An Examination of Therapists' Experience of Impasse in Psychological Therapy

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Abstract

Whilst therapy impasse has been analysed by a number of clinicians based on their interpretations from case studies, there has been a lack of research studies investigating this phenomenon. The clinical literature points to different aspects of the therapy frame and contract, individual client and therapist factors, the alliance and therapeutic interaction which combine in an idiosyncratic way in each case of impasse. The aims of this research was to examine the accounts of a small number of therapists currently experiencing therapy impasse in order to understand the role that these or other factors play in individual cases of impasse as well as to investigate the meaning and effects of an impasse experience for the therapist. A qualitative methodology was chosen in order to undertake a more in-depth analysis, and four participating therapists were interviewed on two separate occasions. The principles of Interpretative Phenomenological Analysis informed both the design of the study and its analysis. The analysis identified that the early development of problematic transferential patterns of relating was associated with impasse. In these cases of impasse therapists appeared to have a powerful personal engagement with their clients and they experienced strong affect in relation to the therapy process. The role of the therapists' ideal self which comes under threat during impasse was highlighted and the management of impasse was associated with therapists' regaining their therapeutic stance and attending to the therapy process. The implications of the study, in terms of how clinicians may recognise and respond to cases of impasse at an early stage, are addressed, along with a theoretical discussion of how we might define and understand therapy impasse. A critical analysis of the study is included and suggestions for further research are offered.

Table of Contents

1. Introduction

In this first chapter I will introduce the concept of therapeutic impasse and my own interest in it. A comprehensive review of the relevant clinical literature will follow leading to a description of the research methodology of this study. The research questions are specified at the end of the chapter.

People who seek out psychological therapy usually do so because they have reached a point of impasse in their lives which they are unable to negotiate themselves. Given that psychological difficulties usually have their origins in the context of interpersonal relationships and have been influenced by ongoing patterns of relating to others, it is not surprising that the therapeutic relationship will be subject to impasse as particular interpersonal processes are evoked. Therapists, too, bring their own areas of interpersonal impasse which may or may not be available to conscious awareness. Each therapist and patient dyad, therefore, will create its own unique pattern of relating and encounter its own blocks to relating or points of therapeutic impasse. Psychoanalytic therapies not only acknowledge this process of re-experiencing previous patterns of relating within the therapy relationship, but are defined by their use of the therapy relationship to experience and analyse those patterns or, what is referred to as, the transference neurosis (Greenson 1967). Increasingly other therapeutic approaches have begun to acknowledge and utilize the therapeutic relationship in promoting change (Beck & Freeman 1990, Ryle 1990)

Much research has focussed on measuring the overall effectiveness of different psychological therapies, often in an attempt to promote a particular type of therapy. Global outcome measures, usually in the context of randomised controlled trials, are used to give weight to conclusions regarding the value of a specific therapy independent from the therapy relationship in which it is being applied. Cases where successful change was not accomplished may be viewed as realistic evidence that no therapy will be a hundred percent effective and no further analysis of the "therapeutic failure" will be undertaken. Clinicians themselves may be naturally keen to downplay or not disclose the extent to which their therapeutic attempts are not resulting in fruitful change.

My own interest in therapy impasse has developed from my clinical experience of being involved in many therapy relationships and the continual process of learning, about psychological functioning, what works for whom and the factors which mitigate against change. Through personal analysis the process of addressing core anxieties has led me to question the anxieties aroused and often avoided in clinical work, namely those relating to difficulties in the therapeutic relationship. Impasse represents perhaps the greatest challenge to therapists but is still something we are reluctant to disclose. In undertaking this study my hope is that its findings will go some way in understanding the development of therapy impasse and promote further research as well as more personal and professional examination of this phenomenon.

1.1 Literature Review

Much of the literature on therapeutic impasse has been written by clinicians, usually from a psychoanalytic orientation, on the basis of their extensive experience of treating patients in therapy and supervising colleagues and training therapists. The literature, however, also encompasses writers from other therapeutic traditions and, as my preferred position in relation to understanding impasse is a more integrative one, this review will cover the range of publications from different sources. One of the few published empirical studies in this area, and the only one primarily addressing impasse, was carried out by Hill and her colleagues (Hill, Nutt-Williams, Heaton, Thompson & Rhodes 1996). This qualitative study examines therapists' experience of impasse in therapy using Grounded Theory. As a key study for this research it will be examined in greater detail at the end of this review.

Definition of impasse

There has largely been a consensus in the definition of therapeutic impasse. Weiner (1982) refers to it as:

"An acute or chronic failure of treatment in which the patients' presenting problems and overall level of coping with themselves are not ameliorated or significantly worsen in spite of the active efforts of the therapist and the patient working together" (p.35)

An impasse, therefore, can be seen as a therapeutic stalemate although Nathanson (1992) stressed that the impasse may or may not be available to either the patient or the

therapist's conscious awareness and that many impasses remain hidden from view. It is generally agreed that even the most well conducted psychotherapy does not follow a smooth path upwards (Mahoney 1991). The therapy is likely to stall at times as well as have points of rapid change and it is not uncommon for a therapy to reach a plateau where little therapeutic change is apparent. Weiner (1982) notes that impasses may be distinguished from the minor fluctuations encountered regularly in most therapies stating that the underlying function of the impasse relates to more serious difficulties in the therapeutic encounter rather than more minor problems of settling in to the therapy. He stresses, however, that these minor fluctuations may develop in to an impasse if not attended to, and the importance of resolving impasses quickly, to avoid secondary difficulties which may complicate the patient's life as well as threaten the therapy.

Response to impasse

Weiner points out that therapists have much at stake in recognising an impasse.

> "They have pitted their expertise, effort, narcissism and omnipotent strivings against the patient's maladaptive psychological state. They have more than a rational mature involvement in helping patients change for the better; they also have an irrational involvement tied to their self-esteem and personal needs." (p.217, Weiner 1982)

The impasse is seen as representing evidence of therapeutic failure and threatens the therapist's sense of competence and self-efficacy. Where an impasse extends over time, Leiper (2001) suggests that periodic feelings of incompetence can develop into a sense of fraudulence and the therapist may fear that the work has become a charade. As a state of helplessness and despair may surround the therapy it becomes prone to further therapeutic errors and failure. He also notes how therapists may experience their own feelings of frustration and irritation with their patient as unacceptable resulting in a tendency to self-blame and feelings of guilt as well as fears of exposure. Nathanson (1992) has identified shame as being the core emotional reaction evoked in the therapist following the recognition of a developing impasse. He suggests that the therapists' attitude towards therapeutic failure will depend on the individual way therapists defend against shame.

Both Weiner (1982) and Leiper (2001) have elaborated on how the way in which therapists interpret the meaning of an impasse can pose a threat to the therapeutic

relationship. Leiper (2001) suggests that blaming patients for their resistance is one of the most seductive and dangerous elements in an impasse as it can lead to the therapist demanding more emotional expression or experimentation without proper agreement or a safe framework. He describes how therapists may try to overcompensate for feelings of incompetency by becoming more rigid and more closed off to feedback from the patient or the results of interventions. Alternatively therapists may become more passive and helplessly inactive, paralysed by their sense of guilt.

Recognition of impasse

Green (1988) points to the difficulty in recognising the presence of an impasse, suggesting that what constitutes an impasse is in the eye of the beholder. Leiper (2001) emphasises how the differences between therapeutic models will contribute to whether an impasse is recognised, noting that what may constitute a vital indicator of impasse in one model may be misleading or irrelevant in another. In addition, each dyad of therapist and patient is, by definition, unique and, therefore, the ways in which the process in which they are engaged might become stuck is similarly unique to them. Whilst the clinical literature points to the importance of analysing impasse on a case by case basis and the use of supervision to take a 'second look', common signs of impasse have been identified which appear to cross the boundaries between different therapy models (Leiper 2001). These include signs relating to the therapeutic framework (such as the therapist or patient missing appointments or arriving late), relating to the goals of the therapy (such as new problems emerging, lack of direction or loss of momentum), relating to the techniques of therapy (including failure to undertake assigned tasks or deviation from usual therapeutic practise), and relating to the therapeutic process (including diminished rapport, unacknowledged negative shifts in sessions). Weiner (1982) particularly stresses the importance of therapists using their own awareness of their tendency to allow the therapy to drift and allowing issues which threaten the frame or process of the therapy to go unchallenged.

Analysing impasse

There is a growing consensus within the literature on impasse that the absorption of a therapist within a particular therapeutic model hinders their analysis of an impasse. In rejecting the notion that only one approach to psychotherapy may be correct, Omer (1994) stresses the importance of taking a broadly integrative or 'pluralist' approach in

relation to analysing impasses. He suggests that, as what is central to one model may be missed out or poorly addressed by another, impasses may occur due to the inadequacy of the model in either addressing the full range of the patient's core difficulties or responding to previous therapy ruptures. The fact that each individual therapist is likely to have his or her own blind spots and areas of tunnel visions is also cited as the reason for the therapist needing to disengage and seek an alternative perspective (Kluft 1992).

Whilst different writers have placed an emphasis on different aspects of the therapeutic encounter in analysing therapy impasse, with psychoanalytic writers in particular examining an impasse purely from within the therapeutic process, most frameworks developed to analyse impasse suggest that the source of the impasse can be in one or more different areas of the therapy. Leiper (2001) proposes four main areas where blocks occur: firstly, the way in which the therapy contract and its aims have been set up and the extent to which the patient has been engaged collaboratively; secondly, the degree to which patients' social eco-system and therapists' professional context supports or undermines the work; thirdly, the accuracy of the assessment of individual characteristics of patient and the extent to which these are matched to therapy format and technique; and fourthly, the way that the therapeutic process is handled and remains relatively free from unacknowledged cycles of interaction. Omer (1994) has developed a model emphasising three aspects of the therapy; the extent to which the therapy has become engaged in a hopeless narrative, the failure of the therapeutic strategy and the strength of the therapeutic alliance.

Clinical protocols, which therapists may employ to help them cast a second look at an impasse, have been developed by a number of writers. Green (1988), from a systemic perspective, proposes the use of the POETICS protocol which encourages clinicians to analyse various aspects of a therapeutic system. Weiner (1982), from a psychoanalytic tradition has also developed a protocol with greater emphasis on the therapeutic process, whereas Kluft's (1992) model adopts a more integrative perspective. Leiper (2001) points to the importance in using some type of framework when analysing therapeutic impasse to help draw attention to neglected areas within the therapy. However, he stresses that having a framework is only the starting point. Viewing the

impasse as a complex product of interacting factors or systems, he wonders whether, in taking a 'second look' clinicians are any more likely to see the real picture.

Assessment and treatment selection

Impasses can often be traced to errors occurring in the assessment process and the selection of the appropriate therapy. Leiper (2001) points to the reluctance of therapists to engage in the process of diagnosis and treatment selection but believes that many impasses could be avoidable with better assessment and the development of an appropriate therapy contract.

A number of patient factors, which can mostly be identified at assessment, have been noted to contribute to the development of therapeutic impasse. Kluft's (1992) initial concern in assessing impasse is to consider whether the problem being presented is amenable to psychotherapy. Several writers warn against ignoring the presence and influence of biomedical conditions and automatically interpreting symptoms as having a psychological basis (Striano 1988; Taylor 2000). Striano (1988) found that, in fifteen percent of patients in psychological treatment, an undiagnosed physical illness was either causing or worsening psychological symptoms. Leiper (2001) lists other factors which go undetected by clinicians and could have a dominant role in impasse including the misuse of drugs and alcohol, the degree to which psychotropic medication is competing with the psychological therapy and unrecognised major forms of mental illness.

There is general agreement that the most important client factor which appears to influence therapeutic failure and impasse is the psychological capacity of the patient and the therapist needs to make a judgement regarding the capability of patients to undertake demanding personal change and extent to which they can undertake the tasks inherent in specific therapies. Bauer and Kobos (1987) identified factors affecting treatment suitability for short term psychodynamic psychotherapy including: psychological mindedness, ego strength, ability to sustain co-operative relationships, motivation for change and the availability of a focal issue. Safran and Segal (1990) suggest that similar factors are important in considering more complex forms of cognitive therapy. More generally there is some consensus of opinion on which factors relating to the patient's internal functioning would be more suitable to a more

supportive as opposed to a more expressive form of therapy (Weiner 1982). Kluft (1992) notes that the intensity of a therapy may be an important factor. He suggests that for some patients with whom a therapeutic impasse has been encountered the intensity of the therapeutic strategy has not been right and that patients may require either a more or less intense therapeutic approach dependent on their psychological functioning.

Selection of therapeutic strategy has undergone recent scrutiny (Cape, Hartley, Patrick, Durrant & Graham 1998) including the Department of Health's 'Review of Psychotherapy' which concluded that particular forms of therapy may be more suitable for some types of problem (Roth and Fonagy 1996). Yalom (1966), in an evaluation of the effectiveness of group therapy, found that a significant proportion of patients who dropped out from group therapy went on to improve after undertaking other forms of therapy. Kluft (1992) identifies problems due to an over-reliance on a single therapeutic approach suggesting that theories can impair as well as illuminate therapeutic efforts. He points to clinicians' tendency to stick to a single paradigm, believing it to be the 'one true faith'. Although the limitations of the paradigm may contribute substantially to an impasse, he suggests that therapists would choose to either deny the evidence of a lack of effectiveness or blame the patient rather than acknowledge the failings of their chosen approach.

Whilst there is evidence supporting some general guidelines for matching patient problems to therapeutic strategy, Garfield (1994) found that patient characteristics, on the whole, do not predict outcome well with different types of therapy. Beutler and Clarkin (1990) have proposed an integrative model of matching therapy strategies to individual needs of the patient. Leiper (2001) points out, however, that there is still little evidence that enables the prediction of the subtle interactive chemistry within the therapeutic alliance which underlies most successful therapies.

In addition to the selection of the most appropriate treatment, the skill and experience of the therapist in being able to apply the treatment and work with particular types of problem must also be considered. Kluft (1992) emphasises the difficulty therapists may individually have in working successfully with certain types of problems. Weiner (1992) provides an interesting view on the relationship of therapeutic impasse to the

therapist's life cycle. He proposes that, as therapists progress, diagnostic and contractual errors are less likely to occur and impasses are more likely to relate to processes within the therapy relationship and the increased levels of narcissism and omnipotence in therapists which leads to the adoption of a more rigid approach.

The therapy contract

The importance of maintaining a secure frame to the therapy is common to most therapies and the literature on impasse suggests that contractual failings contribute significantly to the development of therapeutic impasse (Weiner 1982, Kluft 1992, Leiper 2001) Kluft (1992) suggests that if the circumstances of the therapy are not secure then the seeds for the development of an impasse are already sown, and that setting a contract and discussing what is involved in therapy and likely to happen operates as a safeguard, protecting both patient and therapist during difficult work. The necessity of this process is highlighted, Leiper (2001) points out, when threats to the frame of therapy do occur and that these are encountered particularly when working with more fragile patients. As setting the contract is the first collaborative task undertaken by patient and therapist it may be possible at this stage to predict whether later difficulties are likely to emerge (Yeomans 1992). Green (1998) stresses the importance of ensuring that there is a consensus regarding the causal explanation of the focal problem between patient and therapist as difficulties are more likely to arise if therapist and client hold different ideologies.

Leiper (2001) emphasises the importance of the contracting phase in which realistic goals are set relating to the client's concerns and the expectations of what is achievable from therapy. He suggests that this is crucial to the heart of the therapy and in harnessing client motivation but warns that the overt communication of goals may be misleading and that patients may have a number of different goals at different levels which may be contradictory. Bordin (1979) found that when tasks of therapy were more comprehensively negotiated the rate of therapy drop out was reduced significantly and the likelihood of a successful outcome was increased.

Duncan, Hubble & Miller (1997) emphasise the need to work within the patients' 'theory of change', to develop interventions that work with it and to go at the pace set by the patient as the best way of not repeating earlier impasses. In their seminal work

Prochaska and DiClemente (1984) deconstruct the motivation to change process, offering an alternative perspective on the notion of resistance to change and they emphasise the difficulty of initiating change in some systems.

Given that most therapists tend to work on an individual basis with patients there is a tendency to ignore the wider social network in which the patient is engaged (Hurley 1982). Leiper (2001) points out that when working with an individual a therapist does not see all the players involved in problem and that when resistance is encountered it may relate to a resistance in the social network, suggesting the need to take a broader relational and 'ecological' perspective. Systemic therapists recognise the difficulty of one family member undergoing a significant change on their own (Minuchin 1974; Boscolo, Cecchin, Hoffman & Penn 1987) and emphasise the strength of any system to maintain its own equilibrium. In managing an impasse, Green (1988) stresses the importance of considering which level of system to work with depending on the view of where the problem is being maintained, but adds that even when working with the wider system a therapist can get drawn in to a similar impasse. Kareem and Littlewood (1992) write about the importance of a cultural and ethnical understanding when analysing a patient's difficulties but suggest that whilst a therapist from a different cultural background may attempt to integrate a cultural perspective they are likely to still encounter unacknowledged assumptions.

The therapeutic alliance

Horvath and Symonds (1991) concluded that the best predictor of therapeutic success was the quality of the alliance between therapist and patient. They suggest that the therapeutic alliance can have a mediating function in the collaborative setting of therapeutic goals and similarly underpins the development of therapeutic impasse and its resolution. Safran and Muran (1996,2000) describe a good alliance as the effectiveness of the therapist in noticing subtle emotional shifts occurring during sessions and bringing them to the attention of the patient. They propose that the detection and resolution of alliance ruptures forms the basis of the change process and stress the importance of the early detection and repair to alliance ruptures for managing further impasses. Similarly Ferro (1993) conceives an impasse as an accumulation of microfractures in communication which block the therapeutic process until the fractures are attended to and remedied.

Whilst Feltham (1999) emphasises the importance of obtaining a good patient/therapist fit in order to improve therapeutic effectiveness, there is still little evidence regarding the possibility of predicting or creating a good match based on any observable characteristics of patient or therapist. Leiper (2001) emphasises that, although collaboration in the alliance is more actively sought in some therapeutic approaches, it is a process that is not completely conscious and that some resistances may be out of awareness. He also warns against collaboration masking as collusive avoidance and suggest it needs to be balanced by the ability of the therapist to strategically challenge the patient. Gaining the 'right balance' was also emphasised by Fisch, Weakland & Segal (1982) who referred to coalitionary processes in the alliance in which there may exist problems in the degree of proximity or hierarchy.

The therapeutic process

Whilst studies suggest that the encountering of an impasse is a common occurrence in therapy, views on its function within the therapy process have varied. An impasse in therapy can be seen as having a negative function and it has been argued that it is better not to allow therapists to rationalise what are essentially therapeutic stalemates (Weiner 1982). Others, such as Leff (1970), adopt a more constructive approach, defining impasse as occurring at points when there is more value in sustaining opposition rather than in resolving it. In this view, impasse can be seen to have a positive function, for instance, in sustaining intrapsychic equilibrium. Resistance, defined as the active opposition in the minds of patients against the remembering of significant events, thoughts and feelings, has been a concept in psychoanalytic practice since Freud first identified it, firstly as a patient misbehaviour then as necessary part of therapeutic process (Breuer & Freud 1895, Freud 1940) and the analysis of resistance remains the basic work of psychoanalysis. Cognitive therapists conceptualise resistance not as a defence against painful memories but as way of protecting the construction of reality. Mahoney (1988) proposed that patients' resistance serves a natural and healthy function in protecting their core organizing processes from rapid or sweeping reconstructive assault. He emphasises that it is change itself rather than some underlying pathological process which brings about resistance. Bugenthal and McBeath (1995) concluded that the forces underlying resistance are the same forces which provide stability, whilst Brehm and Brehm (1981) describe resistance as a way

of preserving personal freedom and refer to reactance rather than resistance . They suggest it is aroused when patients face an uncontrollable outcome as a means of striving for control. Several writers emphasise that patients possess their own wisdom as to how quickly they can become open to change, and suggest that efforts to overcome resistance may do more harm than good (Ginter & Bonney 1993; Cowan & Presbury 2000). Both Beitman (1992) and Ginter and Bonney (1993) have articulated resistance not as a patient defence but as emerging between the patient and therapist and as a reaction to therapist forces.

Many approaches now, including interpersonal, psychoanalytic and humanistic, share the concept that a patient's world cannot be understood apart from its relational context including the relational processes between patient and therapist. Recent literature suggests that resistance is embedded in the transference activity of the patient and is a response to some activity of the therapist that the patient experiences as potentially re-traumatising (Stolorow & Atwood 1992). The protective function of impasse is again emphasised but is seen as occurring at key moments when the therapist is not fully attuned to the patient's emotional state by the therapist and that the therapists' ability to stick with the experiential world of client determines whether they meet resistance or enable new patterns and experiences. In this view impasses can be seen as representing a creative opportunity for the therapy to progress. Elkind (1992) refers to 'nodal points' in the therapy when the patient's 'primary area of vulnerability' is exposed and there is a chance to rework attitudes and ways of feeling and behaving. She suggests that if nodal points are successively not addressed an impasse is likely to develop. There is a consensus now on the emphasis on the therapeutic system in understanding impasse. Green (1988) proposes that impasse is not a linear process but a result of intertwined realities and the mutual influence of two sub-systems. He argues that the 'fit' cannot be predicted on the basis of the characteristics of each participant.

Transference and countertransference

The concept of transference, in which past relationships form the basis of current ones and are re-enacted in the therapeutic relationship, is central to many psychoanalytic writers views on impasse. Sandler (1976) suggests that, as role-responsiveness is universal in humans, therapists will inevitably be drawn into participating in re-enactments. Whilst the process of identifying and analysing these re-enactments is at

the heart of psychoanalytic work, the strength of them often results in patients provoking vicious cycles which confirm their worst fears and perpetuate a distorted conception which underpins the therapeutic impasse. Fine (1982) described how patients manoeuvre to avoid the emergence of their fears, either by applying pressure to change the therapeutic frame or tasks or pressure on the interaction. In analysing impasse, psychoanalytic writers suggest that close attention needs to be paid to the emotionally charged relationship with the therapist in order to shed more light on how the process is stuck. Atwood, Stolorow & Trop (1989) note that therapists will be subtly drawn into patients' patterns of resistance, through fear of hostility or distress and that this type of collusive avoidance can be seen to underlie 'interminable therapies', which can be viewed as another form of impasse. Green (1988) points to the systemic function of a problem for the therapist and client and recognises the value of an interminable therapy in allowing therapists to feel important.

Therapists' own reactions may contribute significantly to the development and maintenance of an impasse. Psychoanalytic writers emphasise the role of counter-resistance which, they suggest, is usually hidden at the core of impasse. Counter resistance is described as the ways in which therapists' deaden, ignore or invalidate what the patient is bringing due to an inability to bear the patient's pain or similar issues not dealt with in their own lives (Schoenewolf 1993). Elkind (1992) suggests that this is more likely to occur when there is a pathological fit between patient and therapist. Counter resistance is also referred to as 'characterological counter transference'. Whereas situational countertransference refers to the therapist being drawn into the patient's pervasive patterns of relating, characterological countertransference refers to the therapist's own difficulties and patterns of relating and is likely to prove more problematic. Sussman (1995) relates it to the ordinary human vulnerability of every therapist and to the reasons they chose to engage in therapeutic work. In referring to the 'helping professions syndrome', he describes how therapists can be seen to project their own neediness onto clients and that contained in this is an element of hostility linking to their own previous experience of rejection as well as feelings of envy in relation to the patient. Leiper (2001) points to the difficulty therapists encounter in being honest in regards to their responses and their roles which are likely to evoke feelings of shame. He suggests that they are often only acceptable when they have been mastered and used to therapeutic effect. Winnicott (1958)

described how therapists' hostility may be expressed in a number of ways including pushing a patient to a certain point of view, taking sides in a conflict, or disparaging the patient, and Searles (1979) suggested that a sense of guilt arises when the therapist fears the eruption of their hostility. Weiner (1982) refers to psychonoxious therapists who are coercive and do not tolerate patient dependence or autonomy but rather use patients as a means to fulfil their own needs, blaming them if they refuse to get better on therapists' terms. Whilst he suggests that therapists are unlikely to behave consistently in this way, he warns against the tendency for therapists to force their frame of reference on their patients.

More current literature demonstrates a move from the individual analysis of resistance and counter resistance to a transactional one. Langs (1976) refers to the bi-personal field where elements of each person contribute to a unique relationship pattern which is neither purely objective or subjective. Mutual participation in this process is viewed as inevitable. Elkind (1992) proposes that it is when the vulnerabilities of the patient and therapist intersect that an impasse is likely to occur. Ferro (1993), who also adopts a bi-personal model, introduces the concept of 'bastions', referring to the blind spots of the couple where interpersonal structures become defensive and rigid. He suggests they serve to protect the couple from experiencing persecutory or depressive anxieties. His view of an impasse is that it represents the time necessary for metabolization of the bastions and operates as a prelude to change. Atwood, Stolorow & Troy (1989) refer to conjunctions and disjunctions. They refer to conjunctions as co-joint blind spots or defensive collusions. Disjunctive enactment relates to a process of a negative spiral where worsening ruptures are not repaired and in which the patient's emotional needs are consistently misunderstood. In these therapies patients' longings are viewed as an expression of pathological resistance and traumatic injuries are repeated which may have an impact similar to pathogenic events of earlier life.

Managing impasse

Green (1988) stresses the importance of therapists reconsidering their work in the light of a theoretical model that yields new perspective. However, it has been asserted that no therapist can be part of a system and above it and able to view it objectively (Watzlawick 1984). Omer (1992), too, suggests that therapists are too immersed in their own conceptualisations to be able to modify them. He believes that there is no

one right way of dealing with strains and ruptures in therapeutic alliance and that a strong identification with a particular therapeutic approach may hinder the analysis of an impasse. Kluft (1992) identifies the need for a protocol, to provide a framework in which therapeutic impasse can be analysed. He asserts that the same blind spots that contributed to development of the impasse may handicap its reassessment. The protocol, therefore, operates as an ombudsman. Several protocols have been developed which draw the therapist's attention to various aspects of the therapeutic contract and frame, the patient's functioning and social system as well as the alliance and aspects of the therapeutic interaction including countertransference reactions, which subsequently can be addressed (Kluft 1992; Leiper 2001; Weiner 1982; Green 1988).

Therapeutic approaches which emphasise the role of the relationship in enabling change view the enactment between therapist and patient as an opportunity as well as a problem, seeing it as a means for learning about the clients core problem as well as putting it right. Atwood, Stolorow & Troy (1989) describe the development of a therapeutic impasse as a 'royal road' leading potentially to a richer understanding and process of transformation. They suggest that when the principles unconsciously organising the experiences of both patient and therapist in an impasse are investigated and illuminated, a significant new understanding and enhancement of the therapeutic process is possible. Ferro (1993) calls for therapists to attend to the microprocesses of the session and identifies the importance of countertransference metabolisation by the therapist. He suggests therapists need to adopt new and original non-guilt inducing conceptions of the impasse which link to mental pain and that the impasse needs to undergo slow subterranean transformation before it can be confronted. Safran and Muran (1996, 2000) similarly outline a process in which the therapist draws the patient's attention to ruptures occurring in the alliance in order to access difficult underlying feelings. They propose that resolving continual problems in the alliance is a vehicle for change where the patient may risk something new. Symington (1983) describes how the enactment during impasse allows for different ways of responding to the patient's vulnerability but this transformation makes a great emotional demand upon therapists and they have to step outside safety of their accustomed position, to release their thinking and set in motion a creative interpersonal process so something new can happen. In a similar vein Newirth (1995) describes the therapist's task as encouraging clients to engage in a type of 'therapeutic play' in which a transitional

experience is created that challenges the client's assumptions about what is real and unreal.

As a general principle in tackling impasse Leiper (2001) stresses striking a balance between supporting and challenging the patient. He acknowledges the temptation to undertake a new and dramatic intervention which may at times work but is usually useless or damaging. Strategic responses, such as those described by Fisch, Weakland & Segal (1982) and Omer's (1992) critical intervention are designed to jolt the patient, whereas paradoxical injunctions recognise the value of going with the patient rather than battling with usually powerful resistances. Erikson (1980) suggests that these may be useful when the therapeutic relationship is embattled and may encourage a possible realignment of forces.

The use of supervision is also an important means of managing therapeutic impasse. It has been noted, however, that therapists often do not disclose relevant information to supervisors but engage in 'impression management' (Ladany, Hill, Corbett & Nutt 1996) due to a need to appear competent. Kluft (1992) points to the same reluctance to make effective use of supervisors and suggests therapists fear disclosing the full story regarding the therapeutic encounter due to feelings of guilt and shame in relation to a sense of failure. Leiper (2001) notes that some types of supervision are more exposing than others and that in getting the help we need we must go beyond our 'comfort zones'. Omer (1992), using a strategic solution focussed approach, recommends the use of group supervision to develop a critical intervention which is usually represented by a reformulation which the therapist can deliver to the patient. The intervention is based on a map of the impasse based on an analysis of three aspects: unhelpful narratives; therapeutic strategies; and therapeutic interactions. An empathic characterisation is created and a new therapeutic contract devised. Saretsky (1981), too, describes a group supervision context in which therapists are encouraged to explore experientially their countertransference entanglements.

An in-therapy consultation is a less common but apparently effective intervention. Elkind (1992) engages in separate meetings with both patient and therapist in order to obtain a separate focus on the problematic intersection of vulnerabilities and resistances of both parties to the therapeutic interaction. Although in-session

consultation is more commonly used in systemic work with families and couples, Hoffman (1994) describes its use within individual work where the consultant attempts to displace the negative transference away from the therapist onto him or herself and Green (1988) also describes the impact of providing a consultation message given on the basis of analysis of all aspects of system using the POETICS protocol.

Leiper (2001) concludes that the final way of managing impasse is by giving up and accepting that the therapy is not going to progress. He emphasises that there is a correct way of giving up where the therapist does not rule out the possibility of other therapies having an impact but does not hide behind it in referring on. He also suggests the option of giving up hope of change but continuing with therapy, adding that this may paradoxically prompt a break through.

Summary and critique

To summarise, the literature appears to emphasise the relationship context of impasse and suggests that different aspects of the therapy contract and frame, individual client and therapist factors, the alliance and the therapeutic interaction contribute to its development. In each scenario different factors might play a greater or lesser part. There is very little systematic research on impasses occurring in clinical settings and much of the literature cites case studies analysed from a certain model of therapy or impasse which have been selected to highlight conceptualisations being put forward in the paper. As such, conclusions expressed within this literature are open to critical analysis regarding their accuracy and validity in the absence of any experimental rigour. Many of the conclusions reached, which may be based on an accurate perception of processes occurring in the therapeutic relationship have yet to be backed by systematic programs of research in this area.

Analysis of the Hill, Nutt-Williams, Heaton, Thompson & Rhodes (1996) study

In a previous related study Rhodes, Hill, Thompson and Elliott (1994) used a qualitative methodology to study clients' retrospective recall of resolved and unresolved misunderstanding events in therapy. Based on questionnaire responses of only five clients who dropped out of therapy the study identified that clients reacted either to therapists doing or failing to do something of key importance to the clients which the clients were subsequently unable to discuss in therapy and led to them

terminating therapy prematurely. Limitations of this study included small sample size, reliance on limited questionnaire data, and the inclusion only of impasses arising from misunderstanding events. It also focussed exclusively on clients' recall of events which were followed by other events, namely the ending of therapy, which were likely to have influenced their recall. This study also does not directly relate to therapy impasse per se.

A further study by some of the same authors represents the only identified published study relating directly to therapy impasse (Hill, Nutt-Williams, Heaton, Thompson & Rhodes 1996). Using a qualitative methodology and a grounded theory analysis it focuses on twelve therapists' recall of impasse experiences which subsequently led to clients terminating therapy. The method involved an initial questionnaire followed by interviews with eight of the twelve therapists. The authors outlined a number of findings. The therapists described experiencing three 'sets' of feelings in relation to the impasse: confusion and anxiety regarding the therapy process; frustration and anger towards their client; and negative thoughts and feelings in relation to their own self-efficacy. Whilst the study did not identify a link between the quality of the early alliance and the development of impasse it did recognise a number of factors associated with impasse. These included therapist mistakes (being too pushy or too cautious, being unclear or losing neutrality, misdiagnosing the client), triangulation (when another person 'intruded' into the therapy relationship threatening the alliance), transference (where clients reacted to their therapists as they had to parental figures) and therapist issues (problems dealing with strong affect or behaviour, adopting a rescuer-fixer role, own family-of-origin issues, concurrent life stresses). In this study therapists appeared mainly to respond to therapy impasse by discussing the impasse with their clients and attempting to understand it in terms of the therapeutic process. They also recalled a tendency to react by becoming more active and directive.
The authors recognised that their low return rate of the initial questionnaires (15 out of 270), led them to question whether the sample could be viewed as representative. Whilst they asserted that the eight participants who returned their questionnaires and whose interview data were included in the analysis did not differ essentially from those who declined to be interviewed, part of their questionnaire data set on which they base their findings was obviously not substantiated by further interview investigation. The data from the interviews themselves was also limited due to the fact they were carried

out by telephone and therefore more subtle information, gained more easily from face-to-face contact, may have been lost. Other aspects of the study could challenge the reliability of the findings. One may question the accuracy of therapists' recall in relation to past events, and the fact that clients dropped out of therapy is likely to influence the way in which the therapist perceived the preceding therapy. The authors recognised that they were restricted to analysing only what the therapist told them but argued that this was a limitation in all qualitative research. No interpretative analysis of the interviews took place which may have added substantially to their findings as well as offered support to the descriptive data.

1.2 Methodology

This study was developed with the limitations of the Hill et al. (1996) study and the clinical literature in mind. In keeping with the assertion from the literature that impasse can only be understood from analysing the individual and micro features of the therapy, a qualitative approach was selected. Rather than covering a greater range of therapy impasses, breadth was sacrificed for a more in depth examination of the development of impasse within a therapeutic encounter. As the literature also suggests there is no one truth in regards to the process of impasse, less emphasis would be placed on trying to obtain the 'objective reality' of the impasse but more on the experience of facing and responding to an impasse.

Why a qualitative approach

Understanding a therapeutic impasse is important on several different levels, the theoretical, the individual clinical, as well as clinical service levels. Any methodology which examines impasse will have to address the complex interrelationship of client, therapist and external factors likely to be encountered. A qualitative methodology which does not impose an a priori theory will facilitate the search for detailed knowledge about therapists' understanding and experience of impasse. This heuristic approach is particularly useful in the study of a subject where there has been little systematic research as it allows for the development of ideas, theories and research hypotheses which could be subsequently be tested out by other methods.

Qualitative methods are used specifically to examine the lived world of the participants and their relation to it and have as their core principle the importance of gaining an 'insiders perspective' (Conrad 1980) which is essential when trying to develop a detailed understanding of a complex experience such as therapy impasse. The emphasis of a qualitative method is on the constructive nature of knowledge created through the interaction of partners in the interview conversation (Kvale 1996). It seeks to gain an understanding of a small number of participants' own frames of reference, focussing on how meanings are constructed and shaped discursively. The methods of analysis and the development of explanations are holistic in nature, recognising the complexity, detail and context of the social world which they attempt to understand (Mason 1996).

Which qualitative approach

Interpretative phenomenological analysis (IPA) takes a middle position on the positivist/relativist spectrum in that it assumes that what interview respondents say has some significance for them and there is some, though not transparent, relationship between what they say and their underlying psychological constructs (Smith 1995, 1996). It is allied, therefore, with the phenomenological tradition (see Giorgi & Giorgi 2003). It also recognises that meanings are constructed within a social as well as personal context and so relates to a symbolic interactionist position (Denzin 1995). IPA acknowledges that research is a dynamic process with the researcher playing an active role. In recognising that access to participants' personal world can only be gained through the researcher's own conceptions, it emphasises the researcher's role through the process of interpretative activity. Essentially it encompasses a two-stage process with the researcher making sense of the participant's attempts to make sense of their world. The fact that IPA adopts this dual position, of trying to understand what it is like for the participant as well as asking critical questions of the participant's account, renders it a useful method for investigating the process of psychotherapy impasse where one may expect to uncover different levels of meaning.

IPA encourages the interpretative activity of the researcher in analysing the interview texts for levels of meaning which the researcher considers may underlie the participants' consciously spoken accounts. However, the use of semi-structured interviews inherent in IPA has been viewed by researchers coming from more

narrative traditions as potentially restrictive, hindering the individual telling of a participant's experience (Mischler 1986; Murray, 2003). A narrative approach to interviewing allows the interviewee to tell their story in an unrestricted narrative, unfettered by the leading questions and closed questions inherent within semi-structured interviews. Hollway and Jefferson (2000) have argued that, as it encourages the narrator to determine the path of the story, these pathways will be defined by emotional motivations rather than rational intentions and that the narratives offer a structured account to unconscious logic. In this type of interviewing the choices inherent in story telling regarding details and manner of relating are often more revealing than the narrator realises or intends. In this aspect this approach is similar to the psychoanalytic method of free association.

This approach, therefore, is more likely to afford the researcher greater access to the subjective experience of the interviewee in cases where the interviewee may be likely to 'defend' (Hollway and Jeffson 2000), i.e. where the area of study is intricately related to the participant's personal self and where the participant may have both conscious and unconscious motivations for restricting access to certain core experiences or functions. As this study is concerned with gathering information on experiences which have considerable implications for the participants' personal and professional selves, they will consequently have much invested in the picture they provide regarding both their work and the way in which they explain the development and meaning of an impasse. The fact that they will also be interviewed by a fellow therapist who is likely to be seen as someone able to evaluate their work means that participants will probably, to some degree, defend against having aspects of themselves or work examined.

Careful consideration, therefore, had to be given to the interviewing framework which would be most likely to elicit material pertaining to the core experiences of therapists working with an impasse. The schedule developed would need to be designed to answer the research questions but, at the same time, allow the participants to tell their story about their experience of impasse in order to give as much freedom as possible for them to gravitate naturally towards those areas which have the greatest meaning for them. The overall research design was, therefore, based mainly on the principles of

IPA and the data would be analysed using IPA procedures. However, the interview schedule was to be strongly influenced by the narrative method of interviewing.

In keeping with this model it was decided to use a smaller number of participants and opt for greater depth rather than breadth by carrying out two interviews with each participant. The second interview would allow the participant to reflect on their account in the initial interview, to bring material that came to mind after first interview and may encourage a richer more open description of the impasse experience. It would also give the participant the opportunity to continue the story of the impasse experience and how it was shaped by events and examine whether the first interview influenced the participants' ideas about the impasse and how they responded to it. In this way potentially valuable material will be accessed regarding the way in which the impasse develops and changes over time.

Focus of study

Although an equally interesting examination of impasse could possibly be gained through focusing on the experiences of clients in therapy it was decided to limit the study to examining the therapists' experience. This decision was based on the belief that no single truth can be expected to emerge in the study of an individual impasse (Weiner 1982; Leiper 2001) and one would expect differences between the therapist and client in terms of their individual experience of a therapy in impasse. Focussing on the experience of the therapist rather than that of both participants in the therapy also allows for an examination of my main area of interest, namely the meaning an impasse has for therapists in relation to their particular role within the therapy dyad.

1.3 Research questions

Initial research questions emerged from reviewing the existing literature and considering the different aspects of an impasse experience. These concerned the ways in which therapists first realise the therapy is becoming stuck, what sense they make of the impasse, how it makes them feel and, finally, what they do in relation to the impasse and how it affects their usual ways of working. Four research questions were subsequently specified:

1. How do therapists recognise an impasse?
2. What is the therapists' emotional experience of an impasse?
3. How do they conceptualise the impasse and its causes?
4. How do they respond to an impasse?

During the analysis process it became clear that, in addition to the participant's descriptive accounts of their impasse experience which corresponded to the four questions given above, material relating to the underlying meanings of the impasse experience emerged strongly in the data. Given that this material appeared as a rich seam in the participants' accounts and pointed to a potentially more extensive understanding of the impasse process, another research question was added relating to this new material, namely

5. What meaning can an impasse be seen to have in terms of therapists' personal selves?

Therefore the first four questions relate to the therapists' owned experience of impasse whilst the fifth involves an interpretation of the meaning of the experience for the therapist by the researcher.

2. Method

This chapter comprises a detailed account of how the study was carried out and the process of analysis used.

2.1 Development of materials

The interview schedule for the two interviews was developed with two purposes in mind. Firstly, in relation to the first four research questions, the schedule needed to lead to material regarding how therapists recognised, felt, thought about and responded to an impasse experience. It also needed to encourage the therapist to tell their story about the impasse. The interview questions which emerged from the research questions were subsequently shaped to encourage the therapists to give a narrative account of their experience. For instance, rather than asking, "How did you notice that an impasse was developing" the question was adapted to, "Tell me about the time when you first started to notice the impasse".

The narrative approach was further developed in questions in both the first, but mainly the second, interview, asking the therapist to relate how the therapy and the impasse developed over time and the influence they thought their therapeutic strategies had on the therapy progress. Through a number of consultations with a research supervisor and colleagues from the doctoral course in Clinical Psychology questions were adapted to suit the aims of each interview and create the optimal amount of structure and narrative flow. A more inclusive list of questions was condensed to allow the interview to be more loosely constrained by the questions and encourage the therapists to develop their own narrative. The interview schedule is shown in full in appendix one. Although the ordering of the questions had some relevance in terms of a progressive narrative it was anticipated that the order might be changed across interviews in order to keep as close as possible to the participant's own narrative and not interrupt the natural flow of the interview.

2.2 Ethical approval

A research application including the study protocol was submitted to the local Research Ethics Committee for approval. Based on the committee's guideline referring to the different levels of scrutiny required by the committee in relation to the level of patient participation, a request was made for 'Chairs action'. This is more likely to be given in the case of studies where there is no involvement of patients. The chair of the committee did subsequently approve the study by chair's action (see appendix two).

2.3 Pilot interviewing

A pilot set of interviews was carried out with a colleague who was a female clinical psychologist and a fellow course student. Following these interviews only one change was made to the schedule based on feedback from the interviewee who expressed how difficult she had found it to immediately think about and discuss her general experience of being stuck in therapy. Her short and undetailed response to this question also suggested that it might be an ineffective opening question. The question was, therefore, transferred to the end of the first interview where it was likely that the therapist would be able to move from a specific instance of impasse to considering their general experience of it. Asking therapists to describe their work and how, in particular, they were experiencing their therapy work was substituted as an initial opening question. This appeared to be an easier topic for therapists to address initially whilst still stimulating some useful information regarding the current context in which the impasse was occurring. The exact wording of the opening question was,

1. Please tell me about your work at the moment and in particular how your therapy work is going?

2.4 Participants and recruitment

The selection of participants for the study started with the assumption that no particular group of therapists is more likely to encounter impasse or be more open to talking about it. There was no apparent reason to prioritise any particular group and the field of work, gender, level of experience, therapeutic orientation, professional training

or work setting would not determine whether therapists were included in the sample. The only inclusive criterion applied to the sample was the requirement that therapists were working in a broadly defined psychotherapy model in which the therapeutic dialogue represented the means of change and that the therapists saw the value in exploring the therapeutic process and would, therefore, be more likely to produce richer accounts of that process. It was also decided to restrict the sample to therapists working with adult age clients. This does not imply that therapists working with children do not experience impasse but the therapeutic process and experience of impasse could be notably different with children. These differences would be difficult to assess with such a small sample and take the study away from its core concerns and questions. There is support in the literature for defining a fairly homogenous sample in this way within qualitative approaches (Smith & Osborn 2003) in order to be able to make more definite statements about one population group.

Within the sample some purposive sampling took place in order to introduce some variability. Although it was accepted that participants might not necessarily be representative of their particular group, e.g., older adult therapist, male therapist etc, a wider selection of therapists was purposefully sought in order to enrich the data set and extend the range and different types of stories. Whilst one would not be able to draw definite conclusions regarding differences between the therapists a striking difference in the accounts of particular therapists would point to areas that could be investigated more fully in other studies. The first three participants were female and were psychodynamic in orientation and, whilst there was no decision to restrict the criteria for the fourth participant, if there had been a choice of participants a male therapist and or one from a different therapeutic orientation would have been selected. The fourth participant who volunteered fortunately fulfilled both these criteria. Another participant had also been selected and interviewed prior to the fourth participant. Unfortunately the only tape of his second interview was inadvertently taped over. On deciding whether to include this participant the fact that there was incomplete data from him and that, like two of the other participants, he had referred to an impasse experience that was passing rather than current meant his first interview transcript was held in reserve, to be used if needed, and another participant was sought. Due to the sufficiency of data from the four other participants the interview material from the fifth participant was not subsequently used.

In qualitative research, data collection and analysis occur concurrently and the eventual sample size is determined by the quality of the data collected. IPA does not set out to achieve "data saturation", i.e., where no new themes emerge from the data, and it does not assume a theoretical end point can be reached. It recommends that the gathering of data can stop when a degree of "internal coherency" or "persuasiveness" is reached (Smith & Osborn 2003). In this study four interviews were considered sufficient to enable a story to be told about the themes embedded in the material.

Recruitment was initially done by flyers sent to the major organisations within the Leeds and West Yorkshire area which offer counselling, psychotherapy and other psychological therapies, covering approximately 100-150 members of staff. A copy of the flyer is included in appendix three. This approach was seen as most suitable for encouraging participants to volunteer for the interview and to include participants who were attracted to the study by their interest in exploring the therapeutic relationship, the key criteria for inclusion in the study. As this resulted in only three potential participants personal contacts were made by the researcher requesting therapists to again bring the study to the attention of colleagues who may be interested in participating. The fourth participant was found through one such contact. He confirmed that he had been interested in volunteering when he had seen the first flyer and no external pressure had been applied in his decision to volunteer. Potential participants were sent an information sheet and consent form (appendix four and five). They were asked to read the information sheet and the researcher agreed to contact them at a later date to answer any queries they might have. If they agreed to proceed with the study they were asked to complete the consent form (appendix five) and return it at the first interview. All four recruits fulfilled the criteria for inclusion in the study and were subsequently included.

The final sample consisted of four therapists who were all white and had the following defining characteristics:

	Gender	Job title	Work setting	Orientation	Yrs qualified
Alison	F	Counsellor	NHS	psychodynamic	12
Beth	F	Clin psych	NHS	psychodynamic	11
Carole	F	Psychotherapist	Voluntary/private	psychodynamic	10
David	M	Clin psych	NHS	cognitive/integrative	12

2.5 Procedure

Using the interview schedules referred to above two interviews were carried out with each participant with a gap of approximately four weeks between the two interviews. There was some overlapping of interviews between participants. The first interview was carried out for participants one to three followed by the second interviews. Both interviews for participant four subsequently took place. Interviews were held at different locations; for Alison and David they were held at their place of work, Carole's took place at her home and Beth's were at a university location. All interviews were tape-recorded.

At the start of the first interview participants were asked to confirm that they had read the information sheet and had had the opportunity to ask any questions regarding the study. They were also asked to confirm that they had signed the consent form which included consent for the interviews to be tape-recorded and transcribed. The tape recorder was started and the initial question from the interview schedule was asked. Subsequent questions followed according to the schedule although the questions did not always occur in the order of the schedule. Whilst the essential core questions from the schedule were constant across all four sets of interviews some flexibility was seen as not only acceptable but necessary to maintain the flow of the interview and encourage a richer narrative. The interview schedule operated more as a guideline rather than a fixed order of procedure. Additional prompts were given when necessary to encourage the participant to say more about their experience. Questions were added asking for clarification of an area that appeared unclear. At times the researcher would reflect back points of the participant's account either to check the understanding, encourage further exploration or to help the interview to flow by providing a link to the next question. Given the emphasis on obtaining a narrative account participants were

allowed to lead the interview in a direction pertinent to their individual experience. When appropriate, however, the researcher would guide the interview back to the next relevant interview question.

At the end of the first interview information regarding the participants' background, their professional training, therapeutic orientation, current post and number of years qualified was confirmed. The participants were also asked for some restricted information regarding the clients they had discussed including age, previous contact with mental health services, diagnosis or identified clinical problem, and length of therapy contact to date. The date for the second interview was agreed. At the end of the second interview the participants were thanked for taking part. They were told more about how the data would be analysed and asked whether they would like any feedback on the results of the study. One participant asked whether she could have copies of the transcripts of her interviews. This was agreed and copies of the original interview transcripts were sent to her. The first interviews lasted between 45 minutes and 1 hour and 5 minutes. The second interviews lasted between 25 and 40 minutes.

Notes were made immediately after each interview regarding my recall of the participants' interview presentation, the essence of their story and obvious themes, as well as any pertinent impressions or feelings from the interview.

2.6 Treatment of the data

The audio taped interviews were transcribed by a secretary who had extensive experience of transcribing interviews for qualitative studies. The transcripts were subsequently checked by the researcher comparing them to the original tapes. Only a few errors or omissions were noted on each interview and these were subsequently corrected. Almost all of each interview was audible on the tapes with only a few exceptions.

2.6.1 Interpretative Phenomenological Analysis

The initial analysis of the data was undertaken using the procedures of Interpretative Phenomenological Analysis (IPA) as described by Smith (1995, 1996).

The researcher read the transcript through and then, on second reading, made notes in the left hand margin of the transcript in relation to each passage. These notes could be descriptive words or phrases, associations, or preliminary interpretations of the material. Subsequently, in the right hand margin of the transcript, themes were identified which appeared to emerge from the notes and the text. These themes were then listed separately, along with a more descriptive phrase from the text to which the theme related and the line number. They were subsequently clustered according to overarching themes or concepts. If applicable these second level themes were also clustered under a further superordinate level of coding. The final coding system comprised of a small number of superordinate themes each encompassing a larger number of themes which, in turn, contained a number of sub-themes. The sub-themes were accompanied by references to the text including a descriptive phrase from the text and the line numbers indicating where the sub-theme appears. This procedure was carried out separately for the transcripts of participants one and two. As the themes emerging from these transcripts were sufficiently similar they were merged into a single coding system. The transcripts of participants three and four were subsequently analysed using this system. Where evidence of the themes appeared in the text the text phrase and line number was added to the developing computer Word files in which the data relating to the coding system were gradually built up. Careful attention was paid to the process of recognising existing themes to ensure that identification of the themes was not 'forced' and to the presence of any new themes which were noted and added to the coding system. This method of using an emerging coding system to analyse further interviews is one of the ways recommended by Jonathon Smith for analysing the data (Smith 1995). The first interviews for each participant were analysed in this way followed by the analysis of the second interviews. Although the steps outlined above appear sequential, the process itself involved a constant to and fro between the codings, the text notes and the text itself as the themes were developed in an iterative process of continual refinement.

Whilst the themes that emerged related closely to the participants' telling of their experiences and to the initial four research questions, there was obviously, within the transcripts, evidence of another level of process occurring within the impasse experience which related more closely to the impact that the impasse had on the therapists' sense of self and which underlay the participants' narratives. In addition,

codes had been collated referring to the interview process itself, regarding areas such as level of openness, reflecting and questioning of self, use of humour, etc which also suggested that the impasse experience and being interviewed on this topic contained further levels of meaning other than the ones offered through the participant's conscious narrative. Both of these supported the need to carry out a more interpretative analysis of the data which was subsequently undertaken as a second and separate analysis. Although in IPA the analysis is meant to combine interpretative and phenomenological analyses with the researcher interpreting the phenomenological accounts, it was decided, in this case, that the two levels of analysis would be kept separate as each appeared to offer important insights into the impasse experience. This method was subsequently debated on the IPA group e-mail site (Hartley 2003) and accepted by several senior researchers involved in the development of IPA as a reasonable means of organising the data provided that the themes were sufficiently different and that the phenomenological codes could not be subsumed under the interpretative ones. In the case of the second analysis each interview was analysed and coded separately with the codes only collated at the end of the analyses and refined into an integrated set of codings. This method was selected here as the emphasis was placed on analysing each participant's personal encounter with the impasse experience where greater differences between participants were more likely to emerge.

The first level of analysis, therefore, focussed on the direct experience of the participants as offered by them at interview. The codes and themes are more descriptive in nature and relate closely to the participants' spoken accounts. They also relate to the first four research questions, namely, how therapists recognise an impasse, how they feel in relation to it, how they think about it and how they respond to it. The second level of analysis, again using IPA, involved a more interpretative engagement with the material. It centred on the less overt expression of how a therapy impasse affected the participants' sense of selves as able therapists. From this second analysis a fifth research question was added which focussed on what meaning the impasse appeared to have in terms of the therapists' sense of self.

Ideas from narrative approaches, particularly regarding the notion that analysing the way in which participants tell their stories can produce a richer understanding of the core meaning of an experience, were also embedded in the research design. The focus

on how the therapists told their stories about impasse and how they experienced being interviewed about this experience was also taken through to the analysis. A third, quite separate, analysis, which was more closely allied with the method of narrative analysis, was carried out on the transcripts. A process of coding was used and themes relating to the interview process were identified. Again this was undertaken separately for each participant and the codes were then gathered into one coding system. Finally, a case-by-case analysis of the interview experience allowed me to look more closely at each of the participants and put their experience of being interviewed about impasse in their own individual contexts.

2.7 Audit of coding systems

An independent audit was carried out on both the phenomenological and the interpretative codings by two clinical psychologists who, together with the researcher had formed a sub-group within the D. Clin. Psych. course interested in qualitative research. The auditors, therefore, comprised a fellow course student and a course lecturer. For the phenomenological codes the auditors were given a copy of a transcript with passages underlined and numbered where a coding had been given by the researcher but was left out. A list of the codes was also attached and the auditors were asked to go through the text and indicate which code they would allocate in each instance. They were also asked to comment on how well they felt the codes related to the transcripts in general. Although the level of correlation between the researchers codings and the auditors was relatively low at 41 and 42% when comparing between specific codes, the level was increased, to 60 and 62%, when they were compared by theme categories. A similar level of correlation was noted between the two auditors. On reviewing the instances where there were discrepancies it was agreed that, in all cases, a number of codes could have equally applied due to the detailed nature of the coding system. Following this audit the coding system was condensed further, particularly in the areas where the minor discrepancies had occurred.

In the second audit, the auditors were given a further transcript and a copy of the codes with descriptive text phrases and line numbers referring to each code. They were asked to read the transcript and then identify each example of the code in the transcript and

indicate whether they thought the code matched the material. There was a much higher initial agreement between both auditors and the researcher in regards to these codes with no significant points of disagreement.

2.8 Researcher reflexivity

In undertaking this type of qualitative research where the results are shaped largely by the researcher's interaction with the data, the researcher's own beliefs, constructs and personality will inevitably effect the process of interpretation as well as the interviewing process itself. Qualitative methods do not try to hide this bias but rather accept it as inevitable, arguing that no truly objective research can be undertaken. It is important for readers of any study to understand something of the researcher's own background, their expectations and beliefs about their area of study and any factors which may affect the way in which the researcher will act in relation to the interviews or the analysis of the data (Finlay 2002).

With a background in both psychodynamic and cognitive therapy approaches, I became interested in the area of therapy impasse through my own experience of encountering impasse, my supervision of fellow members of staff and students who would bring cases where they felt the therapy had become stuck, and the growing willingness in both psychoanalytic and cognitive schools of therapy to understand impasse in relation to what the therapist as well as the client brings to the experience. The beliefs with which I embarked on the study were that therapists find impasse very disturbing in relation to themselves as therapists and are likely to attribute the impasse to the client, especially given the context in which they work where it is the client who is presenting as the one experiencing difficulties.

It is interesting to speculate whether, as suggested by one of the auditors, I could perhaps be 'tougher' in interpreting the accounts of other therapists in a way that researchers who were not fellow therapists would be less likely to be. Certainly the themes which 'emerged' from the data were likely to be influenced from my own clinical background and familiarisation with concepts from cognitive and psychoanalytic traditions. However, in developing codes care was given to use

descriptive terms rather than 'technical' ones and the audit of the codings by colleagues from other clinical and theoretical backgrounds also provided a check on my own blind spots or theoretical bias.

2.9 Writing up

The writing up of the study has been undertaken with reference to conventions on the writing up of qualitative studies using IPA (Smith 1995).

Participants' names have been changed to ensure protection against identification and any identifying details, such as places of work, etc., have been altered or omitted. Footnotes have been used sparingly, only when it has been necessary for me to explain to the reader how a particular term is being used in the context in which it appears.In the results chapter, where verbatim extracts are used to illustrate the theme the extracts have been edited for readability and minor hesitations (e.g., repeated words, "uh" etc) have been omitted. Ellipses (...) indicate omitted material. Each extract has been identified by pseudonym, interview number and line number. Themes and sub-themes appear in italics within the text of the results.

3. Results

The results chapter comprises a number of sections which relate to the different analyses which were undertaken. Pen portraits of the participants introduce the chapter. Subsequently, the results of the first analysis, the analysis of the phenomenological codes, will be given followed by the section on the interpretative analysis. There is then a shorter section on the interview process codes and the chapter is completed with a return to the individual participants and an analysis of the interview experience.

3.1 Pen portraits

Alison

Alison is a counsellor working in an NHS setting. She has been qualified for 12 years and has a degree in Counselling. Her main therapeutic orientation is psychodynamic. The client she selected to discuss in the interviews was a man in his late eighties who had been referred to her by his general practitioner. He had presented as depressed and suffering with shingles and she had been seeing him for over a year. He had had no significant previous involvement in mental health services. His wife had been experiencing dementia and was living in a nursing home and his own health was starting to deteriorate. The client had a history involving an early loss of his father and subsequent major family change, including a more emotionally distanced relationship with his mother. Therapy started with the hope that that by working through some of his emotional experiences the client's depression would lift and his improved psychological state could help his physical condition of shingles. Following a number of changes Alison was no longer feeling as stuck in the therapy.

Beth

Beth works as a NHS clinical psychologist. She undertook a M.Sc. in Clinical Psychology and had been working as a qualified psychologist for 11 years. Her main therapeutic orientation is psychodynamic. Whilst admitting that her work with her usual client group often became stuck in a repetitive process she decided to discuss a client who had been referred for staff counselling and with whom Beth felt more personally stuck. The client was a woman in her early forties who was presenting with

depression and who had had previous involvement with mental health services after suffering a breakdown in her twenties. The client had a history of lack of emotional care and sexual abuse. In her adult life she had experienced relationship problems and had self-harmed. Beth hoped that therapy would provide the client with a secure place where she could begin to explore her earlier experiences and make links to her present problems of depression and relating to others. Beth had been seeing her client for an initial contract of six months of weekly sessions and had just extended the contract for a further six months. She still felt very stuck in the therapy process.

Carole

Carole was completing her training as a psycho-analytic psychotherapist. She had ten years previous experience of working as a psychodynamic counsellor in a number of voluntary settings and she also ran a private psychotherapy practice. The client she discussed was a man in his late forties who she had been seeing as a psychotherapy training patient for over three years. He had been referred by his general practitioner to a voluntary mental health service where Carole worked as he had been suffering with symptoms of anxiety and depression related to severe work stress. He had not undertaken any previous therapy but had been seeing a psychiatrist for out-patient appointments for a short period of time. He had a history of disturbed and emotionally abusive early relationships. Carole's aim in the therapy was to help her client access his emotional reactions to events and his own emotional needs. The therapy was drawing to a close as Carole was leaving the organisation where she saw the client. After a very difficult experience of therapy Carole thought that the therapy process had recently started to improve.

David

David works as a clinical psychologist in an NHS setting. He has been qualified for 12 years and has a M.Sc. in Clinical Psychology. He described his therapeutic orientation as cognitive/integrative. The impasse which he discussed related to his experience of therapy with a woman in her late thirties. She had been referred to the psychology department by her general practitioner and was presenting with problems linked to a borderline personality type, including intense emotional reactivity, interpersonal difficulties, self-harm and substance use. She had several previous psychiatric in patient admissions and had also been seen by the local drug and alcohol service. David

had been seeing her for over two years and was extending the therapy contract following reviews and agreeing defined areas of work. His initial aim had been to help his client identify and modify the cognitive processes underlying her reaction to events and patterns of relating. David was still experiencing the therapy as stuck.

3.2 Phenomenological coding

An initial analysis of the interviews was undertaken focussing on the participants' direct experience of facing impasse in therapy. A consistent pattern of themes emerged from the accounts although there remained significant variation in individual experiences this both enriched the themes and led to an interesting analysis of the individual patterns emerging within the broad framework of the themes. Twelve themes were identified from the accounts each with a varying number of sub-themes. Following a review of the themes they were grouped into six domains which operate as heuristic organising categories. The list of domains, themes and sub-themes are given overleaf in table one.

Each theme will be considered in turn within the six domains. Tables are inserted to indicate which participant account contained the theme (**A,B,C,D**) and in which interview the theme appeared (**1,2**).

Relationship

This domain concerns the central role of the therapeutic relationship and illustrates the features which are present within a 'stuck' therapy.

Theme one: ***Qualities of the relationship***

		A	B	C	D
1.	**Qualities of the relationship**				
1.1	Positive engagement		**1**	**1**	**1**
1.2	Personal liking		**1**		**1**
1.3	Special relationship	**1**	**1**	**1/2**	
1.4	Connectedness		**1/2**		**1**
1.5	Absorption of feelings	**1**	**1**	**1**	

Table one: Phenomenological themes

Relationship

1. Alliance

1.1 Positive engagement
1.2 Personal liking
1.3 Special relationship
1.4 Connectedness
1.5 Absorption of feelings

2. Experience of other

2.1 Drawn in
2.2 Challenged

3. Roles

3.1 Parental Role
3.2 Therapist role

Psychological states

4. Emotional states

4.1 Discomfort
4.2 Useless
4.3 Guilt
4.4 Frustration/anger
4.5 Burdened/responsible
4.6 Rewarded/moved

5. Mental states

5.1 Awareness
5.2 Understanding
5.3 Attention

Progression

6. Becoming stuck

6.1 Lack of progress
6.2 Repetition
6.3 Distraction from focus
6.4 Disturbance to boundaries

7. Making changes

7.1 Progress outside therapy
7.2 Change in therapy rel

Actions

8. Response

8.1 Level of activity
8.2 Punitive interventions

9. Therapy Direction

9.1 Attention to process
9.2 Acceptance/survival
9.3 Revise ideas
9.4 Changing approach
9.5 Changing structure
9.6 Ending therapy

Personal self

10. Personal meaning

10.1 Confidence
10.2 Contrast with other experiences

11. Needs

11.1 Support
11.2 Enabling other
11.3 Self-protection

Conceptualising impasse

12. Conceptualising

12.1 Impasse as inevitable
12.2 Impasse as helpful
12.3 Impasse as necessary

Positive engagement

Most of the therapists recalled an initial positive connection to their clients. Beth had a very intense engagement, noting "powerful dynamics" from the start. The fact that her client was a member of staff working in the same trust and Beth experienced a strong identification with her was a key part of the strong alliance. She recalled feeling "certain" that she would be able to help her client. Whilst Carole felt a strong enough alliance to decide on taking her client as a training patient for her psycho-analytic training her experience of the initial positive alliance did not persist.

"Interestingly at that first meeting there was something about him that 'attracted me'... there was a connection without a doubt. And I think I very quickly sort of regretted that." C1-169

For David his sense that the initial alliance was "fine" was accompanied by "an uneasiness" relating to the genuineness of the connection and the apparent positive start his client was making in undertaking the therapy work.

Personal liking

The sub-theme of personal liking appeared in the accounts of two therapists. Beth described being struck by strong positive feelings of liking her client. She felt she had a "lot in common" with her.

"I think she's also somebody that out of that room...I would like her in real life... she'd be somebody that I'd be quite happy to go to the pub with." A1-1238

Whilst personal liking also emerged as a sub-theme in David's account it was in relation to the opposite feeling. He described his client as, "not very likeable" and admitted that the "personal part" of him would have liked to have "got rid" of her. Given that David later describes how he avoided addressing the therapeutic process the fact that he did hold some negative feelings towards his client could perhaps have contributed to him maintaining a more distant relationship from her.

Special relationship

Characterising the relationship as 'special' was noted in three of the four accounts. The relationships had become personally meaningful to the therapists in a way which differentiated them from relationships with other clients. Therapists expressed a sense of *being the only one to help* which contributed to the pressure to 'cure' the client.

Significant progress in the therapy was experienced as *gratifying* and *extraordinary* and left the therapist feeling *very moved.*

" I feel I'm very touched by the therapy...very touched by the relationship." A1-984

The extent to which this was a feature of the particular relationship or the therapist's personal self cannot be easily determined as both will obviously play a part, but it is interesting to note that David, as the only male therapist did not have *being special* as a theme running through his account. This could, however, relate to the lack of personal liking he expressed in relation to his client.

Connectedness

For Alison and Carole feeling connected to their clients was essential for therapeutic progress. Carole described being connected as "at the heart of good therapy" and she, in particular, emphasised her capacity for great emotional involvement. She felt thwarted when her client remained *disconnected* but responded with energy to his attempts to become more open.

"...we were absolutely related in the room, in the hour, and I was completely sort of attentive and involved." C1-573

Absorption of feelings

The three therapists who worked primarily within a psychodynamic framework thought that the impasse could partly be attributed to them *absorbing the clients' feelings*. This left them feeling overwhelmed by feelings of *despair, fear and hopelessness* within sessions, which they were unable to process. Only when they were able to recognise that these feelings were fundamental to the client's own experience were they able to regain their capacity to analyse them.

"...and there's something intensely unbearable then I think... But I think I was feeling it not him." C1-362

Theme two: *Experience of other*

	A	B	C	D
2. Experience of other				
2.1 Drawn in	**1**	**1/2**		**1**
2.2 Challenged		**1/2**	**1**	

For all four therapists the way in which clients behaved towards the them was central to the development and dynamics of each therapy relationship and corresponded to the way in which the therapy subsequently became stuck.

Drawn in

Being *drawn in* to patterns of relating with the client was common across three therapies, although the underlying process varied with each relationship. Beth's client was very unsure about engaging in therapy and required persuasion by her therapist who worked hard to establish a helpful and safe therapy space and became quite careful in her interventions.

"And yet in the sessions she'll come along sort of with a kind of I don't really know if I should be here, I don't know if this is really helping." B1-96

The relationship between Alison and her client quickly became established around a *wish for cure.* Alison found herself drawn in to *resolve* her client's depressed state and his shingles, feeling more anxious and *working harder* when no symptom change was occurring. David felt *locked in* to the therapy similarly by an unspoken assumption, in this case that he would continue to support his client through the various crises with which she presented. Again therapists recognised how these subtle mechanisms led to the therapy reaching an impasse as, rather than analysing the client's needs, they played out roles within the therapy.

Challenged

Clients were also experienced as directly *challenging* by two of the therapists. Beth's client would *test out* her therapist as if *challenging* her robustness or commitment to her. She continued to question the value of the therapy and the extent to which it was helpful. Beth initially responded anxiously to these challenges, questioning the appropriateness of the therapy herself. Over time she was able to see how these challenges related to breaks in the therapy and was able to manage them more effectively. Carole's client proved challenging in a different way. He would arrive late to sessions and Carole felt that he subsequently *blocked* her out of the session and "wouldn't let me help". For Carole the strength of her client's way of relating, or non-relating, struck a devastating blow to the therapeutic process and her ability to help him. Sessions consisted of her being "bombarded" by her client venting

his frustrations and complaints about life. Although his anger would not be directed towards her she felt herself challenged to respond and find a way through his tirades.

"And - it's awful. All I can remember is just sort of sitting in a chair being shouted at and I'm sure it wasn't quite like that." C1-598

Theme three: *Roles*

		A	B	C	D
3. Roles					
3.1	Parental role	**1/2**	**1/2**		**1**
3.2	Therapist role	**1/2**	**1/2**	**1/2**	**1**

Parental role

Therapists described becoming very *absorbed* and *concerned* for their clients. Beth viewed her client as being quite *fragile*, needing to *be reassured* and *supported* through emotional crises.

" .. and of course what she's wanting is that reassurance but again it's that sort of powerful person to tell her it's all gonna be alright again." B1- 823

Similarly David felt his client turned to him to "smooth out the chaos" in her life and brought new crises to keep him involved and needed. Therapists were able to recognise the anxiety and a wish to be *rescued* underlying the client's presentation. They experienced their client as becoming *emotionally reliant* on them.

"...he wouldn't want me to go." A1-829

Alison empathised with the client's emotionally painful experience of facing major losses in his life. His lack of other support and his own declining health contributed to her response of providing *emotional care* for her client. She expressed concern at making a *safe space* for her client and felt a strong pull *not to abandon* him. *Feeling responsible* for the client was one of the defining themes of the therapists' experience of impasse. They recognised how feeling responsible and being drawn in to enacting a parental role with their clients would run counter to the work they were trying to undertake with the client.

".. and then feeling responsible which immobilises me because I think well maybe she's frightened, maybe she's – 'oh this is all too big and scary'." B1-659

Therapist role

For the therapists this consisted of *not taking responsibility* for the client, *putting back* to the clients the things they felt the client was transferring, such as painful emotional states and responsibility, *making links,* and *enabling* their clients to face painful realities or accept responsibility for their feelings and behaviour. The extent to which therapists were able to stay in therapist mode determined how stuck they felt in the therapy and they would often move in and out of this role but would strive to re-gain it. This would become blocked if the therapist became overly affected by feelings of r*esponsibility* or *guilt.*

" So I guess that's why you know the agenda of therapy gets pulled to what she wants and it's ongoing because that's what she wants... and glibly I haven't got the heart to let her down." D1-570

Psychological states

The second cluster of themes related to emotional and mental states.

Theme four: *Emotional states*

		A	B	C	D
4.	**Emotional states**				
4.1.	Discomfort	1/2	1/2	1	1
4.2	Useless	1/2	1	1	1
4.3	Guilt	1	1	1	
4.4	Frustration/anger	1	1	1	1
4.5	Burdened	1	1/2		1
4.6	Rewarded/moved	1	1		1

Discomfort

Therapists painted a vivid picture of the state of discomfort they suffered at times. David and Carole described feeling *horrible* and *dreadful*. Each therapist experienced feelings of stress and anxiety. For Beth her reaction was so strong that she experienced "somatic pain" and "panic" and her strong sense of discomfort was apparent even as she talked about the client.

"...I feel sick...I'm not going to be sick but I feel kind of really stressed like something awful is about to happen...and that's what I feel like talking about this..." B1-967

The following four emotional states can be split into two groups, in relation to whether the therapists attached blame to themselves (feeling useless and guilty), or to their client (feeling angry and burdened).

Useless

Feeling *useless* and experiencing a *sense of failure* was common to all therapists. This usually was in relation to a *lack of progress* in the therapy or perceived complaints from the client, but it also resulted from the therapists' own recognition that they had *lost their therapeutic stance*. The sense of failing would lead to a severe undermining of the therapists' confidence as they absorbed the blame and hence the responsibility for the apparent non-progression of the therapy.

"...I've certainly sat there and thought I am completely incompetent." D1-625

There was a recognition that, at times, therapists' sense of failing and associated feelings of *helplessness* and *hopelessness* reflected the clients' experience in relation to real events in their lives, including child sexual abuse and loss of spouse.

Guilt

Feeling *guilty* was shared by three therapists and occurred either in relation to them feeling they were *abandoning* their client by keeping to appropriate boundaries or in relation to feeling *punitive* when making interpretations. Carole recognised these interpretations were made from a state of anger and frustration and were likely to be affected by this. Alison, on the other hand, felt punitive in pursuing her client with interpretations when he was communicating that he was seeking respite from his difficult decline. Beth immediately felt she was to blame for the client's lack of awareness of an impending therapy break.

"But then I felt incredibly responsible and bad that I hadn't told her...and I actually ended up seeing her at five o'clock on the Friday..." B1-360

It is interesting to note that the therapists who emphasised being in a *special relationship* also experienced a sense of guilt and points to some conflict between their role as a therapist and that of a special caregiver.

Frustration/anger

In response to the *lack of progress* or the repetition of certain patterns of relating therapists experienced *frustration* and in some cases, stronger feelings of *anger* when they felt the therapy was *being controlled* by the client. These feelings were generally recognised as "untherapeutic".

"I used to get absolutely furious. I mean ... my - my counter transference feelings - I add the counter transference and make it sound professional rather you know childish or out of control 'cos that's what it felt like...I suppose the fury was that we weren't getting through to each other." C1-247

Burdened

The sense of responsibility experienced by Alison, Beth and David, would impact on their emotional states. At times, this responsibility was experienced as overwhelming, leaving the therapists feeling *burdened.* This feeling would often persist between therapy sessions with the therapists carrying feelings of concern and anxiety.

"...so just a lot of work is what it feels like...Part of me just feels quite burdened by it I think." A1-1238

Rewarded/moved

Given the difficulty of working with the stuck therapy and the *mental and emotional effort* required, when therapists were able to see a positive outcome in terms of client change or improved relating they experienced a sense of *personal satisfaction* and strong feelings of *emotional connection.* They experienced the improvements as *validating their work* and therapeutic approach.

"...I feel a little bit tearful now, it does...feel very... rewarding and...I can't think of the word that... not vindicating, that sounds too sort of triumphant, but...it feels like it's been worth it." C1-759

Theme five: ***Mental states***

		A	B	C	D
5.	**Mental states**				
5.1	Awareness	1	1/2	2	1
5.2	Understanding	1	1/2	1/2	1
5.3	Attention	1	1	1	1
5.4	Avoidance	1	1/2	1/2	1

This refers to mental states of the therapist or those of the client as perceived by the therapist. They include the states or processes which the therapist was directly addressing in the therapy and were the basis of therapy change.

Awareness

At points during the therapy both Alison and Beth became more aware of aspects of their client or their way of relating which altered the way they subsequently responded to them. Alison recognised that her client's problems were "not solvable" by therapy and altered her approach. Beth, during the course of her first interview realised that rather than being powerless her client was actually controlling the therapy in a very powerful way. This awareness led to Beth being able to address the issue of power within the therapy relationship more directly. David, like Beth, found that the first interview led to a greater *recognition* of his position in the therapy.

"...having that discussion enabled me to step back even further...I hadn't quite appreciated the pressure maybe that I was putting on us..." D2-167

In the second interviews both Beth and Carole were noting a shift in their clients' awareness of the roles they played in relation to others. Carole described how her client began to make some "authentic realisations" and recognised "to his horror" how he was starting to behave like his mother.

Understanding

Therapists pointed to initial problems involving a *lack of understanding* in relation to the client and the therapy process.

"And it took me absolutely years to realise - well as if I know what's going on now - but to begin to get a grip on what was going on." C1-149

A sense of *confusion* was experienced by Alison, Beth and David as they were *drawn in* to particular patterns of relating and had to make sense of "unspoken messages". For Alison and Carole their supervision provided an opportunity to understand what their client was bringing, although both referred to the need to have continual supervision as they easily became *lost* again within the therapy process. The theme of understanding in the second interviews referred mainly to the client rather than the therapist and the clients' understanding either of aspects of themselves or their ways of relating. Beth

described her client as beginning to link feelings to their context and she was no longer seeing her depression as simply a biological process.

Attention

All therapists engaged very *attentively* with their clients, although for Carole this appeared as a theme only when her client was being more emotionally open with her. The level of *concentration* required in sessions would subsequently leave therapists feeling *drained* and *exhausted.* Beth, in particular, described vividly how she became so *absorbed* by her client that she stopped moving and was left with a "paralysed" leg at the end of one session.

" I'm not able during those sessions to let my mind wander...I have to kind of stay with it. And - it's one of those people that...at the end of the session you don't feel you need to write anything down 'cos you remember it all." B1-121

Avoidance

Avoidance was a major theme both within the therapists' accounts of their impasse as well as their thoughts on processes underlying impasses more generally. Therapists referred to their own tendency to use avoidance as well as their recognition of their clients' avoidance. Beth referred to a *collusion of avoidance.*

" I feel I could collude with her very easily. That the awfulness of what she's been through is - is so awful that it can't be spoken about and has to be forgotten, that actually talking about things doesn't help, it makes you feel worse". B1-427

Alison also recognised she was avoiding painful aspects of her client's experience. She thought her client was also, at times, unable to tolerate his feelings of desperation and she would be the one experiencing those feelings. Similarly, Carole saw her client's central problem as his avoidance of intimacy.

"I really think you know A - couldn't connect. Just couldn't risk that" C1-355

Progress in therapy was marked by either or both therapist and client no longer being so avoidant. For David the first interview allowed him to recognise his own areas of avoidance which he reflected on in the second one.

"At the same time I hadn't really appreciated how much I was avoiding being direct, for example about finishing." D2-169

Progression

The next cluster of codes related to ways in which the therapy became noticeably stuck or, conversely, showed signs of progressing.

Theme six: *Becoming stuck*

		A	B	C	D
6.	**Becoming stuck**				
6.1	Lack of progress	1	1	1	1
6.2	Repetition	1	1	1	1
6.3	Distraction from focus		1	1	
6.4	Noticing boundary disturbance	1			
6.5	Noticing emotional states	1		1	

Lack of progress

The clearest indicator of the therapy reaching impasse was the lack of observable improvement in the client's main areas of functioning. *Lack of progress* was recognised by all four therapists at the initial stages of impasse. On reflection, all the therapists realised that improvements were taking place in the client's life outside therapy, albeit to a limited degree in some cases, and the sense of impasse related to stuck patterns of relating within the therapy.

"I began to think nothing is changing here, this is just going on and on." C2-220

Repetition

In all cases therapists referred to a *repetition* in the client's narratives. Therapists described how their clients would bring back similar concerns to each session and they experienced their work as *being lost* between sessions. Alison described how, for a time, each session felt like "starting all over again" and David noted how, at first, slight variations in material impeded his view of the repetition.

"she would come in, sit down, give me a recap of how things were going, and we'd look at aspects within that, and .. off she would go, come back, and we would start recapping very similar issues.. presented in a slightly different way." D1-147

Distraction from focus

Carole experienced her client's tirades and complaints about the outside world as a means of *distancing* from the main work of therapy. David also began to notice his

client's tendency for *swapping between problems* and how she would *bring in new problems or crises* which, he realised, served to keep him *drawn in* to support her and prevent any real progress which might lead to the ending of the therapy.

"There would always be another crisis, another concern would centre, pull focus away from trying to address the pattern." D1-171

Noticing boundary disturbance

Although Alison, who saw her client at his home, referred to a difficulty in ending sessions as he would not want her to leave, Beth was the only therapist to describe very notable problems in keeping therapy boundaries. She recalled how her anxiety and feelings of guilt regarding therapy breaks had led her, on one occasion, to offer an additional session out of work time. She also admitted to over-running sessions and being unable to address her client's lateness at the start of sessions.

"Yeah. I've also over run on sessions with her…it's a time when I've got to leave because I've got to pick children up..so actually over running at that time is not good for me 'cos it impacts on the rest of my day." B1-861

Noticing emotional disturbance

For Alison and Carole, one of the clearest indicators of impasse was their own emotional reaction. Alison recalled a strong personalised response, whereas Carole's response related more to her feeling that her efforts were being thwarted.

"..and I started feeling…useless like the therapy wasn't working." A1-341

"But I…suppose a lot of it was…in my own counter transference 'cos I would often feel exhausted and frustrated…" C1-206

Theme seven: *Making changes*

		A	B	C	D
7.	**Making changes**				
7.1	Progress outside therapy	**1/2**	**1/2**	**1/2**	**1/2**
7.2	Change in therapy rel.	**2**	**1/2**	**1/2**	**1**

Progress outside therapy

Despite the sense of being stuck within the therapy relationship therapists recognised that progress was occurring simultaneously in the clients' life outside therapy. It was, perhaps, more apparent in the latter stages of the impasse. Therapists referred to their

clients "moving on" and "shifting". Such progress included *improved relationships with others, taking more responsibility* for their feelings and actions, making *important life changes* and taking a more *proactive* approach to responding to their needs. Clients were seen as being more *in control* both of their lives and their emotional states.

"She would be completely withdrawn within her personal relationship…and now she talks to her partner, she'll request cuddles… she's very active in.. owning what she's feeling and she can articulate it…so there's a massive shift." B2-193

Change in the therapy relationship

Whilst all four therapists did experience some progress within the therapy this was most notable for Alison and Carole. By the second interview Carole was experiencing her client as *relating more* and, as they neared the end of therapy, she felt that he was able to *take more responsibility* for his feelings and actions.

" I think it was when he…began to see the part he played in it himself that…it was possible…for some sort of changes to take place." C2-357

Alison felt that she was no longer struggling to achieve symptom change with her client. They had both been able to *accept* the fact that he was dying. Subsequently the relationship had *strengthened.*

"I think that it's the alliance that is changed, it's the feeling in the room that has changed." A2-307

Although Beth and, in particular, David both continued to experience some problems and challenges within their therapies they also recognised some elements of progress. Beth referred to her client as "taking more responsibility" within sessions and as "sharing more". David also noted that his client was "not so extreme" in her presentation with problems to solve but generally felt the progress was "not enough".

Actions

The fourth superordinate theme concerns the way in which the therapist responded to the impasse, including the more immediate responses as well as the more considered strategic changes to the therapy.

Theme eight: ***Responses***

		A	B	C	D
8.	**Responses**				
8.1	Level of activity	**1**	**1**	**1**	**1**
8.2	Punitive interventions	**1**		**1**	

Level of activity

All four therapists cited *working harder* as the main initial response to feeling stuck.

"I think I have to work really, really hard in the sessions with her to not get pulled in to thinking the way she does." B1-114

Beth referred to "keeping struggling" whilst Alison, Carole and David responded by *trying different things*. Alison recalled, "pulling all the tricks out", as she became more anxious regarding the *lack of change*. Both Beth and Alison noticed how they felt impelled to become more active, experiencing an impulse to "dive in and take over". Beth attributed this impulse to the client feeling that in her case the *onus was on the therapist to act*. Alison related it more to her own difficulty of staying with the client's painful emotional state.

"I want to do something. You know I want to do something instead of just being able to listen to the story and try to understand with him." A1-792

Conversely, in response to her client's *bombardment* in sessions Carole recalled feeling that it was *pointless to intervene* and she began to withdraw. The initial sense of *hope* with which she started each session, instilled from supervision, would turn to *frustration* and despair of achieving change.

"At that time I think I would give up…I'd say less... or, not exactly not trust myself to speak - it just seemed pointless." C1-395

Punitive interventions

Two of the four therapists admitted to making, what they felt were, *punitive interventions.* Carole considered that, at times, out of frustration she would respond to her client in a way which she felt was punitive and expressive of her anger. She described these interventions as "untherapeutic" and "unprofessional". Alison, in trying to overcome the apparent lack of progress, recalled *pushing the client into a more emotional state.*

"...you need to grieve more right, ...so I would try to get in touch with whatever it was that he was feeling.... So I would try to kind of hone my skills... to be empathetic enough and reflect back to him to where he would...then fall apart. So in a way it became punitive..." A1-483

Theme nine: *Managing impasse*

		A	B	C	D
9.	**Managing impasse**				
9.1	Attention to process	**1/2**	**1/2**	**1/2**	**1/2**
9.2	Acceptance/survival	**1/2**	**1**	**1/2**	**1**
9.3	Revise ideas	**1/2**		**2**	**1/2**
9.4	Changing approach	**1**			**1**
9.5	Changing structure	**1**		**1**	**1**
9.6	Ending therapy	**1**	**1**	**1/2**	**1/2**

Attention to process

In response to the impasse all therapists *attended more to the therapy process.* Carole described trying to *intervene more* to show the client what he was doing.

"- if I can in inverted commas "catch him doing it", I actually intervene now much more quickly and much more readily." C1-387

Therapists worked hard to process the dynamics of the session and avoid repeating unhelpful patterns of relating. Beth described using her "inner supervisor" and watching herself more closely. Subsequently she would be able to *put things back* to the client and encourage her to engage with her own capacity to think.

"I think what I've been much more aware of is...not taking on board so much of that responsibility...trying to stay in there with her and...put things back to her...I possibly did that before...I'm just much more aware of making sure I do it now." B2-92

Beth and David both referred to *discussing the impasse* within therapy sessions, although David wondered whether he was still *avoiding being direct* in his discussion. Through supervision Alison became more aware of what she and her client were avoiding. Subsequently she was able to address with her client the fact that he was dying and she became more *fully attuned* to the process.

Acceptance/survival

The theme of *acceptance* appeared in all the therapists' narratives. David felt he had to accept the slow rate of change and the prospect of seeing his client on a long term basis. Both Alison and Beth referred to *tolerating* as a means of responding to the

impasse. For Alison this meant tolerating the difficult feelings which were aroused in relation to mortality issues as well as accepting her client's lack of recovery.

"I'm not so afraid...of his death...not feeling this is just too unfair...that's something both of us have been in a process of being able to...an acceptance of that..." A2-236

She recognised that when she *stopped pushing her client to get better* the relationship improved and the sense of stuckness was relieved. Beth recognised that she needed to tolerate her client's stuckness and withstand the very powerful dynamics which operated in the therapy sessions and not resort to "quick fixing" or advising her client whilst Carole referred to the need to *survive* her client's tirades and *accept her lack of control* in relation to his behaviour. She later reflected on the value of remaining "patient" and "steadfast".

Revise ideas

Over the course of therapy all the therapists appeared to revise their ideas about their client and alter the focus of their interventions. When she recognised that his problems were unlikely to resolve Alison began to work on helping her client to grieve and reminisce on his life. Carole *altered her view* of her client in relation to his capacity to emotionally engage but found that towards the end of therapy she was able to undertake more in-depth psycho-analytic work with him to which he responded well. David related how he constantly *changed the focus* of therapy sessions in his attempts to find some resolution to his client's continual presentation for help.

Changing approach

Both Alison and David referred to *changing their model of working*. Alison moved from a more psychodynamic approach to a supportive and client centred one.

"I might go and think about what it means but I'm not...turning it around any long and trying to interpret this and that way...I'm just trying to be there with him." A1-882

Whilst David alternated between using a cognitive approach to working more psychodynamically when he felt process and relationship issues were a more central concern, he felt unsure regarding the effectiveness of his attention to the therapy dynamics and reflected on his difficulty in addressing them.

Changing structure

Changing the frequency was referred to by both Alison and Carole. Whereas Carole increased the intensity of the therapy by moving from once-weekly to twice-weekly sessions Alison moved in the opposite direction, from weekly to fortnightly sessions in line with the change to a more supportive longer term approach. David attempted to introduce greater *structure* to the therapy by *setting a contract* involving a limited number of sessions and *agreeing a focus* for those sessions. The contract-setting was seen as unsuccessful as it led to contracts being renewed or extended.

Ending therapy

For all therapists the ending, or not ending, of the therapy was a core theme and avoidance of ending was, in David's case, apparently at the root of the impasse. Carole described how it was only when she informed her client that she was leaving the organisation where she saw him and that the therapy would be finishing that he was able to recognise the value of the work and become more emotionally engaged.

"When I said that I was going…there was just a sense that he suddenly realised he was gonna lose something…and the work has felt different since then." C1-695

For the other therapists they expressed a *difficulty in leaving* their clients whilst they continued to struggle with their lives. Whilst David referred to "looking at ending" with his client he also recognised that they "can't quit". On his part he admitted he was unable to stop at a point where only limited progress had been made as this would leave him questioning the value of his work and the time he had invested in it. Alison felt that it "would not be tolerable" either for her or her client to end therapy whist her client is in such a state of decline and envisaged seeing him until his death.

Personal self

The therapists' narratives contained material linked to their personal selves. The material appeared to centre around two main themes; *personal meaning* and *needs.*

Theme ten: *Personal meaning*

		A	B	C	D
10.	**Personal meaning**				
10.1	Confidence	**1**	**1**	**1**	**1**
10.2	Contrast other experiences	**1**	**1**	**1**	**1**

Confidence

The therapists set the impasse in the context of their general work experience. All therapists presented themselves as working in demanding roles with clients with complex needs. Their experience of working in these areas had given them a belief in their own *competence*, an *ability to work with challenging clients* and a sense of being a *good enough therapist*. Carole remarked on her own level of self-confidence.

"I think actually I do know what I'm doing now." C1-48

Contrast with other experiences

The experience of being stuck in an impasse with clients and the ways in which therapists had to tolerate difficult feelings and uncertainty contrasted with therapists' general experience of work. All therapists referred to their work being *enjoyable, varied* and *interesting*, markedly different from the *stressful* and *repetitive* nature of being stuck in therapy. Other sub-themes emerging from individual accounts related to experiences of *emotional connection*, *effectiveness*, and *being valued by others*, which again contrasted with the therapist's account of their impasse experience.

"It's huge, challenging but just incredibly kind of exciting. And again at its heart is - is the connection with another person." C1-48

Theme eleven: ***Needs***

		A	B	C	D
11.	**Needs**				
11.1	Support	**1**	**1/2**		**1**
11.2	Enabling other	**1/2**	**2**	**1**	**2**
11.3	Self-protection	**1**		**1**	

Support

Angela, Beth and David emphasised the importance of the support they received from other members of their team as well as, for Alison, from her supervisor. The function of that support appeared to be the way in which it *re-establishes the therapists' sense of self* through their *identification with others who understand* their experiences.

"we're quite good here in terms of supporting each other...if we're having a cup of coffee...we'll quite happily roll eyes at each other and say you know I'm still trying to figure this out." D1-273

Enabling other

Both Alison and Carole valued their supervision, seeing it as *crucial* and *empowering*. Whilst supervision helped these therapists *make sense* of the stuck therapy process, this was an ongoing need, particularly for Carole who experienced the positive effects of supervision but became *lost* as she faced the "bombardment" from her client in the following session. For Alison the *containing* process of supervision was transferred to the therapy process as she felt "freed" and more able to provide a "safe space" for her client to explore his painful feelings about his life.

"I ended up not being so overwhelmed by the therapy. So I think it shifted some of the stuckness in the therapy. It freed me to be able to start to think about what might really be going on at - at a deeper level." A1-690

Beth and David had received no supervision on their cases and both found the interview process helpful in thinking about their case and their own role in the impasse. They differed from the other two in the extent to which movement occurred in the therapy process following the first interview. This appeared to validate the critical role of the supervisory relationship in helping therapists to be able to think about the complex interpersonal process in which they are engaged.

Self-protection

Looking after self appeared in the narratives of both Alison and Carole. Alison stressed the importance of maintaining a healthy home life to balance the emotionally demanding nature of the work. They referred to the personal impact that therapy work can have and the need to find ways of *protecting* themselves. Carole noted that she does not "take on anyone too readily now" following her difficult experience with her client. Alison emphasised the need to *de-personalise* aspects of the therapy process.

"it's about being able to understand those mental mechanisms yeah? ... it's made me more aware which I think is very...helpful and not... making it personal." A1-1432.

Conceptualising impasse

The final codings in the first analysis relate to the ways in which therapists generally conceptualise impasse in therapy.

Theme twelve: *Conceptualising*

		A	B	C	D
12.	**Conceptualising**				
12.1	Impasse as inevitable	**1**	**1**	**1**	**2**
12.2	Impasse as helpful	**2**	**2**	**2**	**2**
12.3	Impasse as necessary		**2**	**2**	

Impasse as inevitable

The inevitability of encountering impasse was a theme for all four therapists. Impasse was referred to as being *part and parcel* of the therapy process as clients were viewed as already being in a state of impasse when entering the therapy.

"I suppose if people weren't going to get stuck they wouldn't be in therapy..." C1-817

Therapists also linked impasse to the difficult client group with which they were working and Beth noted how "low motivation goes with the territory". Generally therapists believed that impasse started with the client and related it to unrealistic expectations of rescue, unachievable longings, and unconscious resistance to change.

"The times I have felt stuck is when they are unable or don't want to think and pass it on to me to...make them better in some way or to find some way round it." B2-454

Therapists believed they could be caught up in the clients' stuckness due to a lack of awareness of these processes and the lack of clear therapy direction or boundaries. Viewing impasse as inevitable and relating fundamentally to the client's unachievable desires meant that it was not indicative of a personal lack of competence.

Impasse as helpful

In contrast to the negative experience of feeling stuck in therapy impasse was also seen as a potentially *helpful process*, providing the therapist and client with an opportunity to discover something about the core difficulties and experiences of the client. In this view working through impasse becomes the main aim of the therapy.

"Well I think that impasse is the work of the therapy...impasse is part of ...the story the clients are trying to tell us...it's part of the unconscious mechanism that gets to where the client is stuck that they can't verbalise." A2-490

Impasse as necessary

Both Beth and Carole's accounts referred to the impasse as a *necessary* process.

Having completed the therapy Carole looked back on the years of withstanding her client's "battering" as necessary in order for him to work through unresolved feelings. Beth, too, believed she had to "bear" her client's stuckness and that there were no short cuts through the difficult phases of their work.

3.3 Interpretative coding

Following from the initial analysis, a second, more interpretative analysis was undertaken which focussed more on the experience of impasse in terms of the therapists' sense of self. Five themes emerged from this second analysis.

Table two: Interpretative codings

1. Ideal self	**2. Threat to self**	**3. Loss of therapeutic self**
1.1 Capacity to give 1.2 Special therapist 1.3 Able therapist	2.1 Threat of failure 2.2 Disturbance to ideal rel 2.3 Role pressures 2.4 External challenge	3.1 Loss of thinking self 3.2 Loss of therapeutic stance 3.3 Splitting 3.4 Self focussed
4. Threat reduction	**5. Restoration as effective therapist**	
4.1 Internal distancing 4.2 Normalising 4.3 Regain equilibrium 4.4 Strengthen boundaries 4.5 Reliance on other 4.6 External relief	5.1 Understanding impasse 5.2 Processing core problems 5.3 Regaining thinking self 5.4 Regaining therapeutic stance	

Theme one: ***Ideal Self***

	A	**B**	**C**	**D**
1. Ideal Self				
1.1 Capacity to give	**1/2**	**1**	**1/2**	**1/2**
1.2 Special therapist	**1/2**	**1**	**1/2**	
1.3 Able therapist	**1/2**	**1**	**1/2**	**1/2**

Within their accounts of their experience of impasse therapists conveyed a view of their *ideal self,* how they would like to be perceived by others and the self that they strive to achieve within their role as therapists.

Capacity to give

Therapists portrayed themselves as having an internally valued self which afforded a capacity to give to others. In this view they were able to be *hard working, minimising their own needs* and *able to juggle competing demands* for their time and attention. A view of themselves as *containing therapists*, able to recognise and respond to the needs of both staff and clients, was a dominant theme. Therapists talked of their ability to create a "safe environment", their capacity to make an "emotional connection" and be "attuned" to their clients' "unspoken needs".

"I know that what I kind of desire is ...you know healthy good lively connections with people. That's what I want for myself and it's what I want to offer to clients." C2-494

Within this role was a sense of the therapists' own needs to be in the *enabling* position, a *wish to cure* their clients and the gratification gained through emotionally and mentally difficult work.

"You know that some how enough therapy, enough of being there, enough of the framework, would some how - the shingles would disappear and then I'd at least released something yeah?" A1-443

Special therapist

All the female therapists conveyed an ideal self as being in some way *special*. For Alison and Beth their work roles contained the notion of them *rescuing difficult cases*. Inherent in this role was the idea of them succeeding where others either had failed or were likely to fail in engaging the client in a *special* therapy.

"I felt that...I could actually provide that sort of safety but also the boundaries that she would need to feel safe and not feel pressured, not...get worse in a way... that if she saw someone else they may not be able to maintain those boundaries." B1-252

The idea of therapy work being *special* and unlike other relationships or lines of work came through strongly in both Alison's and Carole's narratives.

"I was talking about my new job...and almost straight away she said, "God that must be so real, that sounds fantastic." And I said, " Well, that's exactly what it is."" C1-63

Able therapist

The accounts of all four therapists contained an ideal self as being *able*, involving inner qualities such as *internal robustness* and *self-awareness*. They portrayed themselves as being *knowledgeable* and *skilled*, and able to engage clients in an appropriately challenging therapy.

"if there is something that I bring to it it's that what I will offer is an environment in which the problem is going to be reached." C1-546

Their ability to *maintain appropriate therapeutic boundaries* and be *clinically and professionally responsible* was emphasised, as was their *capacity to undertake complex and challenging work*. Both David and Carole emphasised their level of *self awareness* and ability to reflect on their own contribution to the therapy process which related to their view of themselves as competent therapists.

"I think I still see and I think I've always seen in that sense the role I can slip in to which is a parenting type role." D2-433

Theme two: *Threat to self*

	A	B	C	D
2. Threat to self				
2.1 Threat of failure	**1/2**	**1**	**1**	**1**
2.2 Disturbance to ideal relationship	**1/2**	**1/2**	**1/2**	**1**
2.3 Role pressures	**1**	**1/2**		**1**
2.4 External challenge	**1**	**1**	**1**	

The therapists' ideal self came under threat in several ways.

Threat of failure

The fact that the therapy was failing to result in substantial change appeared to fundamentally challenge therapists' sense of selves as competent therapists and they questioned themselves in regards to what they were "doing wrong". Whilst all therapists experienced a disconcerting *lack of progress*, David also expressed how he felt that all his therapeutic efforts were thwarted.

"there's that sort of therapist awareness of seeing something happening and yet despite attempting to address it by different methods or mechanisms it still continues." D1-199

Therapists struggled with feelings of failure and became *locked in* to the therapy in their need to find some resolution.

"the more I put in the more expectation I have of you've got to get somewhere…if we acknowledge that this is where we've got to…it doesn't feel sufficient…it's almost like looking back on myself and saying what was that all about then." D1-714

Disturbance to ideal relationship

In experiencing the therapy as failing to live up to an ideal version of therapist and client engaged in a fruitful and mutually fulfilling process, therapists idea of themselves as being able to create that ideal scenario again appeared to come under threat. A *disturbance to the equilibrium* was experienced in different ways by all therapists. For Alison, coming up against her clients' hopelessness in relation to change and her own uncertainty of providing a secure and stable relationship challenged her ideal version of a nurturing therapy whilst Beth struggled with processing the sense of *client disillusionment* which undermined her view of herself as an enabling therapist. Beth appeared disturbed by her client *challenging* the therapy and expressing doubts about its value and she felt she was "pulled into" very "powerful dynamics" which left her feeling very destabilised and disturbed.

"there's got to be some sort of big sort of testing out stuff that's going on that's…making all those…dynamics worse…this kind of thing that I feel when I'm with her…panic and uncomfortable, and actually I don't want to be here." B1-923

The *balance of control* in the therapy relationship appeared as a central theme in Beth's, Carole's and David's account. Therapists hold ideas of how a therapy is ideally balanced in relation to levels of therapist and client control and react to the therapy deviating significantly from this ideal. Although Beth, had felt disturbed by her experience of being pushed into playing a more powerful role, after her first interview she felt equally concerned by her feeling that she had little control over the therapy.

"…trying not to get in to the …role where I'm the person that's powerful and telling her what to do that actually what I'm feeling is kind of the opposite.." B1-928

David expressed surprise at his inability to respond to the powerful hold his client exerted in the sessions and Carole also experienced her client as controlling the sessions by his tirades against the world leaving her feeling thrown off course and powerless to intervene. Her client's *lack of emotional connection*, proved a substantive

threat to Carole's ideal of a therapy relationship and she described feeling thwarted by the level of his emotional withdrawal from her.

"I have a great preparedness for an emotional involvement...so at times it can just feel horrible for me (laugh)." C1-285

Carole felt similarly disturbed by her own response of *lack of concern* for her client which contrasted with her prevailing view of herself as a caring therapist.

"Actually my kind of response is much more one of boredom and lack of interest which ...actually I find that painful because...at some level it's like, oh I couldn't care less. And that's...a horrible way to feel about another human being." C2-452

Role pressure

Whilst therapists held an ideal view of themselves as being *containing* and *able to undertake complex and demanding work*, the dissonance with the reality of carrying out such roles proved challenging to the therapists' sense of self. In the actual experience of therapy strong emotional states had to be endured and the position of having something to offer their clients turned into a heavy feeling of responsibility.

"(she) looks to me all the time to...feed her even though she's not an eating disorder but to give her something to lead her." B1-172

External challenge

External influences appeared to pose some degree of threat or challenge. Carole referred to her own difficulty of undergoing therapy and being challenged by her therapist which, she felt, helped her to empathise with the experience of her clients. In discussing her client with a fellow member of staff Beth recalled reacting to the challenge of whether the client was appropriate for their service, experiencing it as an attack on her clinical judgement.

"...(she) said, "Oh this person shouldn't come through the NHS they should go privately", and I remember feeling quite defensive about that..." B1-214

External reality intruded directly into Alison's experience of therapy with her client whose health was deteriorating. She described feeling disturbed by feelings of helplessness in the face of death which contrasted with her ideal self as enabling positive change and alleviating emotional pain. This experience also forced a more acute awareness of her own human vulnerability.

"...he has really brought me up against my own mortality." A1-977

The fact that Carole had, early in the therapy, selected her client as a training patient for her psychotherapy training also served as an external threat as she felt impelled to continue the therapy. This subsequently influenced her experience of his controlling behaviour and her sense of having to tolerate it.

" and I suppose I was a bit locked in to it as well. Not least because he was one of my psychotherapy training clients." C1-261

Theme three: ***Loss of therapeutic self***

	A	B	C	D
3. Loss of therapeutic self				
3.1 Loss of thinking self	**1/2**	**1**	**1/2**	**1/2**
3.2 Loss of therapeutic stance	**1/2**	**1**	**1**	**1**
3.3 Splitting	**1/2**	**1/2**	**1/2**	**1**
3.4 Self focussed			**1**	**2**

The impact of experiencing a threat was most notably observed in regards to the therapists' ability to maintain their position within the therapy relationship

Loss of thinking self

The capacity to think and process material both within and between sessions was, in all cases, impaired as the impasse became established. Therapists experienced states of *confusion* and a lack of understanding in relation to the therapy process.

"But...I can get lost in those feelings." A1-604

"And it took me absolutely years to realise - well as if I know what's going on now - but to begin to get a grip on what was going on." C1-149

David found himself being easily *distracted* by new problems presented by his client which prevented him from addressing the core concerns and dynamics which were consequently being avoided. Beth and Alison recognised how feeling *overwhelmed by their own emotional and physical states* blocked their ability to think about the client.

"it's this whole thing about ...a meeting with one's...humanity...is very painful...it's very hard to tolerate and so there are times when it just...gets too tender, it's gets too...hard to bear." A1-784

"and then feeling responsible which immobilises me..." B1-659

Whilst Alison and Carole benefited from supervision on their cases they emphasised how critical supervision became and the extent to which they relied on their supervisors to process session material and liberate the therapists' capacity to think.

Loss of therapeutic stance

Another core experience of impasse was therapists' difficulty in maintaining a therapeutic stance. This was mainly seen in the extent to which they were "caught up" in responding to clients' "unspoken agendas" or found themselves in a position which related to the client's core dynamic. In all cases therapists found themselves either acting or wanting to act in ways which, on reflection, appeared to fulfil some unresolved attachment needs for their clients.

"the expectation of therapy which is I'm going to keep supporting, ...I'm going to continue to be there, unlike other people in her life, but continue to be there in a way that she wants..." D1-566

There was considerable variation between therapists in the extent to which they attributed their responses and loss of therapeutic stance to themselves rather than their client, with Beth owning her responses more than the other three.

"but because I'm kind of practical and resourceful then I will think of strategies to...get out of that...I don't know if I've done it...I probably have, but there's a danger in my getting in to my kind of way of managing stuckness." B1-681

Hostile responses appeared as a further indication of a loss of a therapeutic stance. Both Alison and Carole admitted to acting out of frustration at times and believing that their interventions related more to their anger than to therapeutic intent. Whilst Beth did not consider her interventions punitive she did refer to her reaction of "pushing things back" when she felt her client was asking her to "do the work for her". She would subsequently feel guilty and that her response could be experienced as rejecting.

Lack of clear boundaries and the extent to which the client, or experiences the client is facing, connects with the therapist's personal self also appeared to relate to a loss of therapeutic stance. Beth acknowledged that her identification with her client as a likeable fellow member of staff within the same trust drew her away from her usual therapeutic position and led to her feeling overly responsible. Alison found that as her

client stirred up anxieties for her about her own mortality she experienced a difficulty in maintaining appropriate boundaries and felt her anxieties became confused with his.

"I think I was very ambivalent about getting ...closer to this fellow, going over the boundaries...so they were no longer his lack of boundaries but then my lack of boundaries...his mortality, my mortality." A2-265

Finally, the loss of therapeutic stance was also demonstrated by a *loss of therapy direction.* Therapists found themselves either losing the overall direction of the therapy and even doubting its value, as well as losing direction within individual sessions.

"I'd approach each session with a sense of hope and the hope would...die somewhere and turn to really very, very powerful feelings in me of ... anger, frustration, desperation." C1-344

Splitting

Another way in which the therapists experienced a loss of their therapeutic stance was in the extent to which they engaged in splitting. This refers to the therapists experiencing themselves as caught in polarised positions or 'traps'. The first trap related to therapists feeling either *powerful* and in control of the therapy or *helpless* and out of control. All but David appeared to experience this dilemma.

"so trying not to get in to the...role where I'm the person that's powerful and telling her what to do that actually what I'm feeling is kind of the opposite, panic and uncomfortable, and actually I don't want to be here." B1-930

The second common trap related to the therapists experiencing themselves either as *rejecting or containing.* This was common to all therapists and was particularly dominant in David's narrative where he felt locked in to a position of offering continual support to his client for fear of "letting her down". He was prevented from challenging his client by the fear that she would experience this as an attack on her.

"Do you know my first gut response is it will probably end the relationship." D1-427

Alison felt she had to continue to support her client as to end would be experienced by both therapist and client as abandonment.

"it would become a punitive act that isn't tolerable for a client right....possibly for the therapist as well to walk away from a situation where someone is declining." A1-625

Within sessions Beth also became caught in the containing/rejecting trap. She felt guilty at not offering something more concrete in response to her client's request for help, feeling that she had not given the client what she wanted.

"...I remember feeling very pulled into thinking, oh god maybe I should have just given her a bit of advice or maybe I should just tell her to try this or - before she was leaving it was like a sort of wanting to give her some sort of quick fix." B2-136

Whereas the others feared yet avoided becoming the rejecting therapist Carole recognised how, in her responses to her client, she transferred from a containing mode to becoming frustrated and dismissive of him.

"...and I was completely sort of attentive and involved. And the week before I'd been interrupting and sighing." C1-574

Self focussed

In response to a sense of pessimism regarding their ability to influence their clients, both Carole and David would focus instead on attending to themselves. David would seek comfort for his therapy ordeal from colleagues who would empathise with his experience of a 'difficult client' whilst Carole's strategy was one of survival in relation to her client, reducing the impact he had on her sense of competency.

"..to a great extent I think I did, a lot of the time...just sort of survive with a sense with of myself as a practitioner intact." C1-621

Theme four: *Threat reduction*

All therapists used a number of ways to reduce the threat to themselves.

	A	B	C	D
4. Threat reduction				
4.1 Internal distancing	1/2	1	1/2	1/2
4.2 Normalising	1/2	1/2	1/2	1/2
4.3 Regain equilibrium	1/2	1	1/2	1/2
4.4 Strengthen boundaries	1	1		
4.5 Reliance on other	1/2		1	
4.6 External relief	1/2		1	1

Internal distancing

Distancing self from fault appeared as one of the most effective ways for therapists to reduce the level of internal threat. This was usually achieved by therapists reassuring

themselves that it was the client who was blocking the therapy process or who had unrealistic expectations of the therapy.

"It was like he wouldn't let me help him." C1-257

Therapists' emotional and mental states could also be attributed to the client through the process of projection. Even the ways therapists responded could be seen as "set up" by the client who has "pulled in" the therapist to make certain responses.

In a similar way therapists would *distance themselves from the therapy process.* Here therapists were not necessarily blaming the client but seeing the therapy process as somehow separate from either party.

"I think the kind of therapeutic engagement is - a large part of it to be along side the client while that work's happening in...its own time, at its own pace." C2-171

David's account was striking in his use of the passive voice to explain areas of therapeutic impasse. This seemed to serve the function of avoiding blame or responsibility for the impasse and distance himself from the process.

"But that hasn't been done with her. It's almost as if that can't be acknowledged or allowed even though that's sort of what we're doing over this period of time." D1-493

Locating the stuckness in the client was a further means of reducing threat. Seeing the client as already deeply entrenched in a personal impasse and thereby either resistant or slow to change was shared by all four therapists.

"But the type of work that I am asked to do in the trust, given the section I'm in...it's set up for being stuck." A1-1411

Finally, under the distancing process, therapists appeared to gain some relief by *externalising the clients' problems.* Alison, Beth and Carole all referred to the emotionally disturbed family backgrounds of their clients. In doing so their narratives flowed much more easily as though by locating the clients' really problematic relationships in the past, the therapy relationship subsequently appeared as relatively healthy or was understandably difficult. The same function was served for David by the external pressure of the waiting list which placed time limits on the therapy. By externalising the blame the therapy relationship can perhaps be strengthened.

Normalising

Therapists used internal cognitive processes to normalise the sense of threat. Firstly, they used the process of *reasoning* whereby they found explanations for events which alleviated the threat and restored a view of themselves as a good therapist. This process often appeared in the narrative immediately following an obvious threat.

"she said she didn't want to see me any more and it didn't... feel as if it was a negative thing, it felt as if this was how she had dealt with difficulties in the past." A2-96

Beth reduced the threat to her competency by explaining her lack of therapy success as a phase. All therapists appeared to gain some relief from the notion that the impasse could not have been avoided.

"I suppose that all - all those years of...his ranting...were necessary...it's like I don't think you can hurry the work of the mind." C2-167

Accepting a lack of control was a similar strategy for reducing threat which Carole used when facing her client's tirades. She was able to use reasoning to conceptualise the lack of control as part of a useful therapeutic strategy.

"it's like that sort of battered teddy bear that still stays around to be kind of loved or loveable when the child is ready." C1-662

Several participants found other ways of *transforming the threat* which provided more palatable ways of viewing problems. This included transforming the problem into some form of opportunity, challenge or learning experience.

"Stuckness is about...you've been on a plateau ...and now this is the next rise to climb." A2-511

The process of *justifying* appeared in all the narratives. It arose at points of possible criticism of their conduct and served to alleviate the sense of responsibility. Both Beth and David justified their areas of avoidance and Alison was able to justify why she maintained an emotional distance from her client.

"What we know is that it doesn't actually help everybody to talk. There are times when it's actually best for you to find ways, strategies, to block rather than talk." B1-437

"when I first met him it felt as if he was very intrusive in to my space. It was like having - wanting to put these boundaries down." A2-262

Reassurance was used by all therapists to confirm themselves as able therapists in the face of threat. Both David and Carole reassured themselves that the responsibility for the impasse lay with the client.

"having been in a psychotherapy training for about...two and a half years and supervised weekly I'm...very much in the habit of kind of tracking my responses and feelings quite closely." C1-460

Generalising to other therapists was the final way in which two therapists normalised the threat. David and Carole related their own difficulties encountered in therapy to the general experience of therapists undertaking this challenging type of work.

"but then, of course, we all have similar experiences." D1-638

Regain equilibrium

The therapists described ways in which they regained a sense of equilibrium within the therapy relationship. This was primarily achieved by *re-establishing a safer role*, i.e. moving into a less threatening position within the therapy. This often involved moving *alongside* the client, helping the client with difficulties outside the therapy relationship and thereby taking the focus off the relationship. For Alison this meant moving to a more supportive relationship which reduced the pressure on her. In returning to a more familiar role of being a sensitive listener Alison appeared to be more at ease.

"it's like being the mother with him. Sort of try to feed back to him that he's heard... but it's also about being very sensitive to when he's had enough." A2-317

Beth established a more comfortable relationship with her client by moving from the position of being a "powerful" therapist with an inappropriate level of responsibility for her client, to handing over control of the direction of the sessions to her client.

"...and she decides the agenda. She comes along with whatever she wants to talk about and we just don't go anywhere that she's not raised." B1-1081

Transferring responsibility to the client was a theme in all the therapists' accounts. Placing the onus on the client, carried out in different ways in each therapy, helped therapists regain a sense of equilibrium. Therapists talked of doing this as part of a

useful therapy process although, in all cases, it served the function of reducing the pressure on themselves.

Distancing from challenging material was a third way in which therapists regained their equilibrium. All four therapists appeared reluctant to face areas of their clients' experience or the therapy process which were likely to contain some anxiety for them. Alison admitted to becoming more active as she felt unable to hear her client's despair and Beth was surprised at how she was not picking up on aspects of the therapy process in ways she usually would with other clients.

"and then of course it dawned on me that I hadn't been there for two weeks and actually maybe this was about the fact that...she'd missed sessions." B1-316

The use of *avoidance* as a means of ensuring stability was evident for all the therapists, apart from Carole. David avoided being in a leading role or facing the issue of ending with his client. Through a strong sense of empathy for her client Beth recognised that she was involved in a complicit avoidance.

"I feel I could collude with her very easily. That the awfulness of what she's been through is...so awful that it can't be spoken about and has to be forgotten..." B1-427

Focussing on the positive was another way in which Alison was able regain a more comfortable position. Moving away from her client's despair, which left her feeling helpless to encouraging him to focus on positive aspects of his life, returned Alison to her preferred role of enabling emotional relief.

Strengthen boundaries

Alison and Carole both responded to a threatened self by *strengthening personal boundaries*. Alison referred to her need to take care of herself.

"I think that I have to look after myself in the world...I garden a lot, and I DIY, I walk the dogs and stuff...I have to watch not getting depressed by it all." A1-1418

Distancing her personal self by understanding processes inherent in therapy was also apparent in Alison's approach to coping with threat whilst Carole appeared to protect herself from difficult and stuck therapies by becoming more selective in who she agreed to see for therapy. *Resisting other views* was a theme running through Carole's account. She referred to the way she maintained a consistent view of her work which

provided a greater sense of security for her. She stayed within a defined model of working and defended the value of that model as well as her view of what was happening in the therapy process.

"What I would try to do is to stay with my idea of what was...going on." C1-599

External relief

Within Alison's narrative it appeared that the impasse was relieved mainly by the significant changes in the client due to his progressive *health decline*. Subsequently she experienced a different relationship with her client as he became more absorbed by his state of health rather than focussing on making internal or life changes and the pressure on her as a therapist was seemingly reduced.

"he's not as well defended any more. He's kind of given up on having to be... the clever father/husband/client. And because of that I think that it is about sitting alongside him." A2-314

The theme of a *forced ending* appeared in Carole and David's accounts. Carole recognised how her leaving the organisation where she saw her client led to an obvious shift in her client's level of engagement and openness, which she attributed to him being able to recognise the value of the therapy as he was faced with losing it. The fact that the ending was *forced* on them by her leaving the organisation meant that the impasse was not serving to put off an ending as was apparent in other narratives and there was not the same imperative to resolve the impasse in order to finish. The ending could also be attributed to external forces which may have protected the client, and hence the therapy relationship, from facing more personalised meanings of it. David also referred to the possibility of experiencing a premature ending of the therapy as his client was moving outside the department's catchment area. David recognised he had begun to feel quite relieved to find an easier way out of the impasse through an enforced ending, though this was subsequently blocked when he realised that this move did not necessitate the ending of the therapy

"so that became sort of well now I can't end on that basis then (ha)...and part of me was disappointed because that would have been quite nice for me." D1-850

Theme five: ***Restoration of effective therapist***

As well as therapists attending to the threat to self they also, and often simultaneously, were able to restore themselves to a position where they were able to become an effective therapist to their client.

	A	B	C	D
5. Restoration of effective therapist				
5.1 Understanding the impasse	1	2		2
5.2 Processing core problems	2		2	
5.3 Restoration of thinking self	2			
5.4 Regaining therapeutic stance		2	1	1

Understanding the impasse

Both Beth and David appeared, over the course of the interviews, to reach a greater understanding of why the therapy had reached an impasse. In Alison's case this understanding was gained through supervision.

"...she was saying that for a period of time it's been more stable than historically. And I suppose that made me think well maybe that's one of the reasons why I'm having difficulty coming out and moving in the way that I'd like to move." D2-101

Processing core problems

In both David's and Beth's accounts, there was evidence of them starting to feel that they were addressing either the client's core difficulties, or had at least identified areas of more central concern to the client.

"I think that's come about from being in a - in a relationship in therapy where she has had an opportunity to - to think and process some of those stuff that was completely unthinkable before." B2-235

Restoration of thinking self

In Beth's case there were also indications that, by the second interview, her ability to think and process material had been, to a large extent, restored.

"...but I think also I'm just much more able to kind of recognise the pattern or think about where some one is at rather than jumping straight in to action mode. I'm more able to kind of stay with what's this about." B2-540

Regaining therapeutic stance

Carole referred to her increased capacity to intervene with her client rather than withdraw into a helpless position.

"...what happens now if - if I can in inverted commas "catch him doing it", I actually intervene now much more quickly and much more readily." C1-367

Beth also described feeling more able to stay with her client's emotional state, whilst David felt he had been more able to hold the therapeutic frame in place.

"I suppose what I'm doing in my head is trying ... to stick to the new plan without being pulled away from that either by her or maybe even by me." D1-439

Beth and David also noted ways in which they attended to the ways in which they could be drawn into responding to the clients unspoken needs and would hold back from these responses and manage the therapy process in a different way.

"Conscious that I could actually feel like I could have been shoved over, you know, behind or...then have to work extra hard to...please. And so I think consciously being aware of how I was feeling and that I had to be not doing that." D2-294

3.4 Interview Process

In undertaking the interviews and in the process of subsequent note-taking observations regarding the way in which the participants acted within the interviews appeared to point to material worthy of further analysis. The texts were, therefore, purposefully analysed looking at themes relating to the interview process. The five themes which emerged have been collated under a third analysis.

Table three: Interview process themes
1. Reflecting
2. Openness
3. Presenting a balanced view
4. Professional linking
5. Humour

Reflecting

All four therapists engaged in a process of reflection during the interviews, however, there was considerable variation between participants in the extent of these reflections.

Both Beth and David, who were still absorbed in the therapy impasse and had not received supervision in relation to their work, tended to reflect much more during their interviews than either Alison or Carole. The reflecting material was organised according to the topic of the reflection.

Reflecting on the client

Beth and David used the interview to think more about their clients. Beth questioned the extent of her client's stuckness whilst David reflected on how his client had initially engaged with him.

"And it's interesting 'cos I'm thinking about well is she really stuck 'cos...I don't really think she is stuck." B1-90

"it seemed to be going okay but that seemed to be, looking back I think more of B pleasing me in terms of doing what's expected, what a client should be doing." D1-139

Reflecting on own actions

Questioning and reflecting on their own behaviour within the therapy relationship was common to all therapists. Interestingly these reflections mainly centred around the therapist concerns about being punitive to their clients. Alison and Carole referred to pushing their clients in ways which, they wondered, may not be therapeutic.

"...it's horrible, it sounds so manipulative and I really don't see the process as being manipulative - but what I was going to say was and try...and get A to see that" C1-607

In a similar way David and Beth were concerned that they were not being more direct with their clients and were avoiding certain areas, again with the notion that their actions might upset their clients and leave them feeling like bad therapists.

"But I am conscious, in thinking about it in this way, that I don't feel I've done that for some time and it's been more about focusing on that pattern...acknowledging those frustrations, we're acknowledging them... but not really owning it." D1-397

Reflecting on therapy process

Much of the reflecting on the therapy process related to the therapist making links. For Beth this was between the client's questioning of therapy and gaps between sessions.

"...and I wonder that the times when she says that to me partly either that I've - there's been a gap." B2-66

David initially linked the therapy to his client's other relationships before realising that it was operating as an 'exception to the rule'. In considering her use of supervision, Alison realises that her experience of it relates to the atmosphere occurring in the therapy sessions. Beth, in particular, engaged in a long process of reflection on the therapy process generally, and, in her first interview, was startled by her sudden awareness of areas to which she had turned a blind eye.

"She's getting extra time (laugh) at the end. She ends up kind of - I'm having to watch what I'm saying all the time. Oh my god!" B1-955

Reflecting on choices

Both Beth and Carole reflected on choices they had made regarding their own attachment to their clients. In considering the length of her therapeutic engagement Carole wondered about her persistence in the light of such apparent difficulty.

"I am now sitting here thinking, why on earth did I work for three years with somebody who was stuck." C1-203

Reflecting on conceptualisation

Carole also engaged in some reflection on the way she conceptualised the impasse and her reasoning of it as inevitable.

"I think it was kind of inevitable and necessary. But I'm not sure. 'Cos how can you ever be? How do I know if I'd been different through all those months, would it have been different?...It's very easy to make sense of things in retrospect." C2-239

Reflecting on interview presentation

In the extract given earlier Carole is aware of herself in the interview as sounding manipulative. Beth also reflects on how she is presenting herself in the interview.

"...but when I hear myself talking I feel like a knowing powerful professional that you know I...often don't see myself as with clients." B1-257

Openness

The participants exhibited similar levels of openness within the interviews. Alison, Beth and David were more open than Carole in regards their willingness to look at

their own role within the impasse. Carole was, however, open in relation to her ability to think in the interviews.

"but it was...my lack of recognition that...going through this whole grieving process is not gonna sort this." A1-504

"sometimes I doubt whether it is anything to do with my client or whether it's much more to do with me." D1-1071

"I think better when I'm talking rather than on my own. I'm actually not great at thinking on my own." C2-545

Alison and Beth were more prepared to disclose their own vulnerability to emotional states and Carole also revealed her vulnerability to criticism.

"It...sort of takes something away from me in terms of my - I don't know whether it would be confidence, self esteem or you know what it is, but it chips away at me. And I know it doesn't make me feel good about myself." B1-724

"...and I do relate sort of sensitive to...the kinds of criticisms people have." C1-629

Finally David acknowledges his own personal agenda in the success of the therapy.

"And therefore it's almost like looking back on myself and saying what was that all about then." D1-717

Presenting a balanced view

Participants appeared keen to present their views in considered ways and would often add qualifying statements or in other ways attempt to balance their views or portrayal of themselves. This did this in relation to the frequency they encountered impasse.

"I do go through episodes where I feel that...a lot of people are doing really well and I'm discharging people, and I guess I'm going through that period where I feel that there's quite a lot of people I'm seeing that are quite stuck." B1-37

"I mean I am very positive about the work but I think I have that sort of feeling of feeling stuck and frustrated frequently actually." C1-114

It also occurred in relation the description of their general work experience.

"...it can be very enjoyable but...it can also be very stressful." A1-132

Both Alison and David were striking in the splitting of themselves in to different parts and in David's account, this appeared to serve the function of the more socially acceptable self reining back the more unacceptable self.

"Part of me is...I feel...well I'll need support in doing this which I could do in everything I do any way (laugh). Part of me thinks...what a challenge. Part of me thinks...oh god what a challenge (ha), how difficult." A1-1175

"...and part of me was disappointed because that would have been quite nice for me. But the therapist part of me knows that isn't a good ending." D1-850

Professional linking

The therapists would, at points throughout the interview, appear to relate to the interviewer as a fellow professional. This was achieved through the use of professional language which it was assumed the therapist and researcher had in common and in so doing appeared to ally the two in the study of the client. It also served the purpose of identifying the therapist within the wider community of therapists.

"...so they are actually experiencing acute stages of separation anxiety." A1-194

"...I think it would be fascinating to analyse his presentation (laugh)." C1-151

Professional linking was also achieved by suggesting that the participant shares the same experiences with the researcher and the general body of therapists.

"...of course what we know is that it doesn't actually help everybody to talk." B1-265

"...but then, of course, we all have similar experiences." D1-638

"You know and I know ...it's like I have to sit next to the feeling of this is hopeless and helpless..." A1-595

Humour

Participants used humour continually throughout the interviews. As with professional linking this also appeared to serve the purpose of increasing the connection between the researcher and therapist as the researcher was invited in to the therapists' more personal space. Therapists would laugh most frequently at points were they were disclosing something about themselves or their behaviour. Alison and David used humour to accompany a self criticism.

"you know not just waffling about, which I can have a tendency to do (ha) quite easily…" A2-594

"As compared to me just being a crap therapist…(laugh).".D1-611

It was also used when therapists revealed something of their personal experience of feeling stuck, or their 'untherapeutic' desires.

"if I'm not aware of it this actually when I walk in there…I'm walking out and I feel really bad (ha)." A1-1429

"(Laugh) Do you know my first gut response is it will probably end the relationship (laugh) which is, hey but that's what I want (laugh) but then no it's not." D1-428

In referring to the ways in which they recognised they were caught up in responding to rather than analysing client needs therapists would often laugh, as though acknowledging they could see they were acting inappropriately.

"She would feel patronised if I started suggesting why don't you try this, why don't you try that (laugh) …and I don't know if I've done it (laugh)." B1-690

"…and still avoid (laugh) currently, although there is a master plan (laugh)." D2-176

At times the use of humour served the function of adding a touch of self-mockery when the therapists were suddenly aware of how they might be perceived.

"I think I feel pretty confident (ha) that I…don't and wouldn't do that." C2-485

Carole added humour in an implied criticism of other therapeutic approaches. But she also was able to laugh perhaps more at herself as she reverted from the use of professional language to a more 'real' experience.

"I don't know what it would be like to work cognitively or you know or in a sort of reassuring person centred way (ha). 1-545

"what I would distinguish between a kind of stuckness that's an attachment to the bad object or an impasse which is actually (laugh) which is more about the therapist having a bad time while the client does what they need to do (laugh)." C2-516

Finally humour was used when making a more direct connection with the interviewer.

"So it's like you have street cred (ha)." A2-653

3.5 Interview experience

Finally, I looked at how the participants appeared to have experienced the interviews and the relevance of the interviews in terms of the participants' sense of impasse. This material was initially covered in the coding of the interview process but as it contained only a few codes I have chosen to present it in more of a case study style. This also facilitates the focus to return to the participants' individual experiences.

Alison

From the start of the initial interview Alison presented as being 'willing to help'. She was also obviously interested in understanding the process of impasse and the different levels of meaning it can have for the therapist.

"And ... so I've...appreciated what you are doing to try to pick it apart because it's so close it touches so many professional issues, a lot of human issues." A1-1490

Alison appeared caught in the tension between the need to be emotionally involved in therapy versus the costs this may have on her own personal well-being and the need to protect herself. Whilst she received helpful supervision this appeared to focus on the client and the feelings evoked by the client in the therapist. For her, therefore, the interviews provided her with an opportunity to think about this tension and the way she experienced stuckness in her work. She acknowledged that this was a useful process, given the tendency in the therapy field to ignore this experience.

"I think what's been really helpful is...that we have the chance to think about that you know 'cos it just - it's not stuff we talk about." A2-594

Beth

Beth's experience of taking part in the interviews was striking in its intensity. The fact that she had not previously had an opportunity to discuss her work with her client with anyone else meant that she came to the first interview in particular with a lot of raw and unprocessed feelings about her client. This client appeared to disturb Beth in a very specific way, and evoke a powerful physical response which recurred in the interview as Beth spoke about her client. Notably Beth attempted to move the interview away from discussing her client which she was able to acknowledge.

"I'm not sure how it affects me. But actually I'm not completely relaxed and you know as I'm talking about it now I'm not...and that's what I feel like talking about this, I just want it to be over with, which of course will be her experience so many times in her life." B1-606

For Beth the initial interview appeared to serve the same purpose as a supervision session. Subsequently she described being able to see aspects of the therapy process more clearly, had regained her therapeutic stance and was no longer so overwhelmed by her emotional and physical reaction to her client. Like Alison, she acknowledged the value of examining an experience seldom discussed within the profession.

"I think it's quite a positive experience you know to sort of focus on some - you know an area that often is seen as a very negative thing within...clinical work..." B2-575

Out of the four participants, Beth was the most open in terms of self-disclosure, least likely to use professional language and the most willing to consider her own part in the development of the impasse. Whilst this undoubtedly reflects Beth's usual ease in being open in regards to her work and to her self, the fact that she knew the interviewer may have also influenced her willingness to be so open.

Carole

Carole had no connection at all with the interviewer or the service in which she worked and had responded to a flyer to initiate her involvement in the study. This suggests that she was quite motivated to take part, and that the area of therapy impasse represented something significant for her. Of the four participants Carole was the most adamant that the source of the impasse lay with the client and appeared confident in the presentation of herself as an able and insightful clinician after her years in psychotherapy training. As her impasse was no longer current and Carole had received many hours of supervision on her work with this client, her thoughts about her work with him were, to some extent, already rehearsed. Her narrative, therefore, had more of a sense of a case presentation and, although she was able to relate her own difficult emotional experience with her client, the fact that she used mainly the past tense meant that the interviews did not appear to directly tap into a more difficult emotional struggle. Carole felt frustrated, after the first interview, for having not presented all her thoughts on her client, and berated herself for her 'failure'.

"what I'm really frustrated about is that immediately afterwards there were things and I thought oh I should have said that and why didn't I say that. And they've actually completely gone now. I almost feel like my mind is blank on the whole topic." C2-95

She also was more concerned about what may emerge from the analysis. However, she too felt that the focus on impasse had been a useful experience.

"...in a way I'm not sure I can say until I see what comes out of it... but it's been really, really interesting." C2-539

David

David was interesting in the way he engaged in the interviews and, in particular, the way he was so apparently open in owning his contribution to the impasse. What was striking was his lack of any obvious strong emotional effects or involvement of his personal self within the therapy. His use of the pronoun 'we' rather than 'I' and 'she' in describing the therapy process seemed to emphasise this distancing of himself from it, as did his conclusion that the main factor maintaining the impasse was his own avoidance of difficulties. David's continual use of humour, which was often used in self-mockery, also served to keep the interview in a 'lighter' mode. In comparison to the others the interviews did not appear to generate as much anxiety in David.

"I put the research aside - and I just see it as an opportunity to help myself think through what's going on I suppose. So just another form of supervision." D2-532

He did, however, acknowledge the value of the first interview in helping him recognise more of what was happening in the therapy relationship as, like Beth, he had previously had no formal supervision in relation to his work.

"...that sort of actually guides me, helps me to think more about the impact of that in working with her." D1-1019

4. Discussion

In this chapter I will address the core findings of the study and place them in the context of existing literature on impasse and the therapeutic process. The notion of the 'defended subject' will be analysed in respect to the participants' narratives. I will include a direct comparison with the findings from the Hill et al. (1996) study and the clinical and theoretical implications of the research will then be discussed followed by a critical appraisal of the study. Possible avenues for future research will be identified and a reflexive account of my experience of undertaking this study closes the chapter.

This study set out to examine therapists' experience of impasse in psychological therapy using a qualitative approach. The use of a qualitative methodology appears to have been justified in that it has allowed for an in-depth examination of the complex interlinking factors which combine in the development of a therapy impasse. Given the paucity of any systematic programs of research into this area the findings from this study do contribute to the knowledge of impasse and provide more evidence-based support for the existing impasse literature which traditionally has stemmed from the accumulation of clinical experience. The results represent an individual researcher's interpretation of the interview material through a personal engagement in both the interview and analysis process. Whilst the audit of the study supported its findings, the validity of the themes which have developed from the study and the way in which they accurately portray the process under study can also be judged by the reader with reference to the quotations included in the results.

4.1 Discussion of findings

The stories which the therapists told about their impasse experiences, although each individual and containing pertinent differences, were consistent in their central conceptualisation of the impasse as originating primarily with the clients and their unresolved interpersonal difficulties. Within the narratives, the therapists remain culpable, to varying degrees, of allowing themselves to be drawn in to roles ascribed to them by their clients. The phenomenological codes tell the therapists' preferred story of the impasse and provide more detail of aspects of the therapy associated with

impasse, in particular, the therapy relationship and process. The interpretative codes offer another level of explanation, concerning the internal processes that are at work when therapists experience an impasse.

In relation to the original research questions, two of the research questions, how do therapists recognise an impasse and what is their emotional experience of an impasse, relate directly to individual themes namely, *becoming stuck* and *emotional states*. The third question, how do therapists conceptualise the impasse and its causes, corresponds with several themes, including *qualities of the relationship*, *experience of other*, *roles* and *mental states*. The fourth question, how do therapists respond to an impasse, relates to the themes of *responses* and *managing impasse*. Finally the additional fifth research question, regarding the meaning of the impasse for the therapists' self relates to the themes of the interpretative analysis involving the threat to self.

4.1.1 Therapists' accounts of impasse

The four therapists who took part in the study provided vivid accounts of their impasse experiences. Although, without doubt, these experiences proved disturbing and challenging to the therapists, they were not extraordinary in terms of the therapists' general conceptualisation of therapy. All the therapists recognised how the therapy relationship would, inevitably, mirror the real life impasse for which the client is seeking therapy. Conceiving of the impasse in this way meant the therapists could then view the therapy impasse as a necessary and potentially helpful process, drawing attention to the client's core area of stuckness. This may, however, represent a post hoc realisation. Whether therapists are able to hold on to this way of conceiving therapy whilst withstanding the turbulence of an impasse perhaps requires further investigation.

Although general themes emerged which were common to all the participants, the most striking finding was the individualised nature of the accounts and the factors which each therapist experienced as pertinent to their own case. This suggests that any global descriptions of impasse need to be offered with caution. How therapists recognise that their therapy is in impasse appears to relate to their own beliefs regarding what constitutes good therapy and the extent to which the therapy is perceived to be stuck in

areas which they conceive are important to therapy progress. For instance, Carole, who viewed therapy as enabling clients to gain an understanding of themselves through a deep emotional engagement with the therapist, experienced the therapy with her client as stuck in impasse when he seemed either unwilling or unable to connect emotionally.

Defining impasse

This study set out to examine therapists' current experience of impasse. Immediately this sets the scene for a potentially different area of study from the only published research study on therapy impasse, which limits the sample to instances of therapy impasse that have resulted in the client dropping out of therapy (Hill et al. 1996). It also raises the issue of how impasse is defined. The therapists' experience in this study appears to support Weiner's notion that impasse is "in the eye of the beholder" (Weiner 1992). As the therapists were asked to select their own experience of facing impasse the cases chosen appeared to be ones in which they personally felt stuck. Whether their clients also experienced a sense of being stuck and at the same points as the therapists is unknown, although evidence suggests that therapists and clients may conceptualise the therapy process in quite different ways (Stiles, 1980). What appeared more clearly from the study was that impasse is not a static event. Even during periods of apparent impasse, therapists still noted that change was occurring, mainly in relation to the client's life outside the therapy but also at points within the therapy when some insight or connection was made. The impasse, therefore, related to the therapists' sense that they personally felt caught up in and unable to work through a difficult and challenging therapy. In selecting a case to discuss where therapists had experienced feeling stuck, there was a split in the sample between the therapists where the impasse was current and those who felt they were moving through the impasse. This provided some useful information on the difference in the therapists' description of their experience when looking at an impasse somewhat retrospectively.

The therapy relationship

In looking at the therapy relationship in the four impasse experiences, no single pattern clearly emerged. Each relationship had different qualities which the therapists subsequently linked to the development of the impasse. What united them, however, was the impact that the client had on the therapist, which in all cases was very strong and personally meaningful. Some aspect of the way in which the therapeutic

relationship became established later resonated with the developing impasse. A strong finding across all four cases was the therapist's early awareness that the therapy would face difficulties. Either it was very difficult and challenging from the start or there was a sense that all was not going well. This appeared to be separate from the development of the early alliance which appeared, on the whole, to be quite positive.

Whether the therapist liked the client appeared important for two participants. Interestingly, a strong liking and perhaps over-identification with the client was associated with impasse in Beth's case whilst, in David's, in contrast, it was associated with the therapist's dislike for the client. Any strong feeling a therapist experiences towards a client is likely to impact on the alliance and Feltham (1999) points to the importance of subtle similarities in aspects of personal style, interpersonal orientation and key areas of vulnerability which make up the 'chemistry' which can affect the therapeutic outcome so profoundly. However, one might expect that the effects of therapists' personal feelings would be mediated by the way in which they react to and use those feelings within the therapy relationship.

The therapists' accounts also show how different aspects of the therapy relationship are important for individual therapists. For three of the four therapists the *specialness* of the relationship appeared important, although this did not clearly relate to the impasse in a direct way. Whilst this links with the very strong personal impact from the therapy which each therapist noted, interestingly it was only in three cases where the therapy was characterised as special. This could have been due to the fact that more progress had been made in these cases and the relationship was being seen in more positive terms. In the case where it did not appear as a sub-theme the therapist was male and he had expressed a dislike for his client. Whether feeling special is associated with gender differences and how it overlaps with personal liking is not clear from this study but the link between a sense of specialness and therapy impasse could be investigated further in future research.

Absorption of feelings was an aspect of the therapy relationship that the therapists themselves associated with impasse. This also appeared to relate to the intensity of the therapy relationship and level of therapist involvement. Therapists described how their role as therapists became impeded when they were overwhelmed by strong feelings,

usually of hopelessness or fear. This relates to Omer's (1994) assertion of the role of the hopeless narrative in the development of impasse. Therapists concluded that these emotional states belonged to their clients but were being transferred and experienced as their own. The fact that this process, understood within psycho-analytic models as projective identification, was referred to by the therapists who worked primarily within this model, means that it is difficult to assess whether this process was only occurring in these cases, whether these therapists were more attuned to its occurrence or were more likely to use this as an explanation for their disturbed feelings. What was evident, however, in all accounts was that the therapists did experience strong feelings linked to their clients which affected their capacity to operate, at times, as effective therapists. In examining countertransference responses Blake Cohen (1988) discusses how therapists' emotional reactions draw attention to areas of central concern for the client and the therapy process. Although in this study the origin of these disturbed feelings cannot be determined, how therapists understood them did clearly influence the way in which they responded to them and, thereby, the impasse process.

The way in which therapists were powerfully affected by their clients was further elucidated in the theme *experience of other*. They described how they felt their sense of equilibrium or therapeutic stance was shaken by their clients in one of two ways. Either they were drawn in to take care of their vulnerable and dependent client or they felt challenged, where their ability to offer help was questioned and the therapists had to work to engage the client in therapy. In one case the therapist experienced both of these simultaneously. Understanding the transference relationship in psychodynamic therapies, or reciprocal role relationships in CAT, is at the heart of these approaches (Freud, 1912/1958; Ryle, 1990). However, all the therapists, even the more CBT based therapist attributed the impasse, at least in part, to the extent to which they felt caught up in responding to some unspoken need or core dynamic of the client. The definition of the role of a therapist is important here and Malan (1979) stipulates that the therapist's task is to help the client understand and come to terms with their experiences of emotional deprivation rather than attempt to make up for them. The way in which therapists become involved in clients' core patterns of relating does link to the existing clinical literature on impasse in which a number of common transference patterns are outlined (Weiner 1982; Atwood, Stolorow & Trop 1989; Elkind 1992). The contribution of the therapist in operating in these types of roles has

also been emphasised in the literature on countertransference. Sandler (1976) regarded countertransference responses as a 'compromise-formation' between therapists' own tendencies and the 'reflexive acceptance' of the role the client is forcing on them (p.46), and suggested that some therapists are more susceptible to certain roles than others.

Taking the notion of role relationships further, participants elucidated their role as therapist, defining it as not taking responsibility for the client, enabling the client to face what had been transferred, such as painful emotional states or responsibility, making links and understanding patterns of feeling and relating. These tasks are similar to those outlined by Malan (1979) in relation to the goals of brief psychotherapy. Three of the four therapists spoke clearly of their struggle between maintaining this role and reverting back to another, more parental role in which they adopted a greater sense of responsibility for their clients, felt absorbed and concerned for their welfare and experienced them as fragile, needing reassurance and support. This struggle reflects the blurred line that exists not only in the mind of clients but also within the therapy profession regarding what constitutes good therapeutic care, especially between different models of therapy. Questions such as what level of concern, care and responsibility is appropriate and when should therapists provide supportive as opposed to more challenging interventions are ultimately left with the therapist to determine. It is no surprise then that therapists find themselves wandering in the borders between what they perceive is an appropriate therapeutic stance and acting in a way that is responding to and fulfilling some desire of the client to be nurtured. With these clients, however, therapists recognised that they had stepped well into the territory of acting in a parental rather than therapeutic role and needed to be pulled back, either by their 'internal supervisor' (Casement 1985) or, if available, through external supervision.

Whilst the therapists tended to attribute their responses and the ways in which they acted in the therapy to their clients and felt quite trapped during periods of impasse in the role ascribed to them by their clients, the narratives did suggest that aspects of the therapist were also pertinent. A more complex relationship between the two parties consisting of an interplay of therapist and clients needs, beliefs and personalities was apparent. It was interesting to find that, in Alison's case, a therapist who defined her work role in relation to 'rescuing' difficult-to-treat clients, was stuck with someone

who was facing a terminal decline, Beth, who described herself as self-reliant, was stuck with someone who she saw as fragile and needing protection, Carole, who had a "great capacity for emotional involvement", felt trapped by her client who offered little of his emotional self, and David, who presented as able and resourceful, was stuck with someone who was chaotic and overly reliant on others. This complementarity between therapist and client is referred to in the psychoanalytic literature on transference and counter-transference where it is suggested that aspects of the self which the client wishes to project onto the analyst link with some characteristic of the therapist (Feldman 1997; Sandler 1976). Elkind (1992) also emphasises how, in impasse, the primary vulnerabilities of both client and therapist interact. It may be the case that therapy becomes stuck when therapists are faced with aspects of their client which they have failed to resolve in themselves and defend against in various ways. Whilst therapists' own issues can be addressed in their own therapy it is seldom brought into supervision in a systematic way. However, as suggested by Ferro (1993), it appears that it is only by studying the contribution of both parties in the therapy relationship will any fuller understanding of how the impasse has developed and is being maintained be possible.

Mental states

This theme encompassed the states of mind of both therapist and client. It concerned the states associated with impasse as well as those central to the therapeutic effort. Awareness appeared as a main sub-theme and constituted another factor underlying impasse. The therapists' lack of awareness, either of aspects of the therapy process or, in one case, the unrealistic nature of the expectations of therapy, was clearly related to the impasse. Conversely, positive change in the therapy relationship was preceded by the therapist or the client becoming more aware of processes which had previously remained hidden from view.

Understanding (and its opposite, confusion) also appeared as a core sub-theme. Due to the complex nature of the therapy relationship and the difficulty of unravelling some of its strands whilst being immersed within it, therapists struggled to gain an understanding of the process and were, therefore, unable to help the client understand it either. They felt stuck in a state of confusion for periods of time, for which again they turned to supervisors, where available, for elucidation. On returning to the

complexity of the relationship these insights would be lost and have to be continually sought in further sessions of supervision.

Perhaps the mental state most central to the impasse experience, however, was avoidance. Therapists were able to recognise the extent to which they were turning a blind eye to aspects of the therapy, such as the way in which the contract was being extended and other threats to the therapy frame such as client lateness, as well as to core aspects of the therapy process and client behaviour. They linked this avoidance to a fear of upsetting the client and being perceived as an unhelpful therapist. Both Caper (1995) and Strachey (1934) have identified this predicament in relation to the difficulty in making mutative interpretations, i.e., interpretations that encompass the client's core difficulties. They suggest that both therapists and clients may feel endangered by this direct connection and Caper suggests that therapists experience the threat of the client's superego in terms of a belief that it is they who are to blame for being, in some way, a 'bad therapist'. Avoidance was also noted in relation to the client's emotional state. Alison recognised how reluctant she had been to acknowledge her client's sense of helplessness for fear of being overwhelmed by the feeling herself, whilst Beth doubted whether helping her client to face painful memories would be a helpful process. Client avoidance was also seen as central to the impasse. Feelings which clients were avoiding, such as helplessness, despair and loss of control were, according to several of therapists, projected onto the therapists and they considered that one of the key processes which drove clients to enter therapy was their avoidance of painful aspects of themselves or their lives which they wanted therapy, in some way, to resolve. A collusion of avoidance was noted between therapist and client which again suggests that each party is both attuned to and responding to the other and the impasse occurs somewhere in the developing relationship between the two. As with the other mental states supervision, or the process of looking at the impasse with a third party as seen by the effects of the research interviews, draws therapists away from their avoidant position into one in which they have to take responsibility for their responses. Subsequently, their function can be understood and the therapeutic stance can be regained.

Whilst these mental states are not referred to in the existing literature as factors directly associated with impasse they underpin several factors which are listed. For

instance, lack of awareness relates to clinical error and avoidance is often implicated in both transference and countertransference responses and is central to client resistance.

Emotional states

Blake Cohen (1988) refers to therapists becoming aware of their own feelings of anxiety as an early and important indicator of something going wrong in the therapy relationship. Participants in this study described experiencing a general sense of discomfort and feeling 'horrible' and 'dreadful'. These feelings were taken to an even greater extreme in one case where the therapist experienced stronger symptoms of somatic disturbance and anxiety and described herself as feeling physically sick in relation to her client, an experience which was partially repeated as she discussed the therapy during the interview.

Subsequent emotional states appeared to be split into two groups depending on whether the emotion linked to an event for which they blamed themselves or the client. Therapists shifted from feeling angry, frustrated and burdened by their clients to feeling useless and guilty when they attached the responsibility to themselves. When the therapy appeared stuck and the therapists attributed this to the client, feelings, ranging from mild frustration to fury, would follow. This was particularly noticeable in Carole's case where she felt her client was blocking her out and 'spoiling' the therapy. Alternatively, and even simultaneously, therapists could experience this stuckness as an indication of their own failure and could quickly descend into feelings of uselessness, and despair at their ability to move the therapy forward. Accompanying feelings of hopelessness and helplessness would mean that the therapist was rendered temporarily incapable of maintaining a therapeutic position in the sessions. If, however, they were able to attribute these helpless and hopeless feelings to originating in their clients and being transferred through the process of projective identification, they were able to restore both the therapeutic alliance, which could be enriched by this understanding, as well as their own therapeutic stance. This was evident both in Alison's and Beth's accounts who used their knowledge of the process of projective identification to gain some relief from these difficult emotional states and a perspective on what function they served. This type of management relates to the notion of 'containment' as described by Bion (1962), where the therapist is able to experience

something near sensory and somatic emanating from the client and transform it into mental content which can subsequently be processed and worked through.

The two other emotional states, feeling overly responsible or burdened and feeling guilty, linked to the notion of what was being expected of the therapist, in particular how they were supposed to behave towards their clients. If they accepted responsibility for making the client feel better they could feel overwhelmed and burdened by this unspoken agreement and silently blame the client for overloading them with these demands. When they perceived themselves as abnegating responsibility for being a 'good therapist' in some way, either by making punitive interventions or feeling that they were, by other means, being rejecting, abandoning or anti-therapeutic, therapists were beset with feelings of guilt. Guilt of acting in an uncaring or unhelpful way towards their clients would appear to stop therapists even before they carried out these actions, which often, on reflection, represented appropriate therapeutic behaviours, such as keeping therapy time boundaries, discussing issues of ending or aspects of the therapy relationship. Again this links with Caper's (1995) suggestions regarding the difficulty therapists can face when making certain key interpretations, and the way they can struggle with doubts and feelings of guilt regarding the therapeutic nature of these interventions, worrying that they are more reflective of their own undesirable feelings.

Becoming stuck

Besides a general sense that therapy was not going either as anticipated or as desired, therapists were able to articulate what first brought their attention to the therapy impasse. In all cases an obvious lack of progress in terms of client's problems, accompanied by a repetition in the clients' narratives were the main indicators. The idea that 'nothing was changing' was subsequently disputed by the therapists as they brought evidence of their client achieving change in their external lives. What remained was the realisation that the stuckness lay within the therapy relationship and linked directly to the clients' unresolved core relationship problems. Ways in which the therapy process would be 'distracted' from the main aims of the therapy were also noted as an indicator of the impasse. For instance, David noted that his attempts to keep the therapy focussed on central concerns was 'sabotaged' by his client pulling his attention to new problems or interpersonal crises. This supports Leiper's (2001)

description of the 'resistant forces to change' and suggests that clients may have alternative, perhaps even unconscious, agendas for the therapy that may run counter to the aims pursued by the therapists and even their conscious selves. The final two indicators related to the therapists awareness of their own behaviour and emotional state and link with the signs of a countertransference response outlined by Blake Cohen (1988). The therapists also recognised that their awareness of their own strong emotional responses towards their clients was a strong indicator that the therapy was experiencing difficulty. Interestingly, only one therapist referred to noticing a tendency to act differently, in this case by failing to attend to the therapy framework as she would normally do and avoiding the client's challenges to the therapy frame. These indicators, on the whole, fit with Leiper's (2001) list of signs of developing impasse.

Making changes

Interestingly, at the same time that the therapy was experienced as stuck, therapists were aware that changes were being achieved in the clients' lives outside the therapy. These were mainly in the areas of their relationships with others but also, quite critically, in the way they were beginning to feel able to direct their lives, take more responsibility for their actions and feelings and have a greater sense of agency. Change, to varying degrees was also noted within the therapy relationship, depending on whether the impasse was in the middle or latter stages. For all, however, there was a clear pattern emerging, that the impasses, as defined and experienced by these therapists, did not represent a complete standstill in therapy as suggested by Weiner (1982). Rather the experience of these therapists suggests whilst a therapy may appear to be in difficulty and achieving little change, 'subterranean' progress may be occurring outside of the awareness of the therapist which relates to Ferro's (1993) observations in describing impasse as representing a prelude to change. This finding again raises the debate about the definition of impasse. Can a therapy be defined as being in impasse, if some change is occurring, albeit at a slow rate or only in limited areas? Perhaps it either has to be determined, as in the Hill et al. (1996) study, by therapy drop out, or as in this study, defined as the therapists own sense of stuckness rather than conceiving of it objectively as a therapy standstill.

Responding to impasse

The primary response of the therapists when facing impasse was in relation to their level of activity. The therapists appeared to feel that the onus was on them to provide something more to relieve the impasse. They recognised how this was usually an unproductive response, preventing the client from taking responsibility for thinking or staying with difficult feelings. They also recognised that it represented a defensive strategy of their own, at points when they felt unable to tolerate a difficult experience in the therapy. Withdrawing and becoming more distant was only noted in one case, linked to a sense of hopelessness when the therapist's interventions failed. Both of these responses correspond with the countertransference responses listed by Blake Cohen (1988 p.79-80). These responses, she argues, indicate that a therapist is involved anxiously or defensively with a client and highlight the fact that therapy is based on the personalities and vulnerabilities of both parties engaged in the process.

The tendency for some therapists to engage in what they felt were punitive interventions was an interesting finding and one wonders whether the clients experienced them as such. Meares and Hobson (1977), in reflecting on patients' accounts of their experience of analysis, suggest that patients are very attuned to any behaviour on the part of the analyst which appears derogatory, intrusive or invalidating. The therapists obviously felt they were acting more in response to their own emotional state and feared that their actions contained some feelings of hostility or frustration. In this way these responses could be seen as the therapists' counter-resistance (Schoenewolf 1993), or as indicating a tendency to act as 'persecutory therapists' (Meares & Hobson 1977). However, as mentioned, feeling guilty about one's interventions and perceiving oneself as a 'bad therapist' is also recognised by Caper (1995) as a response commonly experienced by therapists when they are faced with making core interpretations to clients about aspects of their behaviour. Only through a more careful analysis of the context of the session could a more accurate understanding be gained regarding the punitive nature of these interventions.

Managing impasse

On the whole, the therapists remained allied to their usual model of working, in keeping with Leiper's (2001) suggestion that it is wise for therapists to stay in their own base. There was little evidence of a questioning of their approach by looking at

areas, or the 'blind spots' (Kluft 1992) which their approach was poor at addressing. One therapist did, however, move from a more active interpretative psychotherapy to a supportive therapy as she revised her ideas regarding the client's needs and capabilities. Another therapist, working in a cognitive framework, referred to adopting a more psychodynamic approach, but seemingly this meant looking more at the therapy process whilst maintaining an essentially cognitive therapy stance.

Changing the structure of the therapy was noted, with two therapists either increasing or decreasing the frequency of sessions in relation to their views on the impasse and how they felt the therapy needed to change. These changes were also undoubtably affected by the therapists' work setting and the extent to which they were either able to increase the session frequency or, needed to decrease the frequency in order to offer a longer-term contract. Unfortunately, the study was unable to focus more closely on the impact of these changes on the therapy relationship and the impasse.

Therapists did *revise their ideas* about their clients as the therapy progressed. In two of the therapies this involved the therapists altering either their goals for therapy or the therapy focus. Schulte-Bahrenberg and Schulte (1993) found that a change of therapy goals occurred mainly in therapies which did not go well from the outset. They suggest that a resigned change of goals may have an adaptive function in that the adoption of more feasible goals may prevent drop out or complete therapy failure. It also serves to protect the therapist from a personal experience of failure. Whilst, in this study, a more detailed examination of how therapy goals changed over time was not a particular focus, the therapists' account did show that, due to the impasse, therapists had to question their ideas about the clients and what level of change was feasible. What was not clear was the extent to which the therapists had engaged in a discussion with the client about therapy goals either at the start of therapy, when the goals were changed or in ongoing reviews during the course of therapy.

Attending to the therapy process was referred to by each therapist as they recognised the impasse lay primarily in what was happening within the therapy relationship. This meant both attending to their own tendency to repeat unhelpful patterns of relating as well as drawing their clients' attention to the dynamics occurring between them. It was notably easier for therapists to examine what the client was doing and offer

interpretations of why they acted in this way rather than address the relationship more directly. This relates to the reluctance referred to by many writers that therapists exhibit in discussing the impasse with their clients (Omer 1992; Wiener 1982). In this study only two of the therapists suggested that they had discussed how the therapy had become stuck with their clients and one of these admitted he had done so rather indirectly. Rhodes et al. (1994) point to the importance of therapists attending carefully to any ruptures in the therapy relationship through accommodation, discussion and apology whilst Safran and Muran (1996) suggest that it is critical, when the client expresses any hostility, to become aware of what is occurring in the therapy relationship and to engage in a metacommunication about the rupture.

Interestingly, another theme to emerge regarding the management of impasse was that of *acceptance/survival*. Therapists talked of the need to tolerate either aspects of their client or the impasse. In a paper on tolerating the countertransference, Carpy (1989) points out that clients need to see their therapists' being affected by what is projected on to them, and to see them struggling to tolerate it and maintain their analytic stance without grossly acting out. Carole, in particular, felt she managed the therapy better when she was able to adapt, in part, to her client's behaviour rather than resist it. Staying with or tolerating difficult aspects of the therapy whilst at the same time continuing to work on these or other areas which were more amenable to change were a feature of all the therapies. The therapists began to recognise that change would not occur easily or quickly and this led to a reduction of pressure on themselves and their clients. This appears to differ from the sense of hopelessness which is commonly associated with impasse but is a more realistic appreciation of the difficulty of change, or, in one case, the realisation of mortality and the limitations of therapy. It relates to the process of resignation as described by Schulte-Bahrenberg and Schulte (1993), as the therapists reconsider over-optimistic therapy goals. Nathanson (1992) also warned that deep changes occur at a slow pace and that either party may complain that the therapy is at an impasse out of ignorance of the problem being treated. For some this acceptance led to the impasse being at least partially alleviated. For others, they were able to gain an understanding which helped them personally manage the impact of the impasse.

The *ending of therapy* appeared as an important theme in this study. Ending therapy or the avoidance of it seemed to be closely linked to the impasse. In one case a forced ending appeared to lead to a shift in the client's engagement in the therapy and so relieve the impasse. In others the lack of any discussion regarding ending was evident, and the therapies had apparently been developed on the assumption that they would continue until the client had improved and no longer needed the therapy. This subsequently led to initial contracts being extended and the idea that the therapy would continue indefinitely. Clearly the difficulty in ending is connected to other themes, including the tendency for therapists to be pulled into a *parental role* or engage in a *special relationship* with the client. The ending of the therapy represented the confronting of the reality of the relationship and its boundaries and an inevitable disillusionment if the fantasies built upon it have not been worked through. The judgement regarding whether a therapy has achieved as much as it is able to (Nathanson 1992), or whether 'more of the same' is needed over a longer term is also set against the reality of what a therapist is able to provide in a particular context or setting. Where there is uncertainty the emotional pressure to 'not abandon' the client seemed to tip the balance in favour of extending the initial contract in the hope of eventual change. This dilemma concerning ending also emphasises the extent to which, in many settings, the pressure to treat chronic and complex problems in quite brief forms of therapy can lead to the adoption of unrealistic expectations on behalf of the therapist as well as the client (Gustafson 1986).

Personal self

In their narratives therapists indicated how the impasse was experienced within their own personal context and had a *personal meaning* for them. They presented the impasse within a broader picture of themselves as able therapists, suggesting that the impasse impacted with this self-perception. They also referred to their own *needs* within the work they undertake, specifically for support and supervision, but also, in two cases, the need to protect themselves in what is acknowledged as an occupation which is potentially damaging to the self. It was this theme in the initial codings which led to a further, more interpretative analysis of the transcripts, examining the impact of the impasse on the therapists' self.

4.1.2. Interpreting a threat to self

Ideal self

It was clear from the narratives that the therapists had much invested in their therapeutic endeavour and they were concerned about making a difference for their clients. A therapy in impasse appeared to pose a threat to the therapists' *ideal self.* This ideal self represented the best of themselves as a therapist, i.e., able, caring, knowledgeable and containing. For some it also included an ability to form *special and meaningful relationships* and be engaged in *special work.* Due to the nature of the role of therapist to which are attached qualities of a magical healer (Blake Cohen 1988), this ideal self is not only supported by therapists themselves but also by clients who enter therapy with a belief about the power of the therapist. Psychoanalytic writers have noted how easy it may be to engage in a gratifying relationship which satisfies the client's dependency needs and, at the same time, the therapists need for power. Caper (1997) discusses the possible identification of the therapist with a role encouraged by the client which encompasses a narcissistic relationship. He concludes that the ability of a therapist to stand back from the clients' material will depend upon his perception of the client as having 'a mind of his own' and the aim of the therapy as being to analyse rather than to cure. Blake Cohen (1988), in her paper on counter-transference, recognises that, in addition to the therapist's own need for creative accomplishment, there are real social pressures operating on therapists, requiring them to facilitate successful therapies in order to maintain their reputation. However, it appears that it is the therapists' own ability to acknowledge and reconcile a more real awareness of their abilities with an idealised version of themselves that will determine the extent to which the ideal self hinders the processing of therapy impasse. Meares and Hobson (1977) refer to 'omnipotent therapists' who are loath to acknowledge the sense of impotence engendered by a client's failure to improve and, in response to the anxiety from the threat to their role, they may act to enhance their omnipotence by becoming more rigid and blaming the client, leaving both parties feeling impotent.

Threat to self

The fact that the therapy was experienced by the therapists as failing to progress appeared to pose a direct *threat to the therapists' self* and the view of themselves as

competent therapists, leading them to question what it was they were doing wrong. They portrayed vividly their feelings of frustration and helplessness as they saw their therapeutic efforts having little effect but felt even more compelled to keep going and not accept therapy failure. Bird (1972) explained how the client's ability to bring the therapy to a standstill , seen as the undermining of the therapists' actions, is the single event capable of hitting the therapist "in the very center of his functional life" (p.352). Equally threatening appeared to be the way in which their ideal relationship was disturbed. This was noted in several ways. A disturbance to the therapy equilibrium, where therapists either felt challenged by the client or unable to perform their ideal role, was common to all therapists. This material provided greater insight in to the kind of relationship which therapists were trying to achieve and the commonalities and differences between individual therapists. Interestingly, whilst attention has been paid to the attachment style of clients, leading to the development of the Client Attachment to Therapist Scale (Mallinckrodt, Gantt & Coble 1995), there is scant reference to attachment style of therapists. One therapist expressed her dismay at her client's lack of emotional connectedness, which, for her, was the cornerstone of therapy and was equally dismayed to realise her own lack of concern for her client, threatening the view of herself as a caring therapist. Obviously, when a therapy does not follow a smooth path envisaged by the therapist strong emotional responses might be stirred up in the therapists. The capacity to manage the therapy difficulties in a flexible way will depend upon the therapists' ability to process and manage their own emotional reactions. King (1978) suggested that it depends on whether the experience projected by a client is ego-syntonic that determines how the therapist will respond to it. If it is ego-dystonic it is hard for the therapist to accept the discrepancy between what the therapist experiences himself to be and the feelings and roles being projected into him. She suggests that more experienced therapists are usually able to differentiate clients' challenges to their competence from their own assessment of their professional competence.

For some therapists the issue of control appeared as a central theme. Again therapists appear to hold ideas regarding how a therapy relationship should be ideally balanced in terms of levels of control. They experienced these clients as challenging this ideal balance and experienced themselves as being pulled in to take responsibility for the clients' well-being. Although their ideal self involves providing containment and being

able to undertake demanding work, it seemed that the reality of those demands, when perceived as excessive, threaten the therapists view of their capacity to fulfil this ideal.

Whilst Hill et al. (1996), and other writers on impasse such as Leiper (2001) and Green (1988), emphasise the role of others external to the therapy relationship, this study did not associate processes of triangulation or any significant influence by others linked either to the client or therapist with the impasse. What the study did identify, however, was the presence of some external challenge which appeared to pose a threat to the therapist in three out of four cases. This varied from a colleague challenging the appropriateness of the client receiving therapy through their service, to the reality of a client's failing health for which the therapist was unable to provide a resolution, and to the pressure imposed on a therapy due to the therapist adopting it as a psychotherapy training case. Whilst it is perhaps inevitable and also desirable that external realities have to be accommodated in therapy it seems likely that there will be considerable variation in the extent to which they will influence the course of therapy. In this study the effect the external factors appeared to have on the therapies was, to a large degree, dependent upon the way they were experienced and responded to by the therapists.

Loss of therapeutic self

The threat to self was manifested most clearly by a *loss of the therapeutic self.* Therapists experienced a loss of their capacity to think and process session material, their therapeutic stance was no longer secure, they engaged in a process of splitting in their reactions to their case and became more self-focussed. A *loss of the thinking self* was evident in the therapists accounts of their confusion regarding the therapy process and the tendency to lose their way within sessions and become distracted from the central focus. Strong emotional reactions to the client also interfered with the ability to think and process material. This was most evident in Beth's case, when strong and disturbing feelings of "stress" clearly prevented her from recognising how this state related to her client and what was being transferred in the therapeutic relationship. Whilst therapists need to be emotionally attuned to their clients they also need to be able to stand back from the therapy dyad to reflect on and understand the processes that are at work. In these cases that balance was lost as the therapists felt caught up in strong personal reactions which they found difficult to use within the therapy. This loss, however, was not constant or total and the therapists did manage to regain, at

different points, their capacity to think. For two of the therapists supervision helped them regain a perspective on what was happening in the therapy although it is not clear whether supervision helped them regain a capacity to think or, instead, provided them with an expert view of the case. However, in the cases where supervision was available it was required continually as insights gained were insufficient to prevent a further loss of the therapists' ability to think clearly. In line with Caper's (1995) description of stuck therapies, it suggests that something quite powerful was being experienced within the therapy involving an impairment of the therapists' capacity to think.

The impasse was characterised for all four therapists by a *loss of the therapeutic stance*. This appears similar in nature to the 'professional attitude', as described by Winnicott (1960). The loss of therapeutic stance was seen most clearly in the way therapists were 'pulled in' to respond to the clients unspoken requests and role enactments. King (1978) writes that partly due to anxiety and partly due to repetition compulsion clients will try to turn the therapy situation into an ordinary human relationship. In responding to their clients in a more 'human' way, the therapists described losing their therapeutic position, i.e., helping the client to recognise and understand their needs and patterns of relating. Again this loss was not constant, with therapists losing and regaining this stance within sessions, or losing it only partially. Two therapists talked about engaging in hostile responses to their clients, for which subsequently they experienced feelings of guilt. A third referred to feeling 'as if' she had behaved untherapeutically. Only a more detailed further investigation of these 'punitive actions' would elucidate to what extent they represent an enactment as described by Tarnopolsky (1995) (where the therapist unconsciously enacts what the client has disowned and 'impersonates' the clients' pathology), evidence of the therapists acting as 'persecutory therapists' (Meares & Hobson 1977), or a counter-transference response involving the therapist feeling guilty when contemplating making more challenging interventions (Caper 1995).

Two therapists also noted a loss of clear boundaries between themselves and their clients. This differs from the therapists finding it difficult to hold the boundaries or the frame of the therapy itself. It refers instead to therapists losing a sense of themselves or a sufficient degree of separateness in relation to their clients and/or their problems, where feelings become confused and there is a strong process of identification. This

identification appears to pull the therapist off their usual course. Tarnopolsky (1995) speaks of 'empathic countertransference' where therapists relate empathically with the client's state due to their own knowledge of that experience. In one case here the identification was more with the client as a whole person and, in the other, the empathic identification was with a state which the therapist found difficult to manage herself, i.e., a sense of hopelessness. Therefore, rather than enabling a stronger connection the counter-transference response encompassed a de-stablising of the therapists' self and confusion of the boundaries between therapist and client. The therapeutic stance was also notably disturbed through the loss of therapy direction in two cases. This included a loss of the overall direction of the therapy, with one therapist expressing her uncertainty regarding the value and appropriateness of therapy for her client, as well as temporary in-session losses of therapy direction when a therapist referred to losing hope within the session and subsequently giving up on her intended focus. Given that the therapist represents a hope of change for clients entering therapy this loss of direction and uncertainty about its appropriateness poses a serious threat to the therapy, particularly in the way it is expressed or made evident by the therapist. Again it would be interesting to assess how clients pick up upon therapists' level of hope and look at the effects of the level of therapists' positive beliefs of change on the course of therapy.

Splitting was a theme which also linked to the loss of the therapeutic self. This referred to a process where therapists perceived themselves to be caught between two polarities, in this study between operating either as powerful or helpless therapists, and as being either rejecting or containing in relation to their clients. Splitting, described usually in relation to clients, can be understood within a cognitive therapy framework as a 'cognitive distortion' (Beck 1976), within a CAT approach as a 'trap' (Ryle 1990) or within psychoanalytic theory as 'paranoid-schizoid functioning' (Klein 1946). Indeed, Caper (1995) would suggest that at core points of the therapy therapists may feel held back from making key interpretations due their fears of becoming a 'bad therapist' in some way and that this feeling is being covertly communicated from the client. However, as can be seen from the previous material on the therapists' ideal selves, the splitting occurs in areas which are central to the therapists' own concerns regarding the perception of themselves as able and nurturing therapists. This suggests

again that these processes may be influenced by factors within the therapists as well as the client.

Becoming more *self focussed* and attending to their own needs in response to threat was a further sub-theme within loss of therapeutic self. For two therapists this appeared to occur at points when they experienced themselves as being unable to influence their clients and their patterns of relating. Instead they turned to means of relieving the threat to themselves, in one case by 'surviving' the therapy and counteracting her threatened sense of competency, and, in another case, through seeking support from empathic colleagues who had similar experiences of 'difficult' clients. For these two therapists attending to themselves meant the withdrawal of their focus from their clients. It could be argued that attending to the self might also ensure that therapists are able to maintain a therapeutic position. However, this depends on the appropriateness and type of attention. In both these cases attending to the self appeared to mark a retreat from the client and the therapy material. Given the difficulty of a challenging therapy, however, some level of withdrawal and strengthening of the therapists' self might be regarded as both inevitable and appropriate.

Reduction of threat to self

Therapists appeared to employ a number of mechanisms to *reduce the threat* to themselves. The first two processes of internal distancing and normalising represented mental mechanisms through which the therapists would reduce the threat. Distancing the self from fault was one of the most widely used means through which the client rather than the therapist becomes the one who is responsible for blocking therapy progress. Locating the impasse in the client served a similar purpose, as did the externalising of the client's problems and locating them in the clients' past. The study does not conclude that these assertions have no validity, rather it points to how this distancing serves a purpose in terms of the therapist's threatened self. Leiper (2001), however, warns how the seductive temptation to blame the client can be dangerous as the therapist can become cut off from further internal experiences. Whether this distancing suggests that the participants feared behaving as persecutory therapists (Meares & Hobson 1977) or were simply presenting as defended narrators (Hollway & Jefferson 2000) was not clear. However, quite notably the flow of the therapists' narratives improved as they regained a more objective stance in relation to the

impasse. A similar level of objectivity appeared to be sought in the way several therapists would distance themselves from the therapy process itself. Taking a more passive position in relation to the therapy process and seeing it as almost separate from either party reduced the element of blame or responsibility. As the emphasis was no longer on their individual selves it also reduced the need to address what was happening between the therapist and client, which the therapists faced with some anxiety and reluctance.

The second internal or cognitive mechanism used was that of normalising. This encompassed a number of cognitive processes through which the threat was altered or reduced. Therapists used reasoning to explain either the therapy difficulties, or how evidence of their more untherapeutic behaviour was not indicative of any real fault on their behalf. Money Kyrle (1956) emphasises the fact that therapists are human beings and, therefore, as likely as clients to wish to avoid the pain of certain experiences. Rather than seeing this process as evidence of therapists abnegating their responsibility I would suggest that it might operate as an appropriate mechanism, balancing self-accusations regarding the lack of therapy progress. These 'silent accusations' may also be emanating from the client through a process of projected rather than expressed hostility. Although, again, this study is not able to comment more concisely on the processes at work between therapist and client, it is likely that aspects of the clients' hostility which were not either easily recognised or addressed were implicated in the therapists' self-accusations. Therapists were also seen to reassure themselves more directly. This corresponds with the Hill et al. (1996) study where the use of self talk was noted in relation to therapists attending to the longer term impact of an abrupt termination by their clients. Both of these mechanisms employed in the protection of the therapists' self are also linked to processes of containment (Bion 1962), involving the transformation of anxious content into manageable thoughts, which form the basis of therapeutic work with clients.

Other mental mechanisms also appeared to provide some relief. By justifying their actions therapists could also regain a sense of themselves as good or at least reasonable therapists. They appeared to be, in these instances, presenting their case to their peers and to me, as a representative of them. Accepting a lack of control, noted in the case of one therapist, similarly served the function of reassuring the therapist there was

nothing more she could do, whilst through transforming the threat and seeing the problem as a challenge or opportunity therapists moved their position from carrying the weight of the problem to encouraging their problem solving selves to emerge. In one therapist's account generalising to other therapists suggested that the problem of impasse is a common one, challenging all therapists and not simply a reflection of his own competence.

The next two types of mechanisms related to making changes in the therapy relationship. *Regaining equilibrium* within the therapy was a strategy used, perhaps unconsciously, to help reduce therapy difficulties and return to a preferred way of relating, consistent with the therapists' views of their ideal self. This often involved therapists getting alongside their clients, thereby moving away from the dynamics which are pertinent to the clients' main difficulties. The therapists would justify this change, if aware of it, in terms of supporting the client's needs, however, it also served the purpose of bringing relief to the therapists as they were able to resume a role and position where they felt more comfortable. Distancing from challenging material, the use of avoidance, focussing on the positive and transferring the responsibility for change to the client all served a similar function in terms of therapist self-preservation.

The need for therapists to create a relationship in which they maintain a good working alliance with their clients, as well as expose both themselves and the clients to reasonable rather than excessive levels of anxiety, is important here. This allows us to consider the function of this 'regaining equilibrium' and whether it represents an appropriate rather than avoidant mechanism in relation to the clients' main difficulties and tasks of therapy. The therapists were aware, however, of the way in which their therapies were being extended and the problems circumnavigated to some degree, by their avoidance of areas of interpersonal difficulty in the therapy. In discussing therapists' avoidance, Feldman (1997) recognises the difficulty therapists face in extricating themselves from an enactment and recovering their capacity for reflexive thought, particularly when the enactments do not disturb the therapist but constitute a collusive and comfortable arrangement. He suggests that the role the therapist is playing is congruent with some internal fantasy of the therapist and that the interaction provides a defensive function for both client and therapist.

External relief also played a role within the therapy relationship in reducing the experienced threat. In one case this referred to the client's health decline whilst, in two others, a forced ending either promised to or did provide a way out from a difficult therapy. These events could be seen as saving the therapists from experiencing a personal sense of failure and threat to their competence as the failure to fully attain therapy goals could be attributed to these external factors. They also served to remove the problem which in itself provided some relief. The fact that the forced ending in one case did lead to significant progress being made in the time leading up to it suggested that external events do not only serve as distractions from the task of therapy but may introduce a needed element of reality into the therapy process.

Lastly, in terms of threat reduction, the strengthening of boundaries was apparent in the case of two therapists. This included the strengthening of personal boundaries, with therapists protecting themselves in different ways from the more difficult aspects of their work. Through understanding the therapy process more one therapist was able to 'de-personalise' the effects of it and another resisted the views of others which led to a greater sense of security and confidence about the therapists own preferred approach. Again, one might argue that some level of self-protection is not only inevitable but quite adaptive and appropriate as therapists need to model a capacity to take appropriate care of themselves. It might, however, indicate that there are issues to be addressed in the way the therapists are experiencing their work that are being avoided rather than processed by the strengthening of boundaries. It is likely, therefore, that acts of self-protection involve both costs as well as benefits for the therapy process.

Restoration as an effective therapist

The final theme within the interpretative codes was the *restoration of an effective therapist*. This referred to the ways in which the therapists regained their therapeutic stance and abilities. Initially this was achieved by gaining a fuller understanding of the impasse. In two cases, discussing the impasse during the first interview had led to the therapists developing greater insight into the therapy process, whereas, for a third, this awareness had been gained through supervision. This suggests how vital is the opportunity for therapists to step back from the therapy and take a look at what is happening, particularly in regards to the therapy dynamics (Omer 1992; Leiper 2001; Weiner 1982). This understanding appeared to enable therapists to subsequently feel

more confident in tackling and processing the client's core difficulties in the therapy. This was apparent in the cases where the first interview had led to a clearer understanding, as therapists began to address areas which they and/or their clients had previously avoided. Alongside this one therapist noted her increased capacity to think and process material within sessions and not be distracted.

Regaining a therapeutic stance and preventing inappropriate role responding similarly reflected the therapists' increased ability to remain in therapist mode. There was evidence of therapists intervening appropriately to indicate to clients how they were relating, leading to an exploration of underlying processes and feelings. They also appeared to be able to hold the therapy frame more effectively. Therapists were more able to recognise points when they might have been drawn in to responding to the roles ascribed to them by their clients and were able to resist doing so. These elements of an effective therapist also emphasise the areas which become impaired in a therapy impasse and suggest that, in supervision, these abilities of the therapist might be addressed initially, when trying to resolve the impasse. These findings link with some of the therapy process research on therapist responsiveness as reviewed by Llewelyn and Hardy (2001). Studies in this area suggest that it is the therapist' attunement and responsiveness to the client which facilitates change, and Hardy, Davidson, Rowe, Reilly and Shapiro (1999) considered appropriate responsiveness to occur when therapists were able to provide a sense of security by responding to moment-to-moment attachment needs of the client. In this current study, the sense of impasse was replaced by the therapy shifting significantly when therapists were able to regain their stance and thinking capacities and return with a sharper focus to the therapy process which they could examine in a collaborative way with their clients.

4.2 Therapists as defended subjects

The interview process was analysed separately in order to consider the ways in which the therapists presented themselves and interacted within the interviews and the extent to which they appeared to operate in a defended manner. Several themes emerged. Most notable was the extent to which therapists engaged in a process of reflection. Interestingly, the results showed that the two therapists who were stuck in the middle

of a therapy impasse reflected much more during both of their interviews than the two therapists whose impasse was passing. These first two therapists also reflected much more on the therapy process, and it appears that it is through this process of reflection that these therapists subsequently felt able to approach the impasse in a different way. Whilst each therapist was prepared to demonstrate their thinking processes 'at work' it was clear that the extent to which they felt the need, or were prepared to reflect did relate to the stage of impasse which the therapist was facing.

All the therapists exhibited a significant level of openness, particularly in relation to areas of avoidance, but also in respect of how they were feeling in the interview. They also offered quite pertinent personal information, including admissions regarding their own areas of vulnerability. This has to be considered alongside the mechanisms referred to in the interpretative analysis for reducing the threat to self. It suggests it is not possible to categorise participants as defended or not defended (Hollway & Jefferson 2000), but rather that all participants are likely to engage in some self-protective processes which are both essential and unavoidable, and that the level of these may vary across the course of an interview. This pull between openness and self-protection was evident in the ways therapists presented a balanced view, often qualifying a statement where they perhaps felt they had exposed some less desirable aspect of themselves. The splitting in to different parts, with one part representing the more 'human' or 'instinctive' response and another a more acceptable therapist response, also served the same purpose.

Throughout all the interviews therapists engaged in both professional and personal linking with me. This is hardly surprising given the nature of their work roles which involve an ability to connect and form an alliance with others. However, these processes could also be self-protecting, concerned with participants developing a safer alliance with the researcher in which they feel less exposed or vulnerable to possible internal or external criticism. Professional linking was noted in the way in which the participant joined with me as a fellow therapist, as well as the wider community of therapists through using professional language which they expected me to share. Using a collective noun such as 'we' also offered an invitation to join in observing the client and the impasse from a professional standpoint. Humour was also evident and appeared extensively throughout the interviews and similarly seemed to serve the

purpose of encouraging a personal joining between myself and the participant. It was notable that it was used to accompany self-disclosures, 'guilty' admissions, in self-mockery or to downplay implied self-criticism, and at other moments when the therapist was aware of how they may be coming across in an undesirable way. This links with Freud's (1916) conceptualisation of humour as a disguise for implicit criticism or other types of hostility. It also accompanied one therapist's responses regarding the interview process when the relationship between participant and researcher was addressed more directly and where one might expect increased anxiety.

Whilst the interviews might have incurred some degree of threat for the therapists they did find the interviews thought-provoking. For some they represented an opportunity to focus on areas of their work and their personal experience of it which they rarely discussed with their peers. Although Beth found the examination of her relationship with her client quite disturbing, experiencing a strong emotional response to her even whilst discussing her in the interview, both she and David found the initial interview therapeutically beneficial for the insights they gained into the therapy process.

4.3 Comparison to Hill et al. study (1996)

As the only published research study located on therapy impasse it may be useful to compare the findings of the Hill et al. (1996) study with the results of this study. It must be noted, however, that as that study looked at cases of impasse which had led to an early termination of therapy through client drop-out the two studies are examining slightly different groups. Although the research designs vary in significant ways, on the whole there appears to be reasonable agreement between the findings of the two studies. They both concluded that the impasse was not related to one particular event in the therapy and no one pattern emerged in terms of the initial therapeutic alliance in either study, although in this study therapists' awareness of early warning signs was a stronger finding. The Hill et al. (1996) study noted that there was significant disagreement regarding the tasks and goals of therapy and whilst there was not a recognised disagreement between therapist and client here, it was clear that therapists and clients might have had different agendas and aims which appeared to remain largely unexplored.

The Hill et al. (1996) study identified four factors relating to impasse. Firstly, therapist mistakes was a general variable encompassing therapists reaction to the client, being too confrontive, too supportive or not supportive enough, losing objectivity or direction, or being inaccurate in their diagnosis of the client. The therapist's role in the impasse was clearly seen in this study. Therapist avoidance was the main factor although loss of therapy direction and errors such as unrealistic therapy expectations were also noted. Secondly, issues of triangulation which featured strongly in the Hill et al. (1996) study were not found here. Thirdly, although transference issues were identified in both studies, in the Hill et al. (1996) study these related to the way clients experienced their therapists in a similar manner to their experience of figures from their past with whom they had problematic relationships whilst here, in the main, clients appeared to project on to their therapist their 'ideal other' who would provide the care and attention absent from their past experiences. It must be noted, however, that the therapists in the Hill et al. (1996) study were all psychoanalytic psychotherapists and the patterns of client-therapist relationships which were allowed to develop would be likely to be quite different from those encountered by therapists not trained in this approach. The fact that Carole, the only participant in this study with a psycho-analytic training, uniquely did not find herself stuck in a more care-taking role supports this possibility. The fourth factor identified in the Hill et al. (1996) study, that of therapists' personal issues does resonate with the findings of this study, although there was no direct support here for therapists' family-of-origin issues or therapists' concurrent life stresses. There was consistency in terms of therapists adopting a rescuer-fixer role, a strong theme in this study, and to some extent in the difficulty therapists had in dealing with strong affect. However, whereas in the Hill et al. (1996) study the affect appeared to be expressed more directly, here it appeared more indirectly as hopelessness, desperation and chaotic presentations.

Similar emotional reactions were noted in both studies. The Hill et al. (1996) study identified feelings of anger, frustration, anxiety and confusion as well as negative thoughts regarding self-efficacy which corresponds closely with the emotional states identified here. They also noted feelings of hurt and disappointment, but this may have occurred in relation to the abrupt termination of therapy by the client. In addition, in this study therapists described feeling burdened and guilty which links more directly to

being drawn in and feeling responsible for the clients' emotional state. The main strategic response, of attending to the therapeutic process within sessions, was common to both studies although Hill et al. (1996) suggested that the therapists in their study were more likely to discuss the impasse with their clients. Each study identified working harder as a common response to impasse and, finally, both sets of therapists emphasised the importance of seeking an external consultation.

The Hill et al. (1996) study cited severity of client pathology as an important factor. This did not emerge as an obvious theme here although all four therapists pointed to early abusive or emotionally disturbed relationships and described their clients as presenting with significant levels of psychological disturbance including depression, post-traumatic stress, alcohol abuse, self harm and other 'borderline' behaviours.

4.4 Clinical and theoretical implications

This study does, I believe, elaborate a number of findings which would prove helpful for clinicians working across the range of psychological therapies, in particular in relation to cases where they were experiencing a sense of stuckness.

Firstly, in order to recognise the early stage development of an impasse, therapists could be vigilant for the indicators outlined here, in particular, significant disturbances either within their own emotional state or their behaviour towards the client. Continual review of how the client is progressing in line with the aims and goals of the therapy is also indicated from the results. This is consistent with the recommendations from the study by Whipple, Lambert, Vermeersch, Smart, Nielson & Hawkins (2003) in which they found that clients who received feedback regarding the progress of therapy stayed in therapy longer and had better outcomes than those who did not receive feedback. The link between impasse and unclear or rarely discussed therapy goals suggests that the clarification of both the initial therapy goals as well as the boundaries and the limitations of the therapy is critical in order to re-orient it, not only at the start of therapy, but as the therapy finds itself going off-route (although the 'route' may not always be clear or definable in advance). Emphasising the limits and tasks of therapy appears even more important in light of the findings on the role of the therapists' ideal self in encouraging the therapist to either set up or at least go along with unrealistic

expectations regarding what the therapy is able to achieve. In a similar way it would be helpful for therapists to be more aware of the roles which they can easily find themselves adopting in the therapy and how these fit with their notion of an ideal therapist. Coming to terms with the reality of what they can and should provide is a pre-requisite before addressing this with the client. The study suggests that if therapists were able to recognise these roles at an early stage and face their anxiety of addressing this area with the client this might influence and perhaps prevent the subsequent development of an impasse. It also emphasises the need for therapists to be continually engaged in a process of reflection regarding how they are operating in the therapy, their contribution to any state of impasse and to their own patterns of avoidance.

The results contribute to the knowledge of how therapists' respond to impasse and emphasise the importance of recognising instinctive reactions to work harder or become more active. In addition they stress the need for therapists to attend to ways in which they have lost their therapeutic stance and the importance of their ability to manage the impasse through a careful examination of the therapy process with the client. Extending this to discussing the status of impasse in the therapy appears a key issue. Padesky (2000), in her conferences on 'Transforming Personality', encourages her audience of therapists to apologise to the client for having allowed the therapy to become stuck and to gain a more collaborative relationship with the client in considering how the impasse could be alleviated. Certainly, it seems clear that therapists need to take hold of the therapy in a way that makes a difference, to jolt both parties, as suggested in Omer's (1992) 'critical interventions', and interrupt the repetition of impasse-forming patterns of relating. Finally, and most critically, the study emphasises the essential nature of consultation or supervision in order to provide another perspective on the therapy as well as allow therapists to reflect on the therapy process out of the context of the sessions.

The study also has a number of theoretical implications in relation to previous ideas and theories on impasse. Firstly, it suggests that therapy impasse, at least as experienced by therapists, is not a constant state. Variations occur within sessions as well as between sessions and, even whilst the therapy relationship itself is felt to be blocked, changes can still be occurring in other aspects of the clients' lives which relate to the therapy. Therapists, from moment-to-moment, appear to lose and then

regain their therapeutic stance, at least partially. The study also supports the notion that impasse is not due to single factors but to a complex interplay of client and therapist factors which weave together over time. Rather than simply being viewed as evidence of client resistance these results suggest that impasse arises in relation to subtle mechanisms at work in the interpersonal space between client and therapist and may serve an important protective function for both, against anxiety as well as disillusionment about aspects of themselves. This study emphasises the role of therapists' ideal self in the initial way the therapy is set up, and the mainly unspoken expectations which continue unchecked, as well as the subsequent development of a state of impasse, in which the ideal self is threatened and therapists respond to protect it. The emphasis of the role of therapists' anxiety, their avoidances, the threat to the ideal self and the loss of the therapeutic stance, within this study does offer an elaboration of the part played by therapists in the development of impasse. In addition this study suggests that the loss of the therapeutic self, encompassing the loss of a capacity to think, the loss of therapeutic stance and the tendency to revert to splitting, may not only occur in cases where therapists face making a crucial, possibly mutative, interpretation, as outlined by Caper (1995), but also when they experience their ideal selves to be under threat.

4.5 Critical appraisal of the study

Due to basic differences in epistemology, knowledge construction, approaches to sampling and types of analyses, qualitative methods use different means from quantitative methods for evaluating validity and reliability (Henwood & Pidgeon, 1994) and several writers have undertaken the work of defining what constitutes good qualitative research (Kvale 1996; Lincoln & Guba 1985). Elliott, Fischer & Rennie (1999) have recently produced a guideline for evaluating qualitative studies which outlines a number of 'publishability' factors. However, the attempt to encompass all qualitative methods in a single definition of good practice has been questioned by others (Reicher 2000).

In developing this study reference was made to 'key features of good practice' as defined by Larkin (see Larkin website), in relation to qualitative studies in general and

IPA in particular. These included, amongst others, ensuring the study had theoretical sensitivity, owning one's perspective, situating the sample, undertaking a transparent analysis and grounding this with examples from the texts, focussing on meaning, being sensitive to the context in which the research is being carried out and providing credibility checks. Whilst these standards provided a framework for the study and the subsequent writing of it, several issues arose which do relate to the credibility and dependability of the findings

Issues of transferability are usually raised in relation to qualitative studies which tend to use relatively small numbers of participants. In this study the overall aim was not to reach conclusions regarding the development of impasse in psychological therapy as this clearly could not be done within type of study. Rather it focussed on an in-depth analysis of the experience of several therapists in order to try and understand something about the relationship of factors which comprise impasse. Statements about the universality of these factors cannot, therefore, reliably be made. The sample was limited even further in size due to my decision to opt for interviewing participants for a second time rather than increasing the sample. As a slightly larger sample would not have significantly influenced the concerns of generalisability, going for greater depth rather than breadth was considered to be potentially more useful.

The question of whether the sample was representative is pertinent in any qualitative study, with concerns raised when researchers approach or select their participants as well as when they are self-selecting as in this case. Although some homogenisation of the sample was sought (i.e., therapists working with adults, who were interested in exploring the therapy process) it was intended, if possible, that the participants would vary in terms of work setting, role, therapeutic orientation and gender. Seeking out variability in this way tests the robustness of the findings and strengthens the case for their transferability to wider populations. From the four participants a fairly good mix was achieved in terms of the above characteristics. However, with the limited sample size and the fact that participants self-selected, one may question to what extent this group of four does represent the wider body of therapists. For instance, it may be the case that these therapists were more confident of their own role within the impasse and, therefore, found it easier to volunteer for a study where their work was being examined. They were also responsible for selecting their own case to discuss in the

interviews. Again this raises concerns about any conclusions drawn about the nature of impasse from these cases. Rather they represent instances where the therapists perceived themselves to be stuck. Whether an external observer, or standard therapy related measures, would judge the therapy to be in impasse is debatable. Statements regarding impasse, therefore, need to be qualified. One could also query whether therapists only selected a case which they felt more comfortable to discuss, although, from the evidence of the interviews this did not appear to be the case as they all brought experiences which had disturbed them personally in different ways.

For two of the four participants, the impasse which they chose to discuss was no longer current, although in both these cases it was also not completely resolved. They had, however, already done a lot of thinking about the impasse with their supervisors and, to some extent, the sense of a current intense experience was missing. The issue of therapists using retrospective recall was raised as a limitation in the Hill et al. study (1996). Here, the impasse was still fairly fresh in the minds of these two participants and was not affected, as possibly was the case in the Hill et al. (1996) study, by the abrupt termination of the therapy by the client. It did appear, however, that the narratives of these therapists appeared a little more 'prepared', in comparison to the more 'raw' experiences of the two therapists facing a current impasse and discussing it in depth for the first time. The fact that the sample did split into two sub-groups in this way did, however, afford the opportunity of looking at this difference.

The analysis of a qualitative study such as this depends upon what participants are prepared to say and so there may also be questions about the relevance of the material provided and whether pertinent aspects of the impasse experience were either not brought into the interview or not elicited by it. Set against this is the interpretative process of the analysis which attempts to take the spoken account one stage further and, as suggested by writers from a narrative perspective, the belief that central concerns or experiences are likely to emerge within an open discussion although not necessarily in a straight forward way or through conscious intentional speech.

This interpretation of the data was carried out by me individually and this does inevitably introduce a bias to the study. Although an independent audit was carried out by two researchers who were also practitioners, a panel of researchers undertaking an

analysis of the material might have afforded the interpretative analysis a greater level of credibility. Whilst the IPA method does require a very in-depth and systematic involvement with the data which, it is difficult to imagine, could be achieved easily with a group of researchers, a panel could have been useful at various stages during the process in order to strengthen the credibility of the findings. The conclusions from the study, particularly the ones emerging from the interpretative analysis which are even more prone to researcher bias, must be accompanied by a statement regarding researcher perception and interpretation. It can be argued, however, that this individual interpretation of the data is also a strength of the study rather than a limitation. The holistic involvement of an individual in a research project, from the development of the schedule to the experience of interviewing and noticing small nuances or behaviours, through to the editing of transcripts, analysing the material, refining the codings and finally in writing up the study, provides more than can be achieved from a panel of researchers 'blindly' analysing interview data.

The use of the researcher as a thinking and experiencing being is specifically highlighted in narrative research methods and the use of a mixed methodology was a particular feature of this study, combining both IPA and a narrative approach in the original design. On reflection it seems that this combining of methodologies has been successful. IPA has proved a useful method for approaching and organising the data. At the same time holding in mind observations from narrative research methods regarding notions of the 'defended subject' and the importance of allowing stories to emerge has, I feel, enriched the study in a separate and complementary way. This led to the shaping of the interview schedule to encourage a more personal narrative to be told and drew greater attention to the interview process and less conscious aspects of participants' communications.

Finally, the study was developed from the existing literature on impasse and a number of research questions were defined which related to that literature. In retrospect, having several quite defined research questions could have placed a restrictive pressure upon the analysis at a point when it is important to allow the themes to emerge through the data. Whilst the therapists' accounts and the themes do provide material pertinent to the research questions, they do not always do so directly and the analysis has led to interesting findings which are not directly covered by the original questions. It might

have been preferable, therefore, to approach the study with a single, more general or open research question, regarding the way therapists' experience impasse.

4.6 Future research

Given the lack of research studies on impasse in psychological therapy, perhaps the most important starting point for future research is to consider this phenomenon as an area worthy of investigation. There were a number of interesting findings from this study, although further replication is now required in order to support them. It would be interesting to focus on points of resolution in relation to a therapy impasse in addition to the ways in which a therapy becomes stuck. Broadening the study of therapists' experience of impasse to consider that of the clients within the same cases might also extend the findings from this study, although, in comparing the results from their study with the Rhodes et al. (1994), study focussing on clients who ended therapy due to a misunderstanding event, Hill et al. (1996) wondered whether the disparity was due to the fact that therapists and clients generally hold different views on impasse.

Another area worthy of investigation is the role of client attachment style and the way this may influence the nature of impasse encountered in therapy. Mallinckrodt, Gantt and Coble (1995) studied the attachment patterns of clients within the psychotherapy relationship and produced a client-to-therapist attachment scale. Extending this to examine the goodness-of-fit between therapist and client in terms of their attachment styles would elucidate further the findings in this study regarding the function of the 'match' between therapist and client in the development of the impasse.

Further process research would also be valuable. In particular, looking at how clients perceive points in the therapy when therapists feel they have lost their therapeutic stance and are experiencing a sense of hopelessness or believe they are making punitive interventions would provide more information on whether this perception is limited to the therapist. Given that the main 'tool' therapists have is their mind and the capacity to think and process clients' material, examining ways in which this thinking capacity becomes disturbed or, equally, ways in which they regain their position as therapists requires further investigation. In this study conceptualising impasse as, for

instance, necessary or inevitable was one way in which they appeared to regain it. The Hill et al. (1996) study also noted the use of therapists' self-talk and a more detailed analysis of these internal processes would be valuable, perhaps using Comprehensive Process Analysis (Elliot 1989).

Finally, this study identified a possible relationship between impasse and the ending of therapy. Termination issues have been cited in the clinical literature as being a main factor in some impasses (Nathanson 1992). Particularly in relatively brief therapies where only limited change may be expected issues of ending may be very pertinent in understanding a therapy impasse. How the ending is understood at the start and referred to during the therapy would be another area for further investigation.

4.7 Personal reflections of the study

Undertaking a qualitative study of this type has proved a long and novel journey, although, on reflection, in many important ways it has involved a similar process to that used in the every day clinical practice of psychotherapy with the focus on searching for meaning. Unlike clinical work, however, it has allowed me to engage in a much deeper analysis of individual narratives which has proved a valuable experience. The topic of the study, impasse in psychological therapy, clearly had personal meaning for the therapists involved and, in selecting it, it also had a personal meaning for me. Whilst, to some extent, its findings do correspond with my initial expectations when embarking on the study, particularly in regards to the threat to self, other aspects of the interpretative analysis emerged as new ideas. The extent to which therapists' ideal selves feature in the process of psychotherapy and the ways in which the therapeutic position and capacity to think are prone to fluctuations have been an interesting finding which will influence my own clinical work and will, hopefully, stimulate debate in a wider audience. As Nathanson (1992) observed,

"The study of these interruptions in the flow of therapy can illuminate the entire subject of psychotherapy...It is from our errors, our failings, and our frailty that comes the lessons that inform and advance the art and science that is our life." (p.513).

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6. Appendices

Appendix One: Interview Schedules

The main questions are in bold type. The supplementary questions, which serve as prompts, will be only added if the participant does not fully understand the question or requests further clarification.

Interview One

1) **Firstly, I would like to hear about your general experience of being stuck in therapy.**
(How do you see being stuck in the general context of your work?)

2) **a) Can you tell me about your current caseload at the moment and how the therapy is going?**
(The range of clients, the type of work you are doing, how the therapy appears to be progressing)

b) Can you think of a particular case where you are currently feeling stuck and tell me something about the context in which the therapy started and how it progressed at first?
(How did the client come to the service? How did you initially think about the client? What was the therapeutic relationship like at first?)

3) **Can you tell me about the time when you first noticed that the therapy was becoming stuck?**
(How did you know that the therapy was not progressing? What signs did you notice in yourself and the client?)

4) **What did being stuck feel like for you?**
(How did affect you? What feelings did you have during or after a session?)

5) **How did being stuck affect the way you worked with the client?**
(What effects did it have on your overall therapeutic approach or your usual style of working?)

6) **What did you think was going on?**
(What do you think caused the impasse or was maintaining it? What did either you or your client contribute to it?)

7) **Can you tell me about anything you tried to deal with the impasse?**
(What kind of strategies did you use to manage the impasse? What did you find helpful to you?)

8) **Tell me about what happened then.**
(How did the therapy proceed?)

9) **Where are you up to now?**
(What are your thoughts on where the therapy will go next? How will things proceed from here, do you think?)

10) **Is there anything else you feel it is important to tell me?**

Interview Two

1) **Last time we met we talked in some detail about your experience of being stuck in therapy. Is there anything else that has come to mind since we last met?**
(Anything you missed out or have been aware of since the last interview?)

2) **How have you thought about the case you discussed since we met?**
(In what ways have your views changed about it?)

3) **How have things been in your work with your client since the last interview?**
(How has the therapy progressed? How have you responded to the impasse since the first interview?)

5) **Where do you think the therapy will go next?**
(What do you intend to do next? How do you think things will progress?)

6) **We have been thinking a lot about impasse over the last two interviews, I wonder whether your views on being stuck in therapy have changed since we started the interviews?**
(What are your views now on the nature of impasse in therapy?)

7) **Finally, I wonder what taking part has been like for you?**
(How has it felt being interviewed on this topic?)

Other questions, which come up as a consequence of the first interview, may be added to the second interview.

Appendix three: Research flyer

Do you ever get stuck in your therapy with clients?

Would you like to take part in a study that examines how we become stuck in our therapeutic work?

This is a call for participants to take part in a research study looking at therapeutic impasse. As a qualitative study it will focus on the experiences and views of clinicians working in a range of therapy settings.

I work within the North West Adult Psychology and Therapies Service in Leeds Mental Health Trust and the study forms part of my (top-up) doctorate in Clinical Psychology at the University of Leeds.

I am looking for clinicians working within a broadly defined psychotherapy model of individual therapy of at least 12 sessions who would be willing to examine the ways in which the process of therapy can become blocked or reach a standstill. Ideally I would like to interview individuals working in a wide range of settings.

It will involve participating in an interview lasting approximately one hour and a second follow up interview several weeks later. The interviews could take place at a location convenient to you.

All interviews will be audiotaped but confidentiality will be ensured and any identifying details will be removed from any transcripts or reports.

If you are willing to take part or would like further information please contact me at the address or telephone number below.

Judith Hartley
Clinical Psychology Dept
Unit 2a, Gateway Drive
Whackhouse Lane
Yeadon
Leeds LS19 7XY

Tel: 0113 3055461
E-mail:lindengarth@blueyonder.co.uk

Appendix four: Information sheet

Research Study: An Examination of Therapists' Perspectives of Impasse in Psychological Therapy

Researcher: Judith Hartley

Address: Clinical Psychology Dept., Unit 2, Gateway Drive, Whackhouse Lane, Yeadon, Leeds LS19 7XY

Tel: 0113 3055461

I am a clinical psychologist working in Leeds Mental Health Trust. I am currently undertaking a research project as part of the doctoral course in Clinical Psychology at the University of Leeds and I am seeking participants for the above study. Firstly I would like to provide information on the study before seeking your consent to take part.

I would like to interview a number of clinicians who offer medium to long term psychological therapy (12 sessions +) about their experience of becoming stuck in therapy, where the therapy appears to have reached a standstill or is not progressing as expected. I am interested in your perceptions in regards to the nature of impasse and how it develops as well as your experience of facing therapeutic impasse and how you respond to it.

I intend to use a qualitative approach to collect and analyse the data. If you agree to participate I will meet with you for two interviews each lasting approximately 60 minutes. In the first interview I would like to collect as much information as possible on your experience of being stuck in therapy. The second interview, undertaken within several weeks of the first, will allow time for further clarification, collecting missing information and reviewing the therapeutic impasse. I will also invite feedback on the process of both interviews and their content.

In order to collect the data I will need to audio-tape the interviews. Typed transcripts of these tapes will then be produced. At all times I will seek to protect your anonymity and that of any clients you discuss. Personal details such as names or other identifying information will be removed from the transcripts.

I may want to use extracts from the transcripts in any report of the research. In addition to the doctoral dissertation this may also include articles in professional journals and presentations at conferences. Any extracts from the transcripts which appear in future reports will be anonymised.

If you agree to participate there is a consent form attached to this sheet which you should complete after asking any questions you have on the study. I can be contacted in the Clinical Psychology department on the above number on Mondays, Tuesday mornings or Fridays to discuss your queries. Please note that if you give consent you are free to withdraw from the study at any time.

Thank you for your time in considering your participation in this study.

Appendix five: Consent Form

Research Study: An Examination of Therapists' Perspectives of Impasse in Psychological Therapy

Thank you for agreeing to take part in this research study. Please answer the following questions which ensure that you have understood what will be involved and confirm that you are willing to take part.

1. Have you read the Information Sheet? Yes/No
2. Have you had the opportunity to ask questions and discuss the study further? Yes/No
3. Have you received enough information on the study? Yes/No
4. Do you understand that you do not need to give any information if you do not wish to do so? Yes/No
5. Do you agree to the interviews being audio-taped? Yes/No
6. Do you give permission for extracts of the interviews to be used in reports of the research on the basis that all personal details will be removed? Yes/No
7. Do you understand that you may withdraw from the study at any time and withdraw consent for any information collected to be used? Yes/No
8. Do you agree to take part in this study? Yes/No

Signed.....

Name (block capitals).....

Date.....

Appendix six: Extracts of coded transcripts

6a. Phenomenological coding

The first level of analysis focussed on the direct experience of the participants. The notes on the left of the transcript and the emerging themes on the right can be seen to relate quite closely to the participants spoken accounts and the codes are, therefore, more descriptive in nature.

The domains and themes identified in the participants' accounts were as follows:

Domain	Theme
Relationship	*Alliance*
	Experience of other
	Roles
Psychological states	*Emotional states*
	Mental states
Progression	*Becoming stuck*
	Making changes
Actions	*Response*
	Therapy direction
Personal self	*Personal meaning*
	Needs
Conceptualising impasse	*Conceptualising*

The following extract from Beth's first interview contains material relating predominately to the first three domains.

P2:
It's - what's really interesting in talking about that other client just then when I switched is the relief of talking about someone else.

I:
Mmm.

P2:
'Cos actually I find it very difficult to talk about her.

I:
Mmm.

P2:
And - and it was actually I think as part of the avoidance behaviour in me it was like oh let me talk about somebody else (laugh) that's stuck and it doesn't really matter. Which is - I don't mean that 'cos of course she really does matter you know, I really care about this woman, I really want her to get better. Erm but I don't feel this kind of amount of you know whatever it is that goes on.

I:
Mmm And what is it that you feel with her?

P2:
Erm (pause) I don't know but I can feel it all the way to my throat (laugh) and it's - I mean it - it's like a sort of - it's a panic. It's like kind of you know I feel completely er - I actually feel sort of you know sort of feeling somatic pain with this. It actually makes me feel quite er (pause) yeah very stressed, very very stressed.

I:
Mmm.

P2:
And actually I know in the sessions I feel very stressed when she goes. And it's not that I don't - I don't - I don't dread seeing her or anything like that, I think you know the sessions are - are very kind of - very alive and very full of lots of energy, but I have this sense of - of - of stress.

I:
And how do you react to that, how does it affect what you do?

P2:
(Long pause) Erm when I'm with her?

I:
Mmm.

P2:
(Long pause) Two things. One is that I've got to remember to move. And I remember one session I didn't move, and erm my phone rang at the end of the session to let me know that the next person had arrived, and my leg was completely dead erm so I couldn't have moved for a very long period of time for it to go completely to sleep. Erm so there's something very powerful about what goes on which means I'm kind of paralysed by it at times.

I:
Mmm.

P2:
So one thing I have to do is keep moving. Erm (pause) because she avoids eye contact (pause) it's really interesting I'm acutely aware of - of my sort of what - me looking at her all the time because I can look at her when I'm talking and when I'm listening 'cos she - you know there's fleeting eye contact. Erm (pause) I think it's that that you know for - for a full hour I am completely totally concentrating on her, nothing else at all.

I:
Mmm. And how does it affect your usual flow of therapy or the way that you would usually work?

P2:
(Long pause) I think it must affect me in some way. I'm not sure how it affects me. But actually I'm not completely relaxed and you know as I'm talking about it now I'm not. Erm and so it - you know I don't know how that then interacts with my thinking. When I'm in the session with her I catch myself some times (pause) making sure that I ask the question and not giving the answer or making the interpretation erm because - because I know that's what she wants me to do. She wants me to tell her. So I have to stop myself, and I think that you know the sort of what happens when you're stressed is you become more active and you're more agitated, and I think that you know I have to make sure that I don't sort of talk too much or you know erm (pause) do the work for her, or you know not do the work for her but do what I think is the

work or make the interpretations that she - she needs to make herself.

I:
Mmm. What do you think is going on in terms of the stuckness that you pick up and feel?

P2:
Erm (long pause) I mean the things that came to mind then were things like I like her, I want her to benefit from coming, erm I feel some responsibility. Erm (pause) and I know in saying that I feel some responsibility there's something that's going on that shouldn't be going on. I mean of course as a clinician I have - I have some clinical responsibility but I don't have (pause) me being active in the therapy isn't gonna change her.

I:
Mmm.

P2:
And I wonder that - that actually that responsibility is - is impacting on the activity levels of my self and her.

I:
Mmm.

P2:
And that's why I end up feeling that she's - you know she's somebody that I feel I need to think about before the next session and - and that that does happen with other people but - but this feels different. Erm .. so I wonder if some of the - the stuckness is that she - that she is you know putting on me erm the impetus to - for her to change. Erm and I'm feeling that and although I'm putting that back to her to some extent erm I don't think totally - I think I get - I get - I get caught up in her feeling stuck some times.

I:
Mmm.

P2:
Erm and then feeling responsible which immobilises me because I think well maybe she's frightened, maybe she - oh this is all too big and scary. Erm (pause)

6b. Interpretative coding

Some of the themes in the initial phenomenological coding led me to take a second look at the transcripts. Going beyond the initial four research questions I realised that the therapists were expressing, perhaps less overtly, how the experience of impasse affected their sense of selves as competent therapists. A second, more interpretative analysis was, therefore, undertaken.

The themes which emerged were as follows:

1. Ideal self
2. Threat to self
3. Loss of therapeutic self
4. Threat reduction
5. Restoration as effective therapist

The following piece of transcript taken from Carole's account focuses in particular on the loss of the therapeutic self and the ways in which Carole manages to reduce the personal threat of the impasse.

P5:
I suppose in each individual session - and of course I was being - was and I am being very closely supervised.

I:
Mmm.

P5:
Erm .. it's three clients in the training programme, supervised weekly so erm .. so I go to supervision which was I mean just of course you know very helpful and essential and all of that, so I'd quite regularly go for a session thinking right erm you know I'm all geared up now and - and erm and at some point in the session I think I would give up. So I suppose I'd - I'd approach each session with a sense of hope and the hope would - would die somewhere and turn to really very very powerful feelings in me of .. anger, frustration, desperation.

I:
Mmm.

P5:
Erm .. I actually think - I - I - I will say his - although I should change the name shouldn't I? Erm A (male's name), I'll call him A (male's name). I really think you know A (male's name) couldn't - couldn't connect. Just couldn't risk that.

I:
Mmm.

P5:
Erm .. and there's something intensely unbearable then I think. That that was - that was the sort of quality of something unbearable.

I:
Mmm.

P5:
But I think I was feeling it not him.

I:
Yeah. Yeah.

P5:
Well I mean of course he was having a terrible time but in terms of

the therapeutic relationship I was the one who experienced the unbearable qualities.

I:
And rather than thinking about your kind of strategic or kind of professional response to that, what was your immediate response to that within the therapy when you were feeling desperate and angry and those sort of things, what - what - how would that affect what you did and how you were?

P5:
Erm (sigh) I - I mean - what con - what happens now if - if I can in inverted commas "catch him doing it", I actually intervene now much more quickly and much more readily.

I:
Mmm.

P5:
At that time I think I would give up.

I:
Mmm.

P5:
I'd say less. Erm .. or not exactly not trust myself to speak - it just seemed pointless. There was a sense of utter - of futility really. So I would sort of say - I'd almost give up on the sessions. Latterly we have found a way of talking about it and addressing it and I'll just intervene now much much more. And you know there was a session when he was erm talking where as if he was arguing with me and I wasn't saying a word, I was just sitting there, and I actually did say to him you're arguing with me. 'Cos that was the delivery. And .. but I actually have - I've often got to the point where I feel now as though I've being punitive in my interventions. And I some times - I - some times I can't believe I do this but I do, I some times don't sort of give a massive heart felt sigh but I some times - because there's been a shift now he lapses back in to that kind of unconnected ranting, keep me at a distance. I find it - I'm less able to sort of sit and tolerate it. I do something. And I suppose it feels often untherapeutic or unprofessional or.

I:
And I'm just wondering to what extent feeling stuck with this man

has - throws you off your usual therapeutic course or whether you feel as though you kind of stay with your usual way of working?

P5:
Well I think I do stay within it to the extent that I don't work in an organised way at all. I mean I don't have a sort of - well maybe with the very brief work you know there's the idea of the - the focus and the sort of er keeping that in mind and keeping the ending in mind sort of. Long term I don't work in an organised way. I don't have an idea of what I want this client to achieve or what I want to do in each session. It really is er what's the word for it .. erm .. I'm not sure if there is one. But you know it is - it is kind of therapy that it's just well you - you know you the client sit there and talk and I'll respond. So in that sense I don't think I do work differently.

I:
Right.

P5:
But you know but in another sense I think the way I respond always depends on the clients. It - it's a sort of truism in a way given that what I do is respond to what's said. Erm .. but it's - but that is the way of working. And it will be different with each client.

I:
Right.

P5:
And that different clients bring different material and different ways of being erm ..

I:
Right, and so you were able to hold that way of working rather than for you more drawn in to doing something differently.

P5:
I think so. I think so. I mean I - yeah, yeah, yeah. I mean in detail yes I might get drawn in to doing something different but not radically. And you know that's something - I mean you know you know having been in a psychotherapy training for about what two and a half years and supervised weekly I'm - I - I'm very much in the habit of kind of tracking my responses and feelings quite closely.

6c. Interview process coding

As I was interested in looking at the notion of the 'defended subject' (Hollway and Jefferson 2000), and the initial readings of the transcripts appeared to indicate material which related to the participants' experience of being interviewed, a third level of analysis was undertaken which focussed exclusively on the interview process.

The following five themes were identified:

1. Reflecting
2. Openness
3. Presenting a balanced view
4. Professional linking
5. Humour

These two separate extracts, taken from David's account, demonstrate how the above themes are grounded in the text.

P6:
I'll put it back in to therapy. Erm .. well in a considered way (laugh) I'm not going to "You are really frustrating me here" (laugh). No I don't do that. Erm (sigh) I reflect on how I'm feeling.

I:
Mmm, mmm.

P6:
And in a considered way will bring that back in. But I am conscious in thinking about it in this way that I don't feel I've done that for some time and it's been more about focusing on that pattern, those patterns, acknowledging those frustrating, we're acknowledging them. Erm .. but not really owning it.

I:
Mmm.

P6:
I am getting frustrated here erm compared to it is frustrating.

I:
Mmm.

P6:
And then looking at that. You know in the relationship. You know actually putting that aside and actually addressing the relationship.

I:
Mmm.

P6:
I'm not quite sure if I've done that or why I haven't done that.

I:
What impact might that have do you think on the relationship with you two?

P6:
(Laugh) Do you know my first gut response is it will probably end the relationship (laugh) which is hey but that's what I want (laugh) but then no it's not. You know the sort of - mmm. (long pause) I'm not sure what impact it would have but certainly yeah my - my first thought is it would some how be unmanageable. Erm .. or it would //

880 //come to terms with that and that's fine, I don't have the same
881 // feelings pressure wise. And that's to do with how I react.
882
883 I:
884 Mmm.
885
886 P6:
887 You know it's something I pull in to in terms of like you know that
888 particular person and so I can dismiss the you know pressure.
889
890 I:
891 Mmm.
892
893 P6:
894 Er easily for her because she's not the most likeable person in that
895 sense.
896
897 I:
898 Mmm.
899
900 P6:
901 And again the human part of me would say great you're moving
902 bye. But the therapist part of me knows look you're not ready and
903 you know being aware of that there's something here that I - you
904 know I dislike - not dislike - to me it's like a strong word. I don't
905 dislike her. That kind of emotional pull you get is more difficult to
906 manage.
907
908 I:
909 Mmm.
910
911 P6:
912 Erm .. and I'm not sure how to address that with her. I'm not sure
913 if I could address that with her. Hey there's something you're doing
914 which actually - you know actively erm I struggled with.
915
916 I:
917 Mmm. What about the things that you have done with her to try
918 and kind of you know manage this stuckness? How has that
919 impacted on the therapy sessions and how has it gone from there?
920
921 P6:
922 Just another crisis (ha).
923

putting good/bad therapist own needs vs client's

reassuring not a 'bad' therapist

turns to more professional language style

Preserving a balanced view

professional joining

reflecting on difficulties in therapy models

reflecting on avoidance of difficult area

arguing at.. sabotaging as therapeutic attempts.

Use of humour when acknowledging 'failure'