesty between patient and therapist, which was described as a two-way process. Firstly, they registered their own need to be honest with their therapist so they can receive the correct and necessary help. Secondly, they explained how their therapist's honesty with them in the relationship is incredibly valuable.

> *…I tell her - I tell her I don't… hide or lie or whatever, because that's like uh that's the worst thing you can do with a psychologist. I always say it's like faking an orgasm- you are the one losing out…(Tessa)*

In the above extract Tessa describes how important it is for her to be honest with her therapist. In Tessa's experience, a lack of honesty brings about a sense of "losing out", and it

is clear from her description that she perceives dishonesty to create a disparity between therapist and patient. Moreover, there is something shared and intimate in Tessa's metaphor of "faking an orgasm", where an orgasm—in addition to representing pleasure—captures the sharing of something vulnerable and private and symbolises a closeness between two people. Thus, by essentially 'faking' within the therapeutic setting means losing out on this intimate, shared, close and private experience with another person. Tessa's analogy of an orgasm also highlights a relational experience between two people and captures the relational nature and experience of the psychotherapy.

Kathy describes a similar process in her experience of being honest with therapist 2 and how this enables her therapist to really help, protect and ultimately facilitate change.

> *…I have always been a hundred percent honest with her. You cannot—I do not believe that when you have an attorney—they cannot protect you if they do not know all the facts. And it's the same thing, they cannot treat you properly if they do not know all the facts. You cannot hide some stuff and, um, and think they going to be able to help you properly. You need to be honest with them (Kathy)*

Kathy's use of metaphor linking her therapist to an attorney is significant. An attorney ultimately defends and fights for their clients. They also know their client's deepest secrets that are not shared with just anyone. Therefore, much like Tessa, Kathy highlights an intimate knowing between two people within the therapeutic relationship. This implicit relational knowing within the relationship fosters a sense of protection and safety for the patient. Thus, although this implicit relational knowing can feel quite close and uncomfortable there is also something about it that fosters feeling safe, protected and held within the therapeutic relationship.

Kathy also describes her appreciation of her therapist's honesty in the way she points out the destructive relationships in Kathy's life. The therapeutic relationship seems to allow honesty to be shared in a safe enough space for Kathy.

> *…Therapist 2 is very straight forward; she calls a spade a spade and I, if, if ,if you have a lousy relationship with your husband she will pretty much tell you, "Kathy you are in a lousy relationship with your husband", and, but, I don't think all people will be open to that- you need to learn to read people a bit (Kathy)*

Kathy appears to feel protected and held in her experience of the therapeutic relationship, which does not only facilitate her openness to being honest, but also facilitates her capacity to accept the therapist's honesty even though it may not be comfortable—she can rely on the relationship to carry her through the discomfort of the therapist's honesty.

She describes how in order for this honesty to be possible there is a sense of knowing each other in the relationship. Her comment on "you need to learn to read people" is significant and again illustrates a need for the therapist's capacity to know their patients in an implicitly relational way. Lastly, Lisa explains the complexity of honesty within the therapeutic relationship. Although she describes trusting Therapist 3 absolutely, Lisa still finds it difficult to be fully honest and has kept things from Therapist 3.

> *I can promise you, I trust Therapist 3, 100- 200%. But up to today, there are still things Therapist 3 doesn't know. I mean I trust her with my life. There is still stuff that's blocked. And I know she's going to say, "so…after all these years you still don't trust me, when are you going to trust me? I thought you over that by now?" (Lisa)*

Thus, although there was a theme around mutual honesty, for Lisa her experience around honesty is more difficult for her, which may speak to her own history and internal and interpersonal dynamics. In her description there is a strong sense of shame in that there are certain things in her life she simply cannot share with Therapist 3. This also seems to link with sub-theme 1 (holding the patient in mind—knowing them) and sub-theme 2, non-judgmental stance, under therapists' therapeutic approach (theme 1). Lisa perhaps fears fully revealing her inner most feelings and experiences and being known to Therapist 3 who may, in Lisa's eyes, judge or not understand such experiences. Lisa's words—"there is still stuff that's blocked"— speaks to a potential for these experiences to be unconscious and implicit within her memory, rather than consciously brought to the fore. Perhaps she is also describing something in the relationship that is blocked because of her difficulty with fully disclosing. Lisa also highlights for us the complexity of the therapeutic relationship, which encompasses a multitude of experiences and aspects that intersect and interact in complex ways and cannot be reduced down to its requisite parts. There is no doubt that Lisa's 10-year therapeutic relationship has provided many functions for her, specifically safety and trust which took a long time to develop. However, there still seems something blocked for Lisa driven by her sense of shame. Part of her experience—a very private part—is not sharable with her therapist or others and may never be sharable or fully accessible to Lisa.

Sub-theme 2: Therapist self-disclosure. All patient-participants highlighted the importance of therapist self-disclosure within the therapeutic relationship. This is somewhat linked to the above mentioned sub-theme (mutuality, and being honest). Therapist self-disclosure facilitates the therapist being experienced by the patient as open and honest. Tessa explains how, during the beginning stage of therapy, she found it difficult to be fully open and honest without first receiving some information pertaining to Therapist 1.

Sometimes, it, it initially when I started, um, seeing her I was like, "tell me something about yourself. It's just that I am sitting here telling you the worst things that goes on in my head or things I have done and you're sitting here like this perfect angel. So, I need some dirt on you" … So, ya, uh it, so, in all the years we have seen each other, I have, I have, um, how do you say, I have gotten some information off her. And I really appreciate it… I would appreciate. A little bit more information, not everything but here and there. Ya, snippets of information per session (Tessa)

Tessa describes her need for therapist self-disclosure as a means of negating the vulnerable feeling of being the only person in the relationship disclosing information. She further describes how, over the years, she has gained some facts about her therapist which gives Therapist 1 a more human quality and perhaps levels the power dynamic at play regarding disclosure of information. The human quality Tessa appreciates in experiencing Therapist 1 is further described below.

…She is such a, such a good person and then just randomly I I wou-would like swear or something and say "sorry, sorry, I didn't mean to" and then she would be like, "but when I am with my friends I swear" and I'm like but we're both human (Tessa)

It is important to note that in Tessa's description and experience it seems that she requires more than some information "per session", possibly emphasising her struggle in not knowing her therapist on a personal level. On the one hand there may be a power dynamic at play, but on the other she may have a strong desire to be closer with her therapist. Kathy describes this in the following way:

Because I am a people person, ya, I need to be relatable to her. Ya, she can't sit there like a statue and I don't know anything about her…I want to know that she also has a life, and she also has issues and she also has her own psychologist and I know these things…I know these kinds of things, maybe it's different. I don't know how she does it with all her patients. I think you should choose, as well, who you say things- personal things to… and I will ask her sometimes. But I also respect the boundaries. I also respect the boundaries that I cannot ask all the questions that I would like to ask (Kathy)

Kathy further describes a cautious note regarding self-disclosure and the importance of the boundary and self-disclosure having limits. Although Kathy has the inclination to ask personal information from her therapist she is also able to respect the boundary which largely reflects on the therapeutic relationship between them and Kathy's respect for Therapist 2. Kathy holds value within their therapeutic relationship, enough to acknowledge her desire for information but not to over-step the boundaries. It is apparent that the practice of normalising

the patients' perceptions of their therapist is beneficial. By sharing normal, everyday, human information, therapists appear more human, relatable, less idealised, and therefore realistic. This allows for the therapist to be perceived on the same level as the patient and therefore form a basis of connection. The power differential is reduced and the therapist appears more relatable and therefore the therapeutic relationship can develop more easily. However, there is a cautious note and an awareness of boundaries introduced by Kathy regarding therapist self-disclosure and its appropriate use.

Theme 3: Process within the therapeutic relationship. Process within the therapeutic relationship is the last major theme found to capture the essence of experience for the patient-participants in the study. The following four sub-themes were found within this theme: patients describing the relationship as a lifeline; moment of meeting within the process; change; and the relationship over time

Sub-theme 1: Describing the relationship as a lifeline. Patient-participants described their therapeutic process and the relationship as being a lifeline. On the one hand patients described how their therapist caught them and, in some sense, saved their lives. Alternatively, they talk about how their therapist's consistent presence and promise to be there provides safety for them to continue with the therapeutic process and at times with life itself. Kathy describes how her therapist was the one to catch her and realise she was "not okay" and that she needed help.

> Kathy: *I took my daughter to her because I was worried about my daughter and my daughter was sitting in the waiting room, and she gave one look at me and said "No"… She saw that I was at breaking point, she saw that something was seriously wrong and, um, I was so sick that I didn't even know that I was sick. I was so hanging by a thread that I was just focusing on that moment not to die… She caught me.*
>
> Alex: *What does it mean to you that she caught you?*
>
> Kathy: *Now you want to make me cry.*

Therapist 2, in Kathy's experience, caught her and saw her need for help when Kathy herself could not. She pulled her back and offered a space for help and, most importantly, she identified in Kathy her real need for this help. Thus, in Kathy's description of the therapeutic relationship as a lifeline she describes how her therapist saw her pain and provided a safe space for healing. In asking Kathy what it meant for her when her therapist caught her she becomes emotional and words falter in her attempt to describe what this meant. However, the emotive

valence of the moment was evident as I observed, experientially, the appreciation, affection, and warmth Kathy feels towards Therapist 2 which appears to stem from being provided with a sense of security and assurance that someone will be with her through what Lisa refers to as her "most darkest moments":

>*…Therapist 3 was there for me, I mean in my most darkest moments in my life… (Lisa)*

This links with the sub-theme 4 for theme 1 (consistent presence), whereby the therapist journeys with the patient in their "most darkest" moments and does not flee, but stays present within the relationship. Tessa describes the terrible and desperate feeling of being late for one of her sessions owing to a work circumstance and only having 15 minutes left of her session by saying:

>*…that made me anxious and I wanted to cry and I was just like- it was just not fair…Ya, it's like, like holding your breathe. I, I just hang on to anything and I just keep alive and I-ah, when I see her I know everything- I can take all the crap and just dump it there and I know she will be there and so, I, so it's something, ya. It can be quite scary (Tessa).*

The experience of missing most of her session is terrifying and scary for Tessa as she describes holding her breath between sessions, which again points to the therapeutic relationship being seen and felt as a lifeline and a relief. Holding one's breath could also symbolise holding on and waiting-in-anticipation for another source of life, another breath, perhaps when it is deemed safe. She specifically speaks of the relationship with her therapist as a source of life, release/relief, and or revival. It also speaks to how few spaces offer this, where Tessa must wait between sessions and hold on to the right and safe moment to take her next breath. It is also significant to examine Tessa's words to "keep alive", illustrating the sense of impending doom she experiences when she is late or fears missing her session. This is connected with the lifeline aspect the therapeutic relationship seems to represent. For Tessa she feels saved and caught by the therapeutic relationship to the extent that without it—even just for one session—it may feel as if there is no longer a net to catch her (or her unbearable affects). There is an incredible sense of desperation felt in Tessa's words, where being late is experienced as a threat to her very being, which sets in motion her body's and mind's reaction to stressful and traumatic experiences, hence the desperation and panic.

> ***Sub-theme 2: Moment of meeting.*** All patient-participants described their moment of meeting with their therapists as markedly important, significant, and special to the therapeutic relationship. With regard to Lisa's experience, she described how, when she first met Therapist 3, she was still seeing a different therapist and that Therapist 3 explained the necessity of

choosing between the therapists. Therapist 3 also promised to be there for Lisa, as Lisa would confront the inevitable decision to take a leap of faith and trust Therapist 3.

> Lisa: *… and she (Therapist 3) said to me, "you can't walk the same path with two people, you must choose- or this path or that path" and then I asked, "why don't you choose for me?", and she said, "no, I can't make that choice. You need to decide which path you're taking and if you decide to take it with me I will be there for you all the time no matter what", and I mean that's a promise she made me ten years ago.*

> Alex: *What helped in making your decision to stay with Therapist 3?*

> Lisa: *I don't know, you know that thing they call gut feeling? Ya, so, I chose Therapist 3 and, ya I am here, I am still here. Many times, I thought I don't need to see her anymore "no, no, no, no it's not time yet". I mean after ten years- how much more can a person talk?*

Lisa describes the "gut feeling" aiding her decision and how special and important it has been that Therapist 3 has kept her promise from 10 years ago and stayed with her. This gut feeling during the first meeting that Lisa speaks of describes something intuitive on a visceral/emotional level. It links with a felt connection between Lisa and Therapist 3 wherein the experience with Therapist 3 was intuitively felt on a level beyond the concrete, verbal domain. However, it is evident from her account that she is somewhat ambivalent in this dependence on her therapist and sometimes questions whether they have been seeing each other for too long a period of time. This again may speak to Lisa's tendency to avoid being dependent on others, and her difficulties with trusting those with whom she is in relationships with.

Tessa describes her moment of meeting with Therapist 1 as her last resort. Tessa's previous therapeutic encounters had been negative and she had reverted to using her psychiatrist as her psychologist for some time, before eventually suggesting and taking up a referral for a psychologist. Here she relays their moment of meeting as a desperate and hopeless last option. In Tessa's description, there is a leap of faith in her therapist that matches and meets her hopeless situation.

> *… So, um, ya the first day, I walked in there I was like "Okay, I am going to kill myself". This is the last thing that I am trying not to kill myself. Then she said "Okay, ya, that's quite a bit of a, an expectation", but I told her "Listen I am half dead so, um"… Ya, so let's just try this thing- and ya, ya seven-eight years later I am still here [laughing]*

Tessa's experience of this first moment of meeting also links with the previous sub-theme (describing the therapeutic relationship as a lifeline) where she has reached the end of

the road and has placed all her hope in the person, her therapist, meeting her there. Evident here is also mutual honesty, where her therapist openly acknowledges her sense of responsibility.

Kathy describes how, in meeting five years previously, Therapist 2's non-judgmental stance during that first contact spurred her to go back in her time of need.

... It was like the worst day of my life (emotional) but anyway it was, um, but still Therapist 2 didn't judge me. The day I saw her for the first time, she didn't see me- I was hysterically, I couldn't stop crying and she asked me, "what's wrong?" and I had to tell her and she said, "Kathy stop beating yourself up about this- this woman abused you for 40 years and you, um, how much do you still need to take from her?" and that, that made me go back to her 5 years later... That's how it really happened for me to go back to her... Ya, do you understand? She did not judge- she was seriously young, she was young like you now. She was a young psychologist only starting out in life, but she knew enough, even then, not to judge me and that's what made me return back to her when I really needed her. Well I didn't know I needed her – my daughter needed her (laugh)...(Kathy)

The moment of meeting for all patient-participants is significant in their therapeutic relationship, particularly with regard to the experience as a whole and the meaning that the relationship has to each patient. For Lisa, a positive relationship was cultivated through a promise kept 10 years later, and the leap of faith in trusting another person to be with her and remain. For Tessa, the relationship with her therapists began in a desperate and hopeless place and as a last resort; despite this there seems to be a glimmer of underlying hope or expectation that her therapist will meet her there. Finally, for Kathy, a meeting 5 years previously, with an authentic and non-judgmental presence, allowed her to return 5 years later and be 'caught' by her therapist who saw her pain.

Both Lisa and Tessa make links between first meeting and how they are still around today—regarding their ongoing therapeutic relationship with their therapist and perhaps also still around at all. All these above-mentioned moments of meeting with their respective therapists signify a special moment in memory and in meeting an 'other' who imparts the feeling of being seen, recognised, and remembered for the patient. Alongside this moment of meeting is the continued/sustained therapeutic relationship (for some, up to a decade). There may be many factors which have contributed towards the length of the therapy but, in patients' experiences, this first meeting is key and the fact that they feel it is the reason for why they are still seeing their therapist points to the salience thereof and how meaningful it is to them.

Sub-theme 3: Change. All patient-participants relayed how change was linked to the therapeutic relationship and the experience thereof. Kathy describes her process with Therapist 2 and how their time together came with many insights, including a greater understanding of herself in relation to her past, as well as learning coping resources.

> *And we have been doing some therapy, and there was a lot of light bulb moments…You always wonder why, why you feel about the things you do or why you act a certain way and then with the therapy, it came out why exactly, you know, it's stuff that actually bugs you in your adult life that comes from your childhood life… You understand? So, she helped to make a lot of things for me clearer. That's the one part. The other part was how to deal with certain things, you asking now about many years (Kathy)*

Interestingly, many years have passed, which seems to mean something to Kathy and perhaps makes it more difficult to fully comprehend and relay her experience years later during her interview with me—she can convey that she has experienced change, but distilling this change is challenging. This could speak to the therapeutic relationship, which is an experience that is perhaps so ingrained into her ways of relating that it has become difficult to dissect the meaning or what constitutes the relationship. It speaks to a pre-verbal, visceral, real, felt experience which defies verbalisation.

Tessa describes her experience with Therapist 1 and, although she does not explicitly relate her sentiments to change as such, it does seem to point towards an internalisation of her therapist.

> Tessa: *You know if I do something- "what would Therapist 1 do?" Like that and if I have to, if I do something and I have to tell her - is this the way I want to tell her the story or am I going to behave differently and tell her a different story? Ya, I think about that quite a lot. She is a huge, huge influence in my life.*
>
> Alex: *How long did this take?*
>
> Tessa: *No, it took quite a bit of time and really have, I value her opinion.*

Thus, over time, Tessa seems to have internalised a part of the therapeutic relationship which has given her a space to think about her behaviours and actions as if she was in therapy. This change over time is similar to the insight Kathy developed into her personal relationships as a result of being in a sustained therapeutic relationship.

Change is also evident in Lisa's experience as her account expresses the significance she found in learning to trust and the crucial influence that Therapist 3 had in allowing her to develop trust within the relationship.

...if a person wants someone to bond with and open up. The relationship is all about trust and if there is no trust, it's not gonna work. And I was not a very easy person to trust people and Therapist 3 taught me, that it's OK you can trust, things might change, but you can trust (Lisa)

Lisa's words further describe how change is not easy, in fact it can be a terrifying process, and therefore it is a process that requires trust in the therapist and in the relationship to break forth from old ways of relating and try venture new and untraveled roads. Overall, all patient-participants considered change as an important factor within the therapeutic relationship. They spoke of how the relationship offered them an opportunity for insight linking their experiences with their past, as well as a means of coping. Fundamental changes seemed to occur within the therapeutic relationship in terms of internalisation and integration. Lastly, the relationship itself offers a here-and-now experience of relating with an 'other' and therefore potential ways of relating in more adaptive ways such as, for example, incorporating boundaries and offering opportunities to break old ways of relating and to learn to trust in relationships. What appears significant here is that the changes experienced are all relational in nature and emerge over time, either directly or indirectly, as a function of the patient's experience in, and of, the therapeutic relationship. In other words, patients learned about their interpersonal relationships, and made changes in these relationships, as a result of relating to the therapist in therapeutically transformative ways. The therapeutic relationship, therefore, is key to this process.

Sub-theme 4: The relationship over time. In addition to change, the passage of time was an important sub-theme for all patient-participants because it was a signifier of the strength/quality of the therapeutic relationship. Kathy recalls immediately when her process began with Therapist 2 and describes how well they know each other, linking this with their long-term relationship.

October 2009– 8 years… So, in any case I think, I think she understands me very well. I have to say and you can't be with somebody for that many years and not (Kathy)

Kathy reflects on something very important in this statement, capturing the related and parallel development of an understanding of one another—a knowing—with that of the passage of time and the long-term relationship. She further describes how her relationship with Therapist 2 was "unique" and I was in touch in the moment during the interview with a strong sense of intimacy as if she were describing a relationship with an intimate partner. Similarly, Lisa describes her upcoming 10-year anniversary with Therapist 3, which seems to represent a special moment and an important long-term therapeutic relationship.

Well, I am 10 years with Therapist 3… This year we are celebrating our 10 years (laugh)… I think it's awesome, it's good. I have always told my friends "you want a psychologist, go see Therapist 3", she is the best. Ya, so no, I have a lot of respect for her and she has sat up with me for 10 years so you must know. It's like being married hey? (Lisa)

Lisa's description of the therapeutic relationship with Therapist 3 is synonymous to a 10-year wedding anniversary, which captures the unique, intimate, special, and mutual bond and commitment over the past 10 years. Lisa's comments around how her therapist has "sat up" with her all this time, describes a caring quality. For example, a parent who "sits up" with a child when they are sick, or a partner sits up with their boyfriend/ girlfriend when they're struggling with something. Generally, this is a phenomenon that occurs with people who genuinely care for one another. This is further reiterated in Lisa's description of the therapeutic relationship as a marriage, which signifies commitment, intimacy, togetherness, and shared values.

Tessa though describes something of a different, but related, experience. She comments on how the long-term therapeutic relationship sometimes feels too long and perhaps "blurs" things. This nonetheless reflects the nature of the relationship as it developed over time.

Yes, ya, we have worked through quite a bit, and, ya, she gets angry at me sometimes. That's how long I have been seeing her. She gets very angry at me...so uh, ya… Ya, then then sometimes I think, I think we have been seeing each other too long… There is this small like border that there's just that small little bit, that's a bit blurred, but only on that - that she gets angry at me. That she will tell me (Tessa)

In this extract, she explains how her therapist expresses anger at her. Although she speaks of this as something that is "blurred", it appears that it is a result of a therapeutic relationship that has developed over time in which both patient and therapist have reached a level of relatedness that is congruent and authentic. Tessa's perception of this kind of response from the therapist as being a blurred anomaly—which has negative connotations—is perhaps indicative of a less mature understanding of the dynamics at play. This may be something that, with more time, Tessa may be able learn to tolerate within the therapeutic relationship. She may come to learn—through being in the therapeutic relationship with all its challenges and discomforts—that her therapist's anger is tolerable and will not destroy her or force her therapist to leave and abandon her (Bion, 1962). Overall, patient-participants acknowledged the importance time held when thinking about the therapeutic relationship with their therapists. As the therapeutic relationship developed over time, so the strength of the relationship

flourished and what came with this was understanding and knowing between patient and therapist. With time, the relationship was experienced as intimate, shared, special and unique. However, what also seems to be an outcome of a long-term therapeutic relationship is a sense of dependency and need for the relationship.

Therapist-participant Themes

Three major themes emerged from the therapist-participant data, each with their own sub-themes. The first theme describes patient qualities within the therapeutic relationship, the second theme involves factors facilitating therapy according to the therapist and the final main theme for therapist-participants highlights process within the therapeutic relationship.

Theme 1: Patient qualities. Patient qualities is one of the main themes found to encapsulate therapist-participants' experiences of the therapeutic relationship. Each therapist commented on patient qualities that enabled and facilitated the development of the therapeutic relationship. For example, therapist-participants valued their patient's desire to change. Therapist 2 draws on Kathy's desire to change, her thirst for personal growth, the rewarding effect of "sticking with the process", and her psychological mindedness.

…She really wanted, she wanted to work on herself… So, it was that- it was really her, um, her, um, want to not feel the way that she did and she found it very liberating. She is someone who wants to, she wants to grow… I think in terms of the psychodynamic approach, it is a good approach with her, um, you know someone else wouldn't want to look or address their problems. So, I think who she is and how she is and I think that she wanted to make a difference facilitated therapy, um, that she felt safe… it's probably easier because, um, she is obviously psychologically minded she knows the terms, she understands what it means. (Therapist 2)

Kathy has been described by Therapist 2 as really having a desire to change, illustrated through the multiple use of the word 'want'. Her therapist values Kathy's commitment to change, which is useful in solidifying the therapeutic relationship. It seems to provide a sense that the therapist is not the only one working; rather both are participating in the therapeutic relationship and joining together in helping the patient. This, in essence, links to the theme of mutuality and is buttressed by Kathy's ability—psychological mindedness—and her openness to exploring and continuing with the difficult process that the therapeutic encounter naturally is. Linking with the patient's desire to change, Therapist 1 highlights Tessa's commitment, her respectful attitude within the relationship and her willingness to venture into the challenging material.

> *She was committed. She drove through from Kempton Park every Friday afternoon.*
> *Every Friday afternoon…she never cancelled once and she has never not paid me…she*
> *is always there when she says she will come, so her commitment to therapy… And, also*
> *maybe her willingness to talk about difficult things at times. (Therapist 1)*

Therapist 1 found Tessa's dedication and respectful attitude enabling in forming the therapeutic relationship. The fact that Tessa was willing and committed in driving a far distance to attend therapy every week proved her desire to change and her committed attitude. Her timely payment and her diligent attendance were valued by Therapist 1 as it demonstrates perhaps Tessa's value for the relationship as well as her respect, and it promoted a continuing and strengthening relationship. Tessa's dedication toward therapy and her relationship with her therapist perhaps also fosters a sense of being valued and needed for Therapist 1.

Therapist 3 highlights how challenging the therapeutic process has been for her patient as well as herself. However, despite the hard work involved in the therapeutic process and the sometimes-uncomfortable nature thereof, Therapist 3 draws on her consistent belief in Lisa and her ability to do the work and how she valued Lisa's ability to stick with the process.

> *…but she has stuck with it and I think it says something about her ability and her*
> *tenacity and her capacity. She has a lot of capacity, she chooses to ignore it at times,*
> *but she has a lot of capacity…Um, as I say in terms of approach I have always been*
> *honest with her, direct with her and I really believe that she can do the work.-(Therapist*
> *3)*

Therefore, Therapist 3 has a strong belief in Lisa and her abilities to do the therapeutic work, despite it being incredibly uncomfortable at times, which is related to Lisa's tenacity and commitment. There is also something to be said about Therapist 3's ability to stick with the process with Lisa, again emphasising the mutuality and relational dynamic during the therapeutic encounter. For all the therapist-participants a factor that seemed to strengthen the therapeutic relationship was patient qualities. Patients' desire for change, their committed attitude, tenacity and ability to stick with the long and hard journey were greatly appreciated and valued by therapist-participants as it gave a sense of unity within the relationship and meaning for the therapist and their work.

Theme 2: Factors facilitating therapy. Another main theme found to illustrate therapists' experiences of the therapeutic relationship relates to factors that play a role in facilitating therapy. The following sub-themes were found within this theme: a holding and consistent environment; theoretical orientation; use of technique; and supportive factors for therapists.

Sub-theme 1: Holding and consistent environment. Therapist-participants relayed their experiences of the type of environment needed within the therapeutic relationship. Factors that are experienced and explored are connection, warmth, a holding environment, therapist's commitment to meet the patient, containment, providing a consistent object and maintaining boundaries. Therapist 1 refers to an environment that is warm and facilitates connection. She terms these "simple" factors that are intuitive/visceral factors which are oftentimes difficult to put words.

> *I think very simple things. I think initially, there must be some connection, warmth, um, a holding environment, you can just hold someone, even if they can't initially, and really speak about their own stuff, um, I think a patient—how a patient experiences a therapist's commitment to really understand them to meet them where they are—I think that. (Therapist 1)*

Therapist 1 also draws on being there for the patient—holding them— when they at times are unable to explore their experiences. What comes across is a strong sense of simply being with the patient, which is often difficult to describe and dissect in concrete terms. Therapist 3 reports that Lisa struggled with breaks and separation during therapy and identified that when the patient's life is more chaotic it spills over and 'leaks', which points to a much-needed holding and containing function within the therapeutic relationship.

> *All the time, all the time, with any separation, um, whether it's for holiday breaks or, um, she tests me all the time, whenever she is uncertain, whenever her life is in chaos, it sort of spills over. It is like a leaky container, it's like oil- you know- and it just seeps into everything. (Therapist 3)*

Therapist 3 demonstrates the complexity of providing containment within the therapeutic relationship. Her use of metaphor—"it's like oil- you know- and it just seeps into everything"—exemplifies the need to keep the patient's experience together and also not become contaminated by the powerful experiences that are inevitably present. In relation to her process with Kathy, Therapist 2 comments on providing Kathy with a "constant" object in her life. A relational experience is offered where the therapist can be with their patient and provide a different relational experience that is consistently present.

> *Ya, definitely, ya, having a constant object in her life that seems to know her or think with her, what is in her best interest… (Therapist 2)*

Therapist-participants, however, seemed to struggle to concretely consider facilitating factors towards the therapeutic relationship as seen in the extract from Therapist 1 below:

It's so interesting because you never really think about this. You just work you never really reflect on the process of this…I mean in the back of your mind—you have this secret hope—that people will find something there to help them, but you don't really think in such concrete- Ok, so now I have to give words to what I think it means to her or what she gets… (Therapist 1)

Thus, it seems these factors are more intuitive or ingrained within therapists and the way in which they work—perhaps second nature—and are more difficult to operationalise and verbalise. There is an experiential quality to this as it is not consciously applied but, rather, is inherent to the implicit relational knowing that is functional within the process.

Sub-theme 2: Theoretical orientation. Therapist-participants found their theoretical orientation to be incredibly important in understanding their patients' dynamics and the therapeutic relationship which allowed for a therapeutic frame and approach in working with their patients, which facilitated change. Therapist 1 describes how her change in theoretical orientation strongly influenced her ability to understand Tessa and meet her needs appropriately.

… Um, in my mind, the therapy is going better, since I have a new model. I started to work in the Mastersonian perspective, Masterson way, and that helped me to understand her better and to understand better what she needs…I can confront stuff, when before that, I would be quite hesitant- shall I go there? Or shall I not go there? So, I kind of go there (Therapist 1)

Therapist 1's questioning to herself ("shall I go there? …or … not…?") captures how therapist's theoretical orientation is a strong guiding principal and provides a thinking space to comprehend and make sense of the patient and the relational experience taking place between patient and therapist. Similarly, Therapist 2 relates her experience with Kathy and how her change in orientation to a more psychodynamic approach had allowed for process work and understanding the patient and her defences. Along with this account, she notes change and a transcendence in Kathy from some of her previous maladaptive behaviours. Lastly, Therapist 2 describes how her psychodynamic orientation allows her to work directly with, and within, the therapeutic relationship.

I suppose process work, more than…seeing a person develop, seeing what her defences structures were, seeing that there was a lot of regression and why is it there and with her development…needing someone to be there for her all the time. Which is …transcendent you know she does her own thing…it was special because of an orientation change… it's just a very, very different process, therapeutic process, to

work psychodynamically. To have the opportunity to work in terms of the relationship. (Therapist 2)

Therapist 3, in a similar fashion, values formulation and a theoretical understanding of Lisa.

… I think I have quite, I mean and it changes at times, but I think I have quite a good theoretical understanding of what is going on and I think that gives you sort of the insight as I say or just the perspective and it gives it a predictive quality … so I think it doesn't leave you so vulnerable if you can see what's going on. (Therapist 3)

Therapist 3 describes her use of formulation and theoretical understanding that allows a safe distance and perspective in relation to the patient's behaviour. She finds that her theoretical understanding of Lisa and her dynamic gives some predictive quality within the relationship. The knowledge and understanding equips the therapist with tools in that it does not leave them powerless and at the mercy of their patient's pathology—the theory is the scaffolding which surrounds and supports the developing structure of the therapeutic relationship. Interestingly, Therapist 3 is careful to say exactly what she knows and understands of Lisa, by using the phrase "I think", which seems to be a typical stance of the therapist. That although therapists are equipped with knowledge and vast theoretical understanding they cannot be certain of the exact nature of the patient's experience. Therapist 3 also reiterates how a therapist's understanding of their patients is dynamic and constantly in flux; forever changing and developing as the relationship grows and matures.

Sub-theme 3: The use of technique. Therapist-participants expressed how using certain 'techniques' in their work with their patients enabled them to instil change. Therapist 1, for example, expressed how using confrontation as a technique allowed her to avoid paralysis within the therapeutic process and instead enable activation.

Ya, actually, what the, that confrontation part, is a technique actually, neh, that helped me so much. In terms of not being so, I don't want to say passive, but almost so paralysed in therapy, you know to be able to say, "but listen, look at this, look how far you have come, look at your track record", to be able to get that activation. (Therapist 1)

Therapist 1's use of the word "paralysed" is significant and symbolises how therapeutic technique can equip therapists in their presence within the therapeutic relationship, and not feel powerless and hopeless. This is linked to the function of the theoretical orientation for therapists. Therapist 3 describes how, through the building of rapport and the therapeutic relationship, one can use techniques to challenge maladaptive behaviour. The relationship is

strong enough to handle these challenges and, should ruptures arise, strong enough to overcome them. Therapist 3 expressed how the relationship is crucial in carrying change, regardless of technique.

> *Uh, I think the better rapport you have… I think the more license you have to, I think with her I challenge her a lot and challenge the behaviour in quite a forthright manner. So, I think the stronger the relationship obviously the easier it is. It feels like the relationship has the capacity to survive or withstand that…it carries the change for the patient, the change is carried in the relationship regardless of the technique or how you understand it or approach it… (Therapist 3)*

Therapist 3 further describes being attuned to the patient's needs and not aligned with the pathology, as well as being gentle but firm, and lastly surviving her patient's anger and acting-out behaviours.

> *… acting in your patient's best interest and being attuned to their need, rather than being aligned with the pathology… you have to be as 'gentle as a dove and wise as a serpent' … I think one's interpretations come from a place of empathy, creativity, a place of… understanding… but at the same time, you must not be conned by your patient … I think one's ability to hold it for her and survive it. You know, it's when the baby is really angry and bites you or whatever- you know, you don't say "I don't want you anymore, find yourself another mother". You know and I think it's the same thing you can be angry with me and I will still be there and I will survive it and I won't leave. (Therapist 3)*

What Therapist 3 describes is not reacting to the pathology but rather thinking about what is happening in the therapeutic process and what the patient's needs are. Being kind but firm in one's approach to therapy allows for progress. Moreover, the therapeutic relationship is strengthened when the therapist is able to tolerate and survive the patient's distressing emotions (Bion, 1962). They therefore do not respond to the pathology but act in the best interests of the patient. This provides safety for the patient, demonstrating to them that someone can tolerate, manage and metabolise their distressing experience and emotion without abandoning them to manage on their own, which makes their experience more bearable and less frightening. Therapist 2 describes a similar view of being 'gentle as a dove and wise as a serpent' as experienced by Therapist 3, in her description of being soft and kind, yet saying difficult things to Lisa that does not shut her down.

> *I think I am quite a soft therapist, I am not loud- you know so maybe that, a kind way but stronger way, so say "listen you not gonna like what I am gonna say"… maybe my*

ability to be able to say the difficult things, but not in a way that would shut her down…
it wasn't threatening it was experienced as being kind, although it was difficult to hear
(Therapist 2)

Overall, this sub-theme has encapsulated the use of therapeutic technique in bolstering the therapeutic relationship. The use of technique, in a gentle but firm manner, attuned to the patient's needs rather than their pathology allows for change and progress within the therapeutic process and the therapist is not left powerless and disarmed, overcome by the emotional storm patients' experiences often bring. The therapeutic relationship is the vehicle for carrying this change and is strong enough to hold this often uncomfortable and difficult process. Furthermore, should ruptures arise, the therapeutic relationship is what pulls the dyad through the experience and together they are able to overcome the rupture.

Sub-theme 4: Supportive factors for therapists. Much of the therapist-participants' descriptions reflect how difficult and challenging therapeutic work can be and how it can sometimes be challenging to remain in the relationship. Therapist 3 draws on how important it was for her to have supportive structures such as her own personal therapy and supervision.

… it has been quite difficult… It has really been a lot of therapeutic input, a lot of
supervisory input, to keep me, um, to keep the perspective what is now going on in the
therapy and the relationship in order to not internalise to the extent where it is
damaging to me or to the relationship… I don't think I would have been able to cope
with it survive it, um, work with it in a therapeutic manner if it wasn't for that external
support. Just to have another brain help you think about what is going on. …to help
you think about why did you say that, or what did you react that way and then you know
the beauty of repetition compulsion, is that it happens again, and you will see it again
and then hopefully you know, you can recognise it for what it is and then you can
address it.. (Therapist 3)

In her descriptions, Therapist 3 speaks of the importance of supportive structures for therapists. Therapists work with very difficult material and powerful projections on a daily basis, so it becomes imperative for therapists to also have a holding space of their own where they can be partnered in thinking about their experience of the therapeutic process creating self-awareness and acting in the best interests of the patient. Moreover, Therapist 3's understanding of the therapeutic process, specifically patients' repetition compulsion, allows for some of the pressure to be taken off the therapist. There is a sense that even if the therapist does not understand straight away the thinking, supportive, spaces will facilitate this and when the

situation arises again it can be appropriately managed and held. This is also linked with the previous sub-theme, acting in the patient's best interest and not being aligned to their pathology. Therapist 1 similarly describes how important self-reflection on the part of the therapist is. She further comments on the importance of self-care and how being in a tired place can really impact on the therapeutic relationship and therapeutic work.

> *… so, so if I can stand back and just reflect on what is happening there for me in that moment and for us in the process then I can. And I must also say, Alex, when one is tired you do different work then when you are fresh… And, um, ya, that I always just want to remind myself of that, often "Think, breathe, stand back and look at what's happening here and then we can respond in a different way". (Therapist 1)*

Therapist 1 describes the importance of stepping back and processing, rather than reacting to the powerful projections. Thus, supportive structures are highly valued and needed for therapists to maintain perspective and a reflective function regarding therapeutic process, with the sole aim of the patients' needs in mind rather than being aligned with the pathology. Supportive structures allow for therapists to have their own space of holding to digest and make sense of their experience as a therapist and as a person, which allows them to remain fully present and available within the therapeutic process and therefore contributing to the experience of the therapeutic relationship. There is also something to be said about the therapist having an experience of "being the patient" in their own therapy process that seems to sensitise them to their patient's experience. In essence, they have sat on the other side of the chair, which is often a vulnerable and uncomfortable place.

Theme 3: Process within the therapeutic relationship. The last main theme for therapist-participants relates to process within the therapeutic relationship. This theme consists of the following sub-themes: describing the therapeutic relationship as intimate yet formal; moment of meeting; change; and time within the therapeutic relationship.

Sub-theme 1: Describing the therapeutic relationship—intimate, yet formal. All therapist-participants shared a similar experience of the therapeutic relationship as intimate, yet formal. Therapist 2, for example, captures the realness and human quality experienced and felt during therapy with Kathy, illuminating the notion that patient and therapist are two humans in the room and in relationship with one another. A sense of intimacy is felt and experienced, however, there is also a formal quality to the relationship in that Therapist 2 can confront and be honest with Kathy through the use of the therapeutic frame and boundaries. Therapist 2 describes how together they are aware of each other, in terms of their relating and their flaws.

...I think it's, maar, like a real relationship where someone is now a witness to your behaviour ... I think it is probably an experience…ultimately it is two people in the room you know... I think it's probably the, the, the most honest relationship she ever had. So, I think, um, you know, not to beat about the bush and to sort of, you know, call her on behaviour…It's very um, human, it's very person- you're a person, I am a person. You do think I am the greatest thing ever- but that's what you do. And I am not the greatest thing ever- you know, I don't- I have got my own flaws…(Therapist 2)

Therapist 3 describes this further by elaborating on the intimate yet formal relationship created between patient and therapist—Lisa and herself.

Ya, I think therapy as a process as intimate as it is. I think it's a very privileged position to work with people in that way, um, it's a very intimate relationship, but very formal relationship and I think when you don't participate and you don't become this well-known person. It forces you to renegotiate the relationship and think of the relationship in a different way and I think that's what's therapeutic. So, I think therapy for me, more often than not and maybe for me to, but for our patients it's a very uncomfortable place. It's not a social relationship and I think one has to resist, um, playing our very old patterns and old dynamics. So, you don't do the work for the patient- but it is a very active process nonetheless. I always think of Bion who said, 'it's like an operation without an anaesthetic'. (Therapist 3)

Therapist 3 describes the experience as a privilege and indeed there is a sense that it is rewarding to be able to work with patients on such an intimate level, yet have firm boundaries in place. Certainly, this is very different to a social relationship which, although intimate, can have very blurred boundaries. She indicates that it becomes essential not to re-enact old patterns within the relationship which generates a new experience for the patient, different to all other relationships. The therapeutic relationship is described as incredibly intimate for both therapists and patients, which speaks to what is happening between the two of them as they venture and experience together the patients' world and difficulties. Yet the firm boundaries allow for safety and thinking to remain in the process and not become blurred and engulfed by both the therapists' and patients' old patterns of relating. Therapist 3's analogy of therapy as an "operation without anaesthetic" is useful in portraying how the therapeutic process and relationship can also be incredibly difficult and uncomfortable at times.

Sub-theme 2: Moment of meeting. The second sub-theme that falls under the process within the therapeutic relationship is the moment of meeting. All therapist-participants regarded their moment of meeting with their respective patients as significant and as something

that holds meaning in the therapeutic relationship they endeavoured to build together. For example, Therapist 1 tells of her first session with Tessa, remembering it clearly, and the helpless feeling of the huge sense of responsibility she experienced.

> *With Tessa, Um, when I started seeing Tessa, at our first, she was referred to me by a psychiatrist who works a lot with personality disorders…So, um, at our first, I will never forget this, at our first session, Tessa came in and she said to me, "you know what, I am actually finished with life, this is my last, you are my last resort, so I am here." So that, so, obviously, neh, I hear where she comes from, but then it is also such a huge responsibility… (Therapist 1)*

This experience seemed to lay the foundation for a very difficult journey ahead. Despite this, Therapist 1 later described in the interview becoming deeply attached to Tessa and caring for her. She also described how committed Tessa was so, despite the huge sense of responsibility felt by Therapist 1, there was a sense of togetherness within the relationship. Therapist 1 describes how she will never forget their first moment of meeting. It appears therefore to have been a memorable moment for Therapist 1 which is linked perhaps to her poignant feeling of responsibility stemming from Tessa's experience of desperation and need. Similarly, in response to my question during the interview, "what was your experience with Kathy during therapy?", Therapist 2 first speaks about the context of their meeting and the uniqueness and specialness of this.

> *What my experience was in therapy with Kathy? Um, I think what makes her process, I think special, is that, um, it's a client base that I met when I was an intern… So, when I was an intern at Y Hospital, they were in family therapy and one of her children were in therapy. So, I think what was interesting and then years later, I, I am not sure how many- I think 5 or whatever 6/ 7 years later, she actually came. She wanted to seek therapy for one of her children, and I said, "no I think she needs it." (Therapist 2)*

Therapist 2 seems to find meaning having known Kathy in some way previously, and again, remembers the moment of her return and official entry into therapy. The therapeutic relationship holds a specialness and familiarity from the moment of entry, which may have assisted in solidifying the relationship. Therapist 2 highlights how Kathy was unaware of her need for therapy and originally sought help for her daughter. Thus, from the beginning of the encounter something remarkable occurred, where Therapist 2 saw something in Kathy and stretched out her 'hand' in response. Therapist 3 also draws on her meeting with Lisa at the very beginning of the interview and links this alongside their incredibly difficult journey and

significant outcomes linked with the therapeutic process and, more specifically, the therapeutic relationship.

>*Ok, so, I have seen Lisa, this year it will be 10 years, which has been quite some time and quite a journey. I started seeing her as a patient, an outpatient at hospital X, after she had numerous admissions. During that time that I have seen her I think she has been admitted 3 times, which the last time was 2012. So, she has been doing really well, she is off all her medication, she is on no medication. So, and I think the fact that what has been containing her is the therapy and the relationship and I think the fact that it has been a long-term relationship (Therapist 3)*

Although there is a practical reason for therapists to explain their experience of therapy by orienting me—a stranger to their process—from the very beginning it nonetheless is experienced as significant and is linked with the therapeutic relationship. This is the moment their (patient and therapist) journey began and is acutely held in the memory of all therapists. A relationship starts from the moment of meeting, or perhaps even prior, according to fantasies of what the experience might be like. For Therapist 1 the relationship was experienced as a tall order from the beginning, whilst Therapist 2 described a special connection owing to knowing the patient in some capacity beforehand. Lastly, Therapist 3's moment of meeting seemed to be a forecast of the long and difficult journey of the therapeutic process with the rewarding experience of the patient's growth. All experiences were significant moments in illustrating and appreciating how far the therapeutic relationship has come and where it all began.

>**Sub-theme 3: Change.** Therapist-participants all spoke of how change was part of their experience of the therapeutic relationship with their patients. For example, Therapist 2 spoke of how repair is possible within the therapeutic relationship with Kathy. What seems to have changed over time and within the therapeutic relationship is Kathy's integration of both the good and bad parts within her therapist and perhaps even of her own good and bad parts.

>Alex: *The ruptures are there?*
>
>Therapist 2: *Mmm, but you can overcome it. Um, I think that is the important thing that reparation is possible you know that I am human and that I make mistakes and I think that she has become more tolerant of that in me too. So, ya, so, I think there is a little bit more of an integration in her possibly, that you know, I am not this ideal, perfect, wonderful, angelic therapist- everything but and that is okay.*

Therapist-participants spoke of their patients' changes in therapy with a sense of pride, despite the very difficult journey. What seemed rewarding for therapists was witnessing their patients' healing and being part of a process that offered them a different life, especially considering their roots. Therapist 2 has described how Kathy, through the felt safety of the therapeutic relationship, is more free in her experience of the process, more individuated, and how she can sit and work with her own issues rather than displace or project her problems maladaptively.

...so I think what is different is, um, is possibly the safety. She feels safe and it doesn't have to be about me- it can be about her... it is very um, very um, unfree. So, I think ... there's a freeness in the way she can relate or the process allows her... I think what is different is that it's more individuated and it is all about her, but it is, um, it's not something that she must put on her lap- she can just take what is hers here, without feeling unsafe and with probably being freer- its contradictory to say. (Therapist 2)

Therefore, through the therapeutic relationship and the reflective presence of her therapist, Kathy is able to tolerate her own experience and integrate this with her growing sense of self. Therapist 3 relayed her experience of how the therapeutic process is less straining and difficult and how there is a sense of realness within the therapeutic relationship, which took time to develop alongside her feeling of pride at how the therapeutic relationship between them has fostered growth and development outside of therapy.

Um, I think it becomes less taxing because I don't have to swim through all the nonsense, you know, because at the beginning it was this onslaught of defence and testing behaviour and continuous testing behaviour. So, I think where we are now, um, it becomes less taxing you know because there is an authenticity in the room that took a long time to develop or to get to that point... I think in times in her life, I was probably the most stable relationship she had, um, as I say that has changed significantly. You know I am very proud of her, you know in terms of where she comes from, where she is in her life at the moment outside of therapy... (Therapist 3)

Therapist 3's description of Lisa encapsulates how through the therapeutic relationship Lisa was able to reveal a truer self with a less defensive structure. Therapist 2 raises a similar point related to how Kathy has become more real in her relating and how she has developed awareness of her destructive qualities, both honouring and owning these, not necessarily removing them completely.

… She has definitely a stronger individual- or stronger individualised…I could say I am proud of her… Sort of parenting thing, proudness and I think she has done well with

her circumstances. Um, so, how does it develop? Maybe a real person in a room…, um, that the boldness that she has is not an uncomfortability but it is an asset and, um, she is aware of her destructive stuff, she is aware of all her- well not all- but she is aware …she knows she does that…she knows we laugh about that… but I think, I think that it's not something that is going to go away. It's also part of the framework…You know, so, for her I think the idea of realness is maybe just honouring or owning your stuff- to an extent (Therapist 2)

Therapist 2 considers Kathy's origins and roots when reflecting on her change. It is not about changing the patient completely. Their patterns of relating are still present, yet there seems to be an awareness and a more authentic way of relating, rather than using these ways of relating in a defensive manner. Therapist 3 similarly has described her sense of proudness regarding Lisa's change and growth and immense strides outside the therapeutic process extending the changes into her life outside of therapy. This speaks to the therapeutic relationship between the two parties, where both have worked hard to get to this point, and it is satisfying to look back and reflect on the process and assess how far they have journeyed together. Therapist 2 highlights an important point that defensive processes are not necessarily completely removed as with Kathy, but instead were brought into her awareness, perhaps even smiled upon and appreciated as being part of her experience and who she is over time. Change is therefore a highly significant relational phenomenon for the therapist-participants in this study who—through the therapeutic relationships—have made meaning for themselves in the growth and developments seen in their patients over the course of their respective therapeutic processes.

Sub-theme 4: Time. Time was an important sub-theme, which was categorised under the process within the therapeutic relationship. All therapist-participants attributed much significance to the length of their therapeutic processes with their patients. Therapist 2 draws on the special and unique quality of their long-term therapeutic relationship.

So maybe that's also special, the relationship I think, maybe the fact between the two of us is the fact that it is maybe a long term (Therapist 2)

Therapist 2 has drawn on an important concept regarding the therapeutic relationship with Kathy and reflects on Kathy's desire for a friendship or Kathy's need to check in every now and then. It is described as if she no longer needs the relationship as desperately as she did earlier on, yet cannot be without the relationship and needs check-ins every so often.

I think for her, this is more, she would like this to be more like a friendship and like she was just checking in and I think, if you think objects, um, relation in terms of what is available to her and it's almost like a child that just needs to check in. And I think of her development and in terms of what she needs and needed and what she had- I think that's perfectly fine- considering where she comes from (Therapist 2)

Therapist 1 specifically introduced the idea of time in relation to using confrontation. She describes how because their therapeutic relationship has a solid grounding—they knew each other and had travelled for many years on a long therapeutic journey—she is able to be more confrontational.

…Sometimes, I have said- just to reflect on the relationship- I would say to her 'because this is a relationship and because, um, we have journeyed together for so long, because of that I can say this to you". She would sometimes say "Yus, you are so kwaai?". I would say "you know what we have come a long way, we have, um, spoken about so many things… but because we have journeyed together for so long I can say this to you. Because I can't let you get away with this nonsense and it's because you know my heart. You know my heart for you and that is why I can say this to you"… (Therapist 1)

All patient-therapist dyads have held significantly long-term therapeutic processes, which holds meaning regarding the relationship they have together. Experiencing one another in such an intimate yet formal way gives rise to a strong bond between patient and therapist who have journeyed with one another for a long time. Time seems to strengthen the relationship and allow for the therapist to be honest and open in their communications. There is also something about the therapeutic relationship helping the patient grow and develop outside of the therapy space and not need therapy and the relationship as much compared to previous years. However, there is still a need to check in with the therapist and a means of holding onto the relationship.

Conclusion

This Chapter has highlighted the major themes and subthemes that capture the lived experience of both the patient and therapist in terms of what meaning they attribute to the therapeutic relationship. Until now, the patient and therapist accounts have been analysed and presented separately. Chapter 5 will present an integration of the findings alongside the literature, thereafter highlighting the similarities and differences between the collective patient and therapist experiences.

CHAPTER FIVE: DISCUSSION

In this Chapter patient and therapist themes will be presented together to facilitate comparison and will be discussed in relation to existing literature.

The Therapists' Therapeutic Approach and Patient Qualities

The experience of the therapeutic relationship centred around the therapists' approach according to patient-participants and patient qualities according to therapists-participants.

The therapists' therapeutic approach. Describing the experience of the therapeutic relationship, patient-participants found the therapists' therapeutic approach during therapy to be significant in facilitating the relationship between them. Their descriptions and experiences were clustered around four sub-themes, namely, holding the patient in mind— knowing them; a non-judgmental stance; providing an objective experience—perspective; and a consistent presence on part of the therapist.

Overall, patient-participants described how they experienced their therapists as holding them in mind alongside the associated feeling of being known and understood by their therapist. There was an appreciation for the therapist's ability and willingness to hold them in mind as patients and their efforts to understand them deeply. This is line with the findings of a study by Schröder, Wiseman, and Orlinksy (2009) which suggest that psychodynamic therapists in general appear to follow and reflect their patient's feelings, recall conversations and use more intersession engagement of how best to help their patient and thus hold their patient in mind in a meaningful and therapeutic manner. This process may be an unconscious process or one that is more conscious and in one's awareness. A patient's sense of self is able to develop and deepen as that patient is thought of and held in mind by the therapist (Fonagy et al., 2018). Patient-participants were awed by their therapist's ability to remember information shared years previously. Stadter (2012, p.161) explains that the therapist's ability to remember memories "can evoke integrative moments of meeting—connecting past with present, connecting therapist with patient" indicative perhaps of the intrapsychic equivalent of the physical meeting, potentially pointing toward why the first meeting between patient and therapist is experiences as significant and particularly meaningful for both parties.

Fonagy et al. (2018, p.23) discuss mentalisation—or, reflective function—regarding the treatment of patients with borderline personality disorders and describe this as an individual's ability to comprehend "mental states in self and others" within attachment relationships. This leads to a coherent sense of self and the ability to regulate affect and is cultivated in one's early relationships (Fonagy, et al., 2018). Psychotherapy with these patients is aimed at joining the patient in their experience without becoming overwhelmed, and consistently maintaining a

mentalistic stance which leads to the patient's discovery of themselves in the mind of the therapist, a person who can think and feel with them, which allows for an internalisation and integration of their own sense of self (Fonagy et al., 2018). Being held in mind—mentalised— is therefore formative for patients and may explain why this experience is felt to be significant by patients.

Some patient-participants recognised how through their therapist's knowing and understanding them, they were not able to get away with their usual way of relating outside of the therapeutic process. Therefore, the therapeutic relationship formed with the therapist becomes a new and often healing emotional experience, where old patterns are not re-enacted nor repeated within the therapeutic relationship, and something relationally different and useful is gained and experienced (Alexander, 1950). Again, this ability to provide a new and often healing emotional experience is strongly linked with the therapist's full understanding of the patient and ability to mentalise and engage their reflective functioning (Fonagy et al., 2018). It is important to acknowledge that this does not mean that enactments do not occur within the therapeutic setting, but rather that the therapist's mentalistic stance enables them to stand back and think about what is happening in order to reflect on it with the patient in the moment. Importantly, one patient-participant (Tessa) highlighted how this 'knowing' is one directional and unequal, and she expressed her own anxieties and feeling of vulnerability regarding this. As discussed in Chapter 4, this may point towards Tessa's strong desire for more self-disclosed information on the part of her therapist perhaps in an effort to merge with her or become closer, which will be discussed further, below. However, it also points to a disparity in the implicit relational knowing and use of mentalisation. As Tessa begins to develop her ability to mentalise her own experience, only then can she extend this capacity to mentalising others in her relationships (Fonagy et al., 2018; Wallin, 2007).

Findings also indicated that a non-judgmental approach is significant in forming and maintaining a meaningful therapeutic relationship. Descriptions included an understanding and knowing between patient and therapist. A felt acceptance was highlighted as important alongside a safe and reassuring presence within the relationship. Stadter (2012) states that features such as empathy, warmth, respect and the absence of judgment are the most fundamental aspects of building and maintaining the therapeutic relationship. This reflects a finding by Aspoas (2012) on caregivers' experiences of the baby mat project whereby participants expressed appreciation for, and valued, the non-judgmental attitude from the therapist which the author concludes was an important factor contributing to the success of the service being provided. Clients felt accepted, heard and understood and were able to return to

the baby mat service because of this felt acceptance (Aspoas, 2012), not unlike participants in the present study who have sustained long-term therapeutic processes. A non-judgmental stance creates a space that allows the therapist to challenge and confront painful feelings and experiences. The stance that is non-judgmental is embedded in a containing, safe and consistent frame that is confidential and where the patient is able to fall apart, venture into painful topics and be reassured that the therapist will not leave the relationship or shame the patient (Stadter, 2012). The empathic attunement with the whole person is essential. Therefore, an empathic and non-judgmental stance towards patients' despised, unloved, or shameful parts, including the frightful and helpless parts of themselves renders these acceptable and thinkable and thus less powerful (Stadter, 2012). It may be for these reasons, therefore, that non-judgment is experienced as a core aspect of a meaningful and sustained therapeutic relationship as with the participants in this study.

The third sub-theme expressed the benefit of an objective presence being provided by the therapist within the therapeutic relationship, leading to perspective gained on the part of the patient. Such perspective seems valuable in buffering the patient's sometimes harsh, critical, negative and unrealistic views of themselves and the 'other'. Moreover, descriptions of patients' experiences seemed to capture how another mind is both appreciated and valuable in helping one think, stand back and gain perspective. What comes to mind is the notion of the therapist acting as an auxiliary ego/superego for the patient (Hoffman, 2013; McWilliams, 1994). By the therapist acting as an auxiliary ego/superego for the patient, patients may begin to master their emotions, feelings and wishes in a way that may not have been possible on their own (Hoffman, 2013). The therapist aims to provide the observing position regarding the visceral reactive responses, which eventually leads to patients taking on this role themselves (McWilliams, 1994). Hoffman (2013, p.417) describes auxiliary ego tasks as,

"encouragement, reassurance, perhaps promotion of logical thoughts and reasoning; clarification and reframing of internal and external dangers, prevent the overstimulation of emotional expression, and management, such as setting limits with explanations, education, including promotion of tasks, and facilitation of understanding of cause and effect, thus helping with developing a more realistic appraisal of realistic aspects of life".

Therefore, having another mind present to metabolise patients' experiences and make them more manageable allows for the patient to gain something different to their original experiences and thus offers some perspective, and insight.

The last sub-theme captured within the therapists' therapeutic approach was the therapists' consistent presence. Patients described their therapist's ability of really 'being with' them during the sessions and remaining consistently present and available—emotionally and physically—within the relationship. Thus, the message the patient receives is one that their therapist cares and that their needs are important and should be acknowledged and recognised. This is perhaps linked to Winnicott's notion of the holding environment (Winnicott, 1945, 1960) and Bion's concept of containment (Bion, 1962). Langley and Klopper (2005) associate the good enough mother to the containing function of the therapist who withstands the patient's emotional experiences. Furthermore, they parallel the therapist's presence and availability both in a physical and emotional manner with the provision of a holding environment. Thus, the therapist meets the patient's needs and follows their experience, reflecting and acknowledging along the way, and sets limits and boundaries where necessary. This demonstrates a holding environment that is available and present, and which provides safety and containment for the patient, and facilitates growth (Langley & Klopper, 2005).

Lisa, a patient-participant, specifically ventured into her therapist's presence in terms of the latter remaining within the therapeutic relationship and surviving her acting-out behaviour. Bion (1967) speaks about attacks on linking and describes how when objects (L-Love, H-Hate, K-Knowledge) are attacked by the patient, it becomes essential for the therapist to survive the attack and, more importantly, to keep hold of their thinking capacity and remain thoughtful. Similarly, Winnicott's paper *Hate in the Countertransference* is significant in understanding that hate, and not only love, is present in the mother-infant relationship, and therapist-patient relationship, and it is the therapist's and mother's job to acknowledge these hateful and aggressive feelings within themselves towards the baby and patient, but not retaliate (Winnicott, 1947). In essence, the therapist is required to survive and tolerate these hateful and aggressive feelings evoked by the patient. Thus, by the therapist surviving Lisa's onslaught of attack and, more importantly, maintaining her thinking capacity she demonstrates to Lisa that she can survive her destructive and aggressive experiences and renders these experiences back to Lisa in a less frightening and more tolerable form. Lastly, Wallin (2007) argues that when the 'other' survives the patient's destruction without retaliation, the patient is offered an opportunity to perceive the 'other' as a separate subject rather than object. This links with Benjamin's understanding of "mutual recognition" (Benjamin, 1990, 1999) which describes an intersubjective relatedness between two people where the individual can recognise an 'other' and simultaneously be recognised (Wallin, 2007).

Patient qualities. Each therapist-participant commented on patient qualities that enabled and facilitated the development of the therapeutic relationship. Therapists valued their patient's desire to change, their wish for personal growth, the rewarding effect of perseverance during the therapeutic process, and their abilities (i.e., psychological mindedness, commitment, respectful attitude). This is in line with research suggesting that therapists place high expectations on what their patients bring forth to the therapeutic process and the therapeutic relationship (Bachelor, 2013). This ties in with the sub-theme of mutual collaboration within the therapeutic relationship because it speaks to the patient working with the therapist and making a contribution to their own process in therapy.

The patient's desire for change and personal growth is significant for therapist-participants who experience this as a crucial element within the therapeutic relationship. It provides a sense that the therapist is not alone in his or her efforts to effect change and that the patient is willing to work towards something different and, more importantly, is committed to being in relationship with the therapist as they work towards this change. This correlates with research which suggests that the patient's willingness and desire for change positively influences the therapeutic work and the relationship between patient and therapist (Castonguay at al., 2006). Hope and positive expectations are created between patient and therapist. The therapist may become encouraged by the patient's motivation for change and willingness to venture into the difficult and often uncomfortable processes, and the patient may, in turn, become emboldened by the therapist's willingness to be there with them in these processes.

Secondly, the patient's ability to "stick with the process" was significant and important to all therapist-participants who admired their patient's willingness and ability to do so. As therapists, there was an understanding of how challenging and uncomfortable therapeutic work and processes can be both for patients and therapists. The toughness and challenging aspects were described as a long road or tough journey, therefore indicating that the work is consistently challenging. Moreover, therapists held strong beliefs in their patients and their ability to do the work. Stadter (2012) comments on how psychodynamic therapy takes time and ventures into often very uncomfortable affects and thoughts, which is where the meaningful work happens and where both patient and therapist are encouraged to stay in order to be most impactful. Thus, the ability to stick with the process is indicative of a patient who is able to stay with the uncomfortable and painful material in order for the process to become transformative in the presence of the therapist. This seems to allow the therapist to engage more fully, and feel a greater sense of satisfaction and efficacy in the therapeutic work being done.

Lastly, patient's abilities were drawn upon, in terms of their committed and respectful attitude as well as their psychological mindedness. Some research has suggested patient characteristics such as psychological mindedness may impact the development of the therapeutic relationship (Castonguay et al, 2006; Orlinsky, Grawe, & Parks, 1994), because it may facilitate linking. For example, a review study by Noyce and Simpson (2018) revealed that a sense of familiarity and implicit understanding was encouraged when patient and therapist held similar qualities, thus promoting bonding between the dyad. Commitment and respect are valuable qualities that enable the therapeutic relationship to solidify and flourish, making one's therapeutic work as therapist easier (Castonguay et al., 2006). Additionally, when the patient can think psychologically it also facilitates the work within the relationship and is again perhaps a little easier and less taxing. All these elements (desire for change, willingness and commitment to therapy, and patient's abilities) making up patient qualities are inextricably linked with one another and aid in the development and continuation of the therapeutic relationship. Patient qualities therefore seem to facilitate sharing between patient and therapist, and working together within the therapeutic relationship.

Factors Facilitating Therapy

      Factors facilitating therapy according to patients. Patient-participants highlighted important therapeutic factors in their experience during the therapeutic relationship with their therapist, namely, mutuality and therapist self-disclosure.

      Patient-participants expressed the importance for them of mutuality within the therapeutic relationship. For example, Kathy expressed how she and her therapist were open during the therapy process in terms of learning from one another and trying new things, and Kathy spoke highly of mutual collaboration and working together with her therapist. Kathy further elaborated how important it is for the patient to acknowledge their own responsibility within the relationship with the therapist and how the patient should be willing to work. This links with Bordin's pan-theoretical notions regarding the therapeutic relationship in his description of bonds of mutuality, where both patient and therapist work together within the relationship and, importantly, how the therapeutic relationship is strong enough to withstand change which is ultimately challenging and sometimes uncomfortable (Bordin, 1979). Furthermore, Yalom (2012) argues that patient's acknowledgment of responsibility for his or her difficulties is an essential step in therapy, because if the problem was only externalised there would be no motivation to change. This highlights that while the therapist facilitates the process, the patient must also claim responsibility which suggests the mutual working together

and bonding put forth by Bordin (1976) and is demonstrated in the experiences of the participants in this study.

Patients also identified mutuality, in terms of mutual honesty within the relationship. They highlighted their own need to be honest within the relationship with their therapists in order to receive the necessary help. Tessa and Kathy highlighted how withholding information can be detrimental and, without being honest, the therapist is unable to join and understand the patient's experience truly and completely. Therefore, the patient does not feel like they were helped or gained anything. When the patient withholds information, it prevents the functioning of the auxiliary ego (Hoffman, 2013) and impacts on the therapist's understanding of the patient and therefore their therapeutic approach in terms of holding the patient in mind, providing a non-judgmental atmosphere, providing perspective and remaining therapeutically present. Secondly, patients described how the therapist's honest approach within the relationship was valuable to them and different compared to other contexts and relationships. One patient-participant (Kathy) highlighted that for this type of honesty on behalf of the therapist to be fully possible a therapeutic relationship should be in place, where the patient feels safe and the therapist really knows and understands the patient. Thus, the honesty comes from a kind, authentic and helpful space.

Langley and Klopper (2005) found that honesty facilitated the development and continuation of trust within the therapeutic relationship and propose that this should be a mutual process. One review study found similar findings, suggesting that openness from both the therapist and patient leads to connecting and understanding the patient in a meaningful way (Noyce & Simpson, 2018). Although, mutual honesty seems important for patients, Lisa, despite her complete trust in her therapist, still struggles with being completely open and honest in therapy. It seems she withholds from her therapist owing to shame that certain things in her life simply cannot be shared. Stadter (2012, p.122) argues that patients require extensive time within the therapeutic process before "painfully shameful material" can be brought into the relationship. Thus, as therapists, it becomes important to hold in mind that some patients may find this aspect difficult owing to their unique past. Although a strong and long-term therapeutic relationship was in place with her therapist, this patient still struggled to disclose everything. Saypol and Farber (2010) argue that for the patient to benefit from psychotherapy they should maximise their disclosed information, yet in doing so it is often linked with shame that inherently comes with such personal disclosures. The process is therefore clearly more complex than that which is implied by Saypol and Farber (2010). However, what is evident is that openness and honesty are key aspects of the relatedness inherent in the therapeutic space.

The discussion now examines the therapist's self-disclosure, another sub-theme that captured patient-participants' experiences of factors that facilitate therapy. This links with the sub-theme of mutuality (being honest) as therapist self-disclosure is another form of openness and honesty. However, the difference for this type of honesty involves the therapists' reality compared to the patients' reality. Firstly, findings revealed that patients may have trouble when it comes to the dynamic of unequal disclosure within the therapeutic relationship. For instance, patients are required to self-disclose a great deal of information from the very beginning of the process. More often than not these are frightening and vulnerable parts of themselves, whereas the therapists do not disclose much personal information. For Tessa, this seemed very challenging in the beginning stages of her therapy, leaving her vulnerable and perhaps feeling exposed.

Ginot (2007) explores how enactments within psychotherapy, understood from an intersubjective viewpoint, encourage therapist self-disclosure as a tool for increased patient self-awareness and growth. Often, therapists' accounts of self-disclosure, from a relational perspective, involve disclosing their experience of the therapeutic relationship (metacommunication) rather than disclosure of personal information (Paul & Charura, 2014). Whereas Noyce and Simpson (2018) speak of therapist self-disclosure including therapist's personal information (i.e., relationship status) and found that it promoted authenticity within the relationship. Thus, patient-participants seem to reflect on metacommunication in terms of their reflection on mutual honesty within the relationship, whereas their reflections on therapist self-disclosure seems more directly linked, in their experience, to appreciating therapist disclosing personal information about themselves.

Interestingly, Tessa described how she gained some information on her therapist over the many years of therapy. It seems, therefore, that therapists may be willing to disclose and perhaps chose what they disclosed as the relationship matures. Therapists may become more comfortable making disclosures within a sustained therapeutic relationship due to the professional intimacy that develops over the course of, for example, eight to ten years compared to briefer therapies. Research demonstrates that as the therapeutic relationship develops, trust unfolds between the dyad, and a circular openness to self-disclose information occurs (Noyce & Simpson, 2018). Moreover, the more therapists self-disclosed, the more patients liked their therapist, perceived them as warm, and were more willing to disclose themselves. In line with this Audet and Everal (2010) found their patient-participants valued therapist self-disclosure as it levelled the disproportionate one-way experience the therapeutic

relationship offers and provided momentary relief from being the focus thus easing some of the discomfort.

All patients emphasised how therapist self-disclosure allows for their therapists to become relatable and appear more human. Interestingly, patients tended to idealise their therapist and this move away from the idealised view of the 'other'—through therapist self-disclosure—is more realistic and appropriate. It is apparent that the practice of realigning the patients' idealised perceptions of their therapist is beneficial. By sharing normal, everyday, human information, therapists appear more human, relatable, less idealised, and therefore realistic. This is important as it provides an egalitarian relationship, where the therapist is perceived as more personable, friendly and natural leading to increased connection and lessening the imbalance of power (Audet & Everal 2010). Therefore, as the therapeutic relationship matures and develops the patient may gather and gain more information on the therapist either through self-disclosure or by the experience of being in a therapy relationship with them over time. Their previously idealised views of the therapist become more realistic and the patient is also able to tolerate the therapist's faults.

Kathy describes how therapist self-disclosure should be carefully considered. This is reflected by Stadter (2012) who cautions relational therapists to be thoughtful around self-disclosure as there is the risk of over disclosure in attempting authenticity or possibly owing to their own interests. The Norcross Group suggest several guidelines when self-disclosing during therapy, namely, infrequent disclosure, considerations about self-disclosure such as weighing benefits and risks, and observing the patient's reaction to self-disclosure. Therapist self-disclosure, although helpful for Tessa, may need to be meaningfully thought about as she appears to desire "snippets per session" which may indicate a desire for a friendship rather than a therapeutic relationship. A distinction must therefore be drawn between therapeutically and theoretically-mandated metacommunication, and therapists' personal self-disclosure in psychotherapy. The former is a technique steeped in the process dimension of the therapeutic relationship and is used strategically in order to facilitate the patient's insight into their relational dynamics as they emerge and operate in the here-and-now interactions with the therapist (Hill & Knox, 2009). The latter, however, must be more carefully considered because of the potential risk of boundary violations by both therapist and patient although it seems that this does have some value in lubricating the relational space, and normalising the therapist for the patient.

Factors facilitating therapy according to therapists. Therapists also valued therapeutic factors which seemed useful within the therapeutic relationship. Sub-themes

centred around a holding and containing environment, theoretical orientation, the use of technique, and supportive factors for therapists.

Holding and containment describes the first sub-theme that captured therapists' experiences within the therapeutic relationship. They described an environment where connection, warmth and holding is experienced within the therapeutic relationship. As well as factors like the therapist's commitment to meeting the patient, containment, providing a consistent object and maintaining boundaries. Therapist 2, for example, reflected on representing a consistent object in Kathy's life, which provided a new relational experience of a consistently present other. Stadter (2012) describes how the consistency of the therapeutic frame and the available presence of the therapist provides the patient with a stable, consistent, and secure relationship over many years which leads to integration. Meanwhile, Therapist 1 expressed how between breaks and separations during therapy, Lisa required much containment and holding. Fonagy et al. (2018) describe borderline patients' vast histories of neglect and abandonment which may account for patients perceiving their current relationships—including the therapeutic relationship, at times—as attacking and neglectful. This seems particularly pertinent for Lisa as she exercises her testing behaviour in response to separations. Wallin (2007) describes how separations in therapy require the therapist to repair and contain the patient's distress with the hope that a curative resolution occurs to maintain patients' confidence in the therapeutic relationship as a secure base. Despite this sub-theme, therapists seemed to struggle to concretely consider factors that facilitate the therapeutic relationship. Thus, it seems these factors are more intuitive or ingrained within therapists and the way in which they work—perhaps second nature—and may therefore be more difficult to verbalise in concrete terms. This is, however, not surprising as Schore (2012) explains how the therapist gathers knowledge and clinical experience on an implicit level, that operates on a procedural level of awareness and is spontaneously expressed within the therapeutic relationship. This implicit relating is located within the right brain structures and is responsible for the functions including, "stress regulation, intersubjectivity, humour, empathy, compassion, morality, and creativity" (Schore, 2012, p.7).

Therapist-participants' theoretical orientation was particularly important for them and assisted with understanding their patients' dynamics and conceptualising the relationship between them, thus providing a supportive and scaffolding function, aiding their therapeutic work with patients. Using theory allowed therapists to work within a therapeutic frame and ultimately facilitate change. Therapists are able to recognise patterns in patient relating, name them and therefore work with them, together with the patient using the therapeutic relationship

(Paul & Charura, 2014). Specifically, therapists expressed how a psychodynamic orientation—and, for some, an orientation shift towards psychodynamic—allowed them to see their patients more fully, including their defences and their conflicts, as well as use the relationship in their therapeutic work. This reflects the aims of relational psychoanalytic therapy which situates the therapeutic relationship at the core to therapeutic work and change (Paul & Charura, 2014). Therefore, theoretical orientation influences how the therapeutic relationship is viewed, valued and experienced (Paul & Charura, 2014). Using formulation and theory equips the therapist in maintaining enough perspective within the relationship and surviving the patient's attacks, not becoming clouded by the patient's dynamic or pathology, and therefore not enacting avoidant or attacking responses that may have occurred in other relationships. Theory also provides a predictive quality thus guiding the therapist in the process. Stadter (2012) argues that therapists' professional training and experience (including theory), offer a blueprint for patient dynamics and thus a means of intervention. Therefore, even though every encounter is a unique confluence of the dynamics that are generated in the intersubjective space between therapist and patient, theory serves an organising function, scaffolding for the therapist their developing understanding of these unique dynamic in a way that facilitates the therapeutic action of the therapy relationship.

The use of technique was also an important aspect for therapists which allows them to work therapeutically and facilitate change. Although theory may inform and guide the use of technique, it is captured in a separate sub-theme as technique offers its own benefits and use within the therapy process. Many therapists expressed how the use of confrontation within the relationship—once sufficiently developed and formed—allowed for activation and negated the therapist's feelings of paralysis within the relationship. Once the relationship is sufficiently established the therapist can challenge the patient's more maladaptive behaviours, and the relationship is strong enough to withstand these challenges and, should ruptures arise, strong enough to overcome them (Stadter, 2012; McWilliams, 1994; Wallin, 2007). Although technique is useful, Therapist 3 highlights an important point about how the relationship is crucial in carrying change, regardless of technique. This corresponds with the relational psychoanalytic approach toward psychotherapy which maintains the therapeutic relationship as the vehicle towards change (Paul & Charura, 2014) suggesting that, while techniques are useful, they are cosmetic in the absence of an established therapeutic relationship. They can, however, highlight the strength of the therapeutic relationship but do not define the relationship. Lastly, therapists emphasised that the use of technique is done with consideration and thought, as well as empathy and kindness. Thus, in Therapist 3's expression of "gentle as

a dove and wise as a serpent" the point is made that techniques and interpretations are done with care, kindness and softness yet they are firm and the difficult things are still expressed, but within a therapeutic relationship that is already fortified. Yalom (2012), for example, describes how using here-and-now comments in relation to the therapeutic relationship, which will naturally—in the transference—include patient's old patterns of relating, assists in illuminating problematic processes for patients. The aim is for the patient to be able to explore and integrate what therapists offer them through reflection and interpretation but not be or feel threatened or attacked in a way that results in shut down or premature withdrawal from the therapeutic process.

The last sub-theme involves supportive factors for therapists. As has been described previously the therapeutic journey for both patient and therapist is not an easy one. One topic not often discussed is the therapist's supportive needs (McWilliams, 2004). Therapists described the difficult and challenging journeys that the therapies they have embarked on have entailed. Some discussed the need to survive very destructive and aggressive projections while remaining firmly in the relationship. Therapists offered comment and thought around what helps them remain present within the relationship.

Personal therapy and supervision were salient factors that enabled the therapists to tap into another thinking space, where an 'other' can think with them about the relationship with their patients. This process is similar to how patients appreciate therapist's presence helping them think. Thus, therapists gain perspective and are not as easily pulled into the dynamics of pathology when these supportive structures are mobilised. It is evident, therefore, that therapists also require spaces where an auxiliary ego may assist them in thinking and sorting through their experiences (Hoffman, 2013). Illustrating this, a supervisor commenting in an interview for a South African qualitative study examining parent-infant psychotherapy states, "I'm doing the reverie for the counsellor and the counsellors are doing it for the mothers" (Long, 2013, p114). This supervisor uses Bion's concept of maternal reverie (Bion, 1962) here to describe a chained process that takes place in therapy (as the first link) and then supervision (as the second link)—the therapist does for the patient what the supervisor does for the therapist by transforming "raw sensory data into reflective practice" (Eagle et al., 2007, p.133). This is essentially described by the therapist-participants in this study as crucial to their effective presence in the therapeutic relationship—the chain breaks if the supervision link is missing. Thus, a knock-on effect is described where the therapist has the experience of being held and contained through their various supportive spaces, which allows for them to offer the same function for their patients in turn in a real, authentic and open manner.

Therapist 1 also spoke importantly of self-care practices as therapists and how being in a tired place affects one's ability to work effectively as a therapist. McWilliams (2004) describes a variety of avenues psychotherapists should consider as self-care practices. She emphasises how therapists often encourage self-care practices for their patients, yet are less aware of their own self-care practices. McWilliams (2004) explores self-care practices in three areas: care of the id, the superego, and the ego. The id includes taking care of one's body, emotions, and human needs through sleep and rest, concentrating on health, addressing finances, sublimation, and play. The care of the ego can be sought through attending to professional nourishment (i.e., courses, workshops and conferences), privacy, and self-expression. Lastly, the care of the superego includes considering one's family, exposing one's work, and risk management.

Process within the Therapeutic Relationship.

   Process within the therapeutic relationship: Patient experience. The last major theme identified for patient-participants relates to process within the therapeutic relationship. Patient-participants described the relationship as a lifeline, they spoke of the moment of meeting their therapist, they described change, and they thought about how the length of their therapy was linked with the therapeutic relationship.

   All patient-participants experienced their respective therapeutic relationship as a lifeline. On the one hand patients described how their therapist caught them and, in a sense, 'saved' their lives. Alternatively, patient-participants talked about how their therapist's consistent presence and promise to be there provides safety for them to continue both within the therapeutic relationship and perhaps even extended to life itself. Patient-participants spoke of how therapists saw that they needed help before they themselves recognised they were at breaking point. Others spoke of their therapist being with them in the darkest moments of their life.

   What stands out in the patient-participants' descriptions of the therapeutic relationship as a lifeline, is how patients' experiences of a good enough holding environment seems limited. It appears that patients hold onto the therapeutic relationship much like a lifeline and feel as if they are falling apart when anything threatens the relationship (i.e., breaks or missed sessions), creating what Winnicott has termed unthinkable anxiety (Winnicott, 1987). Bion's concept of containment is useful in thinking about the experience of falling apart without the relationship and/or during separation. It is almost as if the relationship forms a skin—a mental barrier—holding all of the unbearable affects together (Bion, 1962). However, this understanding brings

forth the question of dependency within the relationship. The early phases of therapy often require a level of dependency as the patient does not have the capacities that therapists wish, ultimately, to instil in them. However, the experience of dependency is titrated downwards, and tapered, as the patient individuates during the therapeutic process and begins to take on the containing function for themselves. Mentalisation, for example, is first done for the patient by the therapist but is gradually transferred to a point where the patient can mentalise for themselves. This is, however, only possible because of the initial dependency upon the therapist to mentalise for the patient.

Theoretically, it can be conceptualised that as the relationship develops over time the patient encounters a new relational healing experience (Jaenicke, 2014; McWilliams, 1994; Wallin, 2007). A new attachment relationship is generated and through this experience—encapsulating holding and containment—patients begin to slowly take on these functions themselves. Therefore, they are able to tolerate their unbearable affects better and contain themselves through the experience of the therapeutic relationship.

All patient-participants, however, reflected on the relationship as a lifeline in a retrospective manner. It appears the relationship has evolved over time and the sub-theme centred around change (both patient and therapist accounts) documents how the patient-participants have taken on more of the therapeutic work and need the relationship less, which reflects perhaps the gradual development and internalisation of intrapsychic capacities over time (Wallin, 2007). However, for Tessa specifically, she described breaks and separations in the relationship as "holding her breath" and stated, "It can be quite scary" which perhaps suggests that breaks in the therapeutic relationship are still terrifying for her, suggesting that Tessa still feels a strong dependence within the relationship. It is possible that Tessa's early relational experiences have constellated to solidify a pattern of immaturity—and hence dependency—which may require additional time to disentangle, which is why her experience departs somewhat from those of other patient-participants in this study.

It also appeared challenging for participants to reflect on change within the therapeutic relationship in a concrete manner. Although patient-participants all noted change it was difficult for them to explicitly express this. Schore (2003) comments on how processes of exploration and intervention during psychotherapy become inseparable as the therapeutic relationship develops over time. In line with this, it is the implicit relational knowing within the therapeutic relationship that is crucial (i.e., process communication), rather than the content of the communication, in forming the foundation for the therapeutic action of psychotherapy (Lyons-Ruth, 1998). These are elements which are felt (i.e. implicit) rather than overt,

potentially subverting the possibility of becoming concretised in language, which may be why participants found expressing these changes during the interview process to be difficult.

The moment of meeting for all patient-participants is significant in their therapeutic relationship, particularly with regard to the experience as a whole and the meaning that the relationship holds for each patient. This theme—moment of meeting—is described as the first encounter between patient and therapist, although research understands these moments as occurring throughout the therapeutic process (Stadter, 2012; Lord, 2018; Wallin, 2007). Thus, the significance of the first meeting does not necessarily lie within the physical meeting, but in an intersubjective meeting, and can occur at any point, and potentially even more than once. Stadter (2012, p. 132) describes the moment of meeting as an "intersubjective meeting, a knowing and being known" between two people, which usually occurs after "now moments" resulting in resolution of the now moment. Stern (2004) describes 'now moments' as arising suddenly, being emotionally laden, and having imminent consequences. For Lisa, for example, the highly charged 'now moment' was described in their third session as Therapist 3 asked Lisa to choose between herself and her old therapist she had still been seeing. This 'now moment' following a 'moment of meeting' between Lisa and Therapist 3 was cultivated through a promise by Therapist 3 to remain present in the relationship with Lisa and the leap of faith by Lisa in trusting Therapist 3 to be with her and remain. This was described by Lisa as an intuitive/visceral feeling which guided her decision, thus an "intersubjective meeting, a knowing and being known" (Stadter, 2012, p.132). For Tessa, her desperate last hope with little expectation and her therapist, acknowledging her own sense of responsibility, yet taking the risk and still being there for Tessa 8 years later encompassed her 'now moment'. Finally, for Kathy, a meeting 5 years previously with the authentic and non-judgmental presence of Therapist 2 after Kathy disclosed very painful, distressing and shameful material defined her 'now moment' that allowed her to return 5 years later and be caught by her therapist who saw her pain. Therefore, moments of meeting should not only be thought of as pivotal moments within the therapy process—so-called "ah ha moments"—but may also take place in the very first meeting, first few sessions, with significant time-lapses or even in a passing moment outside of the therapeutic setting. What seems significant, however, is that such moments necessitate the therapist to bring forth an openness, authenticity and reflective stance to remain available in these 'now moments' with the hope of leading to moments of meeting with patients or even potential patients.

All patient-participants relayed how change was linked to the therapeutic relationship and the experience thereof. This is similar to the findings of Timulak (2007) where patients

identified the therapeutic relationship as leading to insight, behavioural change, and empowerment. Many described how they gained insights into their relational dynamics and their past, were provided with coping resources, internalised their therapist as a good object, became more integrated, and learned how to trust within relationships (Timulak, 2007). Patients' reflective functioning is encouraged and developed through the therapeutic relationship with the therapist, who provides a "secure base with communication that reflects consistent awareness of the intentional stance" (Wallin, 2007, p. 187). Patients were less concerned about symptom reduction and instead illuminated more relational changes within themselves (integration and an internalised good object) and in their relationships. It appears that the patients' connection with their therapists is crucial in creating a safe and supportive base from which the patient can explore and develop relationships with self and the world (Wallin, 2007). Similarly, this describes what Bordin (1979) terms bonds within the therapeutic relationship (i.e., trust, acceptance, and confidence).

Lastly, time was an important sub-theme for all patient-participants. They described how because of the length of time in therapy, they know each other very well. There was a deep sense of intimacy and connectedness in patient-participants' descriptions of their long-term relationship with their therapist. Stadter (2012, p.119) describes how long-term psychotherapy encourages dependency needs within the therapeutic relationship and promotes a depth within the therapeutic process and promotes "regression in the service of the therapy". Thus, over time—through the deepening of material—a strong sense of intimacy is created between patient and therapist in relationship with one another. Moreover, long-term work encourages what Bollas (1989, p.235) has termed the "unthought known" where there is "an awareness of self that is sensed but not yet thought" (Stadter, 2012, p. 120). This encourages unobstructed thoughts and emotions, affect regulation, tolerance of the unknown, and reflective capacities for both patient and therapist (Stadter, 2012).

Process within the therapeutic relationship: Therapist experience. The description of the therapeutic relationship as intimate yet formal is a useful one. John Bowlby (1980) argues that individuals' lives centre around close relationships with other human beings. It captures the realness and human quality experienced and felt during therapy with patients with the notion that patient and therapist are two humans in the room and in relationship with one another. A sense of intimacy is felt and experienced, however, there is also a formal quality to the relationship where the therapist can confront and be honest with the patient through the use of the therapeutic frame and boundaries. It was described as a privilege to work with patients in this manner and refreshing and rewarding to work with patients on such an intimate level,

yet have firm boundaries in place. Certainly, this is very different to a social relationship which, although intimate, can have very blurred boundaries. Therapists further highlighted the importance of not re-enacting old patterns within the relationship thus creating a new experience for the patient, different to all other relationships.

Using Bion's concept of maternal reverie offers an understanding toward this intimate yet formal therapeutic experience. The therapist who makes use of maternal reverie enters the patient's world, becoming deeply involved with their experience. This in itself describes a very intimate experience of knowing someone, implicitly. The therapist in turn digests or makes sense of the patient's often intolerable experience/affects and responds appropriately by relieving their distress (Copley & Forryan, 1997; Ogden, 2004). Similarly, a relational standpoint encourages the therapist to join the patient's subjective experience through enactments. Thus, the therapist comes to experience and know the patient in an intimate and feeling manner that is not filtered by language and therefore renders both patients' verbal and nonverbal experiences accessible (Wallin, 2007).

Similar to patient-participants, all therapist-participants spoke of the moment of meeting their patient and regarded the meeting as significant remaining forever in their memory and providing meaning to the therapeutic relationship itself. Therapist 1 experienced an immense amount of responsibility at Tessa's desperation entering therapy, Therapist 2 valued having known Kathy in some capacity beforehand which brought a specialness to the relationship, and lastly Therapist 3 described her first meeting, long journey and significant gains with Lisa in terms of the therapeutic relationship.

Therapist-participants also expressed how patient changes were experienced within the therapeutic relationship. Therapists appeared proud of how far their patients had come, despite the very difficult journey, and what seemed rewarding for therapists was witnessing their patients healing and being part of a process that offered them a different life, especially considering their roots and where they started. Watson and colleagues emphasise how change within the therapeutic process is facilitated by the therapist's understanding of patients' "pretreatment characteristics, psychotherapy process, and outcome" (Watson et al, 2011, p.87). Therefore, therapists take the whole patient into account, reflecting on their patient's capacities and therefore moderating the expectations of change that the patient can achieve as well as taking the appropriate treatment approach.

Patients appeared more free, authentic and individuated in the therapeutic space and their way of relating in therapy as well as gains outside of therapy. This links with Winnicott's understanding of creativity within psychotherapy in facilitating a fuller sense of self (Nolan,

2012) because there is more room for play within the therapeutic relationship. All patient-participants, according to therapists, seemed to evolve into more authentic ways of relating. While their defensive strategies did not fully disappear, they were brought into awareness and smiled upon with kindness, leading these ways of relating to perhaps becoming less rigidly relied upon.

The therapeutic process was described by therapists as less taxing and much easier following this change, owing to patients' more adaptive ways of relating. Wallin (2007, p.284) describes how the therapist changes within the therapeutic relationship and "is no longer straitjacketed by the enactment". A knock-on effect occurs in which the therapist changes leading to the relationship changing and, at times, the patient as well. Importantly, not all patients' dynamics, conflicts and defences disappear. Rather, the patient becomes aware of their dynamics and conflicts—honouring them and owning them. Therefore, although they do not completely disappear, through some awareness and acceptance they do seem to hold less power in the patient's life and relationships. Therefore, when therapists reflected on their experience of the therapeutic relationship, patients' paths toward change seemed to reflect the long journey patients and therapists had travelled with one another and looking back over this time therapists hold a sense of pride in how far they had come.

Lastly, time was also a significant sub-theme related to the therapeutic relationship in terms of therapist's experience. All therapists contributed much significance to the length of their therapeutic processes with their patients. One therapist described how her patient does not need therapy as intensely as she did in the beginning but she still requires check-ins as if touching base. Attachment research (Hoffman, Cooper, & Powell, 2017; Marvin, Cooper, Hoffman, & Powell, 2002; Powell, Cooper, Hoffman, & Marvin, 2014; Wallin, 2007) aids in understanding this experience. The therapist (like the caregiver) offers the patient (infant) a secure base. Through a trusting and safe relationship an individual experiences care and learns to know that someone will be there through life's hardships. Through this knowing and trusting they are able to venture out into the world (Hoffman et al., 2017). The experience of being experienced by an 'other' as an infant (Beebe et al., 2010) is similar to how the patient in relationship with the therapist, and over time, is understood and experienced by the therapist fostering a sense of safety and opening the patient up to explore themselves and others (Powell et al., 2014).

Similarities and Differences between Patient and Therapist Experiences

The first theme introduced for both patient- and therapist-participants highlights several similarities and differences, however subtle. Firstly, both patients and therapists seemed to draw on what each party brings to the relationship or what they offer, and they link this to how it is useful within the relationship. Interestingly, it appeared somewhat easier to reflect and think about what the 'other' contributes within the relationship compared to what oneself brings. This is similar to previous research (Bedi, et al., 2005) where patients mainly accounted for therapists' contributions within the relationship rather than reflecting on their own. Although both patients and therapists could draw on what the 'other' contributed to the relationship during therapy, there are also subtle differences noted. For instance, patients described their experiences more in terms of what the therapist offers them within the therapeutic space and the relationship. They seemed to describe the therapeutic atmosphere rather than specific personal characteristics of therapists. This is somewhat different to existing research highlighting patients' perceptions of therapist characteristics including, "gender, race, age, weight, height, dress, hairstyle and office décor" which may impact on how the therapist or the therapeutic relationship is experienced (Nezu, 2010, p.172). This may be accounted for by the patient and therapist similarities in this study (all participants being white female, for example) or perhaps such characteristics pale in comparison to the therapeutic atmosphere that is created between patient and therapist. In line with this, therapists draw on their contributions within the therapeutic relationship, reflecting on the holding and containing presence they offer their patients and how this facilitates the formation and deepening of the therapeutic relationship. They also attributed the therapeutic relationship and experience thereof to patient's qualities and abilities, which facilitated the therapeutic relationship.

The second major theme is grouped around patient and therapist accounts of factors in therapy that facilitate the therapeutic relationship. What seemed valuable, important and aiding the therapeutic relationship appeared to be different for patients compared with therapists. This is consistent with research that revealed patients' appreciation for collaboration within the therapeutic relationship and therapists' positive, accepting and understanding attitude as facilitating factors (Bachelor, 2013). The patient-participants in the current study also appreciated mutual collaboration in terms of working together to reach change within the patient's life and experience, creating an atmosphere of "we are in this together". However, this is also rooted in therapist-participants' descriptions of patient qualities in terms of their desire for change and commitment and willingness to weather the stormy nature of therapeutic work, which lends itself to a collaborative process. Patient-participants also appreciated and

valued mutuality, recognising the importance of one's own role as a patient to be honest within the therapeutic space and for the therapist to provide honest feedback which is often different to other relational situations in everyday life. Therapist self-disclosure, a separate sub-theme, yet inextricably linked with mutuality (i.e., being honest), is valued and appreciated according to patient-participants. There is a desire, according to patient-participant accounts, for a mutually shared experience, facilitated through therapist self-disclosure. Therapist self-disclosure was valued because of the realistic image and humanness it bestows on the therapist, departing from their previously idealised perceptions of the therapist and therefore encouraging relatedness. However, complexities are noted in patients' experiences of therapist self-disclosure and there is a cautious note given about when and how to appropriately disclose information. These findings are comparable to other research findings (Audet & Everall, 2010; Hill & Knox, 2009), where therapist self-disclosure facilitated an attuned, close, comfortable and egalitarian relationship; however, a note of caution for therapist self-disclosure was emphasised noting it could also lead to role confusion, role reversal, and patients feeling misunderstood.

Therapists on the other hand valued factors associated with their professional training and clinical practice when reflecting on their experience of the therapeutic relationship. Their chosen theoretical orientation provided therapists with more activation within the therapeutic process, and understanding and insight into the patient's world, their conflicts and their defences. Leading on from this, therapists valued technique in the therapeutic process that enabled them to handle the often-challenging relational dynamics and maladaptive behaviours of the patient. Lastly, they noted the importance of having supportive structures (therapeutic input and supervision) that allowed for the therapists to maintain perspective of the therapeutic relational dynamics and essentially remain within the relationship, both physically and emotionally.

Thus, it seems different aspects are valued according to patients and therapists when considering the therapeutic relationship. What stands out are patients' strong needs for therapist self-disclosure which is often a taboo of sorts amongst therapists, although changing (Audet & Everall, 2010; Ginot, 2007; Hill & Knox, 2009; Noyce & Simpson, 2018). It seems important to be thoughtful around self-disclosure as therapists. Although appreciating the patient's real desire for more relatable information on the part of the therapist, one should take into account the length of the relationship, the patient's dynamic and the meaning behind their need for disclosed information, and the type of information they seek (Stadter, 2012). For instance, with Tessa it could be argued that her motivation for therapist self-disclosure is a move to more of

a friendship (which was noted in one of her previous therapeutic experiences), whilst Kathy seems to appreciate bits of information like 'married with children'. Thus, sharing personal information every so often over the years with Kathy seems to foster a relatedness, connection and ultimately facilitated the therapeutic relationship and bonding. Whereas giving in to Tessa's need for "bits of information per session" could become an easy trap for the blurring of boundaries with the consequence of being pulled into a dynamic in a way that diverts from the therapeutic work.

Therapist-participants on the other hand find that theoretical understanding and use of technique is incredibly important and needed when working with patients and developing a therapeutic relationship. What this suggests is the therapists' need for knowledge and understanding, which leads to perspective and the ability to understand the dynamics and not react to them. Theory and use of technique seem to provide another area of support for therapists to be fully present within the therapeutic relationship. Patients emphasise the value of the therapeutic atmosphere provided by the therapist, where therapists seem to lean on theoretical and technical approach as one of the means to provide such a therapeutic atmosphere. On the other hand, therapists find it challenging to think concretely about the therapeutic atmosphere, which may be more intuitive and/or ingrained within the therapist whereas theory and technique are more tangible and consciously thought about and used in therapeutic work with patients. The process of providing a relational therapeutic atmosphere is often unconscious and instinctive, or natural, within the therapist's manner of relating to others hence it may defy representation in concrete terms (Schore, 2012).

Lastly, therapists described the need and usefulness of additional supportive factors such as personal therapy and supervision which allows the therapist to maintain perspective and stay present in the therapeutic relationship, and to survive sometimes very strong and destructive projections from the patient. This links to the idea that theory and technique also provide similar supportive functions for therapists. Overall, the capacity for therapists' reflective function is important within the therapeutic relationship and therefore therapists require their own source of support in helping them remain reflective and present within the therapeutic relationship (Long, 2013; McWilliams, 2004).

Similarities were identified amongst patient- and therapist-participant experiences with regards to process within the therapeutic relationship. For example, both experienced change as an important element within the therapeutic relationship. Patients spoke of how their therapist and the relationship with their therapist enabled change within themselves. Similarly, therapists relayed the experience of witnessing changes over time with their patients and the

rewarding feeling and sense of pride that comes with this. Another similarity between patient and therapist accounts was their acknowledgment and meaning they attach to the 'moment of meeting' with one another. The meeting was significant and special in its own right for each dyad and the patient and therapist within each dyad had similar perceptions and understandings of their meetings and the meaning it held for the therapeutic relationship. It seems each meeting involved a "now moment" followed by a "moment of meeting". The last similarity held by patients and therapists in terms of process within the relationship is the length of time they have been in therapy together and how this has significant meaning to the therapeutic relationship with one another.

The one difference noted relates to the patients' and therapists' descriptions of the therapeutic process. Patients described the relationship as a lifeline, having been saved and journeyed together with the therapist through their darkest moments. Therapists on the other hand described the relationship as intimate yet formal and how it is a privileged position to journey with their patients on such an intimate level, yet still hold therapeutic boundaries and frame.

Conclusion

This chapter has explored this research study's major findings in terms of patient and therapist experiences of the therapeutic relationship and has linked these findings to previous research and theory that allows the findings to be made sense of and contextualised within the literature. Thereafter it explored similarities and differences between patient and therapist lived experiences of the therapeutic relationship.

CHAPTER SIX: CONCLUSION

The overall aim of this qualitative study was to examine the lived experience of the therapeutic relationship in psychodynamic psychotherapy for both patients and therapists. The hope was to gain a rich understanding and insight into the different views regarding the relationship as well as what the therapeutic relationship meant to both therapy participants—patient and therapist.

The specific research question that was explored is as follows:

What are patients' and therapists' experiences of the therapeutic relationship during psychodynamic psychotherapy in a South African context?

This chapter will begin by presenting the major findings in the study based on the research presented in previous chapters. It will then engage briefly in a discussion of the present study's limitations before presenting the researcher's reflexive commentary.

Major Findings in the Study

Both patient-participant and therapist-participant lived experience of the therapeutic relationship clustered around three major and somewhat similar themes, with various sub-themes. Overall, the therapist approach seems essential when attempting to capture the experience of the therapeutic relationship from the perspective of the patient. The therapeutic relationship offers a space to be held in mind and thought about. Therapists offer their patient an opportunity to convert their confused, fearful and overwhelmed experiences into thinkable and more tolerable experiences. The therapeutic relationship is set in the context of a non-judgmental and consistent presence, where the therapist empathises with the patient's experience and offers a whole-hearted and implicitly felt form of acceptance and is fully present in the patient's moment of need. An objective presence is provided by the therapist who offers another mind and a thinking space for patient experiences that are often unthinkable thus providing a space for these intolerable experiences and giving them meaning. Consistency within the relationship was significant and important for patients to have a different experience of an 'other' who is able to be with the patient and stay with them during these difficult experiences and feelings.

Another main theme for patient-participants included facilitating therapeutic factors whereby mutual collaboration and mutual honesty was highlighted as valuable. The former represented that patient and therapist working together within the relationship. The latter describes a two-way honest and open approach that fostered a shared connection and intimacy within the relationship. However, the experience of mutual honesty can also be equally

terrifying for some patients who worry about sharing painfully shameful material. Within this main theme is therapist self-disclosure, whereby patient-participants valued the relatable and more human connection that disclosure brought forth. A more egalitarian relationship was also noted.

Process was the final theme for patient-participants. Patients experienced the therapeutic relationship as a lifeline where they experienced being caught, recognised and saved within the therapeutic relationship. Therapists provided patients with a consistent presence by surviving experiencing patient's darkest moments. Also significant within this theme were 'moments of meeting', whereby patients meeting their therapists signified a special moment in memory and in meeting an 'other' who imparts the feeling of being seen, recognised, and remembered. Alongside this moment of meeting is the continued/sustained therapeutic relationship (for some, up to a decade). There may be many factors which have contributed towards the length of the therapy but, in patients' experiences, this first meeting is key and the fact that they feel it is the reason for why they are still seeing their therapist points to the salience thereof and how meaningful it is to them. Change was another sub-theme falling under process within the therapeutic relationship. Change is experienced as relational in nature and emerged over time, either directly or indirectly, as a function of the patient's experience in, and of, the therapeutic relationship. In other words, patients learned about their interpersonal relationships, and made changes in these relationships, as a result of relating to the therapist in therapeutically transformative ways. The therapeutic relationship, therefore, is key to this process. Patient-participants acknowledged the importance time held when thinking about the therapeutic relationship with their therapists. As the therapeutic relationship developed over time, so the strength of the relationship flourished and what came with this was an understanding and knowing between patient and therapist. With time, the relationship was experienced as intimate, shared, special and unique. However, what also seems to be an outcome of a long-term therapeutic relationship is a sense of dependency and need for the relationship.

Therapist-participants' descriptions of the therapeutic relationship were broken up into various themes. The first, patients' desire for change, their committed attitude, tenacity and ability to stick with the long and hard journey were greatly appreciated and valued by therapist-participants as it gave a sense of unity within the relationship and meaning for the therapist and their work. Factors facilitating therapy were explored by therapist-participants, namely, connection, warmth, a holding environment, therapist's commitment to meet the patient, containment, providing a consistent object and maintaining boundaries. Factors are, however,

often intuitive or ingrained within therapists and the way in which they work—perhaps second nature—and are therefore more difficult to operationalise and verbalise. There is an experiential quality to this as it is not consciously applied but, rather, is inherent to the implicit relational knowing that is functional within the process. Therapist-participants also found their theoretical orientation to be incredibly important in understanding their patients' dynamics and the therapeutic relationship which allowed for a therapeutic frame and approach in working with their patients, which facilitated change. Another sub-theme is the use of technique, in a gentle but firm manner, attuned to the patient's needs rather than their pathology. This allowed for change and progress within the therapeutic process and the therapist is not left powerless and disarmed, overcome by the emotional storm patients' experiences often bring. The therapeutic relationship is the vehicle for carrying this change and is strong enough to hold this often uncomfortable and difficult process. Furthermore, should ruptures arise, the therapeutic relationship is what pulls the dyad through the experience and together they are able to overcome the rupture. Lastly, supportive structures are highly valued and needed for therapists to maintain perspective and a reflective function regarding the therapeutic process with the sole aim of the patients' needs in mind rather than being aligned with the pathology. Supportive structures allow for therapists to have their own space of holding to digest and make sense of their experience as a therapist and as a person, which allows them to remain fully present and available within the therapeutic process and therefore contributing to the experience of the therapeutic relationship.

The last main theme for therapist-participants was identified as process. The therapeutic relationship is described as incredibly intimate for both therapists and patients, which speaks to what is happening between the two of them as they venture and experience together the patients' world and difficulties. Yet the firm boundaries allow for safety and thinking to remain in the process and not become blurred and engulfed by old patterns of relating—both the patients and the therapists patterns. Moment of meeting, another sub-theme, highlighted the beginning of their journey acutely held in the memory of all therapists. A relationship starts from the moment of meeting, or perhaps even prior, according to fantasies of what the experience might be like. All experiences were significant moments in illustrating and appreciating how far the therapeutic relationship has come and where it all began. Change is described as a highly significant relational phenomenon for the therapist-participants in this study who—through the therapeutic relationships—have made meaning for themselves in the growth and developments seen in their patients over the course of their respective therapeutic processes. Lastly, time seems to strengthen the relationship and allow for the therapist to be

honest and open in their communications. There is also something about the therapeutic relationship helping the patient grow and develop outside of the therapy space and not need therapy and the relationship as much compared to previous years. However, there is still a need to check in with the therapist and a means of holding onto the relationship.

Similarities between patient and therapist experiences revealed that patients and therapists had similar experiences regarding the therapeutic approach, the moment of meeting, change, and the length of time. Whilst they differed in terms of importance held for therapist disclosure and overcoming past therapeutic experiences in terms of the patient experiences and theoretical orientation, use of technique and supportive factors for therapists in terms of therapist experiences.

Study Limitations

In qualitative studies the concern becomes transferability rather than generalisability per se. Therefore, although the study sample size of six is considered small in quantitative terms, in this study the focus centres on how our findings transfer from one context onto a similar context which it is believed is possible for this study. However, it is important to note that the sample consisted of only white Afrikaans patients as well as therapists, thus the context to which these findings would be transferable is perhaps onto a similar context of patient-therapist dyads engaged in private practice long-term psychodynamic psychotherapy. Given that many South Africans do not have access to private psychological services, this study may have only narrow applicability and relevance. However, it may serve to stimulate and encourage future research in a diversity of settings in South Africa which could help to elucidate the significance of the therapeutic relationship in various contexts.

Although homogeneity was created by including only psychodynamically-oriented approaches in this study, it may also potentially limit the findings. Other orientations such as cognitive behavioural therapies, for example, may have a different experience and understanding of the therapeutic relationship when explored phenomenologically; this is perhaps an area for future research. In terms of language, although all participants had Afrikaans as their home language, our dialogue with one another was still possible in English. With one patient-participant (Kathy) there were a few occasions where we searched together to come to an English word and she exasperatedly said to me during the interview (in a light tone) why I had not learnt Afrikaans in school. The rest of our communications were, however, smooth and effective.

Lastly, it is possible that issues such as race, class, gender, sexuality etc. impact on the therapeutic relationship in important ways (Eagle et al., 2007; Strous & Eagle, 2004; Knight, 2013; Mbele, 2012; Nezu, 2010; Swartz, 2007; Swartz, 2012; Victor & Nel, 2016). However, these issues were not actively explored in the interviews with participants and did not form a significant theme. This is potentially owing to the fact of similarity within and between patient-therapist dyads. This would be an important area of exploration for future research.

Reflexive Commentary

My reflective commentary seems to be presented at the beginning of this dissertation, in *Chapter One* and is now also introduced at the end of the research study—this is perhaps reflective of the nature of the researcher's role in phenomenological research of this nature in which the findings and interpretations are inevitably filtered through and crucibled within the experiences of the researcher. Although the manner in which it is presented here appears to 'bookend' the dissertation, it is important to note that I have engaged reflectively continuously throughout the entire research process with concentrated efforts towards self-awareness. My interest in the therapeutic relationship began when I first embarked on my training as a clinical psychologist. Although aware of the concept and importance of the therapeutic relationship, the explicit nature and understanding was less apparent to me and I appeared to lack descriptive language that enabled my understanding of what was happening within the therapeutic encounter and in relation to my patients (this is not unlike the experiences of the participants who had challenges in concretely describing the changes and processes in the therapy). Through supervision and training, I understood how incredibly valuable and essential the therapeutic relationship is in our work with patients and in encouraging change. I could also begin to explore my own reactions and internal responses to certain dynamics within the therapeutic relationship, and therefore be mindful and understand how this plays out in the therapeutic relationship. As time went on, I also became increasingly aware of what the therapeutic relationship may be providing the patient and I began conceptualising what the relationship means to patients. I strongly believe in working with the therapeutic relationship in my clinical work with patients and I identify with a psychodynamic approach to psychotherapy. Having felt the impact of the relationship within my work, I was prompted to consider what other therapists' and patients' experiences might be.

I think from a personal perspective I have always been intrigued by relationships in general and the powerful impact they have on us all as human beings. My intrigue perhaps also links with my own dynamic and sometimes strong desire for closeness and connection and at

the same time a fear of engulfment. Thus, my own dynamic tends to hold conflict at times around closeness and distance. I also noticed my intense intrigue into both therapists' and patients' experiences of their therapeutic relationship and felt honoured and privileged to be allowed into such an intimate and sacred space. This can speak to the therapist-participants' descriptions of the therapeutic relationship as intimate, yet formal. My position as researcher in this study, as well as my role as a therapist in general, offers me an incredibly intimate experience with an 'other', yet I remain closeted safely behind boundaries and the therapeutic frame and in this regard research procedure and ethics.

It is also important to note that finding participants proved more challenging than expected. My approach is more inclined towards psychodynamic work and, therefore, I approached therapists with similar orientations. Many therapists were interested in the study and commented on how useful it would be, however they expressed concerns and anxieties about asking one of their patients to participate in the study. Therapists were cautious and considerate by holding in mind what participation in this research study would mean for their therapy process and therapeutic relationship. I was anxious approaching therapists, very aware that I was indeed asking them to share their very close and intimate connections with me. I myself, on a few occasions, reflected how I would feel about discussing my own personal therapy and relationship with my therapist. Although, I generally felt I would be open to this, there was a lurking sense that I would be sharing something very private. These complexities should be thought about by future researchers that may embark on exploring patient and therapist experiences of the therapeutic relationship in a qualitative manner which may yield various anxieties for both patients and therapists.

Having said this, the six willing participants seemed to value speaking about their relationships and each of them seemed to gain something themselves through the interviews. Both patients and therapists commented on how valuable, insightful and useful the interviews were and, in every participant, sparked something they had not really thought about before and either wanted to keep in mind for future or, in some cases, particularly with patient-participants, follow up in their therapy. Research has shown that interviews regarding the therapeutic relationship with patients and therapists potentially enhance the therapeutic process (Bischoff, McKeel, Moon, & Sprenkle, 1996; Joanides, Brigham, & Joanning, 1997; Shilts, Rambo, & Hernandez, 1997).

I was also very aware during data collection and analysis of my role as a therapist and how this may impact the research. During interviews with patients I found myself wanting to slip into the therapeutic role. I would immediately think of theory and patient's dynamics and

because of this awareness I was careful to not over-theorise the patient and rather let their lived experience come to the fore and I had to remain cognisant of my research role. My therapeutic abilities helped me greatly during all interviews—skills like listening, reflecting, and so forth—which enabled the interview to flow. However, I noticed after the first two interviews with patients and with the support of my supervisor, that I was reflecting patient-participant experiences, which I gauged through various and subtle communications during the interview, yet this lead to them agreeing with me saying "yes!" and I missed opportunities for them to capture the experience in their own words. Interestingly, I had used the word "client" throughout the proposal stage of the research and during interviews. However, once my interview with Kathy had ended, she questioned my use of the word "client" indicating that it felt like a financial transaction and she felt the relational aspect was lost. I undoubtedly honoured her experience and consequently changed my wording in all future reporting.

I also recognised my own identification with therapist-participants. This seemed to go both ways and often therapists addressed me as their collegial professional and would say things like, "you know what I mean?" On the one hand this facilitated rapport during the interview, but on the other I had to be aware that our knowing was not simply left there, and I still encouraged therapists to elaborate on their words. This was particularly felt with Therapist 1, who I not only identified with on a professional level, but also on a personal level. Her thoughts about the relationship and using the relationship as well as her very self-reflective stance and awareness is how I tend to approach therapy with patients. Despite this connection with therapists on a professional level, I also felt equally a novice in comparison to their immense experience.

During the write-up of this study I became aware of how I seemed protective of therapist-participants in terms of ruptures experienced by patient-participants. This awareness was only rendered after reading literature where therapists acknowledged their mishaps and were brave and honest in their experience during therapy which was often filled with anxieties and overwhelming emotions (Jaenicke, 2014, Yalom, 2012). Only through other therapists' acknowledgements of the difficult therapy process, countertransferential responses and wrong steps taken in therapy, did I recognise that two patient-participants (Tessa and Lisa) and two therapist-participants (1 and 3) described how misunderstandings or hindering factors occurred within the therapeutic relationship. Upon my realisation I revisited participant transcripts and with relief found that I did not shut down their description of these misunderstandings; I had even asked for elaboration and encouraged talk of their experience. Thus, my very apparent avoidance of these experiences seemed to relate to my own struggle of acknowledging and

making sense of them and protecting my 'colleagues' as well as myself in response to my feelings of shame and guilt and need to get it right. Safran et al. (2001) argue though, importantly, that working through ruptures within the therapeutic relationship is necessary and fundamental to therapeutic change—something I have come to appreciate, with time.

Lastly, and most importantly, the research interviews themselves were an incredible experience for me. As mentioned, it felt like a privilege to have the participants share their experiences of the therapeutic relationship with me. Moreover, many of the stories and experiences shared will stay with me forever and have undoubtedly influenced the way I work as a clinician. Hermeneutic discovery is said to be reached when there is deep interaction between participant and researcher, where deeper insights are reached and the closer the researcher can get to the lived experience of the participant and is changed in some way as a result of the dialogue (Ponterotto, 2005). Empathy and identification takes place on the part of the researcher who experiences the participants' stories and their meaning (Sciarra, 1999). This was profoundly true in the case of this research and my experience thereof.

My unanswered question of what "forming a relationship explicitly meant?" stated at the beginning of *Chapter One*, has been experientially explored throughout this research experience. It has been a process that has evolved over time. It has been a journey of sensing thoughts/experiences and making them known and thought about (Bollas, 1989) with the help of many other minds, including my supervisor, the research participants, my own personal relationships, my personal therapeutic relationship, and relationships with my patients. These relationships and experiences were often used (both consciously and unconsciously) to stimulate my own reverie in thinking about the therapeutic relationship and the experience thereof.

Conclusion

This chapter concluded this research study's major findings in terms of patient and therapist experiences of the therapeutic relationship. Thereafter study limitations were explored. Following this, my reflexive commentary as researcher was offered.

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Appendix A: Patient Information Sheet

The therapeutic relationship in psychodynamic psychotherapy: An exploration of patients' and therapists' experiences in the South African context

PARTICIPANT INFORMATION SHEET

Study information

I, Alexandra Stevenson, am a student psychologist at the University of Pretoria. We would like to invite you to participate in a research study that aims to better understand the therapeutic process and more specifically explore the relationship between the client and therapist. This research is important as we want to understand how the therapeutic relationship supports the client and facilitates or hinders the therapy process. This information will help us gain more insight into the therapeutic relationship in a South African context.

Why would we like to invite you to participate in the study?

You have been attending/ or have attended therapy. We want to understand the experiences of clients who attend therapy as we are interested in knowing how the relationship between the client and therapist assists with the process during therapy.

You are therefore important in helping us understand your experience of the relationship you may have developed with the therapist and your experience of the process. It will be valuable to have your input on what your experiences were. We would like you to share with us important moments or things you may remember during your time with the therapist.

What can you expect?

If you agree to participate in the study, you will be invited to an interview with the researcher in order to develop a thorough understanding of your experience of therapy. The interview will last about 60 minutes. While there will be no direct benefit or reward for participating, your involvement will make an important contribution in facilitating our understanding of the therapeutic relationship in the South African context. No harm will come to you by participating in the study. If, however, you feel in any way distressed following participation you are welcome to contact the researcher (contact details appear at the end of this sheet) who will place you contact with a registered professional to address your concerns.

We would really like to understand the experience of therapy from your perspective and the perspective of your therapist. To help us gain this understanding, it will be really helpful for us to talk to your therapist as well on how they viewed the therapy process.

Keeping the information private

We will not tell anyone what you tell us without your permission unless there is something that could cause harm to you or someone else. If for example you tell us that someone is or has been hurting a child, we may have to share that information with people who are responsible for protecting children so they can make sure that the child is safe. You can refuse to answer any questions you do not wish to answer and you may withdraw from the study at any point, without any consequences. Instead of using your name we will use a pseudonym when making reference to your experience in the final report, or any subsequent research-related outputs. The data may be used for future research, publications, and /or conference presentations and the data will be stored/ archived in the department. No one will know that it is you who talked to us. All the information will be stored and kept securely. Please note that the study relates to your experience of the therapy and the therapeutic relationship. Therefore the content of the therapy itself will not be shared. As such, your therapist will _not_ be asked to disclose any of the information you shared with them during the course of therapy. That information will remain confidential, and only between you and your therapist.

Recording the Interview

I would like to get your permission to use a tape recorder during the interview. The recording is necessary because I would not like to take notes during the interview but rather listen to what you have to say. Once again, all the recorded information will be kept private. The taped recording will not be listed with your name on and it will be stored in a safe place.

Your rights

It is okay if you do not want to participate in the study. You could also remove yourself from the study once you have agreed to participate. You also do not have to agree that we can talk to your therapist. This can happen at any time and the researcher will respect your decision and there will be no negative consequences for you in anyway.

Contact Details

If you have questions, concerns or complaints about the study, please contact me or my supervisor using the information below.

Researcher: Alexandra Stevenson| | 072 964 9991 | alex-louise-stevenson@hotmail.co.uk
Research Supervisor: Ahmed Mohamed |012 420 4006 | ahmed.mohamed@up.ac.za

Appendix B: Patient Consent Form

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

The therapeutic relationship in psychodynamic psychotherapy: An exploration of patients' and therapists' experiences in the South African context

PARTICIPANT CONSENT FORM:

Study information

I, Alexandra Stevenson, am a student psychologist at the University of Pretoria. We would like to invite you to participate in a research study that aims to better understand the therapeutic process and more specifically explore the relationship between the client and therapist. This research is important as we want to understand how the therapeutic relationship supports the client and facilitates or hinders the therapy process. This information will help us gain more insight into the therapeutic relationship in a South African context.

Why would we like to invite you to participate in the study?

You have been attending/ or have attended therapy. Your therapist has identified you as someone who may be interested in participating in the study and who can provide us with feedback on how you experienced the relationship with the therapist and what this process meant to you. You are an important part of this research, having experienced the process yourself.

What can you expect?

The interview is important as we want to get a close enough understanding of your experience of therapy and the relationship you established with your therapist. The interview will last about 60 minutes.

How can the study affect you?

Some questions on how you experienced the therapy and therapist will be asked during the interview. We do not predict the interview to be distressing in nature, however, should you need assistance and you are currently not in therapy, we will refer you to psychological services.

Keeping the information private

All information that you give us will be kept private as far as possible. However, we may not be able to keep information about known or suspected acts of deliberate neglect or physical, sexual or emotional abuse of a child confidential. If we are given such information, we may report it to the authorities such as child welfare or the police. You can refuse to answer any questions you do not wish to answer. Instead of using your name we will use a code. No one will know that it is you who talked to us. All the information will be stored and kept secure, and will be destroyed at the end of the study.

Recording the Interview

I would like to get your permission to use a tape recorder during the interview. The recording is necessary because I would not like to take notes during the interview but rather listen to what you have to say. Once again, all the recorded information will be kept private. The taped recording will not be listed with your name on and it will be stored in a safe place.

Your rights

It is okay if you do not want to participate in the study. You can also remove yourself from the study once you have agreed to participate. This can happen at any time and the researchers will respect your decision and there will be no negative consequences for you and your teenager in anyway.

Do you have any questions?

You can ask me any questions now or at any other time. I will give you our contact numbers (see below) if you would like to make contact at a later time.

We want to be sure that you understand the study

We would like to ask you a few questions to be sure that you understand what we have explained to you. Can you tell me, in your own words, what this study is about? In what ways can the study affect you? Please also share with me what your rights are regarding this study.

Contact Details

If you have questions, concerns or complaints about the study, please contact Alexandra Stevenson or Ahmed Mohamed:

Principal Investigator: Alexandra Stevenson | 072 964 9991 | alex-louise-stevenson@hotmail.co.uk

Research Supervisor: Ahmed Mohamed | ahmed.mohamed@up.ac.za | 012 420 4006

****

Signatures

- I have read and understand the information sheet on the above study and had the opportunity to ask questions.

- I agree to my responses/interviews being used for education and research on condition my privacy is respected.

- I understand that I am under no obligation to take part in this project.

- I understand that I am volunteering to participate in the study and that I can withdraw from the study at any time.

I agree to participate in the study:

Name and surname:………………………………………………………………………….

…………………………………………………… (Signature)   Date…………………………..

Consent for use of tape recorder

I…………………………………………………………on   this…….day   of
……………………….. 2016/2017, agree for the tape recorder to be used during the interview.

Signed……………………………….. Witness
………………………………Date…………………………..

Appendix C: Patient Interview Schedule

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

The therapeutic relationship in psychodynamic psychotherapy: An exploration of patients' and therapists' experiences in the South African context

<u>Provisional interview Schedule</u>

Identifying particulars

Name of client:…………………………………………………….……………

Date:……………………………………………………………………………..

Age of client:…………………………………………………………………….

Gender:………………………………………………………………………..

Race/Ethnicity:………………………………………………………………….

Home Language:………………………………………………………………..

Reason for referral:…………………………………………………………….

Therapist name:...

Number of sessions attended: ……………………………………………..

Reason for ending therapy: …………………………………………........

Areas of Focus:

- Tell me about your experience of therapy.
- How would you describe your relationship with the Therapist?
- How did you experience the therapist during your sessions?
  (Probe for how the client experienced the therapist, thoughts, feelings, stories, perceptions of)
- What did you find challenging during therapy with the therapist?
- What positive things can you reflect on during your sessions with the therapist?

Probe for specific details about the relationship between the client and therapist and the impact on the client.

Appendix D: Therapist Information Sheet

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

The therapeutic relationship in psychodynamic psychotherapy: An exploration of patients' and therapists' experiences in the South African context

PARTICIPANT INFORMATION SHEET

Study information

I, Alexandra Stevenson, am a student psychologist at the University of Pretoria. We would like to invite you to participate in a research study that aims to better understand the therapeutic process and more specifically explore the relationship between the client and therapist. This research is important as we want to understand how the therapeutic relationship supports the client and facilitates or hinders the therapy process. This information will help us gain more insight into the therapeutic relationship in a South African context.

Why would we like to invite you to participate in the study?

You are a clinical/counselling psychologists in private practice and therefore can provide us with valuable insight into your experiences as a therapist. We want to understand the experiences of you as a therapist as we are interested in knowing how you experienced the relationship with the client you have identified and what meaning this may have had for you as a therapist and for your client. It will be valuable to have your input on what your experiences were. We would like you to share with us important moments or things you may remember of your time with the client.

What can you expect?

We would like to understand the experience of therapy from your perspective and from the perspective of your client. To help us gain this understanding, it will be helpful for us to talk to a client of your choice on how they viewed the therapy process. If you agree to participate in the study, we will ask you to select a client you think would be interested in participating. We would like you to approach your client about the study and gain their consent to disclose their contact details to us. Once we have contacted your client and they have agreed to participate, we will arrange a date and time for your interview to be carried out. The interview will last about 60 minutes. While there will be no direct benefit or reward for participating, your involvement will make an important contribution in facilitating our understanding of the therapeutic relationship in the South African context. We do not expect the interview to be distressing in any manner. However, should you feel distressed we will refer you for the necessary support. You are invited to contact the researcher in this regard (contact details below).

Keeping the information private

We will not tell anyone what you tell us without your permission unless there is something that could cause harm to you or someone else. If for example you tell us that someone is or has been hurting a child, we may have to share that information with people who are responsible for protecting children so they can make sure that the child is safe. You can refuse to answer any questions you do not wish to answer. Instead of using your name we will use a pseudonym when making reference to your experience in the final report, or any subsequent research-related outputs. The data may be used for future research, publications, and conference presentations and the data will be securely stored/ archived in the department. No one will know that it is you who talked to us. All the information will be stored and kept securely. Please note that the study relates to your experience of the therapy and the therapeutic relationship.

Recording the Interview

I would like to get your permission to use a tape recorder during the interview. The recording is necessary because I would not like to take notes during the interview but rather listen to what you have to say. Once again, all the recorded information will be kept private. The taped recording will not be listed with your name on and it will be stored in a safe place.

Your rights

It is okay if you do not want to participate in the study. You could also remove yourself from the study once you have agreed to participate. This can happen at any time and the researchers will respect your decision and there will be no negative consequences for you in anyway.

Contact Details

If you have questions, concerns or complaints about the study, please contact me or my supervisor using the details below.

Researcher: Alexandra Stevenson| | 072 964 9991 | alex-louise-stevenson@hotmail.co.uk

Research Supervisor: Ahmed Mohamed |012 420 4006 | ahmed.mohamed@up.ac.za

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Appendix E: Therapist Consent Form

The therapeutic relationship in psychodynamic psychotherapy: An exploration of patients' and therapists' experiences in the South African context

PARTICIPANT CONSENT FORM:

Study information

I, Alexandra Stevenson, am a student psychologist at the University of Pretoria. We would like to invite you to participate in a research study that aims to better understand the therapeutic process and explore the therapeutic relationship. This research is important, as we want to understand how the therapeutic relationship supports the client and facilitates or hinders the therapy process. This information will help us gain more insight into the therapeutic relationship in a South African context.

Why would we like to invite you to participate in the study?

You are a clinical psychologist in private practice and therefore can provide us with valuable insight into your experiences. We want to understand the experiences of you as a therapist as we are interested in knowing how you experienced the relationship with the client and what meaning this may have had for you as a therapist or for your client. It will be useful to have your input on what your experiences were. We would like you to share with us important moments or things you may remember of your time with the client. You are an important part of this research, having experienced the process yourself.

What can you expect?

The interview is important, as we want to get a close enough understanding of your experience of the therapeutic relationship. The interview will last about 60 minutes. We will refer you for support if we find that things are not going well with you or you experience distress during the interview.

How can the study affect you?

We do not predict the interview questions to be distressing in nature. However, should you need assistance we will refer you to talk to someone who can listen to you and provide support. A trained psychologist can help you to cope with your concerns.

Keeping the information private

All information that you give us will be kept private as far as possible. However, we may not be able to keep information about known or suspected acts of deliberate neglect or physical, sexual or emotional abuse of a child confidential. If we are given such information, we may report it to the authorities such as child welfare or the police. You can refuse to answer any questions you do not wish to answer.

Instead of using your name we will use a code. No one will know that it is you who talked to us. All the information will be stored and kept secure, and will be destroyed at the end of the study.

Recording the Interview

I would like to get your permission to use a tape recorder during the interview. The recording is necessary because I would not like to take notes during the interview but rather listen to what you have to say. Once again, all the recorded information will be kept private. The taped recording will not be listed with your name on and it will be stored in a safe place.

Your rights

It is okay if you do not want to participate in the study. You can also remove yourself from the study once you have agreed to participate. This can happen at any time and the researchers will respect your decision and there will be no negative consequences for you and your teenager in anyway.

Do you have any questions?

You can ask me any questions now or at any other time. I will give you our contact numbers (see below) if you would like to make contact at a later time.

We want to be sure that you understand the study

We would like to ask you a few questions to be sure that you understand what we have explained to you. Can you tell me, in your own words, what this study is about? In what ways can the study affect you? Please also share with me what your rights are regarding this study.

Contact Details

If you have questions, concerns or complaints about the study, please contact Alexandra Stevenson or Ahmed Mohamed:

Principal Investigator: Alexandra Stevenson | 072 964 9991 | alex-louise-stevenson@hotmail.co.uk

Research Supervisor: Ahmed Mohamed | ahmed.mohamed@up.ac.za

****

Signatures

- I have read and understand the information sheet on the above study and had the opportunity to ask questions.

- I agree to my responses/interviews being used for education and research on condition my privacy is respected.

- I understand that I am under no obligation to take part in this project.

- I understand that I am volunteering to participate in the study and that I can withdraw from the study at any time.

I agree to participate in the study:

Name and surname:………………………………………………………………………….

…………………………………………………… (Signature)   Date…………………………..

Consent for use of tape recorder

I……………………………………………………on   this…….day   of
……………………….. 2016/2017, agree for the tape recorder to be used during the interview.

Signed………………………………..   Witness
………………………………Date…………………………..

Appendix F: Therapist Interview Schedule

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

The therapeutic relationship in psychodynamic psychotherapy: An exploration of patients' and therapists' experiences in the South African context

<u>Provisional interview Schedule</u>

Identifying particulars

Name of therapist:………………………………………………………………….

Date:…………………………………………………………………………………..

Age of therapist:…………………………………………………………………….

Gender:……………………………………………………………………………….

Race/Ethnicity:………………………………………………………………………

Reason for referral:…………………………………………………………………

Client name:…………………………………………………………………………..

Number of sessions client attended: …………………………………………….

Number of missed sessions by client:…………………………………………..

Reason for client ending therapy: ………………………………………………

Type of Therapy:……………………………………………………………………..

Areas of Focus:

- Tell me about your experience of therapy with the client?
- How would you describe your relationship with the client?
- How did you experience the client during your sessions?
  (Probe for how the therapist experienced the client, thoughts, feelings, stories, perceptions of)
- What did you find challenging during therapy with this client?
- What positive things can you reflect on during your sessions with the client?

Probe for specific details about the relationship between the client and therapist and the impact on the therapist.

Appendix G: Extract—Data Analysis

Patient-participants	Tessa	Kathy	Lisa
Theme 1: The Therapist's Therapeutic Approach			
Holding the patient in mind- knowing them	*Um, I, she knows everything about me. I know nothing about her because she's got the boundary thing going on. And, um, it's actually nice to have somebody that knows you that well, because I can't sit here and bullshit my way out of anything because she knows me and she knows why I do stuff and why I don't do stuff and why I say stuff. So, um, I, I just, ya, I just think it's great (Tessa)*	And she also knows me now, for I don't know how many years…For me – um- I think we quite close- because she, I mean, I mean she knows things in my life that nobody else knows- you understand? Nobody knows- none of my husbands, none of my kids- nobody know- the closest person to me is my daughter (Kathy)	*I used to have a ball and then I would throw the ball against the wall and I don't want to talk to her and then she knows if I walk in with a ball, then I don't want to talk to her. She knows. She knows, and I ask her "how can she knows me so well?", she never lived with me, she just sees me once a week for 45 minutes (Lisa)*
Non- judgmental	Um, it's, when I when I go to her it's a safe space to be…Ya, the one day I was so tired and I was just sitting there so I asked her, "can I just take a nap" and she was like, "yes sure- I will just sit and watch you" and that's what she did in Hospital Y. Ya, she is such, such a lovely person she is really, really- ya (Tessa)	*So, when I was looking. When I was sitting in front of her, I just knew she didn't judge me. She understood that there's a- you come from a certain place – when, when ooooo when, when stuff happens to you and a certain way, you react in life, it's because of stuff that happens to you and reasons that happen to you – its (mumble) better (Kathy)*	*Ya, I think overall the best thing for me was. It's like if I wanted to hit, throw my ball against the wall, and talk to her I was allowed to do it. If I want to go sit in the corner- I was allowed to do it. Um, some people think there is the psychologist chair and there is the psychologist chair. So, you don't cross that boundary…Because, isn't it that when you there that you have to be you and if you want to cry- you have to cry, you're not going to be afraid you gonna cry and your psychologist is going to 'ah no you're a cry baby and all that nonsense' (Lisa)*
Providing an objective experience- perspective	*Um, ya so I really uh, I think it's very good to get an, an objective opinion. I think it's quite, uh, quite nice, ya… She actually had a reason for doing or telling me whatever- so – ya, and just to have someone else's opinion. Because I tend to blame myself for everything…I take it personally, like it's me and I'm not good enough- so if I hear her side… from someone normal, ya- sometimes I just need a reality check (Tessa)*	*Mostly by talking, mostly about talking about things and, um, not, help me to not over react on everything that happens to me. That was one of the biggest things… (Kathy)*	Ya, no, she did. Like in the beginning I don't want to cry in front of her. And she was like, 'no, you can cry, it's alright to cry', and I was like, 'no, it's not'. 'It's alright cry'. Now I can't even help it the tears is just coming (Lisa)

Consistent presence	But I know she is there - should the shit hit the fan she is there…And um I think once in all the years once she was sick and she cancelled on me… (Tessa)	*Ya, you know what also makes Therapist 2 also great at her job- you know when you sitting there and you crying your heart out and you are devastated for whatever reason- she doesn't go (mimics typing on her cell phone) …She is really with you, really with you… (Kathy)*	*If I told Therapist 3 I didn't want to see her anymore, she was still there the next day and I tested her. In every possible way, I tested her and she was there. And she would never leave and she never left (Lisa)*
Theme 2: Factors Facilitating Therapy			
Mutuality	*I tell her - I tell her I don't… hide or lie or whatever, because that's like uh that's the worst thing you can do with a psychologist. I always say it's like faking an orgasm- you are the one losing out…(Tessa)*	*She would come back and she would give me feedback and she would say, "At this conference I have learnt this and I think we should implement this"…And I would also go. I didn't just make it her problem … Like she must do all the work… I will google it and go on You Tube and watch videos…I will also say, "Therapist 2 what do you think about that?" and she would say, "Yes, let's try it" … But you can have the best therapist in the world and if the patient is not willing to work on it and you and, and, it's like a business, you have to be teachable (Kathy)*	*I can promise you, I trust Therapist 3, 100- 200%. But up to today, there are still things Therapist 3 doesn't know. I mean I trust her with my life. There is still stuff that's blocked. And I know she's going to say, "so…after all these years you still don't trust me, when are you going to trust me? I thought you over that by now?" (Lisa)*
Therapist self-disclosure	*Sometimes, it, it initially when I started, um, seeing her I was like, "tell me something about yourself. It's just that I am sitting here telling you the worst things that goes on in my head or things I have done and you're sitting here like this perfect angel. So, I need some dirt on you"… So, ya, uh it, so, in all the years we have seen each other, I have, I have, um, how do you say, I have gotten some information off her. And I really appreciate it… I would appreciate. A little bit more information, not everything but here and there. Ya, snippets of information per session (Tessa)*	*Because I am a people person, ya, I need to be relatable to her. Ya, she can't sit there like a statue and I don't know anything about her…I want to know that she also has a life, and she also has issues and she also has her own psychologist and I know these things…I know these kinds of things, maybe it's different. I don't know how she does it with all her patients. I think you should choose, as well, who you say things- personal things to… and I will ask her sometimes. But I also respect the boundaries. I also respect the boundaries that I cannot ask all the questions that I would like to ask (Kathy)*	She is human, she also gets hurt, you know, mean I've- you know there is so many things that I actually know about Therapist 3, but you know she is human, just like me, she's also got mistake, she also can be sad and she can be happy and I mean it's not… But, I think the fact that she went to that extent to tell me about her life. But Therapist 3 always says this is your space, this next 45 minutes belongs to you (Lisa)
Theme 3: Process within the Therapeutic Relationship			
Describing the	*…that made me anxious and I wanted to cry and I was just*	*I took my daughter to her because I was worried about*	*Therapist 3 was there for me, I mean in my most*

relationship: Lifeline	*like- it was just not fair…Ya, it's like, like holding your breathe. I, I just hang on to anything and I just keep alive and I-ah, when I see her I know everything- I can take all the crap and just dump it there and I know she will be there and so, I, so it's something, ya. It can be quite scary (Tessa).*	*my daughter and my daughter was sitting in the waiting room, and she gave one look at me and said "No"… She saw that I was at breaking point, she saw that something was seriously wrong and, um, I was so sick that I didn't even know that I was sick. I was so hanging by a thread that I was just focusing on that moment not to die… She caught me (Kathy)*	*darkest moments in my life… (Lisa)*
Moment of meeting	*… So, um, ya the first day, I walked in there I was like "Okay, I am going to kill myself". This is the last thing that I am trying not to kill myself. Then she said "Okay, ya, that's quite a bit of a, an expectation", but I told her "Listen I am half dead so, um"… Ya, so let's just try this thing- and ya, ya seven-eight years later I am still here [laughing] (Tessa)*	*… It was like the worst day of my life (emotional) but anyway it was, um, but still Therapist 2 didn't judge me. The day I saw her for the first time, she didn't see me- I was hysterically, I couldn't stop crying and she asked me, "what's wrong?" and I had to tell her and she said, "Kathy stop beating yourself up about this- this woman abused you for 40 years and you, um, how much do you still need to take from her?" and that, that made me go back to her 5 years later… That's how it really happened for me to go back to her… Ya, do you understand? She did not judge- she was seriously young, she was young like you now. She was a young psychologist only starting out in life, but she knew enough, even then, not to judge me and that's what made me return back to her when I really needed her. Well I didn't know I needed her – my daughter needed her (laugh)…(Kathy)*	*…and she (Therapist 3) said to me, "you can't walk the same path with two people, you must choose- or this path or that path" and then I asked, "why don't you chose for me?", and she said, "no, I can't make that choice. You need to decide which path you're taking and if you decide to take it with me I will be there for you all the time no matter what", and I mean that's a promise she made me ten years ago (Lisa)*
Change	*… So, I was thinking about that (her past experience with psychologists), and that was stuff that Therapist 1 didn't tolerate, me phoning after hours or sending SMSs. I can send her SMSs, she just don't reply. So ya, um… I have learned a lot, about the boundaries from her… (Tessa)*	*And we have been doing some therapy, and there was a lot of light bulb moments…You always wonder why, why you feel about the things you do or why you act a certain way and then with the therapy, it came out why exactly, you know, it's stuff that actually bugs you in your adult life that comes from your childhood life… You*	*…if a person wants someone to bond with and open up. The relationship is all about trust and if there is no trust, it's not gonna work. And I was not a very easy person to trust people and Therapist 3 taught me, that it's OK you can trust, things might change, but you can trust (Lisa)*

		understand? So, she helped to make a lot of things for me clearer. That's the one part. The other part was how to deal with certain things, you asking now about many years (Kathy)	
Time	*Yes, ya, we have worked through quite a bit, and, ya, she gets angry at me sometimes. That's how long I have been seeing her. She gets very angry at me...so uh, ya... Ya, then then sometimes I think, I think we have been seeing each other too long... There is this small like border that there's just that small little bit, that's a bit blurred, but only on that - that she gets angry at me. That she will tell me (Tessa)*	*October 2009– 8 years… So, in any case I think, I think she understands me very well. I have to say and you can't be with somebody for that many years and not (Kathy)*	*Well, I am 10 years with Therapist 3… This year we are celebrating our 10 years (laugh)… I think it's awesome, it's good. I have always told my friends "you want a psychologist, go see Therapist 3", she is the best. Ya, so no, I have a lot of respect for her and she has sat up with me for 10 years so you must know. It's like being married hey? (Lisa)*

Table 2. Therapist-participant data extracts.

Therapist 1	Therapist 2	Therapist 3
Theme 1: Patient Qualities		
She was committed. She drove through from Kempton Park every Friday afternoon. Every Friday afternoon…she never cancelled once and she has never not paid me…she is always there when she says she will come, so her commitment to therapy… And, also maybe her willingness to talk about difficult things at times. (Therapist 1)	*…She really wanted, she wanted to work on herself… So, it was that- it was really her, um, her, um, want to not feel the way that she did and she found it very liberating. She is someone who wants to, she wants to grow… I think in terms of the psychodynamic approach, it is a good approach with her, um, you know someone else wouldn't want to look or address their problems. So, I think who she is and how she is and I think that she wanted to make a difference facilitated therapy, um, that she felt safe… it's probably easier because, um, she is obviously psychologically minded she knows the terms, she understands what it means. (Therapist 2)*	*…but she has stuck with it and I think it says something about her ability and her tenacity and her capacity. She has a lot of capacity, she chooses to ignore it at times, but she has a lot of capacity…Um, as I say in terms of approach I have always been honest with her, direct with her and I really believe that she can do the work. (Therapist 3)*
Theme 2: Factors Facilitating Therapy		
I think very simple things. I think initially, there must be some connection, warmth, um, a holding environment, you can just hold someone, even if they can't initially, and really speak about their own stuff, um, I think a patient- how a patient experiences a therapist's commitment to really understand them to meet them where they are- I think that. (Therapist 1)	*Ya, definitely, ya, having a constant object in her life that seems to know her or think with her, what is in her best interest… (Therapist 2)*	*All the time, all the time, with any separation, um, whether it's for holiday breaks or, um, she tests me all the time, whenever she is uncertain, whenever her life is in chaos, it sort of spills over. It is like a leaky container, it's like oil- you know- and it just seeps into everything. (Therapist 3)*
… Um, in my mind, the therapy is going better, since I have a new model. I started to work in the Mastersonian perspective, Masterson way, and that helped me to understand her better and to understand better what she needs…I can confront stuff, when before that, I would be quite hesitant- shall I go there? Or shall I not go there? So, I kind of go there (Therapist 1)	*I suppose process work, more than…seeing a person develop, seeing what her defenses structures were, seeing that there was a lot of regression and why is it there and with her development…needing someone to be there for her all the time. Which is …transcendent you know she does her own thing…it was special because of an orientation change… it's just a very, very different process, therapeutic process, to work*	*… I think I have quite, I mean and it changes at times, but I think I have quite a good theoretical understanding of what is going on and I think that gives you sort of the insight as I say or just the perspective and it gives it a predictive quality … so I think it doesn't leave you so vulnerable if you can see what's going on. (Therapist 3)*

	psychodynamically. To have the opportunity to work in terms of the relationship. (Therapist 2)	
Ya, actually, what the, that confrontation part, is a technique actually, neh, that helped me so much. In terms of not being so, I don't want to say passive, but almost so paralysed in therapy, you know to be able to say, "but listen, look at this, look how far you have come, look at your track record", to be able to get that activation. (Therapist 1)	*I think I am quite a soft therapist, I am not loud- you know so maybe that, a kind way but stronger way, so say "listen you not gonna like what I am gonna say"… maybe my ability to be able to say the difficult things, but not in a way that would shut her down… it wasn't threatening it was experienced as being kind, although it was difficult to hear (Therapist 2)*	*Uh, I think the better rapport you have… I think the more license you have to, I think with her I challenge her a lot and challenge the behaviour in quite a forthright manner. So, I think the stronger the relationship obviously the easier it is. It feels like the relationship has the capacity to survive or withstand that... I think the stronger the relationship the more it can survive ruptures and the easier you can repair if ruptures happen…it carries the change for the patient, the change is carried in the relationship regardless of the technique or how you understand it or approach it… (Therapist 3)*
… so, so if I can stand back and just reflect on what is happening there for me in that moment and for us in the process then I can. And I must also say, Alex, when one is tired you do different work then when you are fresh… And, um, ya, that I always just want to remind myself of that, often "Think, breathe, stand back and look at what's happening here and then we can respond in a different way". (Therapist 1)	So, you know the development for me- uh- that's maybe not right to answer, but just to get me thinking- the development for me, you know, your initial training and what you, um, and then get exposed to later. So, with her, um, I had, erm, I had a much stronger psychodynamic object relations approach and way more relational- it wasn't intervention based (Therapist 2)	*… but it's been tough, it has been really hard. It has really been a lot of therapeutic input, a lot of supervisory input, to keep me, um, to keep the perspective what is now going on in the therapy and the relationship in order to not internalise to the extent where it is damaging to me or to the relationship… I don't think I would have been able to cope with it survive it, um, work with it in a therapeutic manner if it wasn't for that external support. I think that external support is really important. Just to have another brain help you think about what is going on. Because of in the moment as you know, these are unconscious processes, so you don't always see it in the moment and you need somebody else to help you think about why did you say that, or what did you react that way and then*

you know the beauty of repetition compulsion, is that it happens again, and you will see it again and then hopefully you know, you can recognise it for what it is and then you can address it.. (Therapist 3)

Theme 3: Process within the Therapeutic Relationship

... And you know when you see someone for so long, I mean not even just that, but you get to become attached. I care for her on a deeper level, even though I know she is a patient and I know the processes. But I care for her and I want her to have, you know to be healthy. So, then I would sometimes say, "you know, I feel despondent when you say this to me, I am not going to give up on you, but why where does this come from?" (Therapist 1)

...I think the frame, I think really the frame. We see each other on a Friday afternoon, that time, same place- so that. And I must say to you, neh- I am quite honest in therapy. (Therapist 1)

...I think it's, maar, like a real relationship where someone is now a witness to your behaviour ... I think it is probably an experience...ultimately it is two people in the room you know... I think it's probably the, the, the most honest relationship she ever had. So, I think, um, you know, not to beat about the bush and to sort of, you know, call her on behaviour...It's very um, human, it's very person- you're a person, I am a person. You do think I am the greatest thing ever- but that's what you do. And I am not the greatest thing ever- you know, I don't- I have got my own flaws...(Therapist 2

Ya, I think therapy as a process as intimate as it is. I think it's a very privileged position to work with people in that way, um, it's a very intimate relationship, but very formal relationship and I think when you don't participate and you don't become this well-known person. It forces you to renegotiate the relationship and think of the relationship in a different way and I think that's what's therapeutic. So, I think therapy for me, more often than not and maybe for me to, but for our patients it's a very uncomfortable place. It's not a social relationship and I think one has to resist, um, playing our very old patterns and old dynamics. So, you don't do the work for the patient- but it is a very active process nonetheless. I always think of Bion who said, 'it's like an operation without an anaesthetic'. (Therapist 3)

APPENDIX H: ETHICAL CLEARANCE CERTIFICATE

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Research Ethics Committee

Dear Ms Stevenson

Project:	The therapeutic relationship: An exploration of clients' and therapists' experiences in the South African context
Researcher:	A Stevenson
Supervisor:	Dr A Mohamed
Department:	Psychology
Reference number:	28082062 (GW20170107HS)

Thank you for the response to the Committee's correspondence of 30 January 2017.

I have pleasure in informing you that the Research Ethics Committee formally **approved** the above study at an *ad hoc* meeting held on 22 May 2017. Data collection may therefore commence.

Please note that this approval is based on the assumption that the research will be carried out along the lines laid out in the proposal. Should your actual research depart significantly from the proposed research, it will be necessary to apply for a new research approval and ethical clearance.

The Committee requests you to convey this approval to the researcher.

We wish you success with the project.

Sincerely

Prof Maxi Schoeman
Deputy Dean: Postgraduate and Research Ethics
Faculty of Humanities
UNIVERSITY OF PRETORIA
e-mail: tracey.andrew@up.ac.za

cc: Dr A Mohamed (Supervisor)
        Prof D Maree (HoD)