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# **THERAPISTS' EXPERIENCE OF DIFFICULTIES IN THEIR PRACTICE**

**Volume II of II**

**Appendices**

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**University of Warwick**

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# **1. Appendix 1: Therapist Difficulties Taxonomy Rating Manual**

## **Taxonomy of Therapist Difficulties: Rating Manual**

Marc Binns, John Davis, Marcia Davis, Robert Elliott,

Val Francis, Jim Kelman, Tom Schröder

The manual provides definitions for ten categories of therapist difficulty, plus instructions for rating the presence-absence and predominance of each category in therapists' accounts of situations they have experienced as difficult. Along with the definition for each category, examples are provided of accounts in which the category is "definitely present" and "probably present". The examples are not intended to represent pure instances of a given kind of difficulty, since most accounts in practice reveal elements of more than one category of difficulty.



## Presence-Absence Ratings

For every situation, rate each category on the following 4-point scale

- 0 - Definitely absent. There is nothing in the wording of the therapist's experience to suggest that the category is present. In addition, the situation described is one in which it would be somewhat surprising for the therapist to have had the kind of experience defined by the category.
- 1 - Probably absent. There is nothing in the wording of the therapist's experience to suggest that the category is present. However, the situation described is one in which it would be quite plausible for the therapist to have had the kind of experience defined by the category (even though it has not been reported).
- 2 - Probably present. There is definitely something in the wording of the therapist's experience to suggest that the category is present, and the situation described is one in which it would be quite plausible for the therapist to have had the kind of experience defined by the category. However, the therapist's account is not sufficiently explicit or unambiguous to put the presence of the category beyond doubt; presence is implied but not entailed.
- 3 - Definitely present. The wording of the therapist's experience is sufficiently explicit and unambiguous to put the presence of the category beyond doubt. It is abundantly clear from the therapist's account that the category is present. The kind of experience defined by the category is directly reported by the therapist.

## Predominance Judgements

A category is predominant for a given situation if the kind of difficulty it defines is the principal difficulty experienced by the therapist in the situation. For each situation, decide if at all possible which one category is predominant. A judgement of predominance should only be made for a category rated as "probably present" or "definitely present". Record your judgement by entering a score of 7 (instead of 2) or 8 (instead of 3) for the predominant category on the presence-absence rating form. If you are unable to make a judgement of predominance for a given situation, enter presence-absence ratings for that situation in the range 0-3 only.

## 1. T - Incompetent

The therapist questions or negatively evaluates his or her skills / performance / adequacy as therapist. The therapist's expressed concern is not with the consequence of his or her deficiency for the patient, but with his or her own narcissistic injury. The therapist's confidence in self is undermined (If T also feels guilty, also rate as Category 2).

Example 1: During the session with a relatively new patient I have made some - as I saw them - pertinent links between his feelings at work and at home towards his son, who is in fact living with his first, now divorced, wife. I feel ashamed about this gross blunder. How could I have forgotten a fact **as** important as this? Perhaps I should do something else for a living.

**Rate: 3**

Example 2 : I have been feeling somewhat stuck with the patient and have decided to try a paradoxical approach with him. He says he is confused by what I am saying and wonders what game I am playing. I feel bad, but also a bit guilty to have treated him in this way.

**Rate: 2**

## **2. T - Damaging**

The therapist feels that he or she may have harmed or failed the patient in some way ( or may be in danger of doing so). The focus of the therapist's concern is on the consequences of his or her actions for the patient, and on his or her responsibility for producing these consequences. The therapist feels guilty. (If T also questions his or her therapeutic skills, also rate as Category 1).

Example 1: The patient finds it hard to focus on the material and rambles all over the place. I find it difficult because I can easily lose track of the issues or find it hard even to see one, and she may find it persecuting to keep being brought back to a theme.

**Rate: 3**

Example 2: The patient needs therapy but is afraid of what therapy will entail and hovers around the ambivalence, then decides against the risk. I feel a failure. I should have been able to secure greater trust, foster more courage.

**Rate: 2**



### 3. T - Puzzled

The therapist feels perplexed, either about the patient or about the technical aspects of the therapy. The therapist has difficulty in understanding the patient or the ongoing therapeutic transactions, or is puzzled about how best to proceed in the therapy (either because no suitable strategy suggests itself or because it is difficult to choose between alternative strategies).

The therapist feels confused and uncertain, or feels at a loss or conflicted about what to do. The therapist feels conceptually or technically, but not ethically, at sea.

(If T also experiences a moral conflict, rate also as Category 10).

Example 1: A patient I have been seeing for some time starts the session by going into a 'routine' description of his dissatisfaction with his job. This is very familiar and I am increasingly wondering whether I should yet again link the material to therapy, or comment on the repetition, or whether it would be better to take his difficulties at face value. If I don't deal with this issue now, I feel it will get in the way of therapy.

**Rate: 3**

Example 2: A new patient arrives, sits down and doesn't talk. I try silence, empathic guesses, and process comments, but cannot get a response. I am left to my speculations whether she came of her own accord and whether she really wants to be there. I am not sure I want to be there.

**Rate: 2**

#### **4. T - Threatened**

The therapist feels a need to protect self against the patient. The therapist feels threatened by something about the patient, or what the patient does, including feeling persecuted, intruded upon, controlled, made to feel crazy, or emotionally or physically threatened. The therapist feels vulnerable to the patient and may react with anxiety or anger.

Example 1: The patient insists I am feeling something I am not, but gradually I start to feel it. I am perplexed and confused. I do not know any more who is feeling what in here.

**Rate: 3**

Example 2: The patient is critical and hostile in attitude. I get irritated and can't decide whether to reflect my irritation or try and stay with his needs and the feelings underlying his hostility.

**Rate: 2**

## **5. T - Out of Rapport**

The therapist feels that there is little prospect of being able to relate to the patient, to get on the same wavelength, to find a common language, to experience warmth towards or liking for the patient, or to develop any alliance. The therapist feels generally distant, out of touch, or alienated from the patient.

Example 1: I find it difficult to work with a patient I feel little warmth for. The patient is self-centred, absorbed, and unable to show any warmth or caring. This is what puts me off, and it's an effort to relate and to feel and demonstrate concern.

**Rate: 3**

Example 2: The patient is focusing on somatic symptoms, seeing them as unrelated to thoughts or feelings. My efforts are fruitless and I can't get myself heard. I'm left puzzling whether this was an inappropriate referral or whether the patient has successfully reorganised her defences.

**Rate: 2**

## **6. T's Personal Issues**

The therapist is aware of transitory or enduring personal feelings, conflicts, beliefs, attitudes, values, or states, which are felt to originate outside of the therapy. These are experienced by the therapist as intruding into the therapy or as threatening to do so. Their interference (or potential interference) arouses the therapist's concern.

Example 1: My patient is struggling with her guilt at having an abortion several years ago. Having been through a similar ordeal myself, I worry that my feelings about this issue might influence our sessions.

**Rate: 3**

Example 2: I find somewhat to my surprise that I cannot summon up the care required to work with this patient, and think he could be better seen by another therapist. I feel concerned at my inadequacies in this area, and am aware that re-referring would be unfair to him.

**Rate: 2**



## **7. Painful Reality**

The therapist is confronted with a difficult factual situation which must be accepted for what it is. The therapist finds it painful to endure the situation and to accept the way things are, but does not experience any difficulty in seeing how the therapy should be conducted. The therapist may feel sad or angry with the world for ordering things so.

Example 1: My patient is terminally ill and dying. I can easily share her sense of outrage and injustice but there seems nothing that can be done. I find it hard to accept and sadly ironic that 'outcome' will depend on the quality of death - it leaves me with a sense of futility.

**Rate: 3**

Example 2: My patient is an extremely shy and socially isolated man who I think needs more than once weekly therapy. For the second time he has agreed to be assessed for more intensive treatment and for the second time he has pulled out after I have made all the necessary arrangements. Although I am frustrated and annoyed I still feel he could be helped, but I am left with the uncomfortable thought that he might simply not have the capacity to commit himself to intensive therapy.

**Rate: 2**

## **8. T's Ethical Dilemma**

The therapist cannot decide where his or her duty lies or what course of action is more ethical. The therapist may feel that obligations to the patient are in conflict with obligations to other persons. The therapist feels conflicted and morally troubled.

Example 1: After long hesitation the patient has finally revealed that he has been and still is abusing his children sexually. He seems, however, unable or unwilling to stop. I feel torn between my sense of betraying confidentiality if I should alert another agency such as Social Services to this and my sense of responsibility towards his children.

**Rate: 3**

Example 2: It has come to my knowledge that a patient I have been seeing for a while has had a brief spell of psychiatric treatment following an overdose, a fact she has never mentioned to me. The source of information is a colleague of mine who happens to know the patient's husband socially, I feel torn whether to confront her with her 'secret' or whether to wait until she brings it up herself, and I feel uneasy about the surreptitious way in which I have found out about it.

**Rate: 2**

## **9. T - Stuck**

nature of the patient's The therapist feels that the therapy has reached an impasse, seeing no way forward and feeling that there is no escape from the situation. Not only does the therapy feel stuck, but the therapist also feels stuck with the patient. The therapist feels trapped, hopeless, demoralised.

Example 1: We are going round and round in circles getting nowhere. I am losing confidence in our prospects, yet am reluctant to terminate because of the problems. I feel trapped.

**Rate: 3**

Example 2: We've been meeting for months but the patient continues to lurch from crisis to crisis, making no progress. It gets me down.

**Rate: 2**

## **10. T - Thwarted**

The therapist experiences the patient as actively impeding or rendering more difficult his or her efforts to pursue therapeutic objectives. The therapist feels frustrated, impatient, irritated, or angry at the way these efforts are being blocked.

Example 1: I think it would be helpful to involve the spouse in therapy, but the patient is resolute in deciding to keep the spouse out. I feel frustrated and irritated.

**Rate: 3**

Example 2: My patient has shop-lifted during a difficult point in her therapy and I have reluctantly provided a court report. I hear nothing of what happens and after a brief exchange of letters she signs off that she is quitting therapy and would not welcome further contact of any kind. I'm left not knowing what to do with her obvious anger and wish to punish me.

**Rate: 2**



## 2. Appendix 2: Therapist Difficulties Questionnaire, Version 1

### TDQ1 CONFERENCE COVERPAGE

#### **THERAPISTS' EXPERIENCE OF DIFFICULTIES IN PRACTICE**

Dear Colleague,

Thank you for considering completing this questionnaire. I know that during a conference everyone is very busy, so I would particularly appreciate your giving up about half an hour of your time for this investigation into the varieties of experiences which therapists have when meeting difficulties in the course of their work. It will certainly help me with my questions, but I hope that you might gain something, too; perhaps a fresh angle from which to organise your thoughts about your clinical practice.

Although at the beginning you are asked about a difficult situation, for the remainder of the questionnaire I am interested in **your** subjective experience of a difficulty in your practice rather than in how it might appear to an outside observer. For instance, if I enquire about the duration of a difficult situation, I am interested in how long it felt difficult for **you** rather than in how long the situation itself persisted.

It is possible that you have previously contributed responses to some of the material in this questionnaire. If that is the case, I would be very grateful if you would do so again and give your current responses. When you have completed the questionnaire, please drop it in the box in the foyer. If you prefer to take the questionnaire away with you, please send it to me at the address given below.

As this is a pilot survey, I would be especially interested in any comments you have about the questionnaire and about what it was like completing it. Please write your comments in the space provided, or, alternatively, give me some personal feedback during the conference.

Thank you again for your help!

Thomas A. Schröder,  
Southern Derbyshire  
Mental Health Trust,  
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Temple House,  
Mill Hill Lane,  
DERBY DE23 6SA.  
Great Britain

## TDQ1 COVERPAGE

### THERAPISTS' EXPERIENCE OF DIFFICULTIES IN PRACTICE

Dear Colleague,

Thank you for considering completing this questionnaire. I know that most clinicians are extremely busy, so I would particularly appreciate your giving up about half an hour of your time for this investigation into the varieties of experiences which therapists have when meeting difficulties in the course of their work. It will certainly help me with my questions, but I hope that you might gain something, too; perhaps a fresh angle from which to organise your thoughts about your clinical practice.

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It is possible that you have previously contributed responses to some of the material in this questionnaire. If that is the case, I would be very grateful if you would do so again and give your current responses. When you have completed the questionnaire, please send it to me at the address given below. An addressed envelope is attached.

As this is a pilot survey, I would be especially interested in any comments you have about the questionnaire and about what it was like completing it. Please write your comments in the space provided, or, alternatively, give me some personal feedback.

Thank you again for your help!

Thomas A. Schröder,  
Southern Derbyshire  
Mental Health Trust,  
Dept. of Psychotherapy,  
Temple House,  
Mill Hill Lane,  
DERBY DE23 6SA.

**P1. A PAST DIFFICULTY:**

**Please think of a situation in your practice of individual psychotherapy which you have personally encountered some considerable time ago and which you found difficult.**

P1.1      What did you or your patient (client) do which made the situation difficult?

P1.2      What feelings or personal reactions did you experience in the situation?

P1.3      How did you attempt to deal or cope with this difficulty?

P1.4      How did the situation turn out?

(Please continue on the back of this page if necessary)



## P.2 ABOUT YOUR EXPERIENCE OF THE DIFFICULTY

To what degree do the following statements concur with your experience of the difficulty you have described?  
(Please circle one number for each statement.)








RATING  
SCALE

0..... Not at all  
1..... Marginally  
2..... Somewhat  
3..... Partially  
4..... Substantially  
5..... Almost entirely  
6..... Completely

**This statement captures  
my experience :**



- |   |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|---|
| 1. I was emotionally affected by this difficulty.                                       | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 2. Difficulties of this nature were new to me.  | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 3. I experienced this difficulty as 'going to the core' of me.                          | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 4. My other existing patients/clients were not difficult in this particular way.        | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 5. I could ignore this difficulty.  | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 6. I had experienced this sort of difficulty time and again.                            | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 7. This difficulty gave me pause for thought.   | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 8. I was absorbed in this difficulty only when I was with my client/patient.            | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 9. I had been acquainted with this sort of difficulty for a long time.                  | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 10. Thoughts, feelings, or images connected with this difficulty came to mind unbidden. | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 11. I was surprised to be confronted with this kind of difficulty.                      | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 12. This difficulty really 'got inside' me.   | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 13. This was an unusual difficulty for me.  | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 14. I found this difficulty easy to deal with.  | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 15. I felt untroubled by this difficulty.   | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 16. I expected to meet this difficulty again in the future.                             | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 17. It was easy to disengage from this difficulty.                                      | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 18. I knew about difficulties of this kind through previous experience.                 | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 19. I was full of the experience of this difficulty.                                    | 0 | 1 | 2 | 3 | 4 | 5 | 6 |

							
20. This difficulty was uncharacteristic of me.	0	1	2	3	4	5	6
21. I was worried about this difficulty.	0	1	2	3	4	5	6
22. Grappling with this difficulty was a struggle.	0	1	2	3	4	5	6
23. This was a typical difficulty for me.	0	1	2	3	4	5	6
24. This difficulty stayed with me only fleetingly.	0	1	2	3	4	5	6
25. I was not personally conversant with this type of difficulty.	0	1	2	3	4	5	6
26. I could not let go of this difficulty.	0	1	2	3	4	5	6
27. I did not anticipate being faced with this kind of difficulty again.	0	1	2	3	4	5	6
28. I felt concerned about this difficulty.	0	1	2	3	4	5	6
29. This difficulty did not bother me.	0	1	2	3	4	5	6
30. I was used to this kind of difficulty.	0	1	2	3	4	5	6
31. I was able to distance myself from this difficulty.	0	1	2	3	4	5	6
32. I did foresee (or could have foreseen) that I would encounter this difficulty.	0	1	2	3	4	5	6
33. I could easily push aside the thoughts and feelings aroused in me by this difficulty.	0	1	2	3	4	5	6
34. It was then only recently that I had first met this kind of difficulty.	0	1	2	3	4	5	6
35. I was preoccupied by this difficulty outside the therapy session(s).	0	1	2	3	4	5	6
36. I did not feel the need to reflect on this difficulty.	0	1	2	3	4	5	6
37. This was virtually the first time that I had encountered a difficulty of this type.	0	1	2	3	4	5	6
38. I was engrossed by this difficulty.	0	1	2	3	4	5	6
39. At the time, several of my patients/clients presented me with this difficulty.	0	1	2	3	4	5	6
40. I experienced this difficulty as going only 'skin-deep'.	0	1	2	3	4	5	6
41. This kind of difficulty was well-known to me.	0	1	2	3	4	5	6
42. I was untouched by experiencing this difficulty.	0	1	2	3	4	5	6

**P 3. ABOUT THE DIFFICULTY**

P 3.1. How many sessions did the difficulty occur?

approx . . . . . sessions

P 3.2. For how many weeks did the difficulty last altogether?

approx . . . . . weeks

**P 4. ABOUT THE THERAPY IN WHICH THE DIFFICULTY OCCURRED**

P 4.1. On average, over the course of therapy, at what frequency were sessions scheduled? (Please tick the answer which applies best)	... less than once a fortnight ... fortnightly ... weekly ... more than once a week
--	--

P 4.2. After how many sessions of therapy did you first encounter the difficulty?	approx . . . . . sessions
---	---------------------------

P 4.3. Is the therapy still continuing?

... YES



P 4.4. For how many more sessions do you expect the therapy to continue?

approx . . . . . sessions



P 4.5. For how many sessions has this difficulty been going on already?

approx . . . . . sessions

... NO



P 4.6. For how many sessions did the therapy last altogether?

approx . . . . . sessions

**C1. A CURRENT DIFFICULTY:**

**Please think of a current or very recent situation which you have personally encountered in your practice of individual psychotherapy and which you found difficult.**

C1.1      What did you or your patient (client) do which made the situation difficult?

C1.2      What feelings or personal reactions did you experience in the situation?

C1.3      How did you attempt to deal or cope with this difficulty?

C1.4      How did this situation turn out?

(Please continue on the back of this page if necessary)



## C.2 ABOUT YOUR EXPERIENCE OF THE DIFFICULTY

To what degree do the following statements concur with your experience of the difficulty you have described? In the case of a very recent difficulty give the response as you felt at the time.  
(Please circle one number for each statement.)








### KEY

0.....	Not at all
1.....	Marginally
2.....	Somewhat
3.....	Partially
4.....	Substantially
5.....	Almost entirely
6.....	Completely

**This statement captures my experience :**



- |   |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|---|
| 1. I am emotionally affected by this difficulty.  | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 2. Difficulties of this nature are new to me.   | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 3. I experience this difficulty as 'going to the core' of me.                           | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 4. My other existing patients/clients are not difficult in this particular way.         | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 5. I can ignore this difficulty.  | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 6. I have experienced this sort of difficulty time and again                            | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 7. This difficulty gives me pause for thought.  | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 8. I am absorbed in this difficulty only when I am with my client/patient.              | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 9. I have been acquainted with this sort of difficulty for a long time.                 | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 10. Thoughts, feelings, or images connected with this difficulty come to mind unbidden. | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 11. I am surprised to be confronted with this kind of difficulty.                       | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 12. This difficulty has really 'got inside' me.   | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 13. This is an unusual difficulty for me.   | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 14. I find this difficulty easy to deal with.   | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 15. I feel untroubled by this difficulty.   | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 16. I expect to meet this difficulty again in the future.                               | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 17. It is easy to disengage from this difficulty.                                       | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 18. I know about difficulties of this kind through previous experience.                 | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 19. I am full of the experience of this difficulty.                                     | 0 | 1 | 2 | 3 | 4 | 5 | 6 |

							
20. This difficulty is uncharacteristic of me.	0	1	2	3	4	5	6
21. I am worried about this difficulty.	0	1	2	3	4	5	6
22. Grappling with this difficulty is a struggle.	0	1	2	3	4	5	6
23. This is a typical difficulty for me.	0	1	2	3	4	5	6
24. This difficulty stays with me only fleetingly.	0	1	2	3	4	5	6
25. I am not personally conversant with this type of difficulty.	0	1	2	3	4	5	6
26. I cannot let go of this difficulty.	0	1	2	3	4	5	6
27. I do not anticipate being faced with this kind of difficulty again.	0	1	2	3	4	5	6
28. I feel concerned about this difficulty.	0	1	2	3	4	5	6
29. This difficulty does not bother me.	0	1	2	3	4	5	6
30. I am used to this kind of difficulty.	0	1	2	3	4	5	6
31. I am able to distance myself from this difficulty.	0	1	2	3	4	5	6
32. I did foresee (or could have foreseen) that I would encounter this difficulty.	0	1	2	3	4	5	6
33. I can easily push aside the thoughts and feelings aroused in me by this difficulty.	0	1	2	3	4	5	6
34. It is only recently that I first met this kind of difficulty.	0	1	2	3	4	5	6
35. I have been preoccupied by this difficulty outside the therapy session(s).	0	1	2	3	4	5	6
36. I do not feel the need to reflect on this difficulty.	0	1	2	3	4	5	6
37. This is virtually the first time that I have encountered a difficulty of this type.	0	1	2	3	4	5	6
38. I am engrossed by this difficulty.	0	1	2	3	4	5	6
39. Currently, several of my patients/clients present me with this difficulty.	0	1	2	3	4	5	6
40. I experience this difficulty as going only 'skin-deep'.	0	1	2	3	4	5	6
41. This kind of difficulty is well-known to me.	0	1	2	3	4	5	6
42. I am untouched by experiencing this difficulty.	0	1	2	3	4	5	6

**C 3. ABOUT THE DIFFICULTY**

Is this difficulty with this patient still ongoing?

C 3.1. . . . YES

⇓

C 3.2. For how many more sessions do you expect it to persist or recur?

approx . . . . . sessions

⇓

C 3.3. For how many sessions has it been going on already?

approx . . . . . sessions

⇓

C 3.4. How many weeks ago did it first occur?

approx . . . . . weeks

⇓

. . . NO

⇓

C 3.5. In how many sessions did it occur?

approx . . . . . sessions

⇓

C 3.6. How many weeks did it last altogether?

approx . . . . . weeks

⇓

Please move on to question C 4.

**C 4. ABOUT THE THERAPY IN WHICH THE DIFFICULTY OCCURED**

C 4.1. On average, over the course of therapy, at what frequency were sessions scheduled?  
(Please tick the answer which applies best)

. . . less than once a fortnight  
. . . fortnightly  
. . . weekly  
. . . more than once a week

C 4.2. After how many sessions of therapy did you first encounter the difficulty?

approx . . . . . sessions

C 4.3. Is the therapy still continuing?

. . . YES

⇓

C 4.4. For how many more sessions do you expect the therapy to continue?

approx . . . . . sessions

⇓

C 4.5. For how many sessions has this difficulty been going on already?

approx . . . . . sessions

. . . NO

⇓

C 4.6. For how many sessions did the therapy last altogether?

approx . . . . . sessions



**5. ABOUT THE PATIENTS/CLIENTS WITH WHOM THE DIFFICULTIES OCCURRED**

5.1. Sex of patients/clients (please tick):

<u>Current/Recent Difficulty</u>	<u>Past Difficulty</u>
male . . .	. . .
female . . .	. . .

5.2. Age of patients/clients

<u>Current/Recent Difficulty</u>	<u>Past Difficulty</u>
approx . . . . . years	approx . . . . . years

5.3. How disturbed or impaired were your patients at the beginning of the therapy in which the difficulty occurred?  
(Please tick whichever describes them best)

<u>Current/Recent Difficulty</u>	<u>Past Difficulty</u>
mildly . . . . .	. . . . .
moderately . . . . .	. . . . .
severely . . . . .	. . . . .

**6. ABOUT YOURSELF**

6.1. Are you . . . male or . . . female?

6.2. How old are you now? . . . . . years

6.3. For how many years have you been practising as a therapist? approx. . . . . years

6.4. What is your profession? (Please tick as many as apply)

. . . Psychologist . . . Psychiatrist . . . Psychotherapist  
 . . . Social Worker . . . Counsellor . . . Nurse  
 . . . Other (Please specify) \_\_\_\_\_

6.5. What is your therapeutic orientation (Please tick as many as apply)

. . . Psychodynamic . . . Behavioural . . . Cognitive  
 . . . Humanistic . . . Systemic  
 . . . Other (Please specify) \_\_\_\_\_

6.6. Do you conduct at least some of your therapeutic work in the English language?

. . . YES . . . NO

## 7. ABOUT YOUR GENERAL EXPERIENCE OF DIFFICULTIES IN THERAPEUTIC PRACTICE.

<u>Currently, how often do you feel...?</u>		<u>[0= Never.....5= Very Often]</u>					
7-1.	Lacking in confidence that you can have a beneficial effect on a patient.	0	1	2	3	4	5
7-2.	Afraid that you are doing more harm than good in treating a patient.	0	1	2	3	4	5
7-3.	Unsure how best to deal effectively with a patient.	0	1	2	3	4	5
7-4.	In danger of losing control of the therapeutic situation to a patient.	0	1	2	3	4	5
7-5.	Unable to have much real empathy for a patient's experiences.	0	1	2	3	4	5
7-6.	Uneasy that your personal values make it difficult to maintain an appropriate attitude towards a patient.	0	1	2	3	4	5
7-7.	Distressed by your powerlessness to affect a patient's tragic life situation.	0	1	2	3	4	5
7-8.	Troubled by moral or ethical issues that have arisen in your work with a patient.	0	1	2	3	4	5
7-9.	Unable to generate sufficient momentum to move therapy with a patient in a constructive direction.	0	1	2	3	4	5
7-10.	Irritated with a patient who is actively blocking your efforts.	0	1	2	3	4	5
7-11.	Demoralized by your inability to find ways to help a patient.	0	1	2	3	4	5
7-12.	Guilty about having mishandled a critical situation with a patient.	0	1	2	3	4	5
7-13.	Unable to comprehend the essence of a patient's problems.	0	1	2	3	4	5
7-14.	Unable to withstand a patient's emotional neediness.	0	1	2	3	4	5
7-15.	Unable to find something to like or respect in a patient.	0	1	2	3	4	5
7-16.	Disturbed that circumstances in your personal life are interfering in your work with a patient.	0	1	2	3	4	5
7-17.	Angered by factors in a patient's life that make a beneficial outcome impossible.	0	1	2	3	4	5
7-18.	Conflicted about how to reconcile obligations to a patient and equivalent obligations to others.	0	1	2	3	4	5
7-19.	Bogged down with a patient in a relationship that seems to go nowhere.	0	1	2	3	4	5
7-20.	Frustrated with a patient for wasting your time.	0	1	2	3	4	5
7-21.	Something else that is difficult for you [specify]:_____	1	2	3	4	5	

## 8. ABOUT WAYS IN WHICH YOU USUALLY COPE WITH DIFFICULTIES IN THERAPEUTIC PRACTICE

When in difficulty, how often do you...?	[0= Never.....5= Very Often]					
8-22. Try to see the problem from a different perspective.	0	1	2	3	4	5
8-23. Attempt to contain your troublesome feelings.	0	1	2	3	4	5
8-24. Share your experience of the difficulty with your patient.	0	1	2	3	4	5
8-25. Discuss the problem with a colleague.	0	1	2	3	4	5
8-26. Consult relevant articles or books.	0	1	2	3	4	5
8-27. Involve another professional or agency in the case.	0	1	2	3	4	5
8-28. Seek some form of alternative satisfaction away from therapy	0	1	2	3	4	5
8-29. Set limits to hold a patient to an appropriate therapeutic frame	0	1	2	3	4	5
8-30. Step out of the therapist role in order to take some urgent action on a patient's behalf	0	1	2	3	4	5
8-31. Make changes in your therapeutic contract with a patient.	0	1	2	3	4	5
8-32. Simply hope that things will improve eventually.	0	1	2	3	4	5
8-33. Criticise a patient for causing you trouble.	0	1	2	3	4	5
8-34. Seriously consider terminating therapy.	0	1	2	3	4	5
8-35. Review privately with yourself how the problem has arisen	0	1	2	3	4	5
8-36. Just give yourself permission to experience difficult or disturbing feelings.	0	1	2	3	4	5
8-37. See whether you and your patient can together deal with the difficulty.	0	1	2	3	4	5
8-38. Consult about the case with a more experienced therapist.	0	1	2	3	4	5
8-39. Sign up for a conference or workshop that might bear on the problem.	0	1	2	3	4	5
8-40. Invite collaboration from a patient's friends or relatives.	0	1	2	3	4	5
8-41. Express your upset feelings to somebody close to you.	0	1	2	3	4	5
8-42. Offer an interpretation of your patient's resistant or troublesome behaviour.	0	1	2	3	4	5
8-43. Postpone the work of therapy so as to take care of a patient's more immediate needs.	0	1	2	3	4	5
8-44. Modify your therapeutic stance or approach with a patient	0	1	2	3	4	5
8-45. Avoid dealing with the problem for the present.	0	1	2	3	4	5
8-46. Show your frustration to the patient.	0	1	2	3	4	5
8-47. Explore the possibility of referring the patient on to another therapist.	0	1	2	3	4	5
8-48. Cope in some other way [specify]: _____	1	2	3	4	5	

## 9. ABOUT THIS QUESTIONNAIRE

9.1 Overall, I thought this questionnaire was

.. too short                      ... about the right length                      ... too long

9.2. Taken as a whole, I thought this questionnaire was

. . . easy . . . not too arduous . . . fairly laborious . . . difficult

### 9.3 Completing this questionnaire felt

. . . rewarding                  . . . neither a bonus  
   nor a burden                  . . . an imposition

9.4. Please feel free to comment below on any aspect of the questionnaire and of your experience of completing it. Your critical remarks and/or suggestions as to how it might be improved would be particularly welcome:



### **3. Appendix 3: TDQ1 Data Collection, Sample Letter and Reply Form**

Dear

You may recall that some time ago you took part in a survey concerning the difficulties which therapists experience in their practice and the ways in which they cope with such difficulties. Your contribution was much appreciated and helped to validate taxonomies of therapist difficulties and coping strategies. These have since been converted into questionnaire format and now form part of the 'Common Core Questionnaire' of an international collaborative study investigating the professional and personal development of psychotherapists.

As part of a doctoral research project which I am currently undertaking at the University of Warwick, I am further inquiring into the varieties of therapists' experiences of difficulties in their practice. Once more, I would like to enlist your help by asking you to fill in one of the attached questionnaires in confidence and to return it in the large envelope provided.

If you are able to help, I would much appreciate it if you would answer all sections of the questionnaire without any omissions, (incidentally, pages seven and eight consist of the scales which are based on your previous contribution). It does not matter whether you report the same difficulties as last time or whether you relate fresh accounts.

Further included in this mailing are a spare questionnaire and a response form.

If you know of a colleague who might also be interested in participating in this study, please pass the second questionnaire on to him or her.

If you would like to receive a report on the results of this part of the study (which I expect to be completed around the end of this year), please return the response form in the separate envelope provided (to preserve your anonymity).

The form also gives you the following additional options:

- a) to order further questionnaires in case you have more than one interested colleague;
- b) to indicate your willingness to be contacted at a later date in relation to the next stage of the study;
- c) to indicate your interest in the International Study on the Development of Psychotherapists and your willingness to receive further information on the Collaborative Research Network and a copy of the Common Core Questionnaire.

Thanking you in advance for your help and consideration,

Yours sincerely,

Thomas A. Schröder,  
Southern Derbyshire  
Mental Health Trust,  
Psychotherapy Dept.,  
Temple House,  
Mill Hill Lane,  
DERBY DE23 6SA

Please tick as appropriate:

\_\_\_\_\_ I would like to be sent a report on the results of this survey;

\_\_\_\_\_ I would like \_\_\_\_ further questionnaire(s);

\_\_\_\_\_ I would be willing to be contacted in the future in relation to the next stage of the study;

\_\_\_\_\_ I am interested in the International Study of the Development of Psychotherapists and the Collaborative Research Network which is organising the study. I would like further Information and a Common Core Questionnaire.

Name: .....

Address: (only if different from the one at which you received this correspondence)

.....  
.....  
.....  
.....

Telephone: .....

Fax: .....

e-mail: .....

#### 4. Appendix 4: TDQ1 Data Entry Manual

### DATA ENTRY MANUAL

#### ‘THERAPISTS’ EXPERIENCE OF DIFFICULTIES IN PRACTICE’ QUESTIONNAIRE

##### VARIABLE:

##### ENTRY CODES:

SERNUM

CONSECUTIVE NUMBERS 001..

SAMPLE

N(ETWORK) OR C(ONFERENCE)

P 1.1 PDIFFSIT )

)

P 1.2 PDIFFREA )

)

P 1.3 PDIFFCOP )

)

P 1.4 PDIFFRES )

0 = NO TEXT;          1 = TEXT

P 2.1 I\_IMPACT (1)

P 2.2 F\_NOVELT (1)

P 2.3 I\_IMPRES (1)

P 2.4 EXTRA (1)

P 2.5 I\_IMMERS (1)

P 2.6 F\_FREQUE (1)

P 2.7 I\_CONTEM (1)

P 2.8 I\_PREOCC (1)

P 2.9 F\_RECENC (1)

P 2.10 I\_CONTRO (1)

ENTER NUMBERS AS SCALED

P 2.11 F\_SURPRI (1)

P 2.12 I\_PENETR (1)

P 2.13 F\_UNIQUE (1)

P 2.14 I\_EFFORT (1)



P 2.15 I\_MINDFL (1)

P 2.16 F\_ANTICI (1)

P 2.17 I DISSOC (1)

P 2.18 F\_ACQUAI (1)

P 2.19 I\_SATURA (1)

P 2.20 F\_TYPICA (1)

P 2.21 I\_CONCER (1)

P 2.22 I\_EFFORT (2)

P 2.23 F\_TYPICA (2)

P 2.24 I\_SATURA (2)

P 2.25 F\_ACQUAI (2)

P 2.26 I DISSOC (2)

P 2.27 F\_ANTICI (2)

P 2.28 I\_MINDFL (2)

P 2.29 I\_CONCER (2)

P 2.30 F\_UNIQUE (2)

P 2.31 I\_PENETR (2)

P 2.32 F\_SURPRI (2)

ENTER NUMBERS AS SCALED

P 2.33 I\_CONTRO (2)

P 2.34 F\_RECENC (2)

P 2.35 I\_PREOCC (2)

P 2.36 I\_CONTEM (2)

P 2.37 F\_FREQUE (2)

P 2.38 I\_IMMERS (2)

P 2.39 EXTRA (2)

P 2.40 I\_IMPRES (2)

P 2.41 F\_NOVELT (2)

P 2.42 I\_IMPACT (2)

P 3.1 PDIFFOCC

NO OF SESSIONS: AS WRITTEN

P 3.2 PDIFFDUR

CONVERT INTO WEEKS

P 4.1 PTFREQ

1 = LESS THAN ONCE A FORTNIGHT

2 = FORTNIGHTLY

3 = WEEKLY

4 = MORE THAN ONCE A WEEK

P 4.2 PTFIRST

NO OF SESSIONS: AS WRITTEN

P 4.3. PTCONT

1 = YES;                      0 = NO

P 4.4. PTEXPECT

NO OF SESSIONS: AS WRITTEN

P 4.5. PDIFFSES

NO OF SESSIONS: AS WRITTEN

P 4.6 PTDUR

NO OF SESSIONS: AS WRITTEN

C 1.1 CDIFFSIT    )

)

C 1.2 CDIFFREA    )

)

C 1.3 CDIFFCOP    )

)

C 1.4 CDIFFRES    )

0 = NO TEXT;              1 = TEXT

C 2.1 I\_IMPACT (3)

C 2.2 F\_NOVELT (3)

C 2.3 I\_IMPRES (3)

C 2.4 EXTRA    (3)

C 2.5 I\_IMMERS (3)

ENTER NUMBERS AS SCALED

C 2.6 F\_FREQUE (3)

C 2.7 I\_CONTEM (3)

C 2.8 I\_PREOCC (3)

C 2.9 F\_RECENC (3)

C 2.10 I\_CONTRO (3)

C 2.11 F\_SURPRI (3)

C 2.12 I\_PENETR (3)

C 2.13 F\_UNIQUE (3)

C 2.14 I\_EFFORT (3)

C 2.15 I\_MINDFL (3)

C 2.16 F\_ANTICI (3)

C 2.17 I DISSOC (3)

C 2.18 F\_ACQUAI (3)

C 2.19 I\_SATURA (3)

C 2.20 F\_TYPICA (3)

C 2.21 I\_CONCER (3)

C 2.22 I\_EFFORT (4)

C 2.23 F\_TYPICA (4)

C 2.24 I\_SATURA (4)

ENTER NUMBERS AS SCALED

C 2.25 F\_ACQUAI (4)

C 2.26 I DISSOC (4)

C 2.27 F\_ANTICI (4)

C 2.28 I\_MINDFL (4)

C 2.29 I\_CONCER (4)

C 2.30 F\_UNIQUE (4)

C 2.31 I\_PENETR (4)

C 2.32 F\_SURPRI (4)

C 2.33 I\_CONTRO (4)

C 2.34 F\_RECENC (4)

C 2.35 I\_PREOCC (4)

C 2.36	I_CONTEM (4)	
C 2.37	F_FREQUE (4)	
C 2.38	I_IMMERS (4)	
C 2.39	EXTRA (4)	
C 2.40	I_IMPRES (4)	
C 2.41	F_NOVELT (4)	
C 2.42	I_IMPACT (4)	
C 3.1	CDIFFONG	1 = YES;                      2 = NO
C 3.2	CDIFFREC	NO OF SESSIONS: AS WRITTEN
C 3.3.	CDIFFDUR	CONVERT INTO WEEKS
C 3.4	CDIFFONS	CONVERT INTO WEEKS
C 3.5	CDIFFOCC	NO OF SESSIONS: AS WRITTEN
C 3.6.	CDIFFTOT	NO OF SESSIONS: AS WRITTEN
C 4.1	CTFREQ	1 = LESS THAN ONCE A FORTNIGHT 2 = FORTNIGHTLY 3 = WEEKLY 4 = MORE THAN ONCE A WEEK
C 4.2	CTFIRST	NO OF SESSIONS: AS WRITTEN
C 4.3.	CTCONT	1 = YES;                      0 = NO
C 4.4.	CTEXPECT	NO OF SESSIONS: AS WRITTEN
C 4.5.	CDIFFSES	NO OF SESSIONS: AS WRITTEN
C 4.6	CTDUR	NO OF SESSIONS: AS WRITTEN
5.1	CSEX ) ) PSEX )	0 = MALE;                      1 = FEMALE

5.2.	CAGE ) ) PAGE )	YEARS AS WRITTEN
5.3.	CDIST ) ) PDIST )	1 = MILD; 2 = MODERATE; 3 = SEVERE
6.1	TSEX	0 = MALE; 1 = FEMALE
6.2	TAGE	YEARS AS WRITTEN
6.3	PRACTICE	YEARS AS WRITTEN
6.4.	PSYCHOL ) ) PSYCHIAT ) ) PSYCHOTH ) ) COUNSELL ) ) NURSE ) ) OTHERPRO )	0 = UNCHECKED; 1 = CHECKED
6.5.	DYNAMIC ) ) BEHAV ) ) COGNIT ) ) HUMANIST ) ) SYSTEMIC ) ) OTHEROR )	0 = UNCHECKED; 1 = CHECKED
7.	DIFF (1) - (21)	AS SCALED
8.	COPE (1) - (27)	AS SCALED
9.1.	QLENGTH	1 = TOO SHORT 2 = ABOUT THE RIGHT LENGTH



3 = TOO LONG

9.2.        QEASE

1 = EASY    TO    4 = DIFFICULT

9.3.        QFEEL

1 = REWARDING

2 = NEITHER A BONUS...

3 = AN IMPOSITION

## 5. Appendix 5 - TDQ 1: Instructions and Materials for Raters

### **DIFFICULTY DEFINITIONS:**

#### **“TRANSIENT” Difficulties**

These are difficulties in which the situation encountered exposes deficiencies in the therapist’s knowledge, technical skills or experience. Though they may be troublesome, vexing, or irritating at the time of their occurrence, they are essentially impermanent in nature and are potentially capable of being remedied through further training and experience. They are likely to be found difficult by any therapist with similar levels of knowledge, technical skills, and experience. They do not reflect the enduring personal characteristics of particular therapists.

#### **“SITUATIONAL” Difficulties**

These are difficulties which are inherent in the situation encountered by the therapist. They would probably be experienced by most therapists encountering the situation regardless of their levels of knowledge, technical skills or experience. They are not reflective of the therapist’s enduring personal characteristics and though they may be attenuated, they cannot be eliminated through further training and experience.

#### **“PARADIGMATIC” Difficulties**

These are difficulties which arise out of the enduring characteristics of the therapist experiencing them. They may be coped with, accommodated to, or somewhat modified over time, but they are essentially stable in nature. They are idiosyncratic and may be attributed to the therapist’s internal conflicts, interpersonal style, or habitual ways of reacting. Their relatively unchanging character makes them typical of (sometimes even prototypical for) a particular therapist, and the situation that evokes them would not be expected to cause similar difficulties for therapists in general. It would require far-reaching personal change for the therapist to become free of such difficulties.

## **DIRECTIONS FOR RATERS:**

The material which you will be considering consists of therapists' descriptions of their experience of either **past** or **current**/very recent **difficulties** encountered in their practice of individual psychotherapy, given in response to the instructions and headings you have been supplied with. This is supplemented by information about the **sex**, years of **present practical experience**, and predominant **theoretical orientation(s)** of the therapist rendering the account.

(Please note that for *past difficulties* only information about the *current level of experience* as a therapist is supplied; information about experience at the time when the past difficulty occurred is not available.)

There is one narrative to every page. The layout and typography aims to reproduce the original account as closely as possible. The original headings are shown in brackets and italics. In the few cases where words in the original text were illegible, this is represented as {?} for each of the missing words.

**For each account please**

1. **Read the WHOLE narrative**,  
including the therapist's coping efforts and the eventual outcome of the situation.
2. **Rate the SALIENCE of the 'TRANSIENT', 'SITUATIONAL' and 'PARADIGMATIC' difficulty categories**  
for the account you are considering, using the definitions supplied to you  
(see below for points you may wish to take into consideration in making these decisions).

Record your judgement by ticking **one box for each category** on the following scale:

0
---

**not salient for this account**

There is no evidence in the account to suggest that this category would apply to the kind of difficulty encountered by the therapist. Furthermore, the situation described and/or other features of the therapist's account make it somewhat implausible for the difficulty to have come about in the way the category indicates.

---

1
---

**possibly salient for this account**

There is little or no direct evidence in the account to suggest that this category would apply to the kind of difficulty encountered by the therapist. However, the situation described and/or other features of the therapist's account make it quite plausible for the difficulty to have come about in the way the category describes.

---

2
---

**probably salient for this account**

There is clearly some direct evidence in the account to suggest that this category would apply to the kind of difficulty encountered by the therapist, and the situation described and/or other features of the therapist's account make it quite plausible for the difficulty to have come about in the way the category describes. However, the therapist's account is not sufficiently explicit or unequivocal to put the relevance of the category beyond doubt; salience has to be inferred rather than being self-evident.

---

3
---

**almost certainly salient for this account**

There is ample direct evidence in the account to demonstrate that this category applies to the kind of difficulty encountered by the therapist. The account is sufficiently explicit or unequivocal to put the relevance of the category beyond doubt; salience is manifest rather than implied.



3. **Decide which category you would choose if you had to assign the difficulty to just one of the three categories,**  
and tick the 'SINGLE CHOICE' box underneath the relevant scale.  
Do not tick more than one 'SINGLE CHOICE' box for each account!

**EXAMPLE:**

TRANSIENT		SITUATIONAL		PARADIGMATIC
0 ✓	not salient	0	not salient	0
1	possibly salient	1	possibly salient	1 ✓
2	probably salient	2 ✓	probably salient	2
3	almost certainly salient	3	almost certainly salient	3
⋮		⋮		⋮
<div style="border: 1px solid black; width: 40px; height: 40px; margin: 0 auto;"></div>	single choice	<div style="border: 1px solid black; width: 40px; height: 40px; margin: 0 auto; text-align: center;">✓</div>	single choice	<div style="border: 1px solid black; width: 40px; height: 40px; margin: 0 auto;"></div>

*Apart from the supplementary information about the therapist, you may want to take the following points into account to help you make the above decisions:*

- *The therapist's emotional reaction to the difficulty.*
- *The way in which the therapist coped with the difficulty.*
- *Whether the situation was resolved or not.*

*You may also want to ask yourself the following questions:*

- *Is this situation or the therapist's reaction to it within the range I would find reasonable or would have predicted?*
- *Would I expect the therapist to react similarly to a situation outside therapy?*
- *If the therapist possessed additional knowledge, technical skills, or experience, would he/she still find the situation difficult?*
- *How would another therapist react in this situation?*

4. **Please proceed to the next account**  
and repeat steps 1. to 3.



## **C1. A CURRENT DIFFICULTY:**

**Please think of a current or very recent situation which you have personally encountered in your practice of individual psychotherapy and which you found difficult.**

- C1.1 What did you or your patient (client) do which made the situation difficult?
- C1.2 What feelings or personal reactions did you experience in the situation?
- C1.3 How did you attempt to deal or cope with this difficulty?
- C1.4 How did this situation turn out?

(Please continue on the back of this page if necessary)

## **P1. A PAST DIFFICULTY:**

**Please think of a situation in your practice of individual psychotherapy which you have personally encountered some considerable time ago and which you found difficult.**

- P1.1 What did you or your patient (client) do which made the situation difficult?
- P1.2 What feelings or personal reactions did you experience in the situation?
- P1.3 How did you attempt to deal or cope with this difficulty?
- P1.4 How did the situation turn out?

(Please continue on the back of this page if necessary)

## **Directions for Raters:**

The material which you will be considering consists of therapists' descriptions of their experience of difficulties in their practice of individual psychotherapy, given in response to the headings you have been supplied with. There is one such narrative to a page. The layout and typography aims to reproduce the original account as closely as possible.

**For each account please**

1. **Read the WHOLE narrative**, including the therapist's coping efforts and the eventual outcome of the situation. **PLEASE DO NOT TURN THE PAGE OVER AT THIS STAGE!**
2. Having read the account, **try to form A MENTAL PICTURE** of the situation and of the therapist who is describing it;
3. **Rate the SALIENCE of the 'TRANSIENT', 'SITUATIONAL' and 'PARADIGMATIC' difficulty categories** for the account you are reviewing, using the definitions supplied to you (see below for points you may wish to take into consideration in making these decisions). Record your judgment by ticking one box for each category on the following scale:

0

**not salient for this account**

There is no evidence in the account to suggest that this category would apply to the kind of difficulty encountered by the therapist. Furthermore, the situation described and/or other features of the therapist's account make it somewhat implausible for the difficulty to have come about in the way the category indicates.

1

**possibly salient for this account**

There is little or no direct evidence in the account to suggest that this category would apply to the kind of difficulty encountered by the therapist. However, the situation described and/or other features of the therapist's account make it quite plausible for the difficulty to have come about in the way the category describes.

2

**probably salient for this account**

There is clearly some direct evidence in the account to suggest that this category would apply to the kind of difficulty encountered by the therapist, and the situation described and/or other features of the therapist's account make it quite plausible for the difficulty to have come about in the way the category describes. However, the therapist's account is not sufficiently explicit or unequivocal to put the relevance of the category beyond doubt; salience has to be inferred rather than being self-evident.

3

**almost certainly salient for this account**

There is ample direct evidence in the account to demonstrate that this category applies to the kind of difficulty encountered by the therapist. The account is sufficiently explicit or unequivocal to put the relevance of the category beyond doubt; salience is manifest rather than implied.



4. **Decide which category you would choose if you had to assign the difficulty to just one of the three categories,**  
and tick the 'SINGLE CHOICE' box underneath the relevant scale. Do not tick more than one 'SINGLE CHOICE' box for each account!

*Apart from the supplementary information about the therapist, you may want to take the following points into account to help you make the above decisions:*

- *The therapist's emotional reaction to the difficulty.*
- *The way in which the therapist coped with the difficulty.*
- *Whether the situation was resolved or not.*

*You may also want to ask yourself the following questions:*

- *Is this situation or the therapist's reaction to it within the range I would find reasonable or would have predicted?*
- *Would I expect the therapist to react in the same way to a similar situation outside therapy?*
- *If the therapist possessed additional knowledge, technical skills, or experience, would he/she still find the situation difficult?*
- *How would another therapist react in this situation?*

5. **Now record your impressions**

(ticking the boxes provided) of the sex, level of experience, and predominant theoretical orientation(s) of the therapist who has supplied the account. In most instances, this will be conjecture based on the mental image you have previously formed. What matters here is **not** that you 'get it right' in terms of the factual information available about the therapist, but rather that you try and capture the impressions evoked in you by the account of the difficulty.

6. **Please turn over the page now,**

and read the information about the actual sex, level of experience and predominant theoretical orientation(s) of the therapist who has supplied the account.

7. **Reconsider your ratings of the difficulty categories in the light of this information.**

If it causes you to change your salience ratings for any of the categories and/or your decision about the 'single choice' category, or both,  
**please record your new judgments using the scales provided, otherwise re-enter your previous judgments.**

8. Please proceed to the next account and repeat steps 1. - 7.

- 1. In the first year of my clinical training, one of the first 2 or 3 patients I saw in therapy presented in our first session with the admission that, just several days prior to our initial meeting, she had sliced the palms of her hands with a broken bottle during a weekend-long alcoholic binge. In addition, she acknowledged continued suicidal ideation & possible plans in this regard.
- 2. Considerable concern, fear for the patient's well-being, questions regarding my competence to deal with this issue, an inner sense of mobilisation to rescue her safety, and some anger at the patient, I think, for disturbing the fantasy of myself as a burgeoning 'healer'.
- 3. I discussed the patient with my clinical supervisor, kept in close contact with the supervisor in terms of both the internal & external demands of the case, and I also talked about my response to this patient in personal therapy.
- 4. I secured a referral for the patient at an alcohol-treatment centre, where she would also be seen in psychotherapy. Although I wanted to continue seeing the patient, the patient, was deemed unsuitable for the clinic, as it did not offer 24 hour contact.

**SEX**

<input type="checkbox"/>	Male
<input type="checkbox"/>	Female

(tick one box only)

**EXPERIENCE**

<input type="checkbox"/>	less than 6 years
<input type="checkbox"/>	6 - 12 years
<input type="checkbox"/>	more than 12 years

(tick one box only)

**ORIENTATION(S)**

<input type="checkbox"/>	Psychodynamic
<input type="checkbox"/>	Behavioural
<input type="checkbox"/>	Cognitive
<input type="checkbox"/>	Humanistic
<input type="checkbox"/>	Systemic

(tick as many boxes as apply)

**TRANSIENT**

<input type="checkbox"/> 0	not salient
<input type="checkbox"/> 1	possibly salient
<input type="checkbox"/> 2	probably salient
<input type="checkbox"/> 3	almost certainly salient
...	
<input type="checkbox"/>	single choice

**SITUATIONAL**

<input type="checkbox"/> 0	not salient
<input type="checkbox"/> 1	possibly salient
<input type="checkbox"/> 2	probably salient
<input type="checkbox"/> 3	almost certainly salient
...	
<input type="checkbox"/>	single choice

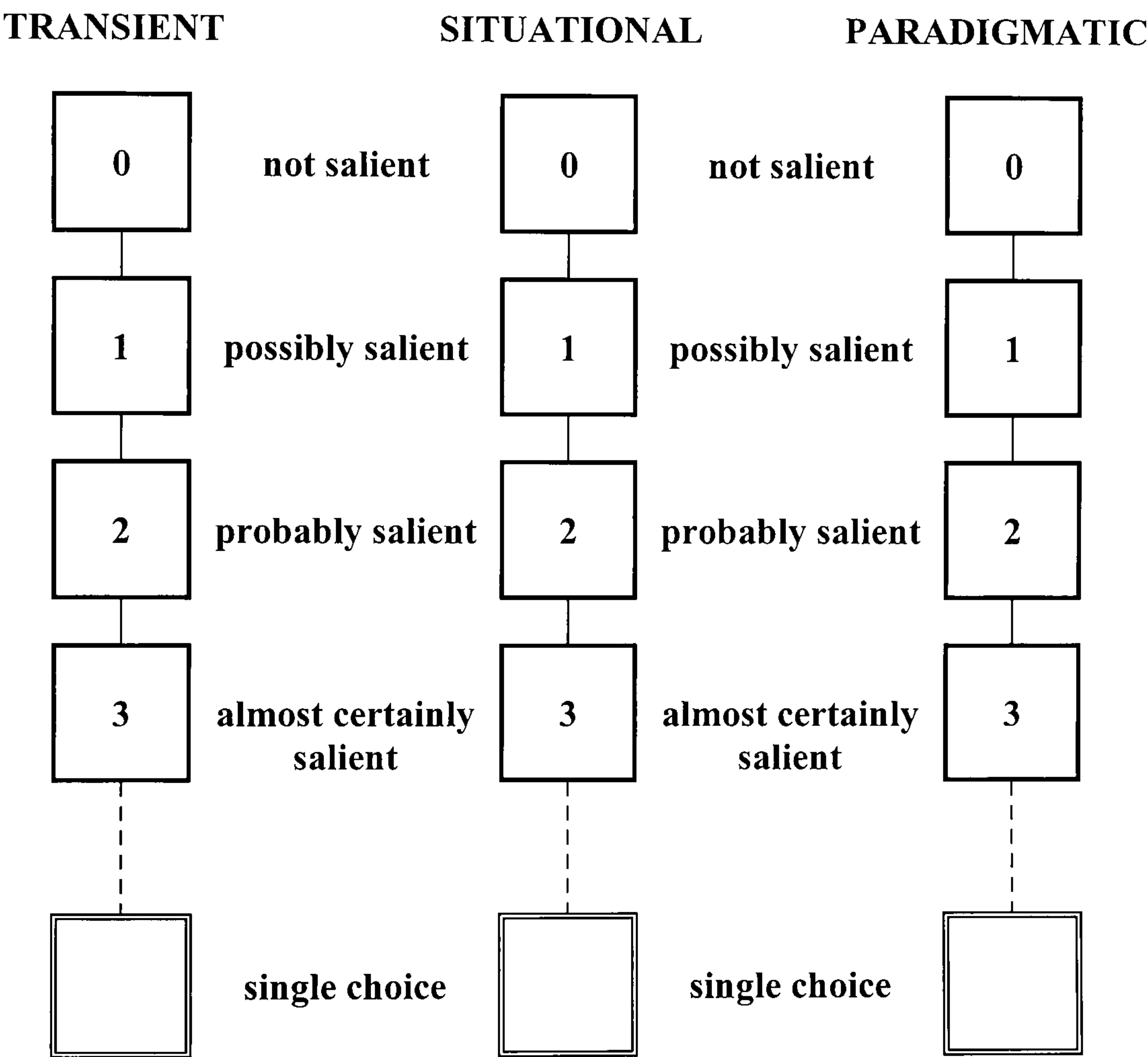
**PARADIGMATIC**

<input type="checkbox"/> 0
<input type="checkbox"/> 1
<input type="checkbox"/> 2
<input type="checkbox"/> 3
...
<input type="checkbox"/>



BACK OF PAGE:

**Female Therapist                      8 Years Experience                      Psychodynamic Orientation**



## 6. Appendix 6: Rating Booklet 1 - TDQ1

Cover Page

### **THERAPISTS' EXPERIENCE OF DIFFICULTIES** **IN THEIR PRACTICE**

Dear Colleague,

Thank you for agreeing to help with this inquiry into the kind of difficulties which therapists encounter in the course of their work. Further on in this booklet you will find a number of accounts by therapists describing their experience of difficulties in their practice of individual psychotherapy, supplemented by self-reported information about the therapist's sex, current level of experience, and theoretical orientation. In relation to each of these accounts you will be asked to

- **judge** how well each account fits the categories of 'TRANSIENT', 'SITUATIONAL' or 'PARADIGMATIC' difficulties on the basis of the **definitions** supplied,
- **record** your judgements using the scales provided, and
- **decide** which of the salient categories is the **most representative** for each particular account.

Together with this booklet you should have received

1. a sheet with **difficulty definitions**,
2. two pages of **rating directions**,
3. a sheet with the **instructions** and **headings** under which the difficulty accounts were elicited.

**Please read the 'Difficulty Definitions' and the 'Directions for Raters'**  
**before you start reading the accounts!**

This booklet may take some time to work through. There is no need to complete it all in one go. You may work through a part of it and come back to it at a later time at your convenience.

**Please make sure that you do not leave out any accounts.**

When you have completed the task, please return all the materials.

\*\*\*\*\*

It would also be helpful to have the following information about yourself:

Your sex.....M / F (Please circle as appropriate)

Years of experience as a psychotherapist since finishing your training: ..... Years

Years of experience as a supervisor of psychotherapists: ..... Years

Your theoretical orientation as you would describe it: .....

.....

**THANK YOU FOR YOUR HELP!**

1.

[What did you or your patient (client) do which made the situation difficult?]

A client I was assessing developed a rapid idealised transference; I thought that she suffered from severe narcissistic personality disorder and that exploratory therapy would do more harm than good. I wanted to conduct a careful assessment over a number of sessions, but simultaneously felt that seeing her repeatedly was tantalizing.
2.

[What feelings or personal reactions did you experience in the situation?]

- sadness at the tragedy of this woman's history

- despair + impotence in facing the limits of what therapy, my chosen profession in which I have invested a lot, can do.

- quite intense fear - paranoia - about what this client might do to me, faced with being told she was not going to be offered therapy.

- fear that she might kill herself. Guilt.

- hatred and anger - feeling exploited + dumped on (by client + referral agent).
3.

[How did you attempt to deal or cope with this difficulty?]

Spent lots of time thinking about our interactions, trying to understand the countertransference - in particular the projective identification + my `readiness' to identify with what was being projected.

Talked to my supervisor

Talked to colleagues.

Monitored myself closely in our meetings, being exceptionally careful for signs of acting out on my part.

Liaised with G.P. and psychiatric services.
4.

[How did this situation turn out?]

I urged the G.P. to refer to a therapeutic community and was told it was too costly. I then tried to set up `holding' through a Psychological Therapies Unit local to the client, offering support and supervision to the nurse therapist there, with the suggestion of monthly support meetings with the client - to no avail.

The client repeatedly phoned + wrote to me, threatening suicide. I wrote back sympathetically but firmly. She ended up hating me and I felt we'd been through a re-enactment, in which I was powerless to do anything different to disrupt the pattern of her relationships.

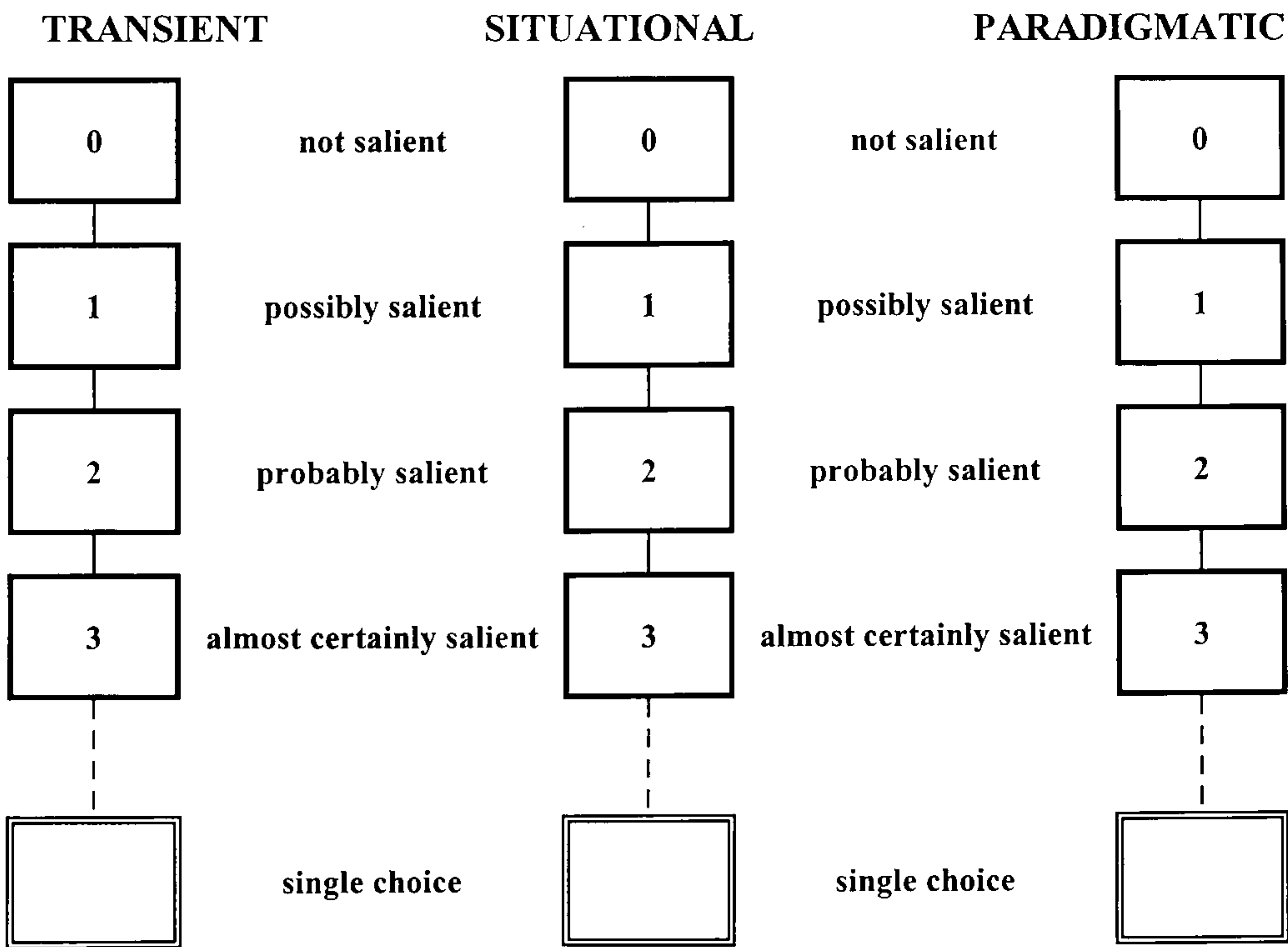
Eventually she stopped contact. I felt drained and frustrated, with her and with psychiatric provision in general for clients with severe personality disorder.

Some months later, doubtless as a coping strategy, I used my experience by using the case mentioned extensively in a conference presentation on `Sadomasochistic Phenomena in Psychotherapy'.

Female Therapist

18 Years Experience NOW

Psychodynamic Orientation





1.

[What did you or your patient (client) do which made the situation difficult?]

Male patient, appearance and manner - aggressive. Referred for anger management - he did not accept this as a problem and some weeks after starting psychotherapy admitted severe sexual "deviations".

In addition, prior testing on an MMPI had shown clear psychotic tendencies.
2.

[What feelings or personal reactions did you experience in the situation?]

As a female therapist I felt very anxious (?fear) about being in the situation, heightened by the fact it was in a distant part of a clinic where there were no individuals anywhere near. Also the room I was using was a Dr's clinic room with a couch. I also felt angry that the GP who referred this man, (and knew of his problems) did not mention these in the referral letter.
3.

[How did you attempt to deal or cope with this difficulty?]

1. Used different room for next session with intercom to reception desk.

2. Borrowed personal attack alarm.

3. Arranged for a colleague to be present next door.

4. Discussed situation with manager and another colleague (CPN) who knew patient - both advised me not to continue seeing patient for my own safety.

4.

[How did this situation turn out?]

As advised by my manager I referred this patient on to someone with more specialist knowledge in a secure unit. This was done with a reasonably full explanation to the client and he appeared happy for this to happen.
- Female Therapist      6 Years Experience NOW      Behavioural/CognitiveOrientation
- | TRANSIENT    |                          | SITUATIONAL  |                          | PARADIGMATIC |
|--------------|--------------------------|--------------|--------------------------|--------------|
| <div>0</div> | not salient              | <div>0</div> | not salient              | <div>0</div> |
| <div>1</div> | possibly salient         | <div>1</div> | possibly salient         | <div>1</div> |
| <div>2</div> | probably salient         | <div>2</div> | probably salient         | <div>2</div> |
| <div>3</div> | almost certainly salient | <div>3</div> | almost certainly salient | <div>3</div> |
| <div></div>  | single choice            | <div></div>  | single choice            | <div></div>  |
- 46



1.

[What did you or your patient (client) do which made the situation difficult?]

• I saw an anorexic patient when I ran an out-patient clinic in a Health Centre as a Clinical Psychologist. I felt at a loss as to what to do with my body in the session - was very aware of being scrutinised for any physical movement - felt very much as though I had my ‘back against the wall’ in terms of the unconscious pressure in the session.

• Repeatedly after leaving her session having not spoken throughout, my patient would either overdose or cut her wrists.

• This was clearly a tricky situation for an inexperienced psychologist, receiving no supervision, seeing a patient once a week for six months!

2.

[What feelings or personal reactions did you experience in the situation?]

• Helplessness. Guilt. Ignorance. Frustration.

• Eventually a lot more anger in terms of her repeated wrist-slashings straight after a silent session.

• Out of my depth.

• Very aware of my inexperience. Isolated.

3.

[How did you attempt to deal or cope with this difficulty?]

• After a pattern emerged, I paid for a one off supervision with an experienced analytic psychotherapist.

• This made me aware of how the patient projected her own feelings of paralysis and being out of control into me, and also my failure to take up the degree of hostility and rage in terms of her own self hatred and her hatred toward me in her cutting/overdosing after the session.

4.

[How did this situation turn out?]

I learnt an enormous amount about the importance of the setting and my not having to omnipotently sort out the most impossible difficulties in a clearly inadequate situation i.e. to be in treatment with me as a very inexperienced, unsupervised worker, once a week for such a short period of time I realised was not helpful, when the degree of psychic pain and disturbance in this woman required a far higher degree of containment. At the end of our six month contract, following on supervision, she went into a specialised therapeutic community with hospital backup.

Female Therapist. *Difficulty occurred seven years ago. No other information available.*

TRANSIENT		SITUATIONAL		PARADIGMATIC	
<div>0</div>	not salient	<div>0</div>	not salient	<div>0</div>	
<div>1</div>	possibly salient	<div>1</div>	possibly salient	<div>1</div>	
<div>2</div>	probably salient	<div>2</div>	probably salient	<div>2</div>	
<div>3</div>	almost certainly salient	<div>3</div>	almost certainly salient	<div>3</div>	
<div></div>		<div></div>		<div></div>	
<div></div>	single choice	<div></div>	single choice	<div></div>	

47

1.

[What did you or your patient (client) do which made the situation difficult?]

Kept failing to attend appointments, would cancel at last minute, or say she forgot, or phone after the event.

Would request/need/have/'demand' further appointments.
2.

[What feelings or personal reactions did you experience in the situation?]

Anger

Frustration

detachment/disengagement    withdrawal from client.
3.

[How did you attempt to deal or cope with this difficulty?]

Tried to address issues when client finally did attend

tried to get at what underlay issue.
4.

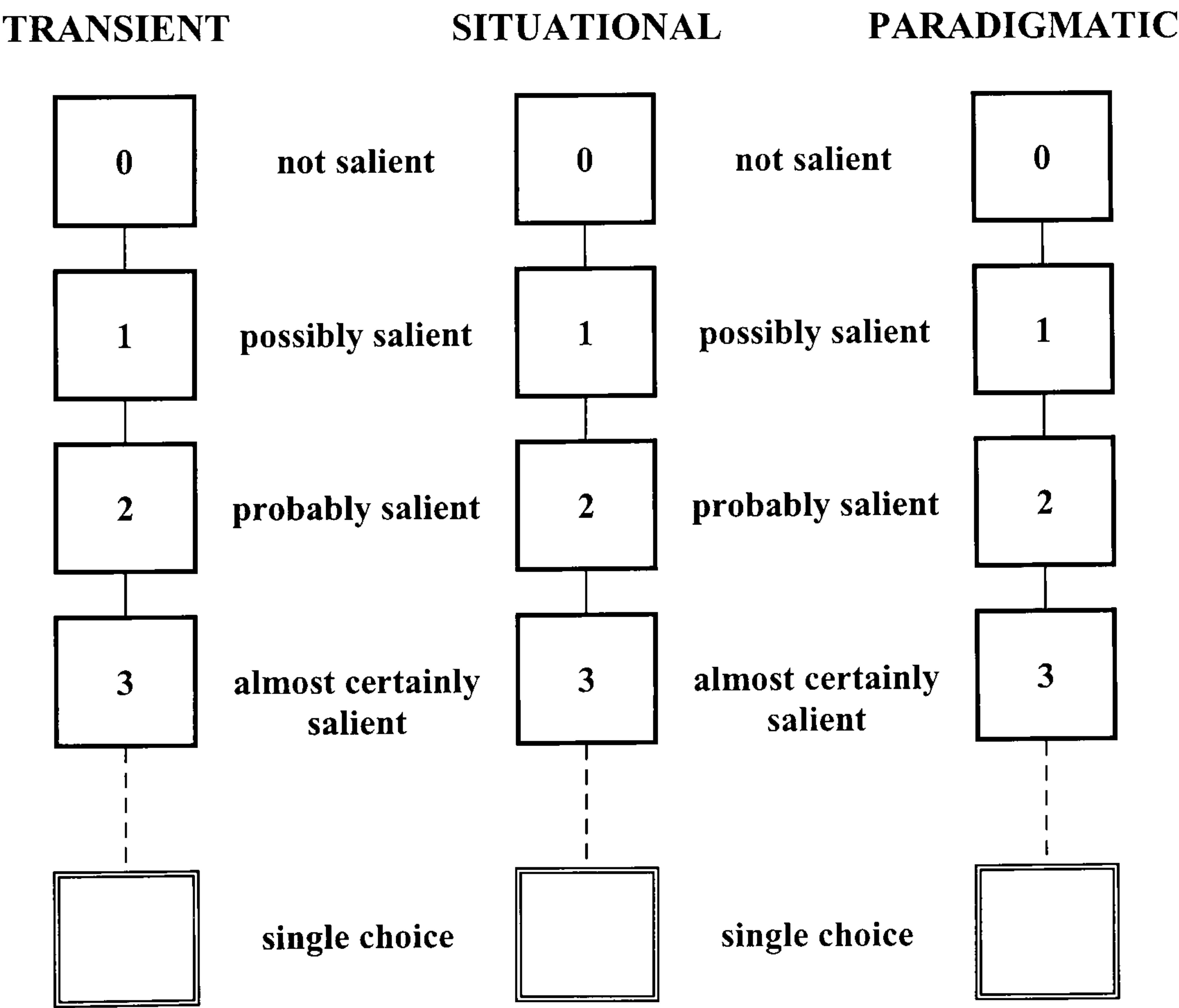
[How did this situation turn out?]

Client continued pattern, yesterday left a telephone message saying she was not coming any more.

No explanation - I will write inviting her to write and outlining importance of endings etc.

I will also send a summary to Dr. of my best view of situation.

Female Therapist    8 Years Experience    Psychodynamic/Cognitive/Behavioural Orientation



1.

*[What did you or your patient (client) do which made the situation difficult?]*

**An unscheduled break was taken due to circumstances outside of the sessions.**
2.

*[What feelings or personal reactions did you experience in the situation?]*

**Felt powerless, unable to take any form of action.**  
**Unable to make any decision.**
3.

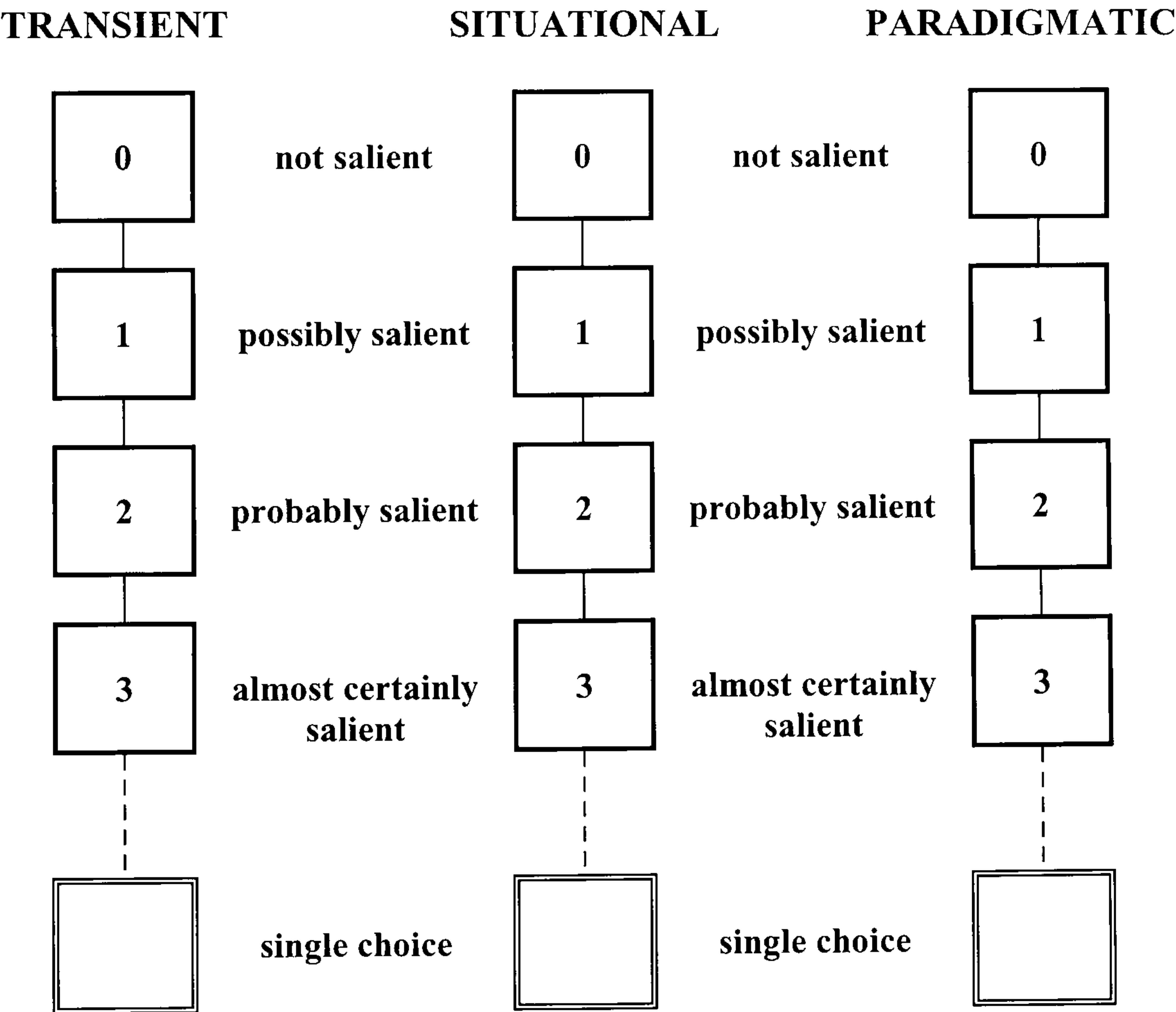
*[How did you attempt to deal or cope with this difficulty?]*

**Discussed this with my supervisor. Information given as situation resolved itself.**
4.

*[How did this situation turn out?]*

**Relationship improved through having the break. Client able to make changes in the situation.**

Male Therapist     7 Years Experience     Psychodynamic Orientation



**Please pause for a moment to consider whether up to this point**

- **you have experienced any problems in the task**
- **you have come across any ambiguities or contradictions in the rating directions**
- **you have any queries relating to the task**

**If so, please do not proceed with the ratings just now, but refer your queries to me either in person, or by contacting me at one of the addresses or numbers given below.**

**If you do not have any queries, please carry on with the ratings.**

**Thomas A. Schröder,  
Psychotherapy Department,  
Temple House,  
Mill Hill Lane,  
DERBY DE23 6 SA**

**Tel.:           01332 364 512**

**Fax:           01332 293 316**

**e-mail:       psrah@csv.warwick.ac.uk**



# **PAST DIFFICULTIES**

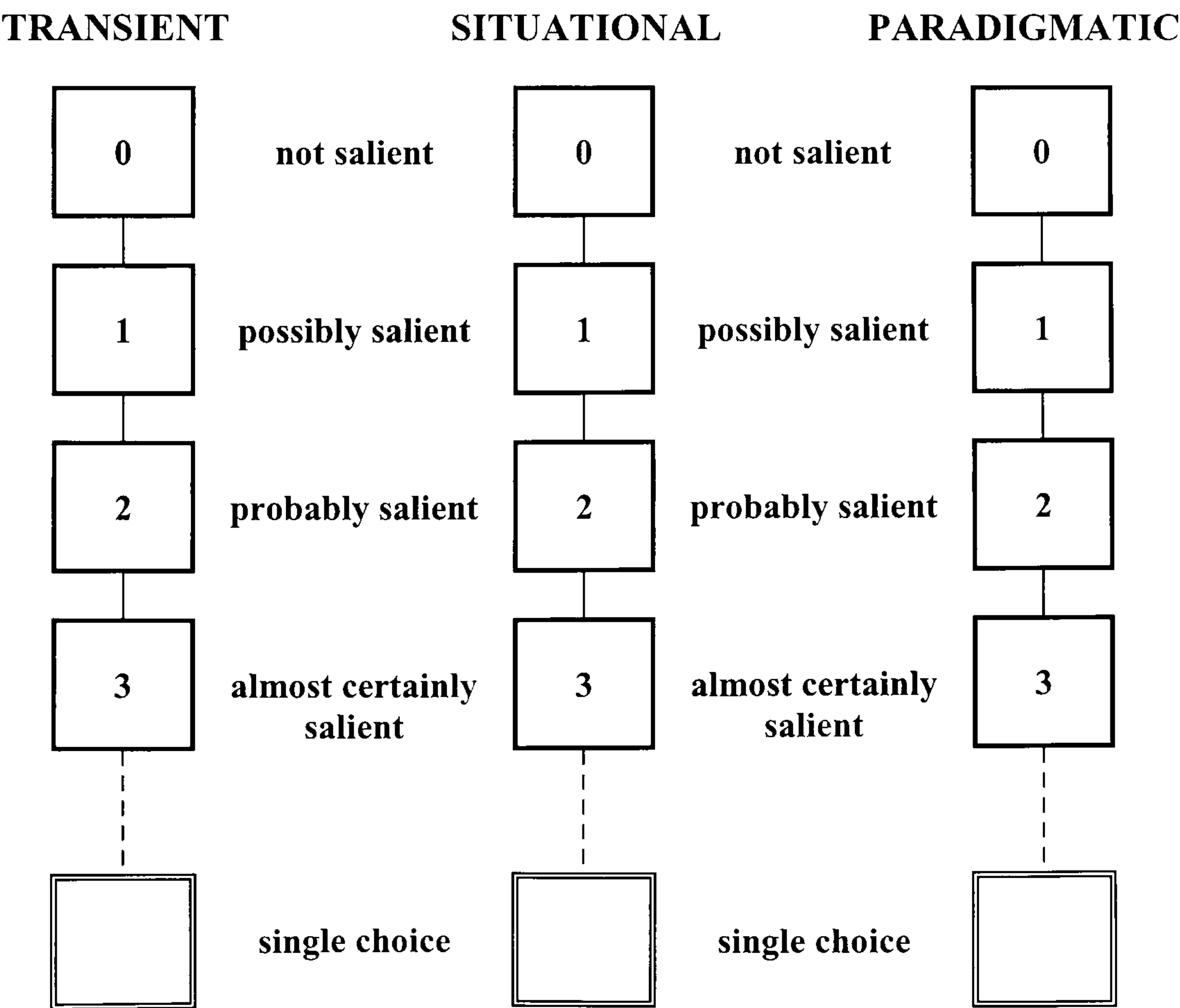
**All the accounts in the following batch relate to difficulties experienced by the therapist in the past.**

**They have been elicited according to the instructions and headings supplied to you on a separate sheet.**

**The self-report information about the therapist's years of experience as a therapist, and theoretical orientation(s) applies to the time when the account was written.**

1. *[What did you or your patient (client) do which made the situation difficult?]*  
Patient arrived at reception, requesting to be seen.  
Unannounced arrival  
Appeared to receptionist as "desperate", upset, crying
2. *[What feelings or personal reactions did you experience in the situation?]*  
angry (as it was anticipated)  
overwhelmed + afraid (suicidal intent)
3. *[How did you attempt to deal or cope with this difficulty?]*  
Offered 5 mins to determine how felt need  
to attend today, establish contact  
& arrange appropriate next action
4. *[How did this situation turn out?]*  
Positively. Pt accessed strengths within self  
to leave & cope with following days.  
Able to use situation to learn more about  
therapeutic reln. (Dependency)

Female Therapist      5Years Experience NOW   Cognitive Analytic Orientation



THE BOOKLET AS SUPPLIED TO RATERS CONTAINED A FURTHER 25 PAST ACCOUNTS WHICH HAVE NOT BEEN INCLUDED HERE. THE LAST OF THE BATCH IS REPRODUCED BELOW:

54

PAST Difficulty

119

1.
- [What did you or your patient (client) do which made the situation difficult?]*

Patient (female)expressed that she felt personally attracted by me (male).
2.
- [What feelings or personal reactions did you experience in the situation?]*

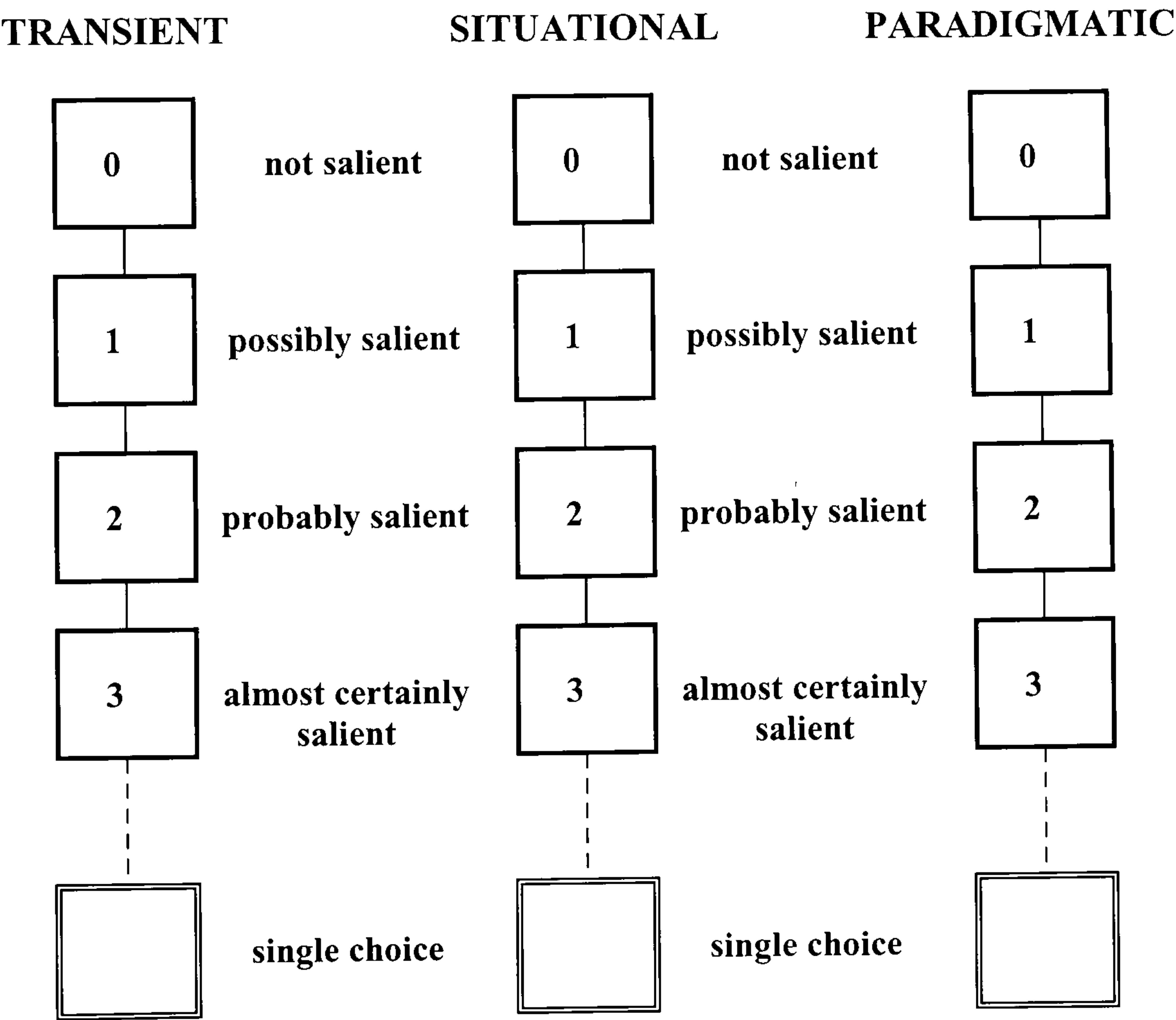
"No troubles please"

plus: I know what I professionally have to do (interpret the affection etc.), yet at the same time even if it can be used productively,  
I feel somewhat dissatisfied with such situations, because although I know better it still keeps the flavour of not taking a patient seriously on a personal level.
3.
- [How did you attempt to deal or cope with this difficulty?]*

By talking with the patient about my perceptions, establishing a shared view.
4.
- [How did this situation turn out?]*

Next session the patient reported the next day she had read an article in a newspaper about sex between therapists and patients which made clear to her how terrible it would have been if I had given in to such wishes.

Male Therapist    17 Years Experience NOW    Behavioural/Cognitive Orientation



# **CURRENT DIFFICULTIES**

**All the accounts in the following batch relate to difficulties experienced currently or very recently by the therapist.**

**They have been elicited according to the instructions and headings supplied to you on a separate sheet.**

**The self-report information about the therapist's years of experience as a therapist, and theoretical orientation(s) may be taken as applying at the time when the difficulty occurred.**



1.

[What did you or your patient (client) do which made the situation difficult?]

got angry with me in a denigrating way  
& in a persistent way
2.

[What feelings or personal reactions did you experience in the situation?]

trapped & powerless  
because I couldn't do anything right
3.

[How did you attempt to deal or cope with this difficulty?]

confronted patient with the unhelpful way  
he was trying to sort this out  
tried to understand what he was cross about  
tried to put right the complaints unsuccessfully!
4.

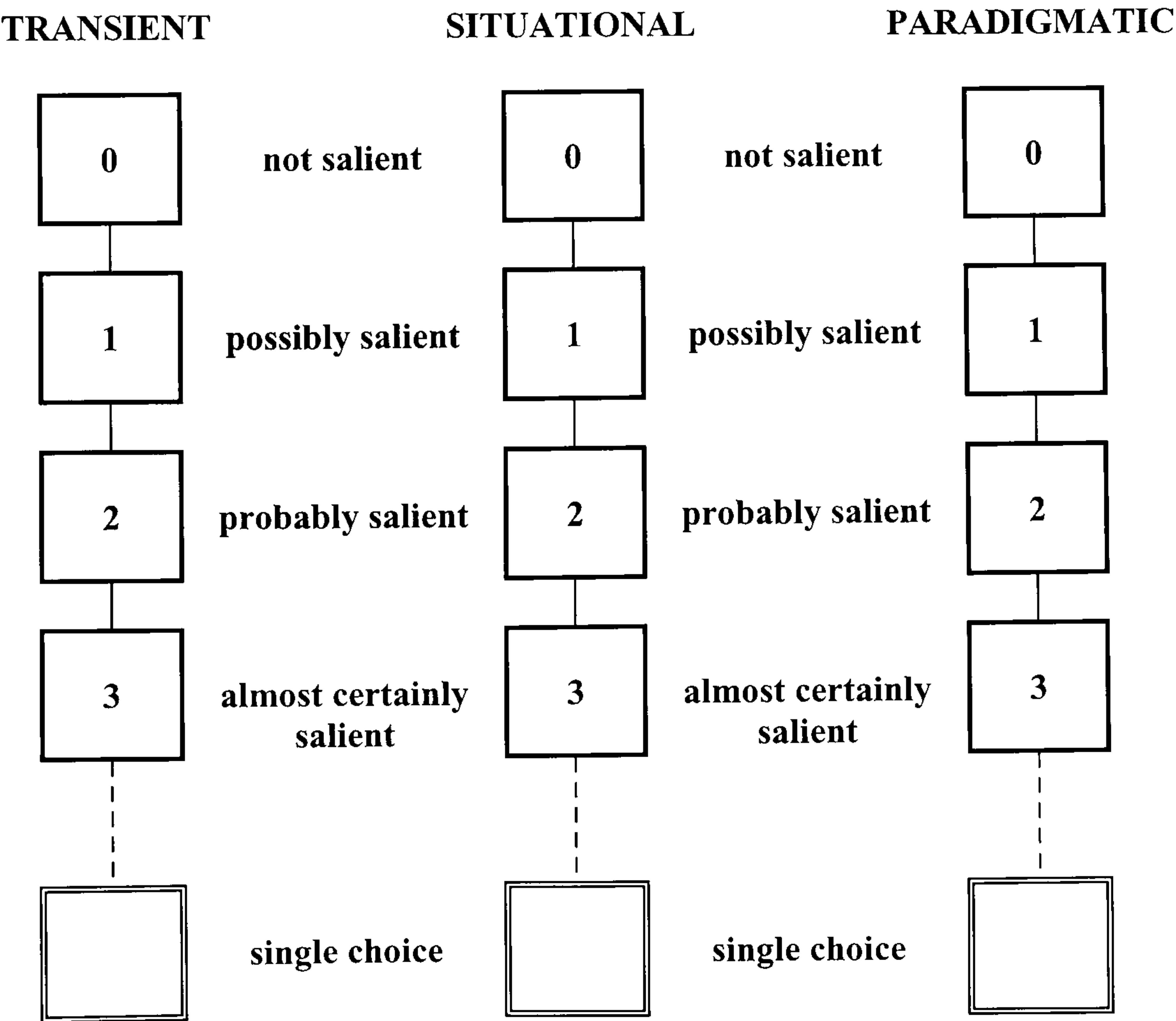
[How did this situation turn out?]

patient stayed in therapy  
continues to be angry. I got better at  
coping with the anger

Female Therapist

12 Years Experience

Dynamic Orientation



THE BOOKLET AS SUPPLIED TO RATERS CONTAINED A FURTHER 24 CURRENT ACCOUNTS WHICH HAVE NOT BEEN INCLUDED HERE. THE LAST OF THE BATCH IS REPRODUCED BELOW:

53

CURRENT (or very recent) Difficulty

208

1.

*[What did you or your patient (client) do which made the situation difficult?]*

I could find no way after a while of helping the client get in touch with the underlying issues that drove his anxiety (anger at dead father and mother). The client resisted and therapy became completely blocked.
2.

*[What feelings or personal reactions did you experience in the situation?]*

Helplessness; confusion; an urge to change models; wondering if I wasn't up to it; Found myself talking intellectually rather than emotionally (projected into me by the client, perhaps, as his defence against pain)? I felt upset and let down as well as feeling that I'd let him down in some way.
3.

*[How did you attempt to deal or cope with this difficulty?]*

I interpreted it - that he seemed to be in fear of discussing such issues; found myself wondering if another would help - it didn't! Struggled within myself about whether therapy should end or "maybe just one more session....."!
4.

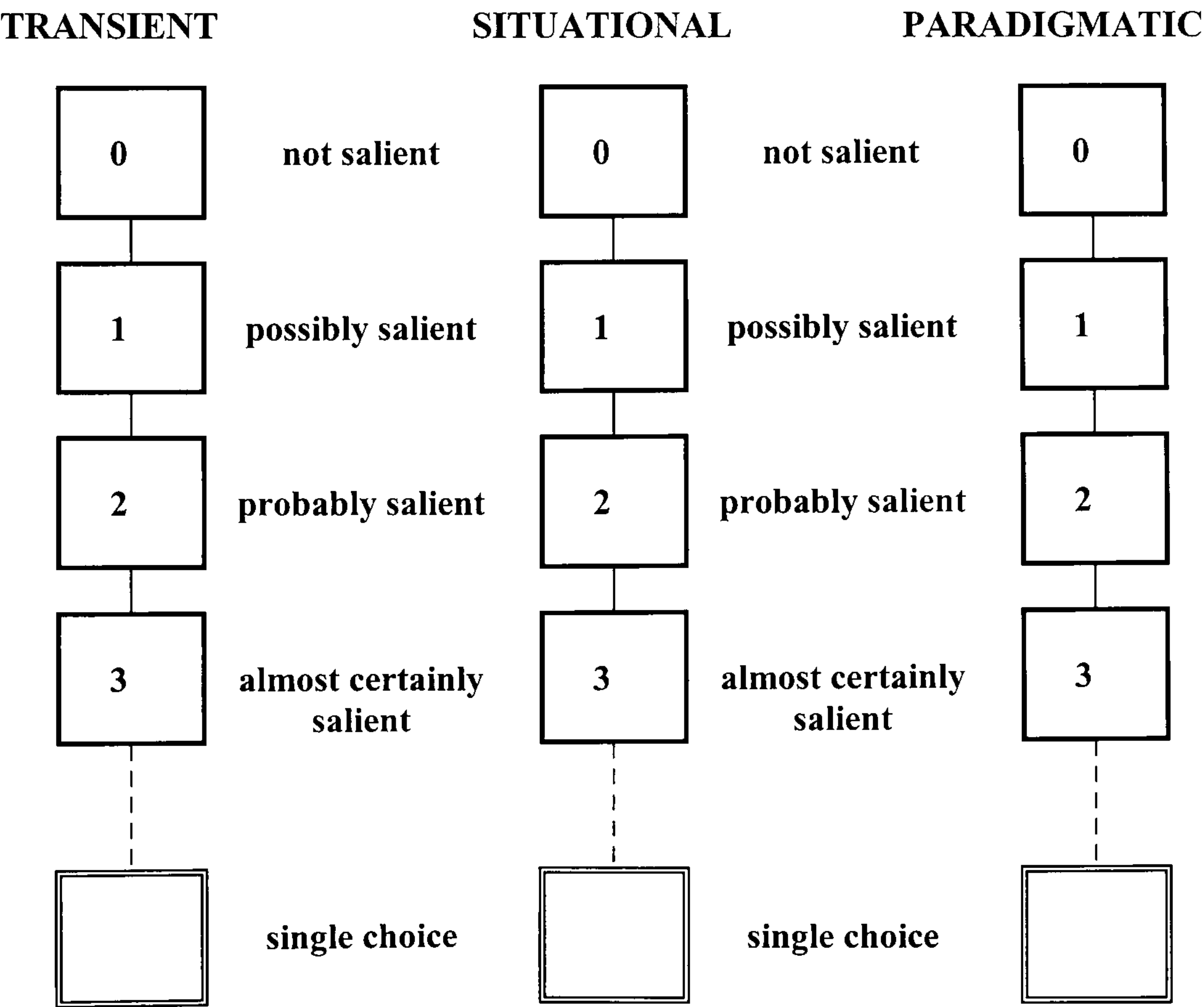
*[How did this situation turn out?]*

I brought up after a few weeks the issue of whether or not the client was benefiting from, or able to work in, therapy. He asked my opinion and I said I didn't think he was or would benefit from therapy and that we might consider ending it. The client became angry and refused to stay to discuss this issue or return another time to do so. He left saying "well I suppose I'll just have to live like this for the rest of my life".

Female Therapist

4 Years Experience

Psychodynamic Orientation



## 7.7 Appendix 7: Rating Booklet 2 - TDQ1

### COVER PAGE

# **THERAPISTS' EXPERIENCE OF DIFFICULTIES IN THEIR PRACTICE**

Dear Colleague,

Thank you for agreeing to help with the second part of this inquiry. In this booklet you will again find a number of accounts by therapists describing their experience of difficulties in their practice of individual psychotherapy, but this time **initially without** supplementary information about the therapist. Your task in relation to each of these accounts is similar but more complex than in the first part. This time you are asked to

- **judge** again how well each account fits the categories of 'TRANSIENT', 'SITUATIONAL' or 'PARADIGMATIC' Difficulties on the basis of the definitions supplied,
- **record**, as before, your judgments using the scales provided,
- **decide** again which of the salient categories is the **most representative** for each particular account,  
**for PAST difficulties only:**

- **take note of** the actual information about the therapist, and
- **record** your ratings again, taking this additional information into account.

#### **for CURRENT difficulties only:**

- **record** your understanding or conjecture as to the therapist's sex, experience, and
- theoretical orientation,
- **compare** your intuition with actual information about the therapist, and
- **record** your ratings again, taking comparison into account.

Together with this booklet you should have

1. a sheet with **difficulty definitions**
2. a sheet with the **headings** under which the difficulty accounts were elicited
3. two pages with **rating directions**

**Please remind yourself of the 'Difficulty Definitions' and read the new 'Directions for Raters' before you start reading the accounts!**

This booklet may take some time to work through. There is no need to complete it all in one go. You may work through a part of it and come back to it at a later time at your convenience.

**Please make sure that you do not leave out any accounts.**

When you have completed the task, please return all the materials.

## **THANK YOU FOR YOUR HELP!**



# **PAST DIFFICULTIES**

**All the accounts in the following batch relate to difficulties experienced by the therapist in the past.**

**They have been elicited according to the instructions and headings supplied to you on a separate sheet.**

**The self-report information about the therapist's years of experience as a therapist, and theoretical orientation(s) applies to the time when the account was written.**

**Please remember to rate each account before you have read the supplementary information. Then turn the page over and rate the account again in the light of the supplementary information.**



1.

[What did you or your patient (client) do which made the situation difficult?]

Seek additional psychotherapy from a second therapist
2.

[What feelings or personal reactions did you experience in the situation?]

feelings of failure

+ feelings of anger
3.

[How did you attempt to deal or cope with this difficulty?]

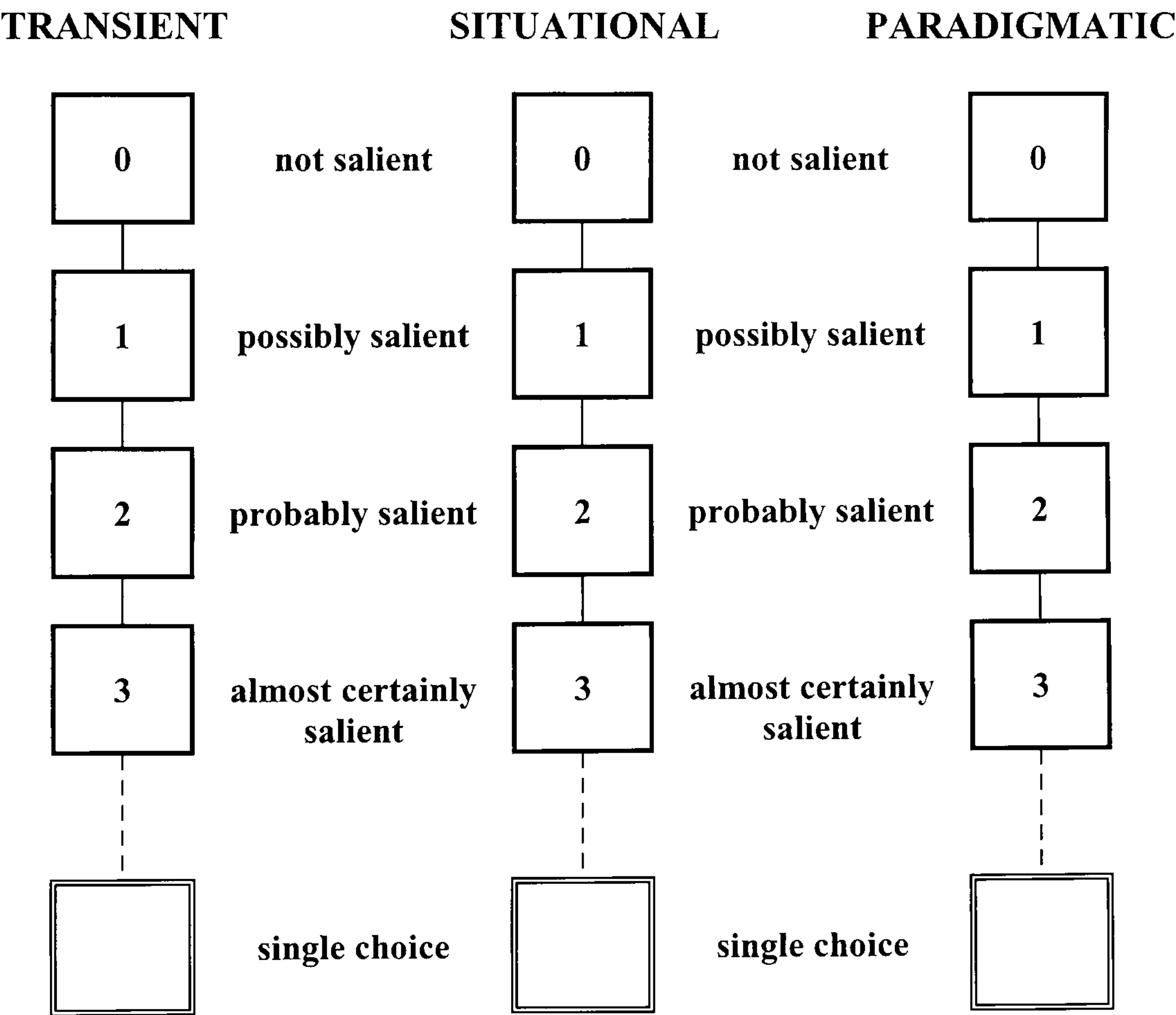
seek advice from supervisor.

understand the psychodynamics
4.

[How did this situation turn out?]

patient stayed in therapy with me.

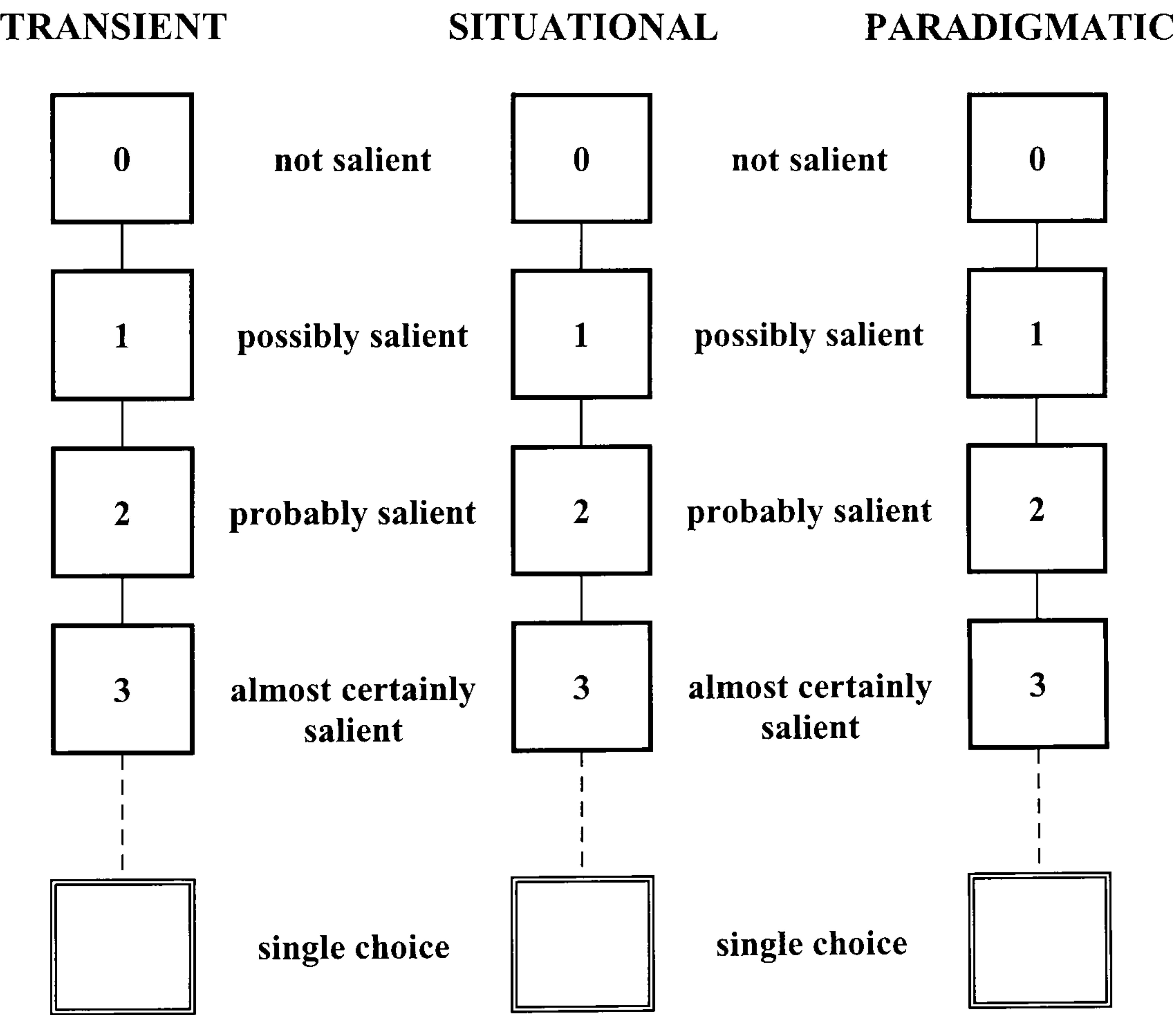
continues to have occasional additional consultation with other therapist



Back Page:

01

Female Therapist      12 Years Experience NOW      Psychodynamic Orientation



THE BOOKLET AS SUPPLIED TO RATERS CONTAINED A FURTHER 25 PAST ACCOUNTS WHICH HAVE NOT BEEN INCLUDED HERE. THE LAST OF THE BATCH IS REPRODUCED BELOW:

1.

*[What did you or your patient (client) do which made the situation difficult?]*

He projected very abusive feelings into me.
2.

*[What feelings or personal reactions did you experience in the situation?]*

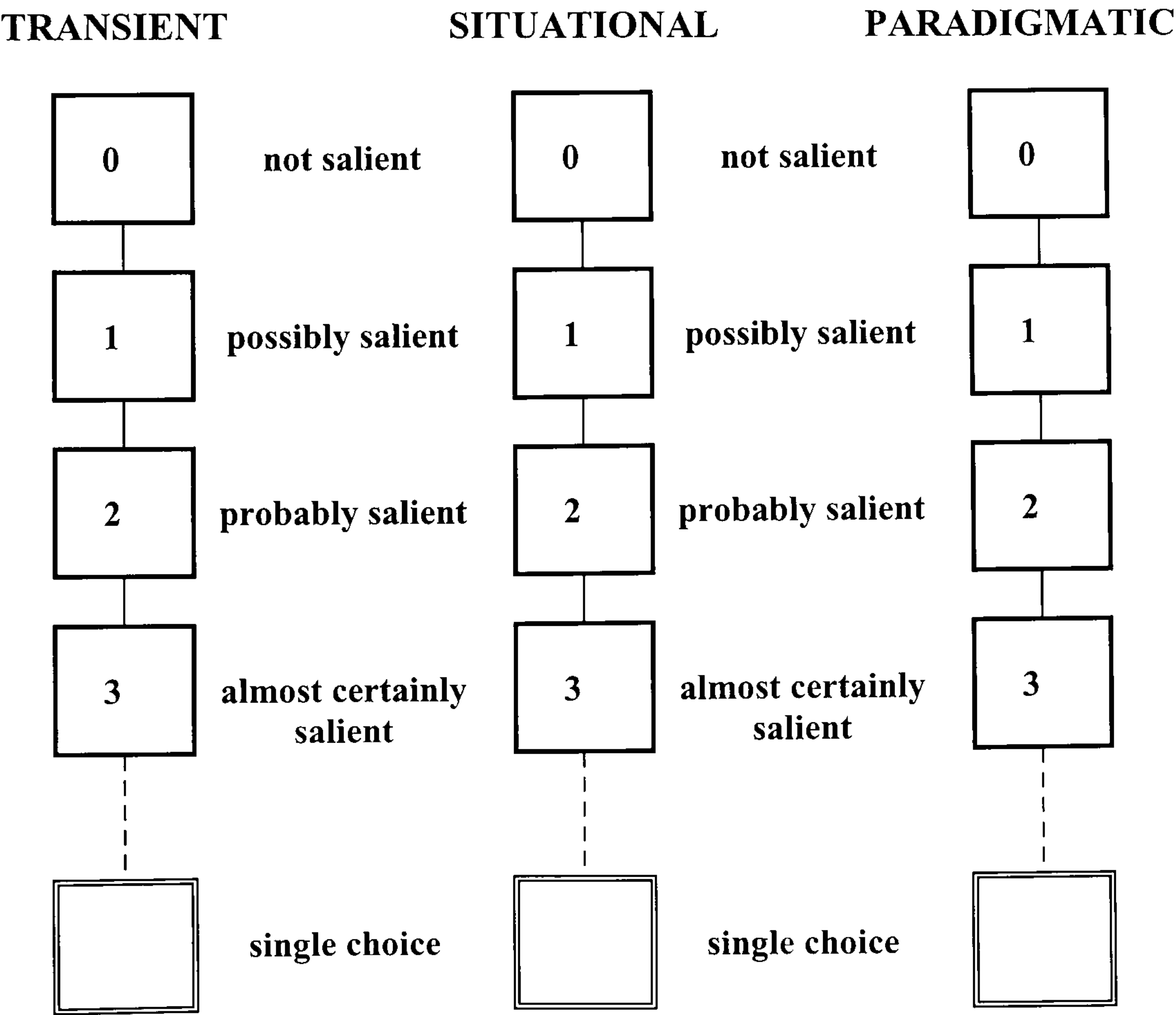
I carried him around with me - he sat on my shoulder in the bath, he inhibited me from making love, he kept me awake at night, he breached my boundaries.
3.

*[How did you attempt to deal or cope with this difficulty?]*

I shared my difficulties with both my supervision group and individual supervisor: interpreted his need to make me feel as bad as he had as a child when he had been sexually abused.
4.

*[How did this situation turn out?]*

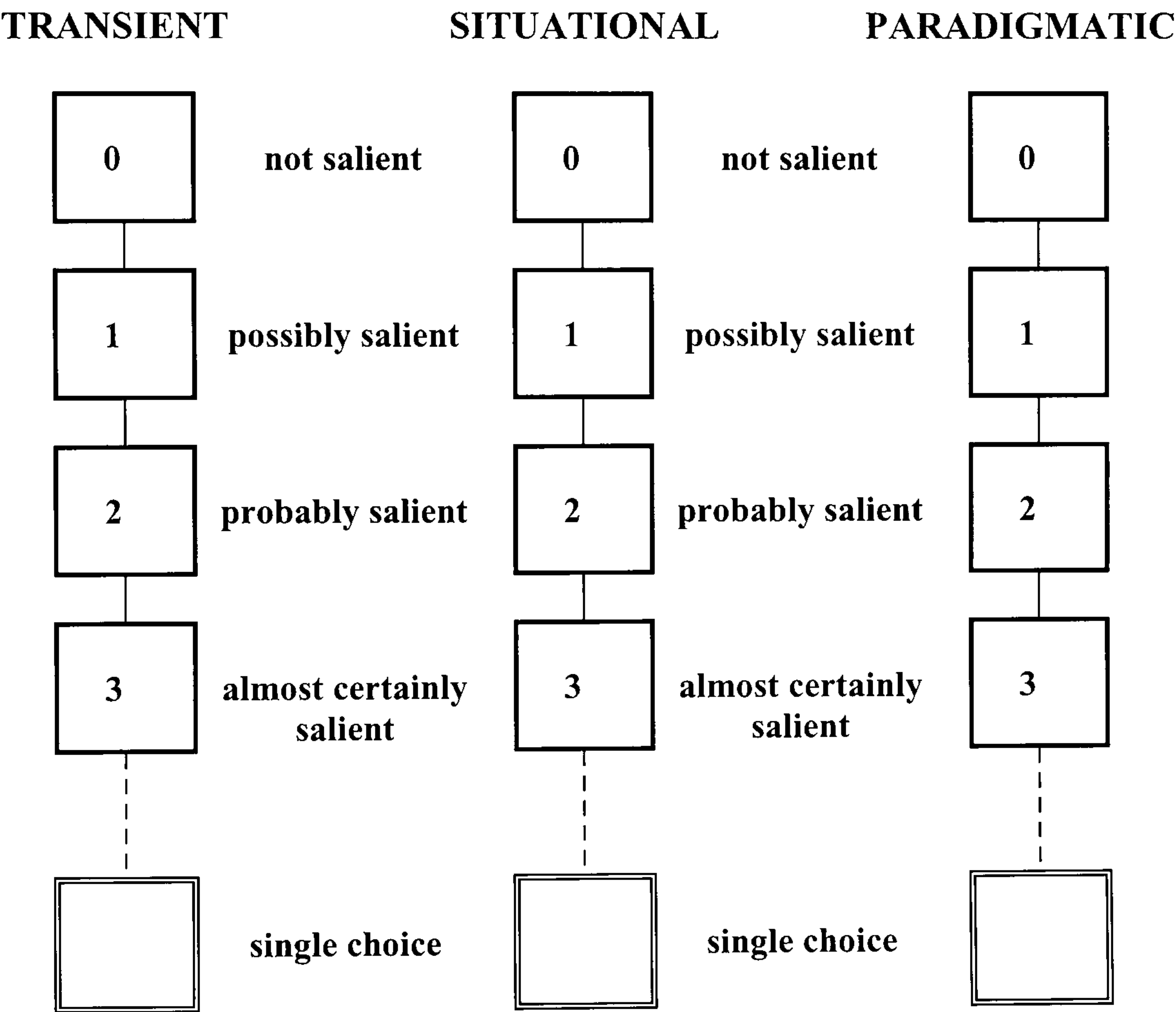
He regarded this as a turning point in his therapy and from then on was able to show vulnerability and work with his child parts, and through this 2 metaphorical characters emerged which we worked with. He's now in litigation.



Back Page:

55

Female Therapist    6 Years Experience NOW    Psychodynamic Orientation





# **CURRENT DIFFICULTIES**

**All the accounts in the following batch relate to difficulties experienced currently or very recently by the therapist.**

**They have been elicited according to the instructions and headings supplied to you on a separate sheet.**

**The self-report information about the therapist's years of experience as a therapist, and theoretical orientation(s) may be taken as applying at the time when the difficulty occurred.**

**Please remember to rate each account after you have recorded your guesses about the therapist's sex, experience and theoretical orientation(s).**

**Then turn the page over and rate the account again in the light of the actual information.**

1.

*[What did you or your patient (client) do which made the situation difficult?]*

**Patient lied about failing to attend the previous session, telling me that they were abroad when cancelled session on phone. In subsequent session, she told me she had been away in the UK.**
2.

*[What feelings or personal reactions did you experience in the situation?]*

**Irritation & surprise that she needed to lie about where she was**
3.

*[How did you attempt to deal or cope with this difficulty?]*

**Gave opportunities in way her non-attendance was explored for her to "come clean"**
4.

*[How did this situation turn out?]*

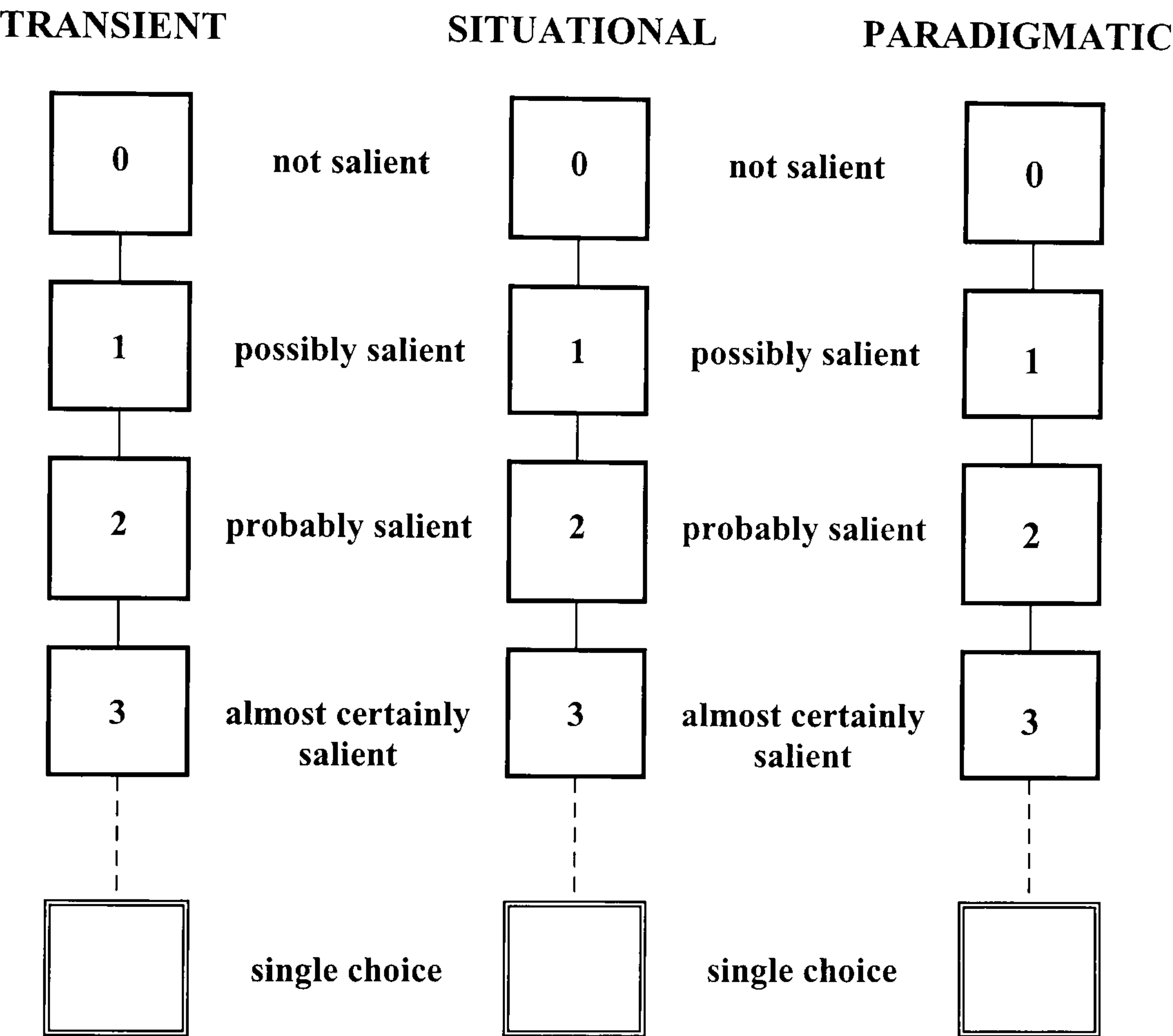
**She maintained "lie" & I envisaged confronting her more directly next session - which she failed to attend**

SEX	EXPERIENCE	ORIENTATION(S)
<div><div></div> Male</div> <div><div></div> Female</div>	<div><div></div> less than 6 years</div> <div><div></div> 6 - 12 years</div> <div><div></div> more than 12 years</div>	<div><div></div> Psychodynamic</div> <div><div></div> Behavioural</div> <div><div></div> Cognitive</div> <div><div></div> Humanistic</div> <div><div></div> Systemic</div>
(tick one box only)	(tick one box only)	(tick as many boxes as apply)
TRANSIENT	SITUATIONAL	PARADIGMATIC
<div><div>0</div><div>1</div><div>2</div><div>3</div><div></div></div> <div><div>not salient</div><div>possibly salient</div><div>probably salient</div><div>almost certainly salient</div><div>single choice</div></div>	<div><div>0</div><div>1</div><div>2</div><div>3</div><div></div></div> <div><div>not salient</div><div>possibly salient</div><div>probably salient</div><div>almost certainly salient</div><div>single choice</div></div>	<div><div>0</div><div>1</div><div>2</div><div>3</div><div></div></div> <div><div>not salient</div><div>possibly salient</div><div>probably salient</div><div>almost certainly salient</div><div>single choice</div></div>

**Back Page:**

**02**

**Female Therapist      5 Years Experience      Cognitive Analytic Orientation**



**THE BOOKLET AS SUPPLIED TO RATERS  
CONTAINED A FURTHER 24 CURRENT ACCOUNTS  
WHICH HAVE NOT BEEN INCLUDED HERE.**



## 8. Appendix 8 - Therapist Difficulties Questionnaire, Version 2

### 8.1. TDQ2, English-Language Version

#### **THERAPISTS' EXPERIENCE OF DIFFICULTIES IN PRACTICE**

Thank you for embarking on completing this questionnaire. It is substantial and you may come to think at some point that it is too long - I, too thought at one point that it was too long. However, it is sizeable for a good reason: therapists' experiences are complex and have many facets. They can neither be reduced to a single dimension nor captured by a single mode of enquiry. So I am asking you to bear with this enquiry in the knowledge that none of the questions have been included lightly, and that many aspects that would have been interesting, but not crucial, have been left out.

One point which may help with the task is that it does not have to be completed in a single session. You will notice that the questionnaire has four sections marked by different colours. It is quite feasible to complete one section at a time and come back to the rest of the questionnaire at another time. If you do this, please make sure that you do not move to and fro between sections and that you complete them in the order in which you find them in your questionnaire.

At the end of each of the first two sections you will find some pages marked 'optional'. They contain questions which are also important to the enquiry, without being indispensable. If you should find yourself short of time or energy, I would rather that you skip these pages than not return the questionnaire at all.

In each of the first two sections you are asked to recall a situation from your own therapeutic practice; one with a patient/client whom you generally experienced as 'difficult', and one with a patient/client whom you overall experienced as 'not so difficult'. For this task it will be helpful if you take a moment to visualise the situation, to recall it in some detail and to try and get back into the frame of mind you were in at the time, focusing on your feelings and experiences. Many people who have engaged in this exercise in the past have reported becoming quite absorbed in the process and reexperiencing the situation vividly. The questions will give you a chance to reflect on your experience, but it may also be important to deliberately 'disengage' from the situation when you come to the end of a section, especially if you plan to go straight on to the next section. Some people find it helpful to do this by a cognitive task (such as counting backwards from 100 in steps of seven), others by focusing on an image which is connected with a pleasant feeling. You may have your own preferred way of doing this.

Finally, I do hope that completing this questionnaire will be an interesting experience and that you will learn from it at least as much as I hope to!

Thank you again for your help!

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### **A DIFFICULTY WITH A 'NOT SO DIFFICULT' PATIENT:**

**Please call to mind a situation which you have personally encountered in your practice of individual psychotherapy which you found difficult, but which involved a patient whom generally you found 'not so difficult'.**

**Please write an account of that difficulty in the space provided below. It is important that you write things down as they come to mind. Please report the difficulty in some detail and try not to censor your account.**

**It would be helpful if your account included**

- **what you or your patient/client did which made the situation difficult,**
- **what feelings or personal reactions you experienced,**
- **how you attempted to deal or cope with the difficulty,**
- **how the situation turned out**

**together with any other aspects which you remember.**

**(Please continue on the back of this page)**

### **A DIFFICULTY WITH A 'DIFFICULT' PATIENT:**

**Please call to mind a situation which you have personally encountered in your practice of individual psychotherapy which you found difficult, and which involved a patient whom you generally found 'difficult'.**

**Please write an account of that difficulty in the space provided below. It is important that you write things down as they come to mind. Please report the difficulty in some detail and try not to censor your account.**

**It would be helpful if your account included**

- **what you or your patient/client did which made the situation difficult,**
- **what feelings or personal reactions you experienced,**
- **how you attempted to deal or cope with the difficulty,**
- **how the situation turned out**

**together with any other aspects which you remember.**

**(Please continue on the back of this page)**

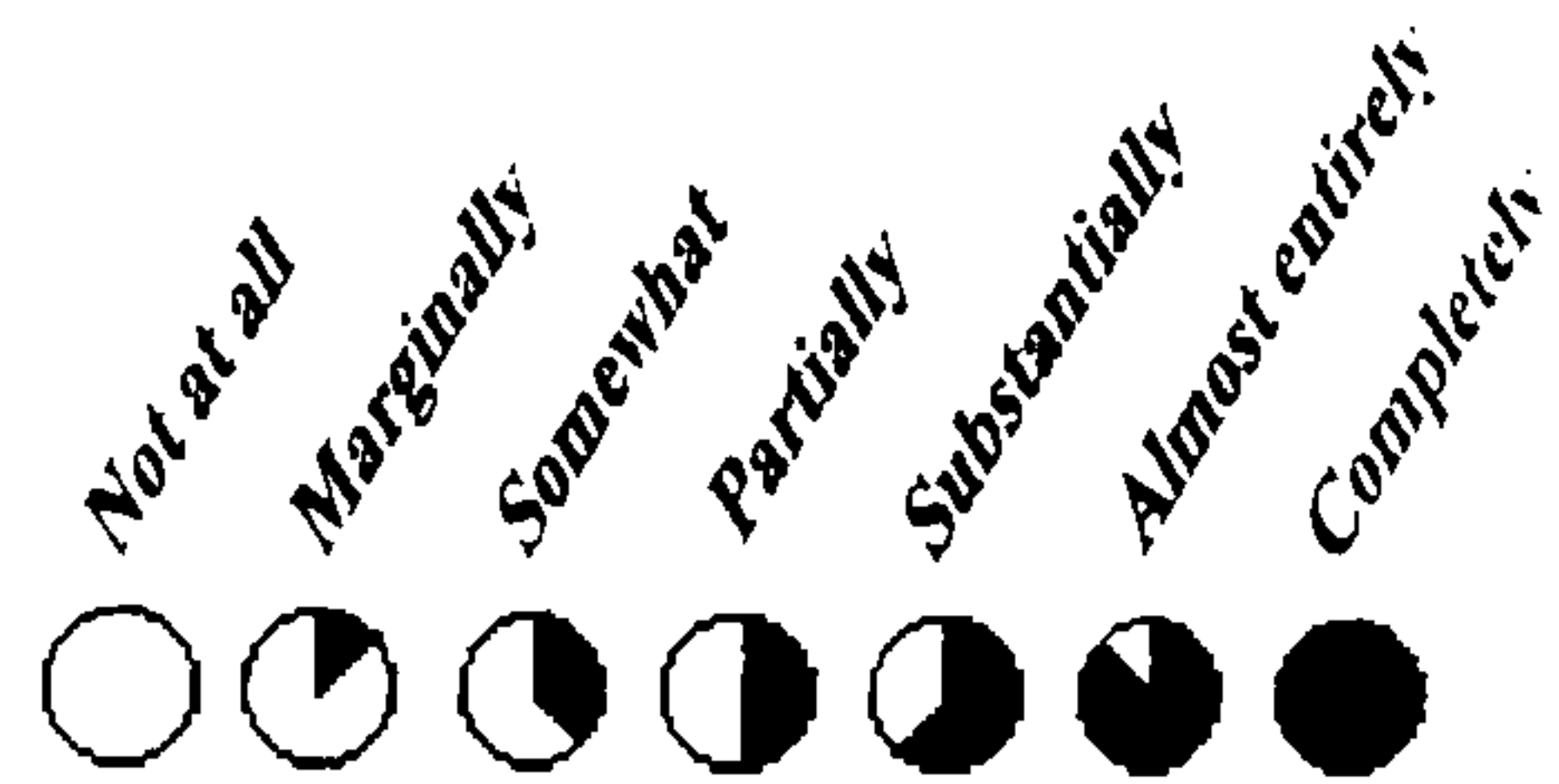
## ABOUT YOUR EXPERIENCE OF THE DIFFICULTY

To what degree do the following statements concur with  
your experience of the difficulty you have described?

Please circle one number for each statement:

0 = Not at all	4 = Substantially
1 = Marginally	5 = Almost entirely
2 = Somewhat	6 = Completely
3 = Partially	

**This statement captures my experience:**



1. I was emotionally affected by this difficulty.	0	1	2	3	4	5	6
2. Difficulties of this nature were new to me.	0	1	2	3	4	5	6
3. I experienced this difficulty as 'going to the core' of me.	0	1	2	3	4	5	6
4. This difficulty unfolded quickly.	0	1	2	3	4	5	6
5. I had experienced this sort of difficulty time and again.	0	1	2	3	4	5	6
6. This difficulty gave me pause for thought.	0	1	2	3	4	5	6
7. This difficulty seemed to last an eternity.	0	1	2	3	4	5	6
8. I had been acquainted with this sort of difficulty for a long time.	0	1	2	3	4	5	6
9. This difficulty really 'got inside' me.	0	1	2	3	4	5	6
10. This was an unusual difficulty for me.	0	1	2	3	4	5	6
11. This felt like a long drawn out difficulty.	0	1	2	3	4	5	6
12. I found this difficulty easy to deal with.	0	1	2	3	4	5	6
13. I knew about difficulties of this kind through previous experience.	0	1	2	3	4	5	6
14. Grappling with this difficulty was a struggle.	0	1	2	3	4	5	6
15. I was not personally conversant with this type of difficulty.	0	1	2	3	4	5	6
16. I could not let go of this difficulty.	0	1	2	3	4	5	6
17. This felt like a brief difficulty.	0	1	2	3	4	5	6
18. I felt concerned about this difficulty.	0	1	2	3	4	5	6
19. I was used to this kind of difficulty.	0	1	2	3	4	5	6
20. Time seemed to stand still during this difficulty.	0	1	2	3	4	5	6
21. It was then only recently that I had first met this kind of difficulty.	0	1	2	3	4	5	6
22. I was preoccupied by this difficulty outside the therapy sessions.	0	1	2	3	4	5	6
23. This was virtually the first time that I had encountered a difficulty of this type.	0	1	2	3	4	5	6
24. I was engrossed by this difficulty.	0	1	2	3	4	5	6
25. This difficulty seemed to be over in an instant.	0	1	2	3	4	5	6
26. This kind of difficulty was well-known to me.	0	1	2	3	4	5	6

27. How long ago was the onset of the difficulty? .....Years .....Months

28. How long did the difficulty last altogether? ..... Weeks .....Months  
or

29. Is the difficulty still ongoing? (Please tick) ..... Yes .....No

30. How useful would the possession of each of the following have been in preventing you from experiencing the situation as difficult?  
(Please circle one number for each item)

[ 0 = Not at all ..... 5 = Very ]

a) More extensive theoretical knowledge	0	1	2	3	4	5
b) A broader repertoire of technical skills	0	1	2	3	4	5
c) A wider range of practical experience	0	1	2	3	4	5
d) Something else (please describe)	0	1	2	3	4	5

31. How helpful would each of the following have been in equipping you to deal with the difficult situation?  
(Please circle one number for each item)

[ 0 = Not at all ..... 5 = Very ]

a) Getting formal supervision or consultation	0	1	2	3	4	5
b) Reading relevant literature	0	1	2	3	4	5
c) Attending workshops or seminars	0	1	2	3	4	5
d) Being familiar with a wider range of clients	0	1	2	3	4	5
e) Something else (please describe)	0	1	2	3	4	5

32. (Please circle one number)

[ 0 = Not at all ..... 5 = Very ]

How **difficult** would another therapist, of a theoretical orientation and a level of experience similar to yours, have found the situation?

0 1 2 3 4 5

33. (Please circle one number)

[ 0 = Never ..... 5 = Very often]

How **often** have you experienced a difficulty of this kind in a situation outside therapy (that is in a family, social or work relationship)?

0 1 2 3 4 5



## ABOUT THE PATIENT / CLIENT WITH WHOM THE DIFFICULTY OCCURRED

Here is a list of problems that people report in relating to other people. Please read the list below, and for each item, select the number that describes how distressing that problem has been for your patient/client at the time when the difficulty in the therapy with you occurred. Then circle that number.

The following are things your patient/client found hard to do with other people:

It was hard for my client/patient to...	Not at all	A little bit	Mode- rately	Quite a bit	Extre- mely
1. join in on groups	0	1	2	3	4
2. introduce him\herself to new people	0	1	2	3	4
3. confront people with problems that came up	0	1	2	3	4
4. be assertive with another person	0	1	2	3	4
5. disagree with other people	0	1	2	3	4
6. socialize with other people	0	1	2	3	4
7. show affection to people	0	1	2	3	4
8. feel comfortable around other people	0	1	2	3	4
9. understand another person's point of view	0	1	2	3	4
10. be firm when s/he needed to be	0	1	2	3	4
11. experience a feeling of love for another person	0	1	2	3	4
12. be supportive of another person's goals in life	0	1	2	3	4
13. feel close to other people	0	1	2	3	4
14. really care about other people's problems	0	1	2	3	4
15. put somebody else's needs before his/her own	0	1	2	3	4
16. take instructions from other people who had authority over him/her	0	1	2	3	4
17. feel good about another person's happiness	0	1	2	3	4
18. ask other people to get together socially with him/her	0	1	2	3	4
19. open up and tell his/her feelings to another person	0	1	2	3	4
20. attend to his/her own welfare when somebody else was needy	0	1	2	3	4
21. be assertive without worrying about hurting the other person's feelings	0	1	2	3	4
22. tell a person to stop bothering him/her	0	1	2	3	4
23. let other people know when s/he was angry	0	1	2	3	4
24. keep things private from other people	0	1	2	3	4
25. make friends	0	1	2	3	4

26. make a long-term commitment to another person	0	1	2	3	4
27. tell personal things to other people	0	1	2	3	4
28. be aggressive towards other people when the situation called for it	0	1	2	3	4
29. be involved with another person without feeling trapped	0	1	2	3	4

**The following are things that your patient/client did too much:**

### **My patient/ client...**

	Not at all	A little bit	Mode- rately	Quite a bit	Extre- mely
30. wanted people to admire him/her too much	0	1	2	3	4
31. opened up to people too much	0	1	2	3	4
32. was too aggressive towards other people	0	1	2	3	4
33. tried to please other people too much	0	1	2	3	4
34. tried to control other people too much	0	1	2	3	4
35. put other people's needs before his/her own too much	0	1	2	3	4
36. was overly generous to other people	0	1	2	3	4
37. lost his/her temper too easily	0	1	2	3	4
38. told personal things to other people too much	0	1	2	3	4
39. kept other people at a distance too much	0	1	2	3	4
40. let other people take advantage of him/her too much	0	1	2	3	4
41. was affected by another person's misery too much	0	1	2	3	4
42. was too dependent on other people	0	1	2	3	4
43. wanted to get revenge against people too much	0	1	2	3	4
44. argued with other people too much	0	1	2	3	4
45. was too envious and jealous of other people	0	1	2	3	4
46. was too suspicious of other people	0	1	2	3	4
47. got irritated or annoyed too easily	0	1	2	3	4
48. was too easily persuaded by other people	0	1	2	3	4
49. worried too much about other people's reactions to him/her	0	1	2	3	4
50. wanted to be noticed too much	0	1	2	3	4
51. fought with other people too much	0	1	2	3	4

52. Is your patient/client (please tick as appropriate)                      .....female                      .....male

53. How old was your patient/client at the onset of the difficulty ?                      approx.                      .....years



*The following section is optional. The questions are important for this study, however, if you should find yourself so short of time or energy that you would rather leave them out, your other contributions would still be very useful and much appreciated. In that event, please skip this and the following two pages and go directly to the beginning of the next, differently coloured, section.*

**ABOUT WHAT HAPPENED DURING THE DIFFICULTY:**

The following questions ask about your attitudes and feelings toward yourself and your patient/client. Please answer the questions as you really think or feel. Your initial reaction to each question will most often be the best answer. There are no “right” or “wrong” answers. It is your view that is important - not necessarily what is “true”, “false”, or what someone else might think you should say.

Please rate for each question how well it describes how you treated yourself, *or* how your patient/client treated you, *or* how you treated your patient/client **during the difficulty**, using the following scale:

NEVER					ALWAYS				
NOT AT ALL					PERFECTLY				
0	10	20	30	40	50	60	70	80	90 100

and circle one of the numbers from 0 - 100.  
A rating of less than 50 indicates ‘false’; a rating of 50 or more indicates ‘true’.  
(If part of a question seems to fit while another part does not fit at all, you should give the question a lower score because of the ‘inappropriate’ part.)

**How I treated myself during the difficulty:**

	NEVER NOT AT ALL					ALWAYS PERFECTLY				
I let myself do whatever I felt like and didn't worry about tomorrow.	0	10	20	30	40	50	60	70	80	90 100
Without thought about what might happen, I recklessly attacked and angrily rejected myself.	0	10	20	30	40	50	60	70	80	90 100
I very tenderly and lovingly appreciated and valued myself.	0	10	20	30	40	50	60	70	80	90 100
I took good care of myself and worked hard on making the most of myself.	0	10	20	30	40	50	60	70	80	90 100
I accused and blamed myself for being wrong or inferior.	0	10	20	30	40	50	60	70	80	90 100
With awareness of my weaknesses as well as my strengths, I liked and accepted myself “as I was”.	0	10	20	30	40	50	60	70	80	90 100
I carelessly let go of myself, and often got lost in an unrealistic dream world.	0	10	20	30	40	50	60	70	80	90 100
To make sure I did things right, I tightly controlled and watched over myself.	0	10	20	30	40	50	60	70	80	90 100

### How my patient/client treated me during the difficulty:

	NEVER NOT AT ALL					ALWAYS PERFECTLY				
S/he liked me and tried to see my point of view even if we disagreed.	0	10	20	30	40	50	60	70	80	90 100
S/he was closed off from me and mostly stayed alone in his/her own world.	0	10	20	30	40	50	60	70	80	90 100
S/he put me down, blamed me, punished me.	0	10	20	30	40	50	60	70	80	90 100
Without giving it a thought, s/he carelessly forgot me, left me out of important things.	0	10	20	30	40	50	60	70	80	90 100
S/he trustingly depended on me, willingly took in what I offered.	0	10	20	30	40	50	60	70	80	90 100
With much love and caring, s/he tenderly approached if I seemed to want it.	0	10	20	30	40	50	60	70	80	90 100
S/he bitterly, resentfully gave in, and hurried to do what I wanted.	0	10	20	30	40	50	60	70	80	90 100
S/he peacefully and plainly stated his/her own thoughts and feelings to me.	0	10	20	30	40	50	60	70	80	90 100
To make sure things turned out right, s/he told me exactly what to do and how to do it.	0	10	20	30	40	50	60	70	80	90 100
S/he deferred to me and conformed to my wishes.	0	10	20	30	40	50	60	70	80	90 100
S/he had a clear sense of what s/he thought, and chose his/her own way separately from me.	0	10	20	30	40	50	60	70	80	90 100
Without caring what happened to me, s/he murderously attacked in the worst way possible.	0	10	20	30	40	50	60	70	80	90 100
In a very friendly way s/he helped, guided, showed me how to do things.	0	10	20	30	40	50	60	70	80	90 100
Without much concern, s/he gave me the freedom to do things on my own.	0	10	20	30	40	50	60	70	80	90 100
S/he was joyful and comfortable, altogether delighted to be with me.	0	10	20	30	40	50	60	70	80	90 100
Filled with disgust and fear, s/he tried to disappear, to break loose from me.	0	10	20	30	40	50	60	70	80	90 100



### How you treated your patient/client during the difficulty:

	NEVER NOT AT ALL					ALWAYS PERFECTLY						
I liked him/her and tried to see his/her point of view even if we disagreed.	0	10	20	30	40	50	60	70	80	90	100	
I was closed off from him/her and mostly stayed alone in my own world.	0	10	20	30	40	50	60	70	80	90	100	
I put him/her down, blamed, punished him/her.	0	10	20	30	40	50	60	70	80	90	100	
Without giving it a thought, I carelessly left, deserted, forgot him/her.	0	10	20	30	40	50	60	70	80	90	100	
I trustingly depended on him/her, willingly took in what s/he offered.	0	10	20	30	40	50	60	70	80	90	100	
With much love and caring, I tenderly approached if s/he seemed to want it.	0	10	20	30	40	50	60	70	80	90	100	
I bitterly, resentfully gave in, and hurried to do what s/he wanted.	0	10	20	30	40	50	60	70	80	90	100	
I peacefully and plainly stated my own thoughts and feelings to him/her.	0	10	20	30	40	50	60	70	80	90	100	
To make sure things turned out right, I told him/her exactly what to do and how to do it.	0	10	20	30	40	50	60	70	80	90	100	
I deferred to him/her and conformed to his/her wishes.	0	10	20	30	40	50	60	70	80	90	100	
I had a clear sense of what I thought, and chose my own separate ways.	0	10	20	30	40	50	60	70	80	90	100	
Without considering what might happen, I murderously attacked in the worst way possible.	0	10	20	30	40	50	60	70	80	90	100	
In a very friendly way I helped, guided, showed him/her how to do things.	0	10	20	30	40	50	60	70	80	90	100	
Without much concern, I gave him/her the freedom to do things on his/her own.	0	10	20	30	40	50	60	70	80	90	100	
I was joyful and comfortable, altogether delighted to be with him/her.	0	10	20	30	40	50	60	70	80	90	100	
Filled with disgust and fear, I tried to disappear, to break loose from him/her.	0	10	20	30	40	50	60	70	80	90	100	

**ABOUT YOURSELF :**

1. Are you (please tick) .....male or .....female?
2. How old are you now? .....years
3. For how many years have you been practicing since you first started working as a therapist? approx. .... years
4. What is your country of residence? .....
5. What is your profession? (Please tick as many as apply)

.....Psychologist .....Psychiatrist .....Counsellor

..... Psychotherapist .....Social Worker .....Nurse

.....Other (please specify)\_\_\_\_\_

6. How much is your therapeutic practice guided by each of the following theoretical frameworks?	[0=Not at All.....5=Very Greatly]					
a) Analytic/Psychodynamic	0	1	2	3	4	5
b) Behavioural	0	1	2	3	4	5
c) Cognitive	0	1	2	3	4	5
d) Humanistic	0	1	2	3	4	5
e) Systems Theory	0	1	2	3	4	5
f) Other (please specify)_____	1	2	3	4	5	

If you have previously filled in the 'Common Core Questionnaire' of the 'International Study on the Professional Development of Psychotherapists', please enter your personal code:

(the first three letters of your mother's maiden name followed by the first three letters of your father's first name)

On the following pages you are asked to answer two sets of questions which you are already familiar with, this time, however, with reference to yourself in your private relationships.

Here is a list of problems that people report in relating to other people. Please read the list below, and for each item, select the number that describes how distressing that problem has been for you in your private life since you began practising as a therapist. Then circle that number.

**The following are things you find hard to do with other people:**

<b>It is hard for me to...</b>	<b>Not at all</b>	<b>A little bit</b>	<b>Mode rately</b>	<b>Quite a bit</b>	<b>Extre- mely</b>
1. join in on groups	0	1	2	3	4
2. introduce myself to new people	0	1	2	3	4
3. confront people with problems that come up	0	1	2	3	4
4. be assertive with another person	0	1	2	3	4
5. disagree with other people	0	1	2	3	4
6. socialize with other people	0	1	2	3	4
7. show affection to people	0	1	2	3	4
8. feel comfortable around other people	0	1	2	3	4
9. understand another person's point of view	0	1	2	3	4
10. be firm when I need to be	0	1	2	3	4
11. experience a feeling of love for another person	0	1	2	3	4
12. be supportive of another person's goals in life	0	1	2	3	4
13. feel close to other people	0	1	2	3	4
14. really care about other people's problems	0	1	2	3	4
15. put somebody else's needs before my own	0	1	2	3	4
16. take instructions from other people who have authority over me	0	1	2	3	4
17. feel good about another person's happiness	0	1	2	3	4
18. ask other people to get together socially with me	0	1	2	3	4
19. open up and tell my feelings to another person	0	1	2	3	4
20. attend to my own welfare when somebody else is needy	0	1	2	3	4
21. be assertive without worrying about hurting the other person's feelings	0	1	2	3	4
22. tell a person to stop bothering me	0	1	2	3	4
23. let other people know when I am angry	0	1	2	3	4
24. keep things private from other people	0	1	2	3	4
25. make friends	0	1	2	3	4
26. make a long-term commitment to another person	0	1	2	3	4
27. tell personal things to other people	0	1	2	3	4
28. be aggressive towards other people when the situation calls for it	0	1	2	3	4
29. be involved with another person without feeling trapped	0	1	2	3	4



The following are things that you do too much:

	Not at all	A little bit	Mode rately	Quite a bit	Extre -mely
30. I want people to admire me too much	0	1	2	3	4
31. I open up to people too much	0	1	2	3	4
32. I am too aggressive towards other people	0	1	2	3	4
33. I try to please other people too much	0	1	2	3	4
34. I try to control other people too much	0	1	2	3	4
35. I put other people's needs before my own too much	0	1	2	3	4
36. I am overly generous to other people	0	1	2	3	4
37. I lose my temper too easily	0	1	2	3	4
38. I tell personal things to other people too much	0	1	2	3	4
39. I keep other people at a distance too much	0	1	2	3	4
40. I let other people take advantage of me too much	0	1	2	3	4
41. I am affected by another person's misery too much	0	1	2	3	4
42. I am too dependent on other people	0	1	2	3	4
43. I want to get revenge against people too much	0	1	2	3	4
44. I argue with other people too much	0	1	2	3	4
45. I am too envious and jealous of other people	0	1	2	3	4
46. I am too suspicious of other people	0	1	2	3	4
47. I get irritated or annoyed too easily	0	1	2	3	4
48. I am too easily persuaded by other people	0	1	2	3	4
49. I worry too much about other people's reactions to me	0	1	2	3	4
50. I want to be noticed too much	0	1	2	3	4
51. I fight with other people too much	0	1	2	3	4

Please rate yourself twice in the following set of questions: **at your best** and **at your worst**.

First, try to remember a specific time a few days/weeks/months ago when **in your private relationships** you were **at your best**, and while thinking of that time, rate the best version.

Then think of a specific time a few days/weeks/months ago when **in your private relationships** you were **at your worst**, and rate the worst version.



How I treat myself in my private relationships when I am at my best:

	NEVER NOT AT ALL					ALWAYS PERFECTLY						
I let myself do whatever I feel like and don't worry about tomorrow.	0	10	20	30	40	50	60	70	80	90	100	
Without thought about what might happen, I recklessly attack and angrily reject myself.	0	10	20	30	40	50	60	70	80	90	100	
I very tenderly and lovingly appreciate and value myself.	0	10	20	30	40	50	60	70	80	90	100	
I take good care of myself and work hard on making the most of myself.	0	10	20	30	40	50	60	70	80	90	100	
I accuse and blame myself for being wrong or inferior.	0	10	20	30	40	50	60	70	80	90	100	
With awareness of my weaknesses as well as my strengths, I like and accept myself as I am.	0	10	20	30	40	50	60	70	80	90	100	
I carelessly let go of myself, and often get lost in an unrealistic dream world.	0	10	20	30	40	50	60	70	80	90	100	
To make sure I do things right, I tightly control and watch over myself.	0	10	20	30	40	50	60	70	80	90	100	

How I treat myself in my private relationships when I am at my worst:

	NEVER NOT AT ALL					ALWAYS PERFECTLY						
I let myself do whatever I feel like and don't worry about tomorrow.	0	10	20	30	40	50	60	70	80	90	100	
Without thought about what might happen, I recklessly attack and angrily reject myself.	0	10	20	30	40	50	60	70	80	90	100	
I very tenderly and lovingly appreciate and value myself.	0	10	20	30	40	50	60	70	80	90	100	
I take good care of myself and work hard on making the most of myself.	0	10	20	30	40	50	60	70	80	90	100	
I accuse and blame myself for being wrong or inferior.	0	10	20	30	40	50	60	70	80	90	100	
With awareness of my weaknesses as well as my strengths, I like and accept myself as I am.	0	10	20	30	40	50	60	70	80	90	100	
I carelessly let go of myself, and often get lost in an unrealistic dream world.	0	10	20	30	40	50	60	70	80	90	100	
To make sure I do things right, I tightly control and watch over myself.	0	10	20	30	40	50	60	70	80	90	100	

The following section enquires into the kind of reactions from others and from self which, in your experience, are likely to be evoked by particular wishes and needs.

- a number of brief descriptions of someone (a subject) who directs a particular wish, need, or intention towards another person (or other people) and at
- a set of possible responses which can be evoked by the subject.

The subjects and responses are arranged on the following two pages in two grids (matrices) in which you are asked to record your judgements.

- 1) your **not so difficult patient**,    2) your **difficult patient**,
- 3) **yourself**, when you are **most struggling** in your role as a psychotherapist,
- 4) **yourself**, when you are **most struggling** in relationships in your private life.

The responses in the second matrix consist of possible reactions of the self, which are customary states associated with the subject or evoked by the wishes/ needs/intentions described ('the subject becomes...').

0 1 2 3

not at all likely not very likely quite likely very likely

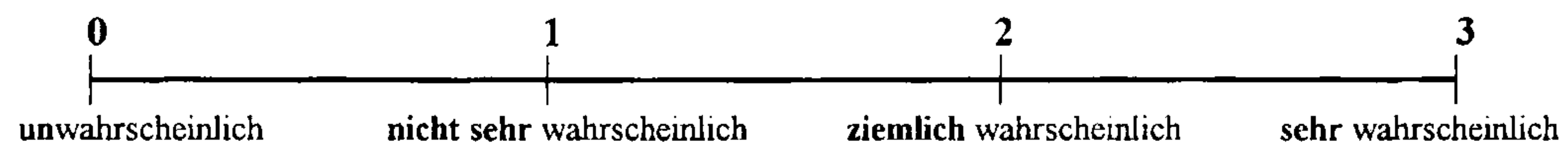
*It may be helpful to work row by row. Try to form a mental picture of the subject described at the beginning of a row and then judge the likelihood of each of the responses described on top of the columns. Then go to the subject at the beginning of the next row. When you have finished, all the cells in the matrix should contain ratings.*

1. Try to picture someone who wishes to assert self and be independent. If, in your judgment, this person is **very likely** to elicit an **Independent and Strong** response from others; **quite likely** to elicit a **Controlling** response; **but not at all likely** to elicit an **Upset** response from others, you would record your judgments as follows:

(This is a part of  
the first matrix)

2. Try to picture yourself, when you are most struggling in relationships in your private life. If you think you are, as a customary state, **quite likely** to feel **Helpful**; but **not at all likely** to feel **Unreceptive**; and **not very likely** to feel **Disappointed and Depressed**, you would record your judgments as follows:

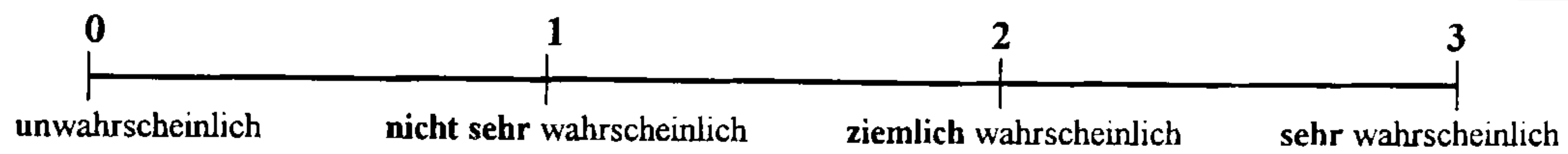
(This is a part of  
the second matrix)



**BEI ANDEREN AUSGELÖSTE REAKTIONEN (ANDERE WERDEN...):**

	Unab- hängig und stark	Kontrol- lierend	Bestürzt, Aufgeregt, Ärgerlich	Schlecht	Zurück- weisend	Hilfreic h	Zunei- gungsvoll	Verständ- nisvoll
Jemand, der sich behaupten und un- abhängig sein will								
Mein(e) 'nicht so schwierige(r)' Patient/Klientin								
Jemand, der Erfolg haben, etwas leisten und anderen helfen will								
Jemand, der sich anderen wider- setzen, andere verletzen und kontrollieren will								
Ich selbst, wenn ich mich in meinen pri- vaten Beziehungen am schwersten tue								
Jemand, der sich gut und wohl fühlen will								
Jemand, der verletzt und kontrolliert werden und keine Verantwortung haben will								
Ich selbst, wenn ich mich als TherapeutIn am schwersten tue								
Jemand, der geliebt und verstanden werden will								
Jemand, der Ab- stand haben und Auseinandersetzun- gen vermeiden will								
Mein(e) schwierige(r) Patientin / Klient								
Jemand, der ande- ren nahe sein und sie akzeptieren will								





**ÜBLICHE REAKTIONEN VOM SUBJEKT SELBST  
(SUBJEKT FÜHLT SICH / IST / TUT...):**

	Hilf- reich	Unempfäng- lich und unaufge- schlossen	Widersetzt sich und verletzt andere	Enttäuscht und deprimiert	Respek- tiert und akzeptiert	Hilf- los	Voller Selbst- kontrolle und Selbst- vertrauen	Ängstlich und beschämt
Jemand, der sich behaupten und un- abhängig sein will								
Mein(e) 'nicht so schwierige(r)' Patient/Klientin								
Jemand, der Erfolg haben, etwas leisten und anderen helfen will								
Jemand, der sich anderen wider-setzen, andere verletzen und kontrollieren will								
Ich selbst, wenn ich mich in meinen pri- vaten Beziehungen am schwersten tue								
Jemand, der sich gut und wohl fühlen will								
Jemand, der verletzt und kontrolliert werden und keine Verantwortung haben will								
Ich selbst, wenn ich mich als TherapeutIn am schwersten tue								
Jemand, der geliebt und verstanden werden will								
Jemand, der Ab- stand haben und Auseinandersetzun- gen vermeiden will								
Mein(e) schwierige(r) Patientin / Klient								
Jemand, der ande- ren nahe sein und sie akzeptieren will								



## ABOUT THIS QUESTIONNAIRE

(Please tick as appropriate)

### Overall, I thought this questionnaire was...

... too short      ... about the right length      ... too long

### Taken as a whole, I thought this questionnaire was...

... easy      ... not too arduous      ... fairly laborious      ... difficult

### Completing this questionnaire felt...

... rewarding      ... neither a bonus nor a burden      ... an imposition

Please feel free to comment below on any aspect of the questionnaire and of your experience of completing it. Your critical remarks and/or suggestions as to how it might be improved would be particularly welcome:

Please return the questionnaire in the envelope provided. If you would like to discuss any aspect of it, or of your experience in completing it, or of the research project in general, please write to me at the address given on the coverpage or contact me by

Tel.: (44)-1332-364-512, Fax: (44)-1332-293-316, or e-mail: [psrah@csv.warwick.ac.uk](mailto:psrah@csv.warwick.ac.uk)

## ERFAHRUNGEN VON SCHWIERIGKEITEN IN DER THERAPEUTISCHEN ARBEIT

Vielen Dank dafür, daß Sie damit begonnen haben, diesen Fragebogen zu beantworten. Er ist umfangreich, und es mag sein, daß er Ihnen während des Ausfüllens als zu langwierig erscheinen wird - dies wäre mir verständlich, denn ich hatte in dieser Hinsicht auch meine Zweifel. Es gibt jedoch einen guten Grund für die Länge: Empfindungen von Therapeuten sind vielschichtig und lassen sich weder auf eine einzelne Dimension reduzieren, noch durch eine einzige Fragestellung erfassen. Deswegen bitte ich Sie, mit dieser Untersuchung etwas Geduld zu haben; in der Gewißheit, daß keine Frage leichtfertig einbezogen worden ist, und daß viele Aspekte, die interessant gewesen wären, aber nicht unentbehrlich waren, ausgelassen worden sind.

Vielleicht hilft es, wenn Sie sich vergegenwärtigen, daß die ganze Aufgabe nicht auf einmal bewältigt werden muß. Wie Sie sehen, hat der Fragebogen vier Abschnitte, die durch verschiedene Farben gekennzeichnet sind. Es ist durchaus möglich, jeweils nur einen Teil zu bearbeiten, und auf den Rest zu einem späteren Zeitpunkt zurückzukommen. Falls Sie so vorgehen wollen, achten Sie bitte darauf, die Reihenfolge der Abschnitte in Ihrem Fragebogen einzuhalten, und nicht zwischen den einzelnen Teilen hin und her zu wechseln.

In jedem der ersten beiden Abschnitte werden Sie gebeten, sich eine Situation aus Ihrer eigenen therapeutischen Praxis ins Gedächtnis zu rufen: die eine, mit einem Patienten / einer Klientin, welche(n) Sie generell als 'schwierig' empfunden haben, und die andere mit einem Klienten / einer Patientin welche(n) Sie insgesamt als 'nicht so schwierig' empfunden haben. Für diese Aufgabe wäre es nützlich, wenn Sie sich etwas Zeit nähmen, um sich die Situation wieder vor Augen zu führen, um sich Einzelheiten ins Gedächtnis zu rufen, und um sich in die damalige Gemüts- und Gefühlsverfassung zurückzusetzen. Frühere Erfahrungen haben gezeigt, daß man sich in diesen Vorgang sehr vertiefen kann und die damalige Situation sehr lebhaft wiederempfinden kann. Die nachfolgenden Fragen werden Ihnen die Gelegenheit geben, über Ihre Empfindungen zu reflektieren, aber es könnte trotzdem wichtig sein, daß Sie sich von Ihrer Erinnerung bewußt wieder lösen, wenn sie an das Ende des jeweiligen Abschnitts kommen; insbesondere, wenn Sie sich dazu entschließen, gleich den nächsten Abschnitt in Angriff zu nehmen. Manch einer erreicht dies am besten durch eine kognitive Übung (z.B. von 100 in Schritten von je 7 abwärtszuzählen), für andere ist es besser, sich eine Szene vorzustellen, die mit angenehmen Gefühlen verbunden ist. Vielleicht haben Sie Ihre eigene Methode.

Abschließend hoffe ich, daß das Ausfüllen dieses Fragebogens für Sie interessant sein wird und daß Sie davon auch soviel lernen wie ich es für mich erhoffe.

Nochmals vielen Dank für Ihre Hilfsbereitschaft!

Thomas A. Schröder  
Psychotherapy Department,  
Temple House,  
Mill Hill Lane,  
DERBY DE23 6SA (GB)

## **EINE SCHWIERIGKEIT MIT EINEM/EINER 'NICHT SO SCHWIERIGEN' PATIENTEN / KLIENTIN:**

**Bitte rufen Sie sich eine Situation in Erinnerung, der Sie persönlich in Ihrer Praxis der Einzeltherapie begegnet sind und welche Sie als schwierig empfunden haben, obwohl der Klient / die Patientin Ihnen generell als 'nicht so schwierig' vorkam.**

**Bitte stellen Sie diese Schwierigkeit weiter unten auf dieser Seite schriftlich dar. Es ist wichtig, daß Sie alles so aufschreiben, wie es Ihnen in den Sinn kommt, ohne es zu zensieren. Bitte berichten Sie ziemlich ausführlich.**

**Es wäre nützlich, wenn Sie die folgenden Punkte einbeziehen würden:**

- Was Sie oder Ihre Klientin / Ihr Patient getan haben, daß dazu führte, daß die Situation schwierig war;
- welche persönlichen Reaktionen oder Gefühle diese Schwierigkeit bei Ihnen ausgelöst hat;
- wie Sie versucht haben mit der Schwierigkeit zurechtzukommen;
- wie sich die Situation dann schließlich entwickelt hat;

**und sonstige Aspekte, an die sie sich erinnern können.**

**(Bitte benutzen Sie auch die Rückseite)**



### **EINE SCHWIERIGKEIT MIT EINER/EINEM 'SCHWIERIGEN' PATIENTIN / KLIENTEN:**

Bitte rufen Sie sich eine Situation in Erinnerung, der Sie persönlich in Ihrer Praxis der Einzeltherapie begegnet sind und welche Sie als schwierig empfunden haben, mit einer Klientin / einem Patienten, die/der Ihnen generell als 'schwierig' vorkam.

Bitte stellen Sie diese Schwierigkeit weiter unten auf dieser Seite schriftlich dar. Es ist wichtig, daß Sie alles so aufschreiben, wie es Ihnen in den Sinn kommt, ohne es zu zensieren. Bitte berichten Sie ziemlich ausführlich.

Es wäre nützlich, wenn Sie die folgenden Punkte einbeziehen würden:

- Was Sie oder Ihr Klient / Ihre Patientin getan haben, daß dazu führte, daß die Situation schwierig war;
- welche persönlichen Reaktionen oder Gefühle diese Schwierigkeit bei Ihnen ausgelöst hat;
- wie Sie versucht haben mit der Schwierigkeit zurechtzukommen;
- wie sich die Situation dann schließlich entwickelt hat;

und sonstige Aspekte, an die sie sich erinnern können.

(Bitte benutzen Sie auch die Rückseite)

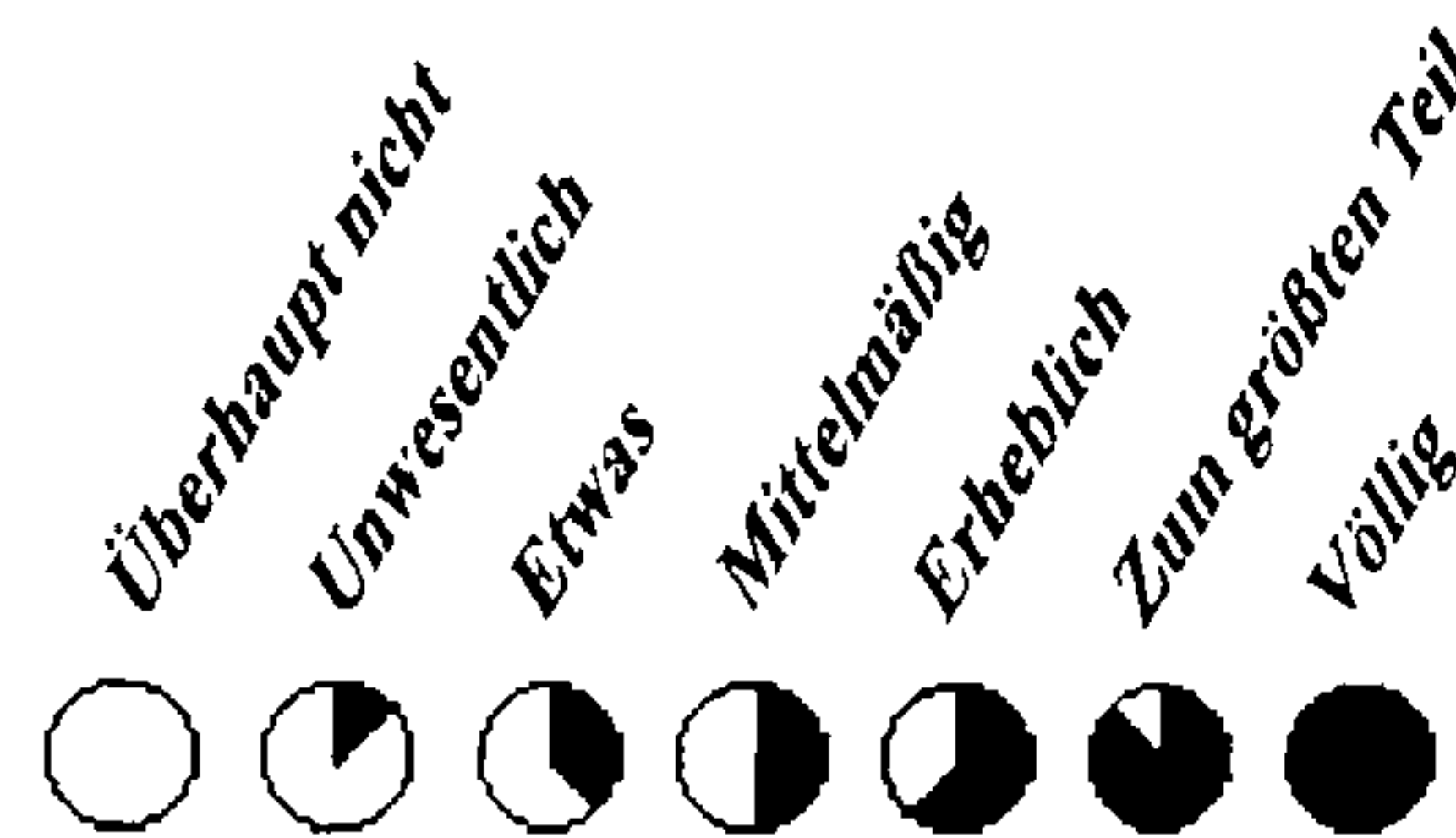


## HINSICHTLICH IHRER ERFAHRUNG DER SCHWIERIGKEIT

In welchem Ausmaß stimmen die folgenden Aussagen mit Ihrer  
Empfindung der von Ihnen beschriebenen Schwierigkeit überein?  
(Bitte kreisen Sie für jede Aussage eine Nummer ein.)

0 = Überhaupt nicht	4 = Erheblich
1 = Unwesentlich	5 = Zum größten Teil
2 = Etwas	6 = Völlig
3 = Mittelmäßig	

**Diese Aussage deckt sich  
mit meiner Empfindung :**



1. Ich war von dieser Schwierigkeit emotional betroffen.	0	1	2	3	4	5	6
2. Schwierigkeiten dieser Art waren mir neu.	0	1	2	3	4	5	6
3. Diese Schwierigkeit ging mir "durch Mark und Bein".	0	1	2	3	4	5	6
4. Diese Schwierigkeit schien sich schnell zu entwickeln.	0	1	2	3	4	5	6
5. Solch eine Schwierigkeit war mir immer wieder begegnet.	0	1	2	3	4	5	6
6. Diese Schwierigkeit stimmte mich nachdenklich.	0	1	2	3	4	5	6
7. Diese Schwierigkeit schien eine Ewigkeit anzudauern.	0	1	2	3	4	5	6
8. Derartige Schwierigkeiten waren mir seit langem bekannt.	0	1	2	3	4	5	6
9. Diese Schwierigkeit traf mich bis ins Innerste.	0	1	2	3	4	5	6
10. Dies war für mich eine ungewöhnliche Schwierigkeit.	0	1	2	3	4	5	6
11. Ich empfand diese Schwierigkeit als langwierig.	0	1	2	3	4	5	6
12. Ich wurde mit dieser Schwierigkeit ohne weiteres fertig.	0	1	2	3	4	5	6
13. Ich kannte Schwierigkeiten dieser Art aus früherer Erfahrung.	0	1	2	3	4	5	6
14. Es war mühsam, sich mit dieser Schwierigkeit auseinanderzusetzen.	0	1	2	3	4	5	6
15. Ich war mit einer derartigen Schwierigkeit nicht persönlich vertraut.	0	1	2	3	4	5	6
16. Ich konnte diese Schwierigkeit nicht loslassen.	0	1	2	3	4	5	6
17. Ich hielt dies für eine kurze Schwierigkeit.	0	1	2	3	4	5	6
18. Diese Schwierigkeit wollte mir nicht aus dem Sinn.	0	1	2	3	4	5	6
19. Ich war solche Schwierigkeiten gewohnt.	0	1	2	3	4	5	6
20. Im Laufe dieser Schwierigkeit schien die Zeit stillzustehen.	0	1	2	3	4	5	6
21. Damals war ich solch einer Schwierigkeit erst vor kurzem begegnet.	0	1	2	3	4	5	6
22. Diese Schwierigkeit beschäftigte mich auch außerhalb der Sitzungen.	0	1	2	3	4	5	6
23. Es war praktisch das erste Mal, daß mir eine derartige Schwierigkeit untergekommen war.	0	1	2	3	4	5	6
24. Ich war in diese Schwierigkeit vertieft.	0	1	2	3	4	5	6
25. Diese Schwierigkeit schien sofort vorüberzusein.	0	1	2	3	4	5	6
26. Derartige Schwierigkeiten waren mir wohlbekannt.	0	1	2	3	4	5	6

27. Wie lange ist der Beginn der Schwierigkeit her? .....Jahre .....Monate

28. Wie lange hat die Schwierigkeit insgesamt gedauert? .....Wochen .....Monate  
oder

29. Ist dies eine gegenwärtige Schwierigkeit? (Bitte ankreuzen) ..... Ja ..... Nein

30. In welchem Maße hätte Sie das Vorhandensein der folgenden Qualitäten davor  
bewahrt, die Situation als schwierig zu empfinden?  
(Bitte kreisen Sie für jede Frage eine Ziffer ein)

[ 0 = Überhaupt nicht. . . . . 5 = Sehr ]

a) Ausgedehntere theoretische Kenntnisse	0	1	2	3	4	5
b) Ein größeres Repertoire technischer Fertigkeiten	0	1	2	3	4	5
c) Umfangreichere praktische Erfahrung	0	1	2	3	4	5
d) Etwas anderes (bitte beschreiben)	0	1	2	3	4	5

31. In welchem Maße hätten die Folgenden Sie besser dazu in die Lage versetzt,  
mit dieser Schwierigkeit fertigzuwerden?  
(Bitte kreisen Sie für jede Frage eine Ziffer ein)

[ 0 = Überhaupt nicht. . . . . 5 = Sehr ]

a) Formelle Supervision oder Beratung	0	1	2	3	4	5
b) Lesen relevanter Fachliteratur	0	1	2	3	4	5
c) Teilnahme an Fachseminaren oder Workshops	0	1	2	3	4	5
d) Vertrautheit mit einem breiteren Spektrum von Patienten / Klienten.	0	1	2	3	4	5
e) Etwas anderes (bitte beschreiben)	0	1	2	3	4	5

32. [ 0 = Überhaupt nicht. . . . . 5 = Sehr ]

Wie schwierig wäre die Situation für eine(n) andere(n) TherapeutIn, mit einer Ihnen vergleich- baren Praxiserfahrung und theoretischen Aus- richtung gewesen?	0	1	2	3	4	5
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33. [ 0 = Niemals . . . . . 5 = Oft ]

Wie oft haben Sie eine derartige Schwierigkeit in einer außer-therapeutischen Situation (d.h. in einer Familien-, gesellschaftlichen oder Arbeits- beziehung) empfunden?	0	1	2	3	4	5
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## HINSICHTLICH DES PATIENTEN / DER KLIENTIN MIT DEM / DER DIE SCHWIERIGKEIT AUFTRAT

Nachfolgend finden Sie eine Liste von Schwierigkeiten die im Zusammenhang mit Beziehungen zu anderen berichtet werden. Bitte lesen Sie diese Liste durch und überlegen Sie ob die einzelnen Schwierigkeiten für Ihre Patientin / Ihren Klienten **zu der Zeit als die Schwierigkeit in der Therapie mit Ihnen auftrat**, ein Problem in anderen Beziehungen darstellten. Kreisen Sie bitte für jedes Problem die Ziffer ein, die beschreibt, wie sehr Ihre Klientin / Ihr Patient darunter gelitten hat.

**Die nachstehenden Aspekte können im Umgang mit andren schwierig sein:**

### **Es fiel meiner Klientin / meinem Patienten schwer...**

	nicht	wenig	mittel- mäßig	ziem- lich	sehr
1. sich Gruppen anzuschließen	0	1	2	3	4
2. sich fremden Menschen vorzustellen	0	1	2	3	4
3. andere mit anstehenden Problemen zu konfrontieren	0	1	2	3	4
4. sich gegenüber jemand anderem zu behaupten	0	1	2	3	4
5. mit anderen nicht einer Meinung zu sein	0	1	2	3	4
6. mit anderen etwas zu unternehmen	0	1	2	3	4
7. anderen Menschen Zuneigung zu zeigen	0	1	2	3	4
8. mit anderen zurechtzukommen	0	1	2	3	4
9. die Ansichten eines anderen zu verstehen	0	1	2	3	4
10. wenn nötig standfest zu sein	0	1	2	3	4
11. ein Gefühl von Liebe für jemanden zu empfinden	0	1	2	3	4
12. jemand anderen in seinen Lebenszielen zu unterstützen	0	1	2	3	4
13. sich anderen nahezufühlen	0	1	2	3	4
14. sich wirklich um die Probleme anderer zu kümmern	0	1	2	3	4
15. die Bedürfnisse eines anderen über ihre/seine eigenen zu stellen	0	1	2	3	4
16. Anweisungen von Personen entgegenzunehmen, die ihr/ihm vorgesetzt waren	0	1	2	3	4
17. sich über das Glück eines anderen Menschen zu freuen	0	1	2	3	4
18. andere zu bitten, mit ihr/ihm etwas zu unternehmen	0	1	2	3	4
19. sich zu öffnen und ihre/seine Gefühle jemand anderem mitzuteilen	0	1	2	3	4
20. ihr/sein eigenes Wohlergehen nicht aus den Augen zu verlieren, wenn jemand anders in Not war.	0	1	2	3	4
21. fest und bestimmt zu bleiben, ohne sich darum zu kümmern, ob sie/er die Gefühle anderer verletzte	0	1	2	3	4
22. jemandem zu sagen, daß er sie/ihn nicht weiter belästigen sollte	0	1	2	3	4
23. andere wissen zu lassen, daß sie/er wütend war	0	1	2	3	4
24. bestimmte Dinge für sich zu behalten	0	1	2	3	4

25. Freundschaften zu schließen	0	1	2	3	4
26. eine langfristige Verpflichtung gegenüber anderen einzugehen	0	1	2	3	4
27. anderen persönliche Dinge zu erzählen	0	1	2	3	4
28. anderen gegenüber aggressiv zu sein, wenn die Lage es erforderte	0	1	2	3	4
29. eine Beziehung mit einem anderen Menschen einzugehen, ohne sich in die Enge getrieben zu fühlen	0	1	2	3	4

Die nachstehenden Aspekte kann man im Übermaß tun:

### Mein Klient / meine Patientin...

	nicht	wenig	mittel- mäßig	ziem- lich	sehr
30. legte zuviel Wert darauf, bewundert zu werden	0	1	2	3	4
31. öffnete sich anderen zu sehr	0	1	2	3	4
32. war gegenüber anderen zu aggressiv	0	1	2	3	4
33. bemühte sich zu sehr, anderen zu gefallen	0	1	2	3	4
34. war zu sehr darauf aus, andere zu kontrollieren	0	1	2	3	4
35. stellte zu oft die Bedürfnisse anderer über seine/ihre eigenen	0	1	2	3	4
36. war anderen gegenüber zu großzügig	0	1	2	3	4
37. verlor die Beherrschung zu leicht	0	1	2	3	4
38. erzählte anderen zu oft persönliche Dinge	0	1	2	3	4
39. hielt sich andere zu sehr auf Distanz	0	1	2	3	4
40. ließ sich von anderen zu sehr ausnutzen	0	1	2	3	4
41. war zu sehr berührt von der Not eines anderen Menschen	0	1	2	3	4
42. war von anderen zu abhängig	0	1	2	3	4
43. mochte sich zu sehr an anderen rächen	0	1	2	3	4
44. stritt zu oft mit anderen	0	1	2	3	4
45. war auf andere zu neidisch und eifersüchtig	0	1	2	3	4
46. war anderen gegenüber zu mißtrauisch	0	1	2	3	4
47. war zu leicht irritiert oder verärgert	0	1	2	3	4
48. ließ sich zu leicht von anderen überreden	0	1	2	3	4
49. war zu besorgt, wie andere auf ihn/sie reagierten	0	1	2	3	4
50. legte zuviel Wert darauf, beachtet zu werden	0	1	2	3	4
51. zankte sich zuviel mit anderen	0	1	2	3	4

52. Ist Ihr(e) Patient(in) (bitte ankreuzen)

.....weiblich

.....männlich

53. Wie alt war Ihr(e) Klient(in) beim Beginn der Schwierigkeit?

ca. ....Jahre



**HINSICHTLICH DESSEN, WAS WÄHREND DER SCHWIERIGKEIT ZWISCHEN IHNEN ABLIEF**

Die nachfolgenden Fragen erkundigen sich nach Ihrem Verhalten und Erleben gegenüber sich selbst und Ihrer Klientin / Ihrem Patienten. Bitte antworten Sie so, wie Sie wirklich denken oder fühlen. Die allererste Reaktion auf die jeweilige Frage ist meist die beste Antwort. Es gibt keine "guten" oder "schlechten" Antworten. Nur Ihre Meinung zählt. Es geht nicht um "wahr" oder "falsch" oder darum, was andere von Ihnen erwarten.

Bitte beurteilen Sie, wie gut die jeweilige Frage beschreibt, wie sie mit sich selbst, *oder* wie Ihr(e) PatientIn mit Ihnen und *oder* wie Sie mit Ihrem Klienten / Ihrer Patientin **im Verlaufe der Schwierigkeit** umgegangen sind.

Bitte benutzen Sie zu Ihrer Beurteilung diese Skala:

[stimmt überhaupt nicht ..... stimmt voll und ganz]  
0 10 20 30 40 50 60 70 80 90 100

und kreisen Sie eine der Zahlen von 0 - 100 ein.

Zahlen von 0 - 40 bedeuten "stimmt nicht", Zahlen von 50 - 100 bedeuten "stimmt".

**So ging ich im Verlaufe der Schwierigkeit mit mir selbst um:**

	stimmt über- haupt nicht					stimmt voll und ganz				
Spontan und wie selbstverständlich tat und ließ ich, was ich gerne wollte.	0	10	20	30	40	50	60	70	80	90 100
Ohne einen Gedanken an die Folgen war ich voller Ablehnung und Zerstörungswut mir gegenüber.	0	10	20	30	40	50	60	70	80	90 100
Ich mochte mich sehr gerne, war sanft und liebevoll zu mir.	0	10	20	30	40	50	60	70	80	90 100
Ich ging mit mir selbst sorgfältig, schützend und achtsam um.	0	10	20	30	40	50	60	70	80	90 100
Ich machte mir selbst Vorwürfe und schämte mich vor mir selbst.	0	10	20	30	40	50	60	70	80	90 100
Ich akzeptierte mich so wie ich war, mit allen meinen Stärken und Schwächen.	0	10	20	30	40	50	60	70	80	90 100
Ich war achtlos mit mir, ich übersah mich selbst, als wäre ich ganz egal gewesen.	0	10	20	30	40	50	60	70	80	90 100
Ich achtete darauf, daß ich alles richtig machte und hielt mich selbst unter genauer Beobachtung und Kontrolle.	0	10	20	30	40	50	60	70	80	90 100

**So ging mein Klient / meine Patientin im Verlaufe  
der Schwierigkeit mit mir um:**

	stimmt über- haupt nicht					stimmt voll und ganz						
Er/Sie ließ mich meinen eigenen Weg finden und verstand mich wirklich, auch wenn wir nicht einer Meinung waren.	0	10	20	30	40	50	60	70	80	90	100	
Er/Sie wollte nichts mit mir zu tun haben und blieb ganz für sich.	0	10	20	30	40	50	60	70	80	90	100	
Er/Sie beschuldigte mich, machte mir Vorwürfe.	0	10	20	30	40	50	60	70	80	90	100	
Er/Sie übersah mich völlig, nahm keine Notiz von mir, als wäre ich ganz egal.	0	10	20	30	40	50	60	70	80	90	100	
Er/Sie hörte auf mich, verließ sich auf mich und nahm meine Angebote an.	0	10	20	30	40	50	60	70	80	90	100	
Er/Sie war sanft und liebevoll zu mir und kam mir nahe, so wie ich es gerne mochte.	0	10	20	30	40	50	60	70	80	90	100	
Beleidigt und verärgert kam er/sie meinem Willen nach.	0	10	20	30	40	50	60	70	80	90	100	
Er/Sie teilte mir klar und unbefangen seine/ihre Gefühle und Gedanken mit.	0	10	20	30	40	50	60	70	80	90	100	
Damit die Dinge ihre Ordnung hatten, kümmerte er/sie sich um alles selbst und war darauf bedacht, daß ich mich an seine/ihre Regeln hielt.	0	10	20	30	40	50	60	70	80	90	100	
Er/Sie dachte und handelte so, wie ich es gerade wollte.	0	10	20	30	40	50	60	70	80	90	100	
Er/Sie hatte eine eigene Meinung und tat, was er/sie wollte, ganz unabhängig von mir.	0	10	20	30	40	50	60	70	80	90	100	
Haßerfüllt griff er/sie mich an, er/sie behandelte mich wie den letzten Dreck.	0	10	20	30	40	50	60	70	80	90	100	
Er/Sie schützte mich fürsorglich, er/sie unterstützte mich wohlwollend mit Rat und Tat.	0	10	20	30	40	50	60	70	80	90	100	
Er/Sie ließ mir die Freiheit zu tun, was ich wollte, ohne sich zu sorgen.	0	10	20	30	40	50	60	70	80	90	100	
Gelassen und freudig genoß er/sie meine Gegenwart so oft wie möglich.	0	10	20	30	40	50	60	70	80	90	100	
Haßerfüllt und voller Wut schreckte er/sie vor mir zurück.	0	10	20	30	40	50	60	70	80	90	100	

**So ging ich im Verlaufe der Schwierigkeit mit meiner Klientin / meinem Patienten um:**

	stimmt über- haupt nicht					stimmt voll und ganz					
Ich ließ sie/ihn einen eigenen Weg finden und verstand sie/ihn wirklich, auch wenn wir nicht einer Meinung waren.	0	10	20	30	40	50	60	70	80	90	100
Ich wollte nichts mit ihr/ihm zu tun haben und blieb ganz für mich.	0	10	20	30	40	50	60	70	80	90	100
Ich beschuldigte sie/ihn, machte ihr/ihm Vorwürfe.	0	10	20	30	40	50	60	70	80	90	100
Ich übersah sie/ihn völlig, nahm keine Notiz von ihr/ihm, als wäre sie/er ganz egal.	0	10	20	30	40	50	60	70	80	90	100
Ich hörte auf sie/ihn, verließ mich auf sie/ihn und nahm ihre/seine Angebote an.	0	10	20	30	40	50	60	70	80	90	100
Ich war sanft und liebevoll zu ihr/ihm und kam ihr/ihm nahe, so wie sie/er es gerne mochte.	0	10	20	30	40	50	60	70	80	90	100
Beleidigt und verärgert kam ich ihrem/seinem Willen nach.	0	10	20	30	40	50	60	70	80	90	100
Ich teilte ihr/ihm klar und unbefangen meine Gefühle und Gedanken mit.	0	10	20	30	40	50	60	70	80	90	100
Damit die Dinge ihre Ordnung hatten, kümmerte ich mich um alles selbst und war darauf bedacht, daß sie/er sich an meine Regeln hielt.	0	10	20	30	40	50	60	70	80	90	100
Ich dachte und handelte so, wie sie/er es gerade wollte.	0	10	20	30	40	50	60	70	80	90	100
Ich hatte meine eigene Meinung und tat, was ich wollte, ganz unabhängig von ihr/ihm.	0	10	20	30	40	50	60	70	80	90	100
Haßerfüllt griff ich sie/ihn an, behandelte sie/ihn wie den letzten Dreck.	0	10	20	30	40	50	60	70	80	90	100
Ich schützte sie/ihn fürsorglich, ich unterstützte sie/ihn wohlwollend mit Rat und Tat.	0	10	20	30	40	50	60	70	80	90	100
Ich ließ ihr/ihm die Freiheit zu tun, was sie/er wollte, ohne mich zu sorgen..	0	10	20	30	40	50	60	70	80	90	100
Gelassen und freudig genoß ich ihre/seine Gegenwart so oft wie möglich.	0	10	20	30	40	50	60	70	80	90	100
Haßerfüllt und voller Wut schreckte ich vor ihr/ihm zurück.	0	10	20	30	40	50	60	70	80	90	100



**HINSICHTLICH IHRER PERSON :**

1. Sind Sie (bitte ankreuzen) .....männlich oder .....weiblich?
2. Wie alt sind Sie jetzt? .....Jahre
3. Wieviel Jahre Praxiserfahrung haben Sie als Therapeut? ca. .... Jahre
4. In welchem Land wohnen Sie? .....
5. Welchen Beruf üben Sie aus? (Bitte kreuzen Sie alle an, die zutreffen)

.....Psychologe(in) .....Psychiater(in) .....andere(r) Arzt(in)

..... Psychotherapeut(in) .....Sozialarbeiter(in) .....Berater(in)

.....Anderer (bitte angeben).....

6. Welchen Einfluß haben die folgenden theoretischen Orientierungen auf Ihre Praxis?	[0=Überhaupt nicht.....5=Sehr]					
a) Analytisch/Psychodynamisch	0	1	2	3	4	5
b) Verhaltenstherapeutisch	0	1	2	3	4	5
c) Kognitiv	0	1	2	3	4	5
d) Humanistisch	0	1	2	3	4	5
e) Systemtheoretisch	0	1	2	3	4	5
f) Andere (bitte angeben).....	1	2	3	4	5	

Falls Sie früher einmal den 'Basisfragebogen' der 'Internationalen Studie zur Beruflichen Entwicklung von Psychotherapeuten' ausgefüllt haben, geben Sie hier bitte Ihren persönlichen Code an:

(dies waren die ersten drei Buchstaben des Mädchennamens Ihrer Mutter, gefolgt von den ersten drei Buchstaben des Vornamens Ihres Vaters)

Auf den folgenden Seiten werden Sie gebeten, zwei Ihnen schon bekannte Frageserien zu beantworten, diesmal aber im Blick auf Sie selbst in Ihren privaten Beziehungen.



## ÜBER SIE SELBST

Nachfolgend finden Sie eine Liste von Schwierigkeiten die im Zusammenhang mit Beziehungen zu anderen berichtet werden. Bitte lesen Sie diese Liste durch und überlegen Sie ob die einzelnen Schwierigkeiten für Sie ein Problem **in Ihrem Privatleben** darstellten, **seit sie angefangen haben als Therapeut zu arbeiten**. Kreisen Sie bitte für jedes Problem die Ziffer ein, die beschreibt, wie sehr Sie darunter gelitten haben.

Die nachstehenden Aspekte können im Umgang mit andren schwierig sein:

### Es fällt mir schwer...

	nicht	wenig	mittel- mäßig	ziem- lich	sehr
	-----	-----	-----	-----	-----
1. mich Gruppen anzuschließen	0	1	2	3	4
2. mich fremden Menschen vorzustellen	0	1	2	3	4
3. andere mit anstehenden Problemen zu konfrontieren	0	1	2	3	4
4. mich gegenüber jemand anderem zu behaupten	0	1	2	3	4
5. mit anderen nicht einer Meinung zu sein	0	1	2	3	4
6. mit anderen etwas zu unternehmen	0	1	2	3	4
7. anderen Menschen Zuneigung zu zeigen	0	1	2	3	4
8. mit anderen zurechtzukommen	0	1	2	3	4
9. die Ansichten eines anderen zu verstehen	0	1	2	3	4
10. wenn nötig standfest zu sein	0	1	2	3	4
11. ein Gefühl von Liebe für jemanden zu empfinden	0	1	2	3	4
12. jemand anderen in seinen Lebenszielen zu unterstützen	0	1	2	3	4
13. mich anderen nahezufühlen	0	1	2	3	4
14. mich wirklich um die Probleme anderer zu kümmern	0	1	2	3	4
15. die Bedürfnisse eines anderen über meine eigenen zu stellen	0	1	2	3	4
16. Anweisungen von Personen entgegenzunehmen, die mir vorgesetzt sind	0	1	2	3	4
17. mich über das Glück eines anderen Menschen zu freuen	0	1	2	3	4
18. andere zu bitten, mit mir etwas zu unternehmen	0	1	2	3	4
19. mich zu öffnen und meine Gefühle jemand anderem mitzuteilen	0	1	2	3	4
20. mein eigenes Wohlergehen nicht aus den Augen zu verlieren, wenn jemand anders in Not ist	0	1	2	3	4
21. fest und bestimmt zu bleiben, ohne mich darum zu kümmern, ob ich die Gefühle anderer verletze	0	1	2	3	4
22. jemandem zu sagen, daß er mich nicht weiter belästigen soll	0	1	2	3	4
23. andere wissen zu lassen, daß ich wütend bin	0	1	2	3	4
24. bestimmte Dinge für mich zu behalten	0	1	2	3	4
25. Freundschaften zu schließen	0	1	2	3	4
26. eine langfristige Verpflichtung gegenüber anderen einzugehen	0	1	2	3	4

27. anderen persönliche Dinge zu erzählen	0	1	2	3	4
28. anderen gegenüber aggressiv zu sein, wenn die Lage es erfordert	0	1	2	3	4
29. eine Beziehung mit einem anderen Menschen einzugehen, ohne mich in die Enge getrieben zu fühlen	0	1	2	3	4

**Die nachstehenden Aspekte kann man im Übermaß tun:**

	nicht	wenig	mittel- mäßig	ziem- lich	sehr
30. Ich lege zuviel Wert darauf, bewundert zu werden	0	1	2	3	4
31. Ich öffne mich anderen zu sehr	0	1	2	3	4
32. Ich bin gegenüber anderen zu aggressiv	0	1	2	3	4
33. Ich bemühe mich zu sehr, anderen zu gefallen	0	1	2	3	4
34. Ich bin zu sehr darauf aus, andere zu kontrollieren	0	1	2	3	4
35. Ich stelle zu oft die Bedürfnisse anderer über meine eigenen	0	1	2	3	4
36. Ich bin anderen gegenüber zu großzügig	0	1	2	3	4
37. Ich verliere die Beherrschung zu leicht	0	1	2	3	4
38. Ich erzähle anderen zu oft persönliche Dinge	0	1	2	3	4
39. Ich halte mir andere zu sehr auf Distanz	0	1	2	3	4
40. Ich lasse mich von anderen zu sehr ausnutzen	0	1	2	3	4
41. Die Not eines anderen Menschen berührt mich zu sehr	0	1	2	3	4
42. Ich bin von anderen zu abhängig	0	1	2	3	4
43. Ich möchte mich zu sehr an anderen rächen	0	1	2	3	4
44. Ich streite zu oft mit anderen	0	1	2	3	4
45. Ich bin auf andere zu neidisch und eifersüchtig	0	1	2	3	4
46. Ich bin anderen gegenüber zu mißtrauisch	0	1	2	3	4
47. Ich bin zu leicht irritiert oder verärgert	0	1	2	3	4
48. Ich lasse mich zu leicht von anderen überreden	0	1	2	3	4
49. Ich bin zu besorgt, wie andere auf mich reagieren	0	1	2	3	4
50. Ich lege zuviel Wert darauf, beachtet zu werden	0	1	2	3	4
51. Ich zanke mich zuviel mit anderen	0	1	2	3	4

In der folgenden Frageserie beurteilen Sie sich bitte zweimal: Einmal in Ihren besten und einmal in Ihren schlechtesten Zeiten.

Zunächst versuchen Sie, sich an eine Zeit vor einigen Tagen, Wochen oder Monaten zu erinnern, als Sie in **Ihren privaten Beziehungen** eine besonders gute Zeit hatten und beurteilen Sie dann, wie Sie damals mit sich umgegangen sind.

Dann denken Sie an eine bestimmte Zeit vor einigen Tagen, Wochen oder Monaten, als Sie in **Ihren privaten Beziehungen** eine besonders schlechte Zeit hatten und beurteilen Sie, wie Sie damals mit sich umgegangen sind.



**So gehe ich mit mir in meinen besten Zeiten um:**

	stimmt über- haupt nicht					stimmt voll und ganz						
	0	10	20	30	40	50	60	70	80	90	100	
Spontan und wie selbstverständlich tue und lasse ich, was ich gerne will.												
Ohne einen Gedanken an die Folgen bin ich voller Ablehnung und Zerstörungswut mir gegenüber.												
Ich mag mich sehr gerne, bin sanft und liebevoll zu mir.												
Ich gehe mit mir selbst sorgfältig, schützend und achtsam um.												
Ich mache mir selbst Vorwürfe und schäme mich vor mir selbst.												
Ich akzeptiere mich wie ich bin, mit allen <sup>←↑</sup> meinen Stärken und Schwächen.												
Ich bin achtlos mit mir, ich übersehe mich selbst, als wäre ich ganz egal.												
Ich achte darauf, daß ich alles richtig mache und halte mich selbst unter genauer Beobachtung und Kontrolle.												

**So gehe ich mit mir in meinen schlechtesten Zeiten um:**

	stimmt über- haupt nicht					stimmt voll und ganz						
	0	10	20	30	40	50	60	70	80	90	100	
Spontan und wie selbstverständlich tue und lasse ich, was ich gerne will.												
Ohne einen Gedanken an die Folgen bin ich voller Ablehnung und Zerstörungswut mir gegenüber.												
Ich mag mich sehr gerne, bin sanft und liebevoll zu mir.												
Ich gehe mit mir selbst sorgfältig, schützend und achtsam um.												
Ich mache mir selbst Vorwürfe und schäme mich vor mir selbst.												
Ich akzeptiere mich wie ich bin, mit allen meinen Stärken und Schwächen.												
Ich bin achtlos mit mir, ich übersehe mich selbst, als wäre ich ganz egal.												
Ich achte darauf, daß ich alles richtig mache und halte mich selbst unter genauer Beobachtung und Kontrolle.												



*Sie können diese Seite gern aus dem Fragebogen heraustrennen!*

## **WIE MENSCHEN AUF EINANDER REAGIEREN:**

Der folgende Abschnitt befaßt sich mit möglichen Reaktionen von anderen und von einem selbst, die - Ihrer Erfahrung nach - von bestimmten Wünschen und Bedürfnissen hervorgerufen werden.

Schauen Sie sich dafür bitte das Folgende an:

- eine Anzahl kurzer Beschreibungen von jemandem (einem 'Subjekt'), der einem (oder mehreren) Anderen bestimmte Absichten, Wünsche oder Bedürfnisse entgegenbringt und
- eine Reihe möglicher Reaktionen, die von den Subjekten hervorgerufen werden könnten.

Bitte beurteilen Sie dann für jede Reaktion **wie wahrscheinlich** es ist, daß sie von einem bestimmten Subjekt hervorgerufen wird. Auf den nächsten beiden Seiten sind Subjekte und Reaktionen in zwei Gittern (Matrizen) angeordnet, in denen Sie gebeten werden, Ihre Beurteilungen einzutragen.

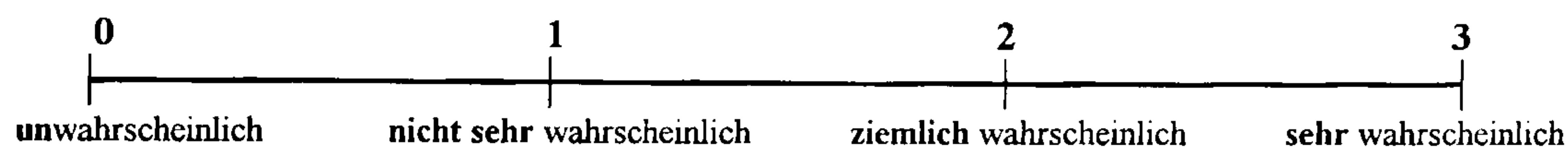
In beiden Matrizen (jeweils am Anfang der *Reihen*) gibt es zwölf **Subjekte**. Acht von diesen sind Personen, die anderen bestimmte Wünsche/Bedürfnisse/Absichten/ entgegenbringen. Die verbleibenden vier sind:

- 1) Ihr(e) **nicht so schwierige(r) PatientIn**, 2) Ihr(e) **schwierige(r) KlientIn**,
- 3) **Sie selbst**, wenn Sie sich **am schwersten** tun in Ihrer Rolle als **PsychotherapeutIn**,
- 4) **Sie selbst**, wenn Sie sich **am schwersten** tun in Ihren **privaten Beziehungen**.

**Reaktionen** (am Anfang der *Spalten*) in der ersten Matrix sind **Reaktionen von anderen**, die vom Subjekt und den beschriebenen Wünschen/Bedürfnissen/Absichten **ausgelöst** werden könnten ('Andere werden ...').

**Reaktionen** in der **zweiten** Matrix sind **übliche Reaktionen vom Subjekt selbst**. Dies sind gewohnte Gefühlszustände und Handlungsmuster, die mit den beschriebenen Wünschen/Bedürfnissen/Absichten einhergehen oder durch die Reaktionen anderer hervorgerufen werden könnten ('Subjekt fühlt sich / ist / tut...').

Bitte beurteilen Sie für jedes Subjekt **wie wahrscheinlich** es die jeweilige Reaktion hervorruft und tragen Sie Ihr Urteil in das entsprechende Quadrat der Matrix ein. Benutzen Sie bitte die folgende Skala:



*Vielleicht ist es am besten, reihenweise vorzugehen. Stellen Sie sich dafür das jeweils am Anfang der Reihe beschriebene Subjekt vor und beurteilen Sie dann die Wahrscheinlichkeiten aller der Reaktionen, die jeweils am Anfang der Spalten beschrieben werden, indem Sie die zutreffende Ziffer in das jeweilige Quadrat eintragen. Fahren Sie mit dem Subjekt am Anfang der nächsten Reihe fort. Wenn Sie fertig sind, sollten alle Quadrate in beiden Matrizen Ziffern enthalten.*

### **ZWEI BEISPIELE:**

1. Stellen Sie sich jemanden, der sich behaupten und unabhängig sein will vor. Wenn , Ihrer Meinung nach, solch eine Person bei anderen **sehr wahrscheinlich** eine Reaktion der **Unabhängigkeit und Stärke** auslöst; **ziemlich wahrscheinlich** eine **kontrollierende** Reaktion , aber **unwahrscheinlich** eine **bestürzte, aufgeregte, oder ärgerliche** Reaktion hervorruft, würden Sie dies wie folgt eintragen:

**BEI ANDEREN AUSGELOSTE REAKTION (ANDERE WERDEN...):**

	Unabhängig und stark	Kontrollierend	Bestürzt, aufgeregt, ärgerlich
Someone who wishes to assert self and be independent	3	2	0

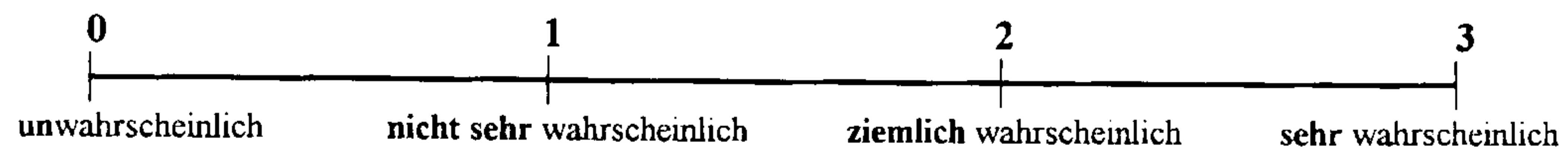
*(Dies ist ein Teil der ersten Matrix)*

2. Stellen Sie sich Sie selbst, wenn Sie sich in Ihren privaten Beziehungen am schwersten tun vor. Wenn Sie sich dann üblicherweise, **ziemlich wahrscheinlich** als **hilfreich** empfinden, aber es **unwahrscheinlich** wäre, daß Sie sich **unaufgeschlossen und unempänglich** fühlten und **nicht sehr wahrscheinlich**, daß Sie **enttäuscht und deprimiert** wären, würden Sie dies wie folgt eintragen:

**ÜBLICHE REAKTIONEN VOM SUBJEKT SELBST (SUBJEKT FÜHLT SICH/ IST/ TUT...):**

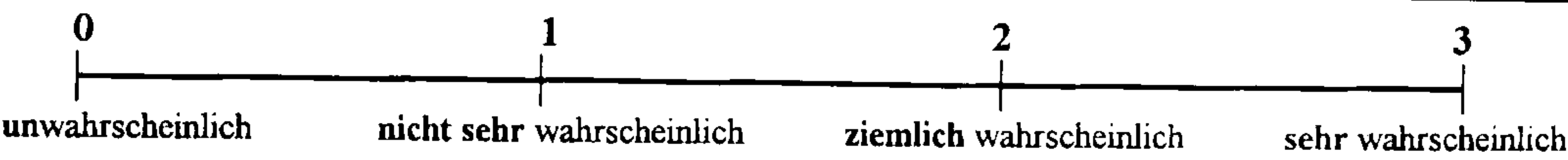
	Hilfreich	Unempänglich und unaufgeschlossen	Enttäuscht und deprimiert
Ich selbst, wenn ich mich in meinen privaten Beziehungen am schwersten tue	2	0	1

*(Dies ist ein Teil der zweiten Matrix)*



**BEI ANDEREN AUSGELÖSTE REAKTIONEN (ANDERE WERDEN...):**

	Unabhängig und stark	Kontrollierend	Bestürzt, Aufgeregt, Ärgerlich	Schlecht	Zurückweisend	Hilfreich	Zuneigungsvoll	Verständnisvoll
Jemand, der sich behaupten und unabhängig sein will								
Mein(e) 'nicht so schwierige(r)' Patient/Klientin								
Jemand, der Erfolg haben, etwas leisten und anderen helfen will								
Jemand, der sich anderen widersetzen, andere verletzen und kontrollieren will								
Ich selbst, wenn ich mich in meinen privaten Beziehungen am schwersten tue								
Jemand, der sich gut und wohl fühlen will								
Jemand, der verletzt und kontrolliert werden und keine Verantwortung haben will								
Ich selbst, wenn ich mich als TherapeutIn am schwersten tue								
Jemand, der geliebt und verstanden werden will								
Jemand, der Abstand haben und Auseinandersetzungen vermeiden will								
Mein(e) schwierige(r) Patientin / Klient								
Jemand, der anderen nahe sein und sie akzeptieren will								



ÜBLICHE REAKTIONEN VOM SUBJEKT SELBST  
(SUBJEKT FÜHLT SICH / IST / TUT...):

	Hilf- reich	Unempfäng- lich und unaufge- schlossen	Widersetzt sich und verletzt andere	Enttäuscht und deprimiert	Respek- tiert und akzeptiert	Hilf- los	Voller Selbst- kontrolle und Selbst- vertrauen	Ängstlich und beschämt
Jemand, der sich behaupten und un- abhängig sein will								
Mein(e) 'nicht so schwierige(r)' Patient/Klientin								
Jemand, der Erfolg haben, etwas leisten und anderen helfen will								
Jemand, der sich anderen wider-setzen, andere verletzen und kontrollieren will								
Ich selbst, wenn ich mich in meinen pri- vaten Beziehungen am schwersten tue								
Jemand, der sich gut und wohl fühlen will								
Jemand, der verletzt und kontrolliert werden und keine Verantwortung haben will								
Ich selbst, wenn ich mich als TherapeutIn am schwersten tue								
Jemand, der geliebt und verstanden werden will								
Jemand, der Ab- stand haben und Auseinandersetzun- gen vermeiden will								
Mein(e) schwierige(r) Patientin / Klient								
Jemand, der ande- ren nahe sein und sie akzeptieren will								



## **HINSICHTLICH DIESES FRAGEBOGENS:**

(Zutreffendes bitte ankreuzen)

**Dieser Fragebogen war insgesamt...**

... zu kurz                      ... gerade die richtige Länge...                      ... zu lang

**Ich empfand diesen Fragebogen im Ganzen gesehen als...**

... einfach                      ... nicht zu beschwerlich                      ... ziemlich kompliziert                      ... schwierig

**Es war für mich...**

... lohnend                      ... weder eine Bereicherung noch eine Belastung                      ... eine Zumutung

**diesen Fragebogen auszufüllen**

Bitte fühlen Sie sich frei, alle Aspekte des Fragebogens oder Ihrer Empfindungen während des Ausfüllens, zu kommentieren. Ihre kritischen Anmerkungen oder Ihre Verbesserungsvorschläge wären besonders willkommen:

Bitte schicken sie diesen Fragebogen in dem beigegeführten Umschlag zurück. Falls Sie bestimmte Aspekte besprechen möchten oder Fragen über die Studie insgesamt haben, schreiben Sie mir bitte unter der Anschrift auf der Titelseite oder setzen Sie sich in Verbindung durch

**Tel.:** (44)-1332-364-512, **Fax:** (44)-1332-293-316, oder **e-mail:** psrah@csv. warwick.ac.uk

## 9. Appendix 9: TDQ2, Sample Letters and Reply Form

### 9.1. *English-Language Samples*

July 1996

Dear Colleague,

#### **Therapists' Experience of Difficulties in their Practice**

I am writing to you, as one of the local specialist psychotherapists, to ask for your help with an inquiry I am currently undertaking into the kinds of experiences which therapists have when encountering difficulties in the course of their work. This study has its roots in a collaborative research programme - investigating therapists' difficulties and coping strategies - previously conducted by practising clinicians meeting at the University of Warwick. It forms part of the work I am currently undertaking for a doctoral dissertation, and a parallel survey is being carried out among German speaking psychotherapists.

If you decide to contribute to this study and to complete the attached questionnaire, it would certainly help to answer some of my research questions. However, I hope that you might gain something, too; perhaps a space for reflection on past experience or a fresh angle from which to organise your thoughts about your clinical practice.

In the questionnaire your contributions are invited in two different ways: in the form of verbal accounts in response to open-ended questions, and in the form of numerical ratings in response to structured items. Some psychotherapists feel uneasy about the latter format which can seem too far removed from clinical and personal experience. However, I believe that adopting different perspectives leads to a richer picture and I am therefore asking you to have patience with those sections which to you may appear of limited relevance.

It may be that you have already helped with a previous stage of the study. If so, you are welcome to use the same difficulty situations once again if they fit the current headings or, alternatively, to contribute fresh accounts, whichever seems more appropriate.

Please seal the completed questionnaire in the larger envelope provided and return it to the address shown on the label. First results should be available by the end of this year. If you are interested in a summary of the findings, please indicate this on the enclosed reply form and return it to me **separately** (to preserve your anonymity) in the smaller envelope provided.

Yours sincerely

Thomas A. Schröder  
Clinical Psychologist / Psychotherapist



July 1996

Dear Colleague,

### **Therapists' Experience of Difficulties in their Practice**

I am writing to you, as one of the local specialist behavioural psychotherapists, to ask for your help with an inquiry I am currently undertaking into the kinds of experiences which therapists have when encountering difficulties in the course of their work. This study has its roots in a collaborative research programme - investigating therapists' difficulties and coping strategies - previously conducted by practising clinicians meeting at the University of Warwick. It forms part of the work I am currently undertaking for a doctoral dissertation, and a parallel survey is being carried out among German speaking psychotherapists.

In this investigation I am aiming to cover as wide a spectrum of practitioners as possible. As my sample is currently weighted towards therapists with a psychodynamic orientation and with a professional background in clinical psychology, I would be particularly pleased to be able to include your responses to help offset this bias.

If you decide to contribute to this study and to complete the attached questionnaire, it would certainly help to answer some of my research questions. However, I hope that you might gain something, too; perhaps an opportunity for reviewing past experience or a fresh angle from which to organise your thoughts about your clinical practice.

In the questionnaire you are invited to contribute in two different ways: in the form of verbal accounts in response to open-ended questions, and in the form of numerical ratings in response to structured items. Some respondents feel less comfortable with one or other of these formats. However, I believe that diversity in approaches leads to more convincing results and I am therefore asking you to have patience with those sections which to you may appear of lesser relevance.

Please seal the completed questionnaire in the larger envelope provided and return it to the address shown on the label. First results should be available by the end of this year. If you are interested in a summary of the findings, please indicate this on the enclosed reply form and return it to me **separately** (to preserve your anonymity) in the smaller envelope provided.

Yours sincerely

Thomas A. Schröder  
Clinical Psychologist / Psychotherapist



January 1997

Dear Colleague,

### **Therapists' Experience of Difficulties in their Practice**

I am writing to you, as a Clinical Psychologist with expertise in psychological therapies, to ask for your help with an inquiry I am currently undertaking into the kinds of experiences which therapists have when encountering difficulties in the course of their work. This study has its roots in a collaborative research programme - investigating therapists' difficulties and coping strategies - previously conducted by practising clinicians meeting at the University of Warwick. It forms part of the work I am currently undertaking for a doctoral dissertation, and a parallel survey is being carried out among German speaking psychotherapists.

If you decide to contribute to this study by completing the attached questionnaire it would certainly help to answer some of my research questions. However, I hope that you might gain something, too; perhaps a space for reflection on past experience or a fresh angle from which to organise your thoughts about your clinical practice.

This study adopts a wide definition of psychotherapy. Your experiences would be most welcome whatever form of psychological therapy or counselling you practise,. In the questionnaire your contributions are invited in two different ways: in the form of verbal accounts in response to open-ended questions, and in the form of numerical ratings in response to structured items. Some respondents feel uncomfortable with one or the other of these formats. However, I believe that adopting different perspectives leads to a richer picture and I am therefore asking you to have patience with those sections which may appear of limited relevance.

It may be that you have already helped with a previous stage of the study. If so, you are welcome to use the same difficulty situations once again if they fit the current headings or, alternatively, to contribute fresh accounts, whichever seems more appropriate.

Please seal the completed questionnaire in the larger envelope provided and return it to the address shown on the label. First results should be available by the end of this year. If you are interested in a summary of the findings, please indicate this on the enclosed reply form and return it to me **separately** (to preserve your anonymity) in the smaller envelope provided.

Yours sincerely

Thomas A. Schröder  
Clinical Psychologist / Psychotherapist

December 1996

Dear Colleague,

### **Therapists' Experience of Difficulties in their Practice**

Thank you for your interest in this research study and for your offer to help with it. If you carry through your decision to contribute by completing the attached questionnaire, it would certainly help to answer some of my research questions. However, I hope that you might gain something, too; perhaps a space for reflection on past experience or a fresh angle from which to organise your thoughts about your clinical practice.

In the questionnaire you are invited to contribute in two different ways: in the form of verbal accounts in response to open-ended questions, and in the form of numerical ratings in response to structured items. Some respondents feel less comfortable with one or other of these formats. However, I believe that diversity in approaches leads to more convincing results and I am therefore asking you to have patience with those sections which to you may appear of lesser relevance.

Please seal the completed questionnaire in the larger envelope provided and return it to the address shown on the label. First results should be available at the beginning of next year. If you are interested in a summary of the findings, please indicate this on the enclosed reply form and return it to me **separately** (to preserve your anonymity) in the smaller envelope provided.

This investigation is also linked with another research project, the *International Study of the Development of Psychotherapists* undertaken by the *Collaborative Research Network* set up by members of the *Society for Psychotherapy Research*. If you are interested in further information about this study with a view to participating, you can also indicate this on the enclosed reply form.

Yours sincerely

Thomas A. Schröder  
Clinical Psychologist / Psychotherapist



December 1996

Dear Colleague,

### **Therapists' Experience of Difficulties in their Practice**

You may recall that I wrote to you earlier this year, asking for your help with this study and enclosing a questionnaire and other materials.

It may be that you have already returned the questionnaire (as it is anonymous I would not know if you have done so unless I had also received a completed reply form). In that case I am very grateful for your help and sorry to have troubled you again unnecessarily.

It may be that you have not yet found time or occasion to complete the questionnaire but are still prepared to do so. In that case it would help me to keep my work on schedule if I could receive your reply within the next fortnight. However, if this is not possible for you, any replies received before the end of January of next year would still be very useful and most welcome. If you have mislaid your copy of the questionnaire, please let me know so that I can forward another one to you.

It may also be that you have decided that you are unable to help with this study. In that case I would be grateful if you could return all the materials to me so that I can use them again.

Many thanks for your co-operation,

Best wishes

Thomas A. Schröder



# REPLY FORM

Please use this form if

- you are interested in receiving a summary of the findings of this study;  
and/or
- you know of colleagues who might also be interested in participating in  
this study (so that I can make further questionnaires available to you);  
and/or
- you have not already participated but are interested in the International Study  
of the Development of Psychotherapists (in which case I will arrange for  
further information and a Common Core Questionnaire to be sent to you).

Your personal details cannot be connected with your completed questionnaire. They will  
not be held on computer and only used for the purposes you have indicated.

Please tick as appropriate:

☐ I would like to be sent a summary of the findings of this study. möchte

☐ I would like to be sent \_\_\_\_\_ further questionnaires.

☐ I am interested in the International Study of the Professional  
Development of Psychotherapists and would like to be sent further  
information and a 'Common Core Questionnaire'.

**Your Name** .....

**Your Address** .....

.....

.....

.....

.....

Thomas A. Schröder  
Psychotherapy Department,  
Temple House,  
Mill Hill Lane,  
DERBY DE23 6SA  
Großbritannien

## 9.2. German-Language Samples

April 1996

Sehr geehrte(r) Kollegin/Kollege

### **Erfahrungen von Schwierigkeiten in der therapeutischen Arbeit**

Vielen Dank für Ihre Bereitschaft, die Beantwortung dieses Fragebogens zu erwägen. Ihre Mitarbeit würde mir sehr helfen bei der Beantwortung meiner Forschungsfragen über die Empfindungen, die PsychotherapeutInnen haben, wenn sie im Laufe Ihrer Arbeit auf Schwierigkeiten stoßen. Ich hoffe jedoch, daß auch Sie von Ihrer Mitarbeit profitieren können; vielleicht indem Sie Raum für Reflektion über frühere Erfahrungen finden, oder indem Sie Ihre klinische Tätigkeit aus einem anderen Blickwinkel zu betrachten und Ihre Gedanken darüber neu zu gliedern vermögen.

Diese Studie hat ihren Ursprung in einem kollaborativen Forschungsprogramm - über Schwierigkeiten und Bewältigungsstrategien in der therapeutischen Arbeit - welche von einer Gruppe praktizierender Kliniker and der Universität von Warwick in England unternommen worden ist. Da sie auch einen Teil meiner derzeitigen PhD Dissertation darstellt, wird sie vom Southern Derbyshire Mental Health Trust und der ihm angeschlossenen Mental Health Research Unit unterstützt.

Bitte versiegeln Sie den ausgefüllten Fragebogen in dem größeren der beigefügten Umschläge. Sie können ihn mir entweder direkt in der ersten der Lindauer Psychotherapie Wochen zurückgeben (jeweils nach der Morgenvorlesung im Stadttheater) oder sonst per Post zuschicken. Falls Sie sich entscheiden, an der Untersuchung doch nicht teilzunehmen, wäre ich Ihnen dankbar, wenn sie den unbenutzten Fragebogen an mich zurückgeben würden.

Parallel zu dieser Studie findet auch eine Umfrage unter Englischsprachigen PsychotherapeutInnen statt. Erste Ergebnisse sollten Ende dieses Jahres vorliegen. Wenn sie an einer Zusammenfassung der Resultate interessiert sind, so zeigen Sie dies bitte auf dem beigefügten Antwortbogen an und schicken Sie diesen **getrennt** (um Ihre Anonymität zu wahren) in dem kleineren der beigefügten Umschläge zurück.

Nochmals vielen Dank für Ihre Hilfsbereitschaft!

Mit freundlichen Grüßen,

Thomas A. Schröder  
Consultant Clinical Psychologist,  
Specialist in Psychotherapy



August 1996

Sehr geehrte(r) Kollegin/Kollege

**SPR - Collaborative Research Network**

**Internationale Studie zur Beruflichen Entwicklung von PsychotherapeutInnen**

**Modul: Erfahrungen von Schwierigkeiten in der therapeutischen Arbeit**

Sie werden sich sicher daran erinnern, daß Sie vor einiger Zeit den 'Basisfragebogen' der Internationalen Studie zur Beruflichen Entwicklung von PsychotherapeutInnen ausgefüllt haben (wie bisher mehr als 3000 PsychotherapeutInnen). Weiterhin hatten Sie angezeigt, daß Sie grundsätzlich zur Mitarbeit an weiteren Forschungsprojekten in diesem Zusammenhang bereit wären. Ich möchte Sie daher um Ihre Teilnahme an einem weiteren Forschungsmodul im Rahmen dieser Studie bitten. Die gegenwärtige Erhebung knüpft an ein kollaboratives Forschungsprogramm an - über Schwierigkeiten und Bewältigungsstrategien in der therapeutischen Arbeit - welches von einer Gruppe praktizierender Kliniker an der Universität von Warwick in England unternommen worden ist und welches jetzt über den englischen Sprachraum hinaus ausgedehnt werden soll.

Ihre Mitarbeit wäre von großem Nutzen zur Beantwortung unserer Forschungsfragen über die Empfindungen, die PsychotherapeutInnen haben, wenn sie im Laufe Ihrer Arbeit auf Schwierigkeiten stoßen. Ich hoffe jedoch, daß auch Sie von Ihrer Mitarbeit profitieren können; vielleicht indem Sie Raum für Reflektion über frühere Erfahrungen finden, oder indem Sie Ihre klinische Tätigkeit aus einem anderen Blickwinkel zu betrachten und Ihre Gedanken darüber neu zu gliedern vermögen.

Bitte versiegeln Sie den ausgefüllten Fragebogen in dem größeren der beigefügten Umschläge und schicken Sie ihn an die angegebene Adresse zurück. Dieses Forschungsmodul wird zur Zeit auch an Englischsprachige PsychotherapeutInnen verschickt. Erste Ergebnisse sollten Ende dieses Jahres vorliegen. Wenn sie an einer Zusammenfassung der Resultate interessiert sind, so zeigen Sie dies bitte auf dem beigefügten Antwortbogen an und schicken Sie diesen **getrennt** (um Ihre Anonymität zu wahren) in dem kleineren der beigefügten Umschläge zurück.

Nochmals vielen Dank für Ihre Hilfsbereitschaft!

Mit freundlichen Grüßen,

Thomas A. Schröder  
Clinical Psychologist/Psychotherapist  
Collaborative Research Network



# ANTWORTBLATT

Bitte benutzen Sie dieses Blatt, wenn

- Sie an einer Rückmeldung über die Ergebnisse der Studie interessiert sind;  
und/oder
- Sie KollegInnen kennen, die auch an der Teilnahme an dieser Studie interessiert  
sein könnten (sodaß ich Ihnen weitere Fragebögen zur Verfügung stellen kann)  
und/oder
- Sie an der Internationalen Studie über die Entwicklung von  
PsychotherapeutInnen interessiert sind (in welchem Fall ich Ihren Namen und  
Ihre Adresse an Deutsche KollegInnen weiterreichen würde).

Ihre Angaben können nicht mit Ihrem Fragebogen in Verbindung gebracht werden.  
Sie werden nicht auf elektronische Datenspeicher aufgenommen werden und nur zu den  
Zwecken verwendet werden, denen Sie zugestimmt haben.

Bitte kreuzen Sie an, was für Sie zutrifft:

- ☐ Ich möchte eine Zusammenfassung der Ergebnisse dieser Studie  
zugeschickt bekommen.
- ☐ Ich möchte \_\_\_\_\_ weitere Fragebögen zugeschickt bekommen.
- ☐ Ich bin an der Internationalen Studie zur beruflichen Entwicklung von  
PsychotherapeutInnen interessiert und möchte weitere Informationen und  
einen Basisfragebogen zugeschickt bekommen.

**Ihr Name** .....

**Ihre Anschrift** .....  
.....  
.....  
.....

Thomas A. Schröder  
Psychotherapy Department,  
Temple House,  
Mill Hill Lane,  
DERBY DE23 6SA  
Großbritannien

10. Appendix 10 - TDQ2: Rating Booklet 1

**THERAPISTS' EXPERIENCE OF DIFFICULTIES**  
**IN THEIR PRACTICE**

Dear Colleague,

Thank you for agreeing to help with this inquiry into the kind of difficulties which therapists encounter in the course of their work. Further on in this booklet you will find a number of accounts by therapists describing their experience of difficulties in their practice of individual psychotherapy. In relation to each of these accounts you will be asked to

- **judge** how well each account fits the difficulty categories of  
**A ('transient'), B ('situational') or C ('paradigmatic')**  
on the basis of the **definitions** supplied,
- **record** your judgements using the scales provided, and
- **decide** which of the salient categories is the **most representative** for each particular account.

Together with this booklet you should have received

1. a sheet with **difficulty definitions** and a sheet with **rating directions**
2. a sheet with the **instructions** and **headings** under which the difficulty accounts were elicited

**Please read the 'Difficulty Definitions' and the 'Directions for Raters'**  
**before you start reading the accounts and**  
**make sure that you do not leave out any accounts!**

When you have completed the task, please return all the materials.

\*\*\*\*\*

It would also be helpful to have the following information about yourself:

Your sex.....(M/ F (Please circle as appropriate)

Years of experience as a psychotherapist since finishing your training: ..... Years

Years of experience as a supervisor of psychotherapists: ..... Years

Your theoretical orientation as you would describe it: .....  
.....

**THANK YOU FOR YOUR HELP!**



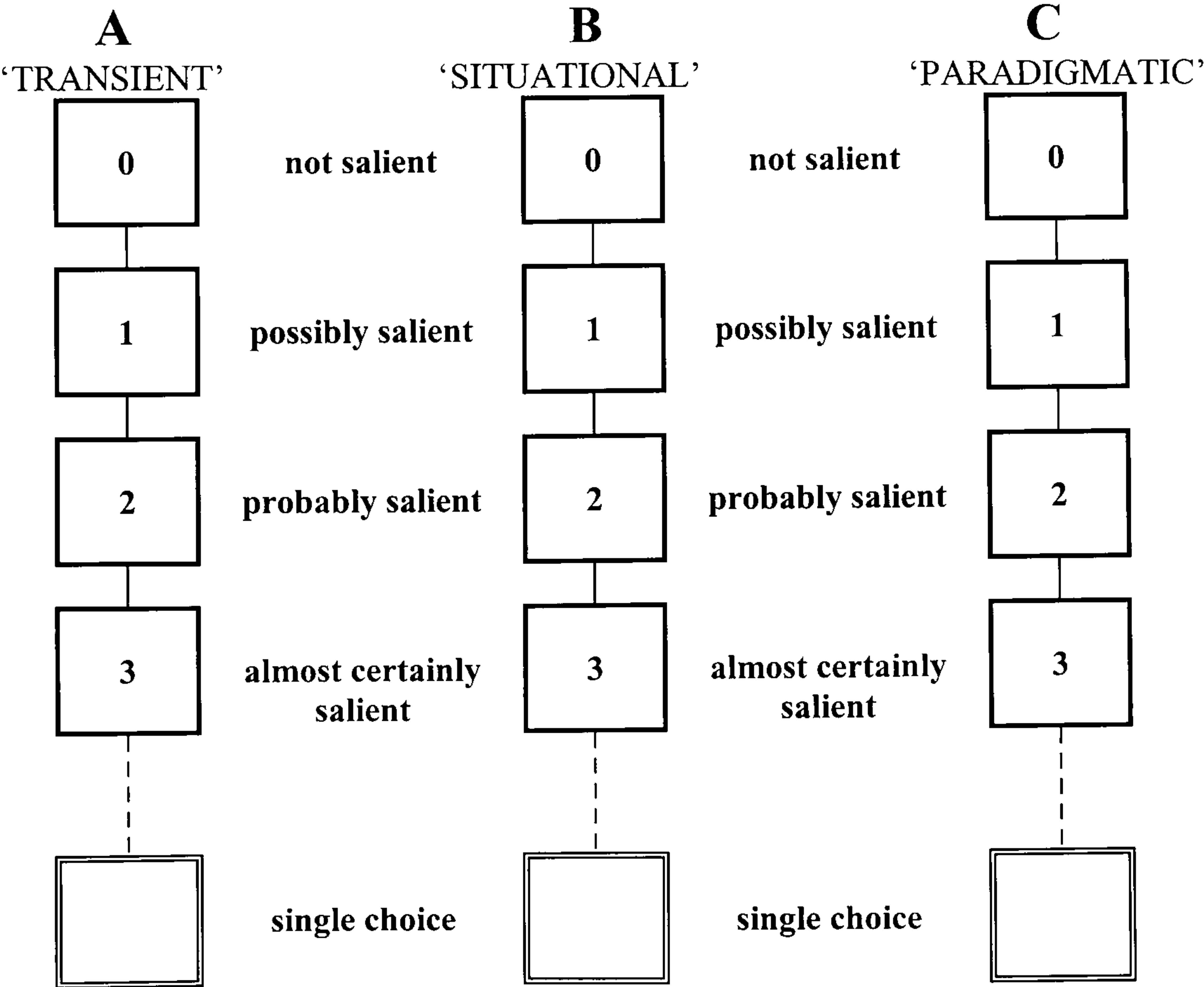
This concerns a lady whom I was seeing for 20 sessions time limited dynamic psychotherapy, with a focus on her childhood, which had been particularly bleak. She had been abandoned by her parents and brought up in a Barnado's home, where she suffered extreme emotional and physical deprivation, physical and sexual abuse. She was about 55 when I saw her, a pleasant conscientious and religious lady who worked hard in therapy and formed a strong therapeutic alliance.

Understandably, recalling childhood events, including frequent previously repressed traumas, caused her great distress, and at such times she would often become silent and tearful for quite long periods, and sit with her head in her hands. On one such occasion she eventually looked up at me with an expression of complete puzzlement and said "Who are you? Where am I?". It was immediately evident that she had regressed to childhood and was in a (hopefully) transient psychotic state. She was very frightened and confused. This was, obviously, a disturbing experience for me. I said, as calmly as I could, "my name is B\*\*\*, we meet here at B\*\*\* every week to talk about your difficulties". She thought about this, then asked the if the door was locked. Without getting up myself I said that the door was unlocked, and invited her to check for herself. She opened the door and looked out onto the corridor, which seemed to reassure her.

I spent the remainder of the session simply sharing her pain and confusion, reinforcing reality and refraining from interpretation. I reiterated that her fears were related to past events, that I was the therapist whom she knew and trusted, and not the past abuser whom she briefly 'saw' in me, and that she was soon going home to her husband, whom I named. She gradually became less confused, though she was still somewhat disorientated at the end of the session. I sat her in the reception area downstairs - I thought she might find the presence of the female reception staff reassuring - and gave her some tea. I checked on her periodically and after about half an hour she said she felt well enough to go home. I checked this out by asking her who I was, where she was, where she lived and her husband's name, also of which she knew.

This was the only such episode of that kind which ever occurred. In subsequent therapy we were able to understand it in terms of repressed trauma, and it proved to be a turning point in therapy. She thanked me for staying with her in her pain, and there was a marked diminution of depressive and anxiety symptoms. The therapy ran its course and I discharged her. I would have thought that her prospects were good.

Though I felt I dealt with that situation reasonably well I was concerned for her at the time and upset on my own account. After the session I found a colleague to talk to and be hugged by.

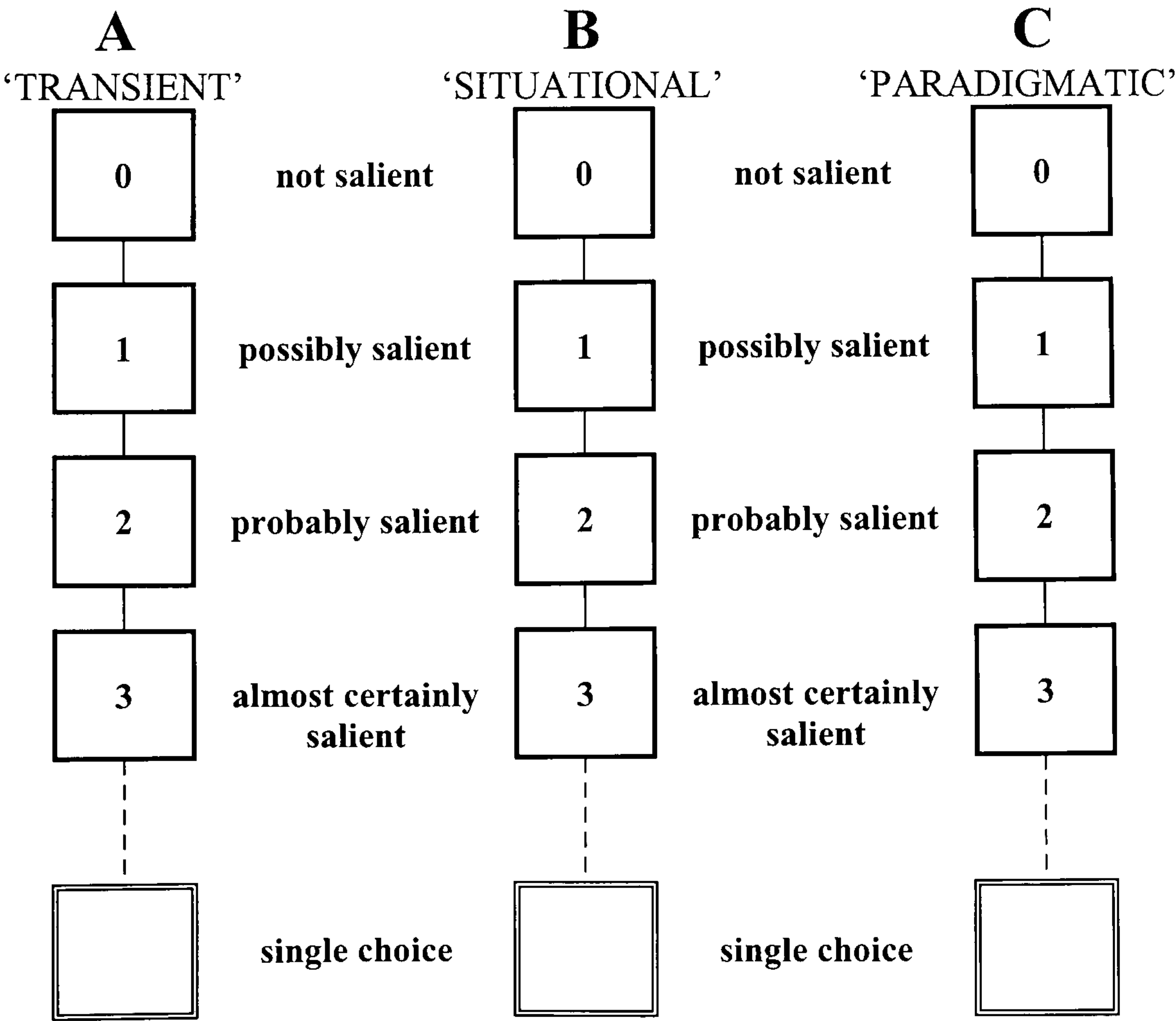




I was seeing someone for a course of cognitive analytic therapy and as part of this was required to present him with my written reformulation of his difficulties, to serve as a focus for our work. In the draft form of this I had left out an important detail from his history. He seemed to pick up on this very quickly and was critical of me for having left it out. I recall having a mixture of emotions. I had genuinely forgotten the incident or series of incidents, which while of considerable significance had only been alluded to briefly up to that point. Initially, I found myself a bit non-plussed, then I tried to defend myself, whilst at the same time trying not to appear I was doing this. Part of me took his criticism on board and I felt rather amateurish about it. At the same time I was aware that being contemptuous, critical, and "disappointed" was one of his typical patterns of relating and I should perhaps have been pointing this out as an example to him. All of this was going on inside me at a very rapid rate, but my overall sense was that I had made a 'boob' which might damage the therapeutic relationship permanently.

We did talk this through somewhat and I acknowledged the omission, which I rectified subsequently. However, this was really only one example of a number of occasions when similar feelings were evoked by his criticisms, and this did become something of a focus for our work.

The wider implications of this specific event are probably to do with my difficulty dealing with a patient's anger/criticism directed at myself, and being open with my own feelings about them.



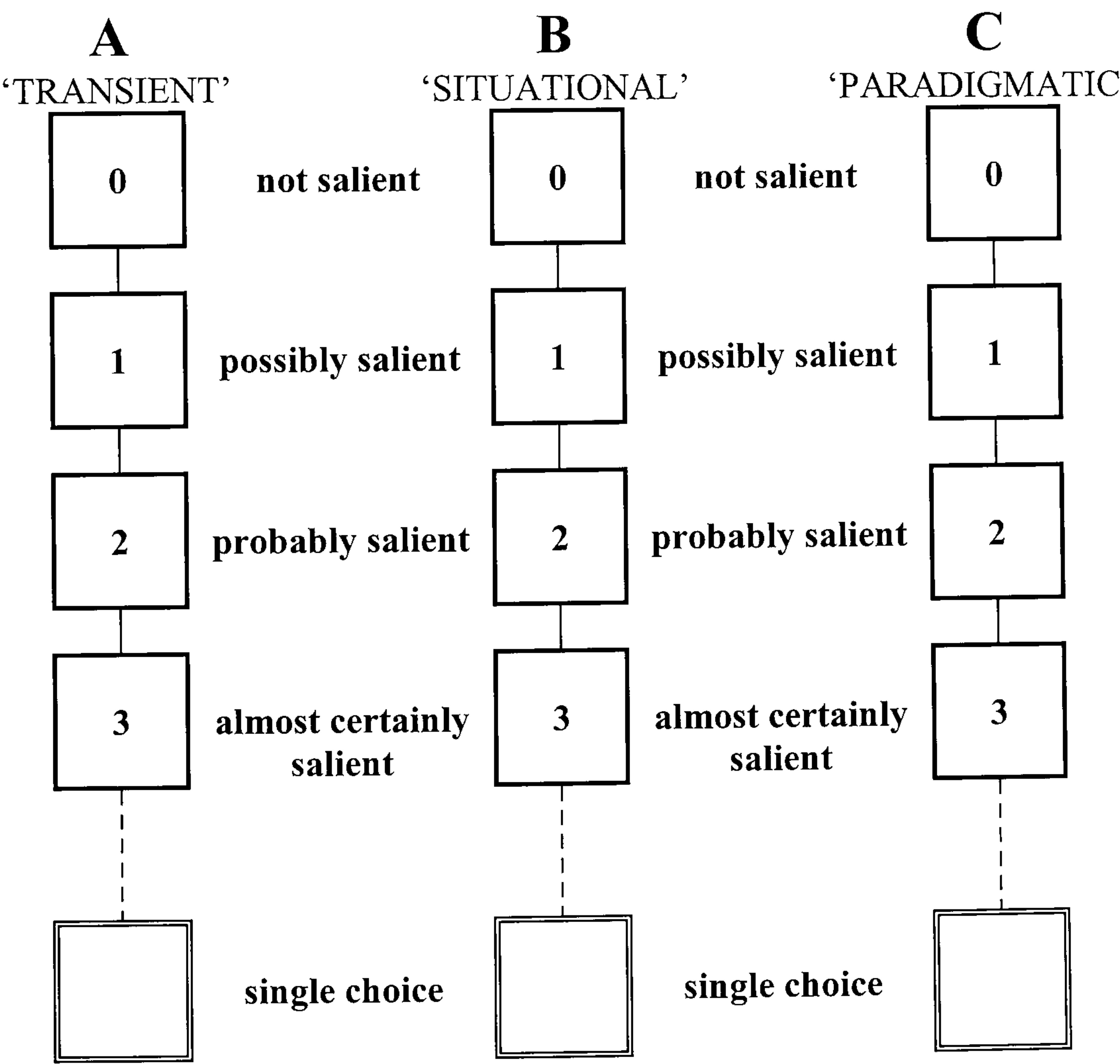
**003 MALE PSYCHOLOGIST - COGNITIVE, BEHAVIOURAL ORIENTATION 91**

Excellent "progress" over three to four months with severely depressed woman.

Arrived in a session in tears. Began attacking me verbally for state she felt in. Felt quite "paranoid", powerful expression of emotions.

Previous very good therapeutic relationship. Because of this I felt confused, unsure of reasons for change. But attack did not "get at core of me". Soon felt relaxed. Explored what had happened to her, what was on her mind.

End of session relationships much better - new issues opened up. Concentrated on these for next series of sessions.





J, who I am still seeing, but now about to terminate, was one of my first patients as a senior trainee. Just prior to starting therapy, and since assessment, she had started {therapy} an affair! with a married man (- I think writing therapy, when I meant affair is significant, and is the crux of therapy).

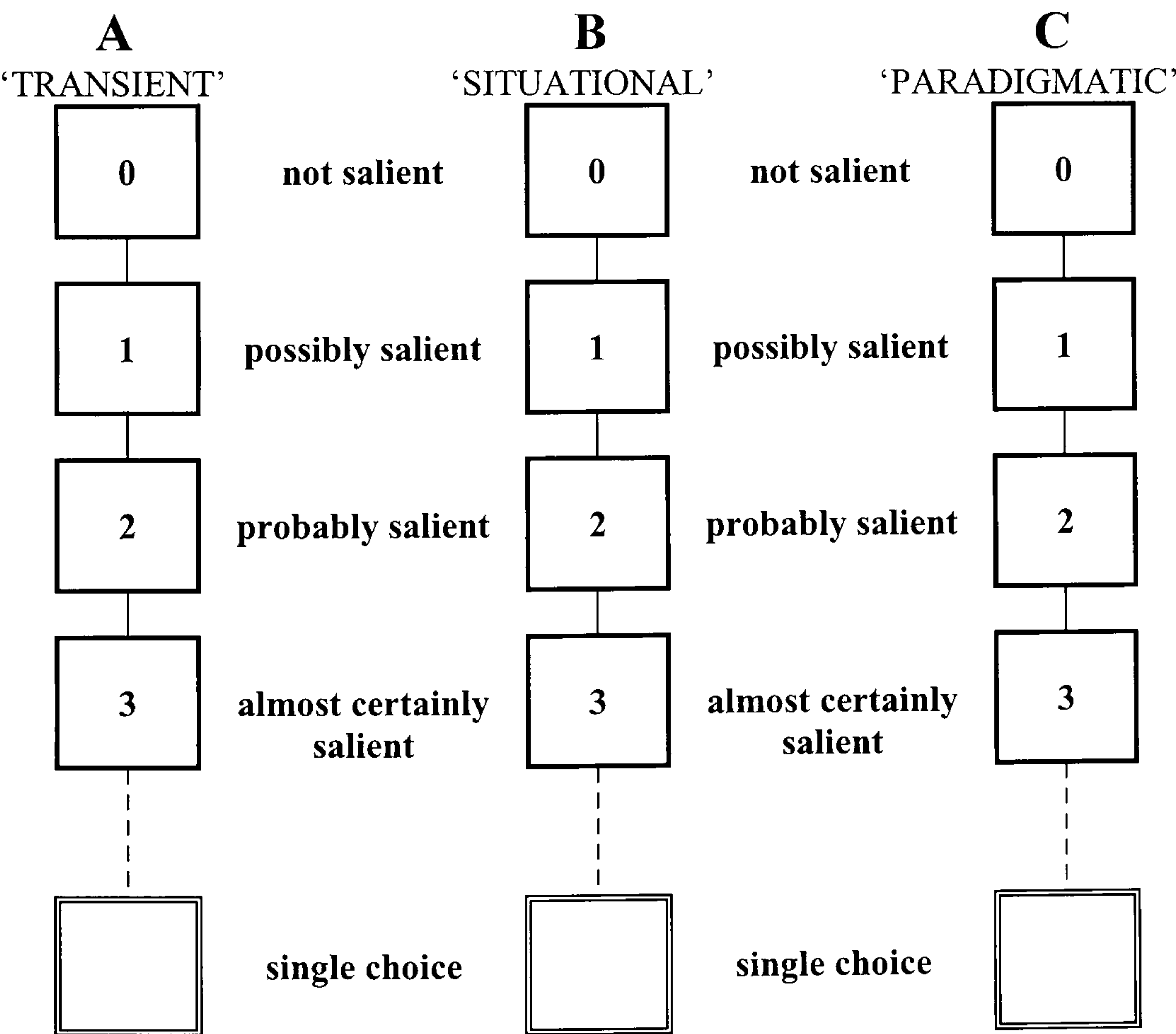
I immediately disapproved of her. She had been referred initially because of long-standing relationship problems, and had started to get involved with her male pupils. This had now stopped. She dressed like a prudish hippy, appeared completely un-psychologically minded, and appeared, on the surface to have no transference feelings towards me whatsoever. Every session she would talk about her obsessions about whether or not her boyfriend was 'clean' - by which she meant physically, ie clothes, hair, and had no means of looking at the deeper issues. I fell into a critical, disapproving mode, wanting her to get a life, and feeling towards her just as I feel towards my (difficult) stepdaughter.

My supervisor pointed out the countertransference aspects of this, and I struggled desperately for about a year to get out of being like my own mother, and her mother, and myself as a stepmother and to see her for herself.

Gradually, this became possible, and I could begin to see her strengths, to trust her judgement in relationships, and to see the parallels between my countertransference role as first critical mother, then weak passively supportive father - a role also taken by her boyfriend, and we are now working through a { ? } in her relationship as is therapy which is repeating her childhood experience of being abandoned (through death) by her father, who neutralised her toxic mother, but who could not allow her to grow into herself, so by dying before she could 'hate' him condemned her to being eternally disapproved of.

And now she is different. A powerful, sensual woman who knows her own mind is emerging. And I feel totally differently towards her, but look back and think how on earth did I get into and out of all that?

Treating J, and being in therapy myself, stirred up a lot and has made me aware of my own critical mother both 'out there' and inside. It has made me wary of my countertransference, seeing it more clearly as contributed to from both sides of the table.







MALE GAY PATIENT IN HIS THIRTIES. PROBABLY BORDERLINE. PRESENTED WITH BEREAVEMENT DIFFICULTIES FOLLOWING LOSS OF PARTNER FROM AIDS RELATED ILLNESS. HE ANNOUNCED TO ME THAT HE FELT THAT HE AND I WERE VERY MUCH ALIKE - IN FACT THAT I KNEW VERY MUCH WHAT IT WAS LIKE TO BE HIM AND VICE VERSA.

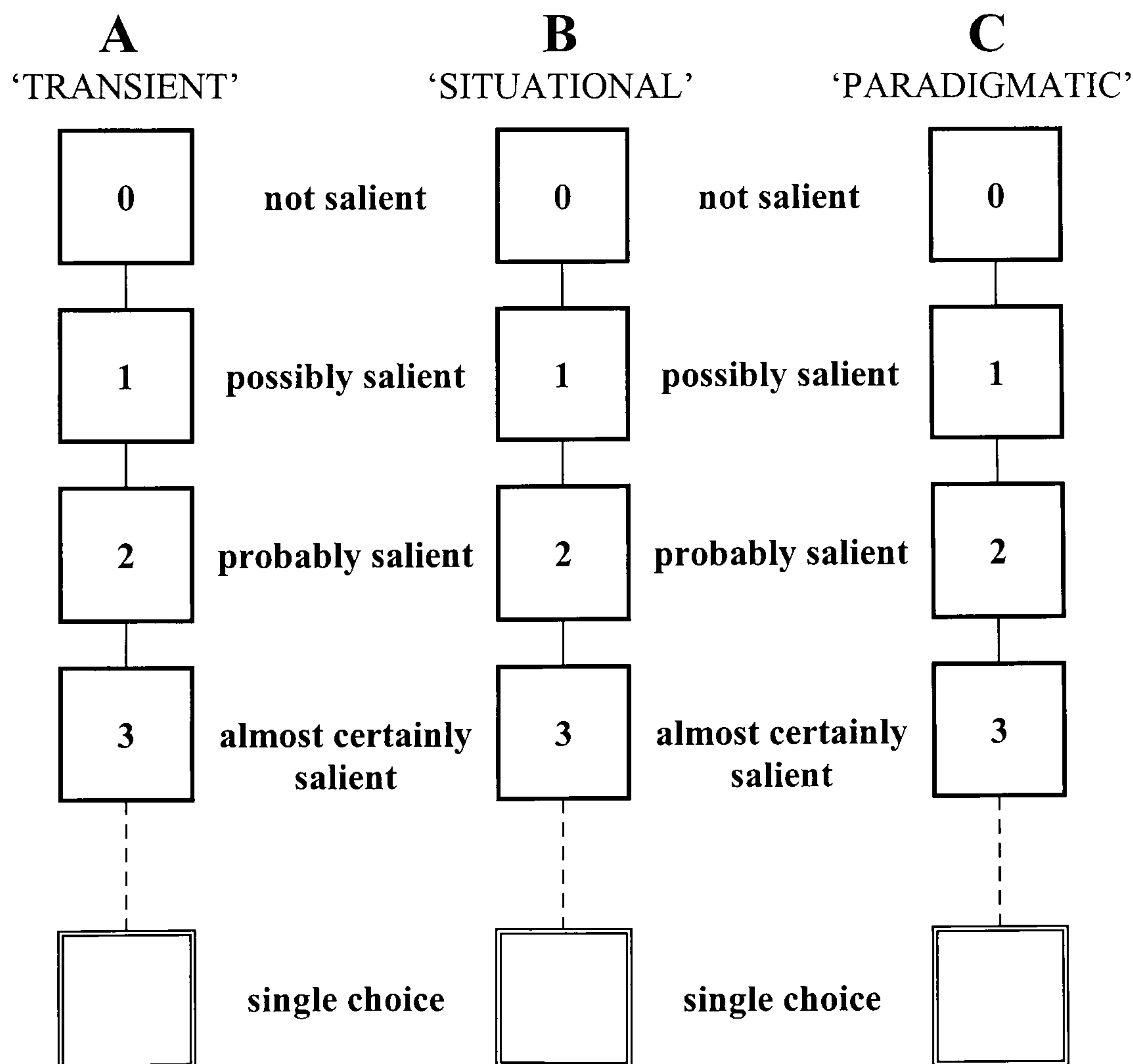
MY THOUGHTS WERE THAT WE WERE VERY MUCH DISSIMILAR, BUT THAT FOR HIM HIS EXPERIENCE WAS VERY MUCH A REAL ONE TO HIM.

AS I RECALL, I WAS INITIALLY {?} VERY PERPLEXED AS TO HOW TO RESPOND. AS I REGARDED HIM TO BE VERY DISTURBED, I SUPPOSE I SOUGHT TO TRY AND DISTANCE MYSELF FROM HIM AS IF TO REMIND MYSELF OF ALL THAT WAS NOT ALIKE ABOUT US!

I THINK I THEN TRIED TO OFFER AN INTERPRETATION OF HIS WISH TO SEE ALL AS THE SAME - IN THIS WAY I WAS LESS THREATENING TO HIM - LESS LIKELY TO DO HIM SOME HARM.

HIS RESPONSE WAS TO GET IRRITATED AND TO CRITICISE MY THERAPEUTIC SKILLS.

THE REST OF THE SESSION WAS RATHER TENSE AND UNCOMFORTABLE.







Bill was 55 years old at the time this event occurred. After 32 years he had just taken early retirement from teaching on the grounds of ill health. I had been seeing him for just over one year. For this session he arrived late - only the third time he had ever been late. This appeared to be significant. I was disturbed by his lateness. He arrived with profuse apologies and appeared restless.

Bill took up a conversation that had been current over a number of previous sessions but in a rather mechanical and lifeless way. Within a few moments I found myself feeling quite unwell, breathless and light-headed - was I going to faint, or even have a heart attack? It took some time to move my attention from my own condition back to Bill and what he was saying. This move of attention was a conscious act of progressive reevaluation - first speculating that my preoccupation with my physical well being was a linear process which could perhaps be viewed from other perspectives. Secondly postulating these symptoms as a manifestation of unconscious mental processes and emotional content. Thirdly locating some understanding of this unconscious process in hypotheses concerning Bill's presentation for therapy, and his repressed unconscious hostility and aggression. My 'symptoms' quickly dispersed.

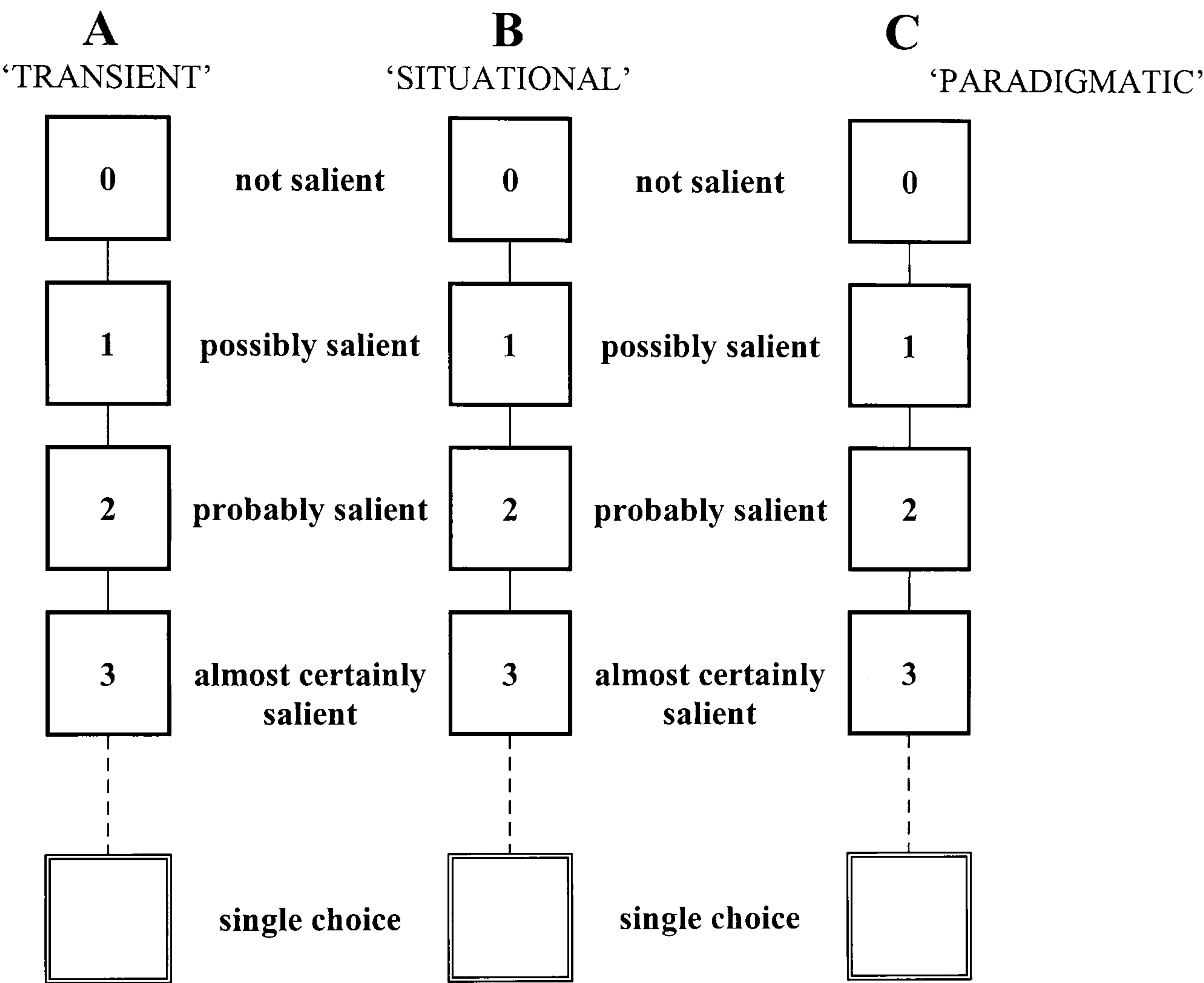
Bill is the eldest child of a large working class family which suffered considerable hardship during his childhood. He describes his mother as a distant and preoccupied woman. His father although described as affectionate is remembered as being relatively absent. Childhood memories are quite bleak but brightened by kindly uncles and aunts. Despite demands to care for younger siblings Bill did well in education and progressed in his profession. He has little contact now with family members and his marriage of twenty six years ended five years ago. He writes and paints, and these reflect aspects of a depressive position portraying an inner world populated by secure, good objects under siege from hostile and aggressive objects driven by envy of care and comfort from which he feels excluded.

As my 'symptoms' subsided I felt relief I was not going to pass out or die. As quickly as the symptoms receded so waves of somnolence came over me. Bill continued to talk but my eyes grew heavy and thoughts swam in the warmth of a sunny summer afternoon. I was preoccupied with staying awake. Again I looked to take another position on what was happening to avoid a linear, causal relationship. I moved from my own predicament to a reflection on themes in Bill's account, attempting to use hypotheses concerning his aggressive and envious impulses to illuminate this reflection.

He was telling me of the headteacher in his last school - a man with whom he vehemently disagreed but to whom he deferred in nearly all situations. He was also telling me of his search for a pathway to a new occupation. He was considering a counselling course as part of his links with a voluntary organisation.

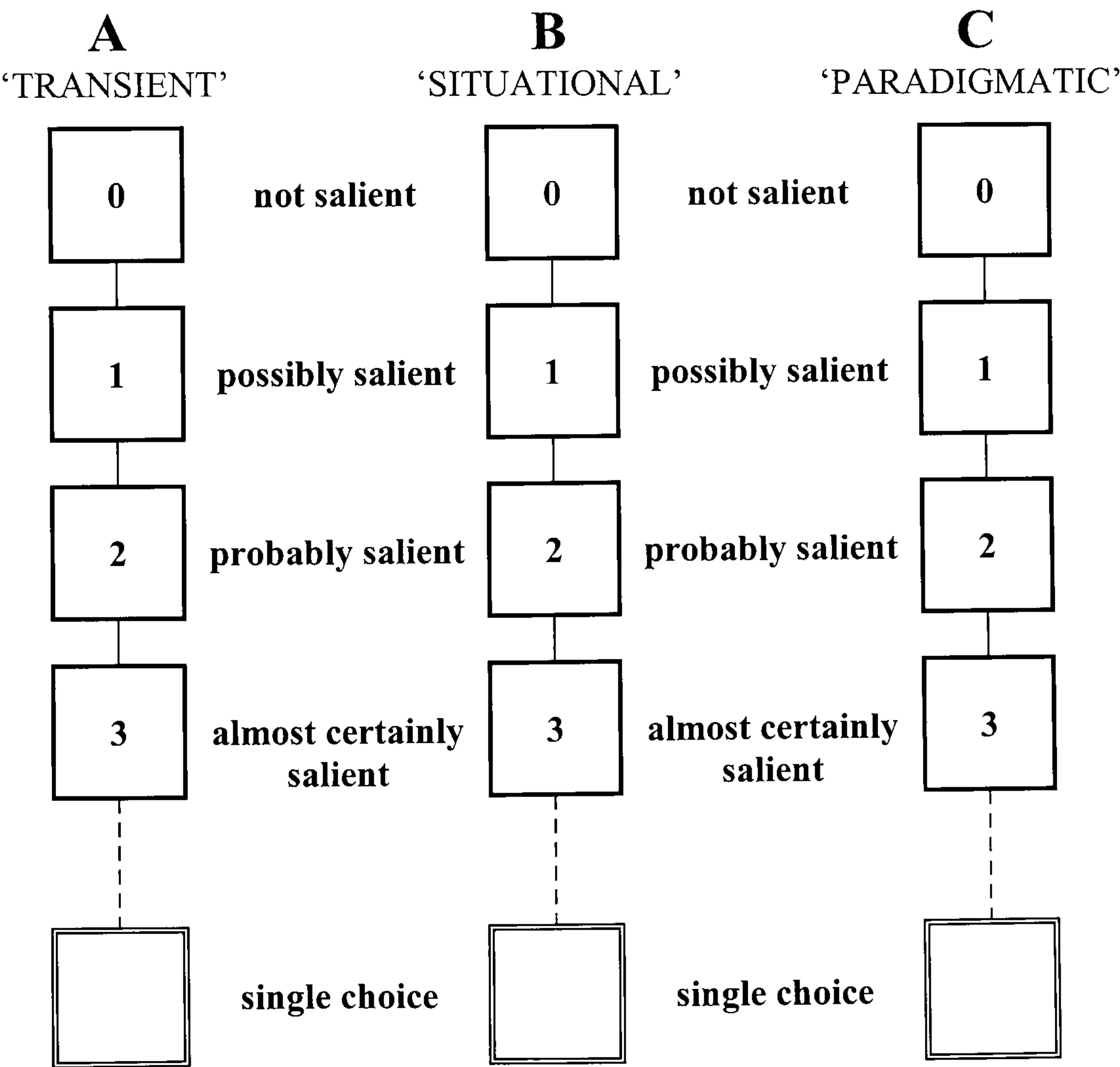
I was able to draw attention to Bill's hostile feelings towards me, like those towards the headteacher, and his mother. People of whom he would like to make demands but with whom he feels guilty and unworthy. Also his envy of me, linked to envy of the headteacher and his mother, who apparently have caring and resources for which he yearns.

*PLEASE CONTINUE ON THE NEXT PAGE*



I think I was swamped by projective identification.  
I think it was about anger.  
I became angry that my patient would not speak - the patient became angry that I would not speak, but in the silence this was hard to comment upon and at times I felt I was speaking to myself.

I felt trapped and prosecuted, and could see no way out. When I tried to address the projective identification, and wonder about the patient's feelings re: trapped and persecuted feelings, I seemed to draw a blank. The patient 'didn't know' about feelings. We remained in this impasse until therapy terminated.





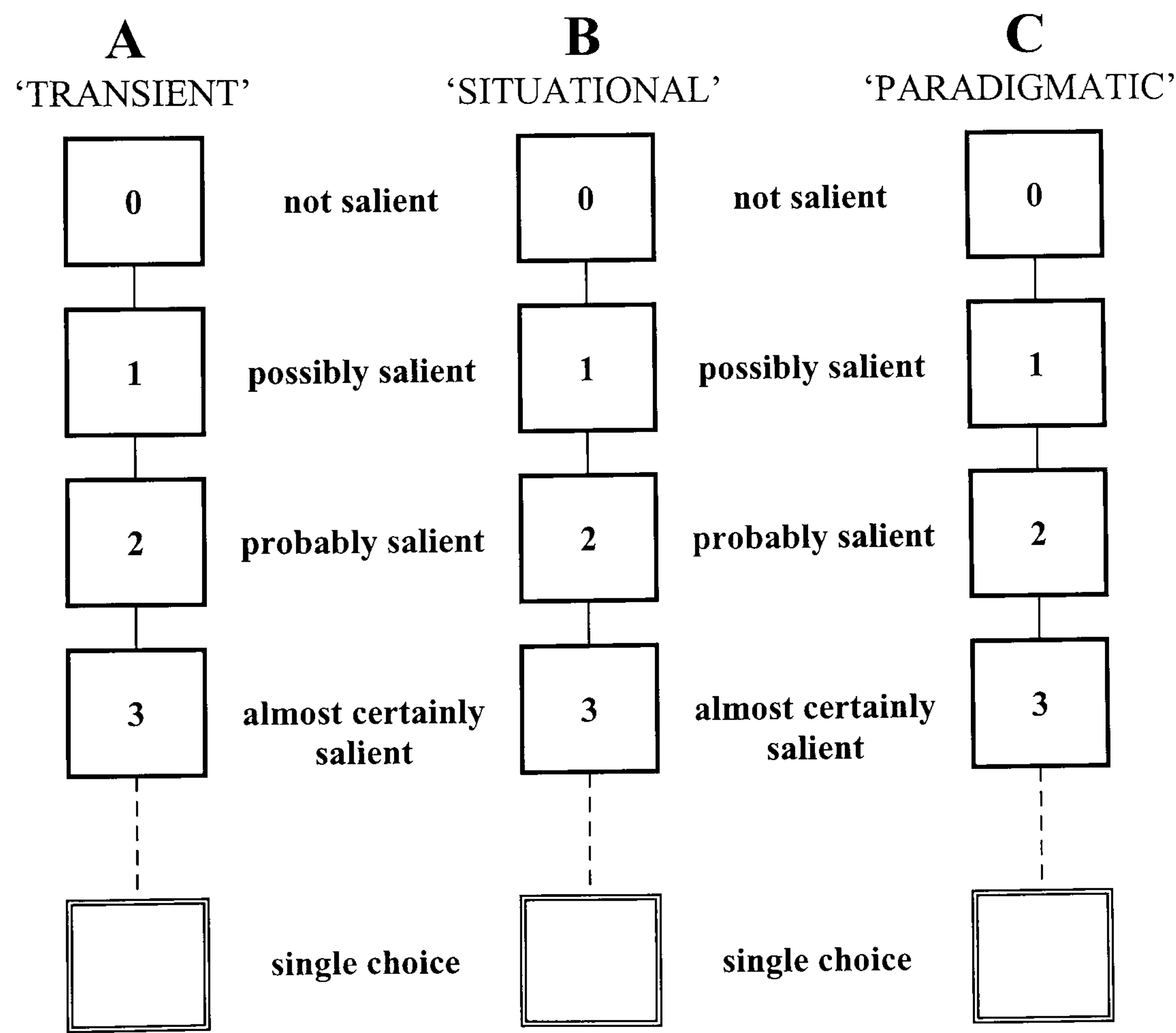
A difficulty emerged with someone that I have been working with for a relatively short time (approximately 12 sessions) although due to a long period of illness this has been in two chunks over approximately nine months. Thus the work feels in the early stages.

J (the client) was speaking over an incident in childhood when she had been criticised first by a woman in a shop who had asked her to read something, (nerves prevented her) then criticised and hit by her mother when she re-told the episode. Writing this, I am wondering whether what happened next was a re- enactment of this experience.

During the session, I noticed myself feeling angry with the adults while J only reported feeling angry with herself for not performing well. First I asked her to view this situation from her position as an adult - Did she see things differently - No. Then I said "I am noticing myself feeling angry with these adults who treated a young child critically and abusively (probably not these words but something along these lines), I wonder what that might be about".

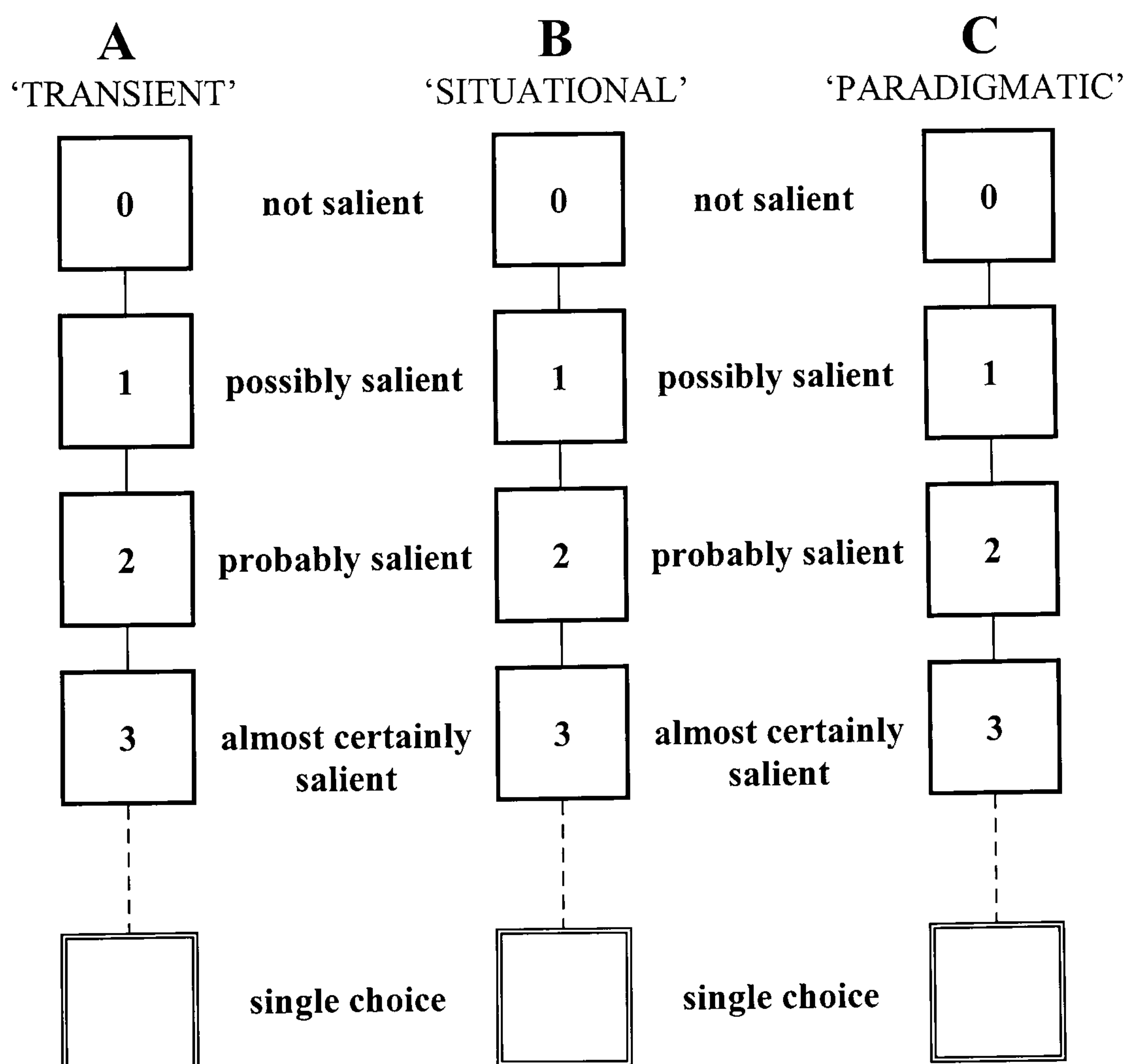
J seemed to become agitated that she could understand me / that I expected something of her which she was not clear about etc. Our conversation became tense and felt difficult to me. Attempting to explore or reflect on this seemed to make things difficult/worse. J did say she thought I expected her to get angry with me / practice? She stated emphatically / clearly that she was not angry with me (I am not sure at all)

Our session came towards an end and I found my self making light talk and attempting small jokes (not usual) to lift the feelings. Client left a touch reluctantly.



But when I asked her if she was trying to test me out, she flared up and accused me of not believing anything she had ever said. The therapy was a complete fake and illusion. I was telling her that she was unacceptable.

She only seemed to be so difficult in therapy with me. In her private life, and with another therapist, she seemed as normal as anyone else. I came to the conclusion that there must be some sort of connection between her basic fault and my basic fault.



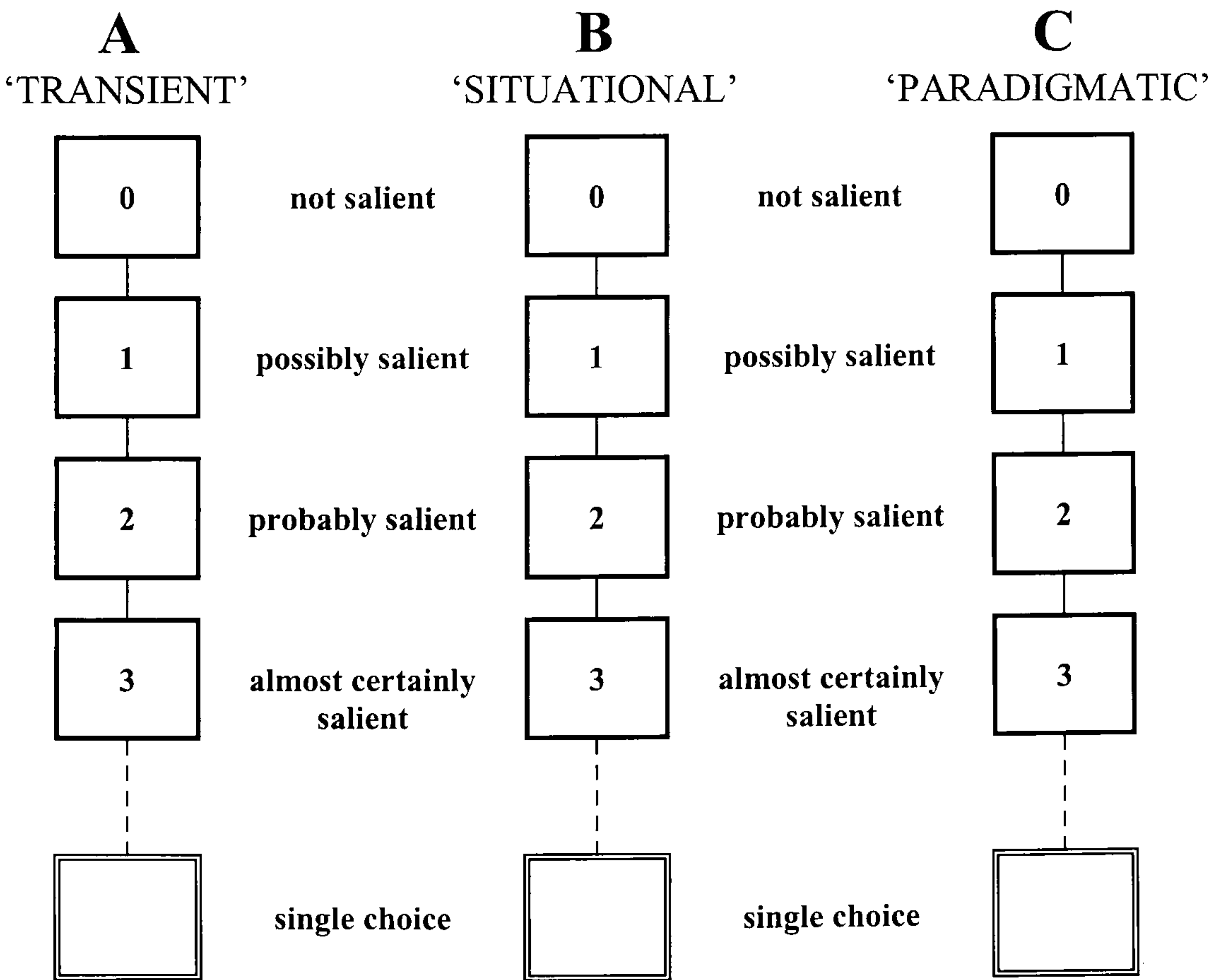


In the initial stages of psychodynamic psychotherapy, my patient, who presented with long standing depression and a variety of anxieties repeatedly cancelled sessions for 'legitimate' reasons which were perhaps preventable with some planning. It was difficult to explore possible avoidance because she had to put her daughter's needs first or else she was ill herself etc. This was also difficult to explore because to raise the issue was to question her role as a caring mother, therefore she felt worthless. She also reassured me how good therapy was for her.

Initially, I felt undermined and a little angry about her commitment(s) and even stopped my preparations for sessions (e.g. reading notes) during this period. She looked for reassurance from me, as she'd 'reassured' (or placated) me and I noted my rescuing tendencies in the countertransference but resisted acting compulsively and put this back to her (e.g. " perhaps.. you're wanting this kind of action ... looking for safety "). Internal supervision in-session and my supervision group helped me hold on to the avoided feelings in the transference; if she failed to live up to my expectations, I would cease helping and become hostile and critical like her mother. Unfortunately, things outside therapy (child protection procedures) meant that she continued to have 'legitimate' problems.

Unusually (with psychotherapy patients), I took the telephone call that came through asking to cancel another session (actually I wasn't told who the caller was) and pointed out the frequency (1 in 3) of cancellations asking her if the arrangements really where so convenient and whether we could work out some contingency plans with a babysitter ahead of time.

Obviously, I'd hinted that her motivation was suspect and her anger was palpable. In the next session she blamed me for ruining her Easter. I felt guilty that I'd hidden behind the telephone receiver rather than confronting her face to face and yet she'd expressed anger that she'd hidden from her mother. Again, I did not act on my rescuing, guilty feelings as reparative work seemed to be under way and that I'd become the critical mother was predictable from the formulation. Subsequently, she has not missed a session and planned one holiday break in advance! Although not a pleasant time for her, my observations about the need to help others before herself have proven useful and the emotional processing has shaped work in the transference to some advantage. Symptomatic relief took place and her anger uncovered significant neglect and abuse in the past. Finally, not preparing for sessions during her avoidant phase in the early stages was similar to her position with her siblings, 'in the middle', not seen as special etc. It seemed inevitable that therapy would re-enact this.





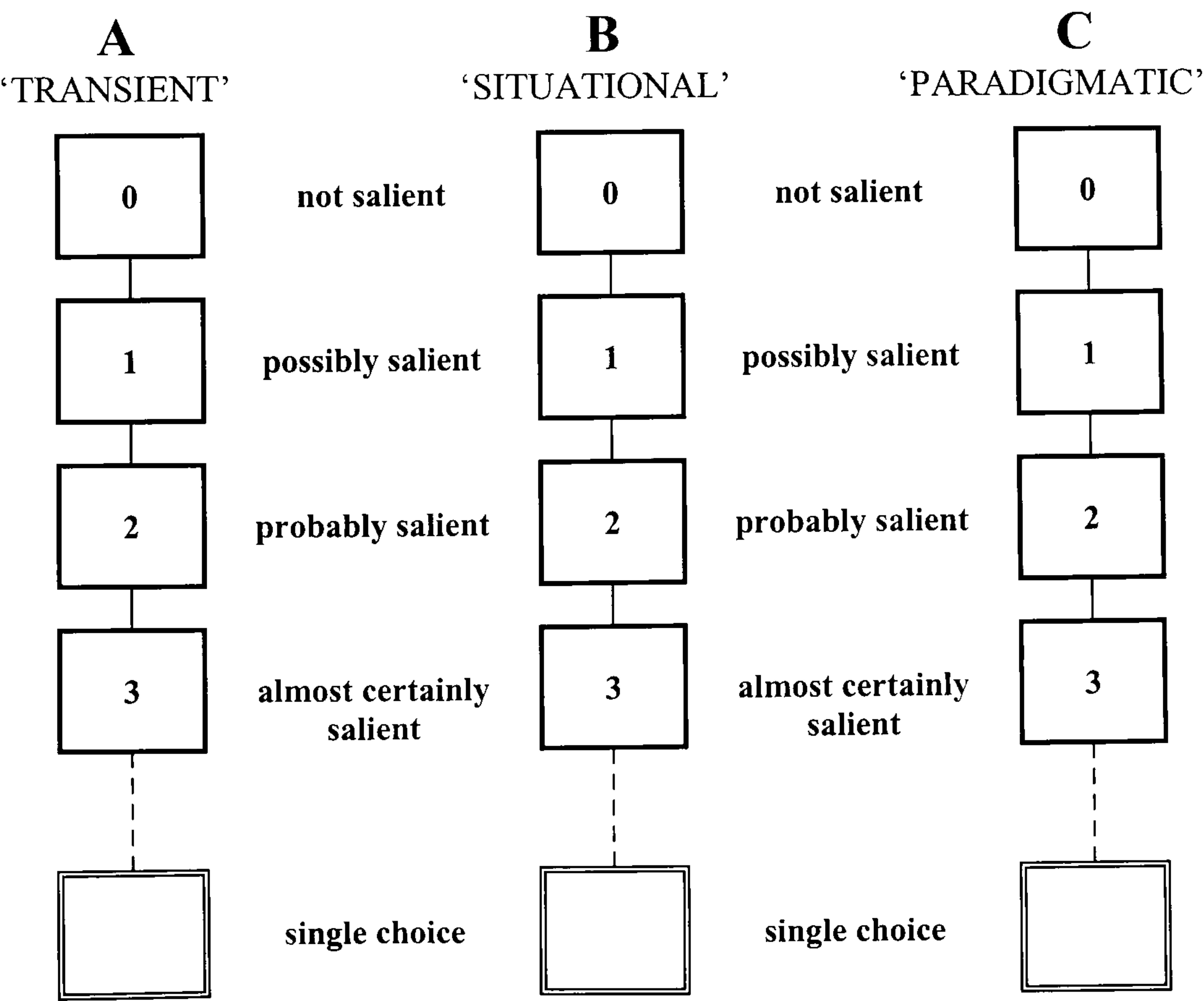
This client was a man who would not have approached a private therapist but came to me in my role as a student counsellor. He was lonely, isolated and grieving over the end of his marriage about which he felt angry and which he felt incomprehensible. He was a middle aged working class man who was in the building trade.

The difficulty was that he developed an erotic transference: he was not a "sophisticated" client. He projected onto me his own loneliness and sadness and repeatedly tried to persuade me to go to bed with him. He "could see I needed a cuddle" etc etc. Although I responded appropriately and always maintained professional boundaries, the truth was that although happy and satisfied in my own sexual relationship, I did find myself attracted to him. I sometimes felt sexually aroused during sessions, and I was concerned that he might be picking up my countertransferential feelings and therefore not believing my assertions that we would not be having sex either now or ever, and not being interested in my interpretations of his sexual fixation on me. In the end, although he did not make the step of grieving deeply for his marriage (which his transference to me had avoided) he did find another, more appropriate, object of desire. At the end of our work together he gave me a tape on which he had collected music for me "to help me relax"! The transference was not resolved and he had in a small way succeeded in penetrating me (in the form of my cassette deck!)

The last time I saw him we ran into each other at the gym. He said "If I'd got here earlier I could have taken you round and showed you the ropes". This made me laugh as I had been using the gym regularly for six years or so, and it confirmed his continuing wish to be the more powerful one in the relationship, even several months after he chose to terminate therapy.

I feel warm towards this man as I write. I felt that what went on between us was a battle of gender and power, and yet it felt loving as a mother and her small son might battle for separation and recognition. However, I felt I failed to confront him consistently and powerfully enough to be as useful - and potent - for him as I needed to be for him to work through his issues... He, on the other hand, succeeded in reaching into me, in invading my boundaries emotionally/sexually. I felt angry and distressed on one or two occasions, to find myself thinking of him whilst in bed with my partner.

My sexual feelings for him departed and dissolved before the termination of our work - but I recognise how he touched some deep issues in my own unresolved material.



Situation involves the development of very powerful erotic countertransference. The patient had at our very first meeting 'hugged' me on his way out - I was not aware of any attraction on my part at this stage but felt extremely uncomfortable by this act. I was however able to address this in following session. The development of my countertransference reaction (to his erotic transference) is hard to recollect but we are nearly into 12 months of his therapy and the last two to three months have felt quite unbearable. I'm the one doing the 'longing to see him'- fantasies around being with him - or searching for him - are intruding into my private life (if we have one!) -

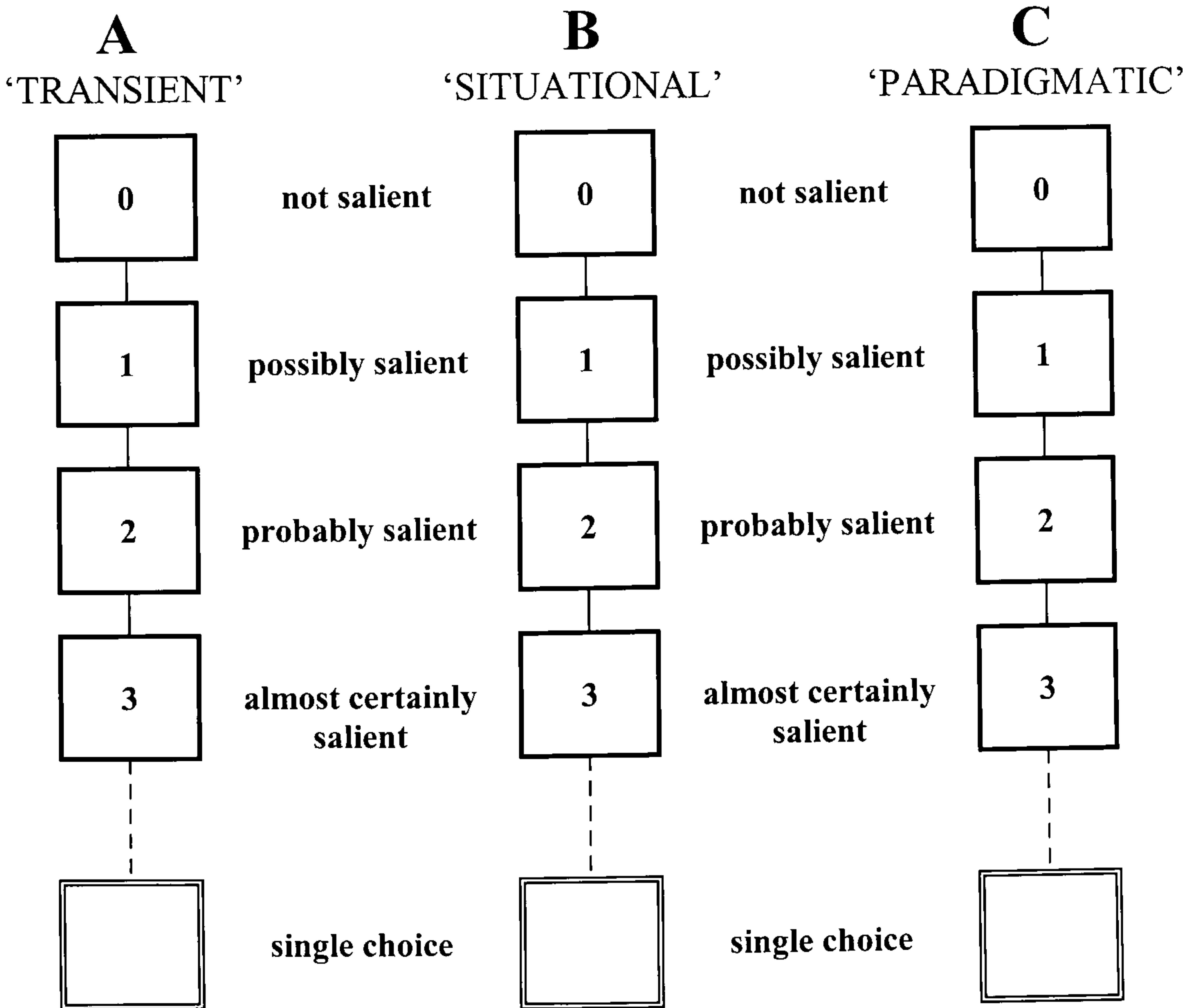
Thoughts around giving up therapy and my life to run off with him are a continual battle - certainly stirring me up and thoughts about myself and my own life. Feels harder to contain all these feelings in the usual supportive way - spilling out of me at times and I end up feeling guilty then - the bad therapist.

What makes it particularly difficult is the way the patient denies the transference. Denies that I affect him in any way or that he thinks about me at all. All this after saying he finds me attractive and did the first time we met. He presents seductively, both presentation, i.e. coming throughout the summer in his shorts, and in the verbal presentations and images he describes - example would be erotic bathroom scene - he once described my room as the size of his bathroom.

My struggle is around trying to give back some of the projection - because I think, his constant rejection of my interpretations around this led me to feel guilty, believing or question, "if it's just me" (though I doubt it?)

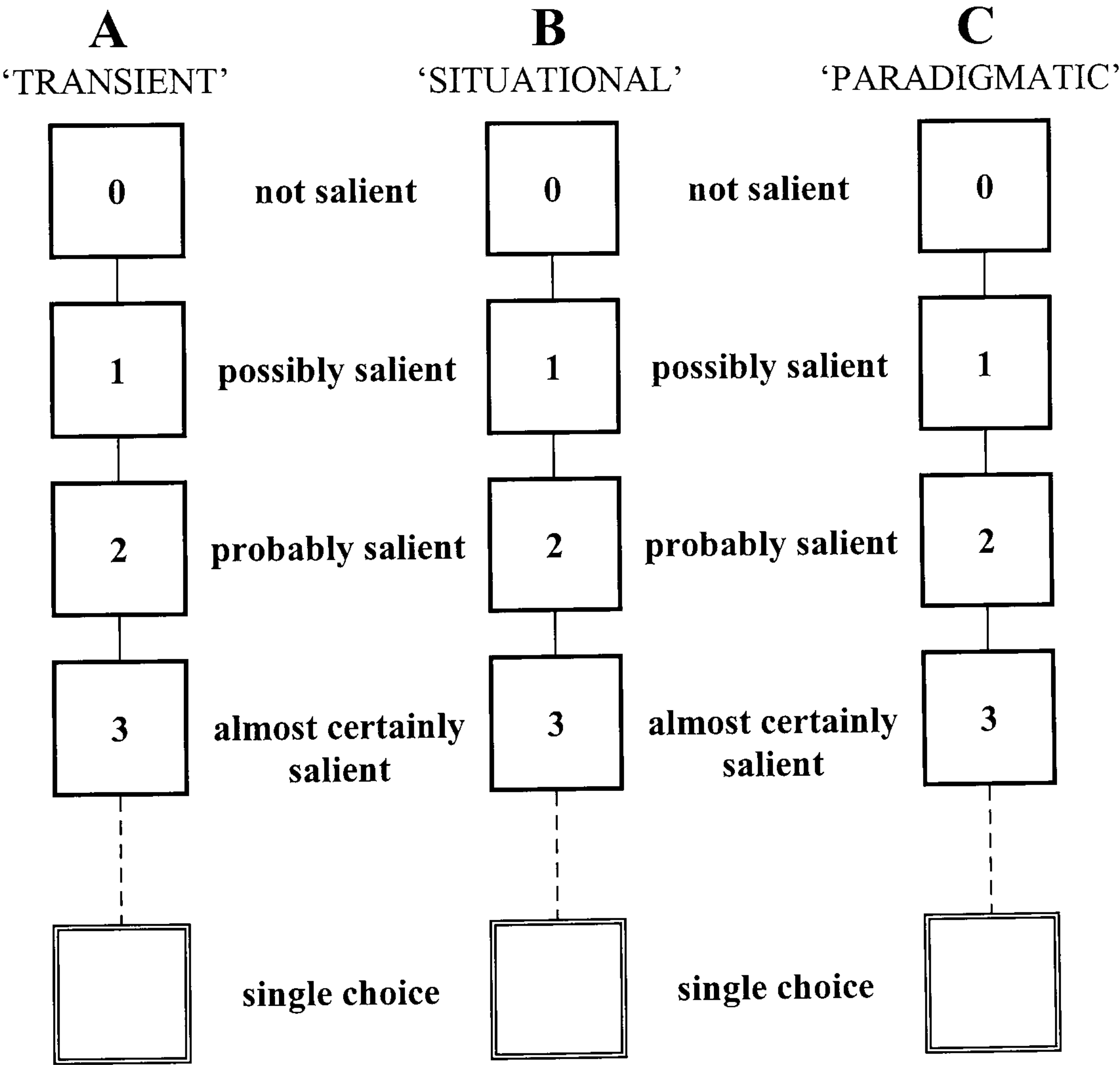
The power of feelings leaves me afraid also to re acting out, so it becomes difficult to talk about, again though I believe this links with the patient.

I cope with all this by honest open discussion in supervision also through exploration in my personal therapy. It's confusing to know what belongs where at times, and the strong identifications.





The client laughed things off very easily, and focusing onto painful material was very difficult. There was something in particular she wanted to tell me, but we found it very difficult to get to the point of her telling me. Initially, the therapy had involved reframing past experiences, helping her understand how they have impacted on her present. She worked on taking less blame and becoming more assertive. She presents as very well dressed, lovely children, lovely marriage etc, and in therapy only covers areas which are 'positive' or successful and that she's proud of. Getting to those parts which she is ashamed of is proving impossible. While we're both clear that doing so is important, and we've discussed ways of helping her explore them, she is backing off.





This is a current difficulty with a female client I see on a fortnightly basis during a session employed in a different trust than that in which I regularly work. The session is conducted in the out-patient department after hours with only obtrusive activity from the cleaners.

The client was sexually abused by her brother and experienced her early life as very damaging. Her father was an alcoholic who left the family home when she was eight.

Despite attempts to leave home the client remains with her mother. They now live alone, the client having told her mother about the past abuse which led to the abusing brother having to leave. The client has recently broken up with a long-standing live-in boyfriend and has embarked on a lesbian relationship with a friend.

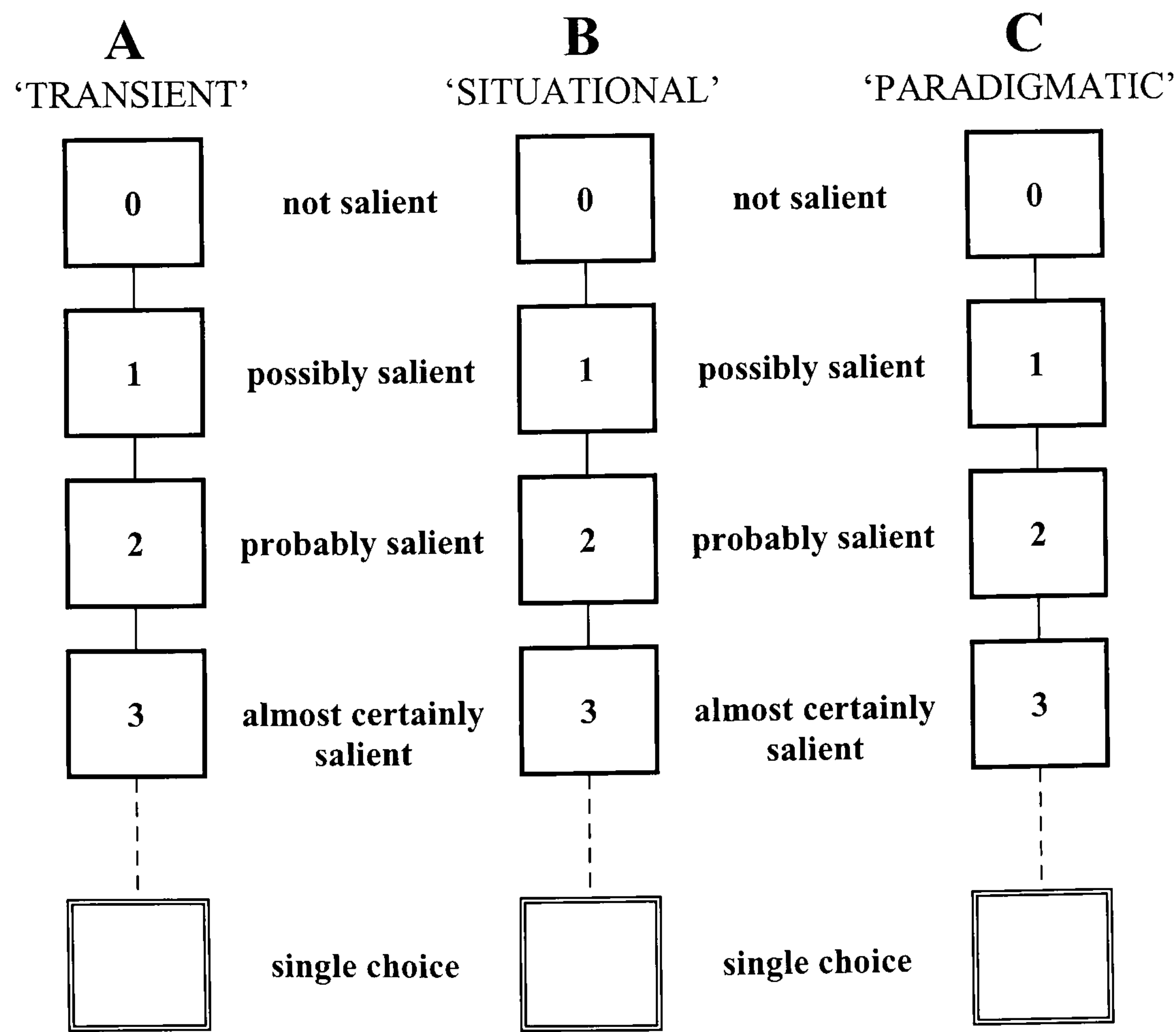
The difficulty revolves around a re-entrenchment of the defences. The client reports feeling very depressed and unconfident particularly because of her looks.

Her brothers have always told her she looks ugly and she, along with her mother and sister, have engaged in a long-standing game about who is the ugliest.

To support her claim she brought along 20 photographs in which she looked 'objectively attractive'.

At one level we take the view that her history would have led her to view herself negatively. That she is in a period of delayed adolescence/sexual experimentation and questions of physical acceptance are obviously to be expected.

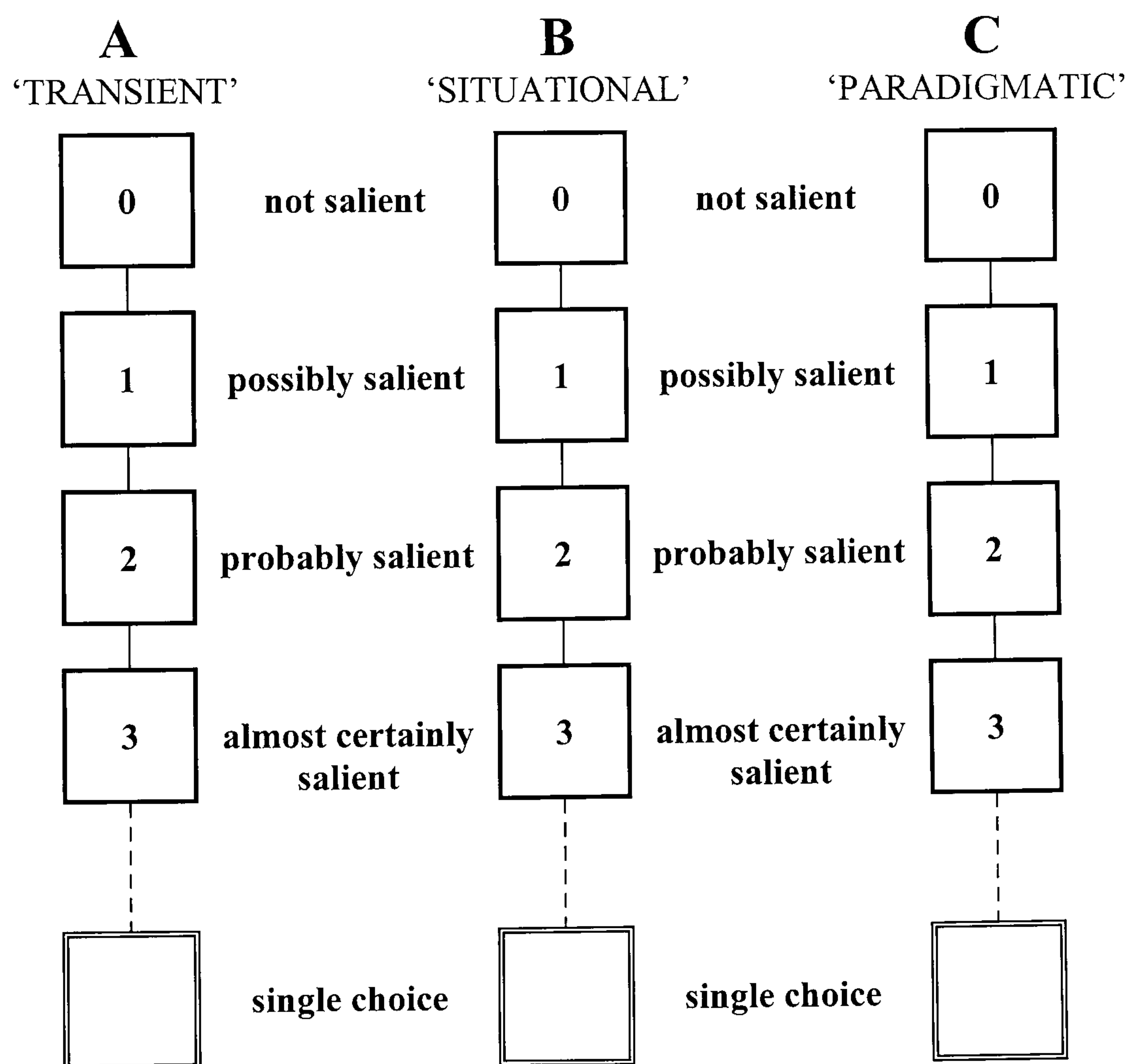
The difficulty for me is about separating out this level of analysis from what is going on in the sexualised transference. I feel put on the spot by the photographs to say 'you are obviously attractive, why do you think/feel the way you do'. The isolation of the setting intrudes and I feel pushed to my limits to contain the situation.





I hope this falls into this "remit". I worked with a client last summer for an assessment session plus 12 arranged sessions. This work was broken up with the summer holidays. I finished with the client in October. The work centred around her relationship with her partner who develops pathological hates of people. During the summer break, he tried to strangle her. The client chose to end the relationship while working with me. On one occasion when she was late to a session, I remember being frightened for her well-being.

The difficulty is that the ex-partner has been seeking appointments with me. I did not realise this initially and send out an assessment appointment which he defaulted on. However, he persisted. I am unclear about whether he wishes to harm me or whether he is genuinely seeking help - which I cannot offer because of my relationship with his ex-partner. I have been frightened and unsettled. The surgery that I work in and my supervisor have been supportive and various practical measures are now in place. I am acutely aware that I remain vulnerable if he seeks me out.

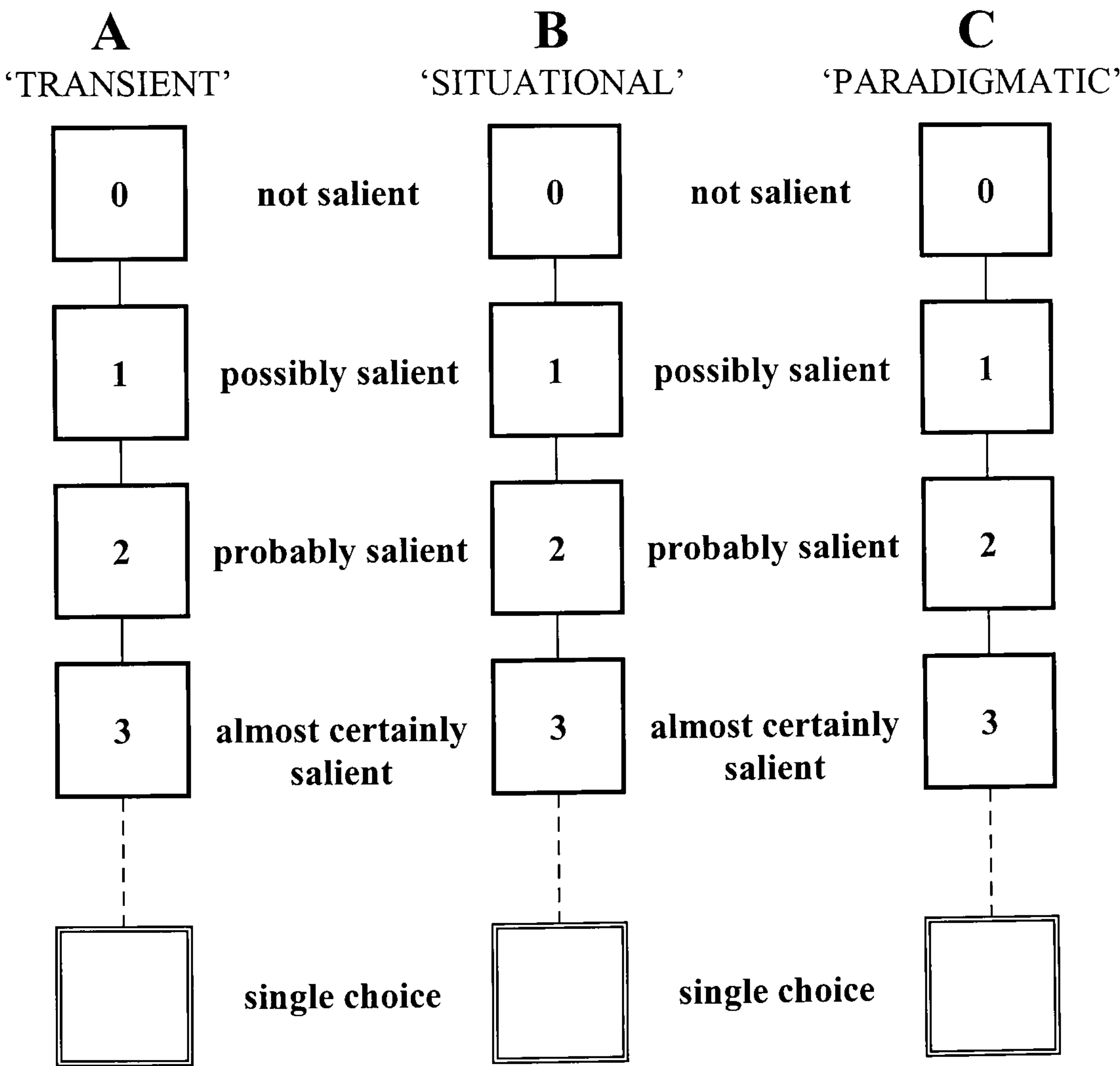




My first CAT training case: female student, borderline, self harming, fixed idea that she might be a lesbian - interferes every time she has hetero fantasies.

Difficulty: during CAT she appears over-diligent with homework tasks and when I stop giving her homework because it reinforces her problems she gets very upset.

I stuck it out and shared her helplessness. The overall outcome was very good and this was a turning point though the sexual issues, while better understood, remained practically unresolved.

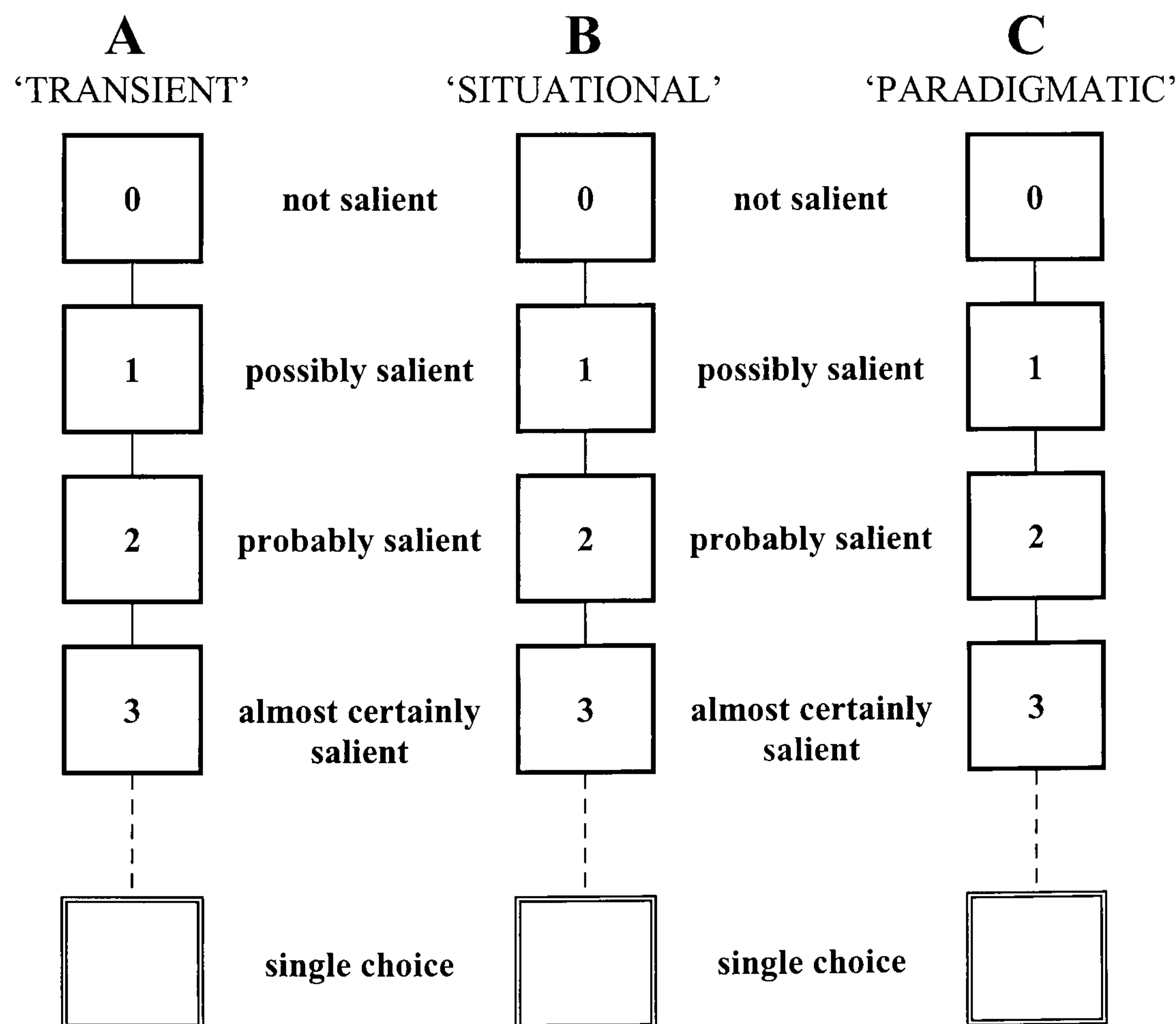


While a trainee, after about a year, an incident with a woman whom I was seeing free in an out-patient psychotherapy department, and who was continually late for sessions, who would denigrate and rubbish the kind of (psychoanalytic) therapy I was offering - sometimes not bothering to turn up or only turn up for 10 minutes or so; on one occasion when I phoned to say I would be about 15 minutes late due to a hold-up (road traffic accident), I arrived at the time - 15 minutes late - I had said, to find that she had gone out shopping. She returned about 15 or 20 minutes later with just under half an hour of session to go. My inner reaction was one of being very angry; I recognised that this trigger got me in touch with all my feelings at having been 'messed around' and rubbished for months, which I'd repressed? in the service of analysing and hearing her reactions. Though I continued to maintain an analytic and 'neutral' stance in what I said, it was nevertheless obvious to her that I was angry and she commented on this. I made some interpretation about the process between us (can't exactly remember), and also said that any anger of mine that was not belonging in the relationship between us, was for me to deal with in myself.

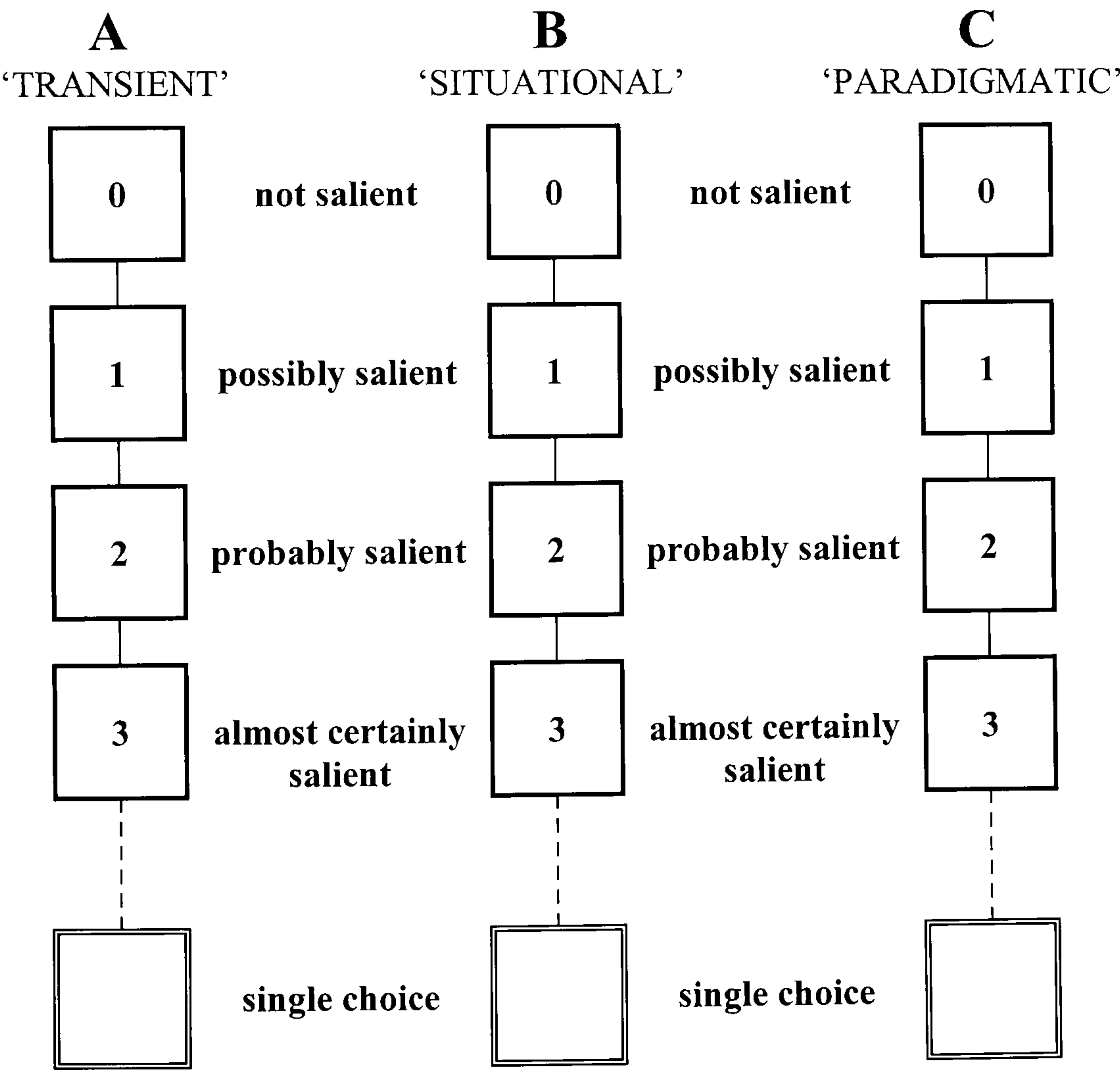
There was no very significant sequel or shift, perhaps a very slight effort on this patient's part to be more 'valuing' or punctual for sessions. Her underlying motivation never did change. Significantly, though she did later acknowledge that she could never be angry with her parents safely, (mother especially), in the way she had been angry with me.

(I thought of the value (and my supervisor also pointed out, among other issues), of Winnicott's notion of the need to 'destroy the object' to make it separate and external.)

My own sense was that with this particular patient, totally free therapy was not a good idea; I had to bear too much (though her status as a training patient helped me in that area) and she was not required to contribute anything to underpin some commitment and motivation on her part.



I have recently been seeing a female psychologist suffering with vaginism aged 27, in a stable long-term relationship, who makes avoiding the issue an art form. I feel great empathy for her, for her Roman Catholic past and current struggles. However, I am now older and the situation is less serious than the last one and the supervisory group is very supportive. These days I seem to have a richer sense of humour for life's issues! It turned out fine - eventually!





This patient is female aged 48. who is single (never married) and who is a fellow professional (a family therapist). Six years ago she adopted a hard-to-place child aged 8, who had been maltreated as a young child and taken into care with her sister when she was about 6.

The patient's initial contact with me (in July/August 1996) was because she was so distressed about her adopted daughter (now aged 14), who was out of control and was threatening to go to social services with a tale about being physically abused by the patient - she wanted to go into care. Subsequently the daughter was voluntarily taken into care - I think because the situation between adopted mother and child was so tense and volatile and the daughter was, at that time, very disturbed and virtually unmanageable (stealing, getting into fights, staying out all night or going missing for several days etc.).

Much of the initial therapy was spent processing the patient's thoughts and feelings, esp. her distress, about the situation. However, eventually the disturbances with the child got less. The child is still with a foster family, but she has regular contact with her adopted mother and their relationship, although still volatile, is less disturbed and destructive (to both).

My difficulty has been and still is to keep the focus on the patient and not be drawn into a discussion on what is happening with the daughter.

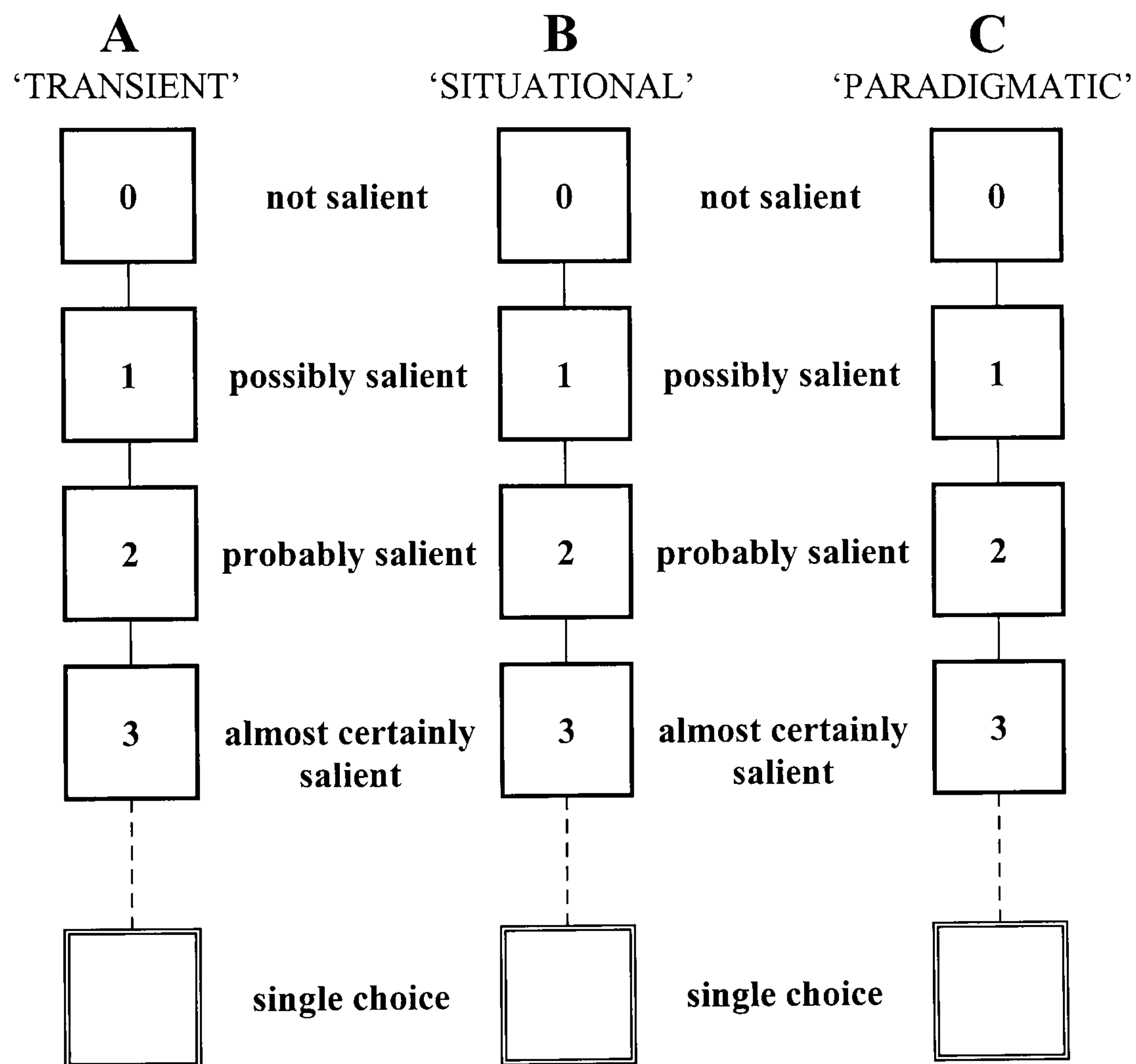
Almost every session starts with an account of what is happening/has happened with the daughter and the patient's distress about the situation, and although I can widen this out to make links with other experiences in her life - with her own parents and her own adolescence and also with her own professional standing and relationships with colleagues etc. - most sessions start with the daughter.

Although I had tried to address my role with the patient twice before the situation I am about to describe - i.e. was I a supporter through a difficult time or were we engaged in psychotherapy for herself? and she had affirmed that she wanted psychotherapy for herself - our sessions continued to be dominated by events connected with her daughter.

So recently I wondered with her whether things were now enough on an even keel for us to be thinking of when our contact might end. She had good liaison now with the social worker, the foster mother and the child's psychiatrist and was feeling more able to cope with her life, both personally and professionally. Was my role as outsider to the situation and supporter still required? Her eyes filled with tears and she looked quite panicky (and little girlish) at the prospect of ending with me. I was surprised by her reaction - had not thought she was that attached to me. We agreed I was important to her and that it was psychotherapy she wanted.

My difficulty is that it remains hard to address her transference to me or indeed to address much of her inner world. She is guarded and I think experiences feelings of inadequacy and shame and yet our sessions remain dominated by the daughter. I guess something is probably happening symbolically, but on the whole I do not know what I am doing!

*PLEASE CONTINUE ON THE NEXT PAGE*





A male client aged 39. His presentation of quite extreme depressive anxiety with a strong intellectual defence.

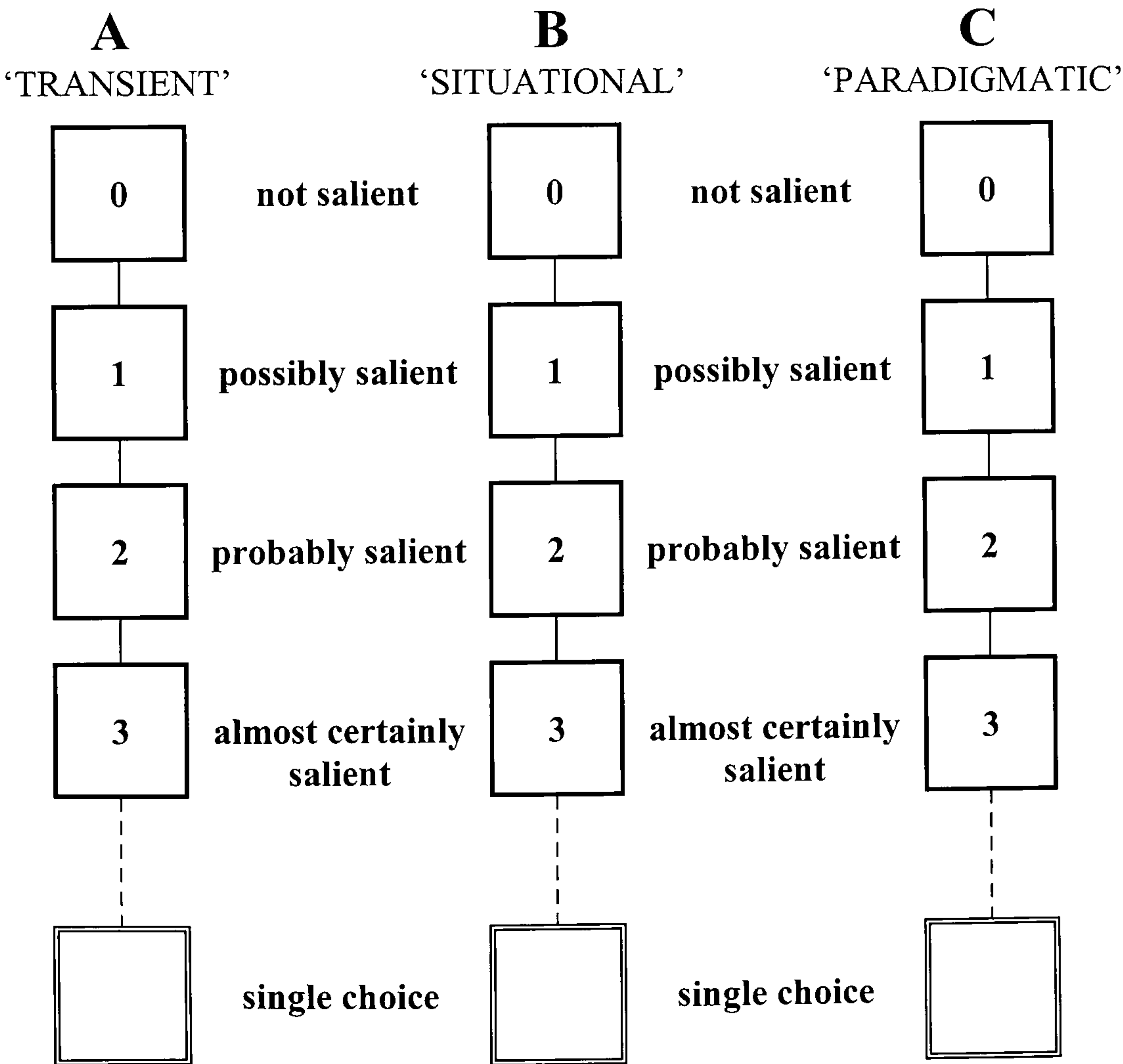
He was an English teacher and was experiencing bouts of acute anxiety as he 'saw himself' in the characters he was exploring. He also had homosexual fantasies as a result of abuse by an English teacher when he was eleven.

My client continually asked questions. I was 'caught' by trying to answer some of these (my justification for this was to attempt to offer a modicum of reassurance as part of the building of a therapeutic alliance). My strategy was not successful and the questions and demand for explanations remained constantly present.

His fear and lack of trust was not amenable to any strategy I employed and yet he was unwilling to be referred back to his GP, declaring that I was the one who had helped him most. I got really stuck in the face of his angry, demanding, vulnerable helplessness. Use of immediacy unblocked things a bit, but then provoked another stream of questions.

Eventually, he had a difficult episode at school and his GP increased his drugs which he hated, but which calmed him sufficiently to 'leave' me.

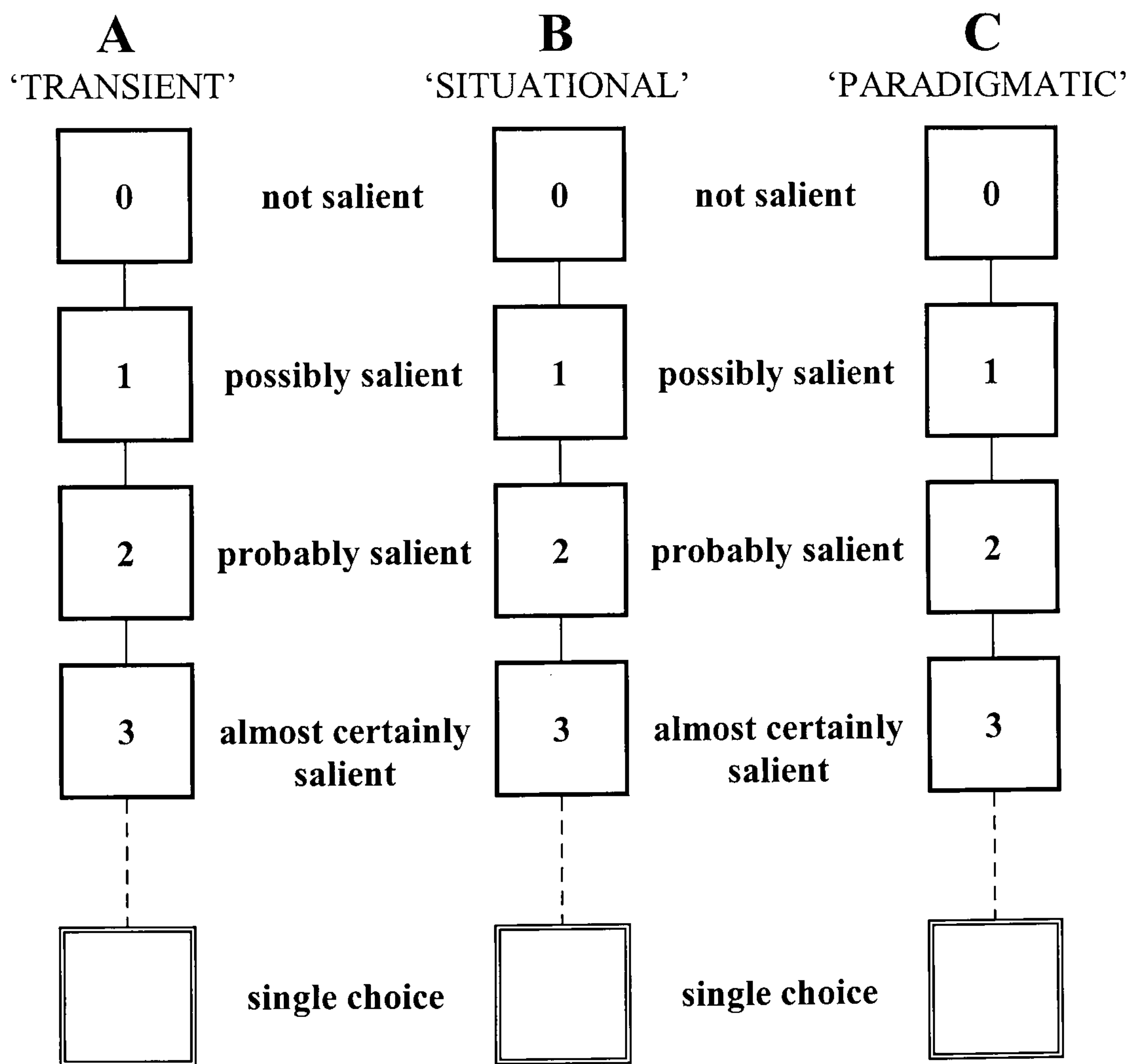
I do not believe I employed any strategy or approach which really moved this client on. At best I managed to siphon off the worst of his anxiety on a regular basis which helped him to go on at work and home.



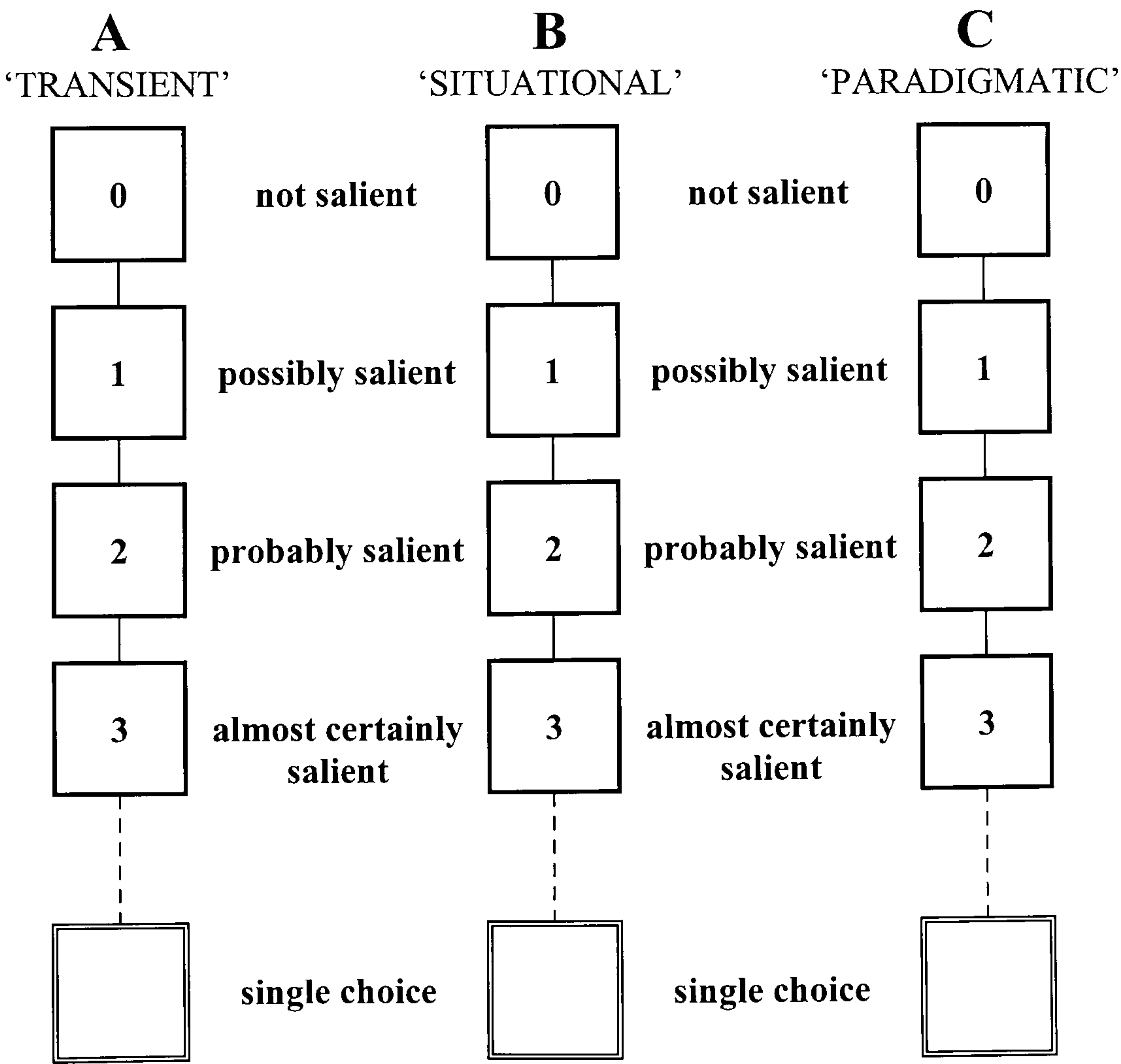


This is a current, ongoing difficulty with a female patient, referred for depression and marital problems. One of the difficulties she has described is "getting in a tizz", ie going round and round in circles trying to solve problems in her head and getting nowhere, (this is not an obsessional difficulty), rambling on.

Latterly she seems to had been "tizzing" in sessions with me, when I challenge her, particularly in the transference. When she does this I sometimes feel confused and caught up in the "tizz" with her. It occurs particularly when anger is the underlying theme. I attempt to address the transference, and make use of the CAT diagram (which guides therapy) to address where we are. After several sessions like this she seems to be "tizzing" a bit less and I am less confused.

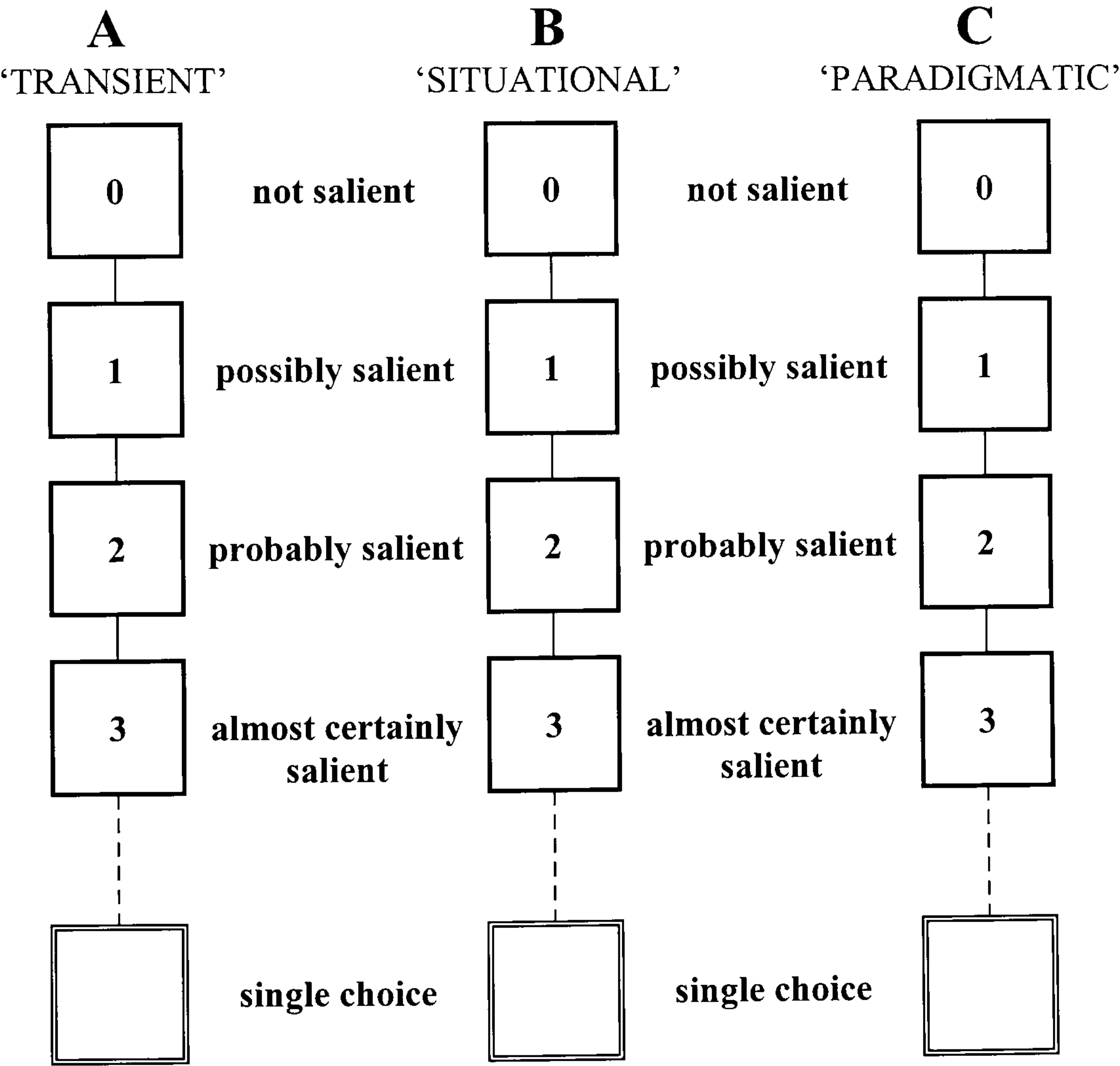


- psychotic patient. Could only deal with it by interpretation - decided to treat him -
- resented tyrannical grip that patient had on me by means of the exclusive use of interpretation that this patient required
- accepted difficulty
- patient improved significantly after course of treatment for a time which was reasonable by NHS standards - Reached Depressive Position - Has manifested progress at CPA's reviews



**FEMALE PSYCHIATRIST, PSYCHOTHERAPIST, PSYCHOANALYST  
PSYCHODYNAMIC ORIENTATION**

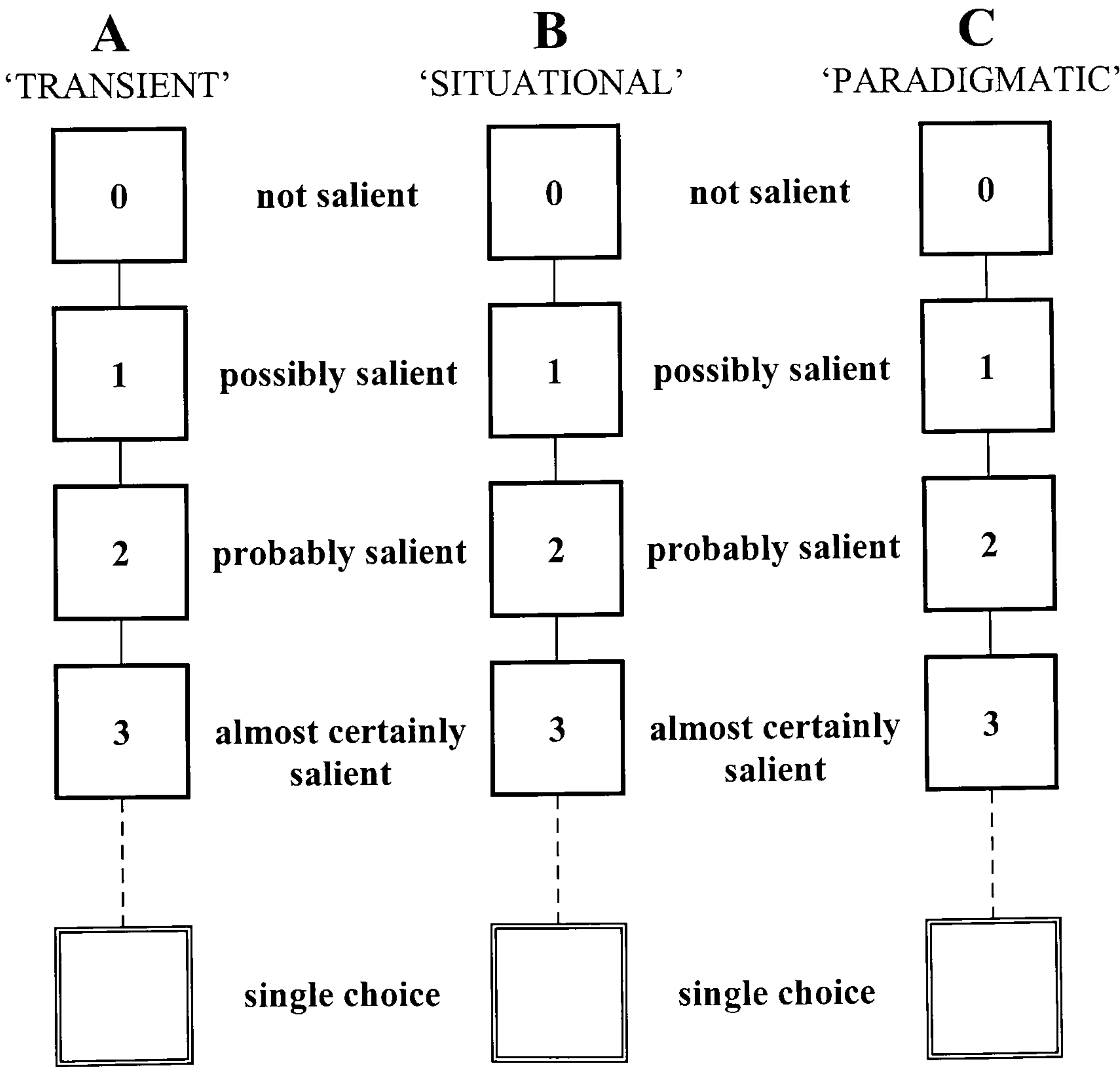
Patient announced she preferred a previous therapist - now emigrated - and did not like my way of working or my gender. The previous therapist had been very exciting sexually (not acted out) to my patient and I was dull, conventional, boring, not in touch. This continued for many months.





I accepted a client without a referral from the GP. A 'friend' had recommended me to her. She was blonde, attractive/vivacious, single and aged 50. She said she was depressed and had had considerable difficulties in her childhood which she wanted to work through. Throughout the therapy she maligned various people in her life including her GP. At one point she brought in a file of people she had taken to court. At this point I felt trapped and that if I was not careful I would be the next one on her list. She decided to have plastic surgery and made a complaint at the surgeon. She was taking a workman to court and wanted me to go for support - I declined and said it was inappropriate. She then asked me if I would see her together with her ex-husband to try and help him understand her. I agreed. This was a disaster. She was angry as I had been impartial and he had actually said he did not want to get back to her.

She wrote to me. I was careful of writing to her as I knew she kept evidence for her court cases. I discussed this with my supervisor and wrote a non-committal letter to her asking her to come to a session to discuss some of her difficulties that had arisen between us. I did not hear from her again and breathed a sigh of relief as I had felt manipulated. I had tried to maintain my professionalism and integrity throughout, not to overstep the boundaries which she was trying to invade. An awareness of the transference and countertransference was helpful in working out what was going on.



**A**  
'TRANSIENT'

0 not salient

1 possibly salient

2 probably salient

3 almost certainly salient

single choice

**B**  
'SITUATIONAL'

0 not salient

1 possibly salient

2 probably salient

3 almost certainly salient

single choice

**C**  
'PARADIGMATIC'

0 not salient

1 possibly salient

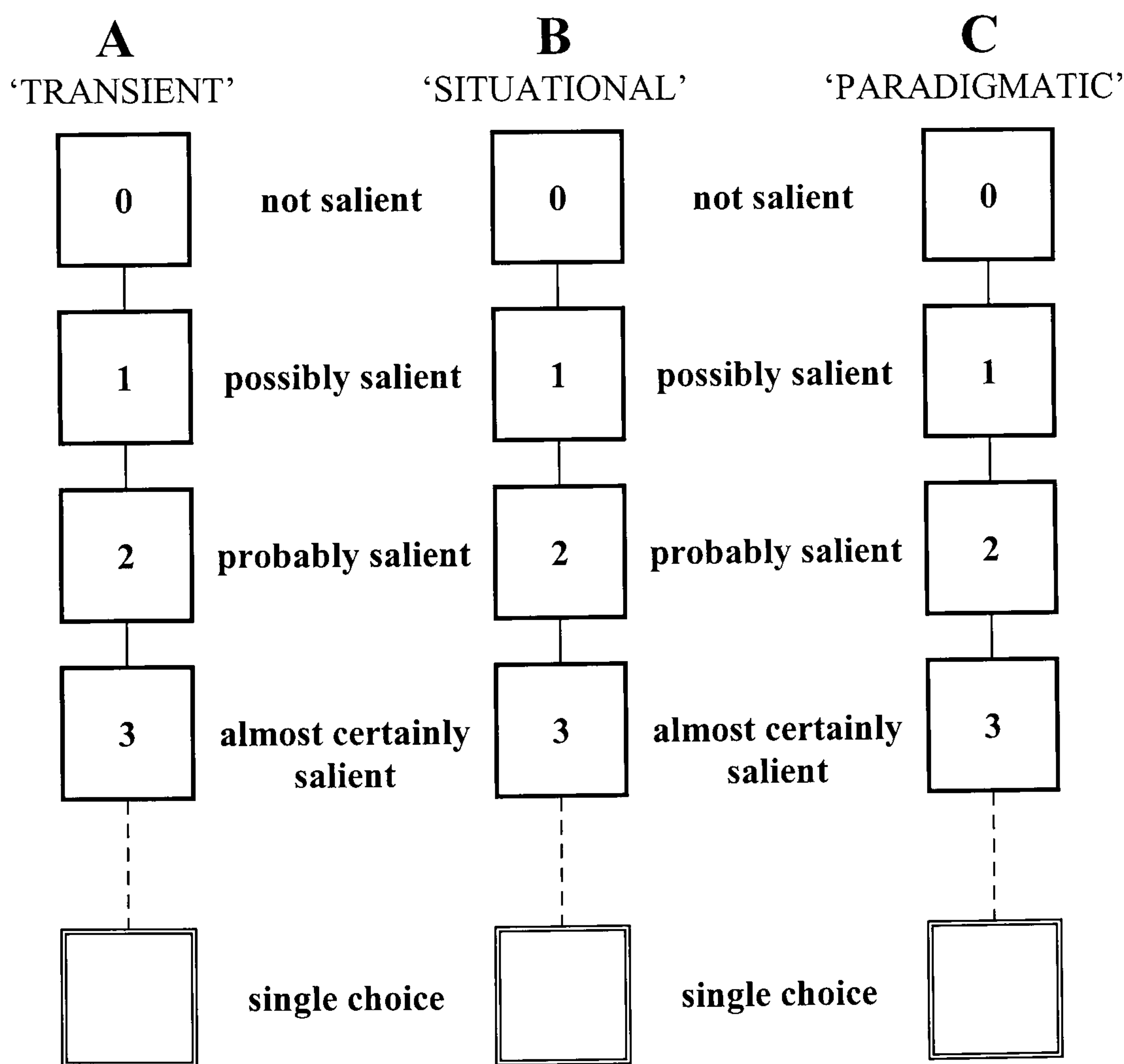
2 probably salient

3 almost certainly salient

single choice

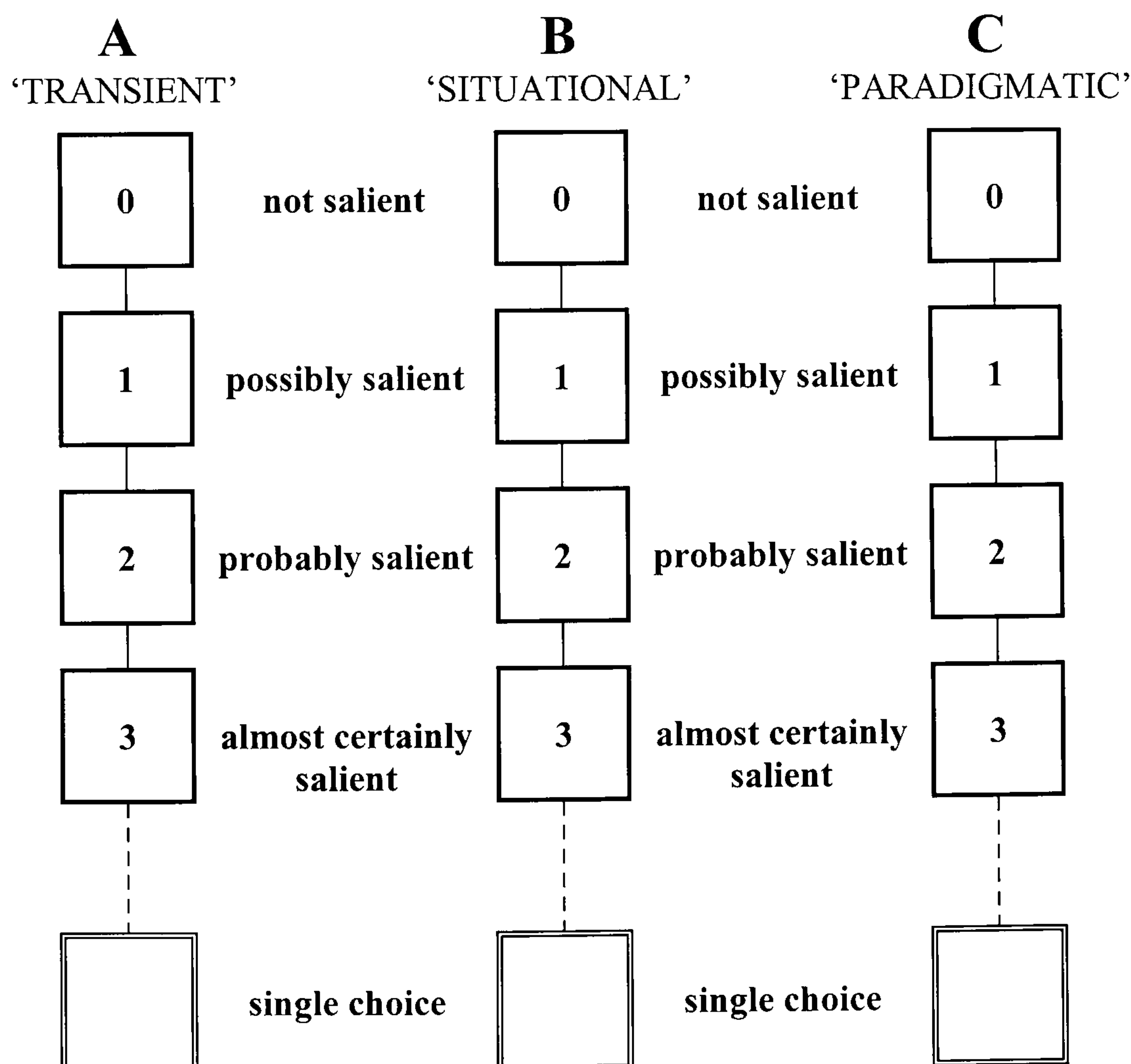
This patient, Anna, 25-year-old nurse, refused to believe that therapy had an endpoint. Although I mentioned ending in almost every session she ignored this and so, in our final session, treated the ending as something I had sprung on her without warning. It was obvious from her affect that she believed this to be the truth and was totally unaware of my struggle to make her think about ending throughout therapy.

Although we were able to explore this problem my feeling at the end was of an unresolved difficulty - central to her psychopathology - that had been "primed" by therapy rather than helped by it.

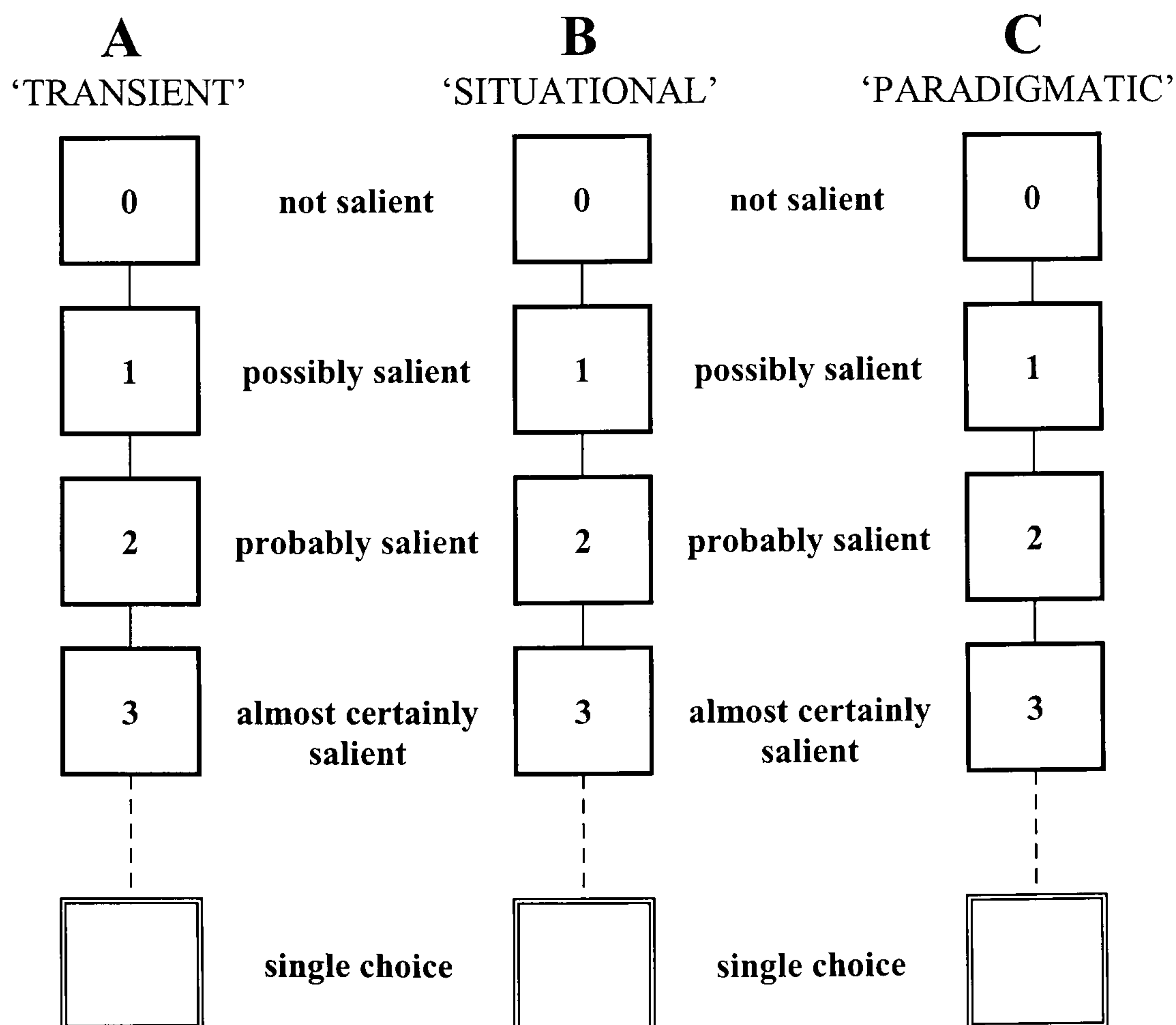




After the break, the client cancelled the next session on the morning we were due to meet because of 'work commitments'. On her return the week after she let me know how angry and hurt she had been by my cancellation, choosing my sister over her, just as she always felt her mother and others preferred her sister to her. She was always second best. She was able to look at her own cancellation as retaliation and we did some useful work around this. I felt annoyed and disappointed in myself for not attending to all aspects of the transference because this client was a 'professional' and not 'a patient'. I was also irritated by the client's retaliation but also very impressed by her ability to look at her feelings and response and to share this with me without my prompting.

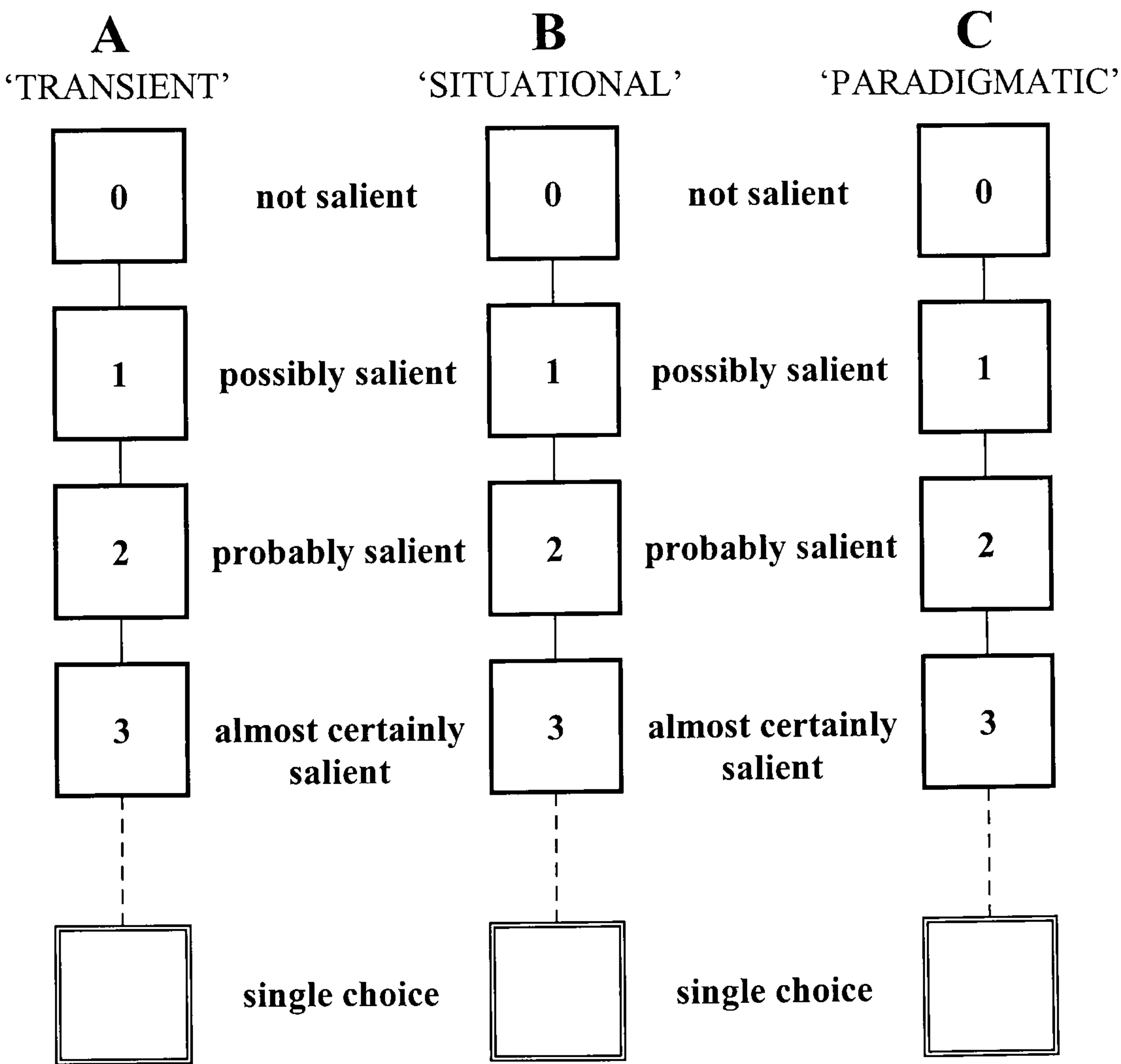


The patient told me that she had three choices - 1) starve herself, 2) get slimming pills from her GP which the GP had refused to prescribe or 3) get her stomach re-stapled. A surgeon had previously stapled her stomach to help weight loss (she was massively overweight). The patient was fearful the GP would not re-refer to the surgeon (as indeed proved to be the case). At the time my main emotion was of feeling stuck and irritated but subsequently on talking to the GP I felt worried about her (the GP) predominantly as she was placed in an impossible position by S., the patient. The GP told me on the phone that S. had said the reason she wished to be re-referred to the surgeon was so that she would die under the anaesthetic. The patient has picked up that the GP and I know each other well (we trained together and had been friends for 20 years) and tends to exploit this. I also feel a bit irritated with the GP as I feel she has said too much to the patient about me personally eg that she (the GP) had visited to see a play that I was in. I would not have told the patient about this. The GP also needed advice from me about how to handle the situation as she was very anxious and I felt my ability to help her was compromised by the triangular situation with the patient. This is a very recent problem so the outcome is not clear. There are long-standing difficulties with this patient, and I feel I am seeing her predominantly to support her GP. I had also told the GP I did not feel the patient unsuitable for exploratory work (as has so far proved to be the case). I feel I am offering supportive work but that this is not really helping the patient - more her GP. I suspect the GP has trouble setting limits and I am being drawn into this.



**MALE PSYCHOLOGIST, PSYCHOTHERAPIST, PSYCHOANALYST**  
**PSYCHODYNAMIC ORIENTATION**

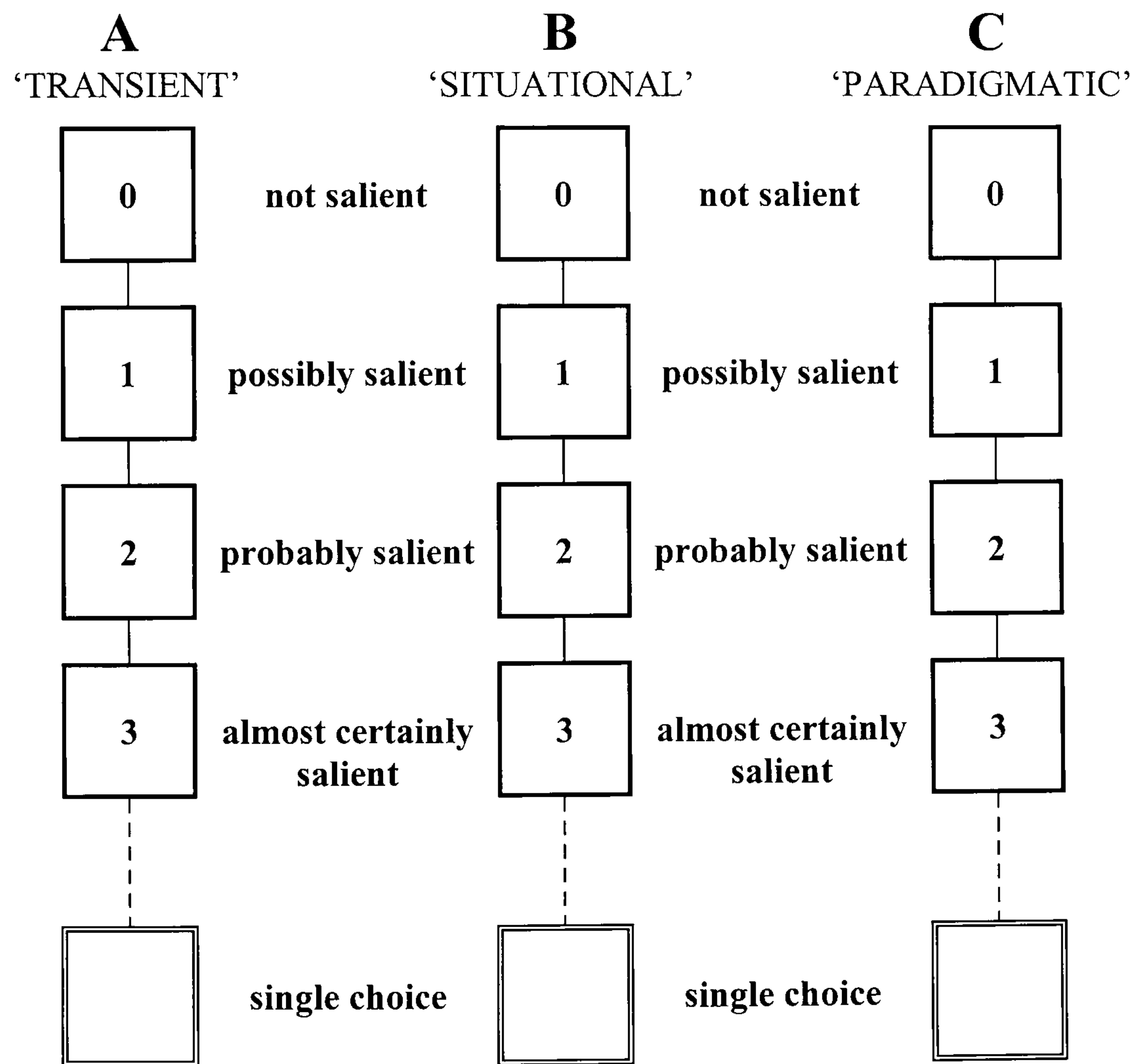
The patient is the 25-year-old trainee teacher, female, and she has been in twice weekly individual therapy (psychoanalytic) for the last two years. The patient, Miss B, has generally been helpful and insightful, and is an honest person. She works hard. The difficulty arose because she became alarmed at the strength of her jealous and possessive feelings towards me, and could not speak for nearly two weeks. She also missed sessions or came 40 minutes late. I felt rather impotent, but also sorry for her. I liked her and worried she'd break off treatment. I worried about whether I had encouraged her positive transference. I approached the problem, when she did attend, by interpretation. This included taking up her hostility towards my other patients and my family, whom she regarded as rivals, but also her affection and trust in me. The problem was worked through successfully.







Forgot to hold the door open (usually 'always' do).  
Felt as though I had committed a crime by the extreme reaction of the patient. Patient was very annoyed and thought that I was playing 'mind' games with her. Tried to get her to reflect on other situations where she felt others had played mind games with her. (She had had a psychologically damaged mother - possibly schizophrenic.) Able to gain 'insight', improve therapeutic rapport.



**MALE PSYCHIATRIST, PSYCHOTHERAPIST**  
**PSYCHODYNAMIC / SYSTEMIC / CONSTRUCTIVIST ORIENTATION**

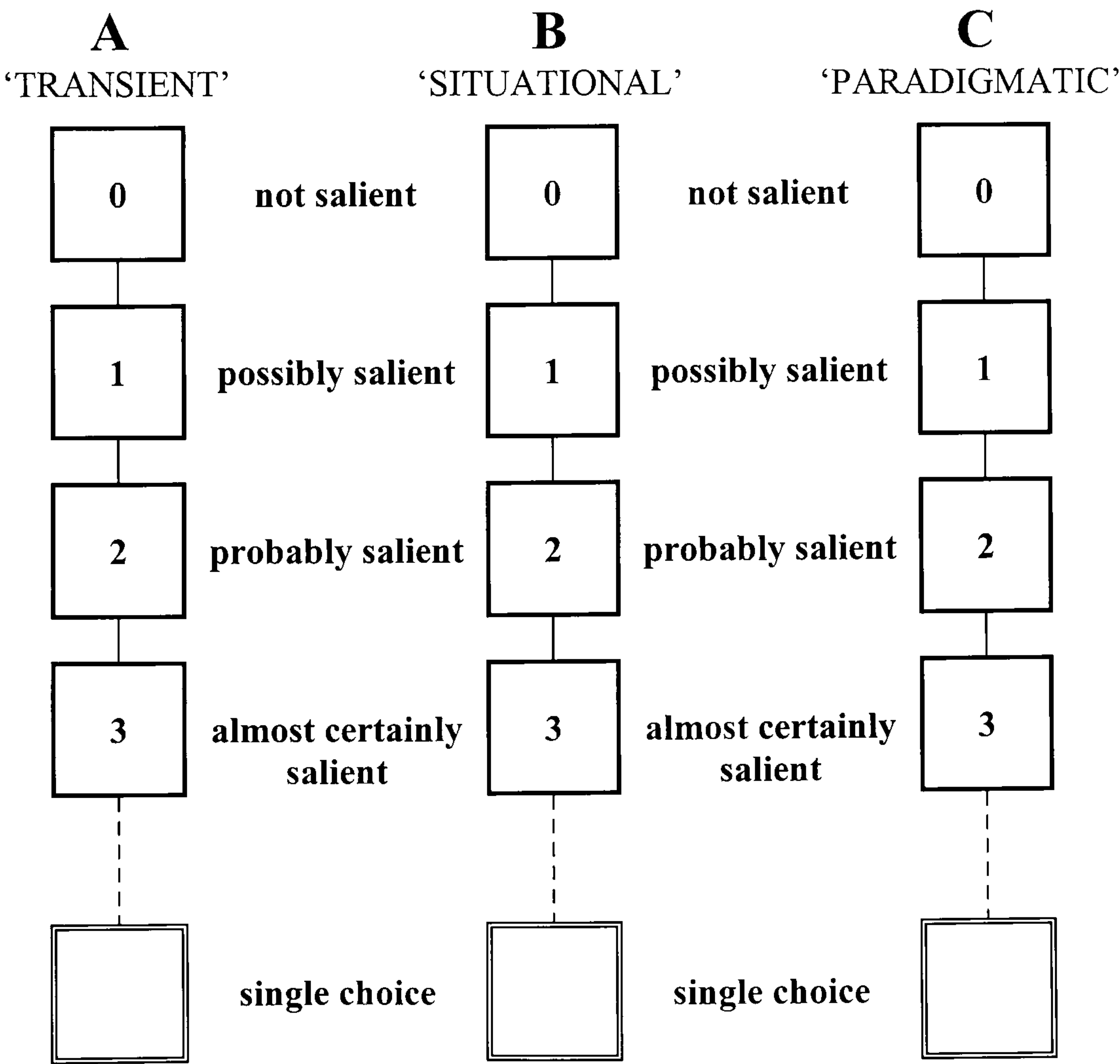
Patient, female, single, a few years older than me, had had many previous individual therapies. Assessed by senior member of staff and accepted for short term work with her. Passed to me instead for longer term (three year) weekly dynamic treatment when I joined department. Gifted patient, (intelligent, artistically very able) with very poor employment record and long history of depression/anxiety and relationship problems.

Patient always late for sessions, often abusive when she perceived any slights to her.

On one occasion she slammed out of the room and damaged wall in corridor kicking a steel waste bin around.

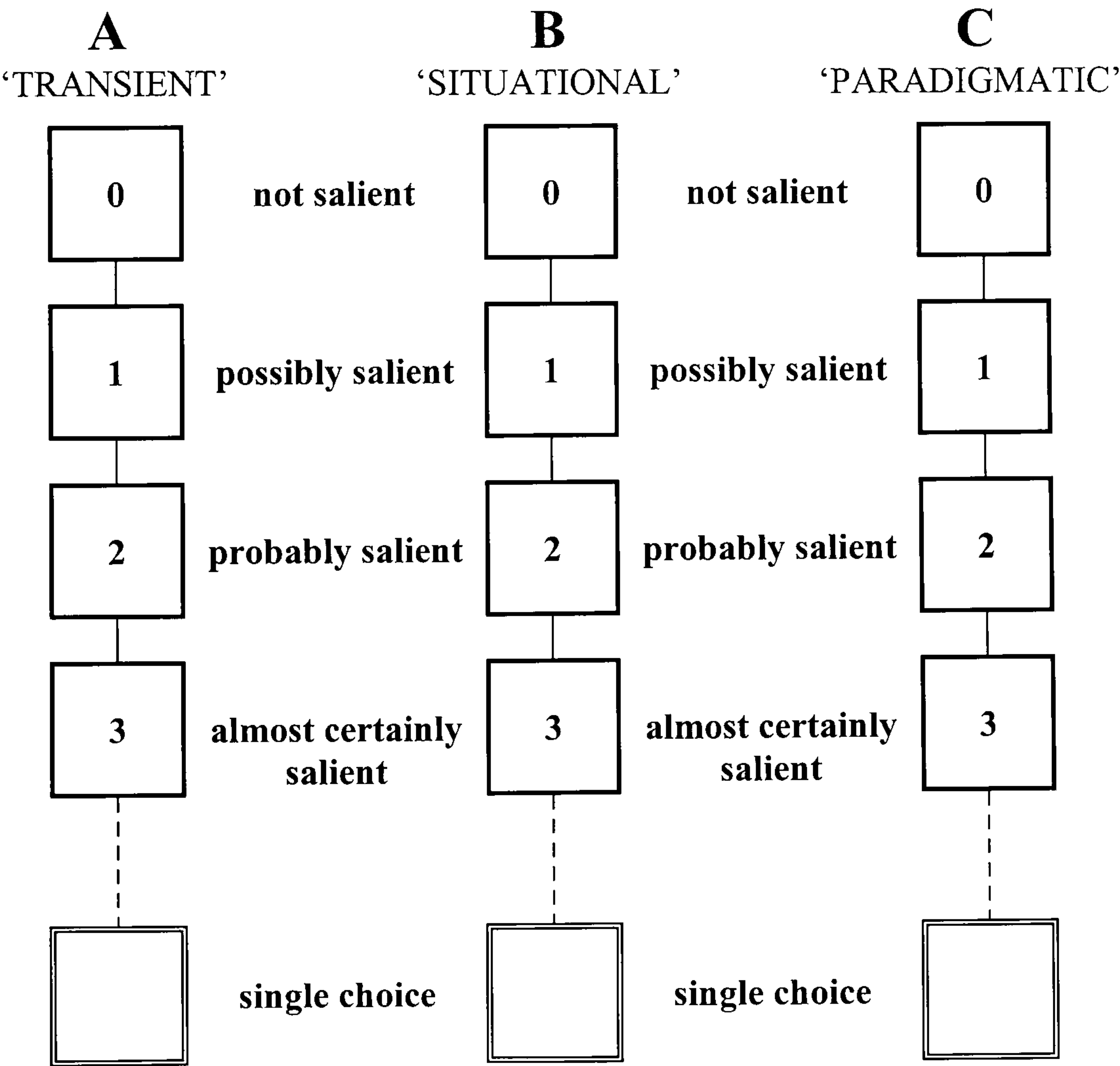
I tried to explain that what she had heard me to say wasn't what I said - she went off in a fury.

Therapy continued but never really recovered. She continues to subject me to telephone assessment since termination over a year ago.





It was my first patient seen over 12 months in an out-patient counselling centre. She had never had therapy and I had never done it before. She always came and was always on time. However, she spent the majority of the session in silence often 'bringing me up to speed' as she put it. This meant she would start off on a dialogue [monologue?] at the beginning of the session of all the things that had happened to her or occurred to her over the last week. I wasn't allowed to interrupt, attempts were usually ignored. Consequently, the room felt full after this and we both had difficulties knowing where to start. I used to feel confused, full, yet anxious to keep going but not knowing what to say. After some 10 sessions we both decided something wasn't working. This led to an exploration of her experiences at home as a schoolgirl having to bring Mum 'up to speed' on the day's events but then being ignored or 'left to my own devices' from then on. Eventually she was able to start the session quietly and let her thoughts, mind wander, bringing forth whatever came up without censor. Thus by following the 'fundamental rule of analysis' she was able to break the previous patterns (resistance).

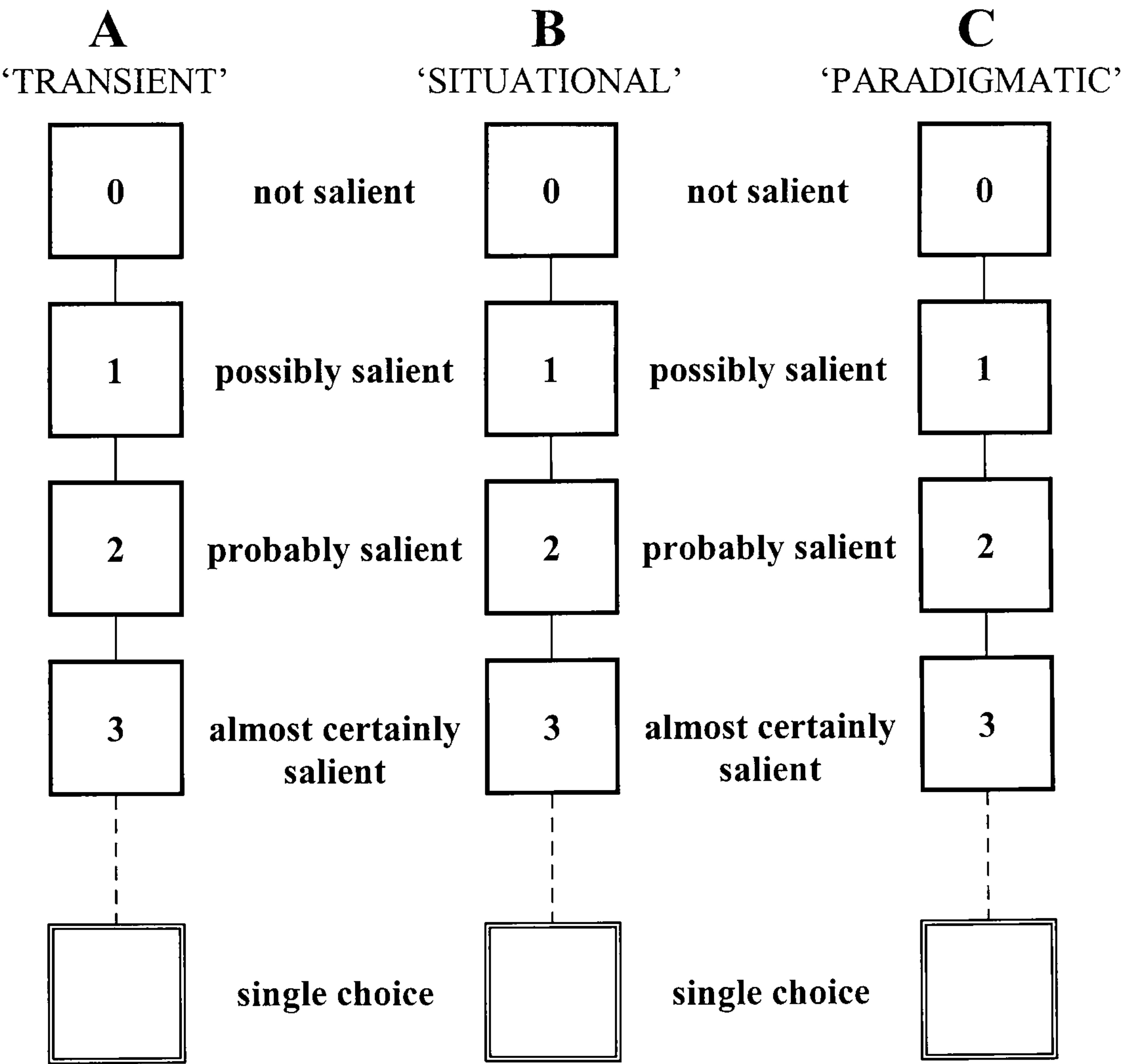


**FEMALE COUNSELLOR, PSYCHOLOGIST, PSYCHOTHERAPIST  
PSYCHODYNAMIC ORIENTATION**

The client was very critical of me and my style of therapy from the beginning. She was frequently distrustful, angry and ended unilaterally and prematurely twice for short periods. She told me I charged too much and was reluctant to continue, using the cost as her reason. It was difficult to survive these attacks without becoming "wounded" for about three years.

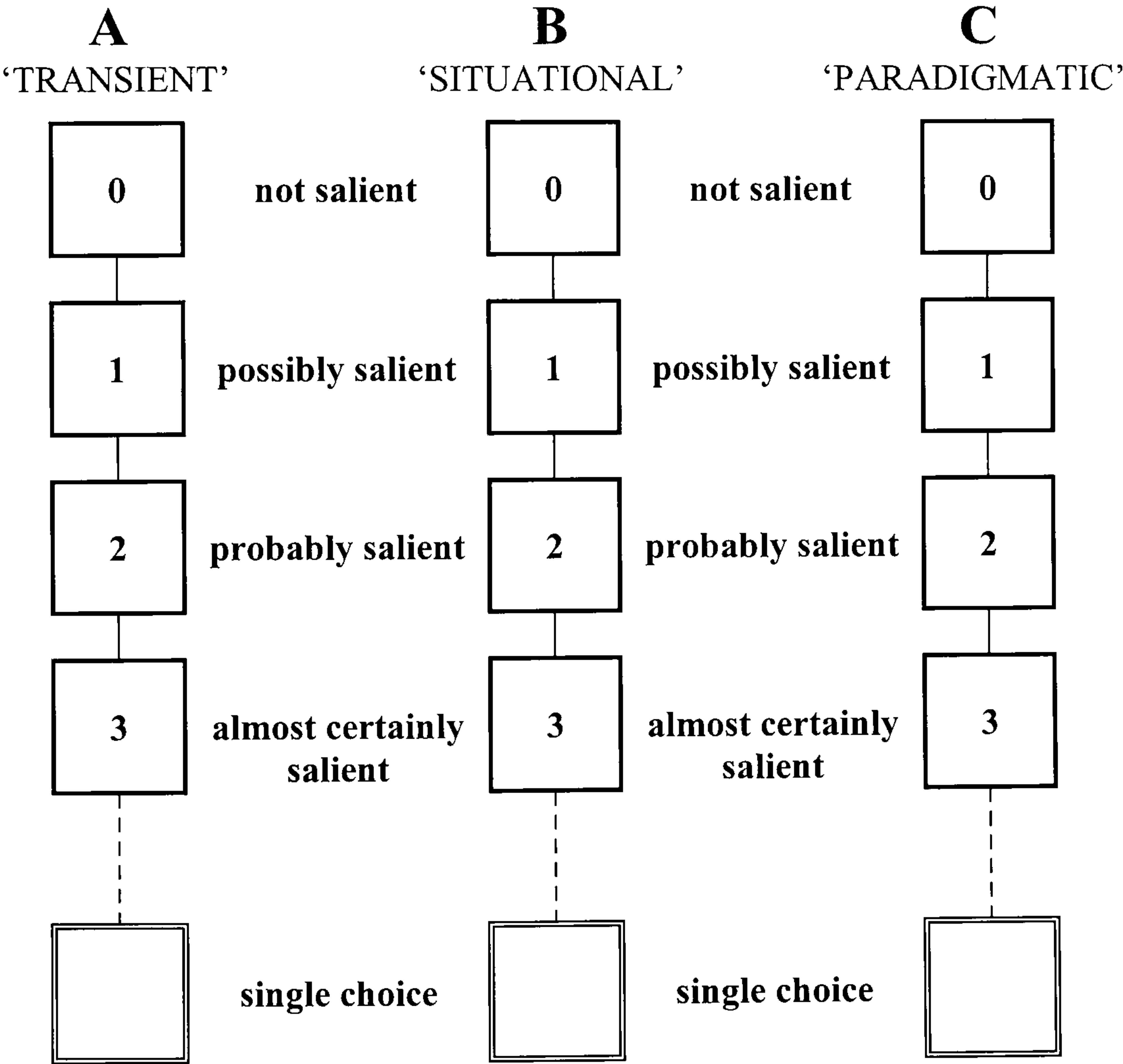
I felt a secure attachment to the client but there were periods when she "left" when I felt disappointed. Underneath I felt that this was useful to the client therapeutically and was pretty sure that I was the right therapist for her and that the conflict would be resolved.

I coped with it by keeping my supervisor in close touch with this work. The outcome was that she left, but leaving the door open to come back again if she wanted to. She told me that she regarded me very highly when we ended.



**MALE PSYCHOLOGIST**  
**PSYCHODYNAMIC / COGNITIVE / HUMANISTIC ORIENTATION**

Angry, abused young man talking about fantasies of murdering his wife and kids, or keeping them hostage before killing them all in a blaze of glory. I believed he was likely to do it and didn't know how to stop him. I had lots of consultations with other professionals and got others to assess him. In the end he was 'excluded' from services and just left.







The client had been referred with a complex history of anxiety and depression including two previous suicide attempts. I had seen her four or five times prior to the 'difficult' session. We had established a good working relationship, talking about what it would be like to trust me enough to tell me about the 'terrible', 'unmentionable' things that had happened to her in the past. I suspected some form of abuse but was not keen to pre-empt or push the process. Half-way through the session the client told me [she] couldn't keep it to herself any longer and launched into a story that started around 3 when she first went to nursery school and was too frightened to talk to anyone. The story of a young girl so desperate to have a friend that she consented to a series of increasingly sexual approaches as she grew up into her teens unfolded. We had got to her at about 16 when the hour was up. When I drew her attention to the time she broke into angry and hysterical crying. She hadn't told me "the worst bit", she couldn't stop now she had started because she couldn't "put it all back in the box" and she couldn't continue because the time was up and she couldn't break the time rules. She couldn't hold it till next week and tell anyone else. I was taken by surprise by the change in her behaviour. She had been talking fluently, with feeling but not with any indication of such distress lurking under the narrative. Although the incidents she reported were obviously difficult for her to have handled, none of them seemed to have been particularly 'abusive' or sexually invasive. I had wondered if this would be a case of child sexual abuse, incest or rape and I had been told of stolen kisses, illicit groping and a desire to be wanted as a girlfriend.

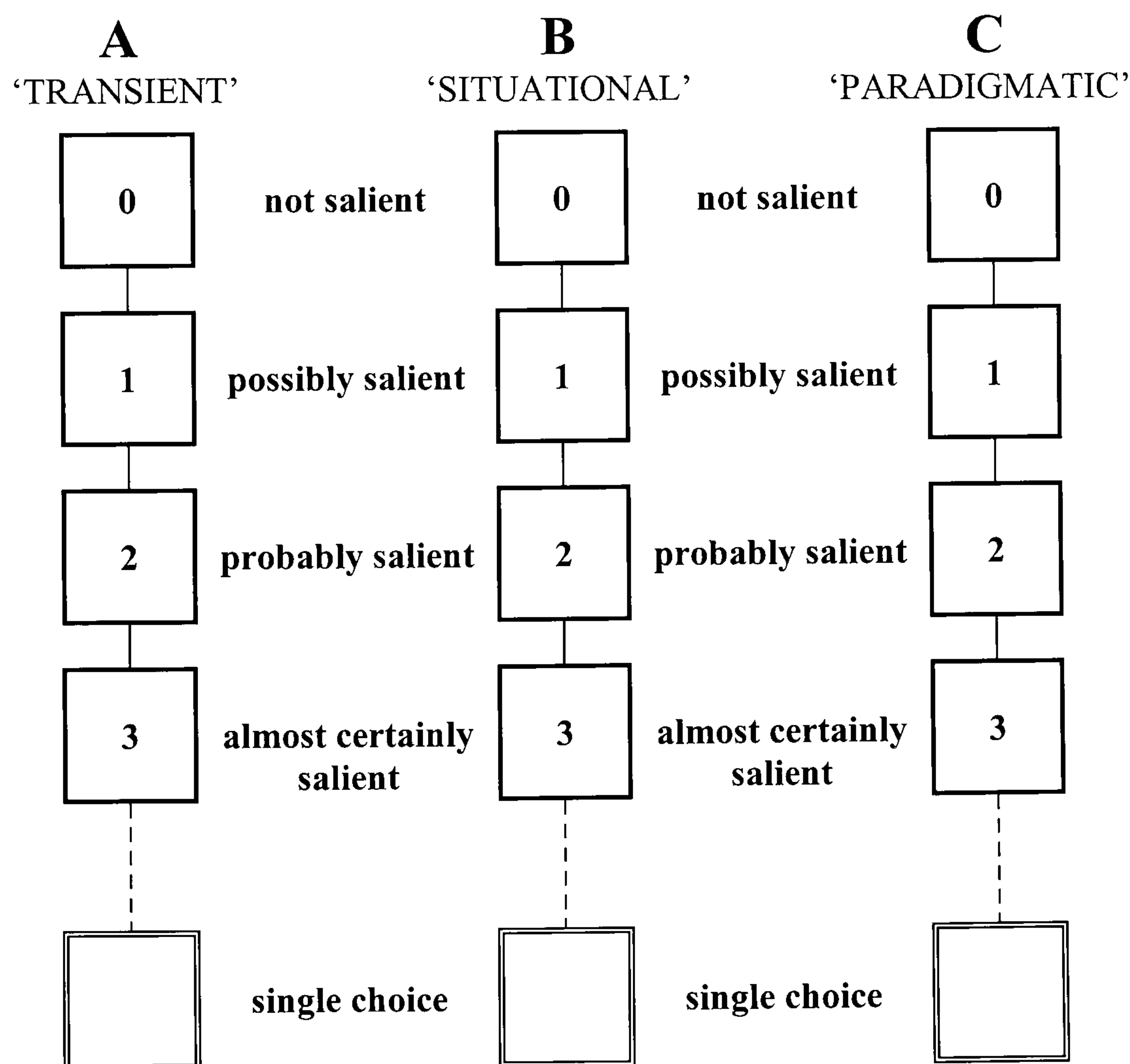
I cursed myself for poor time and boundary management. (Should I have foreseen this? Paced her better? Explored issues of disclosure further?) I was very concerned about her state and remembered the previous suicide attempts. Fortunately it was the last session of the day and though the department had emptied it was not locked up so we could continue. I talked her down from the state of hysteria, reassured her that I could stay and give her the time to tell the 'worst bit' and that the 'rules' could bend without breaking. While she went to the loo, I rang home and cancelled the supervision session I should have taken. When the client returned, calmer, we renegotiated to stay until she had told me the story to the point where she could feel comfortable. We worked for a further 1.5 hours and she completed her story of being the victim of inappropriate sexual advances by someone who had a position of power and influence over her, her sense of shame and a little of the consequences. I carried a lot of anger towards the person who had abused her trust which she denied - it was all her fault, her responsibility - she was bad. I knew I couldn't alter that perception and accepted her experience and evaluation of herself whilst being clear about my perspective. When she felt she had told me everything she needed me to know we talked for a time whether she could tolerate me knowing (she'd never told anyone, including her husband, before) and could hold on and face me next week.. I was very concerned about her turning the angry shame on herself destructively again. I told her so but did not press a 'no suicide' contract. I suggested ways of dealing with the feelings when they arose, gave her the Samaritans' number but not my home number, asked her to see the GP if she felt she couldn't cope and made it clear it was important to me that she come next week however ashamed she felt although she had a choice in that. Although I was aware of the suicide risk I did not feel it was appropriate to report her to her GP -

*PLEASE CONTINUE ON THE NEXT PAGE*



again I was open with her. By the end of the session we were both exhausted. While I was worried about her and thought about her from time to time during the next week I felt certain I had dealt well and appropriately with the situation. I took it to supervision and received support and the advice to keep boundaries very tight and clear.

The client came next week -ashamed and hesitant - with sheets of writing. We worked for many weeks both on her story and her ability to be in relationship to me. I have never met someone with such a 'dark soul' - a total inability to accept any good in herself and any reason for living other than that suicide would hurt her husband and parents. There have been other outbursts of anger but she has held the boundaries and none have felt so cataclysmic, out-of-control and so terribly weighty. The work continues and the client is now beginning very very slowly to enjoy life and even like herself - just a little.



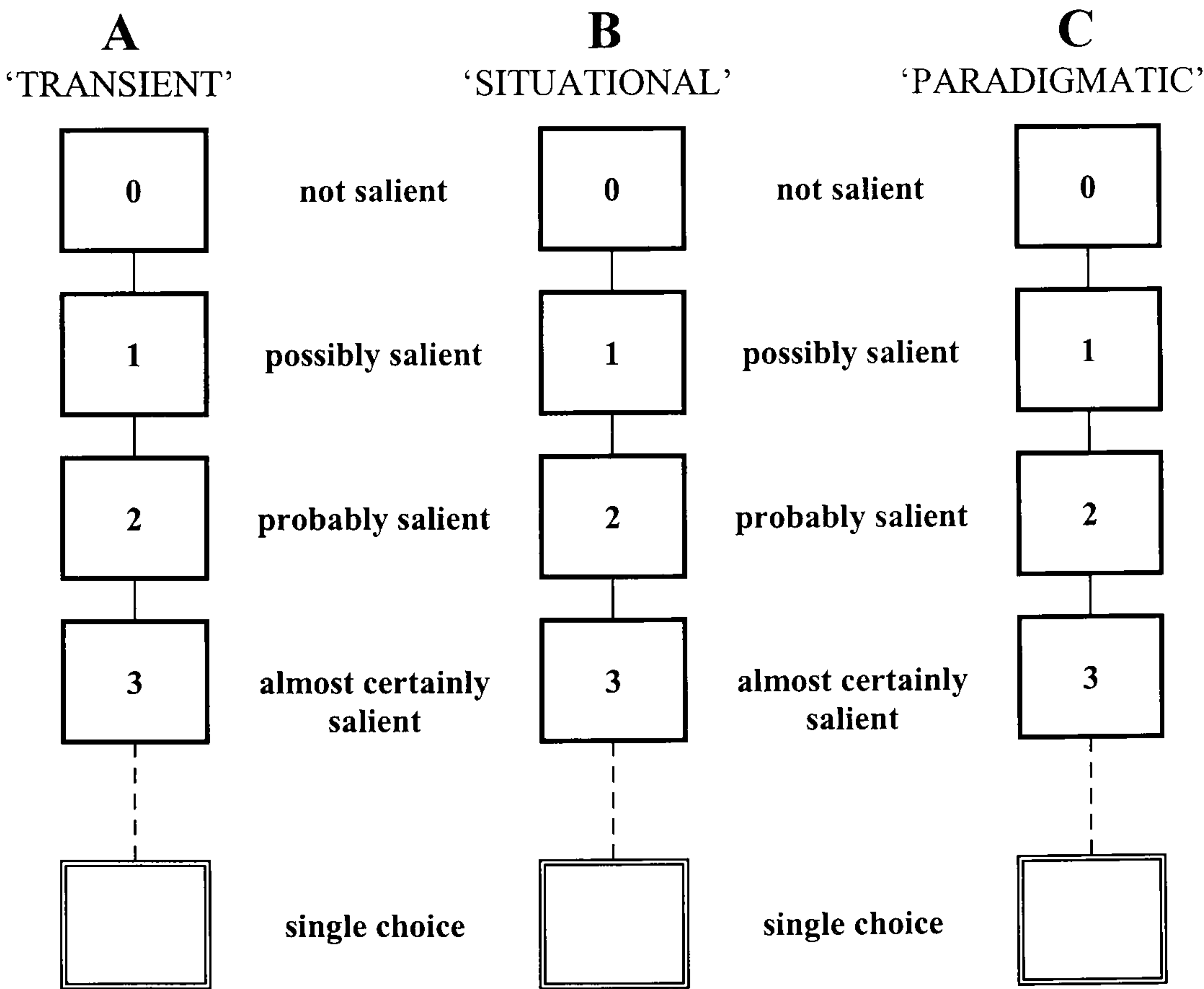




I have searched both memory and diary for a situation/client which fits your criteria of a difficulty which took place with a client who “generally I found difficult”. I note with interest that those clients I found most difficulty during the year were part of couples work and/or do not seem to be associated with difficult incidents or situations. The clearest difficult situation in individual work was with a client with whom I felt a positive bond and a good working alliance - although there was some weariness on both sides at times and what I might now perceive as an occasional competitive edge - so this is a difficulty with my most difficult, but not really difficult, sustained client this year.

The difficult situation arose when my client spoke about the failure of another professional relationship he was in, which he thought/felt was due to the malpractice / unethical conduct of the professional concerned. He brought this up (as the trouble was ongoing) over several weeks. I had considerable personal knowledge of this professional, having been involved in their early training, having seen them socially because they moved on the edge of the same social milieu, having worked with them as my client, having worked closely with someone who was close to them for some years, and having heard with dismay about their descent into poor practice. My client’s account of their failing relationship triggered in me very strong angry and hostile feelings about the professional and (in retrospect) it became clear that on several occasions my concerns about the poor quality practitioner, my client’s rights, the need to protect others / not tolerate this etc. etc. got in the way of me hearing and working with my client’s concerns. Even as it was happening I knew something was wrong but told myself that I’d made it OK by checking with my client etc. After several sessions in which this stuff had been a feature, and when a satisfactory resolution (for my client) had been achieved with the low quality practitioner, my client was able to tell me that he had found my contribution about this bit unhelpful, and he was angry that my feelings had taken up his space.

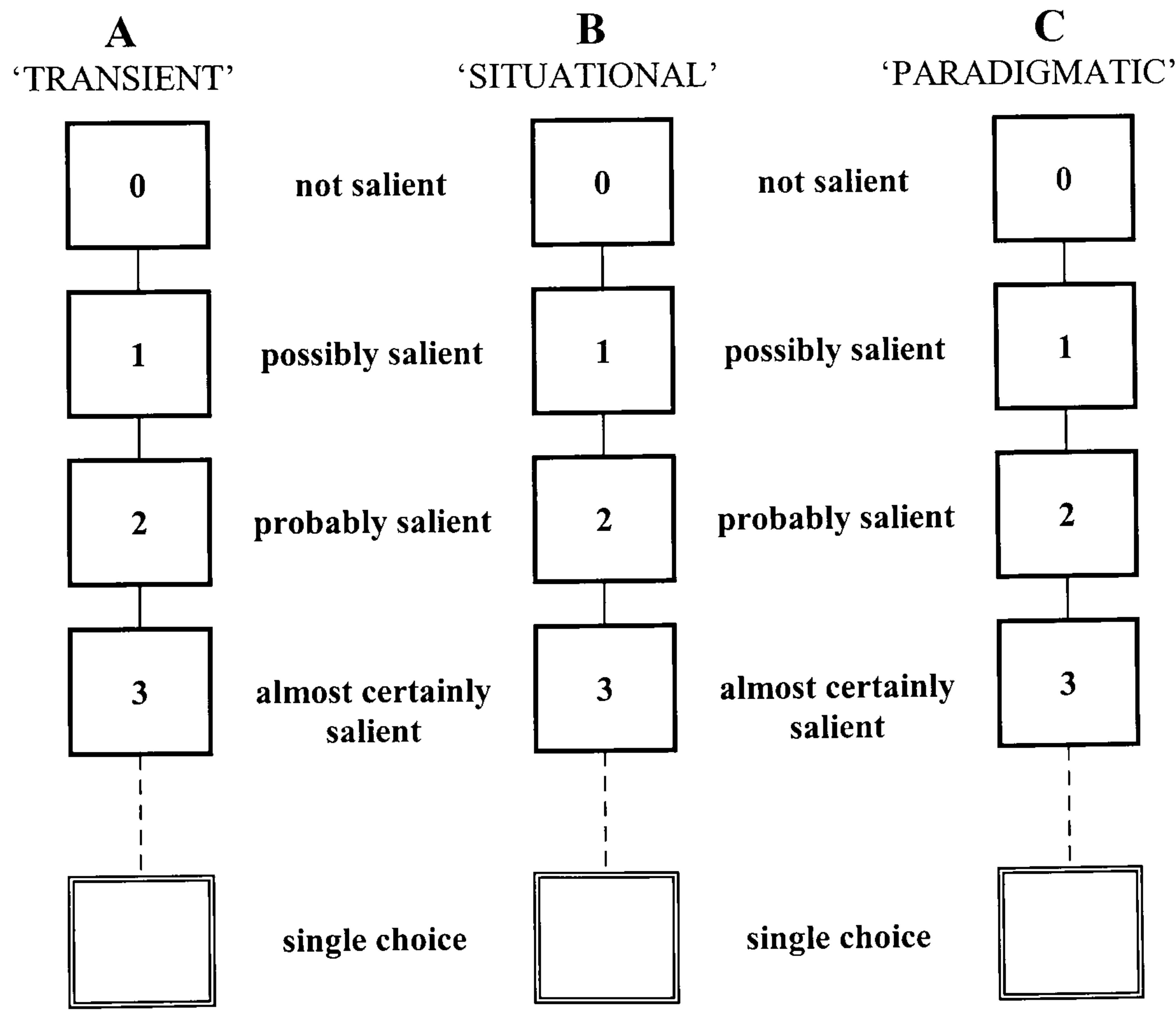
This was a two edged sword. The client being angry and staying with it, with me and moving to a resolution of the issue between us was (and later was jointly recognised to be) enormously significant as a step forward in his therapeutic journey. On the other hand, it was plainly evident to me that I had not worked well, not managed my “congruence” helpfully and had wasted my client’s time - I felt rather. After considerable reflection I asked for some time in the subsequent session, apologised for my mistake (without detracting from the learning gained through my client’s reaction to it) and offered a refund for that part of the time I considered wasted. My client did not want a personal refund, but we agreed to donate the money concerned to charity. We worked on for some months to a successful termination.





The client in question is a man with a Learning Disability who is an opportunistic and persistent sexual offender who has also been oppressive and violent with his carers. He presents as a very charming man who is generally eager to please, is placed in a less than ideal situation and seems grateful for the opportunity to talk. Psychiatric services have suggested that he has psychopathic tendencies. We have done some good work on appropriate/inappropriate actions and relationships, negotiation and social skills, sexual knowledge, recognition of emotions, victim empathy, etc. He was initially difficult to engage, but now seems to value sessions. Difficulty arose when after several months of seeing me, he sexually propositioned me in the session. He did this in powerful and controlling ways that may well work with Learning Disabled individuals (and possibly even some staff in post institutional settings). The difficulty was not so much with the client, although he certainly did make me feel uncomfortable, but more with my own sense of vulnerability. The client had made many allegations against staff for various reasons, some of these are known to be false, but some have been substantiated. My main difficulty was the thought that he could accuse me of something that I had not done and that others may not believe me. I often work with clients who are victims or perpetrators of sexual offences and have more than once felt that I was putting myself in a vulnerable position where I could be open to false accusations. This was emphasised during my training and I have heard of cases where even after allegations are dropped, the character slur remains.

At one point in the session I feared that he would start to undress and at another time that he was going to approach me and make physical contact. I was able to stop him verbally on each occasion. I felt that I handled it well with the client ceasing inappropriate actions while still maintaining (if not improving) rapport. I was uncertain that things would have gone as well had he not complied. He has been involved in physical struggles with other clients in compromising situations and has been found in a state of undress. Each time he has defended himself by pointing to the other person for blame. Although he is known to blame others for his own actions to a ridiculous degree, occasionally he is (at least partially) believed. Sometimes rightly so and sometimes not. I therefore had a fear of being found with him in physical struggle while he was in a state of semi-undress and him pointing a finger of accusation at me. It is difficult to describe how powerful and clever some of his attempts at persuasion were without making it sound as though I was tempted, which there is no question of. His statements involved the promise of secrecy and a pretence of engaging in role play within the therapeutic context and was very sophisticated in view of his general ability level. In the end, I believe that the maintenance of a positive relationship without any sexual or other exploitative element has been of great therapeutic value to the client and, if anything, has improved rapport.





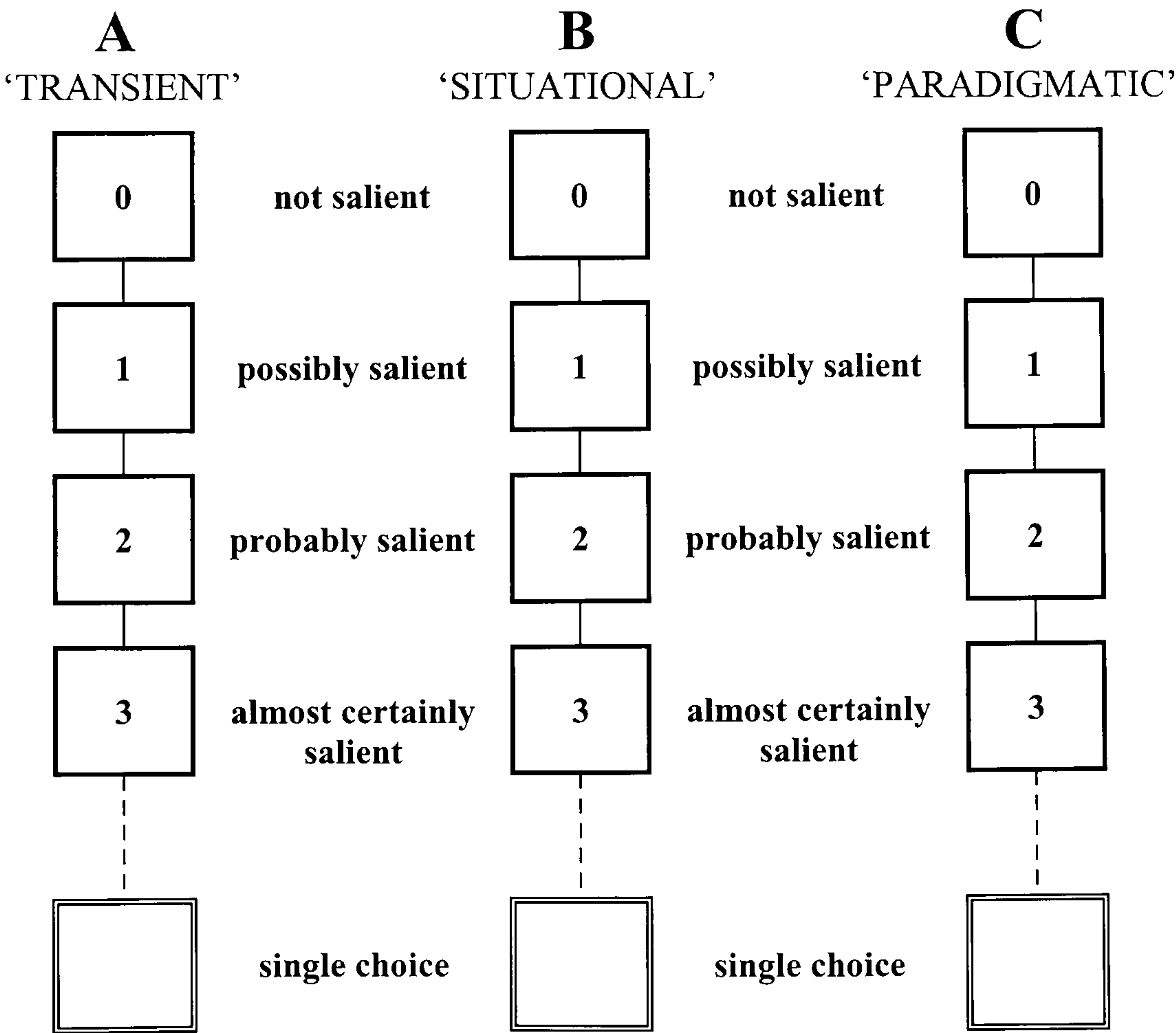
The patient is a 49-year-old three times divorcee. Seeing her once weekly for three years. From the beginning of therapy I have found her very difficult to be with. Generally in sessions I have felt very tired and switch off, quite easily. The patient seemed quite switched off and disconnected too, although she would often report feelings of terror and loss of control in her life outside therapy. In the past year she has been able to get in touch and express her feelings with the result that I have felt more in touch and connected to her.

However, in the past six month the patient has for the first time in her life tried to live on her own away from the usual abusive relationship that she generally is involved in. As my feeling of being tired went, I began to feel congested in my head and nasal cavities. In order to cope with living alone she took on extra work filling all her waking hours as being alone filled her with terror.

My feeling of congestion increased and I began to feel it several hours before seeing the patient. It would also stay with me for hours after the meeting. In the meeting I felt as if I was unable to breathe and a number of times I had the strong urge to walk out. I found this to be a very disturbing experience which hasn't been repeated.

On reflection this meeting was just before a break and I suspect was linked to feeling abandoned although this was not acknowledged. (As the impact of breaks generally wasn't something that would be acknowledged.) It also occurred to me later that her younger sister died at the age of 21 years ( the patient was 20 years) of asthma. The patient also grew up with the belief that her mother was going to poison her and there was also a background of much violence.

I have attempted to deal with all these feelings by addressing them in some way for eg: the need to switch off both herself and me. It seemed to work to some extent but then it would be replaced by something more sinister, for eg. the congestion/breathlessness which I have begun to address.



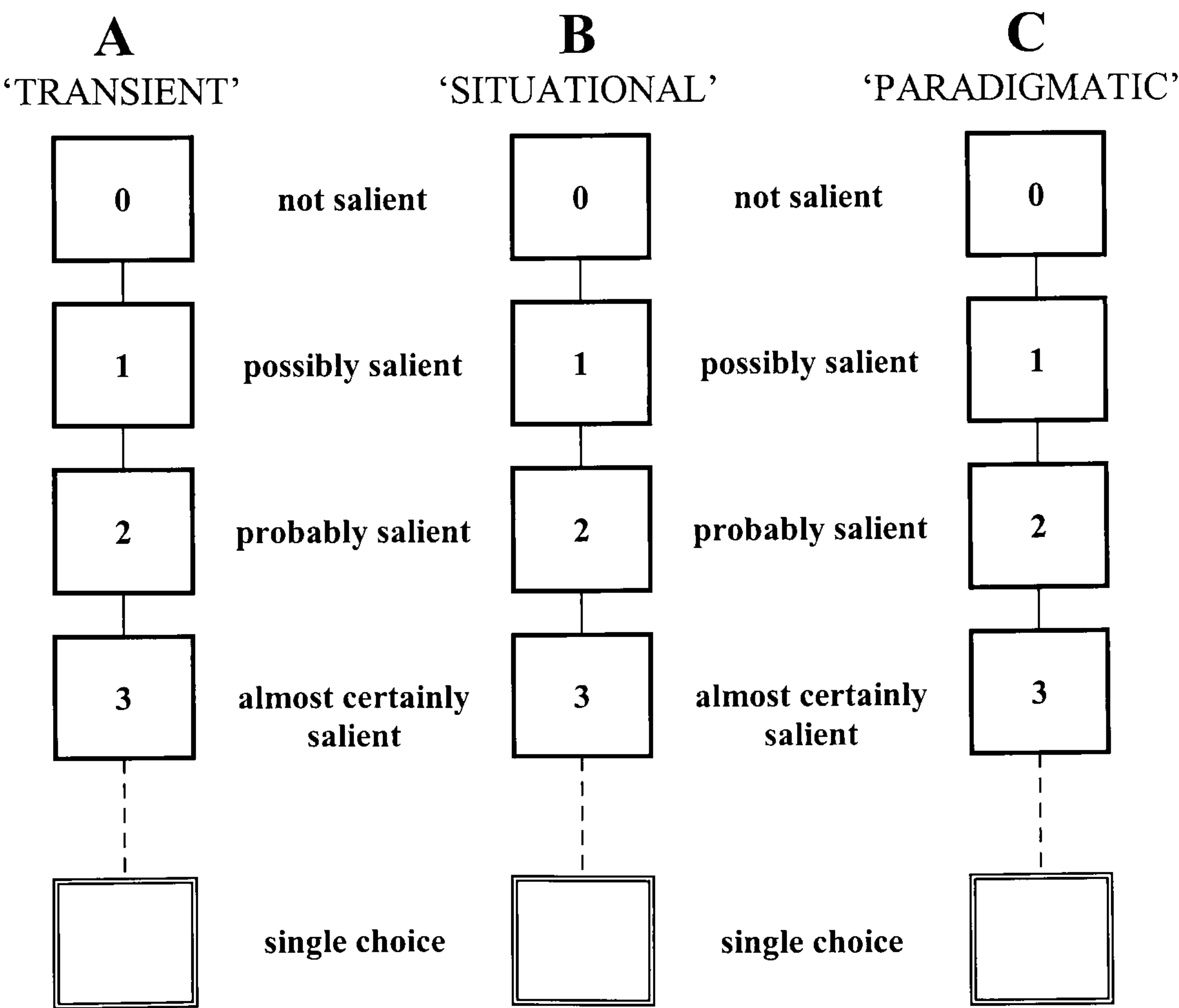
'J' was a 38-year-old female client with a 6-year history of depression and anxiety who contracted for one year's dynamic psychotherapy. Her childhood and adolescence were marred by an emotionally cold mother and a father whose constant verbal abuse of J was sexually explicit, to the extent that J had internalised these parental models into a fixed sense of her own worthlessness and an expectation of emotional abuse in close relationships. She had rarely enjoyed sexual intimacy, and thought sex was "disgusting".

Early in therapy, J described sad experiences from childhood and connections with a current relationship of 8 years duration whose redundancy she was just beginning to realise. Smilingly, she remarked that she could, and would, "never cry in front of anyone." For her, this would be to capitulate to the imposed miseries of childhood, as well as to forfeit the persona of resilience and imperviousness to emotional pain she had carefully nurtured from adolescence onwards.

My own inward reaction was of annoyance and a sense of exclusion; was J not able to trust me enough to share anything more than superficial emotion? What were the prospects of internal change in her if, so early in therapy, she was announcing her resistance to addressing any problematic memory or relationship? My actual response was to challenge gently J's stated determination never to share sadness, Was this because she had never been able to do so in the past, with parents/spouse? "Probably", she said, colouring a little and looking less certain, though still smiling. Perhaps you think sadness or tears are a kind of weakness? "Oh, yeah!" (quickly). Isn't it alright to be sad sometimes? "Yeah, but not so anyone else notices..." - and J added some remarks about having had to develop her veneer of invulnerability.

Continuing, I said it sounded like no-one would hear you when you were down, and now you won't let anyone hear you? "S'pose so - I'd feel a fool if I cried - got to keep happy..." Even though you do get depressed - one of the main reasons you came here? "That's true - but I don't cry" [even when depressed].

In supervision, it was helpful to explore my frustration and sense of ineffectuality. The issue remained an open one until the final session. Most of our sessions had been supportive rather than exploratory, and J had undergone several positive and negative life events within the year, some chosen and some imposed, including two changes of house, separation from her partner, and a short phase of depression with fleeting suicidal ideation. In the light of her damaged capacity for intimacy set against her new-found sense of self-worth, it was to be expected that she would "dread" ending therapy, since I had, in her words, "become the good parent". However, she was able to cry without shame, and herself elected to hug me before leaving.





**FEMALE COUNSELLOR, PSYCHOLOGIST, PSYCHOTHERAPIST  
PSYCHODYNAMIC / COGNITIVE ORIENTATION**

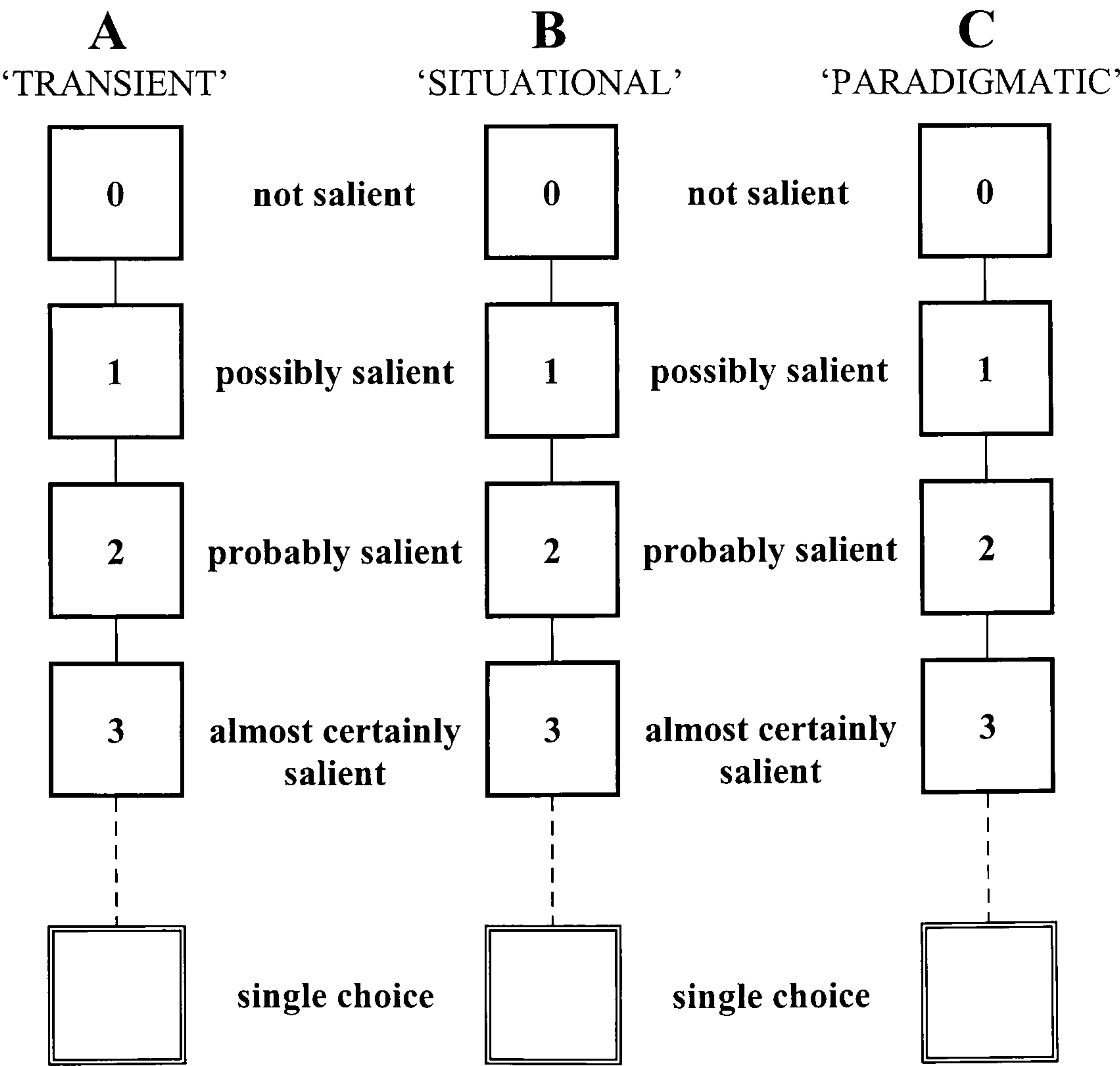
A patient with paranoid personality features who brought in screeds of paper for me to read regarding a discipline procedure to which she was being subjected at work.

I felt persecuted by her requests that I intervene - eg read the material, give my opinion, talk to her line manager. In not meeting her requests, I also at times felt inadequate and punitive/neglectful.

I attempted to cope with the situation by referring back to the boundaries within which we had contracted to work - and the nature of the work with had agreed to.

She found these terms very difficult to accept - yet our relationship did not appear to be adversely affected.

Recently - a year after we terminated our contact - she unexpectedly phoned me to let me know that she was pregnant and that her husband was being posted to Australia so she would be leaving Scotland - and that life was good for her.



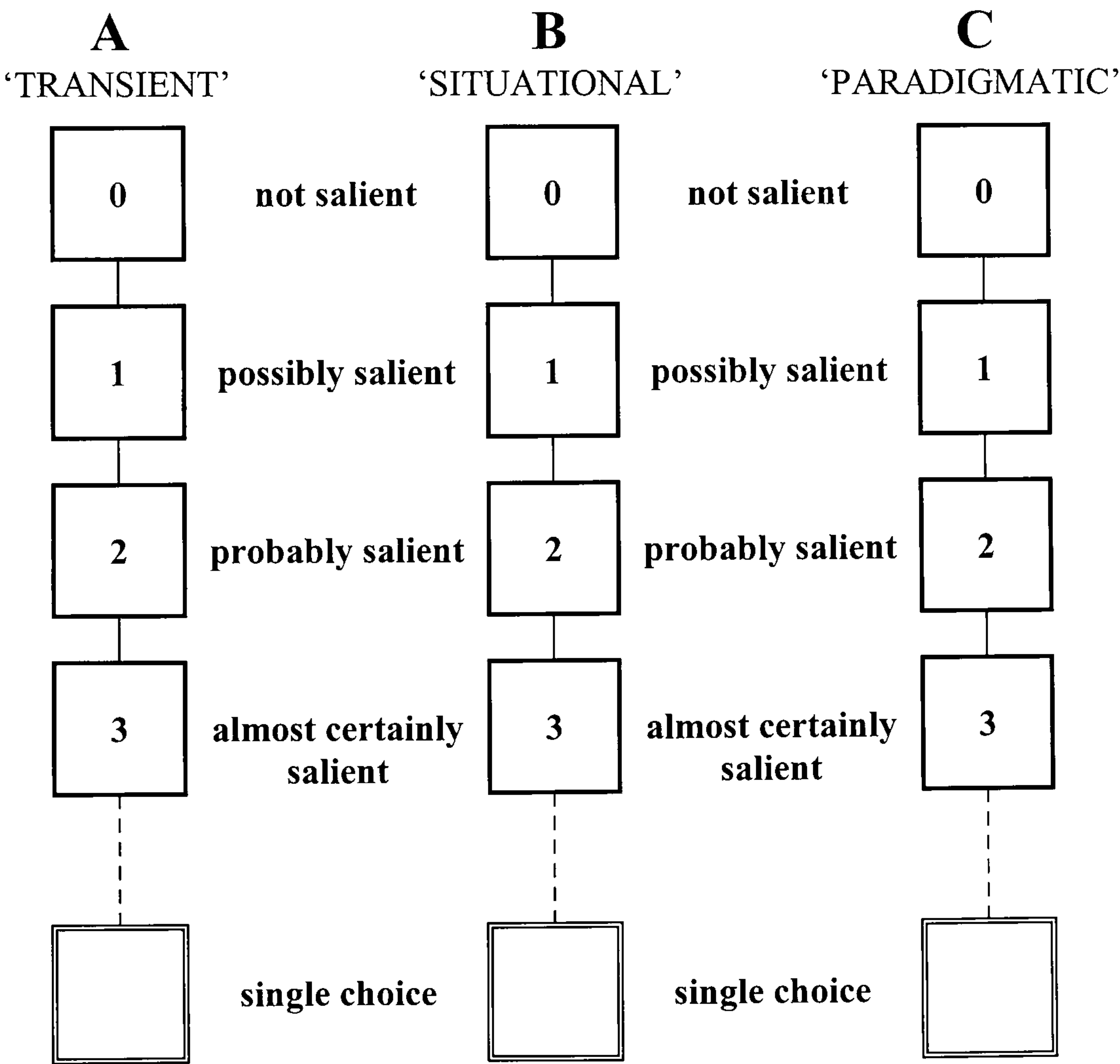


The client presented and insisted on focusing on physical symptoms. Any attempt to focus on other feelings, particularly cognitions, was frustrated by reference to physical sensations, yet from what the client said, I knew she was not being open and honest with her GP.

I felt frustrated, then exasperated with the struggle to boost the clients self- esteem.

I reflected back to the client my view of the process of our sessions, was most insistent that she gave to GP a true account of all the medication she was taking.

The client found our sessions helpful, by her account. Her GP referred her to a psychiatrist. I liaised with the psychiatrist who will admit my client as an in-patient to stabilise her, reduce her medication. The client and psychiatrist would like me to work with her when she comes out of hospital. I have agreed.

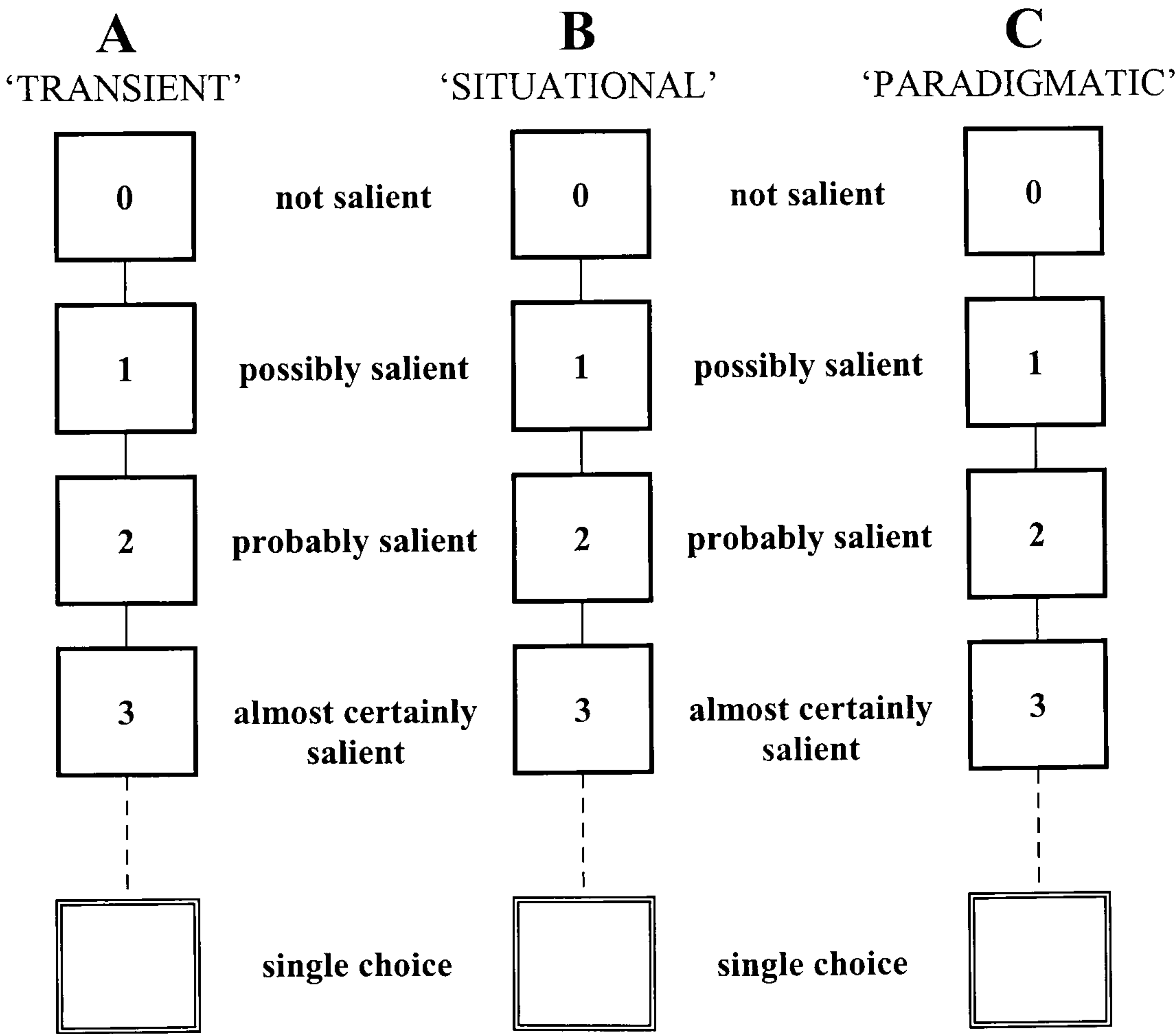


Very dependent client - wingeing and whining constantly, crying without stopping session after session. Phoning constantly between sessions about trivial matters.

I frequently felt angry with her especially with the phone calls/letters etc - although initially I felt protective and wanted to help this miserable "little" girl (aged 26 - came to me because of a double bereavement). I also felt frustrated - everytime she left and I felt we had made progress, she would return the next week with a fresh "disaster" to talk about. Again she would go full circle and returned to the "cracked record" of past sessions. Recognising she needed more than I could offer (one hour week over several months) and that she had a personality disorder - of a long standing nature. I decided to refer her to the Maudsley where there is at special unit - a Day Centre where she could go every day. However she could not consider this option for a very long time, clinging to me emotionally. By this time I was really dreading her arrival each week. But the nurse therapist at the Maudsley began to help me and we had some joint sessions with her and finally she managed to "leave me" and attend the Maudsley - where I understand she makes progress but very slowly. I still get the occasional letter from her.

She used to take notes throughout the sessions of what I said and what she realised. Next week she would return with a pile of more notes - events that occurred through the week which she had to sobbingly tell me about.

I made the situation worse by not setting the boundaries and keeping to them - her extreme distress led me to allow her to break them.



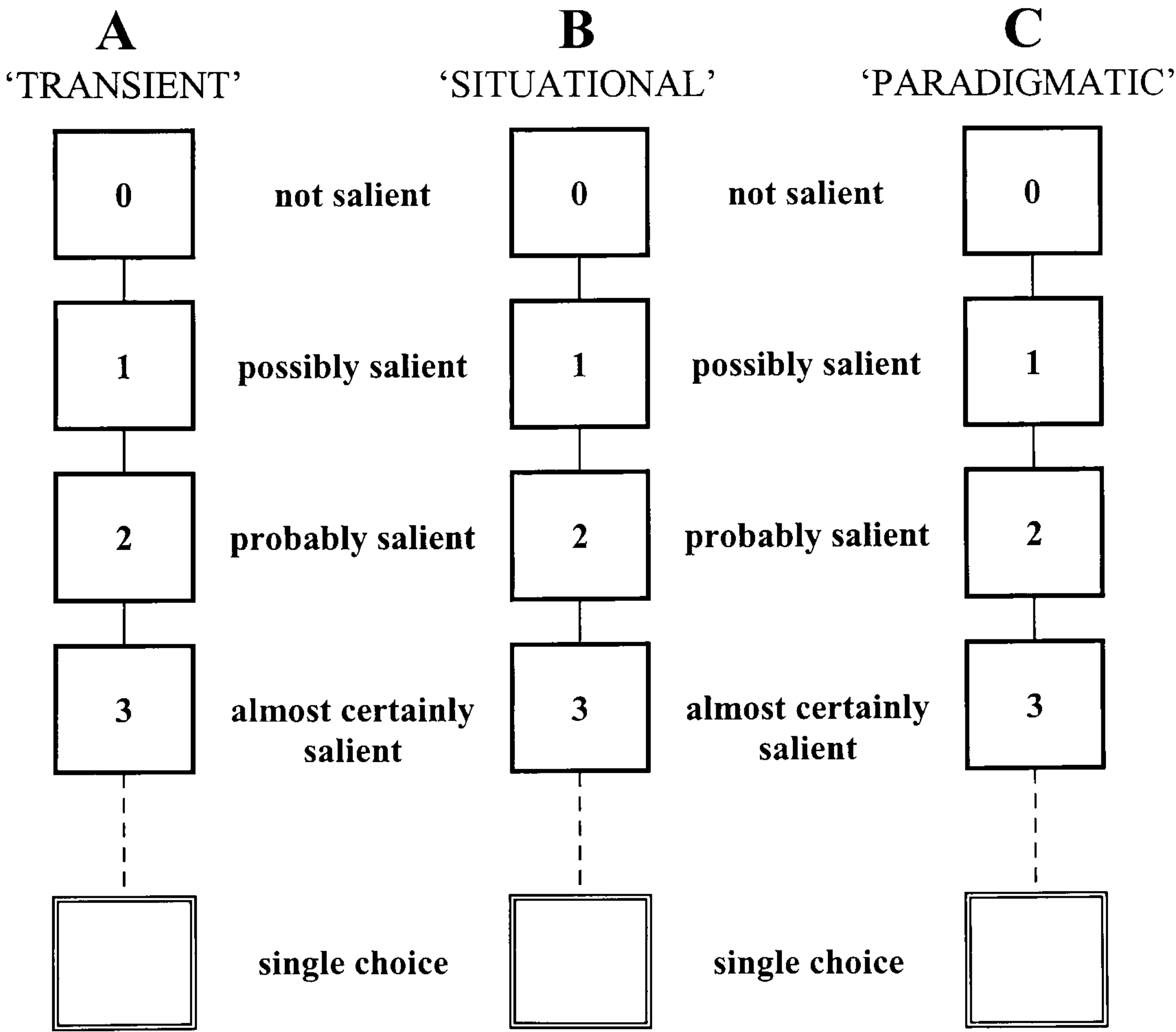


Susan seems an excellent illustration of a client I had difficulty with but who, of herself, was not so difficult.

At the time I saw Susan, I was a psychologist managing an in-house EAP and she was a 27 year old pharmacy technician on sick leave following a depressive episode for which she had been hospitalised. She had been frightened both by her experience of hospitalisation and the depressive episode and was seeking explanations for the episode, reassurance and help in ensuring that it did not happen again. But together with her vulnerability was the inescapable fact she was drop-dead gorgeous. That was not the problem. I have, after all, been involved in therapeutic relationships with very attractive women before. The problem with this particular encounter was that not only did Susan begin to give me the come-on, I began to enjoy it. Wracked with guilt, feeling therapeutically emasculated and not a little embarrassed I battled on.

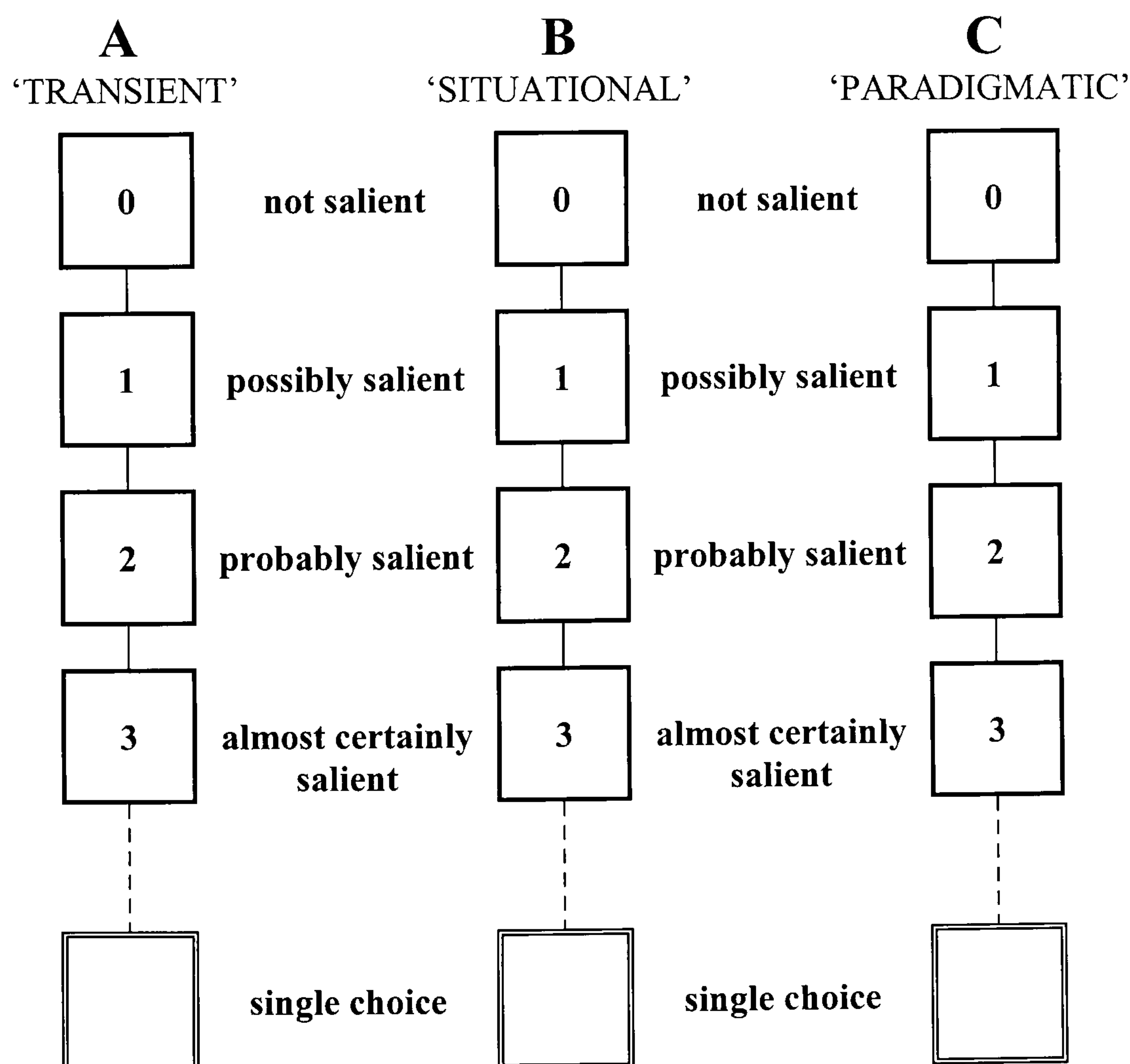
To make matters worse I was a participant in a supervision group which was part of a trainee supervisors course. The group was comprised almost entirely of women who, when I raised this issue, took a very hard line - with me. I was to blame, typical male, sex on the brain, reading things into the situation which were clearly not there, client totally exonerated, clearly not giving me the come-on, clients don't do that sort of thing, go and see a therapist and get yourself sorted out you animal. I do not exaggerate! Despite this setback, I plucked up courage and discussed the issue in my individual supervision with my male supervisor. I described my client's behaviour in exactly the way I had described it in the supervision group together with how I felt about it. He helped me understand that a seduction was indeed taking place - but not necessarily sexual.

After considerable discussion about what I should do, I decided to tackle the issue from my feelings of professional emasculation - which, as it turned out was the purpose of my clients seduction tactic. She did not want, during the course of therapy, to be hurt. Susan's reasoning was that if she 'seduced' me then this would distract/deflect me from the sensitive, difficult areas of her life. It had worked before in so many areas of her life.





This is an ongoing, recurrent problem with a lady who is very multiply symptomatic - PTSD related to multiple childhood abuse, an adult rape, family of origin problems and many others. I like her and see her as "a fighter". However, she frequently shows very extreme and theatrical behaviour in sessions and, as she tells her terrible life story, although I don't doubt that awful things have happened to her, I think she may be making quite a lot of stuff up as she goes along. It's unusual for me to feel "I don't believe you", and it makes me feel very uncomfortable. I'm also very concerned about the implications either of trying to raise it with her or of letting it run and run. I have tried to raise it with her very cautiously - what happens is that my feeling of being told fairy-stories/horror stories recedes for a bit and then re-emerges - I think she does actually change what she does, but it might be me.



This example comes from my work with an Irish woman in her early thirties. She was originally referred for short-term counselling through her Employee Assistance Programme after the suicide of her sister. The initial contract was for three sessions and allowed the client to remain with me if she wanted to continue.

It emerged that she had an appalling history of childhood abuse - sexual, emotional and physical, as well as multiple bereavements throughout her life. She had been married to a violent alcoholic, had had nine miscarriages, had nearly died of an illness in her twenties had often been depressed and had a history of self harming behaviour, as well as taking serious risks at work by tackling violent customers in the off-licence where she worked. This story emerged slowly over several months and much of our early work was concerned with crisis management because of the stress of her job.

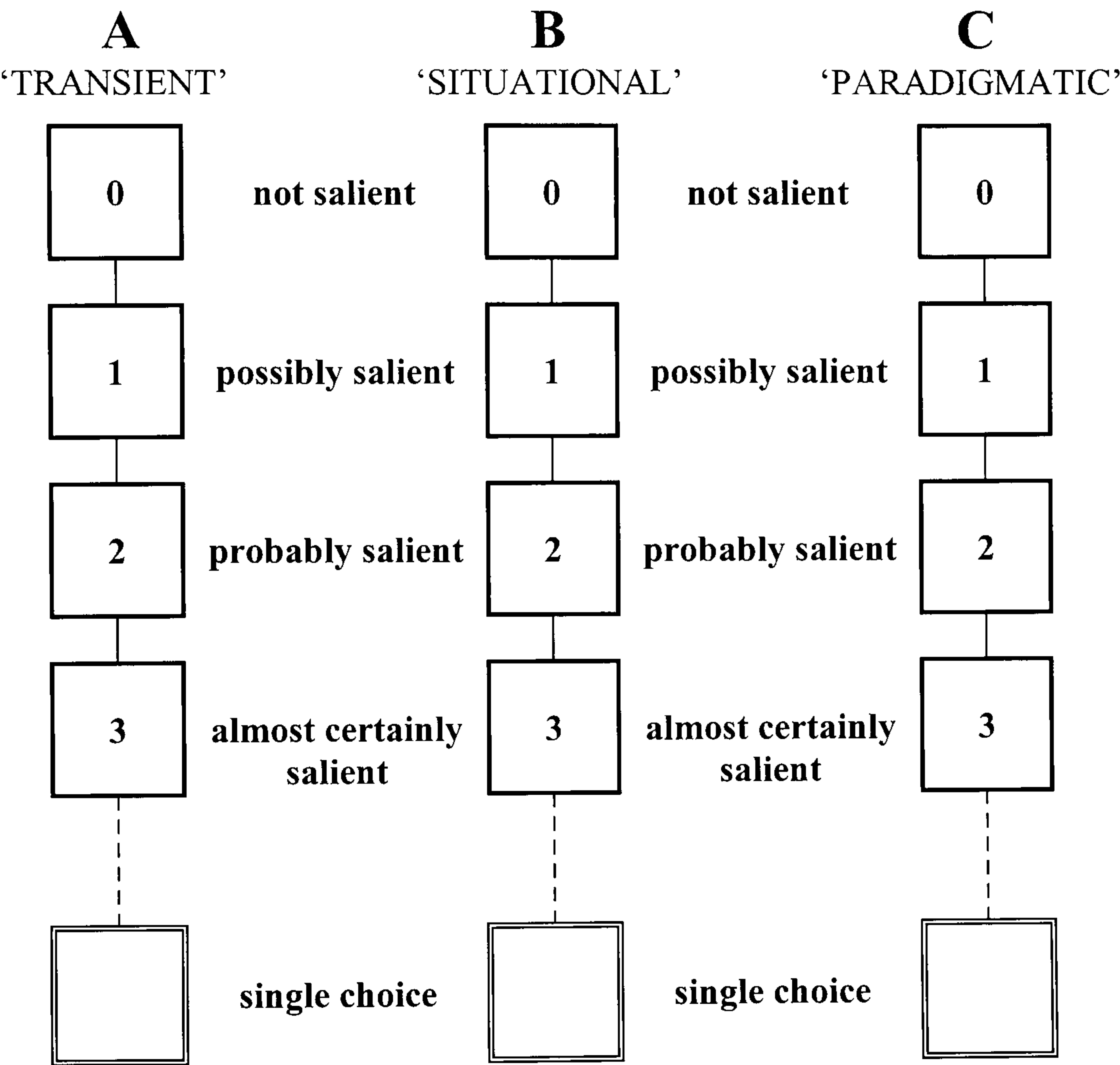
She was a very challenging client in many ways and tested me to the limits. There were many incidents which I found hard to deal with, including threats of suicide, and others which I also found quite abusive towards me. I frequently suggested referring her on and made sure that she saw her GP, although she always refused medication for her depression. She declined to be referred on and she became the main focus of my supervision for a long time so that I had the necessary support to continue working with her and to cope with her acting out behaviour. She was highly intelligent and developed considerable insight into her behaviour and there were periods when I felt we were making considerable progress in dealing [with] her traumatic history.

The most difficult problem for me was in her continued boundary breaking regarding telephone contact. When she was most distressed she developed a pattern of calling day or night and wanting me to be available at all times. She would leave messages while I was working, or hang up without a message and ring constantly until I answered the telephone in a break between clients. This often meant my phone was ringing repeatedly while I was working, although it was in another room. The late night calls were the worst, however, as she would often ring at 11 p.m, midnight or during the night and sound angry when she reached my answering machine. She denied being intoxicated at such times and I found it hard to believe her.

I would remind her that I had said from the start of our work together that I could not deal with telephone calls from clients after 10.30 p.m.. She always ignored this boundary and if I answered the phone she would try to keep me listening and talking for as long as possible, becoming surly when I tried to end the call by saying we would talk further in our next session. These calls would come in spells so that there were periods of calm in between before the next round started up again. It felt like a struggle to maintain my own peace and privacy while respecting her depths of traumatic despair and terror of abandonment.

Our work came to an abrupt end when her husband of six months died as a result of an attack by her first husband. She did make contact some months after this and said she would return when she had settled into a new job. I did not hear from her again.

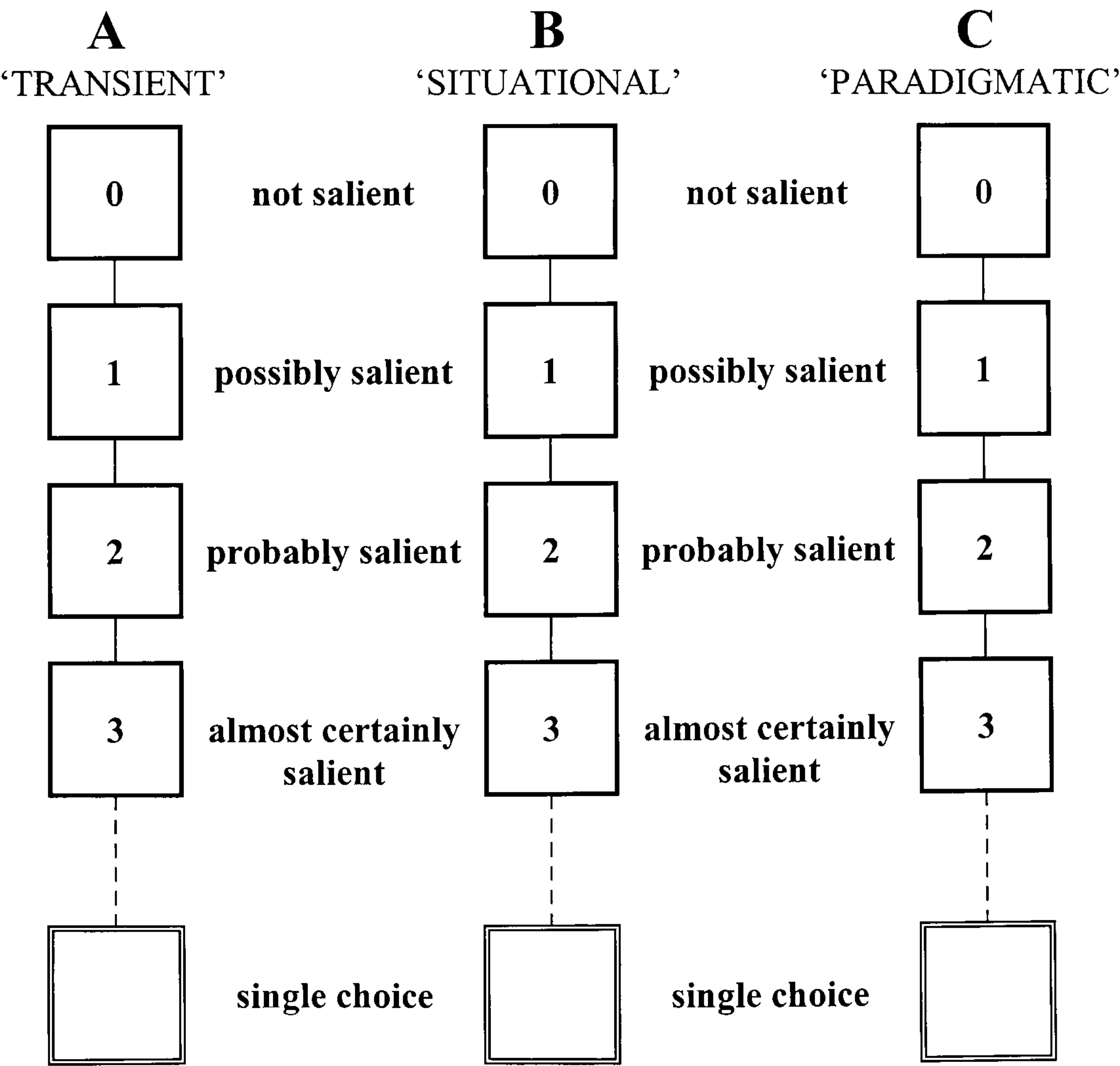
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**MALE COUNSELLOR, PSYCHOLOGIST, PSYCHOTHERAPIST  
PSYCHODYNAMIC ORIENTATION**

This comes to mind as a relatively recent experience. I had been seeing a female client with depression for getting on for a year. She was emerging from her depressed state and getting much more in touch with feelings relating to her upbringing, and also to her present unhappy marriage. As this happened the therapeutic relationship began to become eroticised and she spoke increasingly of her feelings for me and of seeing me outside of therapy as we came towards termination. I found myself drawn into this and intensely attracted, and in fact met with her for coffee a few times, before thinking through what was going on and taking it to supervision. As a result I made explicit all this in our closing sessions and we discussed what was happening for her and the way this represented her increased self-esteem and assertiveness. She ended therapy very much stronger as a result, and was able to handle the ending without feeling rejection.



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This patient came to me at the suggestion of his doctor, who had treated him for depression for some time without success.

There were two children in his family, himself and a younger sister. His parents were on very bad terms with constant quarrelling. Father stayed out a lot to avoid the home and mother worked during the day. She hated cooking and housework, so the children were inadequately fed and the house was always in a state of squalor and chronic disrepair - and neglect everywhere. The children received very little attention or affection from either parent. My patient grew up to hate his parents and his home.

He felt so different from his peers that, although quite bright, he refused school work and truanted regularly from aged ten. His teenage years were miserable and lonely. He wandered the streets during the day, unwilling to return home. He despised the school authorities for letting him get away with his non-attendance.

In adolescence, his slight build, his slow physical maturation and appalling acne set him apart from his peers when their interest in girls came to the fore. He felt a complete failure so he virtually dropped out of school altogether. Again, he felt that all the adults in his world let him down: he made mock of his referral to the educational psychologist.

He worked for some years at various 'blind-alley' jobs - always despising his workmates and employers: he made no friends. Around 19 he decided to study for 'O' levels at night classes. Success led him on to 'A' levels, thus vindicating his belief in his own intelligence. He entered a local Technical College to read for a degree in Environmental Studies around age 24.

For a brief while he even enjoyed this until friendship with a girl student (the only one of his life) went wrong. He believed she liked him until he was finally spurned when he became demanding. He was devastated. He had to resit a year or so of study. He despised his immature fellow students, and found the staff useless. On gaining his degree he could not find relevant work, and was obliged to become a relatively low grade clerk.

These experiences compounded his negative views of the world. He lived alone in a rented flat with few friends and was still a virgin (a source of profound misery).

This patient was very difficult to work with. Nothing, absolutely nothing, could engage his interest in change. All his arguments against change were very well rehearsed. Any interpretation I offered was crushed with 'barrack room' law, politics and philosophy. This poor man emanated hate that met me, his therapist, like hot waves from a coke brazier. At all times he conducted his own person positive crusade of negativism.

Whilst acknowledging the crippling deficits of his upbringing, I endeavoured to get him to accept with appropriate pride his achievement in spite of this; to no avail. I was just like everybody else; I could offer him nothing - he'd known from the start I would be useless. I agreed - since he was so determined that I should be.

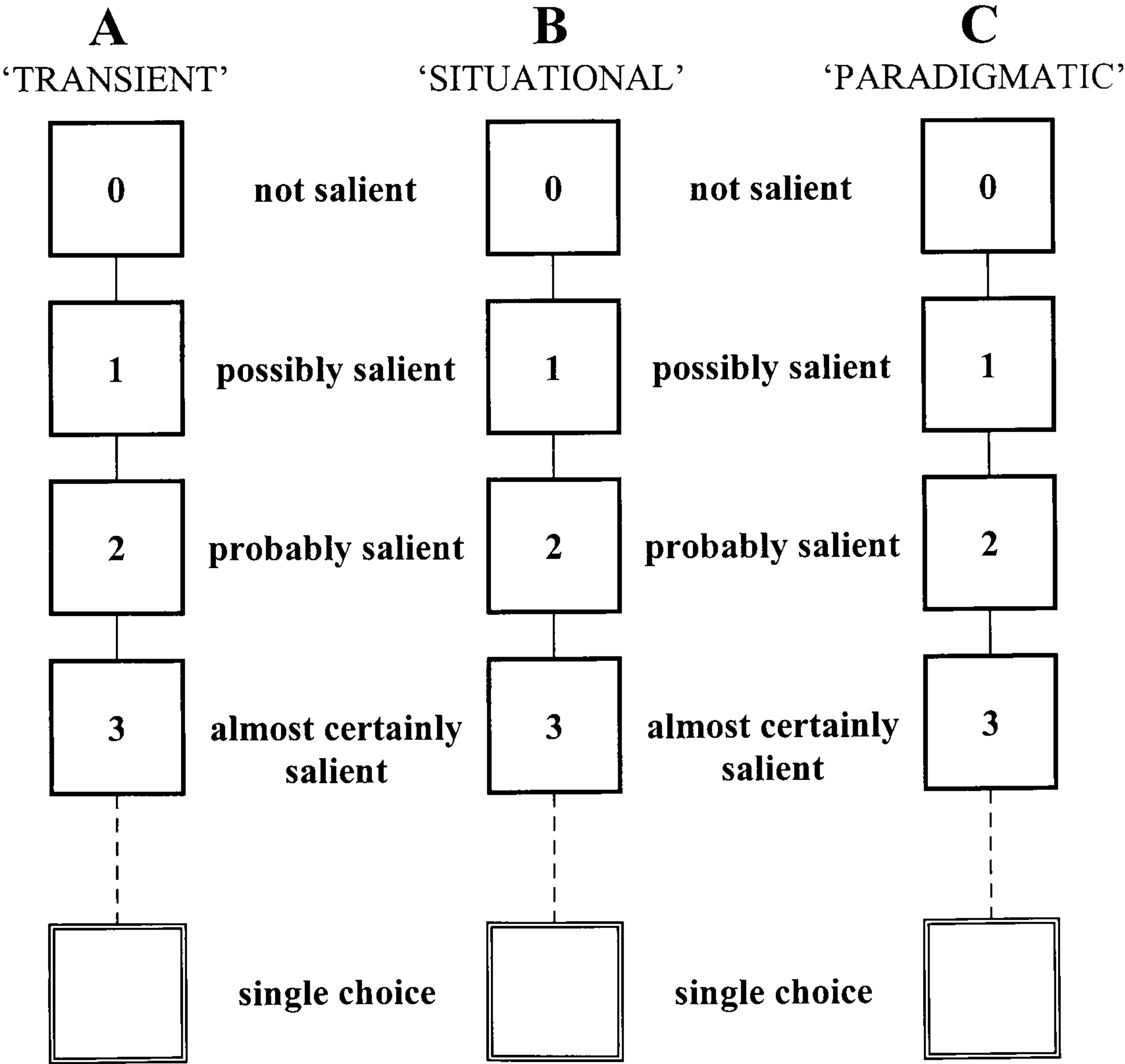
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For some 10 months we 'battled' on in this way. It was amazing that he stayed - but I'm afraid he was really only 'enjoying' his proof that I could not help him. I faced him frequently with this view. He talked often of suicide. I refused to be intimidated. I asked what he felt his 'gain' would be. He talked of punishment of his parents: his mother had dared to kiss his cheek last Christmas: he was revolted, he would never visit home again. Interestingly, very little was said of his sister, for whom he appeared to have no fellow feelings at all - to dismiss her completely.

Most of all, suicide would give him total obliteration: he felt it was his life, and his right to end it if he chose. I felt powerless to help this man. I felt he needed five times per week therapy in a residential setting where he might have opportunity to act out his life-long misery and fury but it was not possible: he would not even entertain such a possibility. The talk of suicide increased until one evening he said he had come to say he was leaving therapy. He would decide if and when he'd kill himself in his own time and way.

I thought much of this was a 'so there' threat but even so, I felt very troubled about his bitter psyche. I telephoned his doctor that evening (he knew I was going to do this) to share my thoughts. The doctor was much more philosophical. She took the view that this was his chosen way of life. Neither she, nor colleagues before her had been able to help this man - so now I had to accept that therapy (my therapy) had failed too.





**FEMALE COUNSELLOR, PSYCHOLOGIST, PSYCHOTHERAPIST  
PERSONAL CONSTRUCT / INTEGRATIVE ORIENTATION**

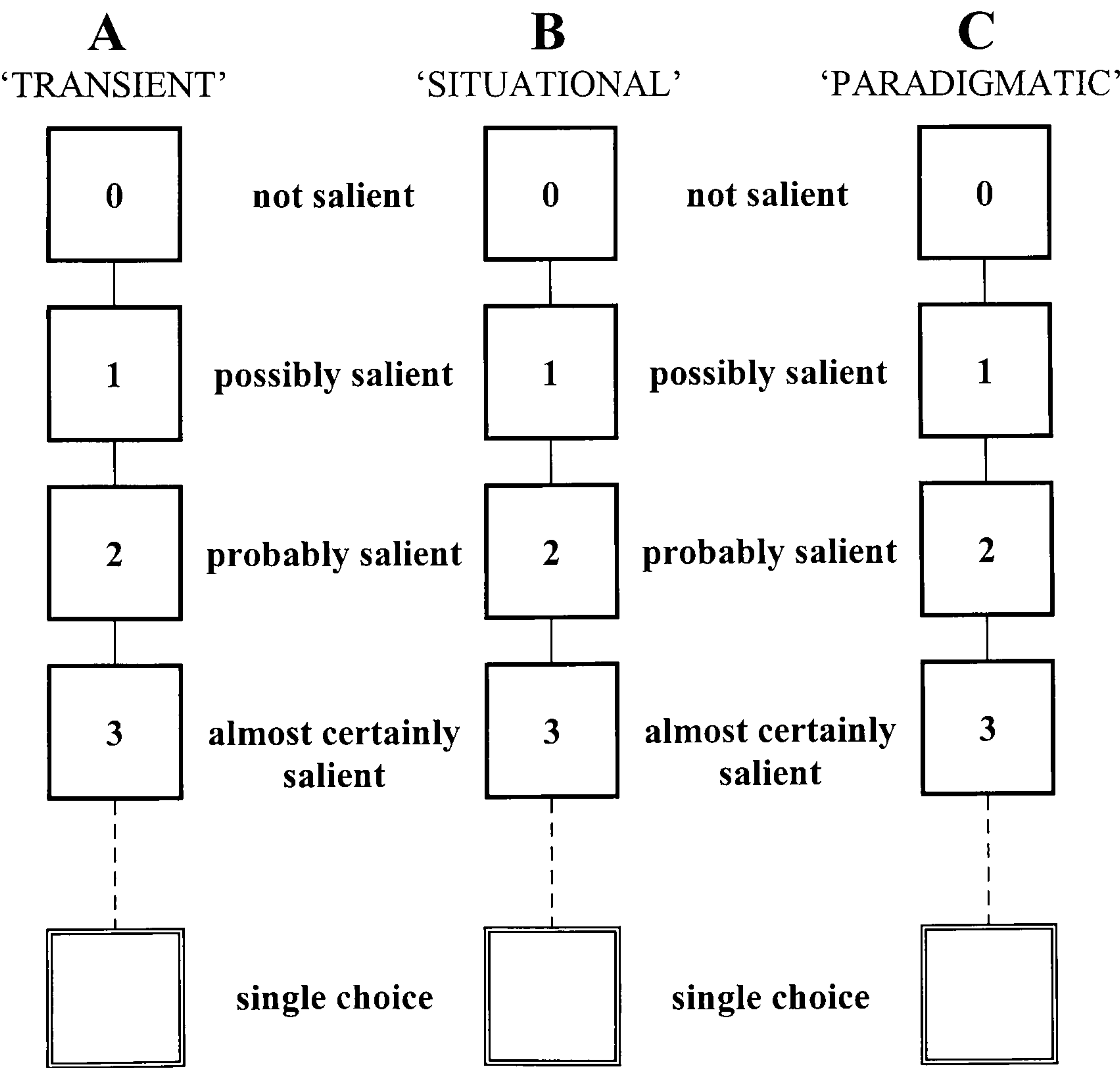
Some four or five years ago, as a volunteer counsellor in a drug clinic, I worked with a young man who had suffered a great deal of verbal and physical abuse. We had completed at least 12 sessions, and maintained good rapport. Our sessions terminated when he suddenly accused me of discussing his confidences with other clients attending the clinic.

I assured him that this was untrue, but that as he was no longer able to trust me, there was no point in our continuing to meet. I reminded him that he was entitled to make a complaint to the management.

We parted politely. Any subsequent casual meetings at the clinic were always good-humoured.

I wrote a report about the incident - I had felt quite angry about his accusation - especially as this young man was not scrupulous about keeping our appointments, except for his Methadone script.

I learned later that he had quarrelled with other staff at the clinic.



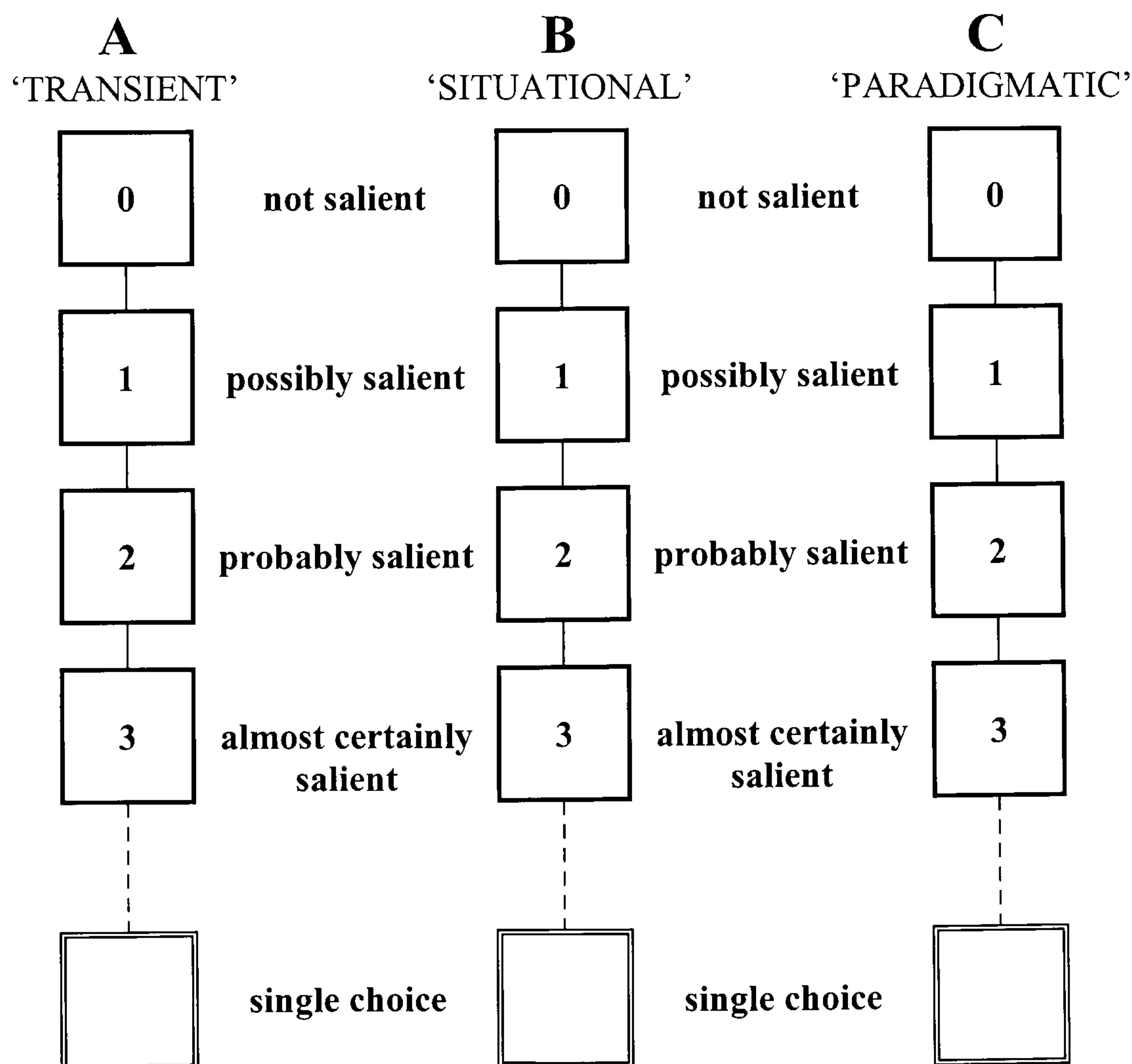
**FEMALE COUNSELLOR, PSYCHOLOGIST, PSYCHOTHERAPIST**  
**TRANSACTIONAL ANALYSIS / HUMANISTIC ORIENTATION**

Client was man - had previous therapy (12 years) for alcohol addiction. He had come to me for therapy as part of his commitment to become a counsellor. (Therapy was prerequisite of course.) I found this man "difficult" to work with because of his very high negative transference with me.

At approximately 14 months into our relationship, he went on a boozing binge. We firstly re-set the counselling boundary - he was to come here sober. The next issue was his working with clients during his binges. I went to supervision, clarified my thinking, deposited the majority of my scene - anger at having to now deal with the ethical issue he posed. I decided, with support, to tell him of my dilemma - I had an obligation to confront his behaviour, and if he didn't take action to protect his clients, I would have to break confidentiality and report his behaviour to the training organisation who also subscribed toward my code of ethics.

He did stop seeing clients at once, passing them to two locums whom I had helped him to find and negotiate with.

I remember my tiredness at the end of this period of negotiation, and my need for supervision while he and I integrated this difficult time into our relationship.



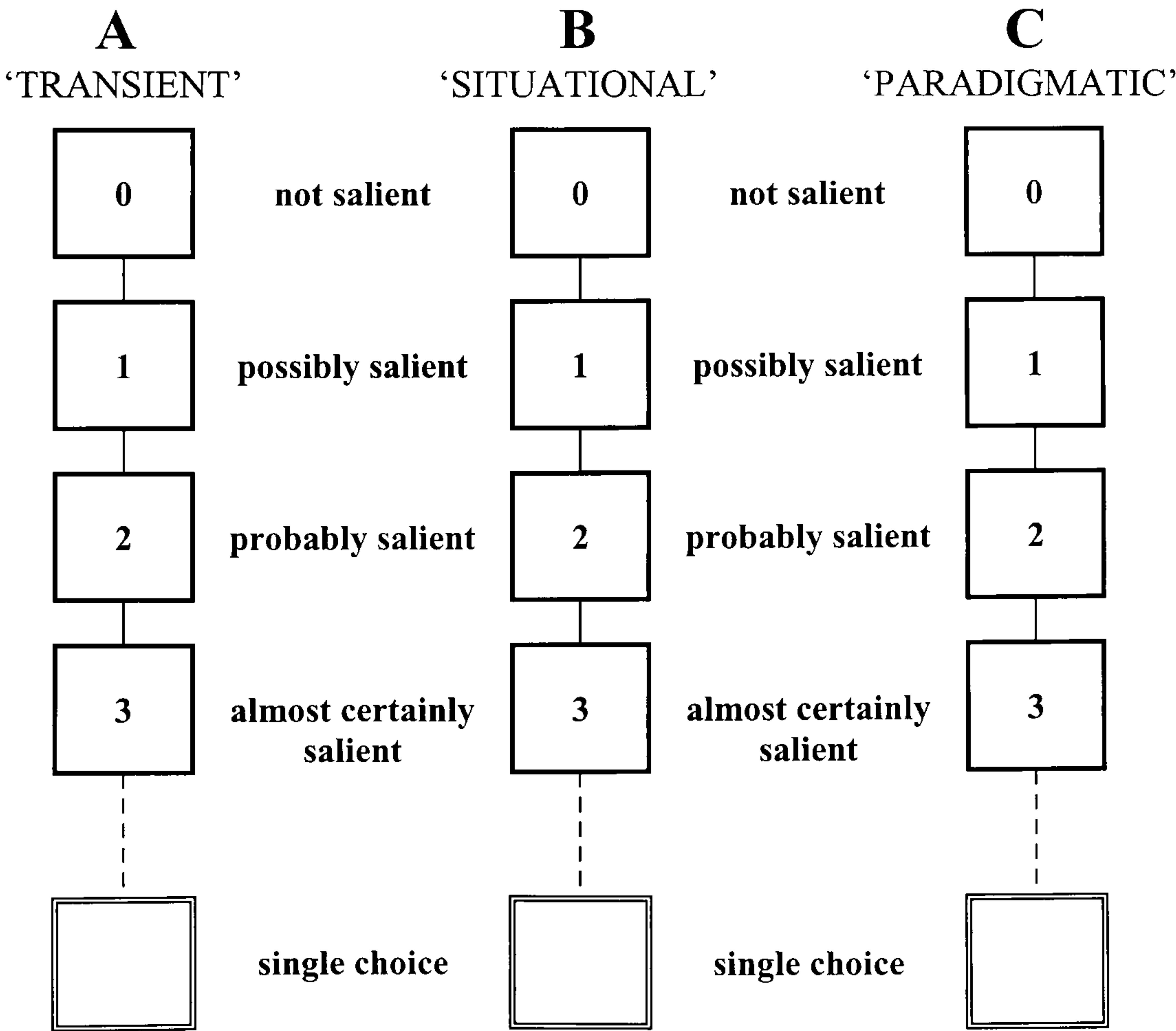


Mr A was chronically suicidal when I began seeing him though up till then he had not disclosed his distress to anybody - not even the therapist who had assessed him. He had/has long-term difficulties with alcohol dependency, didn't work, remained confined to his home most of his day and kept his very patient and understanding wife very much at bay. He comes from a very abusive background - violently physically and sexually abused by his father.

He told me that he didn't expect therapy to help and regardless he was going to kill himself on his fiftieth birthday.

During the opening sessions I felt really anxious about the situation, expecting to hear at any moment that he had in fact killed himself. However, as he spoke some more I felt I was hearing more about feelings of non-existence, futility, hopelessness and despair. I personally knew a lot about these kind of feelings and in ways was beginning work with Mr A following a long personal exploration of this aspect of my own life. (I guess it is important to add that this work was in fact triggered by my experience with Mr B *[the patient mentioned in the other account]*). Mr A responded well to my attempts to really try and hear what he was saying. He continued to speak worryingly about wishing to die, however, "suicide" became redefined in the therapy now as "non- existence" - a living death!

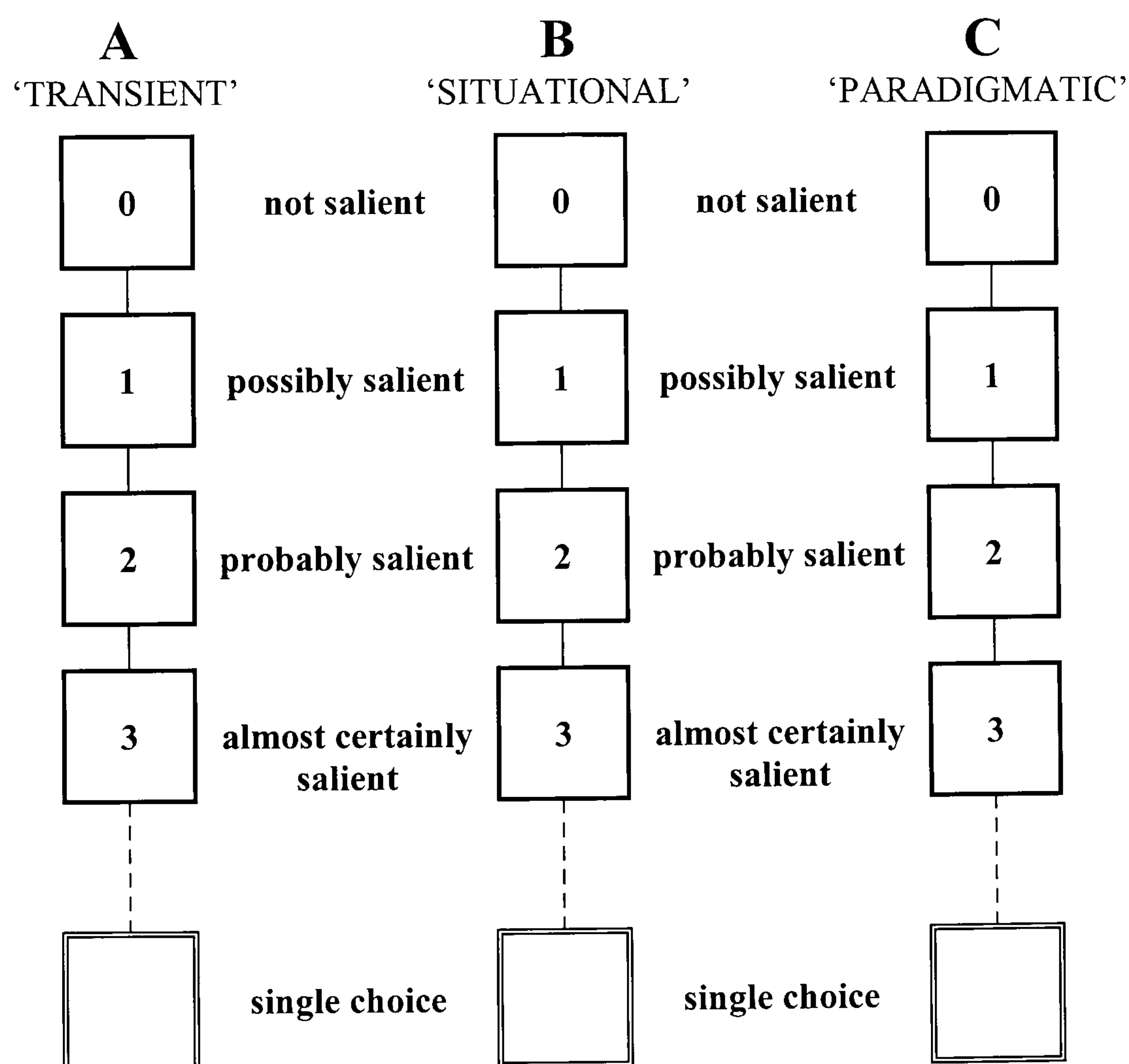
Personally I could bear this about myself and certainly my therapist had done so for several months not so long previously. Mr A and I (the therapy is ongoing) 'get on well'. I like him and suspect that he also likes me. He speaks of wishing to die on occasion now though it does not preoccupy his life. He gets out more - has more enjoyable contact with his wife - is abstaining from alcohol. We have much more hopeful sessions though these can easily be followed by despairing ones. He remains a real suicide risk and maybe he will actually kill himself one day. Sometimes during the roughest of times I felt like our mutual "getting on" together was the only thing that I could trust would sustain his life. The burden of that is scary. My supervision is good though and the resource I find in my personal achievements with my own therapist keeps me steady and calm. Mr A's fiftieth birthday is long past now. I'd like to think that this is a good sign!





The patient has marked personality difficulties and paedophilic tendencies. He is insisting that he should be offered more frequent sessions to sort out his and others' attitudes 'once and for all'. For a number of reasons, which I've talked over with a supervisor / external consultant, I'm not convinced this is the appropriate therapeutic option. However, in his comments about this, the patient conveys that he will feel inclined to divest himself of responsibility for his behaviour "and if anything happens as a result of this poor service (i.e. if I end up in court for abusing boys), it's you who will have to give the better account".

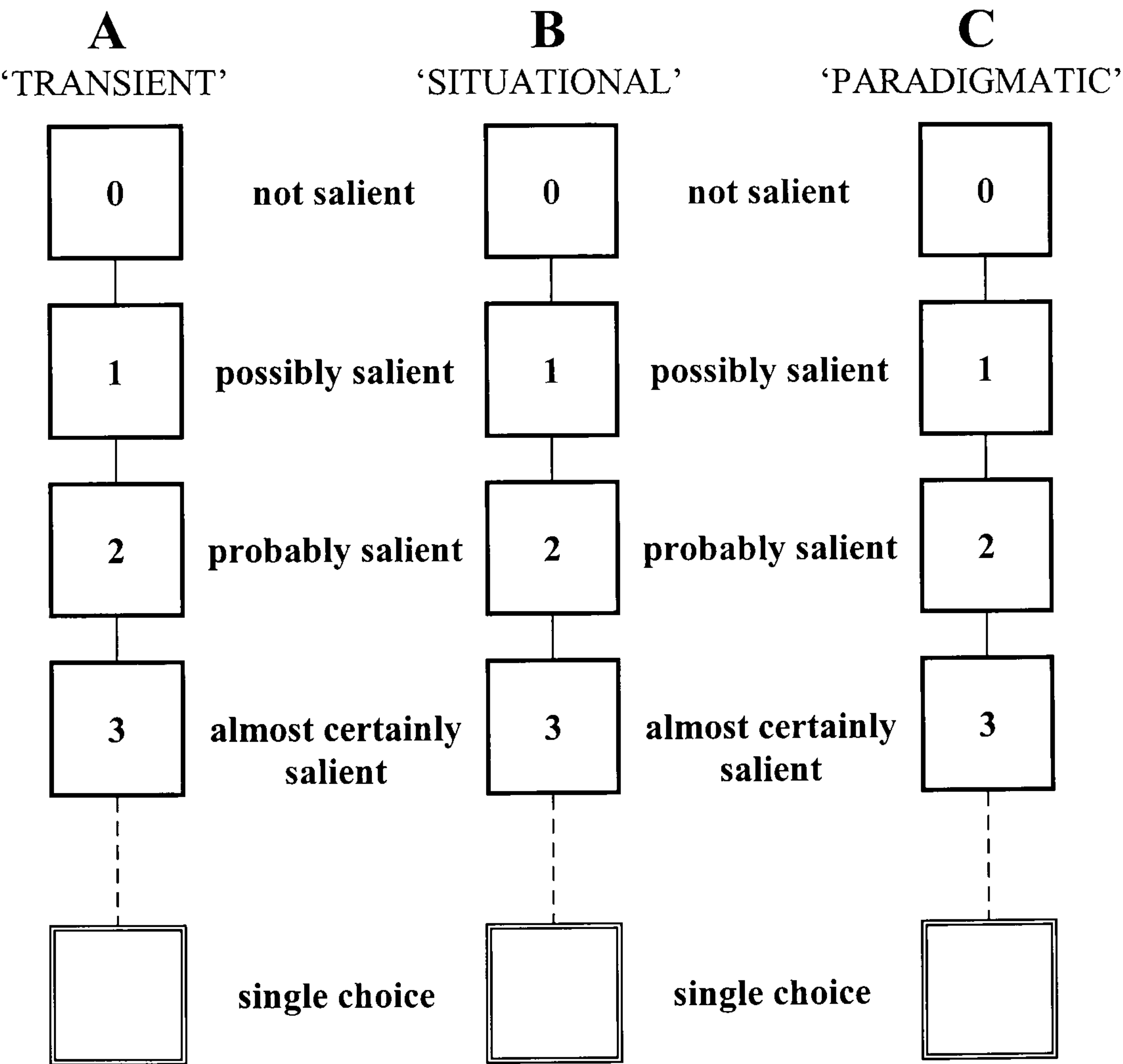
I feel threatened and manipulated; risks certainly exist, but my reservations seem basically quite sound. I decide to maintain the existing pattern of meetings.



A young woman, recently started in therapy was abusive to me, using foul language, making derogatory remarks about me and was sexually provocative.

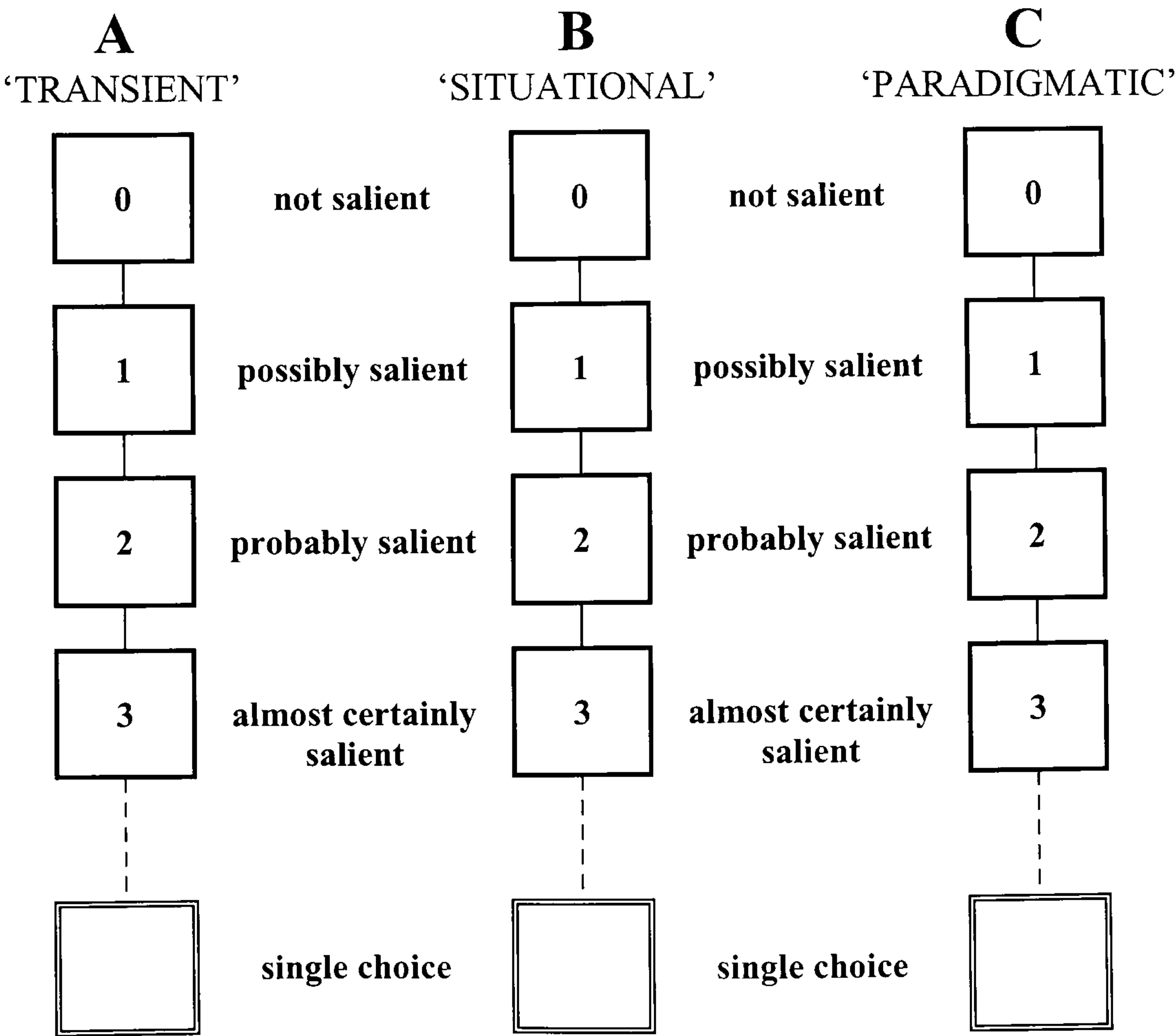
I felt unsure how to respond in a way which would be therapeutic and would not damage the treatment alliance.

I remember 'swearing' in my own head as I tried to work out what to do and I decided that acceptance and non-retaliation would do the least harm but that I would take steps if I felt I was in physical danger. The session ended with the young woman saying the treatment was 'crap' and that she'd rather have hypno-therapy but in fact she returned the following week and apologised.



I was with a patient whom I had been seeing for some weeks and who talked incessantly about what she had been doing during the week since we last met in great detail, as if trying to recall every single feeling and exactly what had been said to her, and she had said. This was normally in a rather monotonous way, and at times I found myself becoming very sleepy, as if we were both being lulled into some calm, deadened state. She was a very disturbed woman with a long history of breakdowns and hospitalisation. Because of her fragility, and her intolerance of previous counsellors, I tended to listen mostly, at first, and to make few interventions other than for clarification and to show empathy. On this particular day I decided it was time to risk becoming a bit more active and I made an interpretation about what was happening between us. The patient became enraged, and began to shout and swear with a violence which took me completely by surprise. This went on for some time and included every insult she could think of to throw at me - I was a clumsy, incompetent, unsympathetic, told, harsh, judging smart-ass! And she felt she should report me for disturbing her equilibrium as I had done.

At first I was quite alarmed by the onslaught, and felt quite guilty, as if I had indeed done something cruel and damaging to her. But as she went on, and I had time to think about what I had said, and what was happening, I began to feel more as if I were with a raging child whose reverie I had interrupted and I became very calm. I let her finish, and then agreed that what I had said had been disturbing to her, and unwelcome, but that we needed to think about why it was so threatening to be disturbed in this way because that might help her understand her own response. I then linked it with things she had said previously, and she calmed down, but remained hostile and wary.







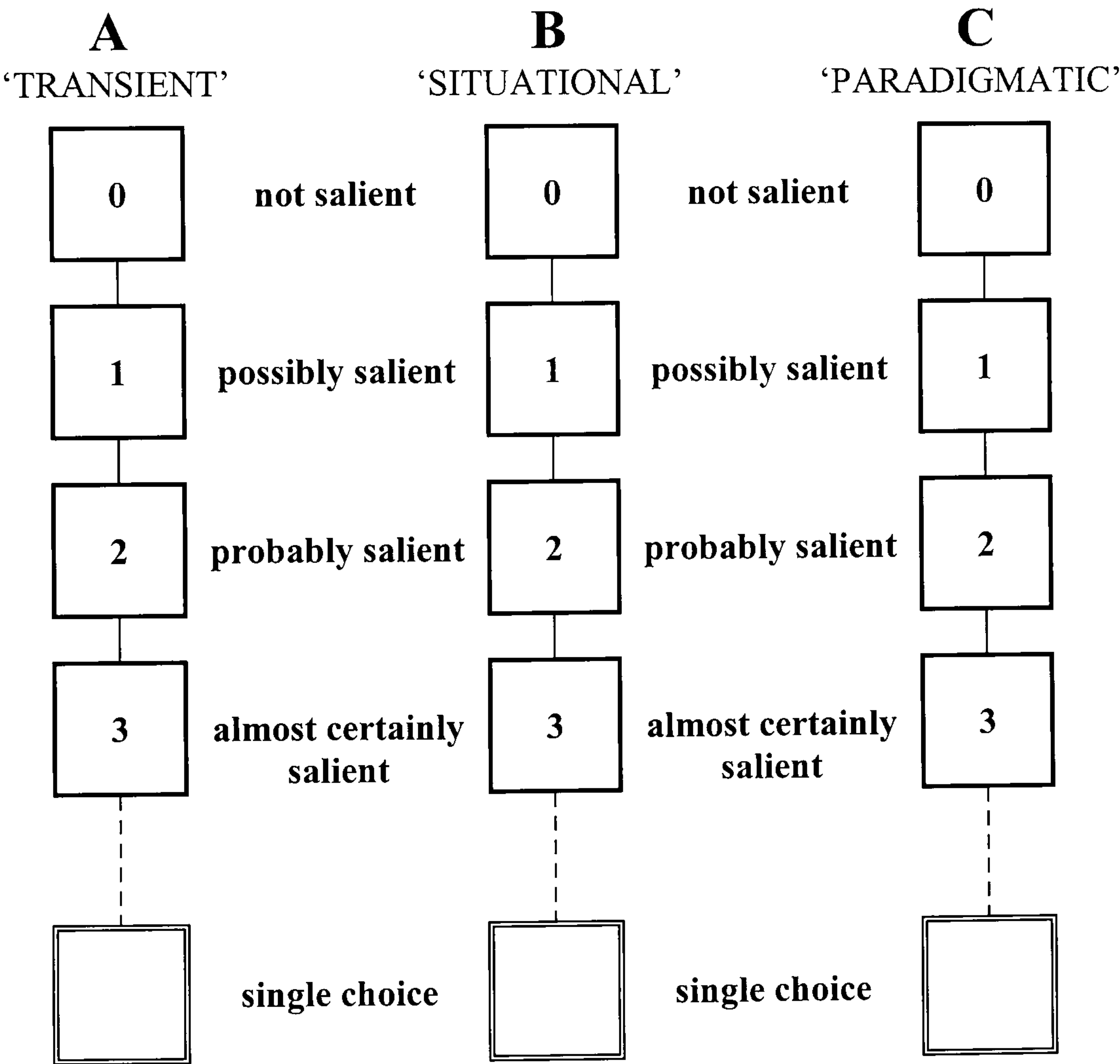
**POWERMAPPING / PSYCHODYNAMIC / HUMANISTIC ORIENTATION**

A longer term alcoholic and drug user arrived drunk to a session. When I said I could not work with him he left. He was briefly abusive to a secretary. Then he went outside and lay in the grass. I went out to see if I could help and he begged me to kick and hurt him.

Reactions:      I felt frightened, foolish, impotent, angry.

Coping:          I asked him several times to go home and eventually left him on the grass. I went back to the office and, after calming the secretary, sat at my desk trying to control my heart rate.

Outcome:        He got up, walked to casualty and admitted himself.







**FEMALE PROBATION OFFICER, COUNSELLOR, PSYCHOLOGIST,  
PSYCHOTHERAPIST**

**PSYCHODYNAMIC / BRIEF THERAPIES ORIENTATION**

I was referred a 57 year old woman by a GP practice. She had received ongoing therapy from the NHS for the past five years. Prior to this she had been diagnosed as having MPD - then DID. She did not believe she had this disorder but went along with the therapy. I was asked to make an assessment to see if I could offer an alternative means of therapy as the previous alliance had irrevocably broken down and the woman was experiencing elevated levels of distress and physical manifestations of her fragmented Mental Health.

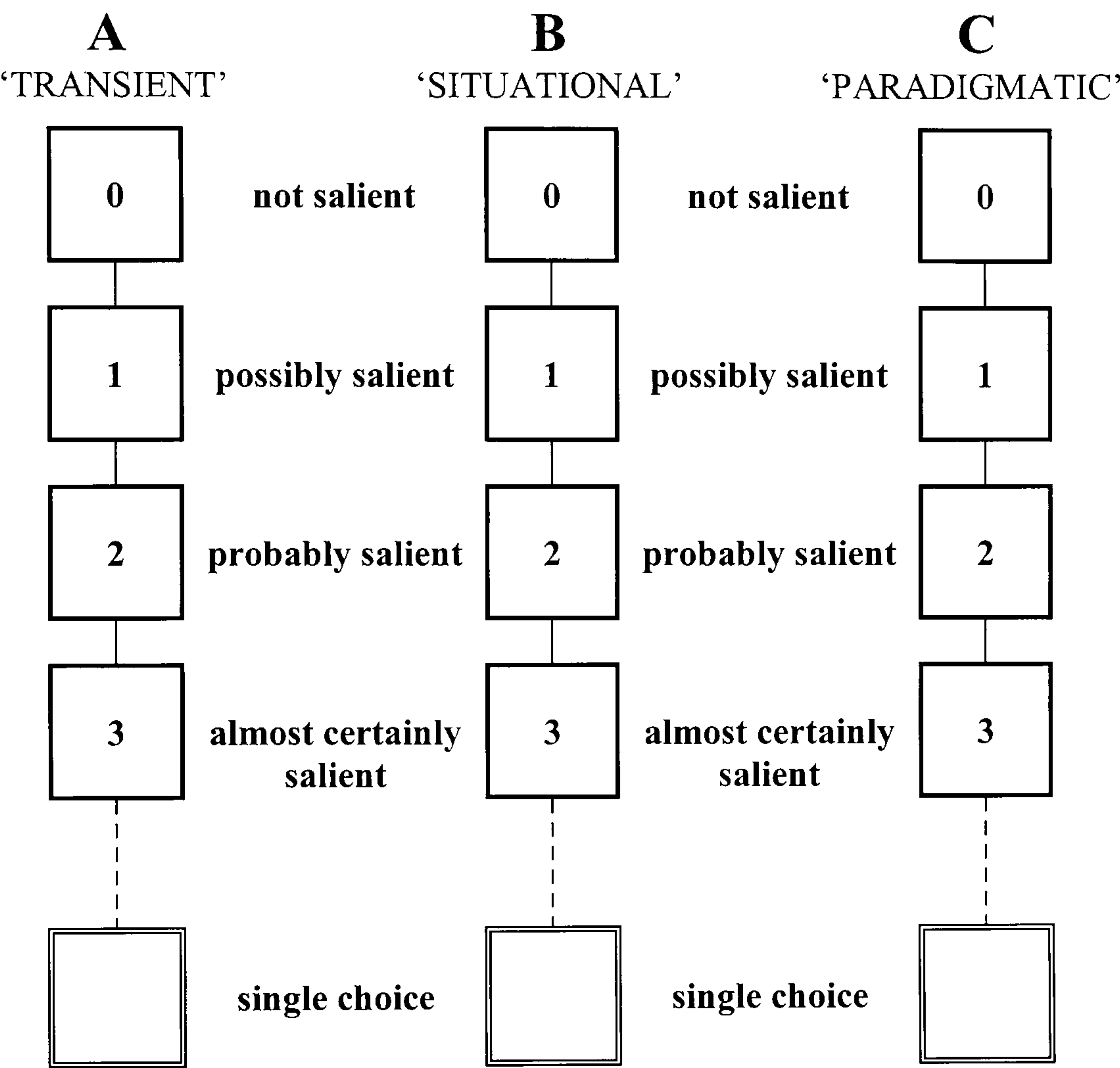
This woman was severely abused from birth - sexually, physically, mentally, emotionally. She had developed different "persons" to cope with each new trauma and seemingly had functioned in a tolerable fashion having gained two PhDs, written and published books, research papers etc. However, she was angry that she had become the focus of somebody else's personal aspirations - as an MPD - and though gaining some notoriety, her system of functioning became seriously impaired.

She presented as very needy, with a love/hate relationship in respect of the former therapist. She was demanding and set out what she wanted in therapy in a subtle manner. I needed to set boundaries. She had experienced a cross-over of professional and social involvement with her previous therapist. She sought to please but at the same time to establish, through her various aspects of "personalities" her frustration and anxiety about past therapy and her expectations of me. I felt each word I said was taken literally. I felt under pressure to engage the various "personalities" and to remain fluid and non-judgemental. Her system of external and internal monitors was highly sophisticated and I was able to address each one as an individual. Her fear was that I would strive to integrate these "defined role players" and thus crush her intricate system of functioning. She believed that the earlier therapy had broken this system by forcing her to recall in detail the torture and degradation she experienced from her earliest beginnings.

I am struggling to retain my own autonomy and professional "detachment" from her past experiences - of cult/ritual behaviour - and deal with the distress she is experiencing currently. Struggling to unpick the model of MPD which has been imposed upon her as she does not fit the criteria. Sometimes I feel as if we are gaining ground but then I am introduced to another member of what I call loosely her "community of selves". There is compatibility within this community and shared knowledge. Although she obviously dissociates on some level, so far each self has been focused and clear about her role. I am trying to spend time with as many selves / or facets of her system as possible. She has almost successfully obliterated or repressed any core personality but seems to cope with this as her reality that there is a collator of information who serves as the "main functioner".

It is difficult to predict an outcome. At first, I planned a series of objectives and goals but this created intolerable pressures for her, so now I have agreed to allow her to provide feedback which in turn will allow me to gain a better awareness of positive change. This work is draining and I appreciate it will be a long term commitment.

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This client - I'll call her Liz - was referred to me after a second acute admission following a second overdose. It was known that her marriage was ending; and it had become known that she had been raped in her teens. At the time of this incident she was in her early thirties. From the beginning of therapy she found it difficult to be verbal, but gradually she revealed that she had been very seriously sexually abused (by her father, mostly) from as young as she could remember, and also physically and emotionally abused by both parents, and emotionally abused by her mother.

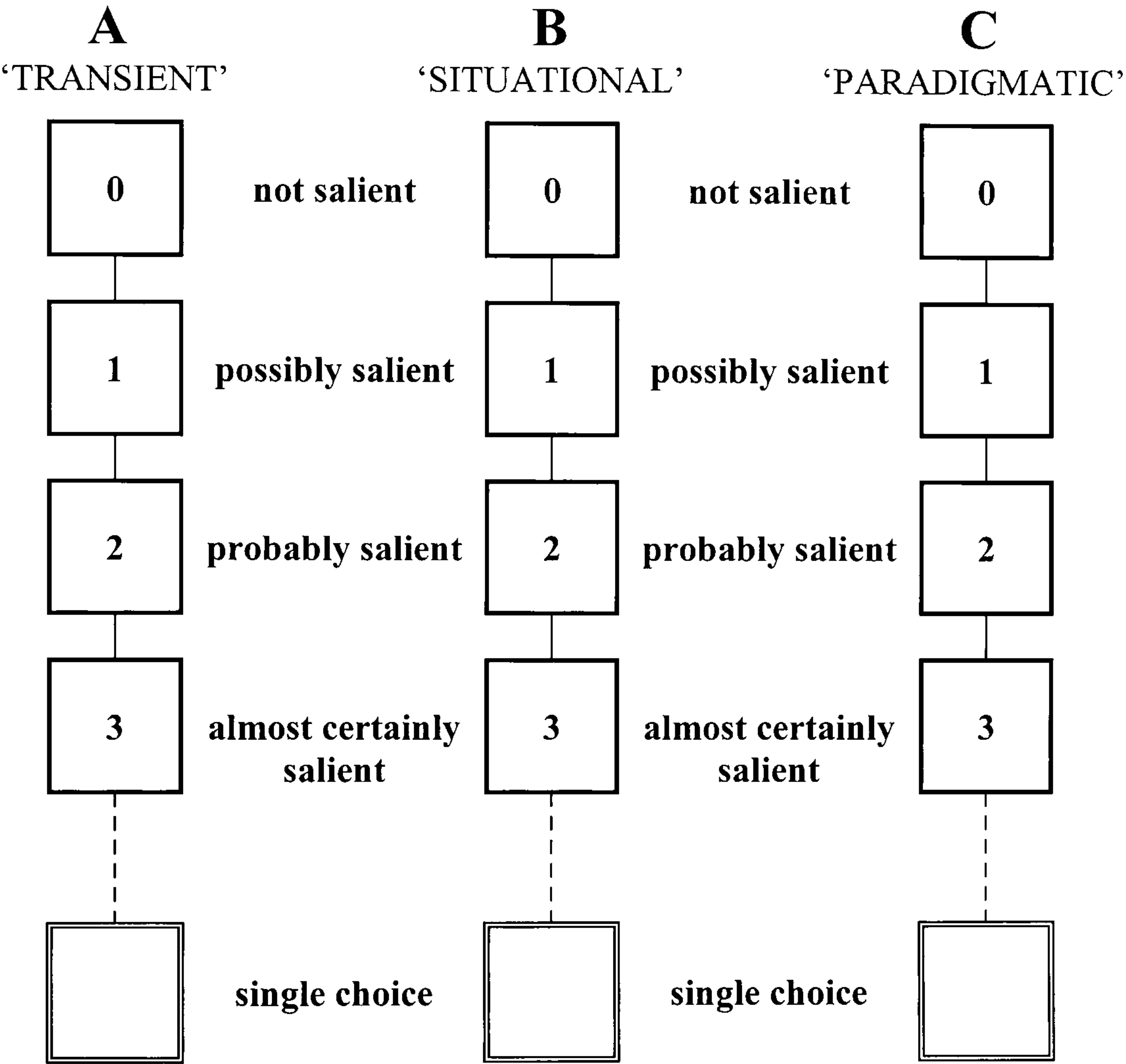
What it is that I find difficult in therapy with Liz is that she finds it very difficult (at times impossible) to be verbal; she becomes very frightened if there are any sounds outside the room we work in (eg. people going in and out of other rooms, or talking on / at the bottom of the stairs); she at times becomes unaware of where she is or who I am; if she gets very distressed she will bang her head with her fist/s - on one occasion while holding her car keys, so that she drew blood.

My feelings when Liz does these things range from: 'God, what do I do now'; 'help, I wish I wasn't having to deal with this right now on my own'; 'I don't know what to do - God what a hopeless therapist I am'; 'I must stop her harming herself further'; 'Its essential that nothing I do reflects the abusive relationships she's had in the past'; 'Grounding her - what can I try next??'; 'The session's nearly over and she's still completely out of it'; 'How can I get her back into a state to leave the building before 5.30??'; 'We're (the client and multidisciplinary colleagues) agreed that admission isn't the answer for her - its crucial for my own security that I share the risks involved in letting her go home'; etc.

My ways of dealing with Liz have developed over the months that I have been working with her. Initially, I offered her my hand as a way of grounding her- which is WELL outside my usual way of doing therapy. I have, having told her that I was going to, gone to take her car keys out of her hand when she was harming herself, banging them against her head (but had to withdraw because she was frightened of me at that time). Of course I have also taken this case to Supervision and Peer Supervision; and the department I am working in is working on Dissociation as a special topic - so my knowledge and skills are growing rapidly! I (all too gradually) clarified that Liz WAS dissociating, and was / [is] also trapped into images connected to her abuse. The first effective idea I hit on was a simple thought-stopping technique (counting down from 1000 in sevens); now I am beginning to use ideas from the Dissociation literature to teach her grounding skills, etc. I am also speaking with her about what's going on. The situation is evolving / improving; and - my! is it a learning experience.

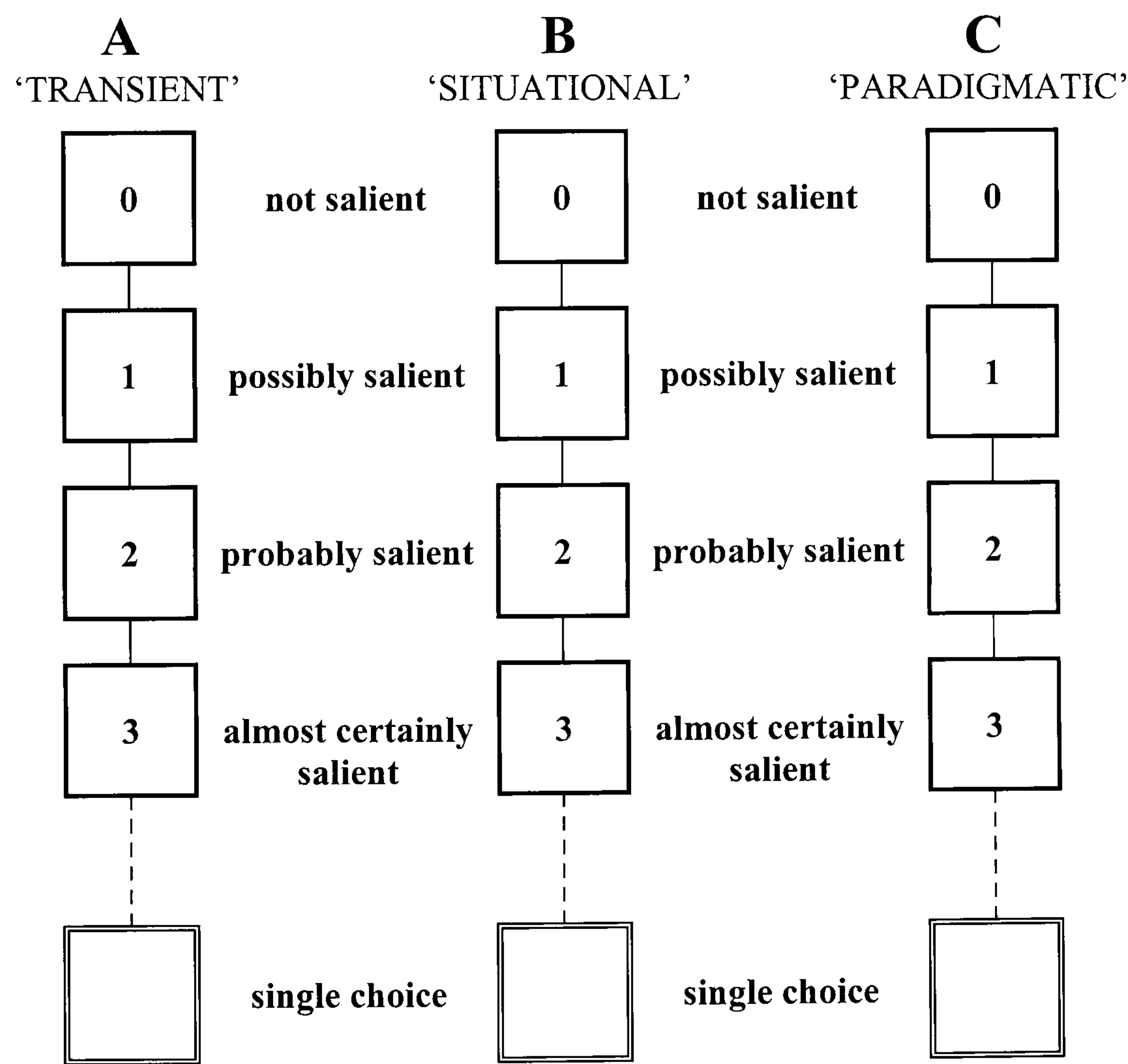
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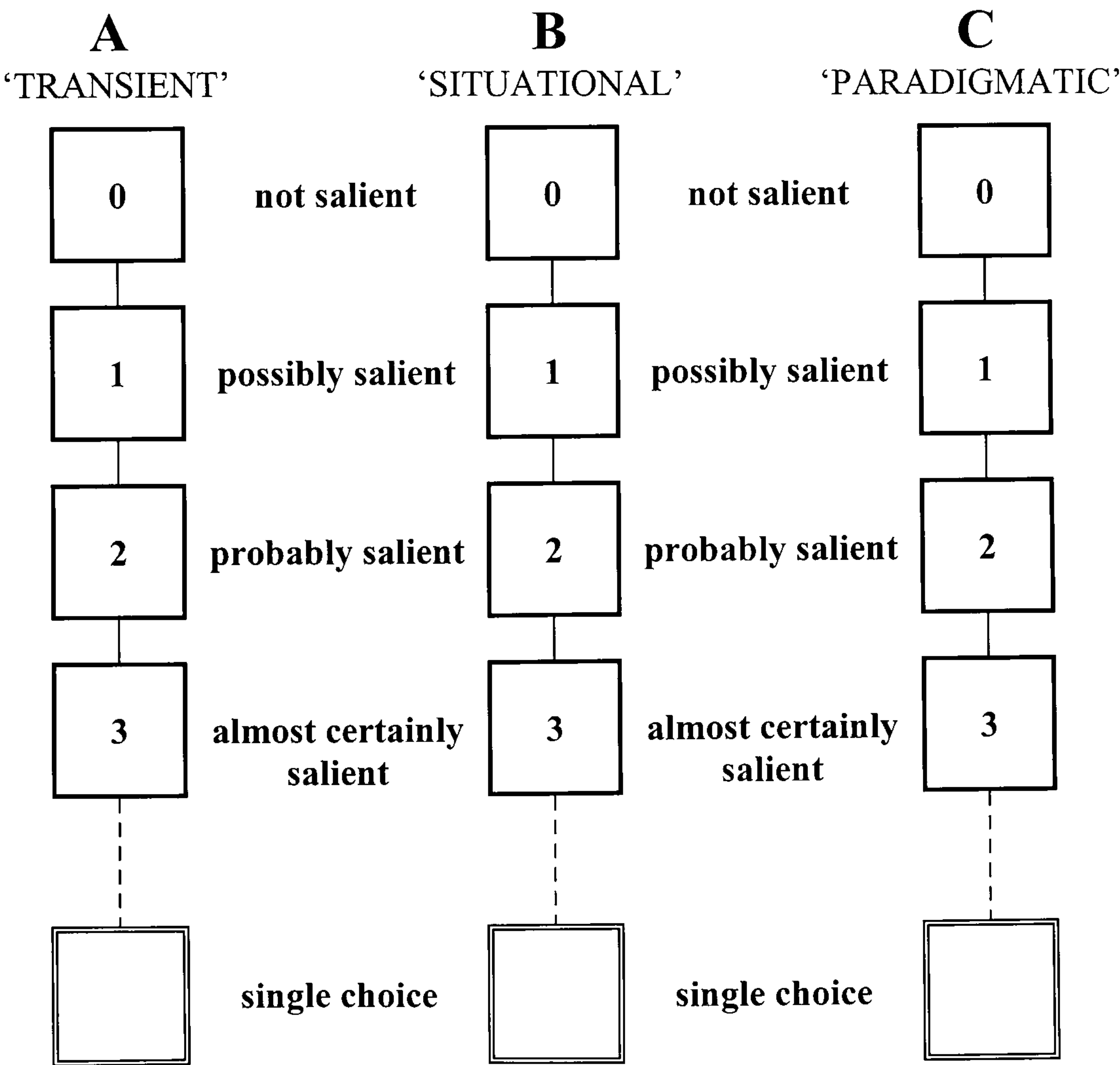


Histrionic personality, prone to exaggerations (behaviour and emotion). Narcissistic. Sent cards, flowers audiotapes.

Interpretation, avoided over reaction.



My first "proper" psychotherapy patient was a young man I saw once a week for three years who presented with depression and fear of failure. He often talked of feeling black and suicidal and then would miss appointments. This regularly left me worrying about him during the following week. However, he would nearly always return to the next session, saying in a light-hearted way, that he was sorry to have missed the previous week but he had been offered the chance to go away with a crowd who had good "stuff" (meaning cannabis/speed) and had had a wonderful time. This left me feeling angry and resentful, and created fantasy images in me of myself as a raging parent, standing on a doorstep, demanding to know what my adolescent offspring was doing staying out all night, worrying me. The patient's appointment missing reduced in the final year of therapy and, with the help of supervision, I was able to make sense of the transference and countertransference.





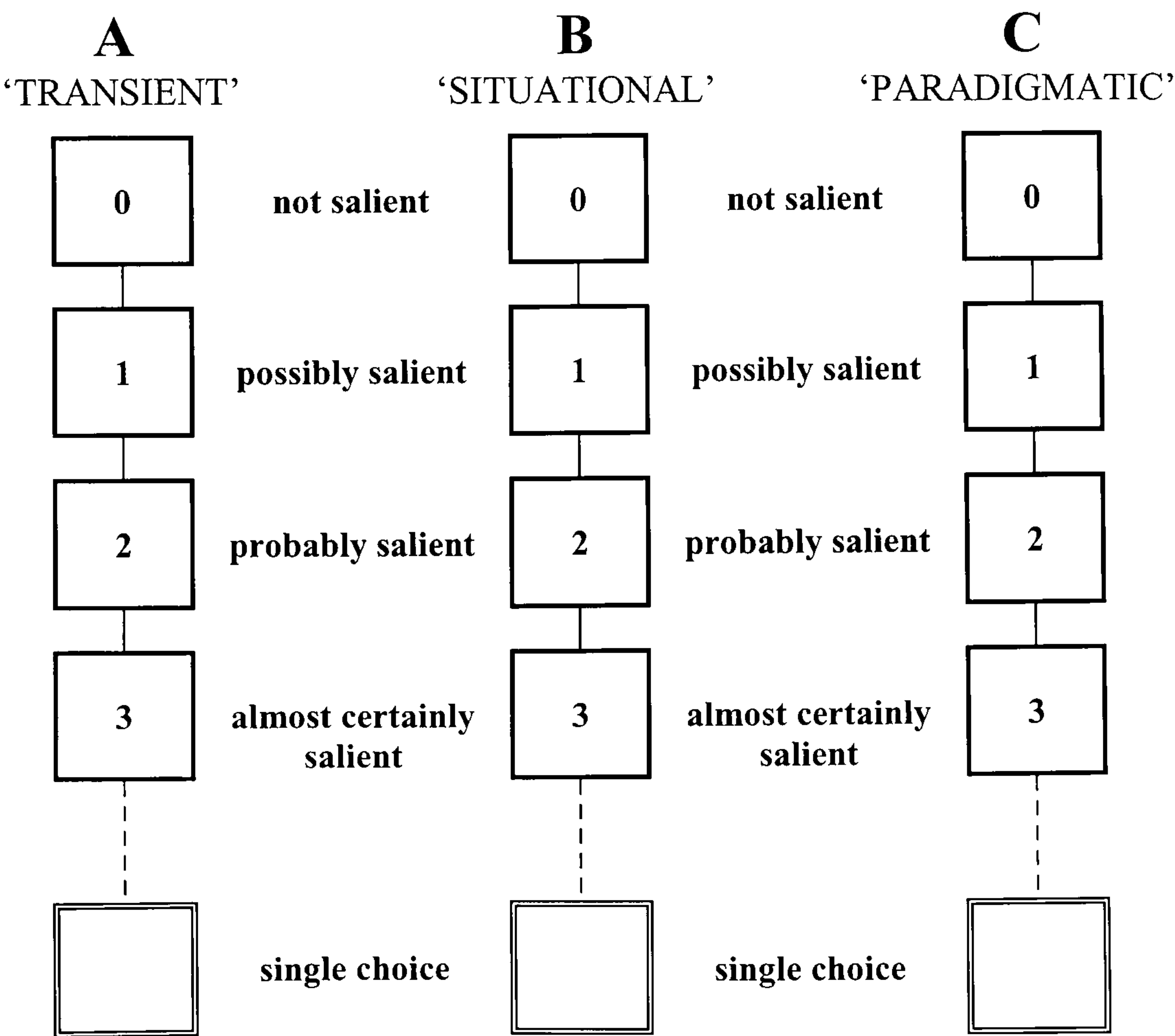
Once there is a therapeutic alliance of some kind it is hard for me to attach the label 'difficult' to clients - whatever happens they are potentially providing me with useful information about what is painful/difficult for them - but I may find the work with a particular client difficult and it is in that sense that I answer this questionnaire.

In the case chosen, the client sought help for feelings of depression and wothlessness. He had well established patterns of sabotaging anything good both in relationships and in achievements. In the former this would include distancing and denigrating as well as making impossible demands for reassurance. In relation to the latter he would abandon or spoil plans leading to good experiences/achievements. It was acknowledged early and explicitly that these patterns would be likely to occur between us - we would need to notice and reflect on them when this happened.

My way of dealing with the difficulty was to try to be open though tentative in putting 'here and now' difficulties 'on the table' - and to invite his collaboration in making sense of them. The tools of cognitive analytic therapy - verbal/written narrative and diagrammatic reformulations - were extremely helpful, as was supervision.

Even so, I hit some low points, experiencing despair and helplessness parallel with the feelings of the client, and doubting my own ability as a therapist.

The eventual outcome was positive - considerable movement with awareness and acknowledgement of likely setbacks. There was a very good outcome at five months follow-up. The client had self- esteem, had maintained and improved a close relationship, and was allowing himself to achieve to a high standard.







This is the first time I've thought in depth about why I found this patient difficult. I think the reasons are probably multiple - maybe by the time I have completed this account, I will realise more, as I did on the pink form. I have divided up under your headings but I think they overlap in my account

#### What the patient did

1. The patient talked a great deal with obvious intellectual enjoyment. I had to be quite assertive to say anything, and ending the sessions on time was problematic. There was an element of display, as the patient were saying " look at me in all my nastiness and cleverness. What is your verdict? " as if he craved attention.
2. The patient was very judgmental of himself, calling himself 'self- centred', 'cold', 'a psychopath'. At the same time he detailed instances of aggression to others as if he were not responsible, almost as if whatever label I or others might apply to him would be an excuse (a reason for him behaving like this and not being responsible).
3. He seemed dissociated from feelings of sadness, love, guilt etc. but in touch with anger, self- hatred etc., and NIHILISM.
4. He could be very rambling, with lots of new material, challenging statements etc. and it was almost impossible for me to help him arrive at a focus for therapeutic work. He did not complete agreed tasks, and there was a sense of shifting goal posts. He was referred, after a major suicide bid, for possible PTSD, but soon he suggested the symptoms were in fact life-long predating the trauma.
5. He seemed to have a serious problem, but I felt we were ' playing games ' rather than seriously co-operating in defining the problem and seeking solutions. He would agree with this, but I hadn't the skills to shift gears.

↑ \* important

#### My feelings and reactions

Complex. I felt a dread when it was his session.

I felt out of my depth. I'd felt as though I was sitting with him, listening, tolerating the session, but not doing anything really constructive. I felt I should be more challenging, more perceptive of the process.

I felt uncomfortable when he described his aggressive acts because I disapproved, and he did not appear to have empathy for the recipient, whereas I did. Yet at the same time he was so full of self-loathing and confused about himself, I felt sorry for him too. I think the most salient feeling was of not being able to understand the patient, feeling out of my depth as if I was missing something, and at the same time seemingly powerless to do anything about it, such as control the session more, arrive at a focus etc. Also in contradiction to other feelings I'd found this man quite attractive and sometimes there was some humour and banter in the session. I felt on a similar wavelength intellectually i.e. confusion.

#### Attempts to cope/deal with

In general I became more technique oriented than I normally would, suggesting relaxation therapy (which he'd had), anger management group (which he dropped out of) and setting various tasks which he did not do.

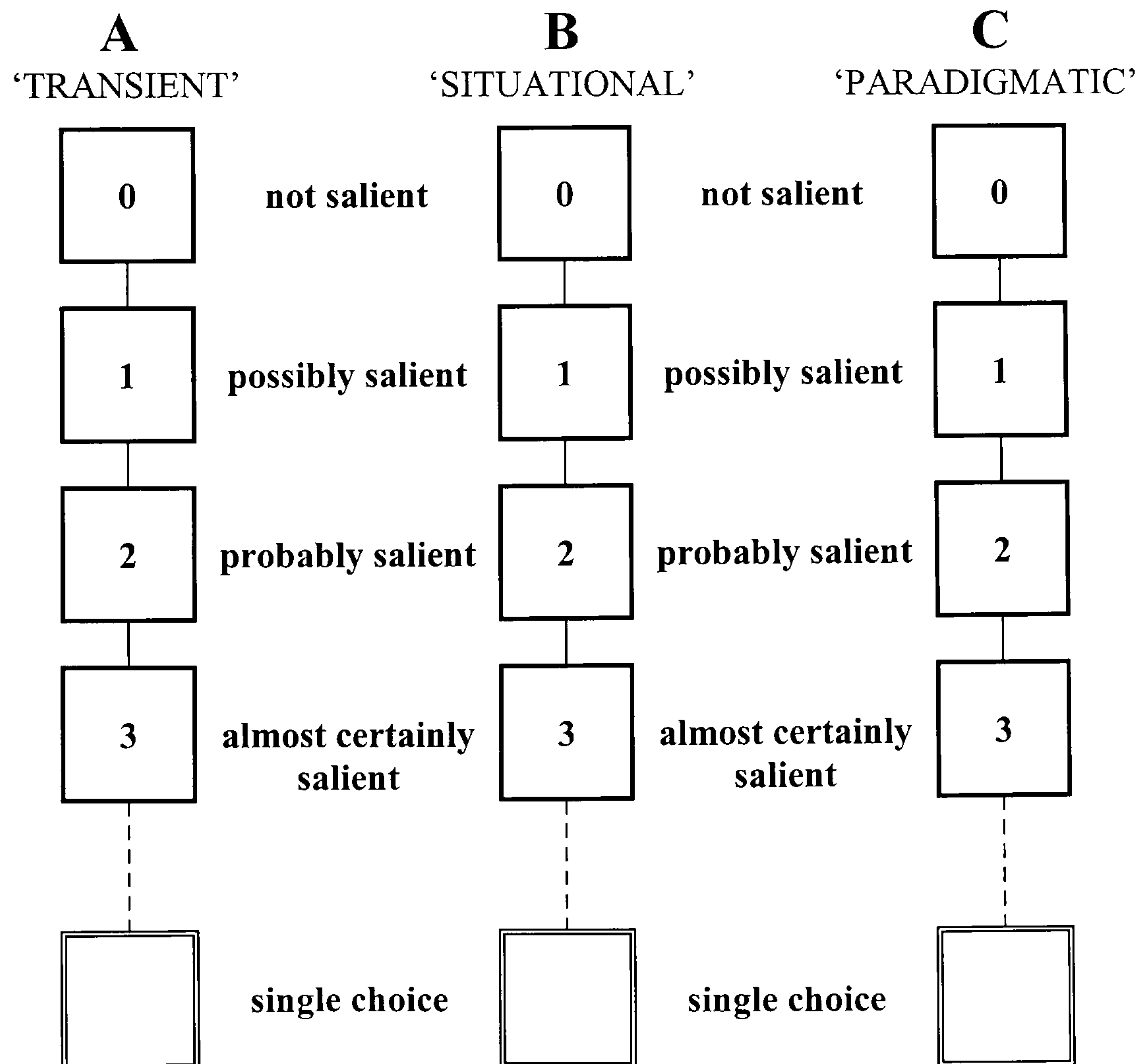
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Tried to hold review sessions along the lines of what have we achieved and where are we going - but these tended to suffer from the same failings as other sessions.  
Tried to make process comments - which often he accepted, but this did not seem to get us anywhere.  
I was aware of the feelings of attraction, thought about them, explained them to myself as due to a similarity between patient and someone in my personal life, and held them in suspended animation.

How the situation turned out

After a session in which he had mentioned severe marital problems he DNA'd for three appointments, then rang to request a further appointment. Seen again after a 7 month gap - he had split up with his wife. He seemed quite unable to deal with any feelings about this in a direct way in sessions, although he became even more nihilistic, and I again felt confused as if I was failing him. He conveyed to me that he was still regularly seeing his wife and hoping to get back with her. It seemed appropriate to offer marital work, although again this was probably an effort on my part to find a focus, feel constructive. He appeared to go for this idea, and it was left that on the next appointment, having talked to his wife, either he would come (and we would continue individual work) or she would come for one individual session with me prior to starting marital work. As it happened, she came alone and made it quite clear the 25 year marriage was over as far as she was concerned (giving me reasons, which rang true to my experience of him in therapy). Thereafter, I have had no contact with him - he DNA'd twice and has not phoned (five months) i.e. the difficulty was not resolved.





I have found it hard to select a difficult situation in this category, I think because many of my patients present 'challenges' from time to time, but in general after many years of experience I feel I am handling them reasonably well, and so don't think of them as difficulties.\* The recent situations which stick in my mind as difficult because I felt unskilled in handling them, are two in which a third person had come into the therapy session for one occasion - the first where a patient I knew asked to bring her friend in, and then disclosed sexual abuse for the first time; the second where an anorexic patient had brought her mother, at my suggestion, and all hell had broken loose emotionally speaking. However, I'm not sure that these two sessions would qualify as 'individual psychotherapy' so I have chosen to write about a more ordinary 'difficulty'. The details of this encounter are unique, but the level of difficulty I experience is probably quite a common experience for me.

The patient is an intelligent lady in her forties who has suffered an extremely bleak childhood characterised by neglect, cruelty and a complete lack of warmth and affection. (Her mother had severe OCD, father was tied up with mother, and she was sent to a very Victorian boarding school very young and farmed out to anyone who would have her during the holidays. Her adult life had also been very difficult and sad.) In therapy she is intense, hard-working and tends to take the lead. She seems determined, and independent.

During the previous session to the 'difficult' one, she told me she felt she needed to 'go back' ie re-live a time in boarding school (aged about 8) when she was absolutely terrified and sure she was dying, yet equally terrified of seeking help from the cold unresponsive staff. She asked if I would sit with her while she did this in the next session, and also wanted to tape-record (which she did).

I felt a bit apprehensive at the start of the session, I think possibly because she was in control of running the session and (I thought) had expectations of me (not yet defined), whilst at the same time I felt I knew better than her (because of previous patient re-living experiences) how painful and intense this might be for her. I suppose there was a conflict between letting her control and do as she wanted versus wanting to protect her and me from pain. At another level, I felt uncomfortable, because it seemed contrived - was she going to act this, would I be distant (cold), unable to take it seriously??

The first conflict was overcome by negotiating with her how she wanted to start, what she would like me to do (just listen she said, ask questions to elicit details and feelings) and anticipating with her how painful it might be.

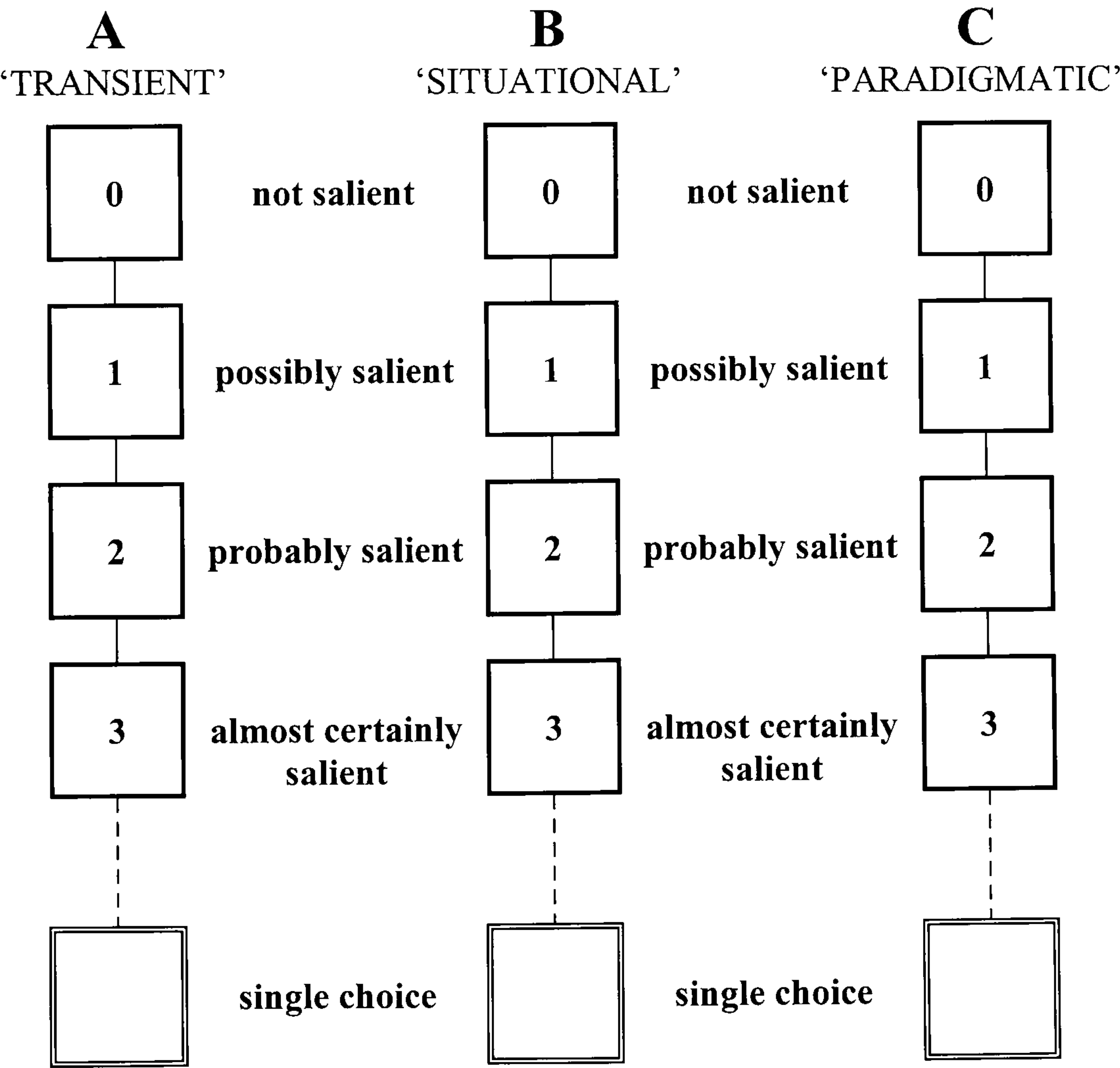
She sat on a cushion on the floor, I stayed in my chair and she 'went back' talking in the present tense through her experience as an 8-year-old. My fear of feeling like a distant cold observer became irrelevant, what she lived through was very moving, and I felt very sad and inadequate (perhaps humble is a better word) in the face of what she had struggled through in the past, and was still doing in her attempt to overcome it. I felt that what I said to her during this, which wasn't much, was OK.

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The difficulty now arose about how to disrupt the process as the session time was coming to an end. Now of course she wasn't in control, and I couldn't expect her to be. The difficulty now was that I would feel almost brutal 'interrupting' from the outside. Would she perceive me as disinterested, unfeeling, uncaring? I think I probably debated for a few minutes what to say, hoping a natural end might arise, and this internal debate in itself took me out of the situation a bit, and I was eventually able to bring the time to her attention, and eventually bring the session to a proper close.

The main difficulty I think, was the feeling of cruelty, letting her re-live all this pain, and not being able to physically hold her and comfort her. I think this was resolved by discussing with her before what we were trying to achieve, and after trying to be open and warm and talk as adults about what she'd been through. However, writing this now, it still doesn't seem quite adequate, and perhaps the difficulty was/is greater than I thought.

\* [On getting to the end of this, I realise that one reason why my difficulties don't seem very big is that I don't normally have time to think or talk about them.]





This concerns Elaine whom I saw on only two occasions. She was about 40, married with children. A colleague had recommended me to her. She had been in a car accident about 18 months previously and had some of the post-traumatic reactions, notably anxiety driving ("terrible") and as a passenger (also "terrible"). She had a bad whiplash injury and was still suffering pain and was also anxious about causing further damage to her back. She felt very frustrated about this as she had "never been an ill person" and she took a lot of this frustration out on her family and had "mood swings" and temper outbursts.

My colleague had seen her to do a medico-legal report (he is also a clinical psychologist) and recommended treatment which was to be paid for out of her compensation money.

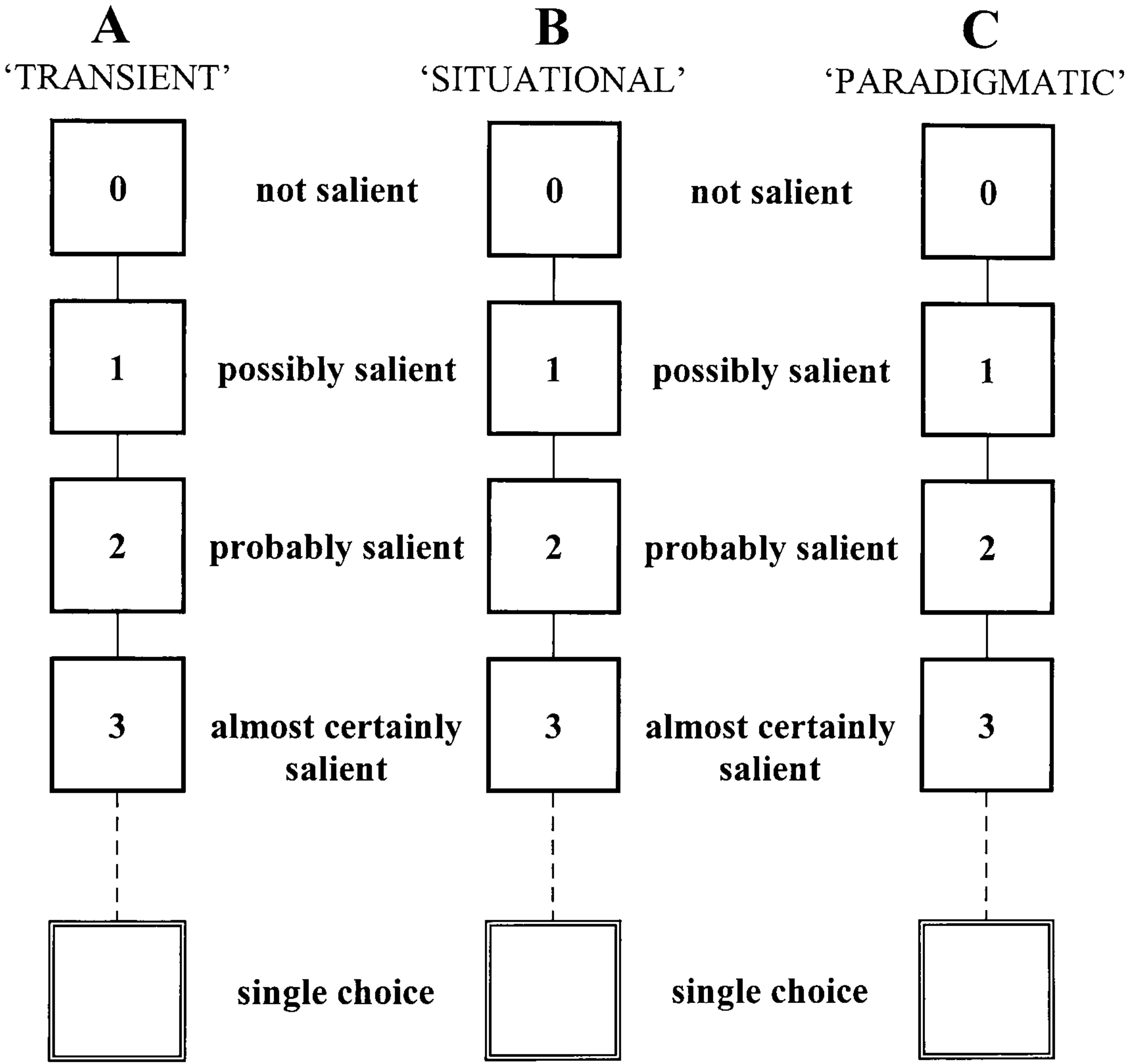
I saw her once for a general assessment and a week later when we started some therapy. The sessions were obviously rather painful for her and, amongst other things two important issues emerged, namely (i) her fear of being "a burden" (now) and (ii) her resentment at having to be the 'carer' in her own parental family in which there is a lot of illness and dependency.

At the end of the second session I did some relaxation work with her and incorporated some imagery for pain relief which she found useful.

I thought we had made an excellent start and I felt that the rapport had been good and I had been able to elicit from her and empathise with some very fundamental emotional concerns. I felt I was 'doing a good job'.

However, a few days later Elaine's husband rang to say that she had decided to see my colleague instead of me because she had felt a lot easier with him. I responded calmly and said that I understood and it was important that she see someone she felt comfortable with. However, for several days afterwards I felt very hurt and angry. I imagined a number of scenarios such as Elaine's telling my colleague that I wasn't very inspiring, or whatever. Another fantasy was that Elaine had suspected me of trying to get more of the compensation money than I was due. This idea arose because owing to my not listening properly to her explanation of the payment procedure I had assumed that I was to send my bill to her solicitor, whereas she had already been given the money. ( This was cleared up later.) So I became very angry with my colleague (in fantasy) because his fees are higher than mine and he deliberately puts them up for legal referrals (I don't). There were a number of other reasons I entertained, some of which made me again think that she would be giving my colleague a bad impression of me. I even had a fantasy that I would end up suing her for slander! At the same time a sensible part of me was telling me I was getting all this out of proportion and these things are bound to happen to any therapist. After a few days I calmed down. Several weeks later I asked my colleague how Elaine was and he said she attended for two sessions then said she didn't need to come anymore. I then felt better as I believed that she was not happy at having any therapy.

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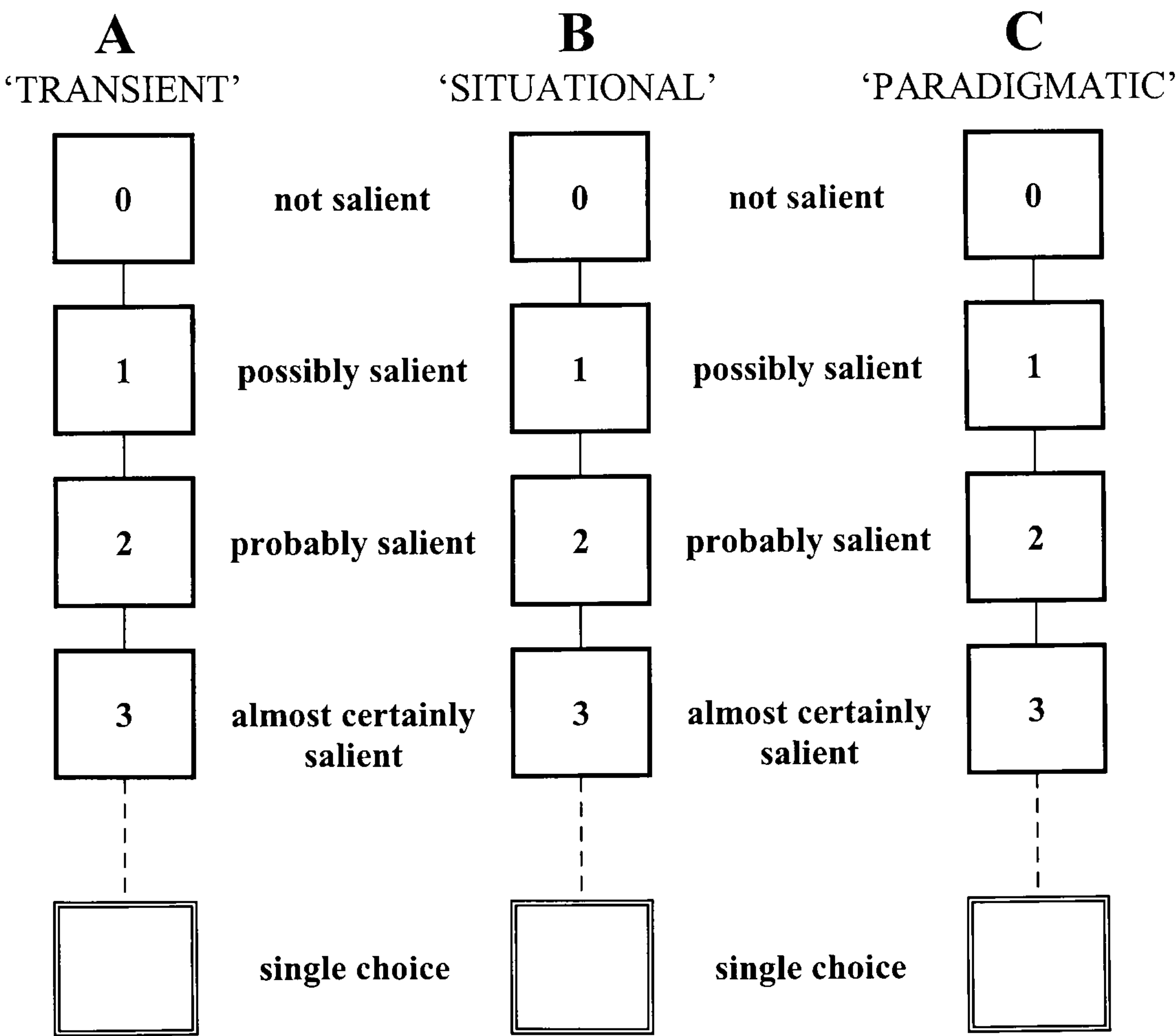


The client in making a (self) referral had rung in several times giving the appointment staff a difficult time by refusing to give a name. Only when the call could be put through to me would he give a name, confidentiality/secretcy were major issues for him. I agreed an appointment time - it was not soon enough for him though it was four days from the time of the call. He rang several times before the appointment wanting to confirm or change it by half an hour. His wife rang in also in a state of anxiety over her husband and the appointment. I suggested she might accompany him if she wished. He arrived half an hour early for the appointment. I waited for the appointment time.

He was a very large man 15 stone plus.

He told me he was suicidal - that he was violent towards his wife that he was on drugs and sniffing. He was in debt, he had seen his GP who had prescribed antidepressants but he had no money for the prescription. I told him that the service was for short term counselling - that his situation would not be helped by short/brief intervention and that a referral to a psychiatrist would be the appropriate way forward - (I paraphrase it took rather longer to get to that!)

He was fearful of losing his job if he sought help for himself - suggested wife - (waiting outside) might join us. Her suggestion was that his line manager had been supportive nine months previously and she would make the necessary referral on to a reciprocal unit. This was managed with a telephone call by husband and wife in the session.





The patient in question had entered into a 16 session contract aimed at looking at themes of loss in his life (of which there were several). He was at the time also attending a speech and language clinic for speech therapy.

a) the patient remarked he'd heard my wife was very nice, he had told his speech therapist that he was coming to see me, and the speech therapist told him about my wife (who is a speech therapist). He seemed to have gathered quite a lot of info about her appearance, personality, job etc. The information was all flattering to my wife and to me but.....

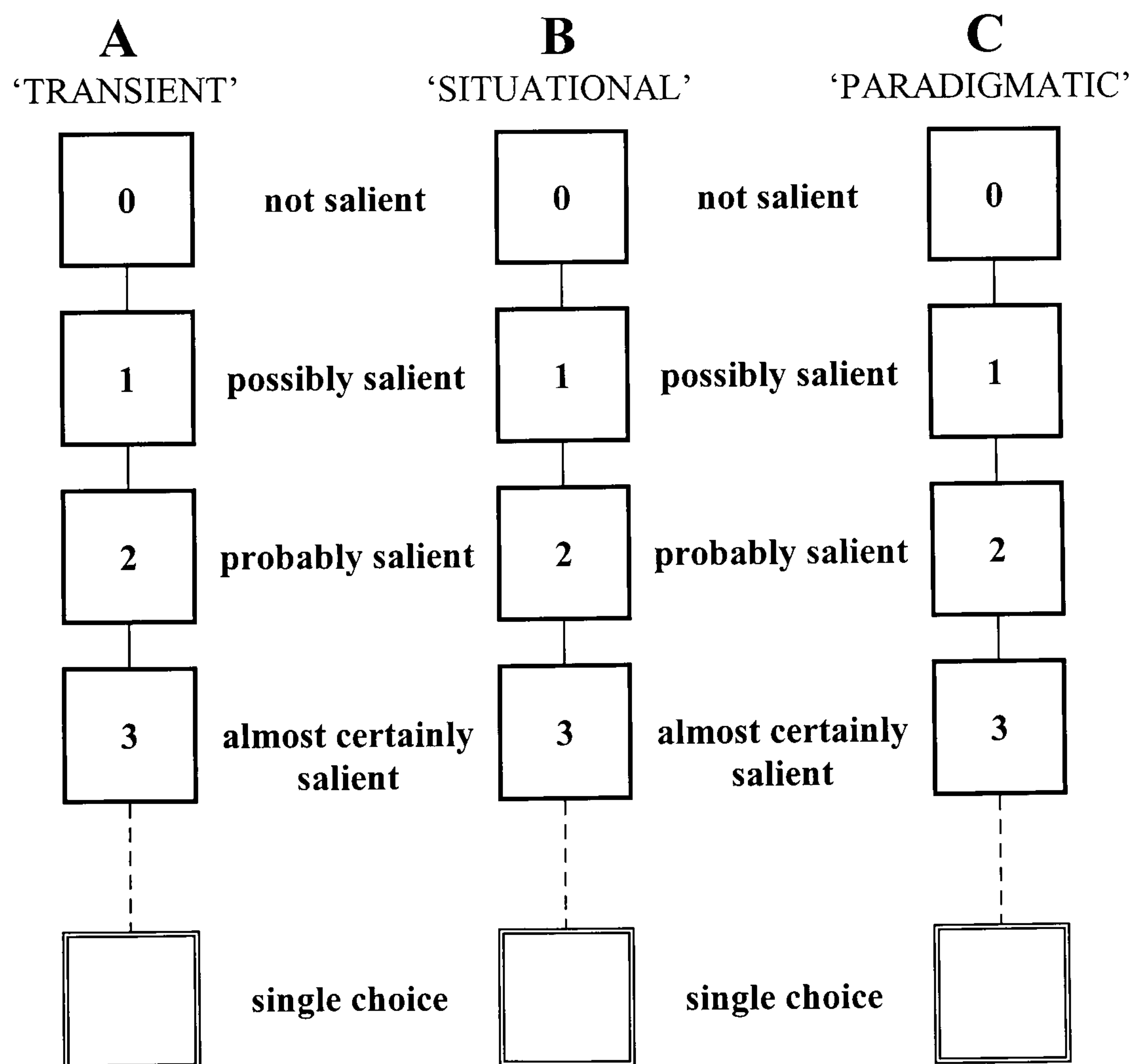
b) felt like a huge boundary breakdown and he was getting all chummy/friendly with me. Felt intrusive.

c) I told myself this was about jealousy and envy and he wanted what I had and what I had not lost.

d) I couldn't get into it, I felt rattled. Instead I merely interpreted along the lines of him trying to distract our session content away from the theme of loss. Later I realised that I was frightened that his emptiness could "lose" my wife. He was projecting his neediness inside of me and destroying what I had.

A very powerful transference from a previously "not difficult" client.

I don't like the fusion of my personal and work life. There is one split I prefer.

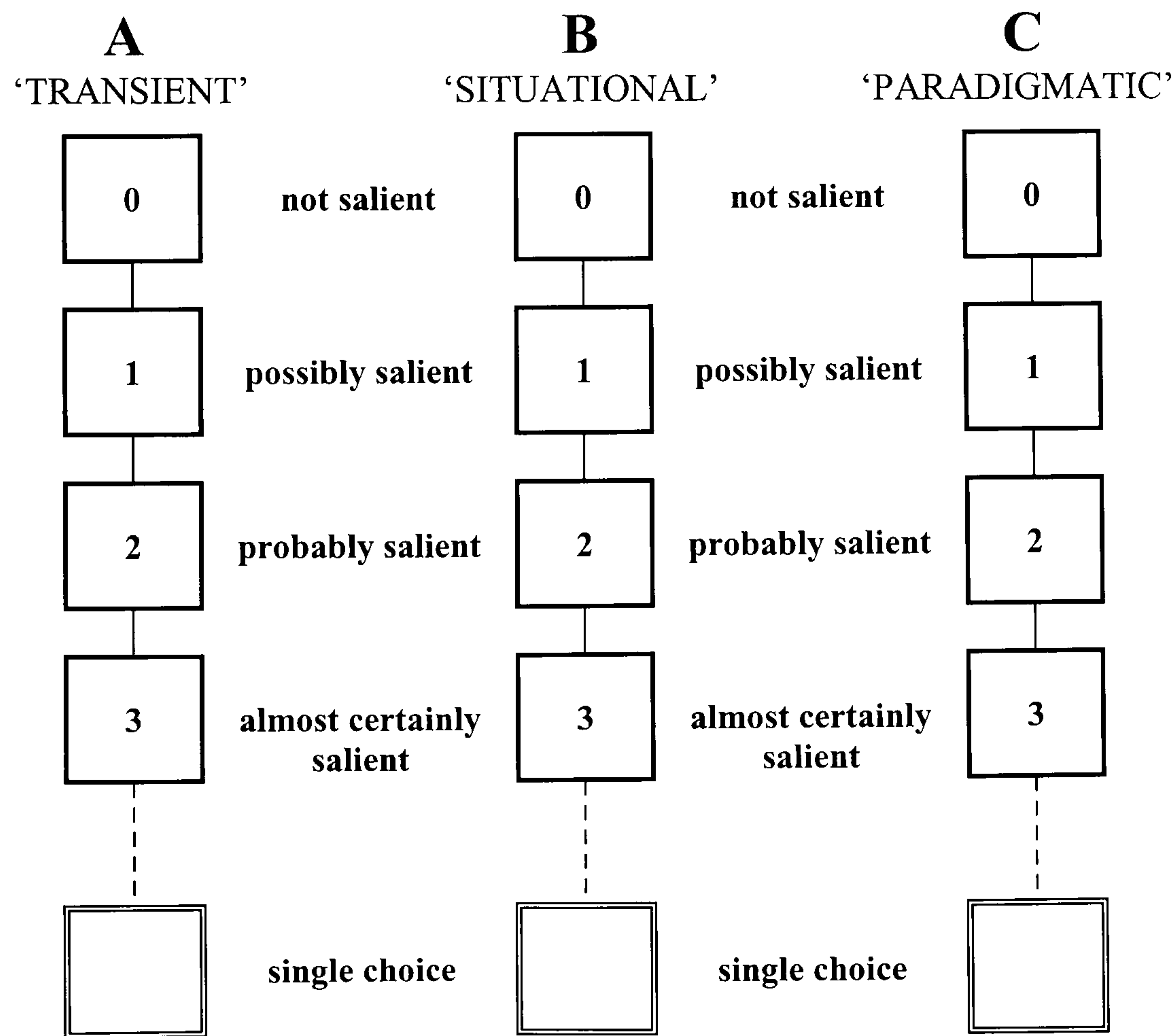


This client is a professional woman aged 51. She referred herself to me when she was off sick from work with stress; when she first came she was distraught and cried throughout the first few sessions. In the assessment session she told me that she had an alcohol problem. She drinks at least a bottle of wine per evening. At this session I said that I would only take her on if she sought help for the alcohol addiction from another source - either AA or the women's alcohol project. I did not feel that I could handle all her problems in the short term. She is the eldest of four daughters. Throughout her childhood she describes having been the black sheep. Scapegoat of the family. She reports numerous violent and abusive incidents. She is very competitive with her mother. She has had numerous husbands and lovers but does not sustain relationships.

In general she makes me feel very anxious. I often do not sleep well the night before I see her first thing in the morning. She seems to idealise me at present - and makes numerous comments about my life/house/appearance/career that she aspires to. I fear the negative transference. I think she could turn very nasty. When I am not careful, I find myself placating her. The incident recounted here is an example of that. It is the summer. She has a planned absence one week for holiday. She does not turn up for session the following week.

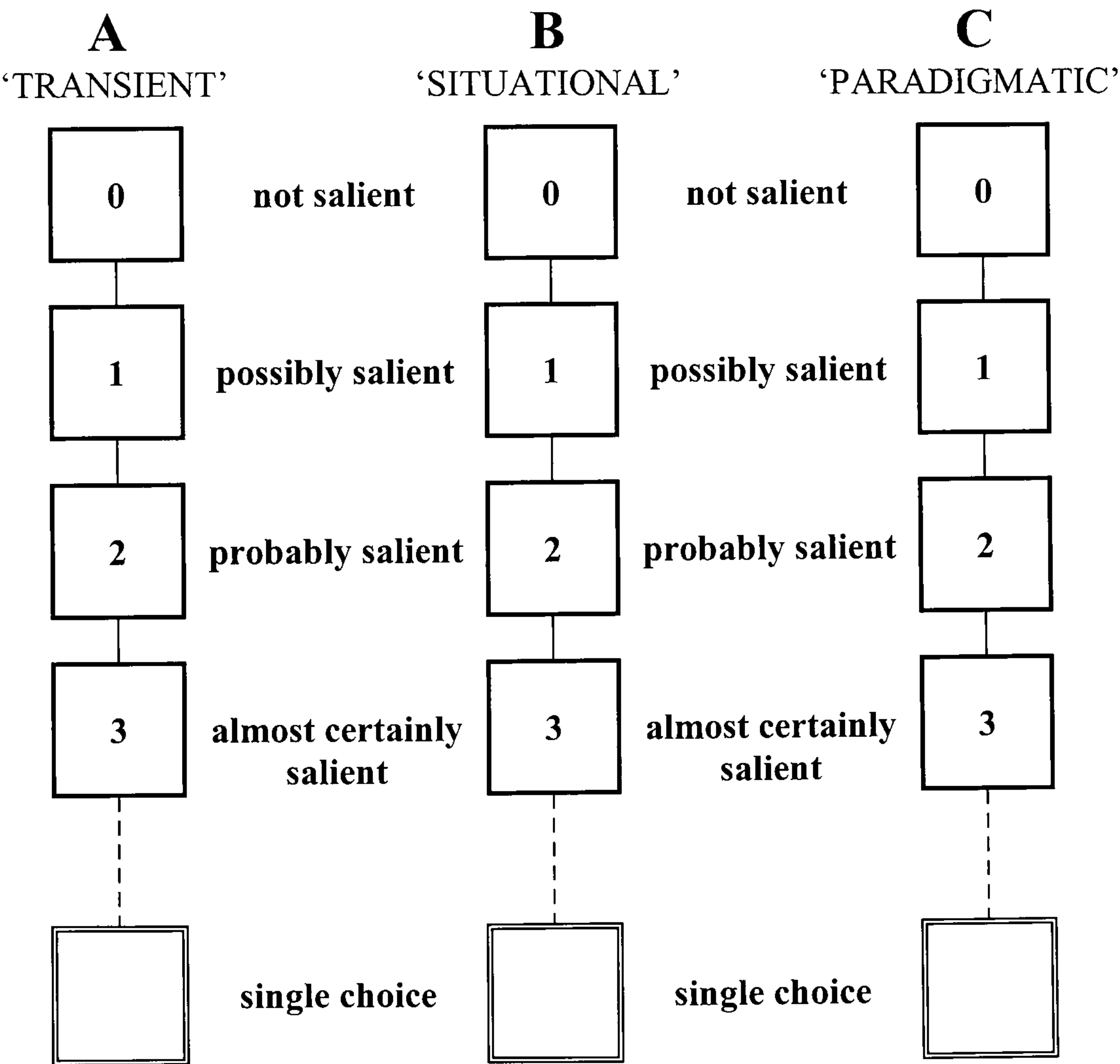
I write her a note saying that we should meet the next week at the usual time 8.45. I wait for her during the next session and she does not arrive.

I am going to be away the following week on holiday. At 9.30 I telephone her. She is in bed asleep and her daughter answers. She comes to the phone, is very apologetic. I feel very anxious and offer to see her at 11.00! I put the phone down, curse myself and try to analyse why I have done this. She comes at 11.00 - has a hangover - drink problem as bad as ever. She is grateful to me for changing time. I squirm. I feel that we are in battle and I have lost my authority. What happens next?





I had one very difficult session with a young seven year old who usually was an enjoyable child in playtherapy. In the session he spent the time engaged in sexualised behaviour and kept wanting to look up my skirt and sit on my stomach and bounce up and down. He then kept 'killing me' and wanted to bring me 'back to life' with a kiss. This became very difficult for me to deal with as the first kiss caught me unawares and so he actually kissed me. On other occasions it then became very difficult to explain that I did not want him to kiss me. At the end of the session he wanted the two of us to 'go to bed together' 'like I was his girlfriend'. I found this a very disturbing session because it was out of character of the preceding sessions and I could not understand where it had come from. I did try to manage the situation by setting clear boundaries and the incident was never repeated. I did however become concerned when I reviewed other sessions that I may have experienced his incident of sex abuse, although there was no evidence of this having ever happened.



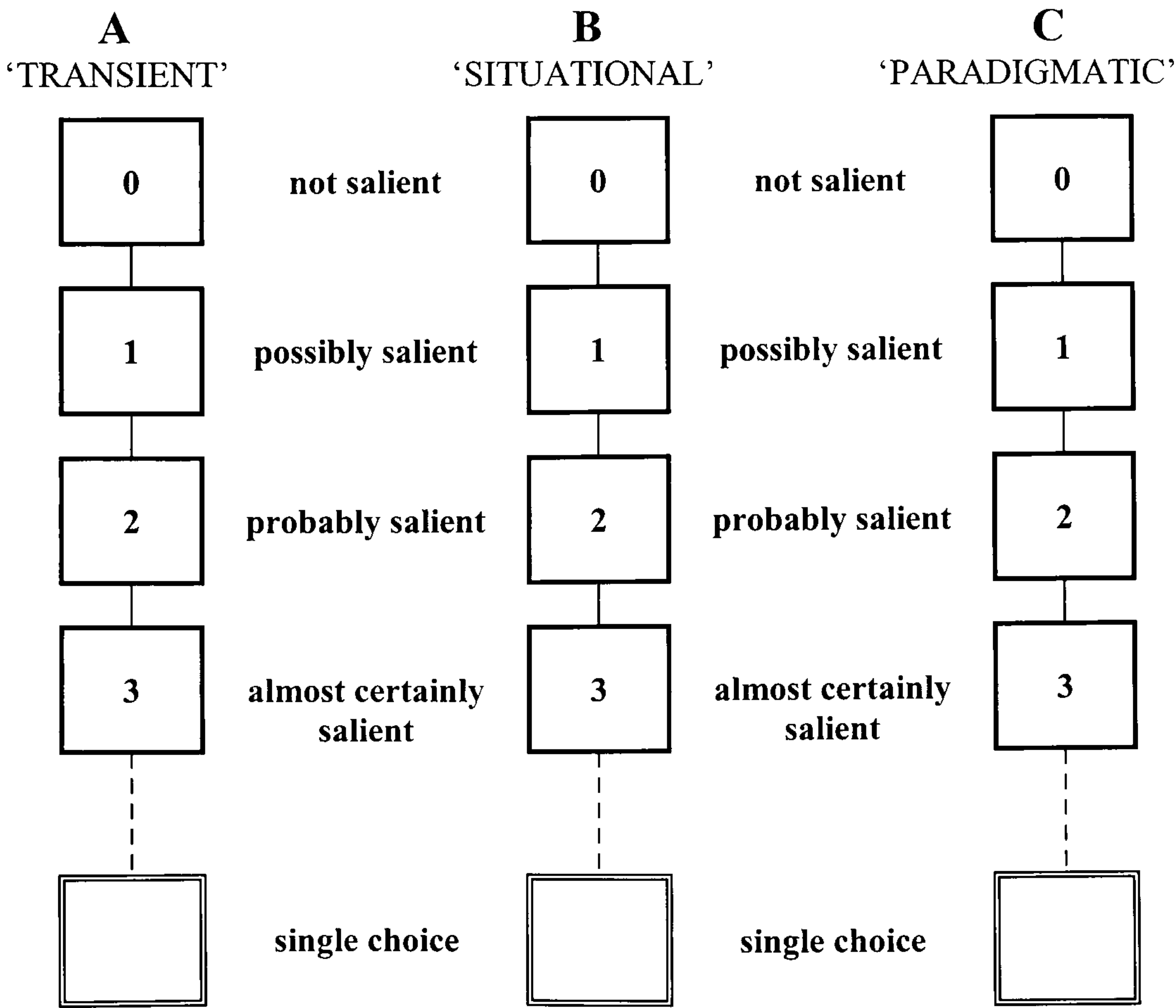


A woman in her late twenties - the most difficult and painful experience I have ever had in my clinical practice. Presented with feelings of depression, emptiness, difficulty in getting on with people, a wish to understand herself better. Very disturbed background; alcoholic parents, marital strife of parents, her mother killed her mother when drunk several years previously. Referrer warned patient was litigious. Patient demanded a white, middle aged, experienced therapist. I was assigned to her (had not assessed her) with hindsight should have challenged her demands and probably not taken her on. She had always an air of 'frighteningness'. Was paranoid and tetchy, but also pathetic and vulnerable. I felt very sorry for her and also very frightened - fantasies that she might pull out a knife. Hard to keep thinking, to find the appropriate level of communication. I dreaded sessions. Much supervision and consultation in which I was encouraged to continue - talk of projective identification. I dealt with it by attempting to maintain a consistent low-key and supportive approach, mainly empathic with offers of insight when she appeared to be receptive. There was an easing of the sense of threat but then her mother died. Not a person who could mourn as such, but I supported her. I felt stuck and could see no end. Her sarcastic criticism and pedantic insistence eg on whether I was punctual or not, I attempted with difficulty to be firm about and work with empathically whilst enlarging it into a broader context of how she dealt with her other relationships and what it meant.

Then over a Christmas break cover arrangements with colleagues went wrong. Though she knew there would be no CPN service at Christmas she phoned and met with the answering service. After the break she was angry, threatened to sue, wrote in a complaint via a solicitor. Attempts to work with this by putting it into context of a general way of coping and why she felt she had to create fights when feeling so desperately let down: not effective. My anxiety increased. Management declined to provide an alternative person to see her. They wrote an apology on my behalf, without consulting me, which confirmed to her that I was at fault. Finally told her we would finished as she clearly was choosing not to work with me and I found litigation threats to be impossible to work with. She was offered a psychiatric assessment which she refused. She issued a complaint via solicitors. Threatened court action if she was not immediately offered certain services (and mine) which she specified. She requested her notes, including my sessional notes. I made a statement through my employers' lawyers. No court case has materialised (over several years). She involved herself with the local service users advocate, requesting her notes yet again. For a year nothing has been heard.

I felt fear, impotence, guilt, compassion, and only after finishing with her anger.

A new department head arrived in the middle of this and established to their satisfaction that I was not professionally at fault in any way.

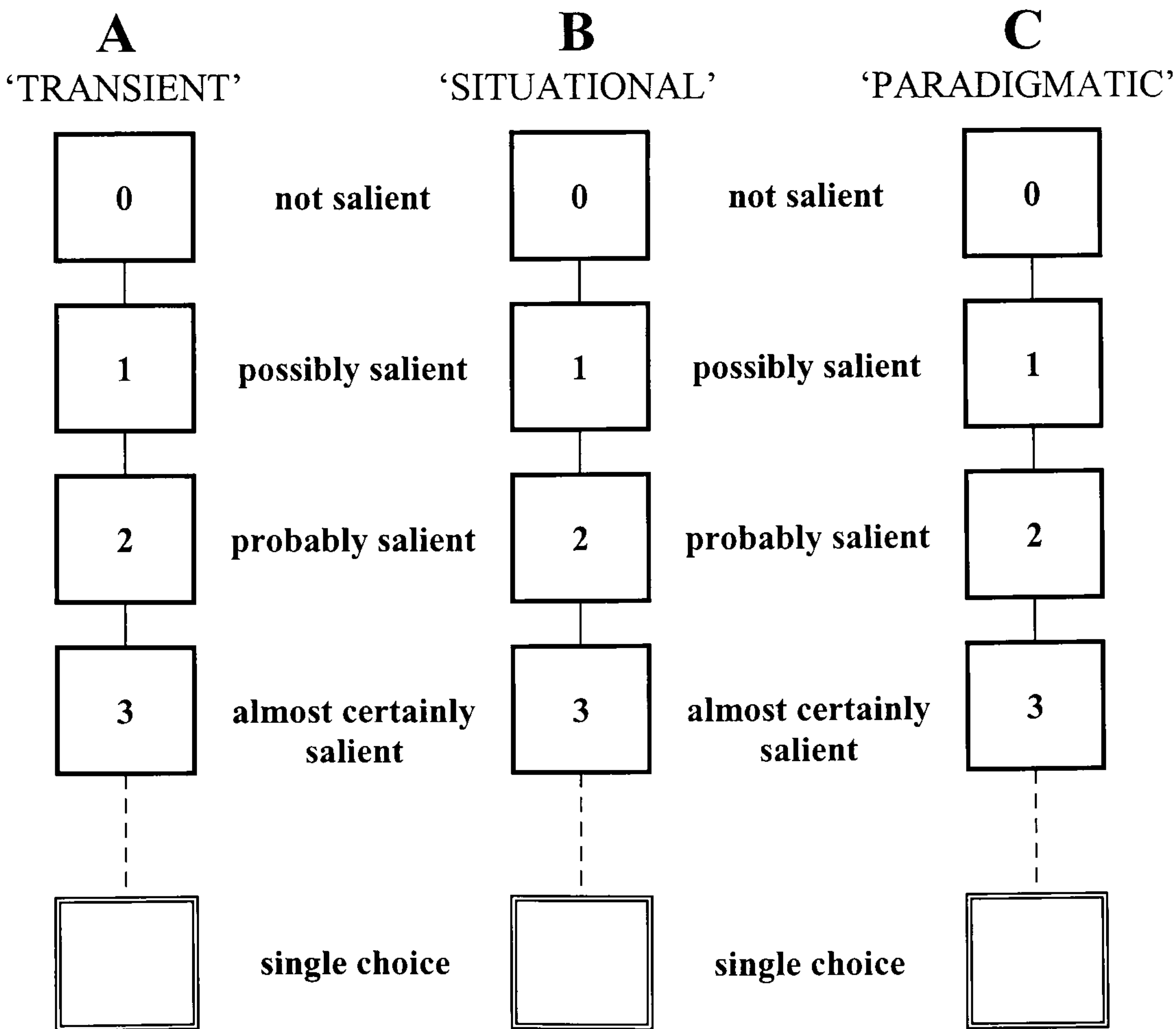


This patient originally developed OCD. But her symptoms were not too debilitating until she had her first child - a son. She developed a post partum depression and with that the OCD was masked/overshadowed but got worse. She couldn't cope - was hospitalised. Her husband, in the RAF, was doing officer exams/training and going from success to success. He then died in a motorcycle accident - knocked of his motorbike by a social worker. She was then transferred to our hospital and I was asked to work with her. She was extremely depressed - felt that she had caused her husband's death, failed to act as a good mother, failed as a person.

Work was good because we engaged well. I felt I became an anchor for her. I saw her two times per week. She remained on the ward - mostly withdrawn but needing to express some feelings directly.

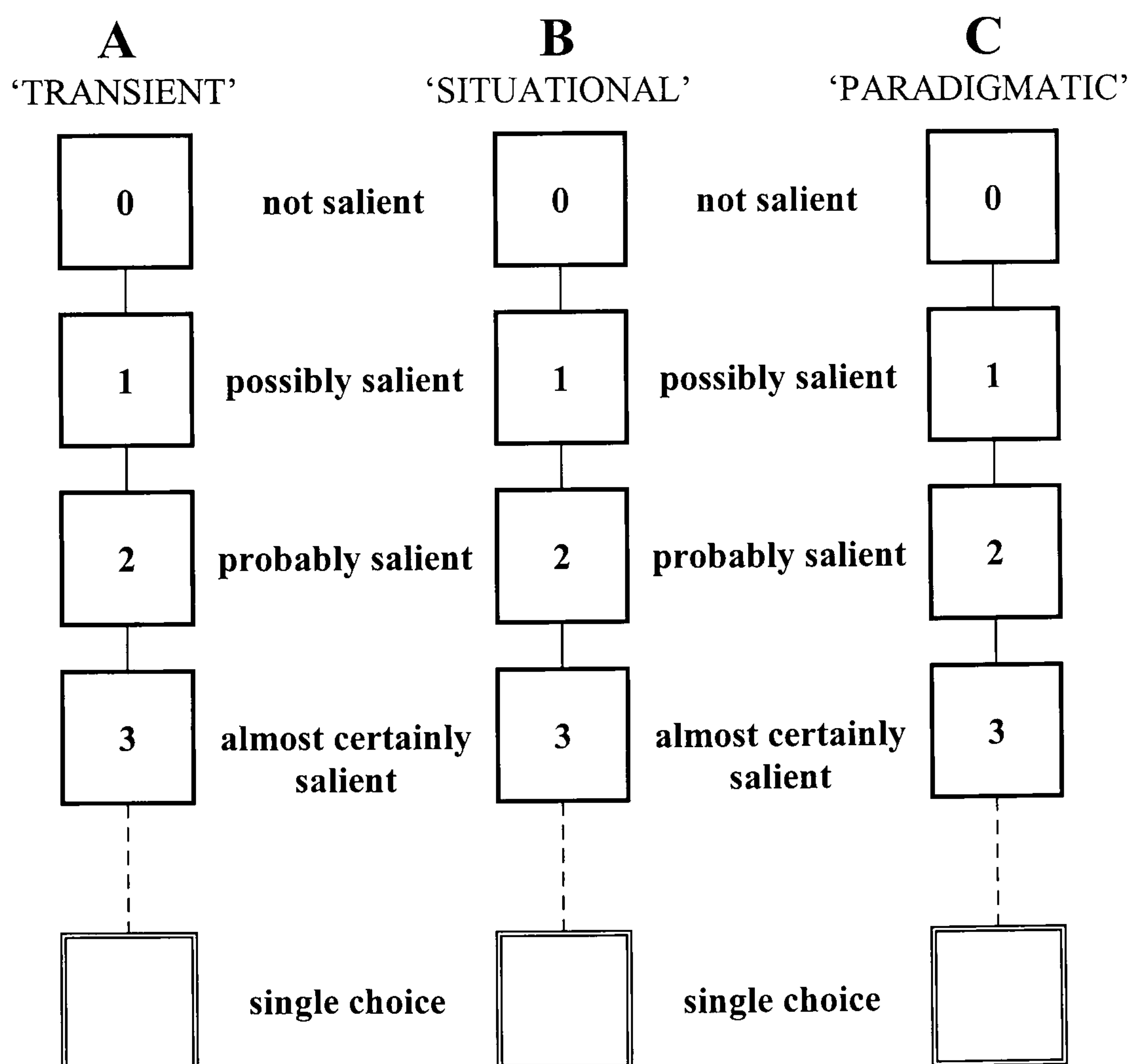
The difficult session came when following some suicide attempts on the ward she saw me on a Friday afternoon and told me she really wanted to die and was convinced she would achieve it that weekend. I became convinced it was genuine and felt hurt at the potential loss (a quite effective transference on her part). I ended up saying goodbye really thinking I wouldn't see her again.

Just out of interest, she didn't kill herself! She was discharged to out-patients. I continue to see her - she's been home six weeks living alone with her son for the first time. Great. But. I'm on leave from today and her GP yesterday decided she was psychotic and has got her admitted to the ward. This consultant psychiatrist went along with this because he wants to give her ECT! So I feel I can't even go on two weeks leave without everyone having a panic! But I'm off anyway.





The patient demanded reassurance about the confirmation of the therapy (for 'ever' or until she was better) and refused to leave until it was given, she also commented that she could trash my room (something she had done in a previous therapeutic setting), and be violent. I was initially very deskilled and anxious and very aware she had also previously cut her wrists in the previous therapist's consulting room when given an ultimatum. Silence, and also an insistence that she leave achieved nothing. Eventually, clearly articulated boundaries - that violence would end the therapy immediately, and also interpreting that her anxieties were the substance of her therapy but that they must be able to be talked about in the session and that limits would be made on the ending of sessions slowly shifted things, and slowly more meaning about the nature of the anxieties has emerged. Interpretation of the fear of loss and of being thought so disgusting that one would not stay in the room and interpretations of her envy of my capacities has slowly become helpful.







On the surface, this client was very compliant, pleasant etc etc etc, psychologically minded, worked hard between sessions - but I often felt distrustful of her and manipulated, and danger. She had experienced a lot of abuse throughout her life, was currently beaten by her partner. She was also a very violent woman - to herself and property, but I never felt at risk physically during therapy. She was very impulsive, often dissociated, and ended up at A & E unaware of what she was doing there. I received regular supervision for this woman.

The difficult (or particularly difficult) situation was two or three sessions leading up to a four week break that I instigated due to a holiday. I had prepared for a difficulty (due to the break) as with other clients. However, with this woman, I found it difficult to hold onto myself and my boundaries. I did actually manage to hold on to myself and my boundaries within the two or three sessions involved, but experienced a lot of unpleasant feelings within and between the sessions.

What the client did which made the situation difficult for me was simply to ask for a tape recording of one of our sessions, to keep during the break. Although I'd had similar requests before (although not necessarily agreed to it), this request from this woman felt very frightening. It felt as if she wanted a piece of me, - a vital piece that I needed (to survive almost) and I felt very out of control. We discussed her request at length. She calmly suggested other options, though I sensed a desperation in her which made the situation very unpredictable and frightening. One of her suggestions was to have her partner observe one of the sessions, and there were other suggestions which I can't remember now. I never said 'yes' or 'no' to any of her suggestions but tried to explore her reasons for the request and her anxieties about the break.

Between sessions I experienced nightmares where she frenziedly ripped off one of my arms or legs, or clawed out a chunk of my stomach. She would mutilated me to the extent that I could no longer contain her or look after her in any way. It felt as if we would both be destroyed by this. It felt as if we would both be destroyed if I was to give her a piece of the therapy (either on a tape or in her husband's memory).

I felt desperate to give her something for the break, for my own 'safety' more than hers. After supervision, I decided that if she still desperately wanted something, I could offer her either a relaxation tape made by myself (even though that still felt a bit scary), or she could choose an empty postcard from my office wall to borrow.

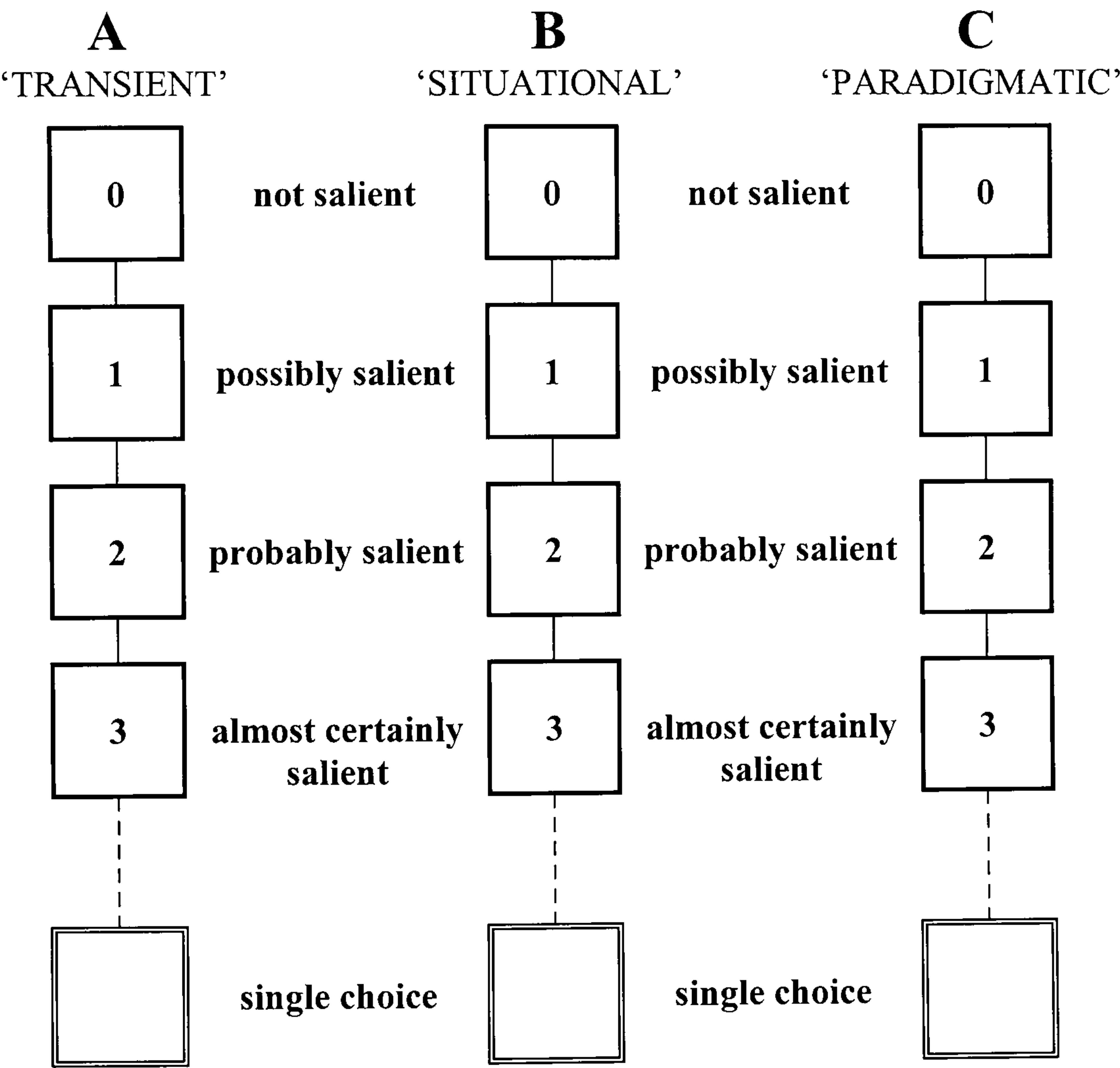
(I had already set up CPN cover (which I had done with her during previous breaks) and reiterated strategies for when she felt violent or suicidal (which I had previously done with her)).

The client did not attend her last session prior to the break, nor several sessions after the break despite me contacting her, and she was eventually discharged. I also discovered when I returned from my break that there had been a dispute over the situation cover (between the CPN and GP) and my client had not received the support we had arranged. For this reason, I allowed her to come back to therapy (ie against normal departmental policy) when she eventually contacted me three months later. She attended one session where we discussed events around the break. She again dropped out and wrote to me saying that she had discovered her husband had been abused as a child, and that she now needed to devote her time to him, and that she no longer had a problem!

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The incident happened around Easter 1995. As well as the one session during the summer, she re-contacted me around the end of 1995. I was advised that she should be re-referred for a new episode of care. She was assessed in 1996 and has requested that she specifically sees me - she is therefore now on a very long waiting list (she could be seen much earlier by another therapist). Her GP phones me monthly (on her behalf), and I explain the same situation each time. I now feel constantly pressured, but helpless to act.





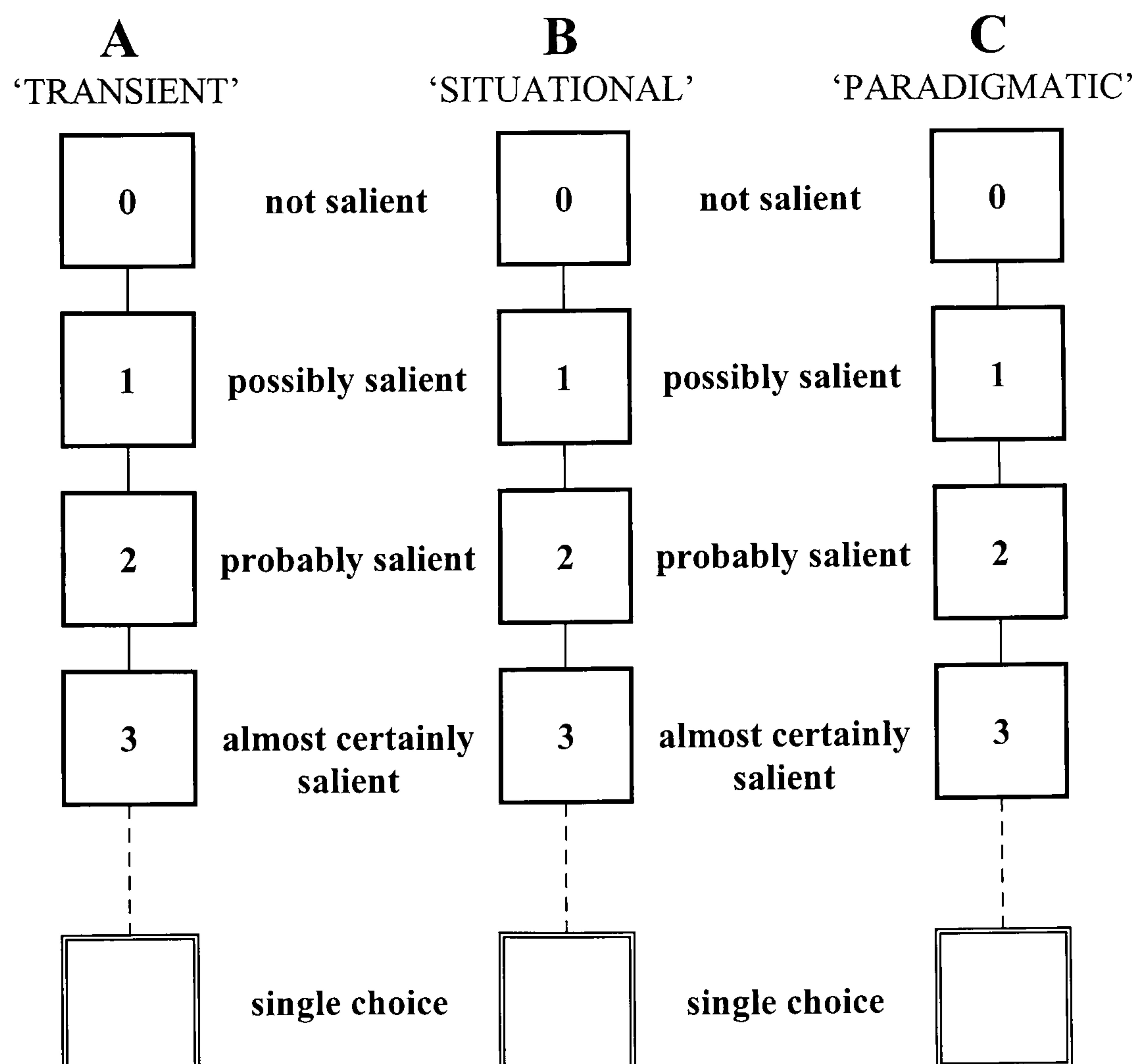
**PSYCHODYNAMIC / COGNITIVE / HUMANISTIC ORIENTATION**

The patient was referred by a specialist medical unit by the clinical psychologist - for psychological therapy. This unit was outside the Trust area. At the time of referral I felt 'put upon' as we are all overloaded with referrals.

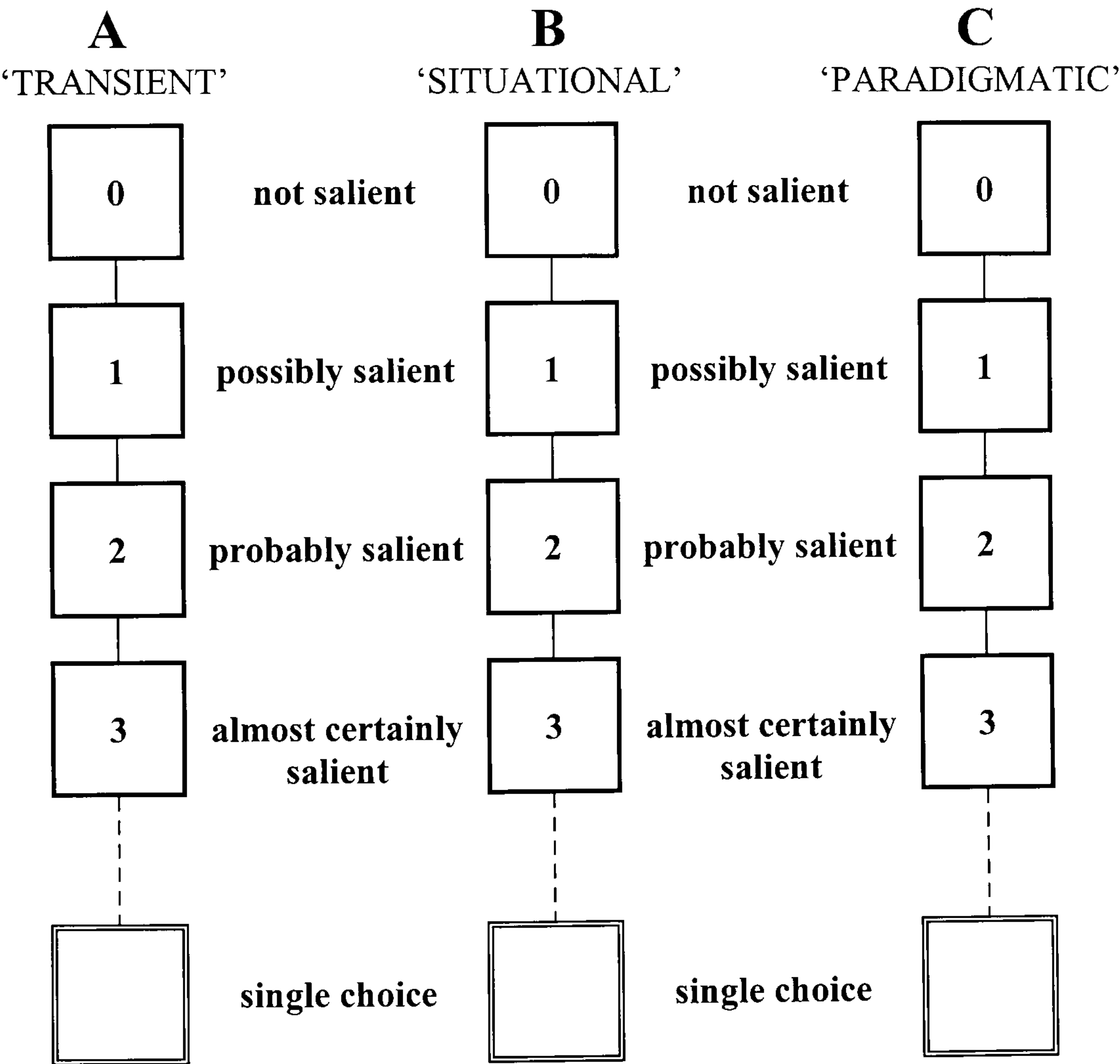
When I phoned the patient she was very angry: angry that I had not understood her position (physically disabled and psychologically very distressed), angry that the appointment letter, sent earlier, had the word "psychiatric" in it. This was humiliating for her. When I called to see her she was angry that I had not walked in (as she told me to) but rang the doorbell instead. The patient's anger made the situation difficult. I was intimidated by this.

I coped with this, initially, by telling myself that clearly I am making the situation worse and I need to politely draw things to a conclusion and leave. However when she began telling her story I became captivated by it - the story was very moving and sad. I became very involved in what she was saying. I became personally touched by what she said. I began to feel close to her and I became aware of how she reminded me of my mother. We met regularly without any recurrence of the anger and I experimented with a technique (rapid eye movement desensitisation) which produced very positive effects.

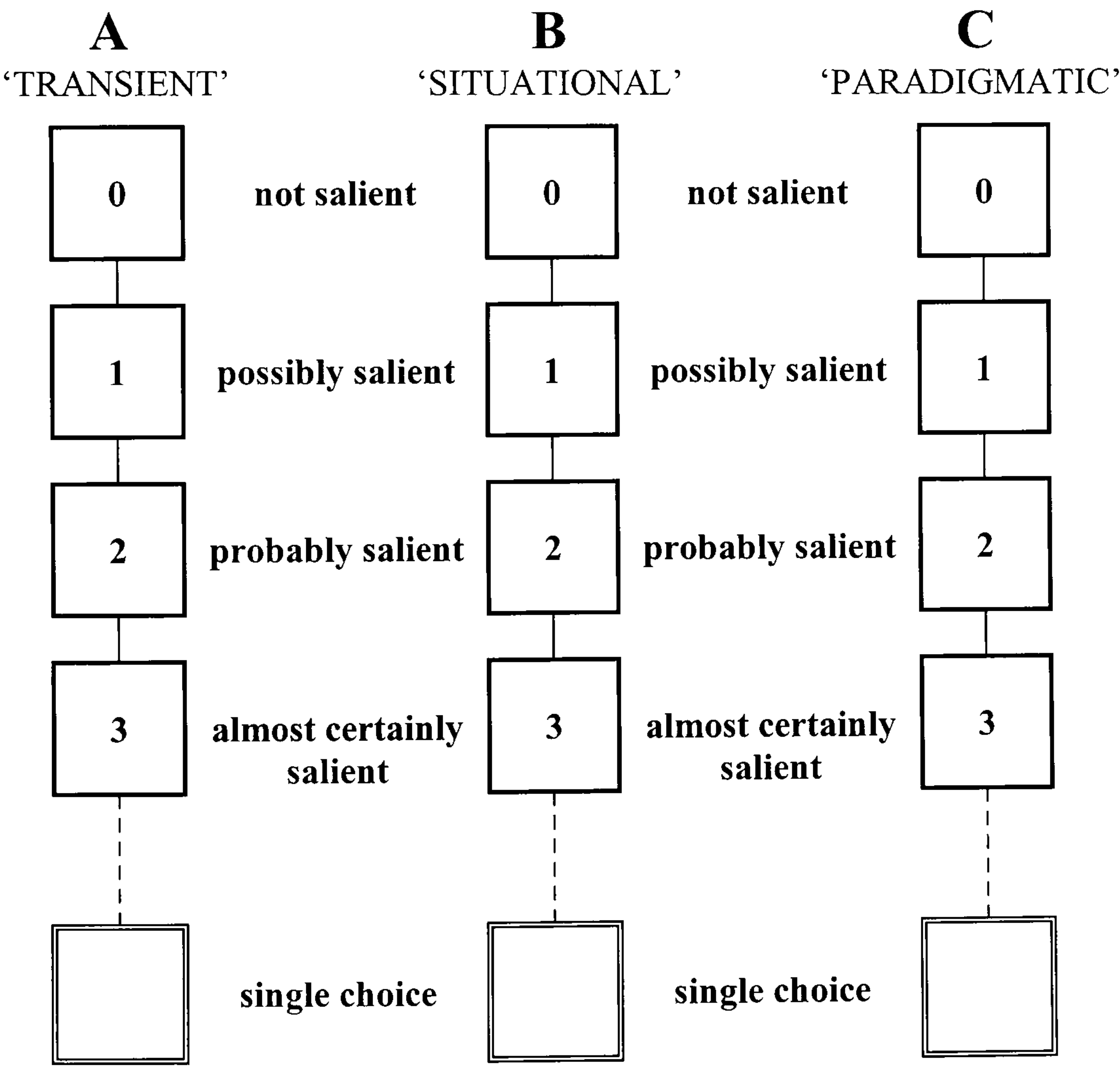
I have been able to discharge her after brief and successful individual work.



A male anorexic patient reacted most adversely to the news of my pregnancy and impending maternity leave, saying that he was upset that the child was not his and thought that I had lost, rather than gained weight. He remained extremely distressed for the remainder of therapy until I started my maternity leave. I felt unsure about how to deal with it and very anxious about his reaction/well-being. Nevertheless I tried to remain calm (!) and to listen to his pain and concerns which seemed to help. I also fixed him up with another therapist for after I left. He had, seemingly, worked out a lot of his feelings by the time I left but at our last appointment he gave me a basket of flowers with a card saying "sadly missed", all of which felt very funereal to me.



The patient started to shout loudly in one session "get off me" repeatedly when recalling with strong emotions a situation from childhood while being abused (sexually) by a teacher. The shouting was very loud and everybody in the building could hear the shouting. This made me feel awkward and angry with the situation I was in; I felt exposed. The patient's emotional outburst was intense and I had to let him go on for a while before I requested some self-control (at least two to three minutes which felt like an eternity). Luckily the patient responded to my request and we could discuss all the various implications of what happened. Strange enough nobody came to see what was going on. It was already late and most people had left the clinic by then. The others thought I had the situation in hand?!



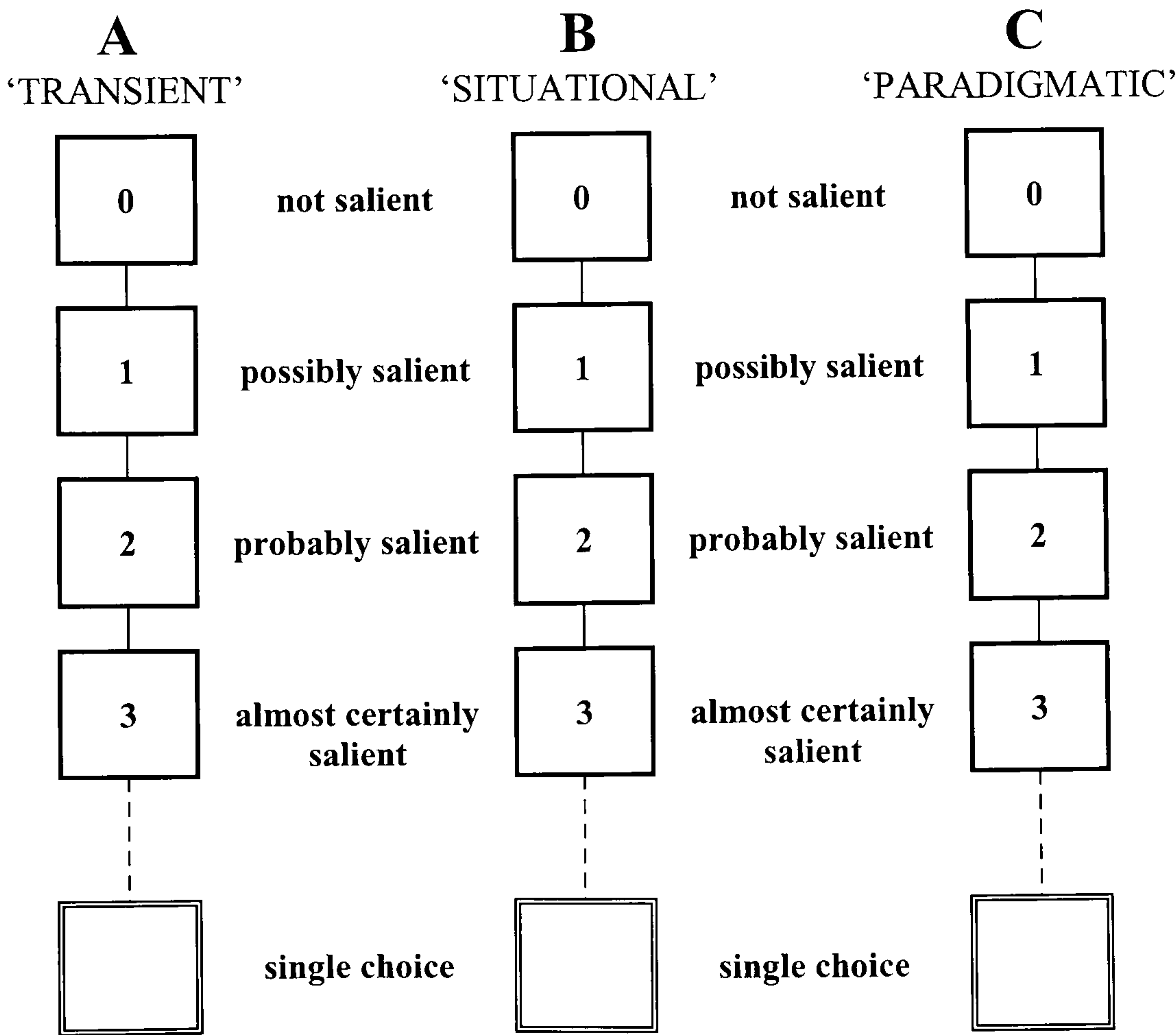


I find it difficult to recall exactly where we had got to in individual dynamic psychotherapy, perhaps 18 months in to the therapy. The patient, a young woman (23) with a diagnosis of borderline personality, frequently displayed the ping-pong behaviour of craving intimacy, finding such intimacy overwhelming, running away, feeling abandoned, then a return to intimacy etc. One evening she turned up for our session but refused to come into the house, stating that she was unable to afford any further sessions. Therapy would have to end there and then. The front door was right by another room where a colleague was in the middle of a session with another patient. Although I tried to maintain a calm and neutral exterior, I was very concerned. Unconsciously I was being manoeuvred into a position of rejection and abandonment. I also felt that I had failed - no other therapist would have got into this mess. I wanted the patient to continue in therapy (avoided my failure? - what about her therapeutic needs?). On my part there was also frustration - I'm never happy about thinking on my feet. There was also some (how much?) reality about the patient's financial situation - low income, living alone... in London.

There and then I introduced a reduced fee scheme! I suggested that this was a possibility and if she was agreeable, she might come into the the session so that we could discuss it.

The patient did this and we looked at her financial situation and what she might afford. ("I can't afford anything" was her initial stand). We negotiated a sessional fee that she was able to afford and then over the next few sessions explored what else might have been around for her.

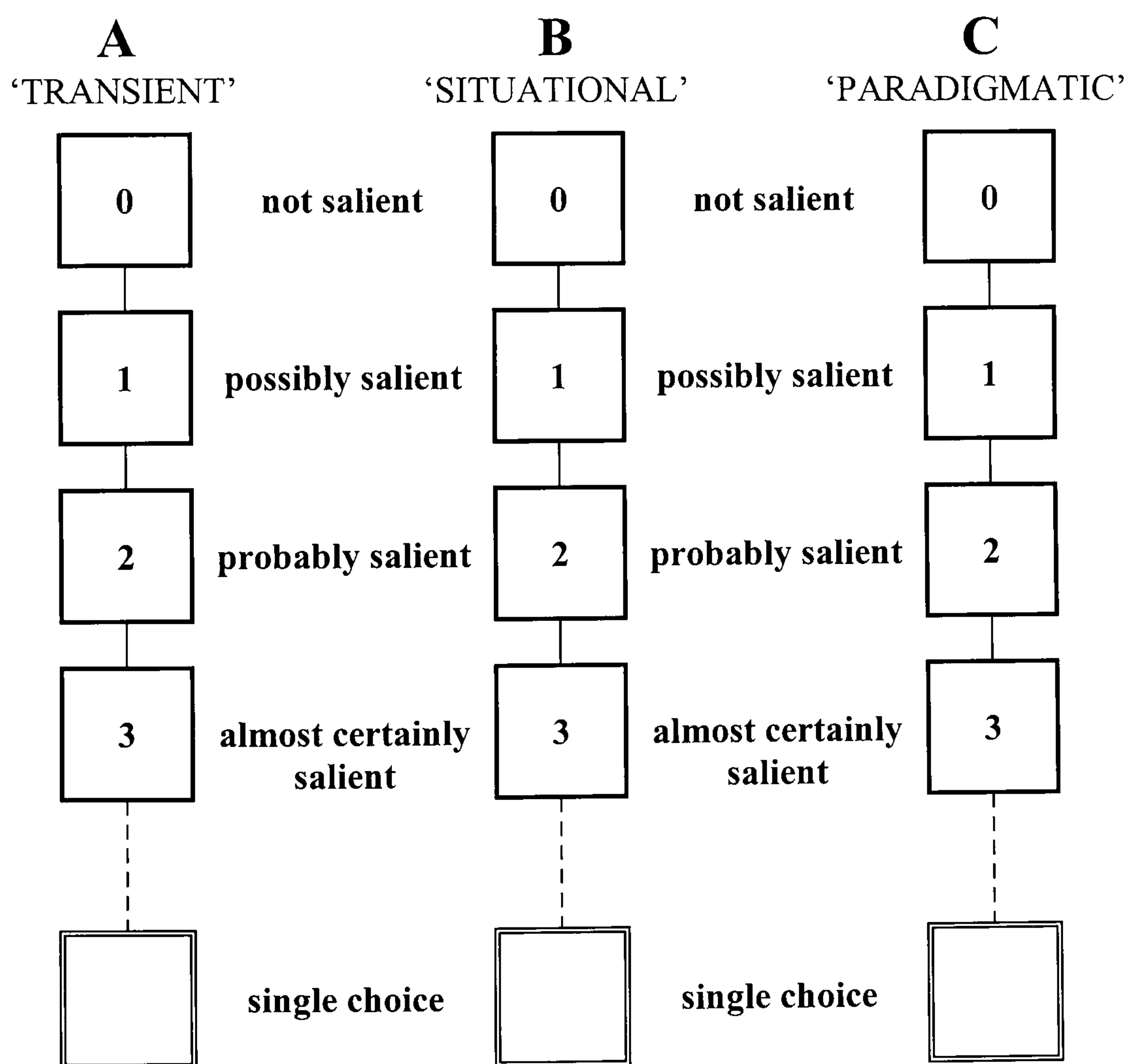
Therapy continued for another two and a half years and was concluded appropriately. That patient made remarkable strides and eventually moved to another part of the country where she has held down a successful job.







Patient referred in a G.U. Medical clinic. Physical symptoms long since cleared up but continued to display depressive/destructive behaviour, in danger of losing her business. In the session she glared at me and angrily demanded to know what I was going to do to help her, insisted that I justify my presence. To that point there had been little in the way of an alliance and nothing had carried over between sessions, each session seemed to contain the same process whereby patient would emphasise her grievances and, passively, demand help and a solution. I became increasingly irritated by her persistent complaining and failure to remember or listen to a word I said, or to undertake any mutual exploration of her problems. Also quite intimidated by her fierce demand that I justify myself. Found myself toying with the idea of fighting back - "crushing" her. I explained what we needed to do to work together and gave her the option to continue according to that or not - she never came back.





## GESTALT-INTEGRATIVE / PSYCHODYNAMIC ORIENTATION

I had been working for some time with a woman in her early thirties who was a victim of prolonged and severe neglect and sexual abuse, both as a very young child, and also when a little older. She had apparently made a degree of progress and integration in individual work with me, having not done well in two consecutive groups, one for adult female survivors of childhood abuse, following earlier one-to-one counselling with other staff members at the local mental health resource centre and in an in-patient setting.

We had agreed a final termination date and worked through to this reasonably successfully, or so I felt. Within a few weeks of this ending, however, she contacted both me and another care worker to reveal her own involvement in abuse, both physical and sexual of one of her own three young children, a boy of four years then.

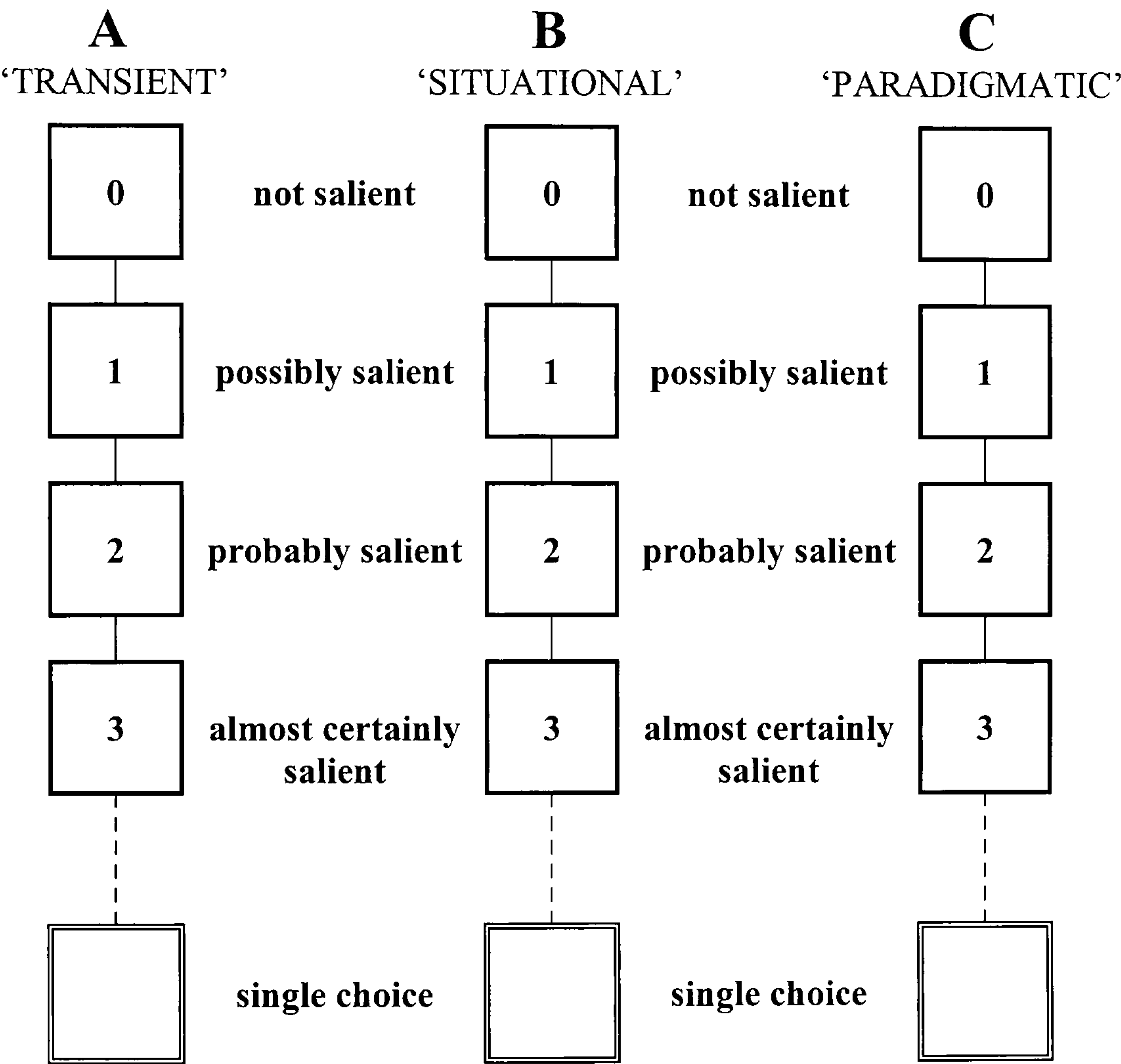
My not having picked up any warning signs of this felt like a failure and incompetence, even though I had periodically liaised with Social Services and others as the family was well known to several agencies. I also felt I had 'abandoned' her children. This all happened in May 1996, since when there has been a major amount of cross agency working, including bringing in a service which particularly works with female offenders. All had again seemed to be progressing fairly well, when two weeks ago (September 1997), this woman, whom I have been seeing again in as much a supportive capacity as for in-depth exploratory work, has revealed much more extensive and earlier targeting of this one son from when he was six months old onwards.

The external expert confessed herself to have been as much 'deceived' as I had been myself when all first leaked out. Although there was a tiny amount of consolation to my professional self-esteem (i.e. as a consequence of 'expert's' admitting this to me), I again feel that I, and indeed of the rest of us, have let ourselves be deflected away again by my patient, whom I actually still like quite a lot. Her profound ability to appear seemingly more open, trusting, accessible and in alliance, while all the time at one level still holding her real self quite out of contact - from herself as much as from any other, raises many questions for me about working with very damaged people.

I have also been more and more forced into thinking that whenever I work with an adult survivor I must even more see them as capable of continuing intergenerational abuse, however much they may strive not to do so. But to have to raise this prospect with those who are as yet childless seems to invoke a very harsh judgement of predeterminism. Whereas for those I see who already are parents it could seem even more of a sentence and a fear.

I still feel 'guilt' about the small boy, and his siblings, who have been hurt even with all my and many other people's attempt to protect them; even though, if we can believe the woman yet, her invasion of his being is not nearly as systematically evil as were her own experiences. (more an adult-child's curious exploration of another real child) we continue to try to work on through this latest crisis and setback, but I endure much self- doubt.

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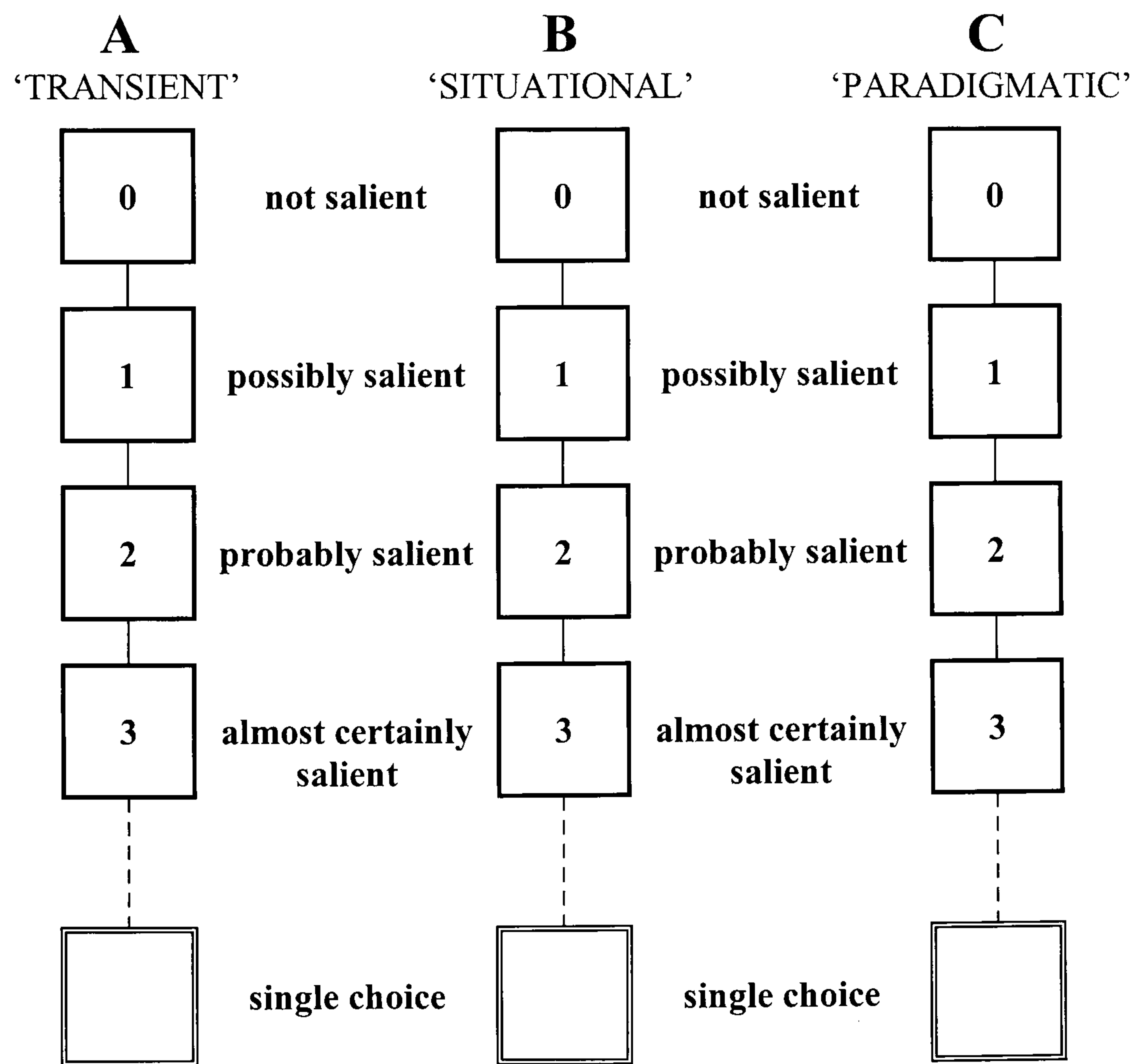
Client brought their five year old son to a therapy session.

I was seeing the client specifically because of her experiencing being sexually abused - in a particularly violent manner and repeatedly - as a young teenager.

I felt confused as to how to ‘handle’ the situation and whether it was ‘o.k.’ to go ahead with the session as asked, or if it was unsuitable given the nature of what was often being talked about. I felt cross with my client for causing this dilemma and concerned for the child. It raised issues regarding ‘protecting children’ for me.

I attempted to deal with the situation by acknowledging that the session might feel a bit different because her son was present and there might be some things that would be unsuitable to talk about in front of him.

It became a good opportunity to model ‘protection’ issues to the client. The session felt less focused than usual. The client came back next week without her son.



This man was my first patient when I moved to a new area. He is unemployed and can only pay a token fee. I didn't mind because (a) I wanted to get going and work with someone and (b) I hoped he would lead to other clients. However, he had no transport and because of this could not come to my office at my home, and refused point blank to come to my in-town office in case he saw "people he knew". (We are still working on this issue - what does it mean to him to "be in therapy".) I agreed to meet him for an initial discussion in a local coffee shop, which I knew to be almost deserted at times, especially in January and February.

Somehow we kept on meeting there and all my attempts to move him to my in-town office where met with a stoic NO. I felt this was a test of me - would I abandon him as everyone else (in his experience) had. I also felt he used the coffee shop venue as a protection, as a way of keeping his distance from the therapeutic experience - and me. Even so, he grew more relaxed and unguarded while I grew more and more aware of people around us and the need to censor what I was saying and to lower my voice when certain topics inevitably arose. There was also the problem of what - if anything - to buy to eat or drink there. It seemed inappropriate for me to eat or drink alone and equally important not to "treat" him. He could not afford anything. So most weeks we bought nothing - adding to my sense of unease at the whole ambience and environment.

After two to three months, I got him to agree to ride his bike to my home - if it wasn't raining. Weeks 1, 2, and 3 thereafter it rained and week 4 he had his bike stolen! By this time I was feeling quite frustrated and was even pondering the wisdom of offering him a lift to and from my home. I did try to find other - more private - venues, but it was the coffeeshop he felt safe in, and wouldn't budge.

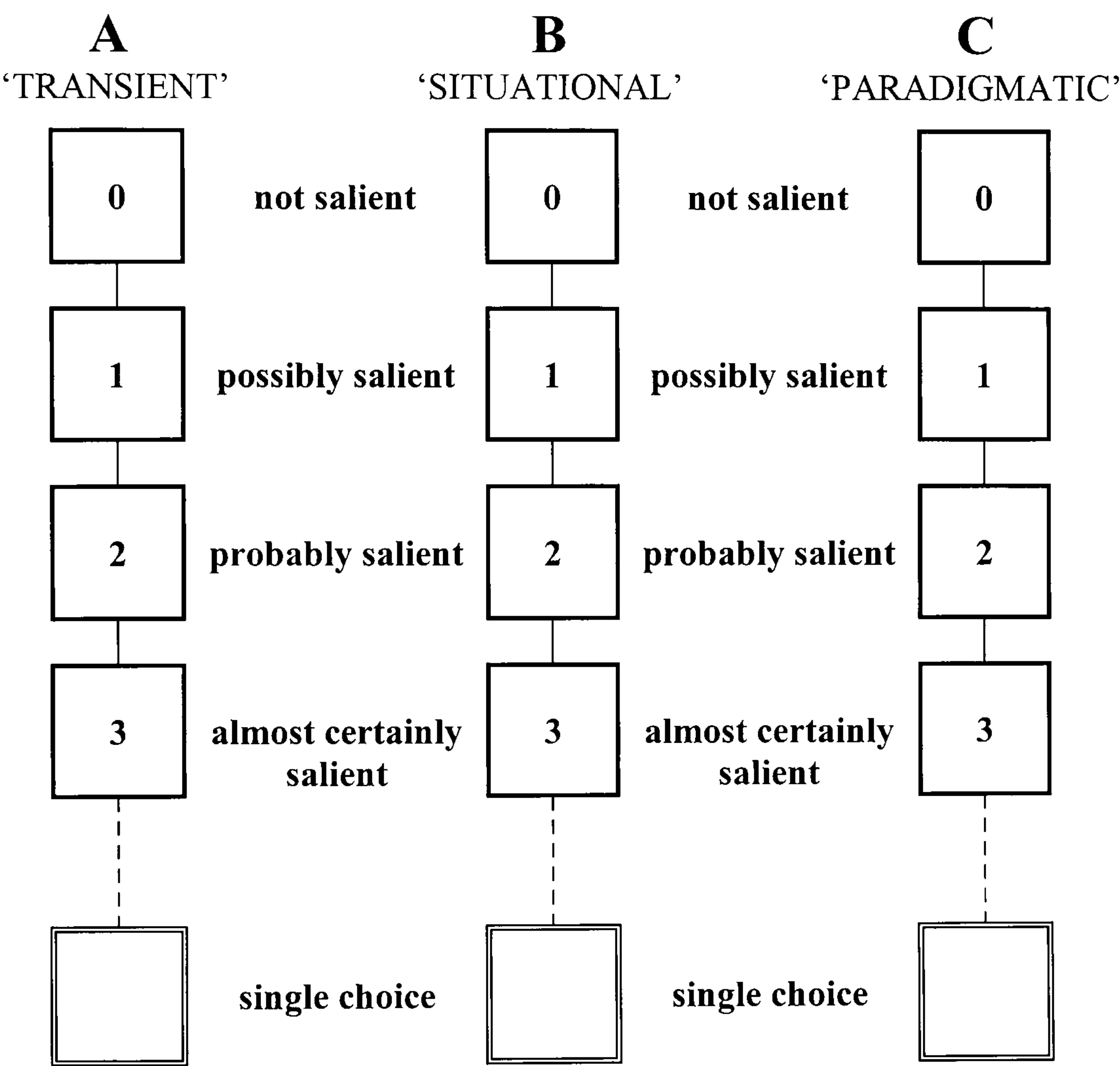
Even so, we did some good work. He was - and is - a "good" patient in many respects and has clearly benefited from my consistency and tolerance of the bizarre situation. My patience paid off: about six weeks ago he told me he had acquired a car. "Good", I said "now you can come to my house".

"I knew you'd say that so I didn't tell you about the car - I've had it a few weeks."

Inwardly very excited I told him he'd told me when he was ready and asked if he would give it a try (my home office) just once. He did - and has been coming ever since with wonderful deepening of the work. It's marvellous to say the word 'penis' without looking around to see who's listening!!

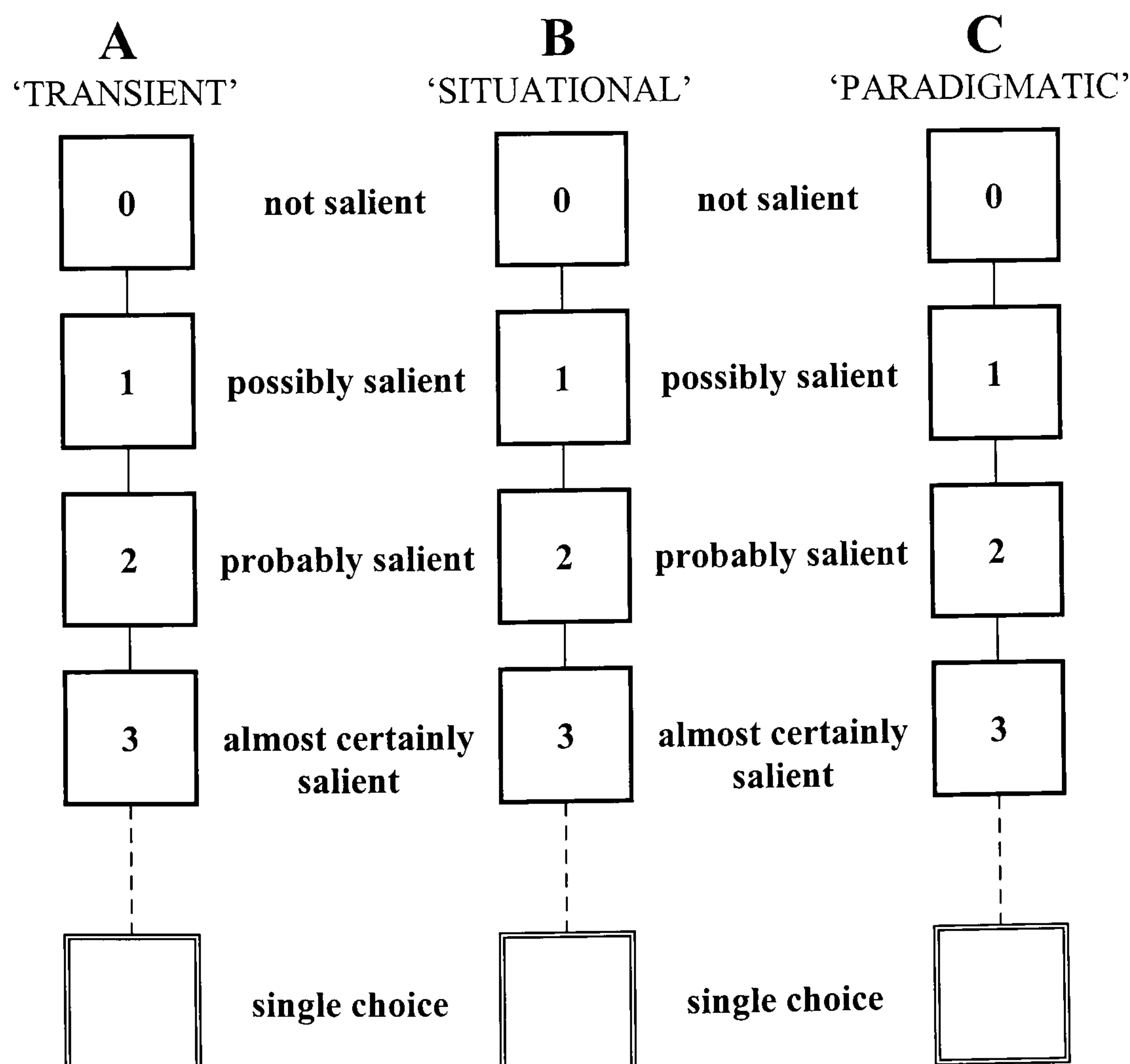
My feelings about doing therapy this way were very conflicting. Reason told me I was being quite unprofessional, yet intuition overrode reason. It felt very important to "contain" this young man's feelings and wait for his strength to let him go deeper into therapy.

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A client who came to me having been told by another therapist (in a first assessment session, and then told her she would not be taken on) that she had been sexually abused. She had no memories of this, although clear memories of physical abuse. She was desperate to have this verified by me. I still don't know if she was or not, and suspect we never will 'know'. From the beginning session I've felt caught up in a powerful negative transference which has been difficult to handle and contain at times. I've felt enormous pressure from her to clarify what can't be, and confirm what may or may not be and in the midst of this her functioning in everyday terms has been very poor. She has acted out a lot (not recently however) but it has remained the pressure to discover something definite that has been most problematic. It has made me feel at times exasperated, at times useless, at times like wanting to give up. It's also felt like a defence against what she does know and an unconscious desire not to deal with that. This is ongoing work as it is getting easier (three and a half years in). She rarely acts out, functions better, is easier to be with, but the difficulty of needing to know the unknowable still remains. I try to keep the balance between working with what comes up, and recognising that memories may yet resurface (although I think not in the 'completed jigsaw' way she wants) but not colluding in redefining events in a way I think would be false, whilst at the same time not in any way wishing to deny any of her experiences and feelings. It feels a very uncomfortable balancing act. I don't know what the outcome will be, except she is bound to be disappointed and I have to work with that.







Married woman in early thirties. History of rape and torture by a doctor at age of 19 years when student nurse. Subsequent pregnancy and miscarriage at approximately five months. Never told anybody until hysterectomy for persistent bleeding. Then suffered distressing flashbacks and other intrusive phenomena.

At presentation was largely amnesic for event and could only 'recall' in detail when in dissociated state of mind. At times this involved re-living elements of the experience in her mind whilst being able to tell me what was happening to her - at other times would simply re-enact the events with no contact with me in the present.

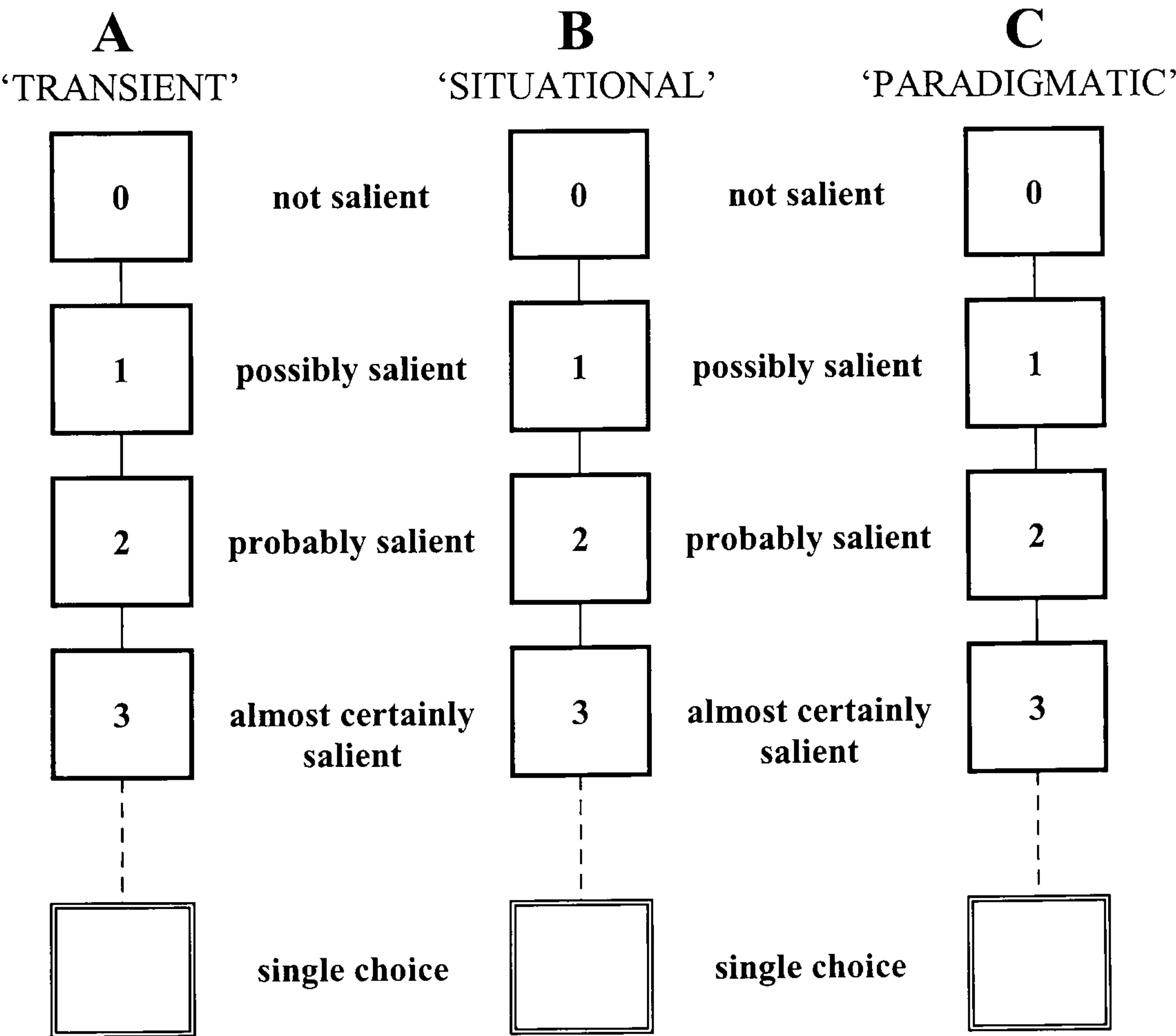
Some of the events were horrific to be witness to arousing intense feelings in me of pain, anger, fury etc. whilst being all too aware of her mental and physical pain and distress in the present. These states of mind where variable in length making it difficult to plan when I could arrange something afterwards. They would often leave me feeling exhausted and not really fit to see other patients.

Sometimes she could not get out of my room - hysterical conversion making it impossible to walk. This would involve my having to physically manoeuvre her out! Also would have to have physical contact - hold her hand/put my arm around her in order to enable her to come out of dissociation.

Thought it necessary to allow this as I thought I knew enough of what had happened to help her make sense of her current experiences.

Used female consultant colleague as supervisor and visit to trauma group which confirmed how difficult a situation this was.

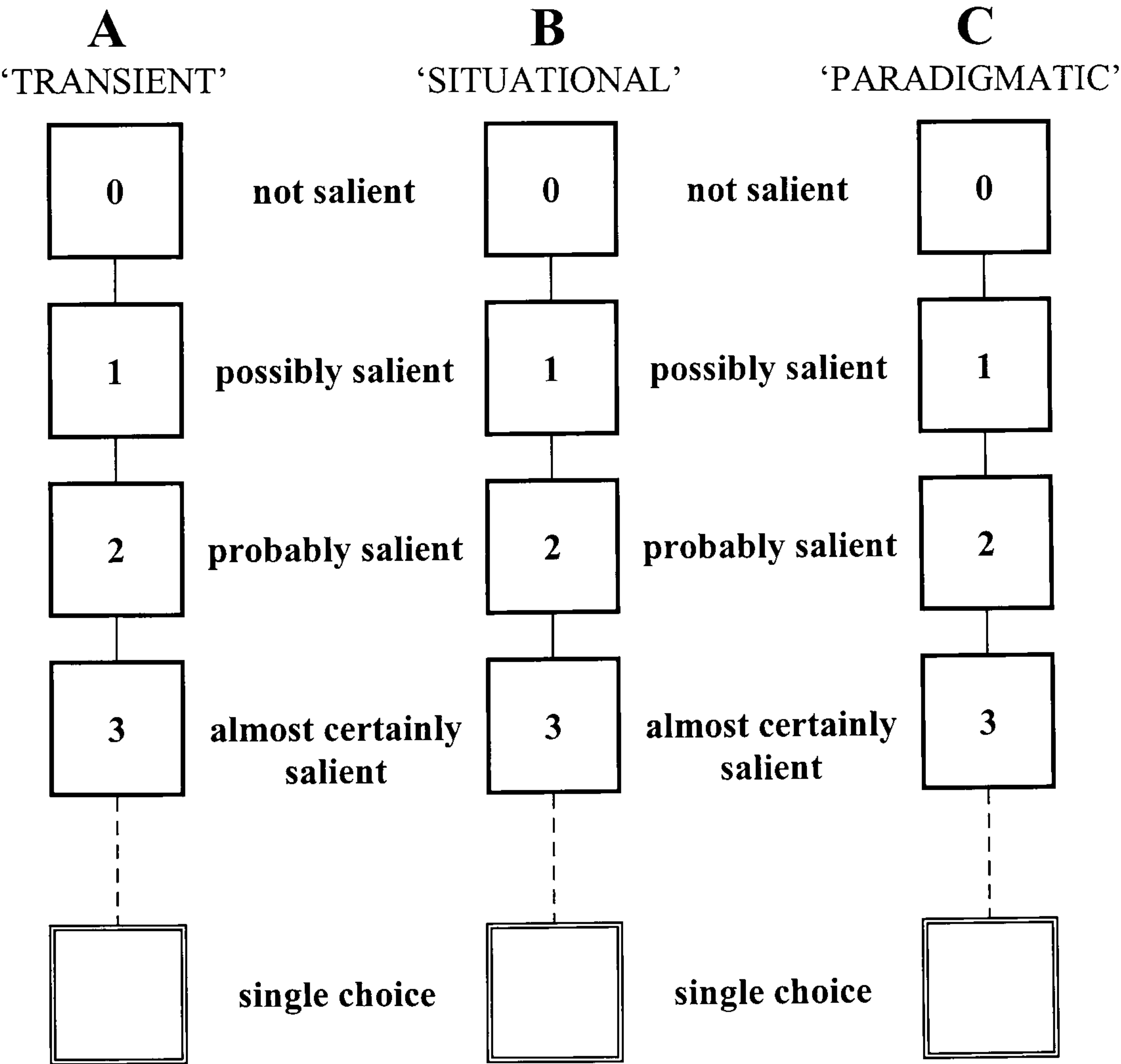
Therapy has now progressed and is more 'ordinary' although she has developed a serious anorectic problem.





Half way through a session this patient suddenly said “I’m feeling totally wet. I can’t help it. My vagina is throbbing. I don’t know what comes over me but you must help me.” This patient had been working well with me for some months. She had difficulties in her relationships with men and was half way through a divorce. She had a history of sexual abuse and claimed to have been sexually involved with a therapist (college counsellor) when she lived abroad while a student.

My feelings were of surprise and alarm because it was totally out of the blue and I had had no warning of her sexual feelings except the story about her having previously been sexually involved with a therapist. I told her that we had a clear contract and that our relationship was professional and that I would not be involved with her in any way except as her therapist and that this did not include any physical relationship etc. She burst out crying and then got very angry and yelled at me that I didn’t care about her or want to help her. I stayed calm and firm with the boundaries. Subsequently we went on to work for three years and she made significant progress. This session proved pivotal and she would sometimes refer to it later as ‘the point where I knew I could trust you’.



## **11. Appendix 11: TDQ2, Rating Booklet 2**

There was no separate cover page for the second batch of ratings. Two of the external judges rated batch I first, the remaining two batch II.

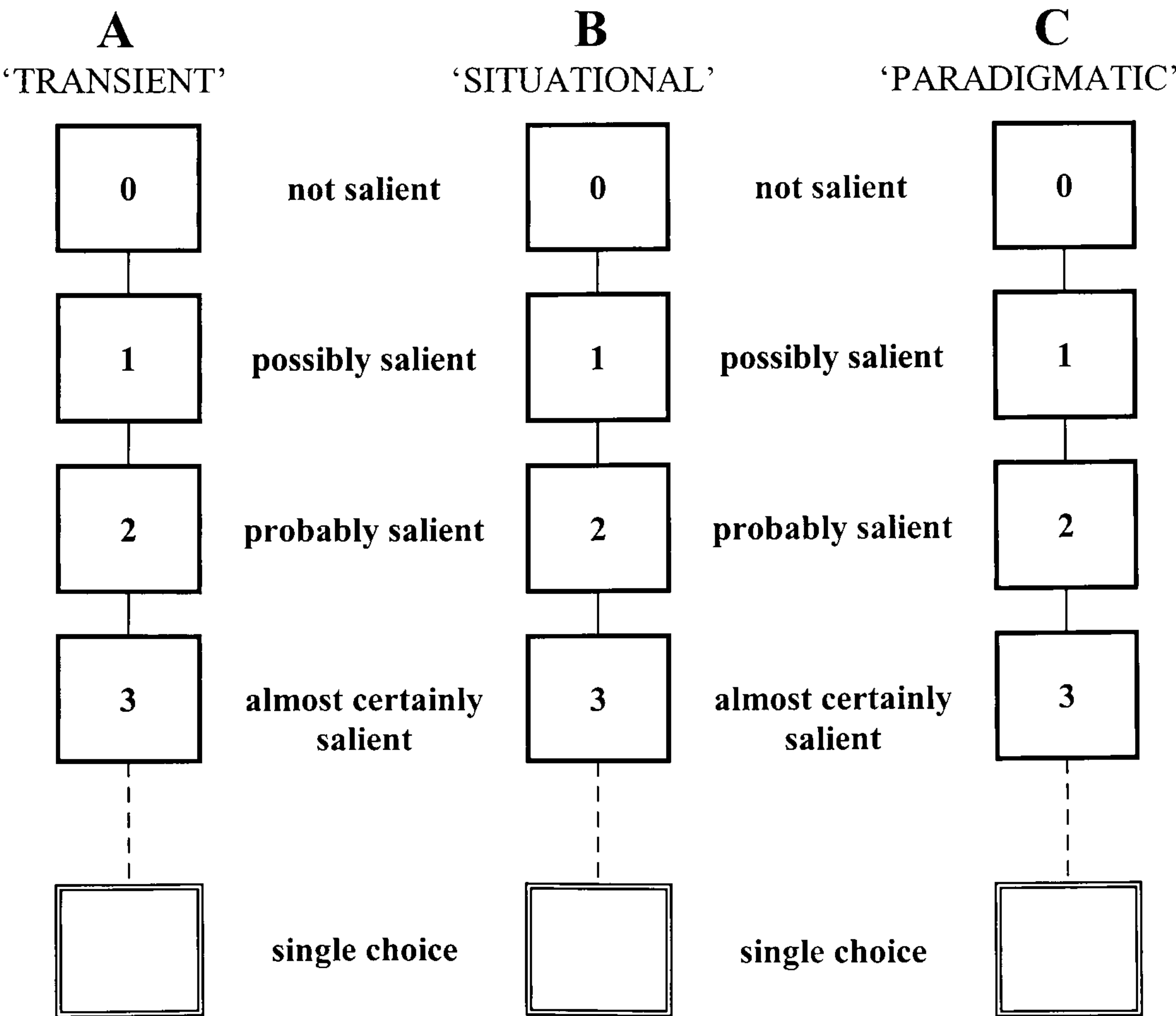
**1 MALE NURSE, PSYCHOTHERAPIST PSYCHODYNAMIC ORIENTATION 430**

This concerned a lady who had been in therapy with me for about three years. Her childhood was both chaotic and abusive. She spoke quickly, constantly, and with a tendency to flit from one subject to the other, which often made it difficult to focus on issues in therapy. The sessions were often a long tirade of rage directed at others, particularly her husband, though she found it very difficult to be angry with her abusive mother, or with myself. She regarded me with a sort of idealised dependency.

In spite of all this she was able to work sporadically with some of the underlying issues and showed some improvement, to the point where she raised the possibility of ending therapy. I acceded and we set a termination date. We later extended this as a result of a personal crisis, which was resolved. As the final session approached she began to express regrets and implied that she wanted therapy to continue. After consultation with a colleague I told her that I felt she needed some time to consolidate the gains she had made, that we should stick to the termination date, but that she could come back to see me to report progress in a year's time. She settled for this but, since she found it difficult at all times to challenge me, this could not be seen as wholehearted agreement.

My difficulty was that I was uncertain about my real motives for discharging her. Was it to do with countertransference? She was very difficult to work with, often rang up outside the session, and gave me a stomach ache often when I saw her! I felt I had run out of constructive therapeutic strategies. I often felt frustrated, due to a sense that she would not allow me to help her as much as I could. On the other hand I felt compassion for her suffering and, on a personal level, a degree of respect and affection. Because of all this (though I recognise some of it as the client's projections) I felt some guilt about discharging her.

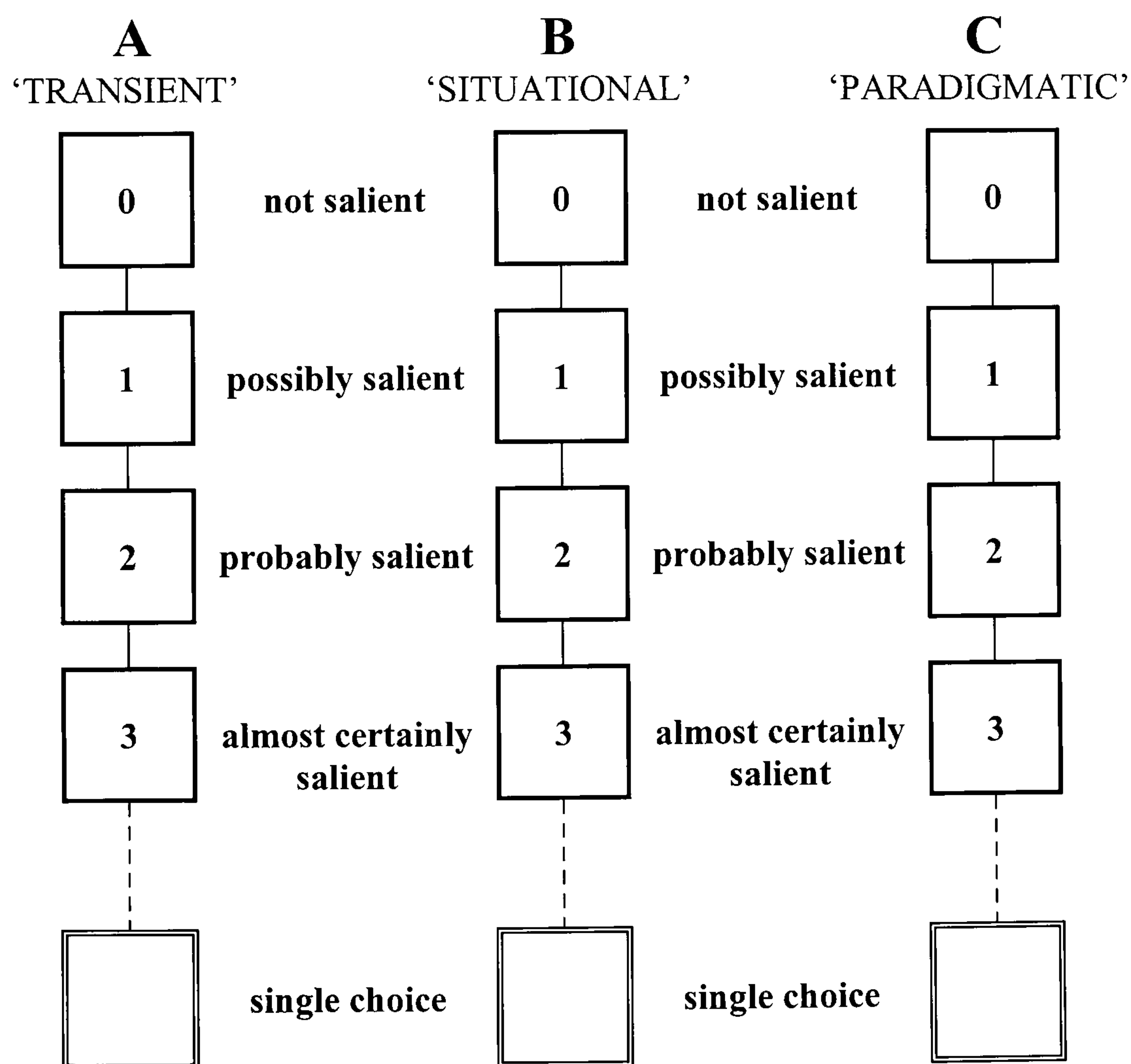
On the level of clinical judgement though, I honestly believed that therapy had taken her as far as it could for the present, (I didn't exclude the possibility of further therapy) and that her idealisation of and dependency on me was an obstacle to her getting on with her own life. We parted with some sadness on both sides and, though the 12 months period has not yet elapsed, she has not been subsequently re-referred either to myself or the consultant.





## PSYCHODYNAMIC/BEHAVIOURAL/COGNITIVE ORIENTATION

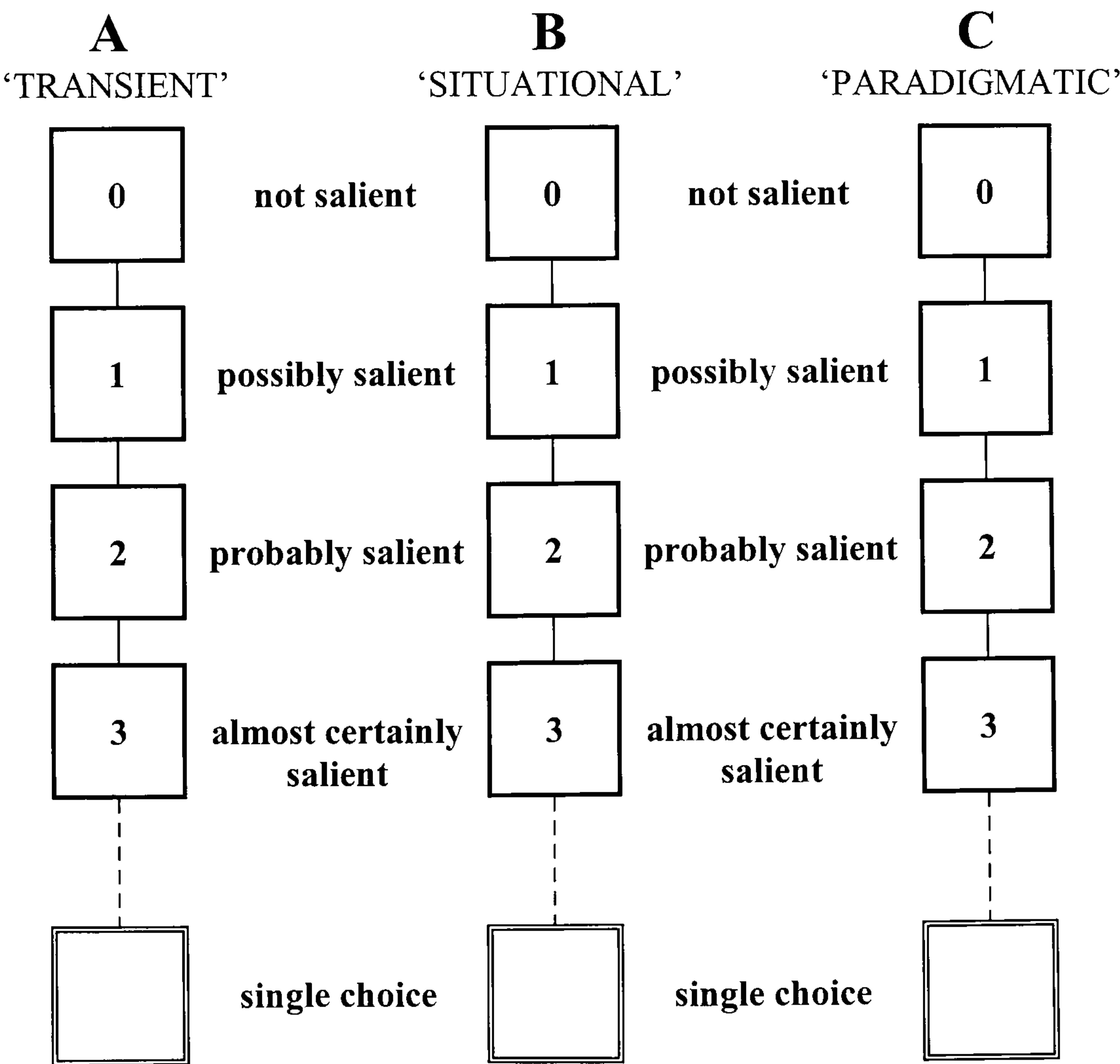
I had been seeing this patient for a long time, initially using a cognitive behavioural approach. We had been on the point of terminating our sessions on several occasions but this never quite happened. He then revealed memories of sexual abuse from childhood and we agreed to look at these. As part of this, given the lack of explicit memories (rather than a vague feeling) I got him to bring in photos of himself and his family from the time when he believed the abuse took place. This did indeed trigger some memories and caused him considerable distress. He was openly upset and angry in the sessions and stated his difficulty with all of this. Whilst I felt we were following the correct 'procedure' or at least a useful one, I did feel somewhat uncomfortable and abusive myself for putting him through this. After two to three sessions of this we moved on from it. The situation is ongoing. In terms of its broadest implications it seems to be to do with being with someone who is experiencing considerable distress and having some doubts as to the therapeutic necessity of this.



Spend three sessions building up to a short "behavioural" plan designed to increase pleasurable activities. At end of final session patient changed subject. Refused to discuss "plan" or feelings associated with it or proceed.

Personal feelings:      frustration, anger  
Thoughts:                "what's the point", "this is hopeless"  
Cope:                     told myself "we've been here before" (ie this kind of situation).  
Said to patient "not to worry, discuss it next week"

Subsequently (next session) - patient said "tired with everything, no point in planning something because I won't do it. "  
Situation returned to previous 'stalemate', ie patient's desire for recognition from others - people in present and past - from success in music but no intention of doing anything about it.







The difficulty presented by this female, same age patient was her scorn, her denigration of me and her desire to get into an argument. Sessions would begin by her not closing the door - that was my job - but I would be criticised for commenting on it - making 'too much' of it. Then her coat would be thrown into a spare chair. Her eye contact was poor but she could express considerable scorn and contempt in her manner.

One particular session I had to firmly restrain myself from shouting at her. There had been several such recent sessions and I had had enough of the denigration. I wanted to tell her I was sick of her attacks, her sulky manner, her accusation of my abuse of my role. Why this session? I cannot easily say - perhaps too many had come together, vaguely I recall an argument with my wife a few days earlier in which I had felt denigrated.

My patient was good at denigration ie it hit home in uncomfortable areas. I don't like being accused of being too omniscient and I don't like a suspicion I am letting myself be pushed around.

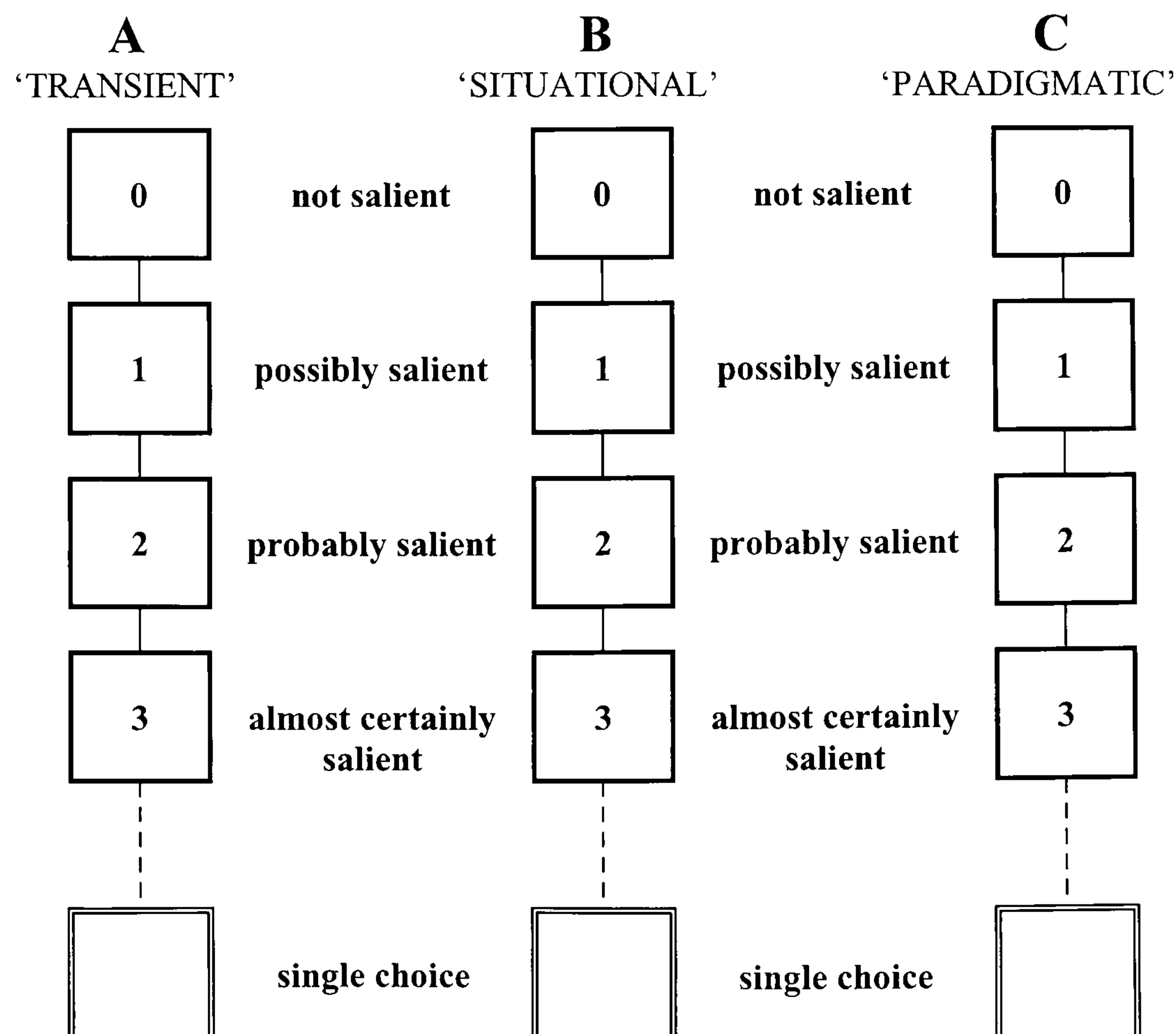
Outcome this session - don't retaliate, sit tight, let her go on a relapse into silence and try again next week after I've had time to reflect, cool down. So I let it run - patient accused, went silent and 'flounced out' at end of hour - no goodbye or eye contact and door pulled too forcefully. Out of earshot I threw myself into my chair and said exactly what I thought of her - horrible bitch!

Sometime after I consulted a female colleague who (courageously) said she used to act like this and had been helped by her partner saying - I will not have you denigrate me like this!

I adopted this stance adding my own perception that any such attack on me reflected her attacks on herself, ie stop denigrating me and yourself. It's not helping. Firmly put several times over subsequent weeks and change did begin and has continued.

In time it has become possible to comment on her underlying dependency wishes. This was illustrated in a session when my door rattled because on a hot day the window was open to keep us cool and a breeze was blowing the door. We tried closing the window as the noise was distracting but it was too hot. She suggested I lock the door which would stop the rattle. I began to and then stopped... realising the implications. I am scorned and rubbished yet she would really like to be locked in and close to me.

Much of this is now discussable rather than acted out. She now closes the door herself, 'sulks' less and denigrates only occasionally and it can now be read as a sign that intimacy has proved threatening.



Female patient Forties. History of Depression and ‘recovered memory’ of sexual abuse by step-father.

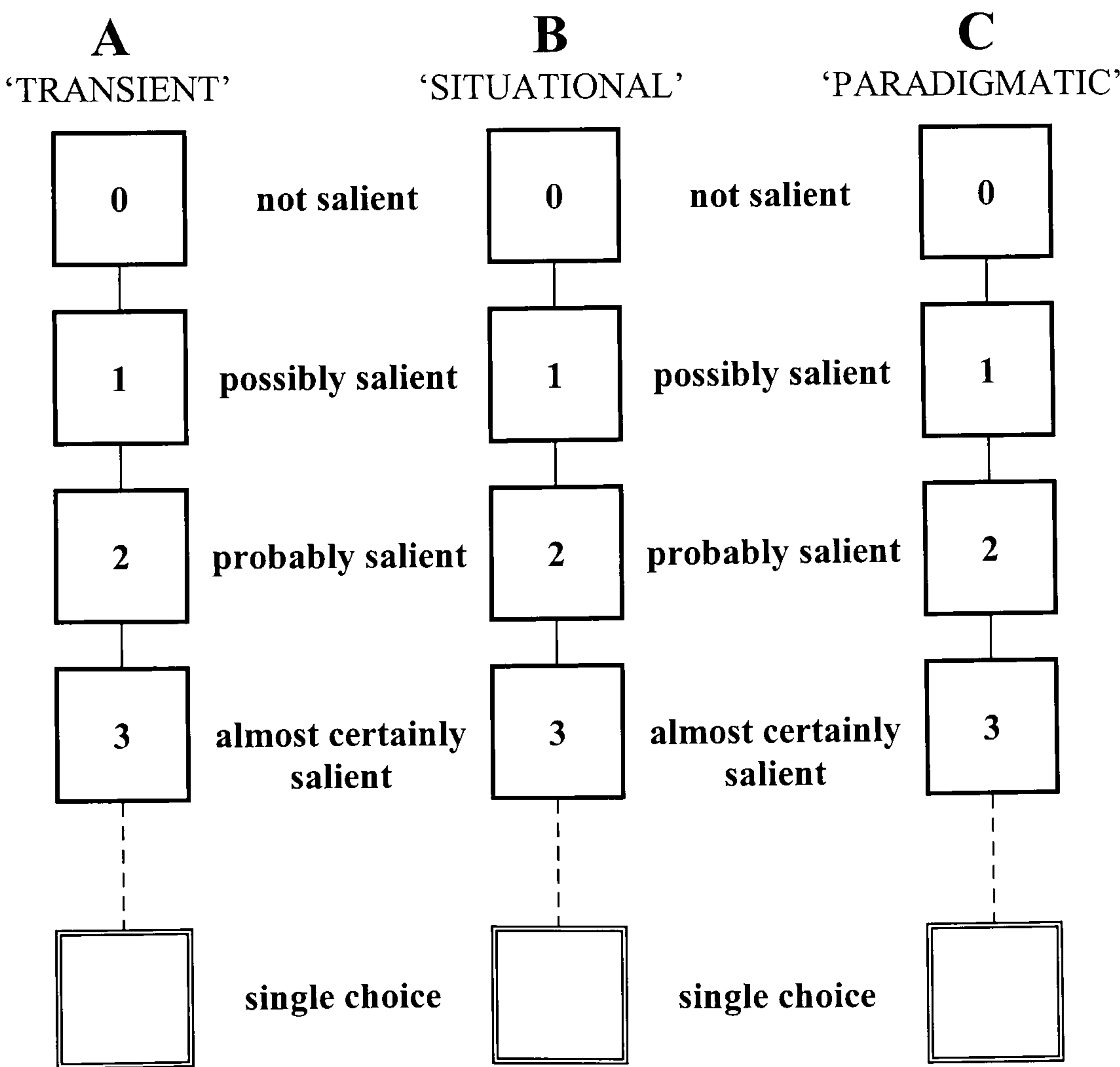
TOWARDS TERMINATION OF THERAPY (less than two months left) PATIENT ASKED WHAT I THOUGHT ABOUT HER, AS A PERSON. DID I DISLIKE HER ETC.

I FROZE, NOT KNOWING HOW TO RESPOND. AWARE OF PREVIOUS DIFFICULTY IN EROTICISED TRANSFERENCE BETWEEN US.

PANIC INSIDE ME WHAT TO SAY, DESIRE TO REASSURE YET ALSO ANXIOUS NOT TO REVEAL TOO MUCH OF MY FEELINGS OF WARMTH TOWARDS HER, IN CASE THEY WERE MISINTERPRETED BY HER.

EVENTUALLY RESPONDED WITH INTERPRETATION OF HER DESIRE TO KNOW HER STEP-FATHERS FEELINGS TOWARDS HER confusion REMAINING RE THIS, AND HER SADNESS AT NEVER HAVING BEEN ABLE TO DO THIS BEFORE HE DIED.

PATIENT ACCEPTED THE INTERPRETATION AS HAVING SOME TRUTH IN IT, BUT FURTHER EXPRESSED HER IRRITATION AT MY HAVING ONCE AGAIN NOT PROVIDED AN ANSWER TO HER QUESTION.

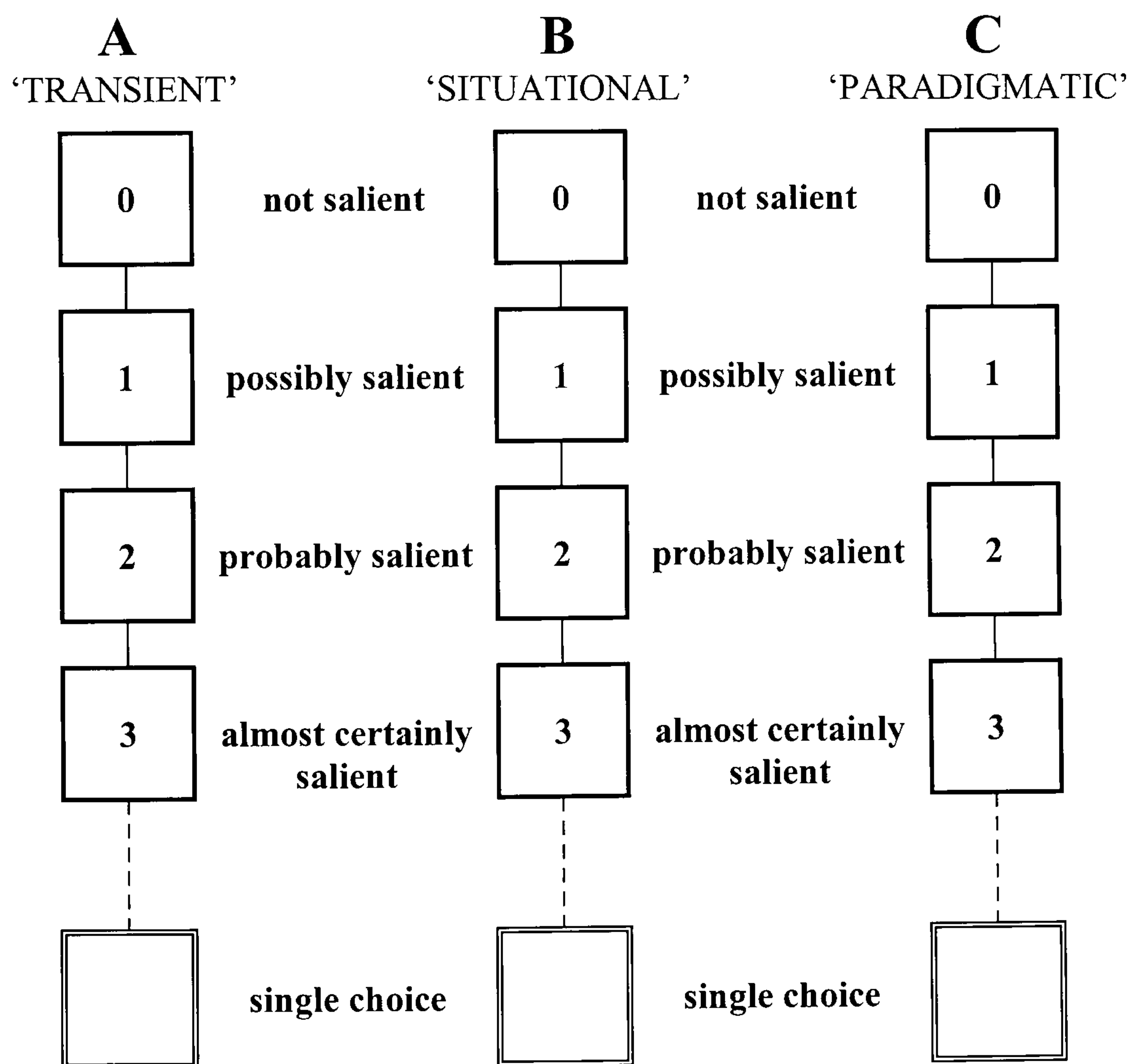




Ending of a short term therapy.

I was determined to end so continued to confront the issue, she did not wish to end "ever", cut off in the sessions. I felt more and more frustrated, often felt like hitting her, hoping she would cancel, I felt a lot of anger and sadness, also feeling useless; why this, when the start had been quite promising.

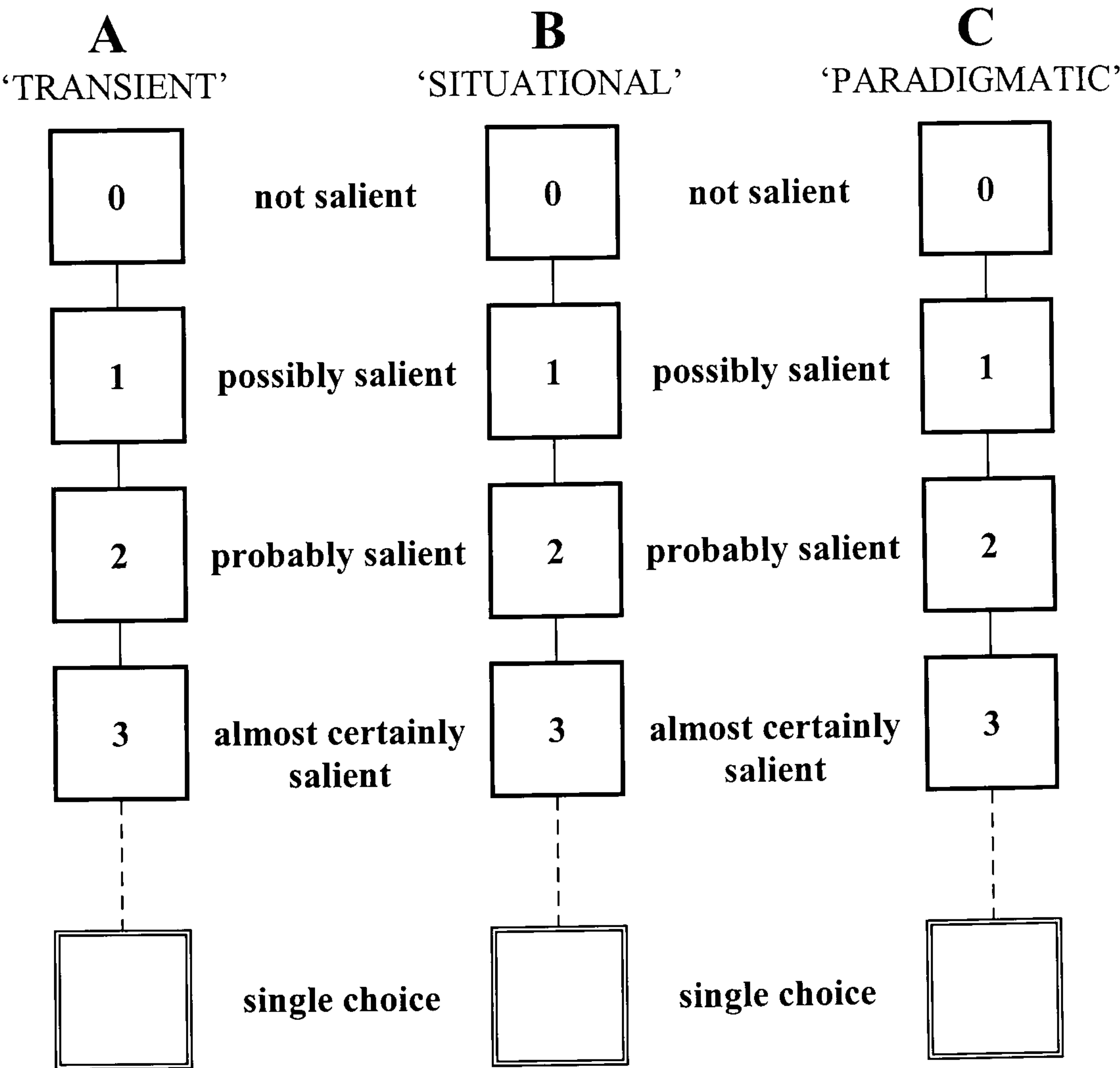
The patient found it very difficult when there were silences, I felt that we needed to stay with her feelings. It was hard for her but it began to pay off and the patient was beginning to accept her feelings back and also beginning to remember the start of therapy and how she pushes everything through at speed.





PSYCHODYNAMIC/BEHAVIOURAL/COGNITIVE/HUMANISTIC  
ORIENTATION

Towards the end of therapy this client started to become verbally abusive and deny everything she had begun to realise about herself and the trauma she had undergone. She started to accuse me of "implanting" false memories (it had been reported a lot on the TV and in the press at that time). I felt concerned that the progress she had made might disappear, but I knew her memories were real (it was an abuse case and the man involved was taken to court where he confessed) even though I am aware that the subconscious mind often can't differentiate. I felt I had to justify my therapy. She left therapy and I have not seen her for over two years.



Jane is 39 years old and I have been seeing her for over eighteen months. She is the oldest of three children. The youngest, a girl, being eleven years younger. Jane has happy memories from her early childhood, being close to her father who was an extrovert and well liked man with whom she spent much time. However as strict Roman Catholic family moral and social expectations were high, and there was much pressure to achieve. When she was age twelve or thirteen it would appear that her father 'became ill' and withdrew to a reclusive position, isolating himself in the front room of the family home. She felt isolated and on her own. She is disparaging of her mother who had a 'traditional role'.

Jane did well at school, went to University, left home, and entered a professional, caring vocation. In this period she developed a severe eating disorder and undertook a long period of counselling. Over the next ten years she entered three relationships with professional men which became abusive and sadomasochistic. She was a high achiever in her chosen profession. Nine years ago she met her current partner and now has two young children. She has been seriously depressed and has considerable difficulty in her personal relationships.

For this session Jane arrived in good time as usual, but as has happened on previous occasions she managed to get herself into the waiting [room] without reception being aware she was there. I discovered this when passing the waiting room four or five minutes after the session was due to commence. 'I want to finish - I'm feeling much better you know'. This is a recurring theme, arising every few months or so, and I am aware that it reflects a number of significant issues. Despite the familiarity of the statement I am thrown by the underlying content, and the harsh tone with which it is delivered.

I am aware of an impulse to argue with her - to point out how despairing she has felt over the last few weeks and how she feels a need to defend herself against these painful feelings. I decide to reflect silently on what she has said and the impact on me at an emotional level. 'Well - are you going to let me go?'. She appears angry and says this with some venom. I suggest to her that she is angry with me and wants to attack me and hurt me because she feels ignored and uncared for. This reflects elements in the relationship with her father and her current partner. She tells me of an argument with her partner this week complaining that he dismisses her as being neurotic - that difficulties in their relationship are her fault.

Jane now appears somewhat more relaxed and tells me of contact with an old friend who lives in another part of the country. This was a significant and caring relationship in which she felt 'unconditionally loved' and cared for. However it is now unsatisfactory and she feels manipulated. I have a remote thought process which I struggle to get into focus - I have heard this account on previous occasions, or something like it, and she has made the same demands of me but it is hard to make links - hard to think.

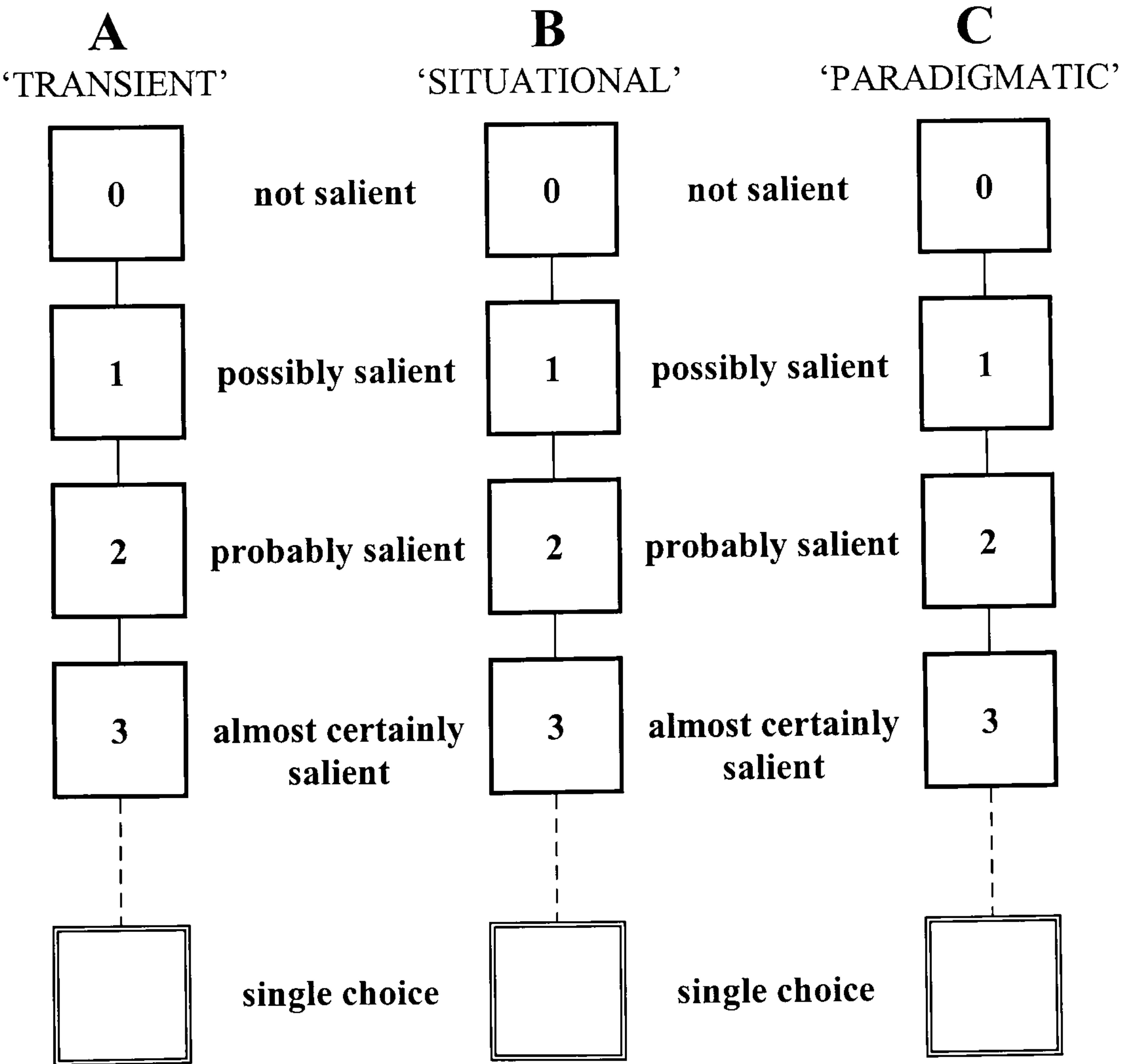
*PLEASE CONTINUE ON THE NEXT PAGE*



I put to her that she wants me to care for her but fears being controlled, manipulated - abused. This feels right at some level but doesn't sound right as I say it, but my head feels clearer. 'Oh here we go psychobabble - you can't just take what I say at face value'. I am suddenly aware of her low self-esteem, lack of self-worth. She sits on the edge of her chair. At this point she has walked out of sessions in the past. I notice I am anxious about her leaving the session early, at this point. I am thinking of her relationship with her father when she was age thirteen.

I become aware of a polarisation of ideas and wonder silently about splitting. I put to her that we get caught in a dilemma. If do not agree with her bid to end therapy I am seen as not valuing her as a person, and the healthy aspects which are becoming more apparent. I become the controlling mother of whom she complains. We also repeat a scenario encountered with her father in which she is left confused as to why distance has grown between them. If I agree that therapy should end I value the progress she has made and the healthy part that is apparent, but I am seen as uncaring and not committed to a relationship with her.

Jane sat back in the chair and told me of an old colleague who would not put up with her 'nonsense'. This colleague could risk a challenge whilst holding a commitment to the relationship. As the session ended on time I am aware that we may be so close, and yet so far, from an integration of conflicting internal objects.

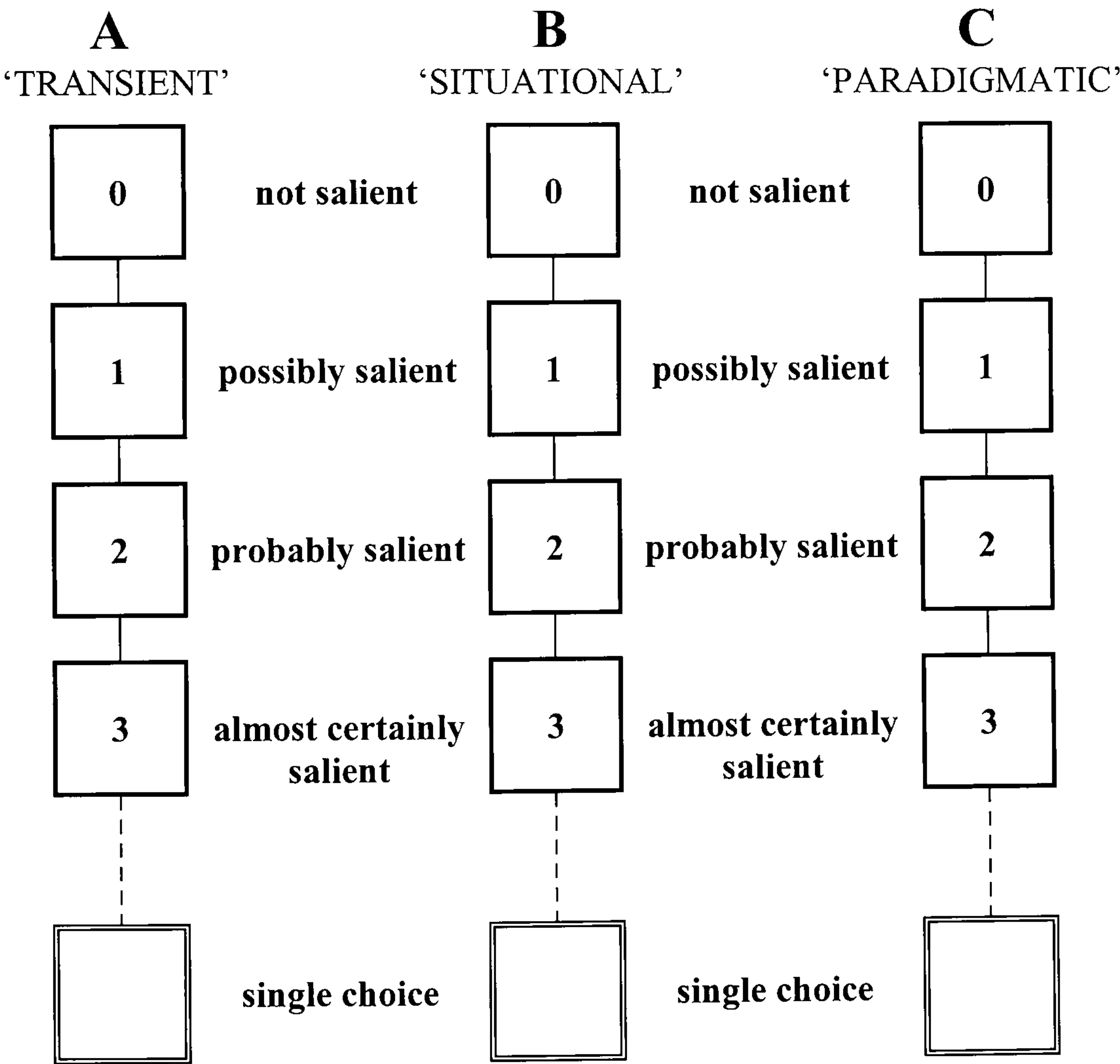




Patient spoke with seriousness about suicide. I felt some anxiety - but at the time somehow 'knew' the patient would not commit suicide.

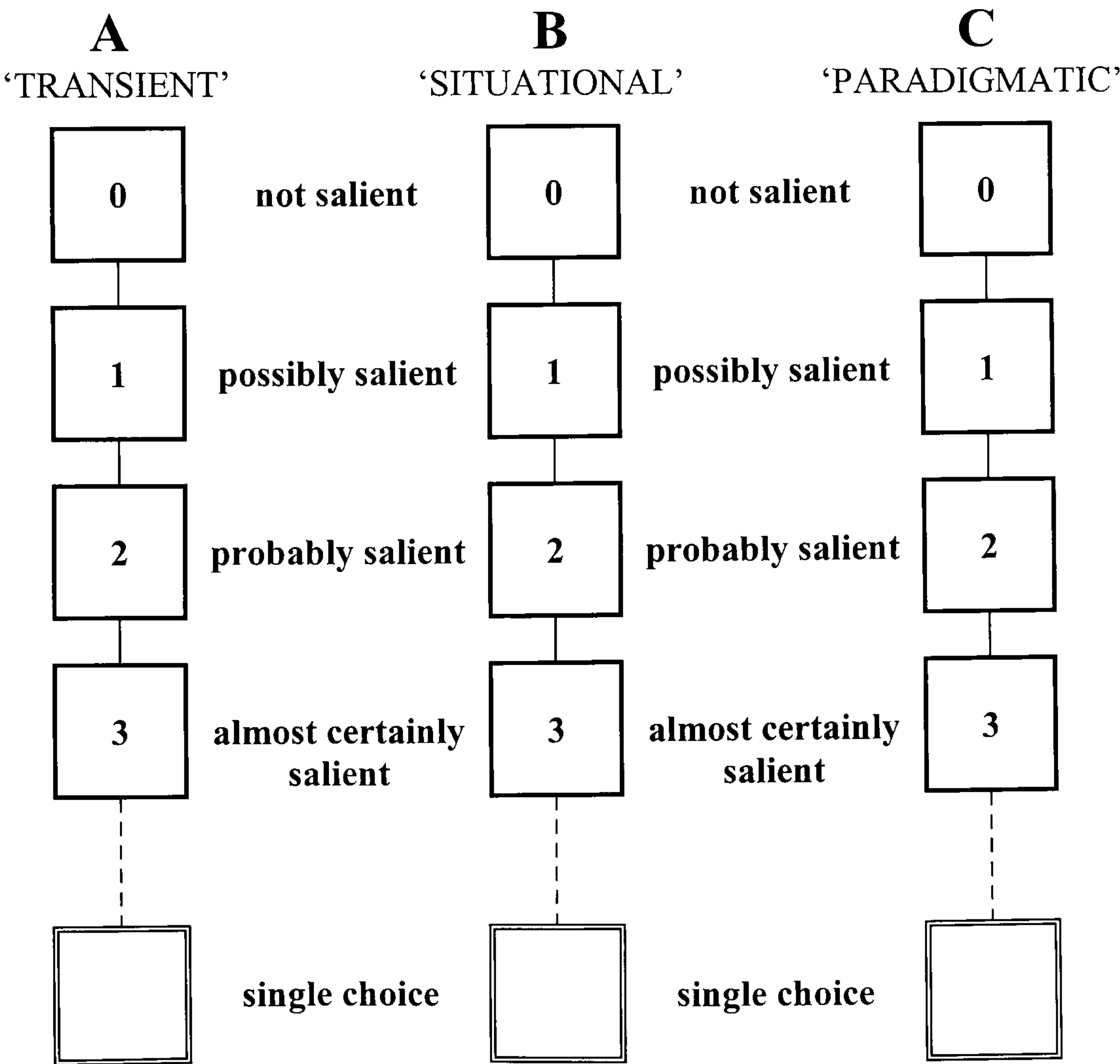
I coped by making sure I picked up on every (suicidal) cue, and opened up the topic for discussion. I managed to address fairly gross splitting and maintained a positive alliance and (on the whole) a positive transference. Psychiatrist contacting me in an "emergency" with fears that patient had committed suicide. I was able to address splitting and contain anxieties.

To my knowledge patient still alive at time of writing.

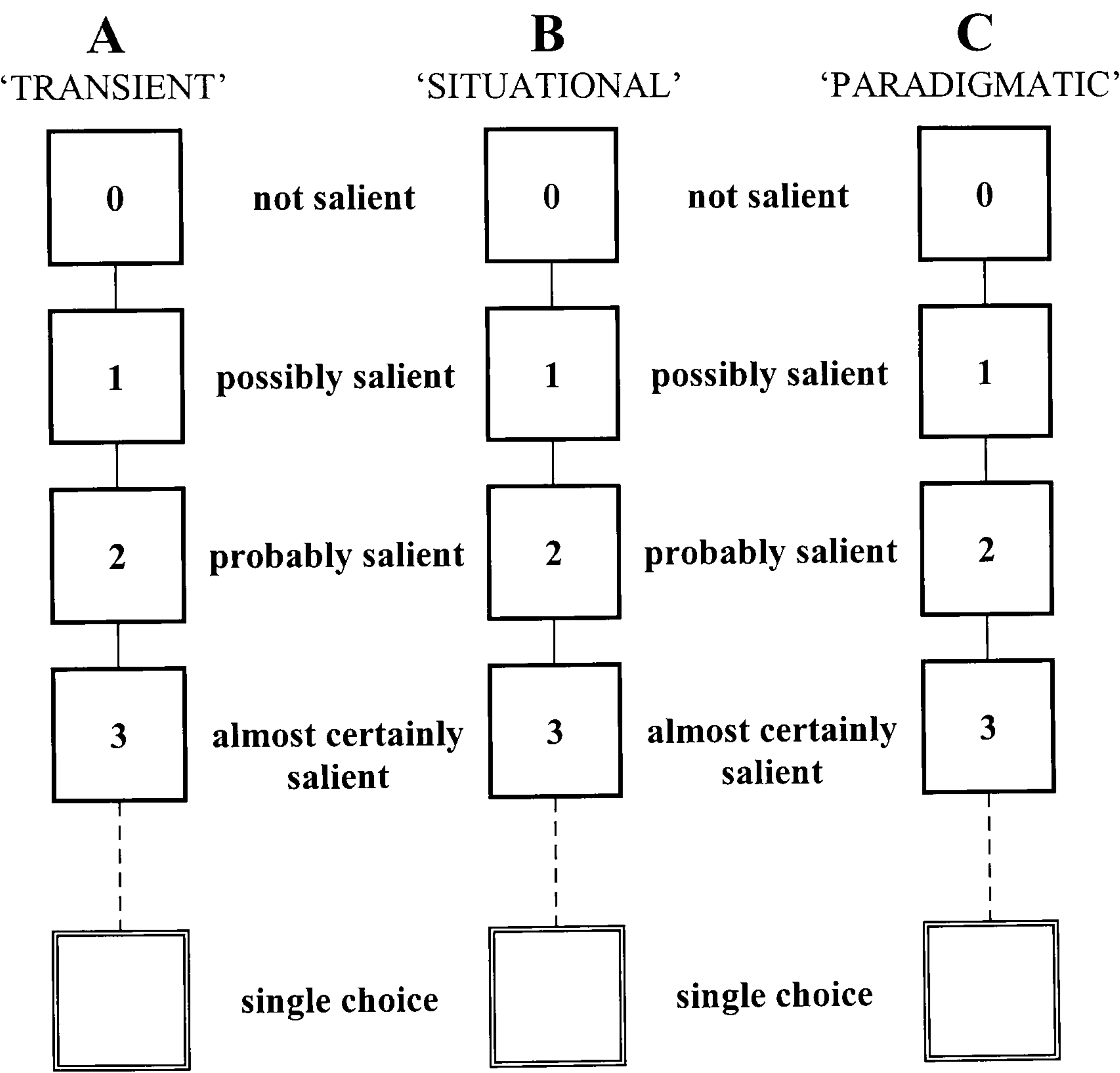


The client who comes to mind is someone I have been working with for about two years. She has been involved with services for the past 16/17 years and is universally described as 'difficult'. Setting and sticking to appropriate boundaries has always been hard work for both of us. C finds it hard to leave sessions most of the time using a variety of tactics to delay or make difficult my attempts to finish.

The particular time I am thinking about was one evening, I think I was left in the building alone. (This is both a blessing and a curse - C uses the presence of other people as a reason to freeze or hide in my room. On the other hand being alone leaves me feeling somewhat vulnerable.) After a particularly difficult session where C was dissociated virtually the whole time, our session time was over. C at first refused (not verbally but wouldn't move from the chair). She then managed to stand but looked like she was frozen, and said she couldn't move physically. This went on for quite some time. Eventually in desperation I said if she really couldn't leave, I would need to call for assistance. (I think we both fully understood the nature of my threat.) C was then able to leave, although using a whole array of delaying tactics. I left her sitting in her car saying she felt dizzy and didn't know how to get home. I offered reassurance throughout the episode, that I felt she could manage and that despite her reservations she would get home OK etc etc . The following couple of weeks both in and out of session were punctuated by angry/garbled/confused messages saying she did not wish to go into hospital. I felt bad about my 'threat' but not sure what else I could have done. Our struggles continue.



Young Italian woman started kissing me on the cheek when in the hall leaving. I felt worried by this and did not know the best thing to do. I took it to supervision, and decided to bring the issue out into the open. At the next session I raised the matter and we talked about it. It seemed to be resolved.





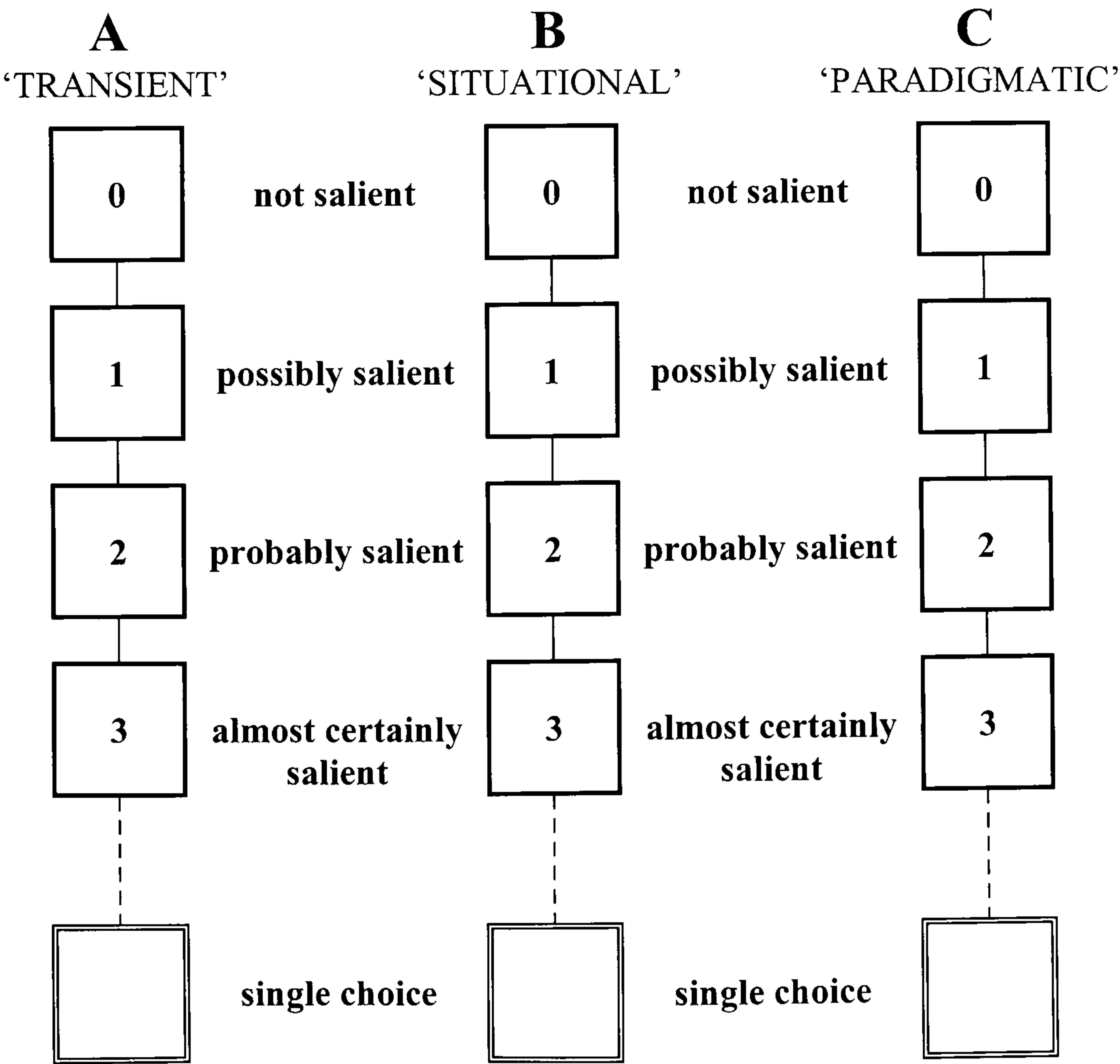
PATIENT WANTS TO FORECLOSE LONG-TERM CONTRACT BECAUSE IT FITS 'LOGICALLY' INTO END OF ACADEMIC STAGE IN HIS LIFE, WANTED TO KEEP HIS OPTIONS OPEN ABOUT APPLYING FOR JOBS.

ENDINGS HAVE SURFACED AT EXPECTED AND UNEXPECTED TIMES, ALWAYS (SO FAR) RESPONSIBILITIES FOR CONTRACT HAVE BEEN PICKED UP BY MYSELF.

FRUSTRATED IN STOP-START NATURE OF ALLIANCE, TO ACT ON THESE FEELINGS MIGHT WELL BE PERCEIVED AS CRITICAL/CONTROLLING BY PATIENT (WITH TRANSFERENTIAL / NON- TRANSFERENTIAL ASPECTS)

- TAKE THIS TO SUPERVISION, PUT RESPONSIBILITY BACK IN THERAPEUTIC FRAME, TRY TO MAKE SENSE OF MY PARENTAL FEELINGS, TALK IT OVER.

- SITUATION LARGELY UNRESOLVED. HE STILL ATTENDS BUT COULD LEAVE AT ANY MOMENT. WARY OF HIS MANIPULATIONS.



I was seeing John for individual therapy. A colleague was seeing his wife, and had been seeing her for considerably longer than I'd been seeing John - (which was about eight to ten sessions). I saw him privately, at home. John's wife (Ann) wanted to meet me and John felt it would be helpful for her to do so, to relieve her fantasies and anxieties. My colleague (Barbara) also felt that if it was something Ann and John both wanted, we could go ahead with a session, the four of us together. Barbara and I discussed how we would work. We had both done quite a bit of joint couples work.

The session happened. I don't remember the content or the process as being remarkable. Ann was an emotionally fragile person and I encouraged her to "check me out". We had the hour, and off we all went.

Two days later I received a four page diatribe from John, starting with "I only wish you knew the effect you've had on my wife" and continued to tell me that I lacked all of Rogers' required core conditions. I had failed to offer them a cup of tea, etc etc. He concluded by suggesting that I rethink my suitability for my chosen profession.

I wrote a brief letter saying I was concerned to hear he was so dissatisfied and looked forward to discussing this in our next session. I offered to waive my fee for that session (?!).

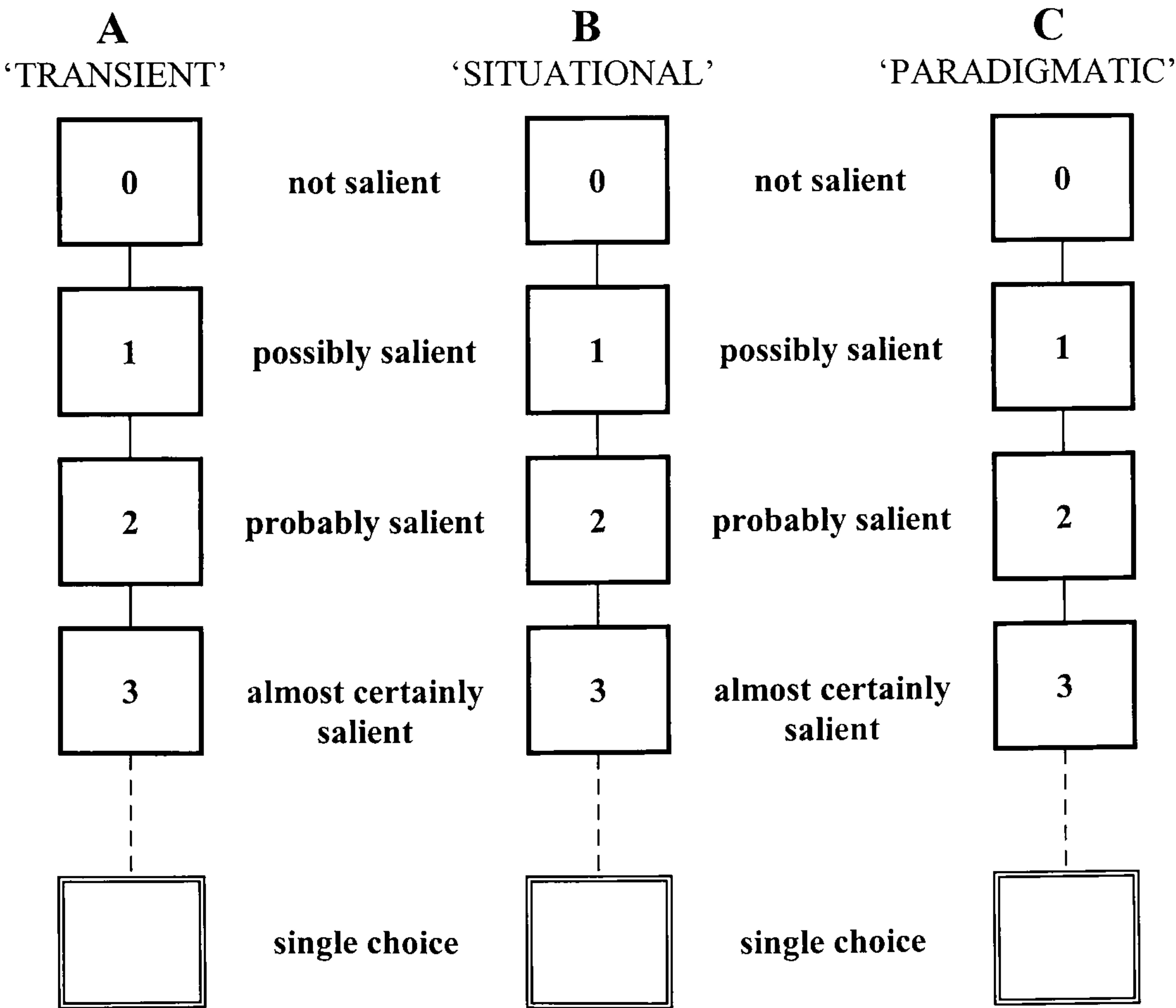
I never heard from him again. I felt deeply shocked. Barbara was rather dismissive of the episode and did not feel that John's (or Ann's) response was rational. My supervisor was extremely supportive and put it in perspective for me in terms of the transference which was going on - but despite all this the letter really got to me and I have kept it to this day as a sort of reminder not to become complacent.

The incident happened 4 years ago.

I think the fact that John was a social worker and able to throw the vocabulary and concepts of counselling at me, was particularly powerful - coupled with my own issues around finding it hard to cope with the disapproval or, rather, violent dislike and rejection, of an older man. John was ten years older than myself though his wife was my age or younger.

Well - endless possibilities for discussion and theorising, but that will do as a summary.

The really damaging thing for me was that he never came back, so we would deal with it. I'm not afraid of clients' anger etc but he just shat and walked away.





The patient arrived in anxious state with six-year-old son and was not happy to leave him in waiting room.

She had not send him to school as he had blisters on his bottom and she felt he'd be uncomfortable sitting down and also anxious what people would think. Not knowing how he'd got them.

I began to feel more anxious and uncomfortable as time went on because I'd rather had drawn this session to a close - but it became obvious she didn't want this - wishing me to also "see to her son".

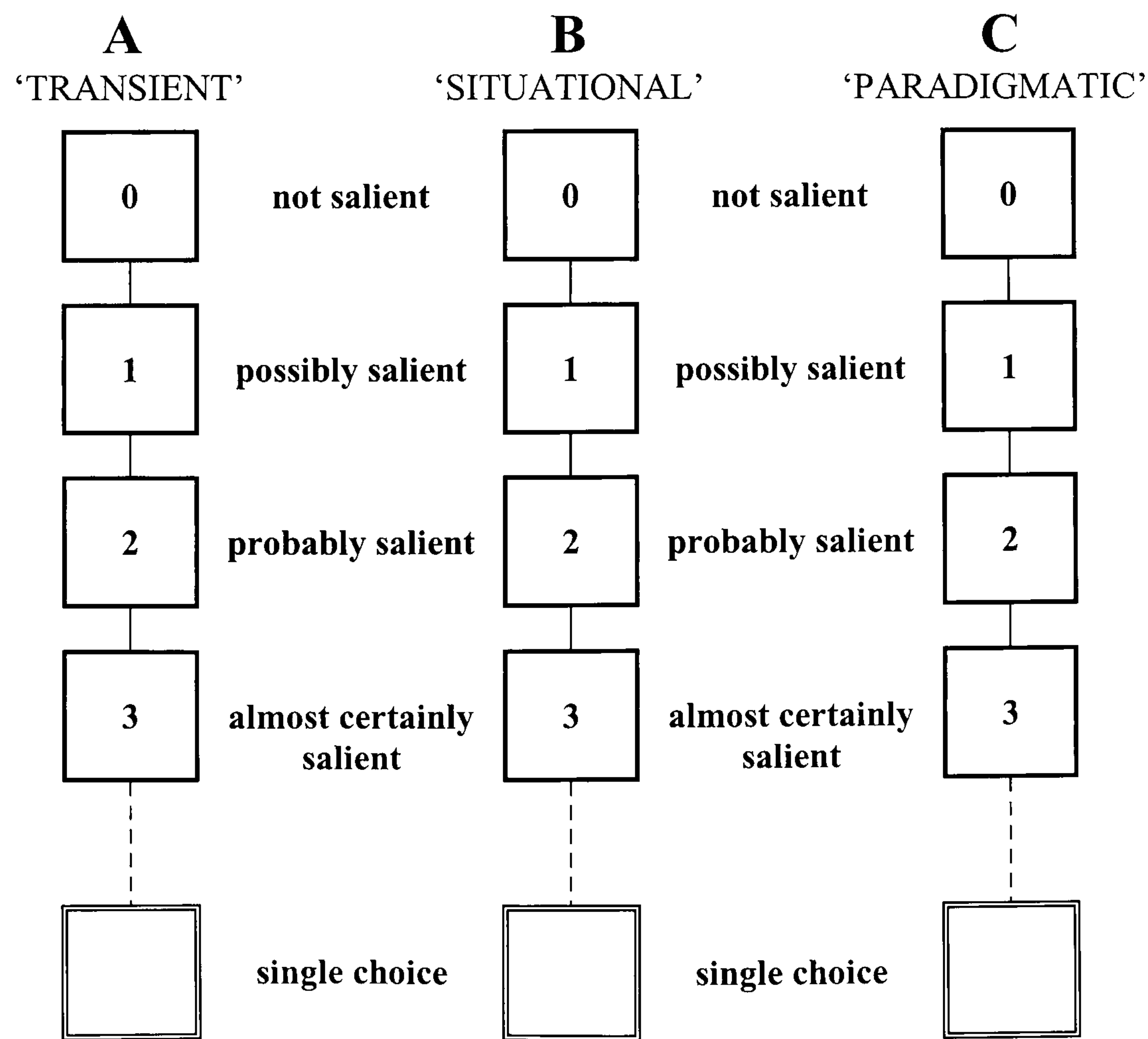
I became anxious for the son and with great difficulty managed to get mother to let him wait and carry on drawing (an activity I gave him) in the waiting room.

I still felt it would have been more appropriate to try and encourage mother to allow herself to stay at home with son and meet me the following week.

There was a tension in the room - she appeared unhappy with outcome of events. I also felt I had handled it all badly - but not knowing what else I could have done.

I kept trying to end session, feeling concern for the mother but also son - he eventually came back to room looking for his mother and we managed to end early but still after a considerable length of time struggling with the situation.

Despite this I was left wondering about whether there were abusive concerns around and if I'd missed this directly, but also took could see acting-out phenomena in terms of the patient's early life experiences, which we were better able to deal with in a later session.

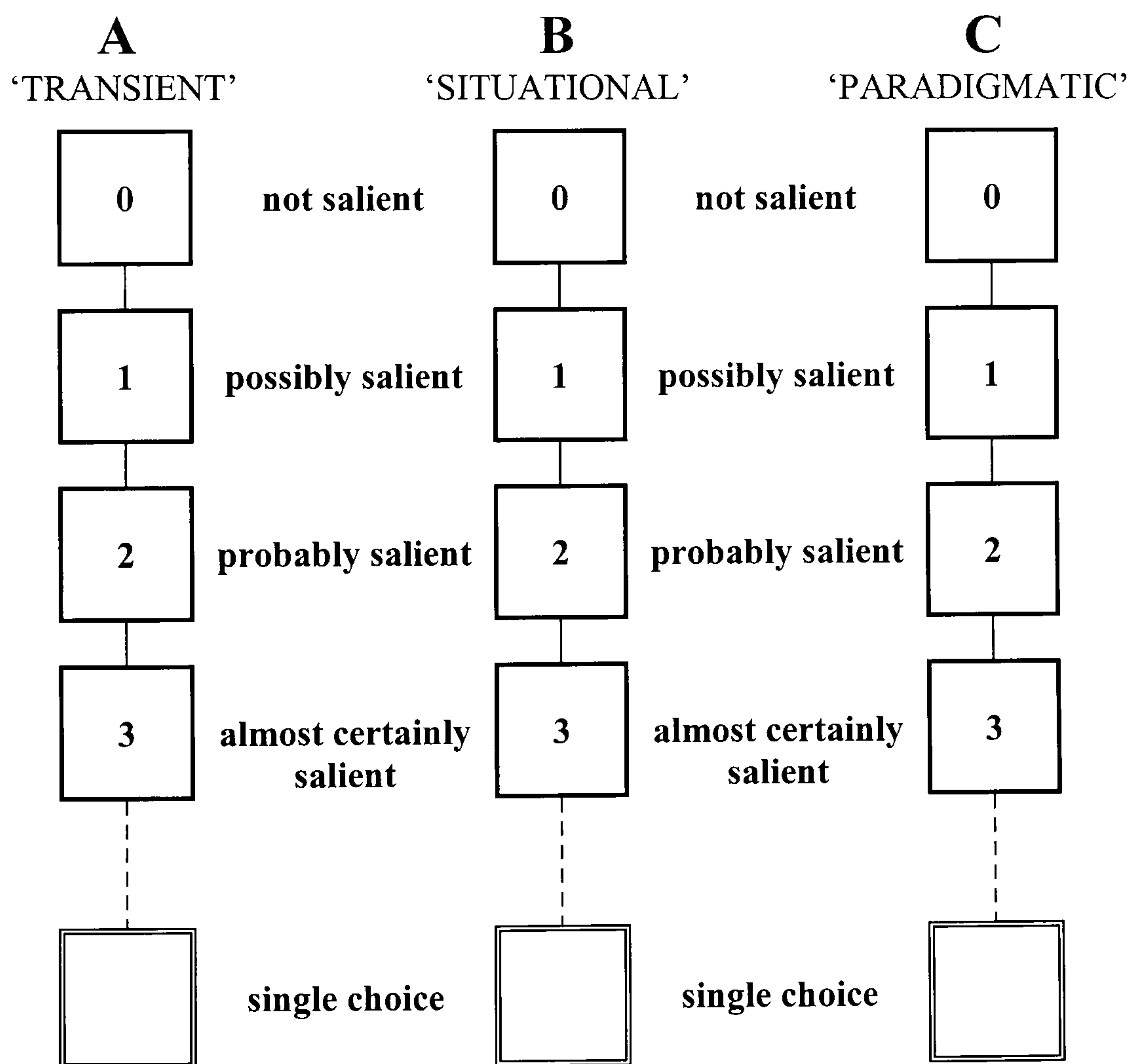




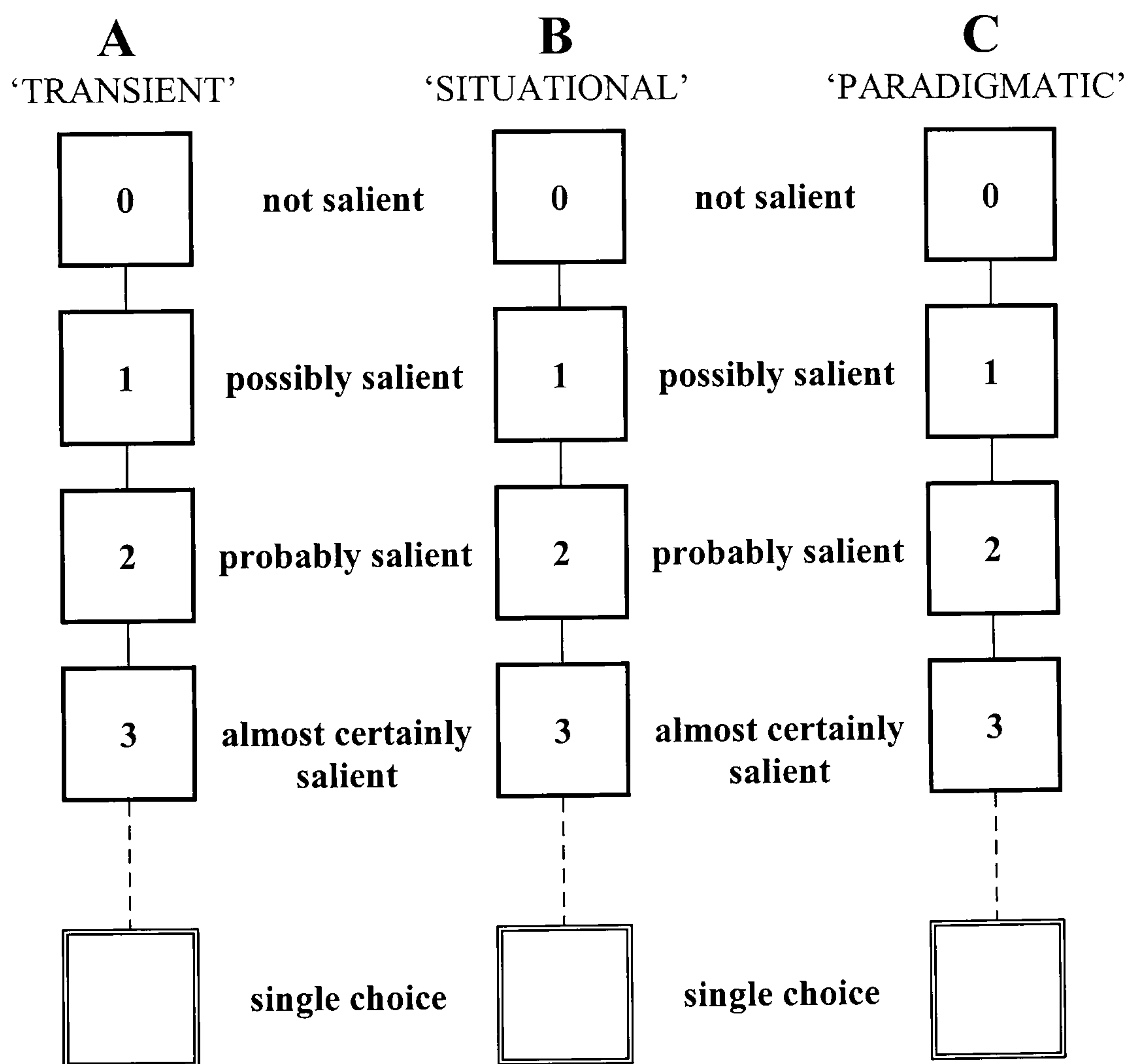


This difficulty involved the ending of contact with a 47-year-old man who had M.E. He had been given up for dead by his family and doctors who had switched off his life support machine. However he had survived and had been placed in a nursing home.

I had been asked to do an assessment of him with regard to his placement. We had worked together on some of the his difficulties in the nursing home (where he was amongst mainly 70 plus-year-olds who were terminally ill). Adjustments had been made and he was saying he was happy there and did not want to move. While I struggled to accept this because I felt that 'better' arrangements could be made elsewhere.

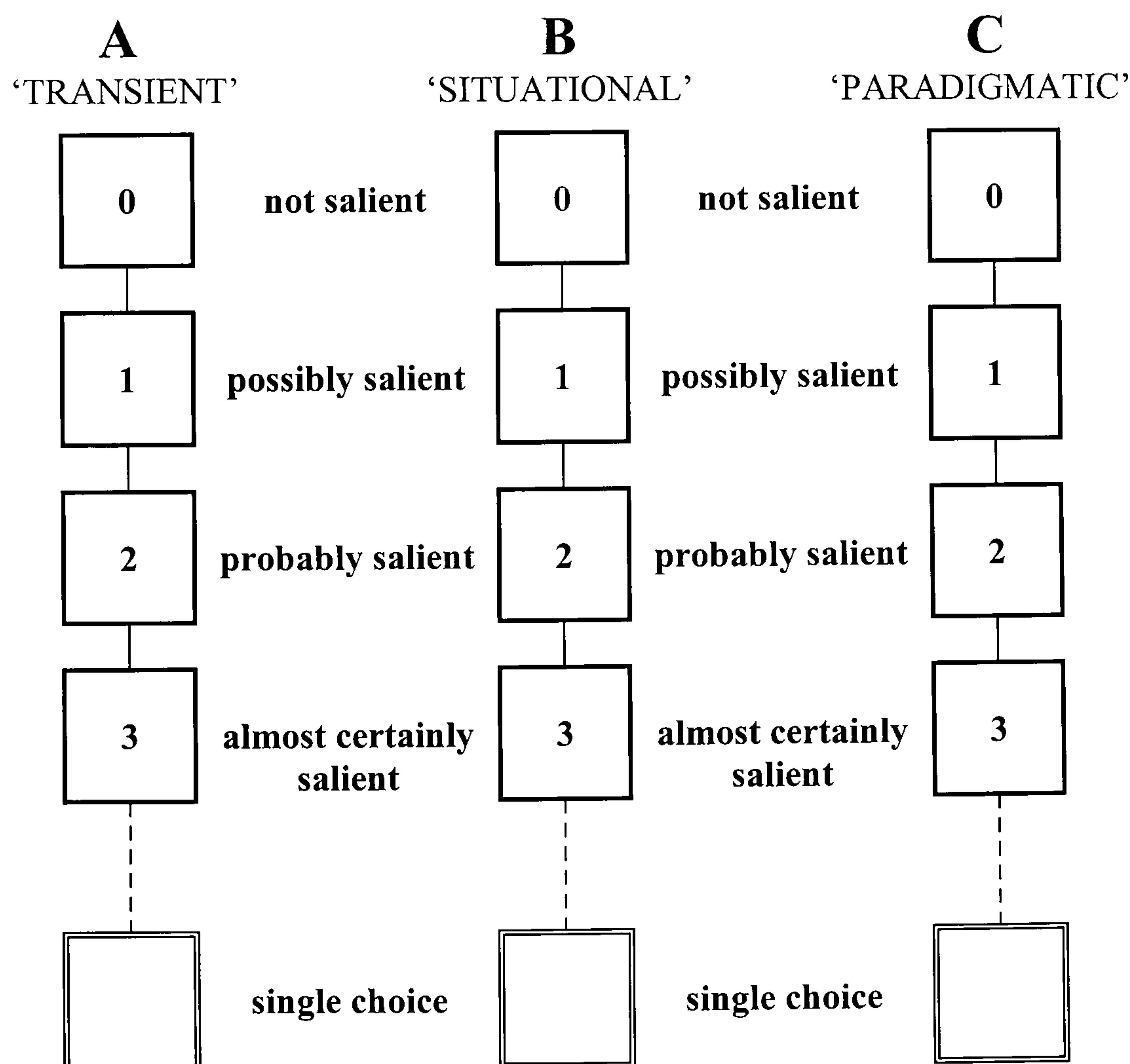


I felt annoyed that he expected the 'impossible' from me.

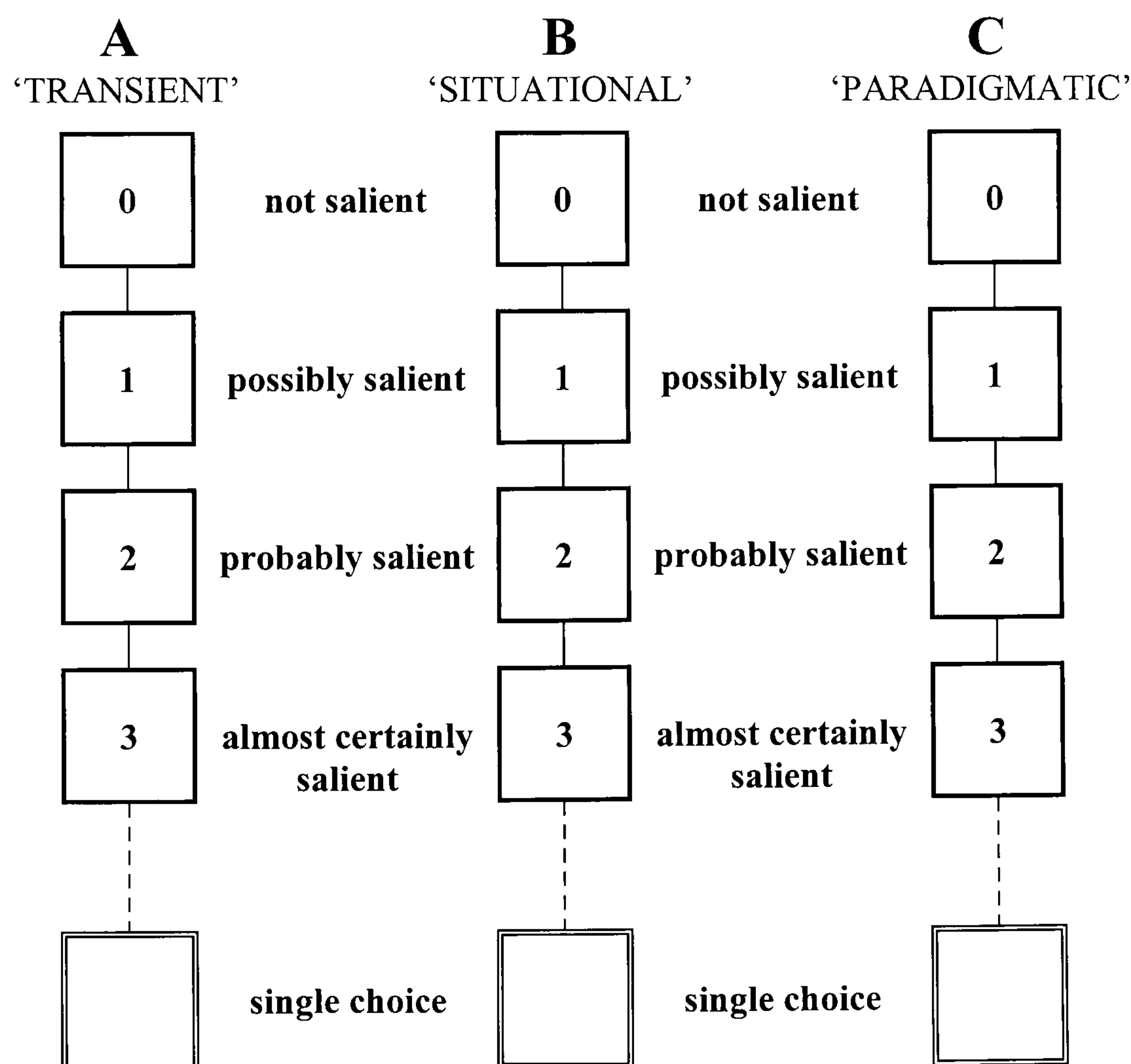




The patient started to tell a story about a neighbour who had been accused of abusing a child. As she recounted the story, it became very difficult to know if she was recounting abuse to herself by this person or abuse to a third person. The current climate of "false memory" intruded on my thinking and made the situation difficult. I experienced increasing horror. The story also raised issues for me and I did not know what I was putting on to the situation. I knew I did not want the client to continue. I attempted to be "super-neutral" about everything - the "perfect therapist"! The client seemed to not notice my discomfort and continued on until the end of the session. After the session I arranged supervision to look at the tape of the session and it was not apparent to my supervisor that she had been disclosing abuse.

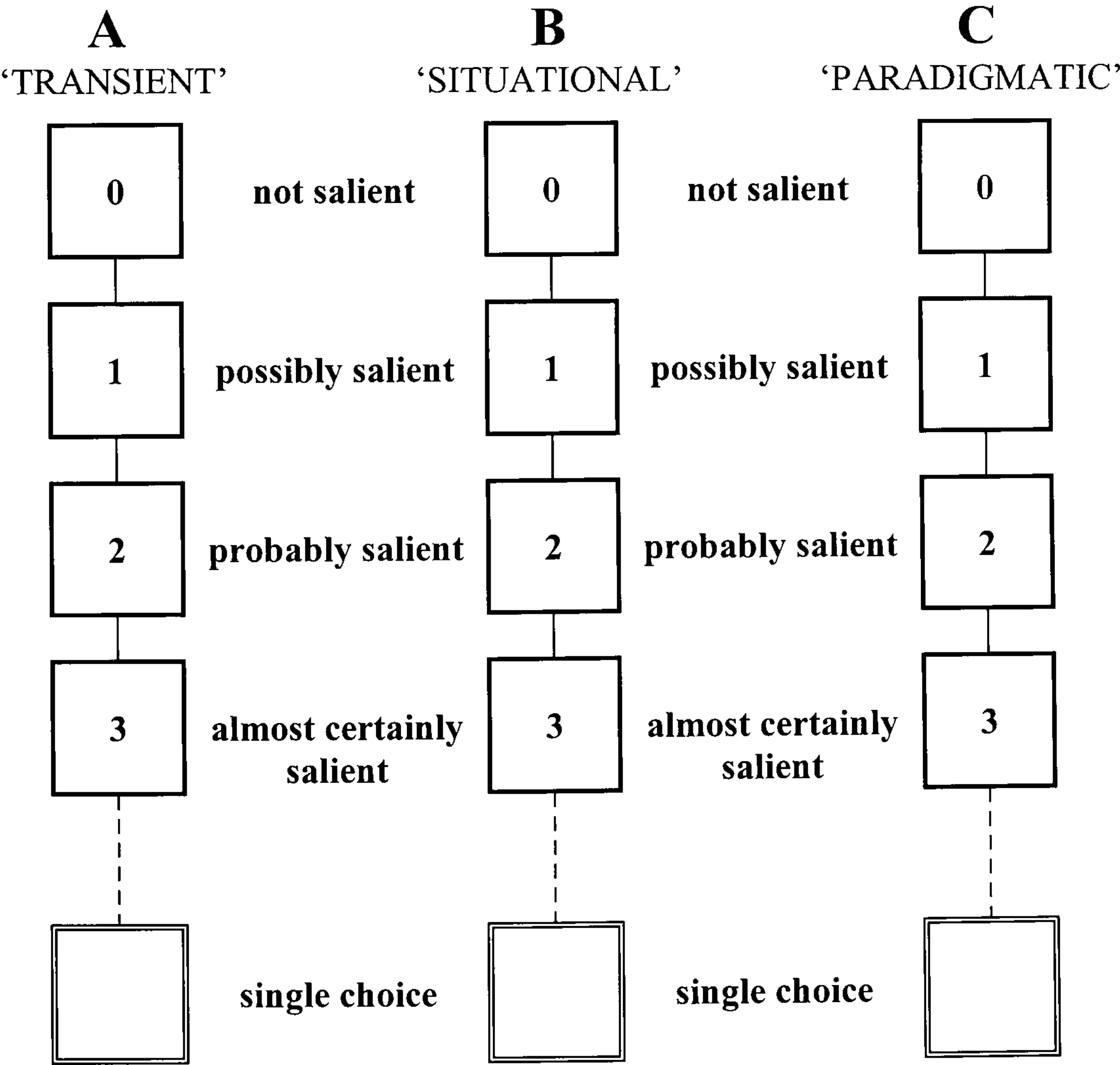


I was trying to terminate / negotiate an agreed termination date with a patient who was in open-ended therapy and not progressing. He was a prominent criminal lawyer and subtly and covertly threatened me with litigation if I persisted. I backed off, and our relationship continued as if nothing had happened. I had tried to address the 'no change' situation before, unsuccessfully. Consultation with colleagues: no difference as result. He eventually found a cognitive therapist and left - not without me having to "discharge" him as he kept the options open for coming back. Last communication: abusive comments on the returned discharge letter which I had copied to him.



Some years ago a man whom I was seeing in private practice began to fall asleep half way through, or getting near to the end of, the session. (NB: this patient had as part of his presenting symptoms sudden attacks of paralysis and collapse of unexplained origin, no medical course had been found. Hence my initial alarm.)

I would have to wake him up at the time to end. (He had earlier expressed a wish to leave before the session time ended.) I was a bit scared, taken aback, non-plussed at first, but became able to let him sleep on, as I concerned myself with thinking what this might mean and let go of my fear that he was paralysed. I was only newly trained, and this was the first time such an experience had occurred. On subsequent occasions I felt more comfortable when it happened, or rather less uncomfortable, - the first time I'd had thoughts of how I might be able (or not) to help him leave. I began to understand it as part of a very deep resistance, or block to continuing with the work and a deeper level; and in fact in spite of my efforts to interpret or enable the patient to contain his fears underlying the resistance, he soon decided to end therapy.





At the student counselling service at the University I was referred a young woman, a 20 year medical student who had had a fairly long term relationship with a football professional. He ended it. It appeared that she subsequently became depressed. At the same time she was doing her psychiatric placement and she felt it was important to 'deny' her depression from her tutors and 'demanded' absolute confidentiality of me - which I gave.

However weekly she got more and more depressed. I was fairly open minded about drugs treatment and had always worked in an interdisciplinary fashion, but she was very anti- drug.

Also it became apparent after several sessions on the loss to her of his family, that she was actually using the loss of him to cover the incipient eruption of many other difficulties, so the original formulation of an reactive depression was clearly not right.

The medics in the centre were happy to follow my suggestion that drugs should be used since suicidal gestures were becoming obvious despite the fact that she still hadn't missed a day at work

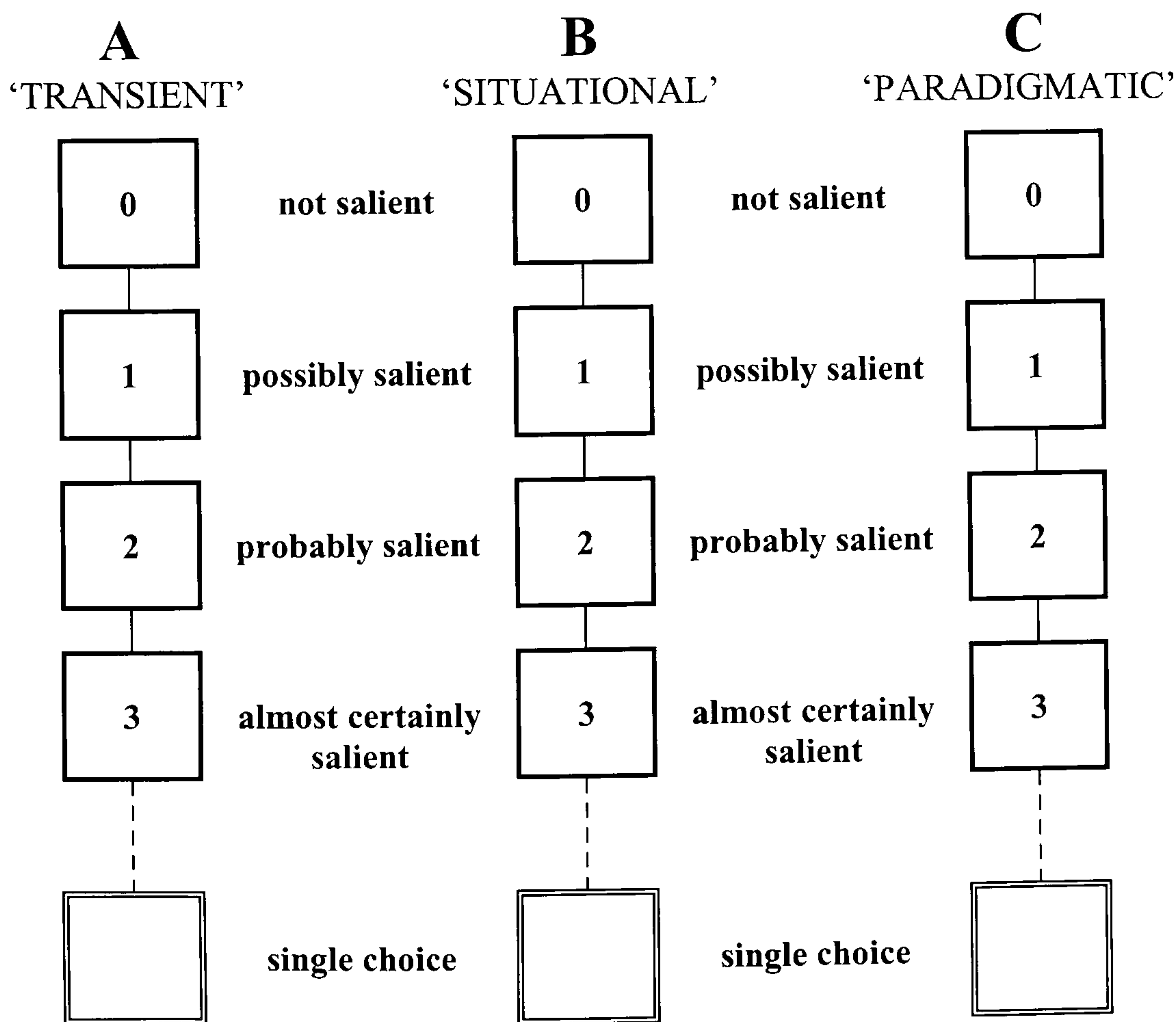
However the major upsetting factors were

- a) the personality of the client
- b) her depression and
- c) the punitive nature of the small psychodynamic supervision group who became very critical and deskilling of me - unable to see that the counselling centre and the supervision group had become the mirror image of the case itself, ie they personalised what was an intergroup issue.

How did it end?

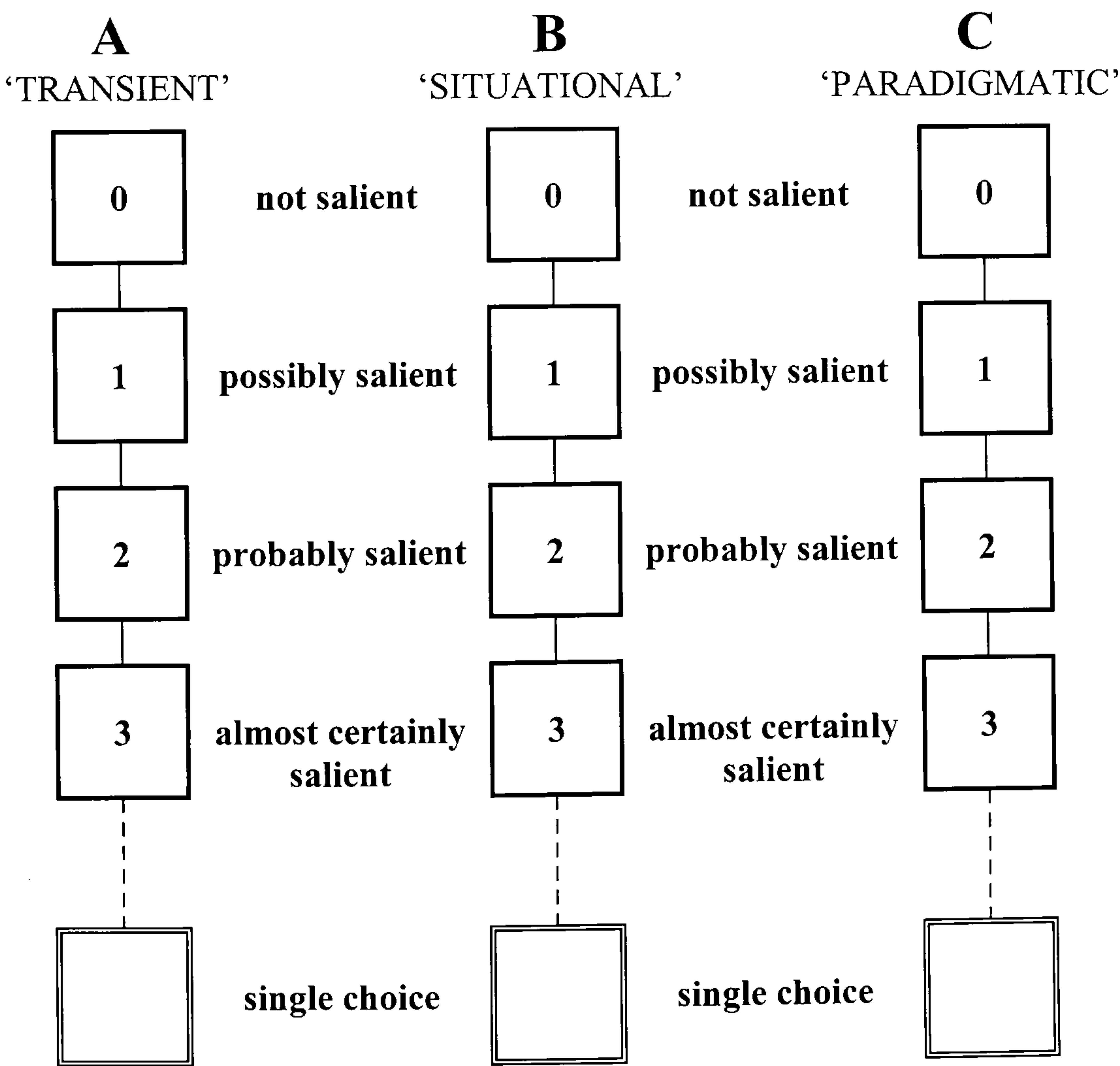
I skipped supervision, got a GP to prescribe after a parasuicide attempt and she was better in three weeks and went on to be a successful doctor

I emerged sadder but wiser, but I should remember that despite the incident the therapeutic relationship did not fail!



I had seen this patient for six months at the point the difficulty arose. He was homosexual and had been promiscuous until recently; I was generally aware of an eroticised attachment having formed towards me. Following a short break he returned to sessions upset about a disagreement with a partner and asked me for a reassuring hug there and then. I said that was not something I do but he could think about what it meant if I had and also because I had not. He became more tearful, saying he had not asked much of me. He had thought I was quite caring and interested in him until that point, but "I no longer understood his needs".

I acknowledged he was feeling rejected and wondered about the relationship he was in which he had said had had a disagreement. Initially, he did not see the point, but did reveal their argument had been about a similar theme of who cares for whom. He remained certain though that I could have hugged him to compensate for his partner's lack of compassion. He returned to this for two further sessions, the pressure on me to be 'good' towards him and repair my rejection. I tentatively began to interpret what had happened as belonging to an earlier disappointment, which did lead us to a more thoughtful exploration, including where a 'hug' could have led to in his fantasies.





I have actually told this patient he is difficult and I consider him to be my most difficult patient currently because of the difficulties I am about to describe.

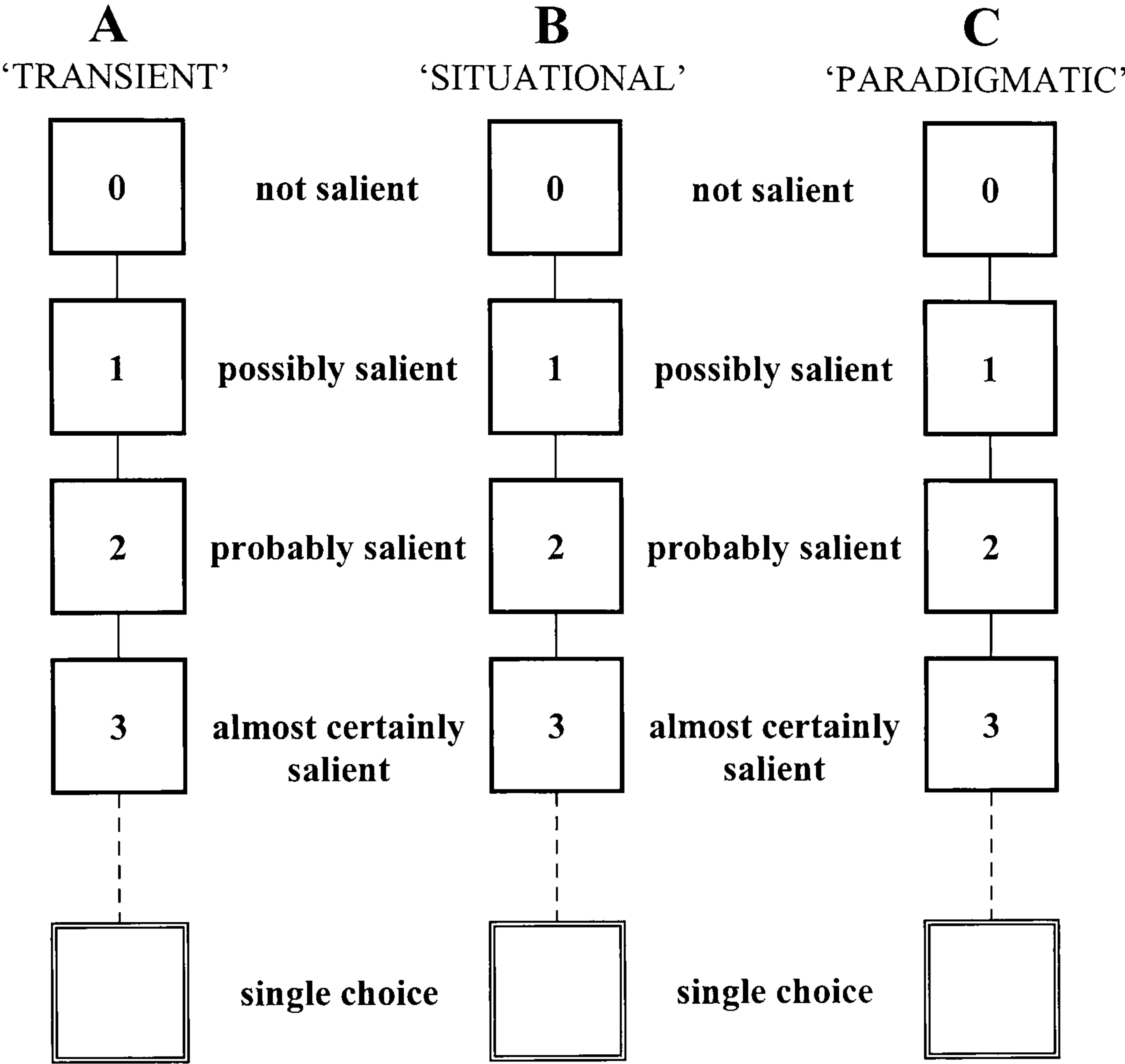
He is a 47 year old male, quite wealthy, an MD of a manufacturing firm (packaging?) and with a penchant for Ferrari cars. He is unmarried, but he longs to be in a secure and loving relationship with a female. He has 'girlfriends' - other men's wives, and 'bimbos', but he cannot properly commit himself and is tortured by jealousy. He was referred by his GP for depression, anxiety and panic attacks. Described himself (in December 1995) as unhappy. Says now he remains 'unfulfilled and threatened' and a theme for him is that he is a fraud / a pretender and the world, one day, will find him out. He is quite self-absorbed and narcissistic, although that doesn't mean he isn't caring of others. His care, however, is designed to elicit what he wants/needs. He wants me 'to tell him what to do' and he wants to stay with me (as a patient) 'forever'. The prospect of ending, however distant, leads to panic and anger.

There are a number of persistent difficulties which are interlinked. I have had an urge to be particularly real and genuine with him. I can see that this is somehow linked with him feeling a fraud and also because he had parents who pretended and fabricated lifestyles. But it has led me into saying more than I would ordinarily say about myself (in response to his questions). I have also found myself saying what I have been thinking in a somewhat extreme way. For example on one occasion I commented that he would be deemed 'a narcissistic shit' (this was in relation to his behaviour with / use of women). However this was said with some humour and was in tune with his wish to regale me with tales of his exploits (to engage/amuse me?). Linked to this is the 'games playing' (with me) which takes place. He is very sharp and by now knows the 'rules' of therapy and what is required of a client, even what material is most acceptable. He also knows my responses ('am I so predictable?' I said on one occasion) and he could almost conduct his own therapy by saying something and then by mimicking my response. Sometimes it is like playing chess except he is better at the moves. We then toy with whether what he is saying e.g. about himself or his experiences or his memories about childhood, or even his dreams are said to please me (in order to stay in therapy with me) or whether he really thinks and feels as he says he does. It was in one of these interchanges that he asked me what I was thinking and I said (probably unwisely, but honestly) 'that he was difficult, too sharp, knew all the moves'.

My feelings are a cross between excitement at the challenge, hopelessness about my inadequacy to be an effective therapist and shame that I am making so many fundamental 'technical' errors which would cause my colleagues to look askance. (As I write this I realise 'being found out' is his fear also). He gets into me in such a way that after the session just described or the following one which included some attempt to disentangle our interchange, I slept intermittently having thoughts like 'am I being fraudulently genuine or am I genuinely fraudulent?'

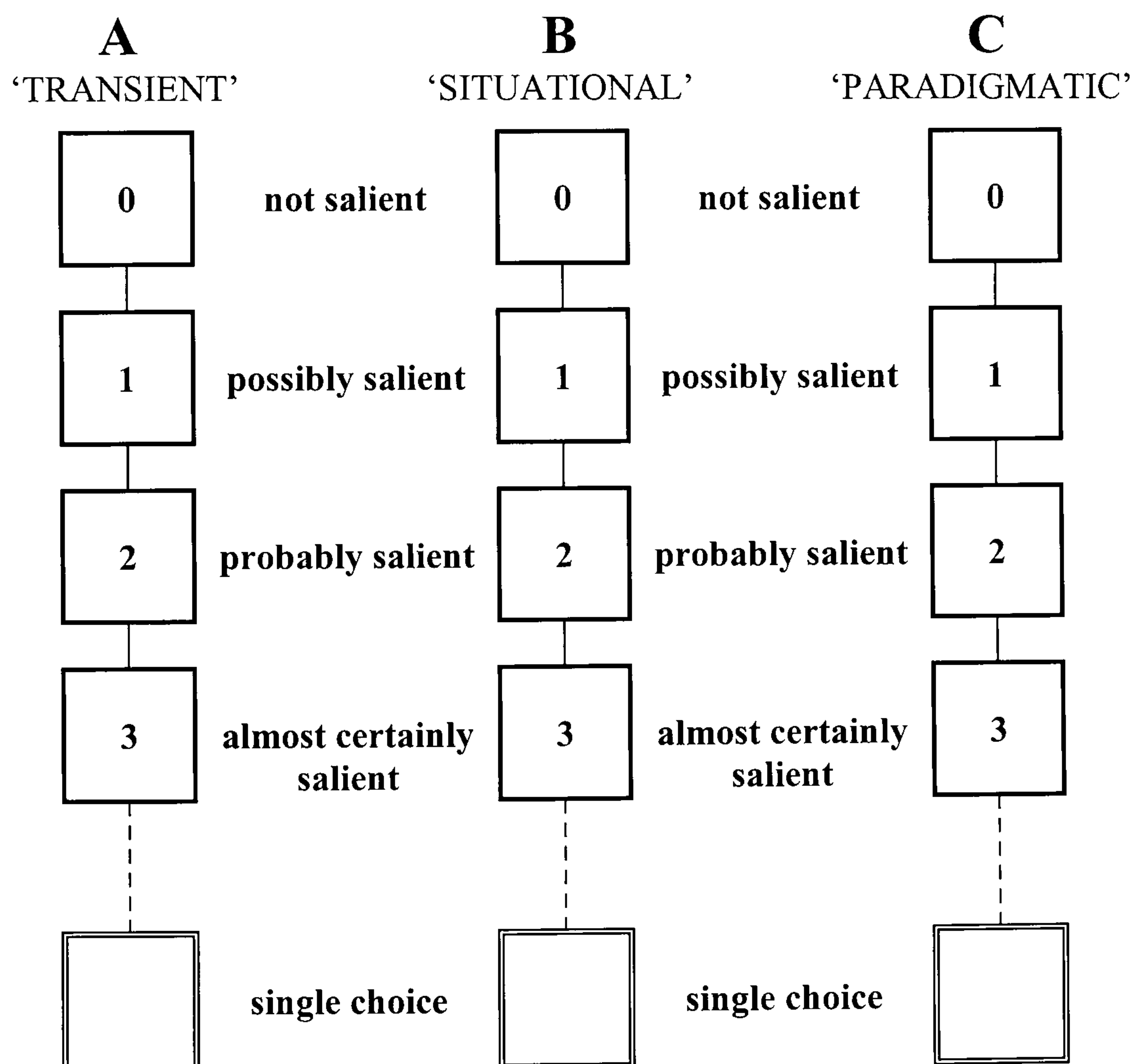
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A female client of 37, presenting with questions about relationships with men in her life. We worked together for several months, with her making more sense of her life, but she became confused and depressed, and unable to go on. We talked together about the changes in her. She had a difficult and demanding job as a teacher with inspectors looming and had run out of energy. My response, from initial surprise and expectation of some delusive responses here, moved to acceptance, of her reality. I 'swapped' theoretical positions from psychodynamic to a mere existential position. As a result, I was able to maintain my non-judgmental stance, she felt heard and valued.

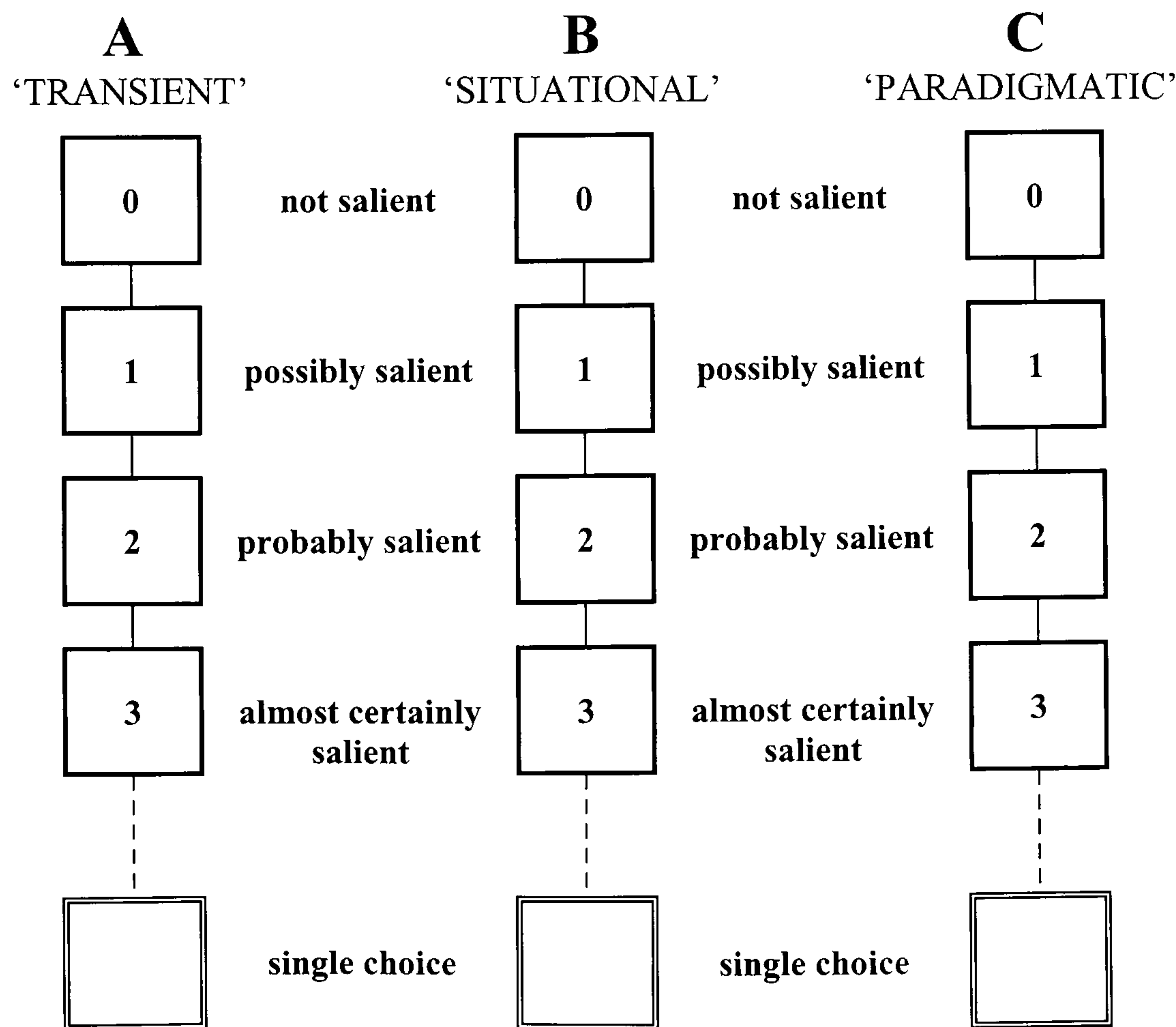
The outcome was a break from our work together of two months, with a reviewing appointment arranged, at which time she re-entered therapy with renewed energy and again made considerable progress in her understanding of herself.



This is a female patient whom I was treating with a 24 session CAT. Psychiatric out-patient, referred for depression, difficulties in mothering, overdose, low self- esteem. Treatment appeared to progress reasonably well until the issue of termination was raised. (CAT involves a time limited contract.) At this point, the patient began to deteriorate - became more depressed, covertly angry. Also began to cut off from me. I attempted to address this withdrawal by more work in the transference, and working with the diagrammatic reformulations of her difficulties I had offered her, but to no avail. I felt increasingly angry and frustrated with her. Her behaviour seemed to me to be a way of "snagging" or sabotaging the termination - as if she thought I would not "abandon" her if she were not better. When I would express such an idea, she would respond with "don't know", and I felt I could not get her to acknowledge the "cutting off". It felt like a battle. There was some improvement in this pattern during some follow-up sessions, but the patient refused to attend her final follow-up sessions. She expressed to another staff member had anger at me, that I had not been a "friend" to her, even though the issue of the distinction between a friend and a professional helper had been discussed several times during the course of the therapy.

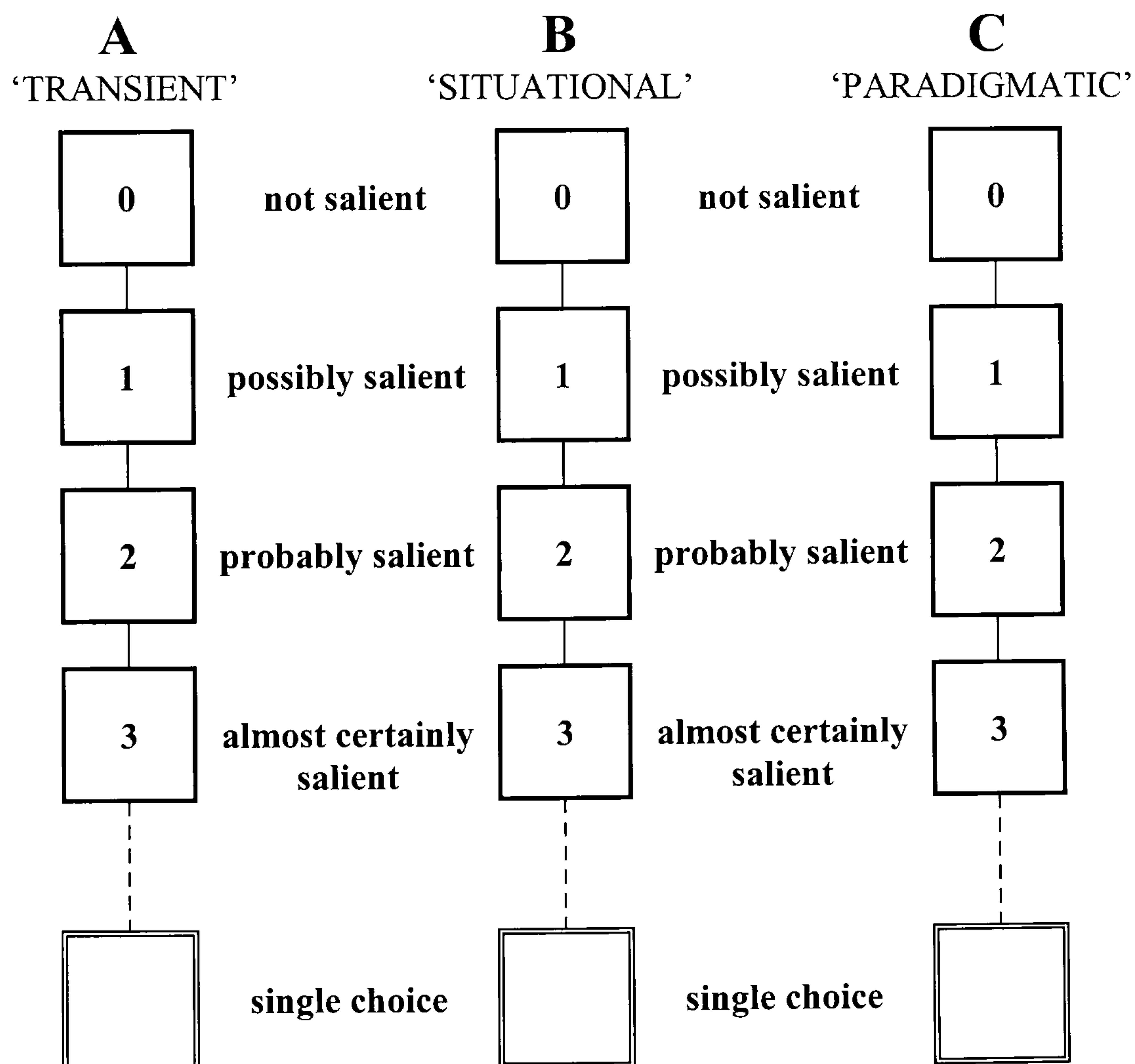
Eventually she responded to a request to return for the final follow-up. She is currently considering whether or not to have further treatment with me - feelings much the same.

I think I did not help the situation by having been pulled into initially into too much of an "ideal care" mode - treating her with kid gloves and not addressing adequately her anger and "spoiling" (very envious).





- patient was contemptuous of my interpretations.
- competition
- self-analysis
- moderately successful. Patient came into contact with difficulty but did not change. Termination (due to lengthy therapy) brought therapy to an end -

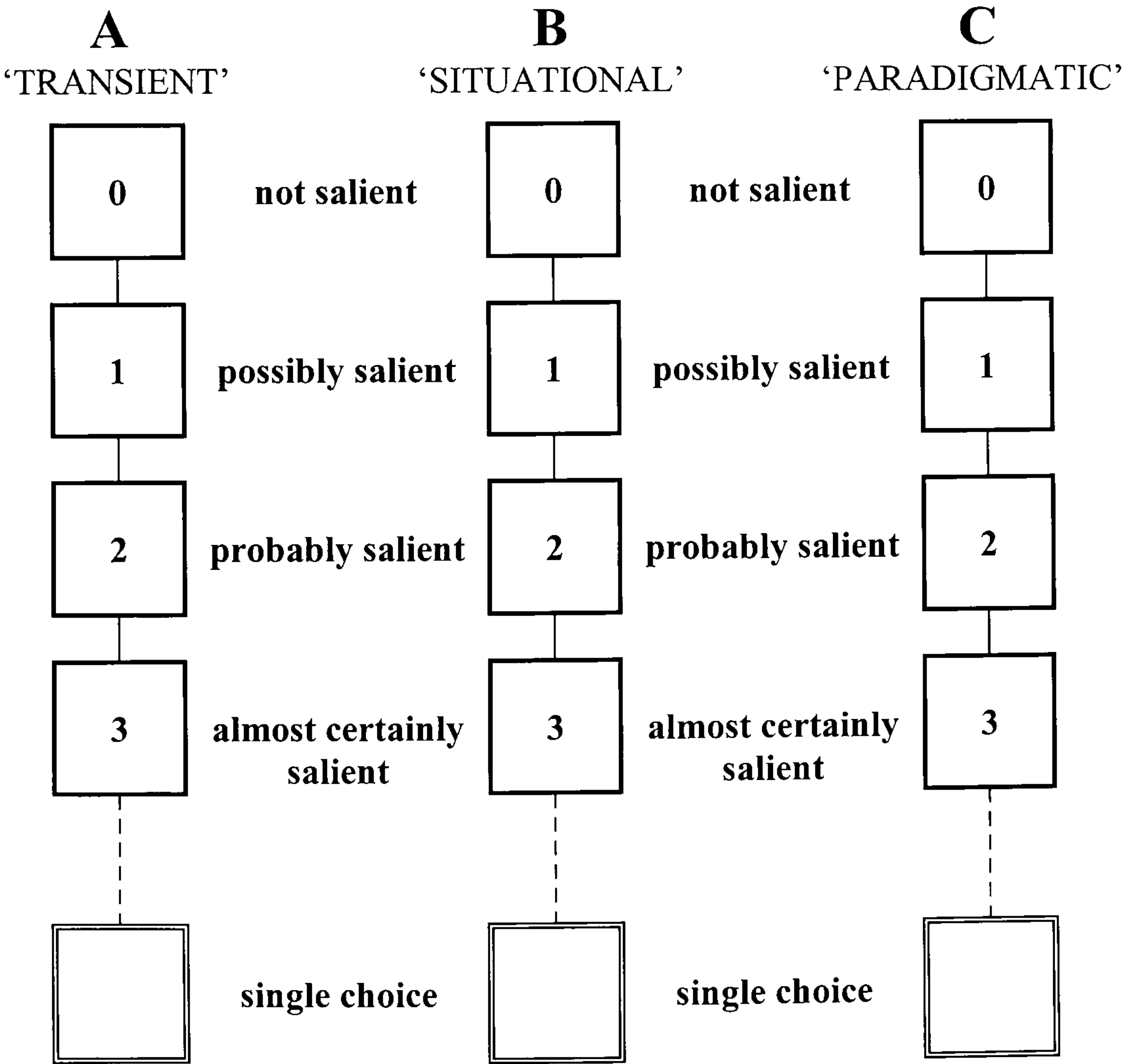


**FEMALE PSYCHIATRIST, PSYCHOTHERAPIST, PSYCHOANALYST  
PSYCHODYNAMIC ORIENTATION**

The patient came and brought two dreams. One involved the patient and another patient of mine, who she has recently realised is my patient, coming to my home for dinner. I give them fish and chips and the patient tipped her plate on the floor. She desperately tried to pick up the food so that I would not be angry.

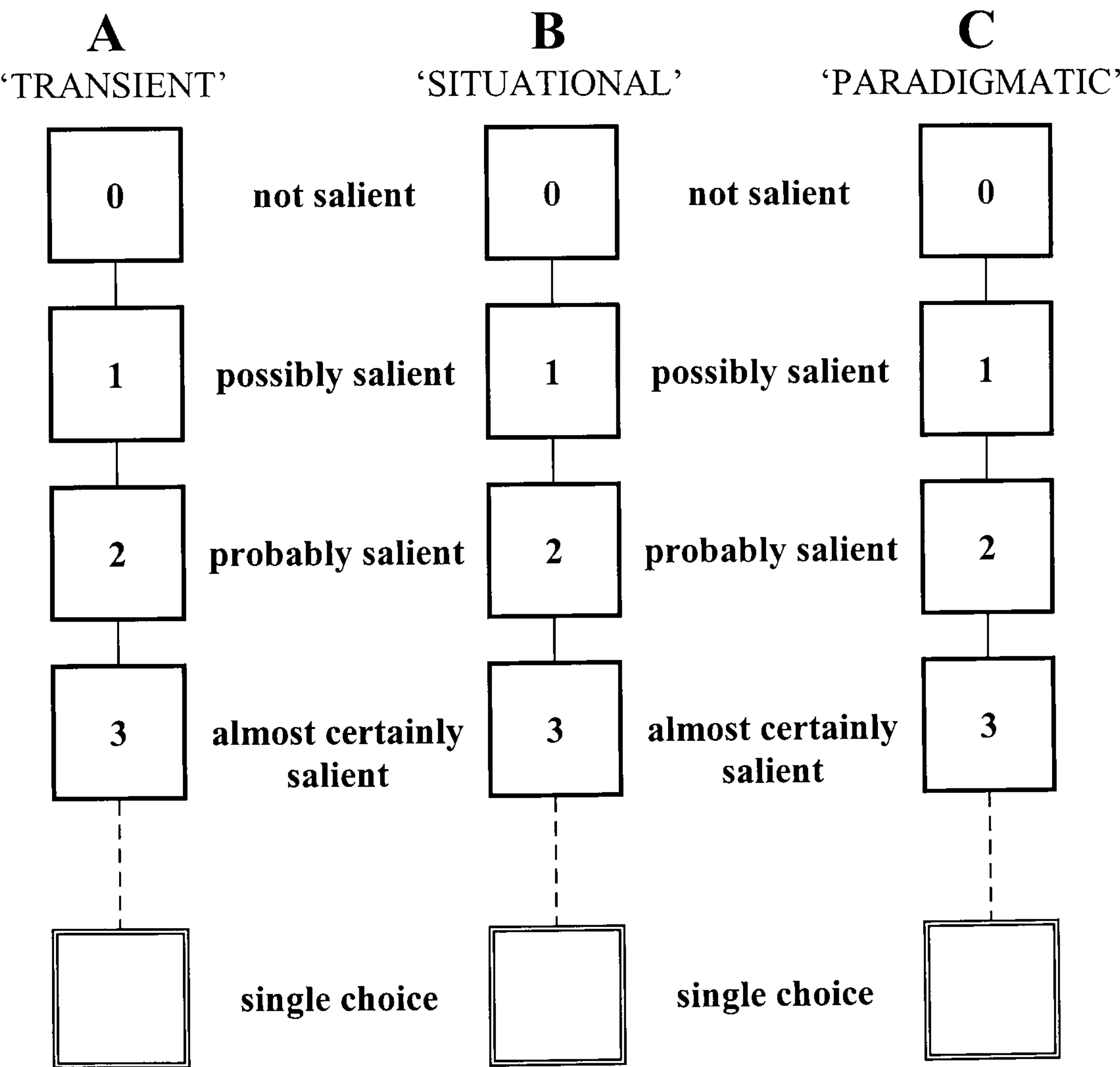
The second involved the patient attending a conference when I was also present. I had a camera and was taking photos of the audience. I took one of the person next to my patient and then of her. I wanted to see if the photos had come out and put the camera into the TV and the photos appeared like pages in a book. The patient appeared with my Chinese son (I have a white and English son) and they move to Cornwall. It is the first week back after the Easter break and my patient has worked out that I am from the West Country (Devon in fact).

My patient began to cry and the room was very sad. She talked about her mother, other people's mothers and I talked about her wish to be involved in my life, part of my family, not my patient. This was very distressing as my patient has a horrendous childhood, abuse + + involving mother. She became quite angry with me for keeping a professional relationship, why couldn't we be 'friends'. She works with an {?} friend. I felt very cruel, hard and depriving as she wept. I talked about the pain and sadness and that I would be thinking about her over the weekend. She stopped crying but was forlorn and vulnerable.



Patient was referred by her manager and was not really committed to therapy. Came because she had to. Husband had left her and she overdosed. Work colleagues were very protective of her. She was angry, bitter - played the victim and relied on others to help her out without learning to do it herself. Lacked insight. I felt frustrated. I tried to show her a different point of view and that she was allowing herself to be victimised. She was passive-aggressive.

She DNAd. I wrote and gave her another appointment but she did not attend.

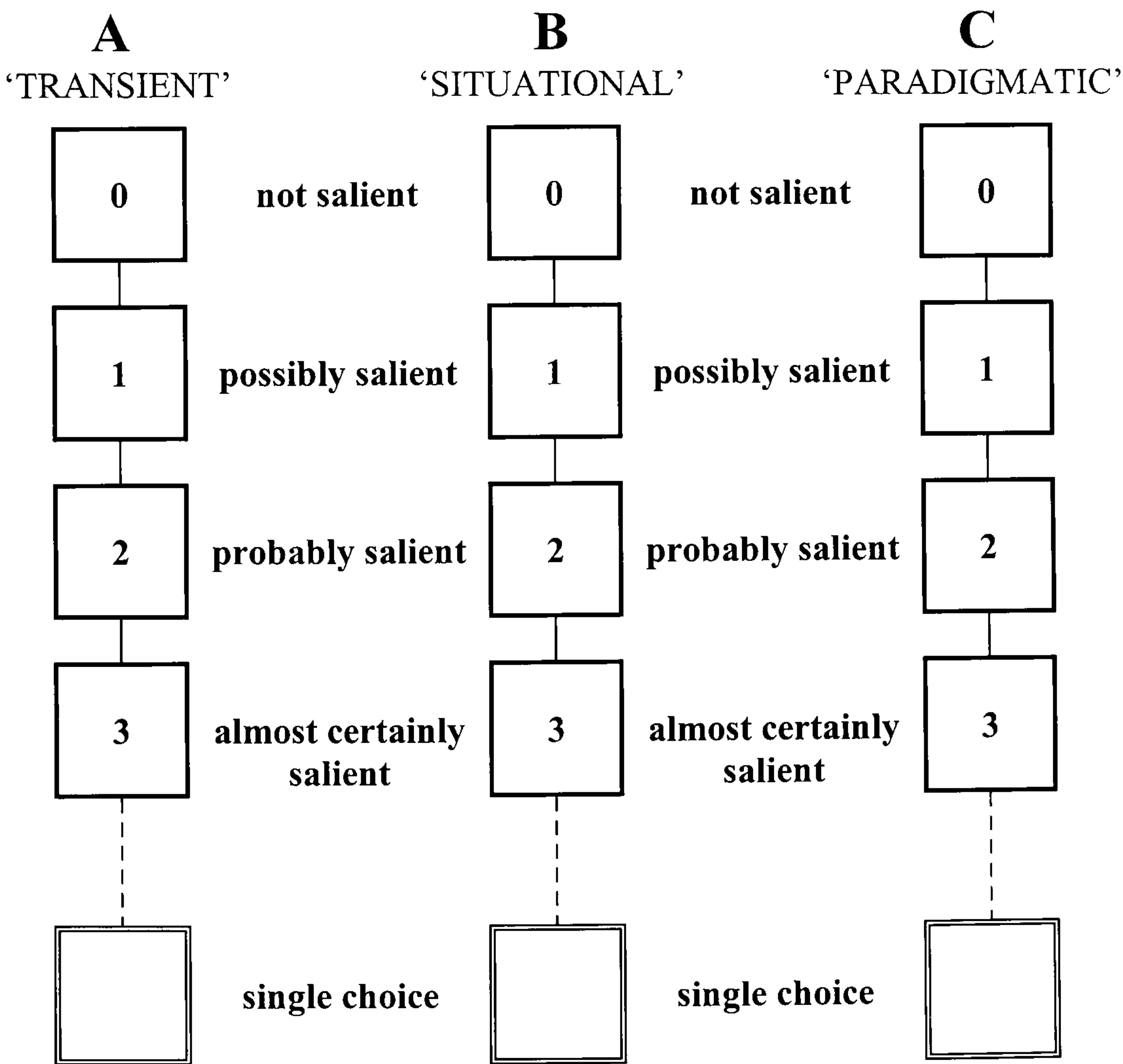




Being told by the individual that they were having a sexual (consenting) relationship with a member of staff - knowing in confidence about an unprofessional relationship and having to decide what action I should / or should not take about it.

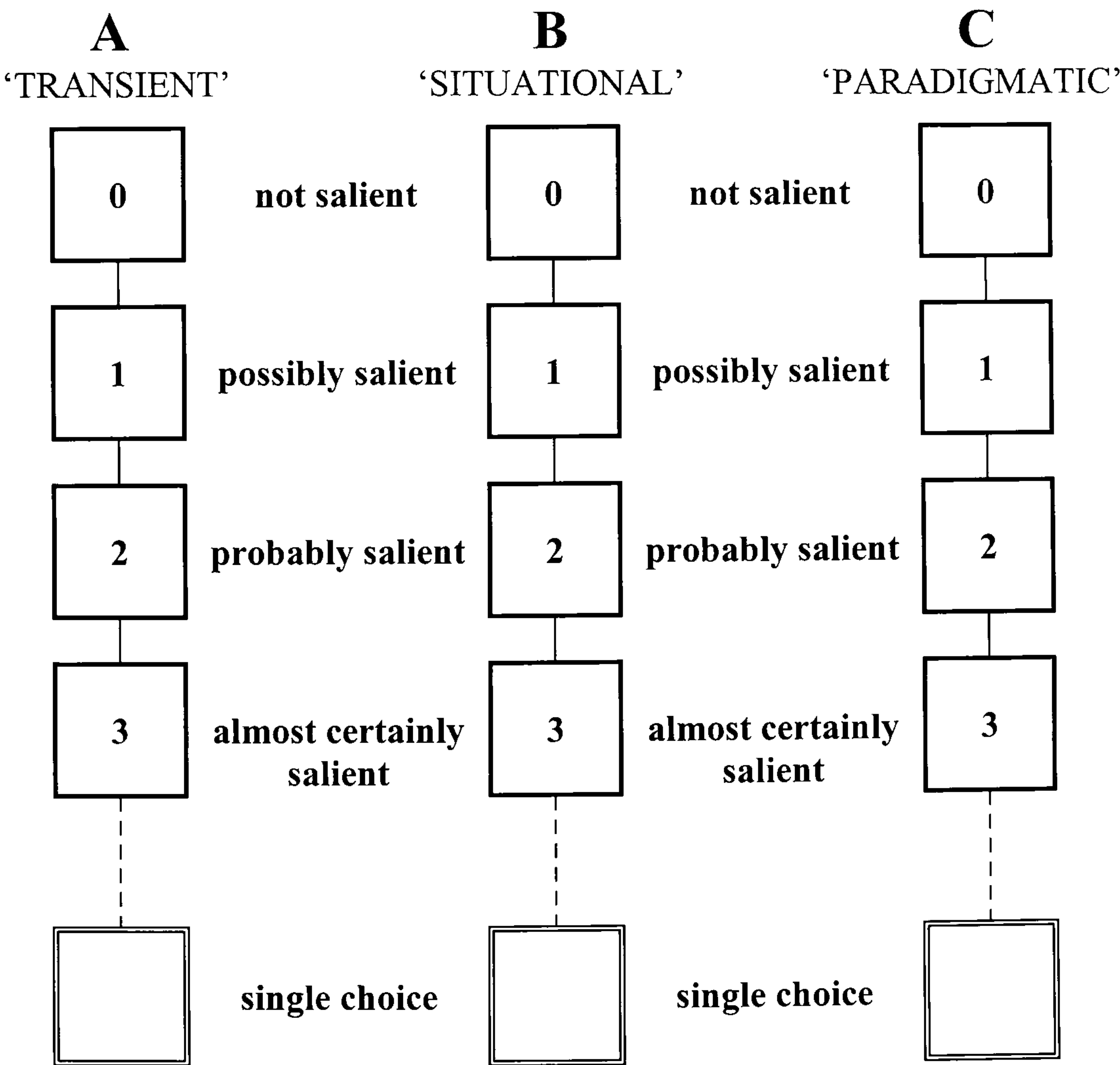
I felt anger towards the member of staff and concern for my patient, although later I also felt sympathy for the member of staff, although he should have known better. I felt anger for being put in an impossible situation, either colluding with an inappropriate situation or betraying confidence.

Discussed the situation with supervisor and other psychotherapy colleagues - decided I could withdraw the offer of therapy if the relationship continued; accept it but register grave concern, or work within the therapy to end the relationship. Eventually chose the latter with some unease. Subsequently it emerged the member of staff was having other inappropriate relationships with patients and at that juncture I had to act to prevent further harm to other individuals. I still cannot decide whether I was very negligent in the first instance and might have prevented what followed by taking more action.



The patient who immediately sprang to mind is Barbara, a 45 year old depressed mother of two adolescent daughters. She was a very rewarding patient to treat in many ways but would insist on bringing me presents to work, anything eg Easter, Christmas, when I had been of ill - times when she might have been expected to be angry with me. Despite regular interpretations, this behaviour continued and I began to find that I had made a serious error in accepting the first present - a home picked bunch of flowers. She, very charmingly, discounted all my efforts at exploration of this problem, refusing to see it as a difficulty. I began to feel tested by her. She then started to send me postcards and cards between sessions: some of these were more obviously testing. One, for instance, was of mother and child, but in the picture the mother is holding the child in an ambivalent even cold way and Barbara asked me what I made of this form of mothering.

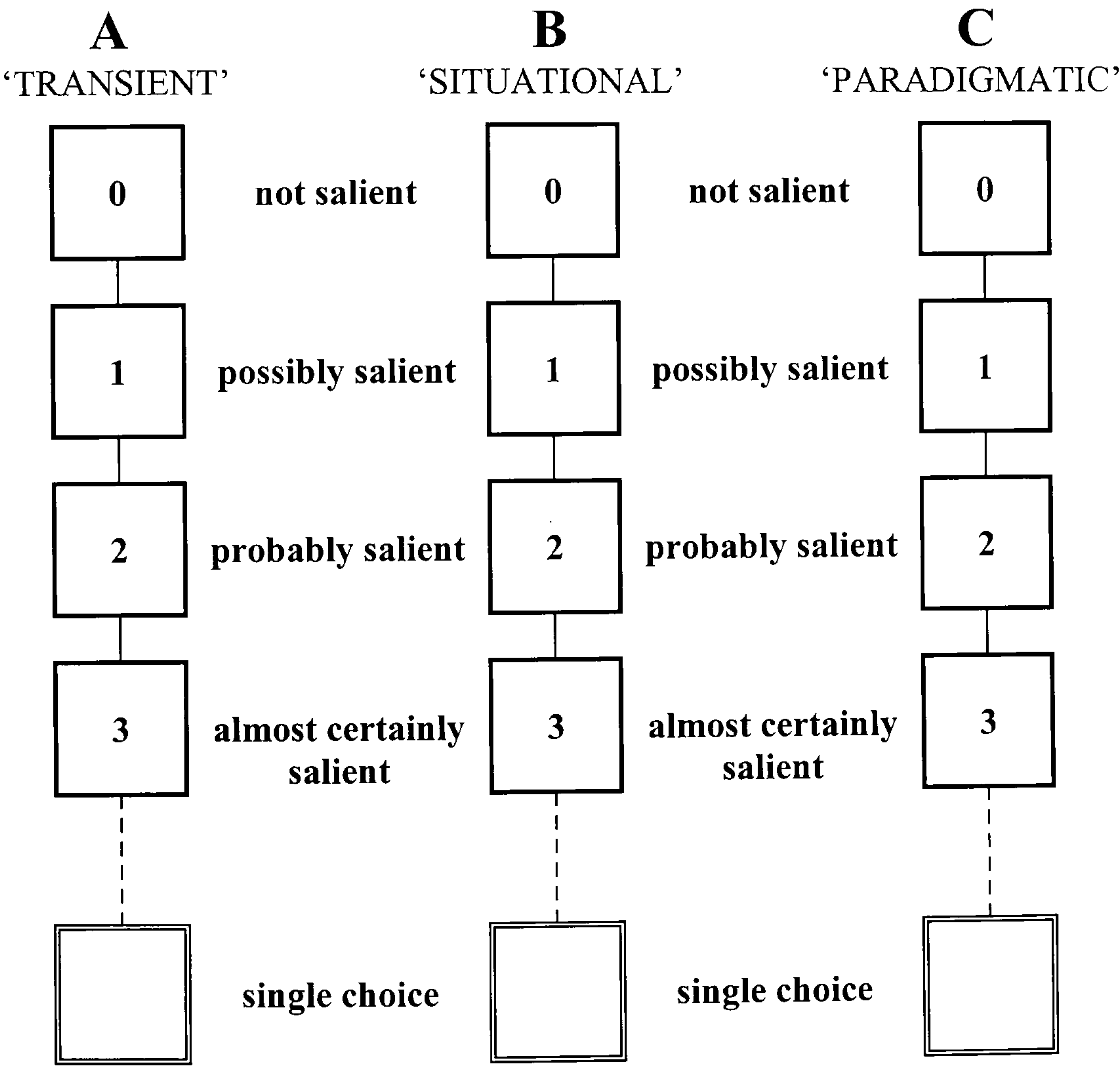
Eventually I told her that I wanted the behaviour to stop so that we could work on the feelings that were thus aroused. Not surprisingly she was very angry with me but it led to her expressing anger towards her mother for rejecting her (Barbara's) attempts to mother her. Considerable envy of mother's capacity to mother became the focus of therapy.







In the penultimate session with a private patient, my cat jumped onto her lap at the start of the session - the door was slightly ajar and he had nipped in and jumped up as I opened the door to go in and start the session. I told her to push him off her lap, he couldn't stay in the room, but she pleaded for him to stay. The cat seemed to collude with this and settled firmly into her lap. It felt more difficult as it was the penultimate session. I felt seduced by the situation and that the patient and the cat were happy and I was nitpicking. Against my better judgement I let them stay as they were and the cat settled to sleep. The patient seemed to love having him there - she had gradually been developing a relationship with the cat and this felt almost inevitable. I was affected by the fact that I am very fond of the cat. I felt weak for letting him stay but secretly quite pleased.

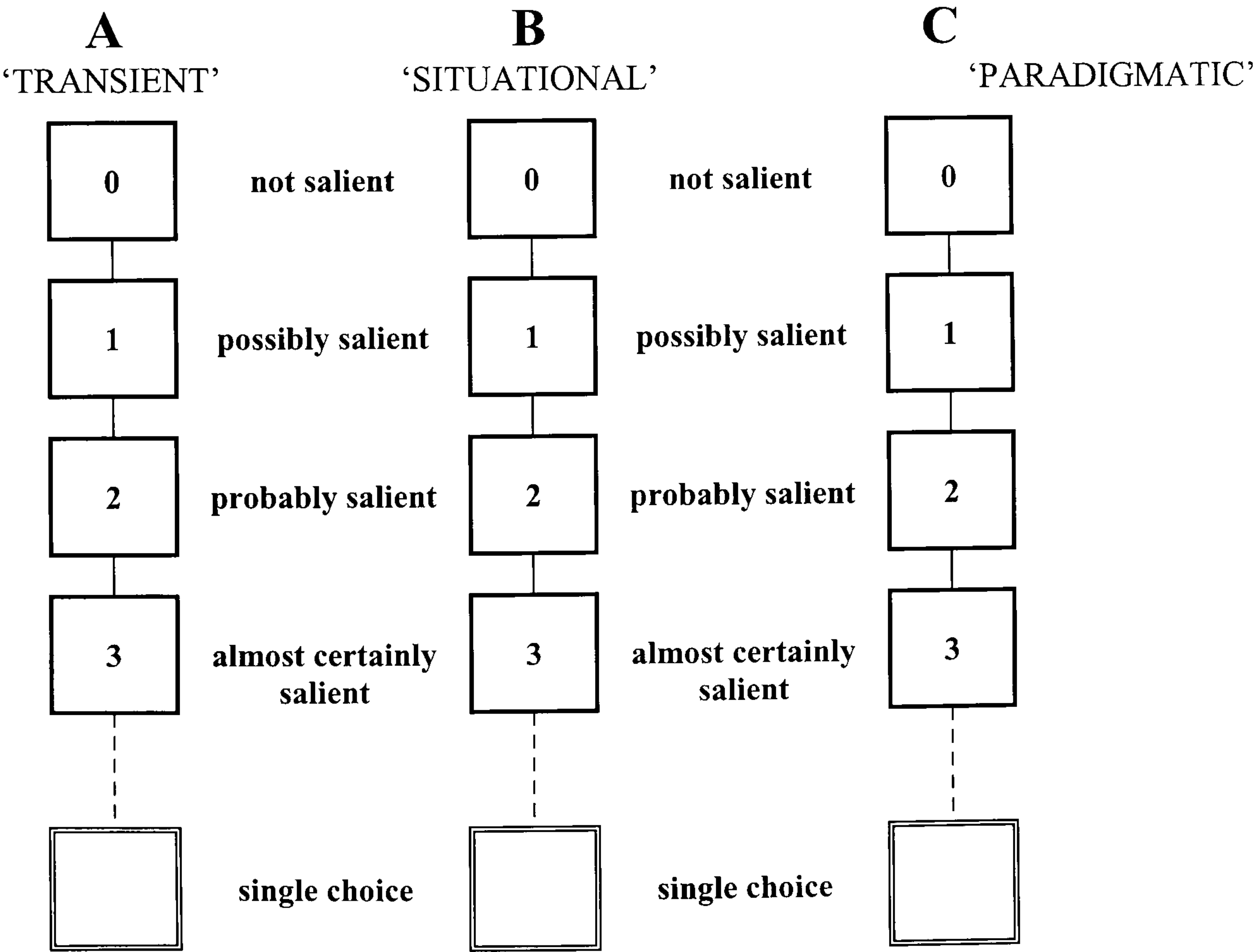


**MALE PSYCHOLOGIST, PSYCHOTHERAPIST, PSYCHOANALYST**  
**PSYCHODYNAMIC ORIENTATION**

The patient was a 45 year old woman who at the time of the difficult situation had been in five times a week analysis for about a year. The patient, Mrs A, spoke of how she had discussed something I had said to her, in previous sessions, with a senior colleague of hers. This seemed to have been with the (successful) intention of enlisting a highly derogatory response, which enabled her to feel that her own attack on and devaluation of her analysis and myself had been justified, confirmed by this respected other. It is difficult in words to describe the particular manner in which this was done by my patient, - the way it got "under my skin". My response, which was not sufficiently digested by me, compounded the problem. I intended, consciously, to show the patient why she had felt the need to reduce the value of the analysis at the end of the previous session, but my tone of voice must have conveyed my annoyance. The patient had recently requested a time change, five minutes, and I'd been able to do this, - but on the day in question I forgot (!), and therefore ended the session five minutes early. When this patient - who has been difficult mainly because of her acting out and undermining behaviour - returned, she affected not to know about being sent away early by me.

A dream, however, revealed that she had "sliced off" this awareness out of a fear of experiencing me as having retaliated against her.

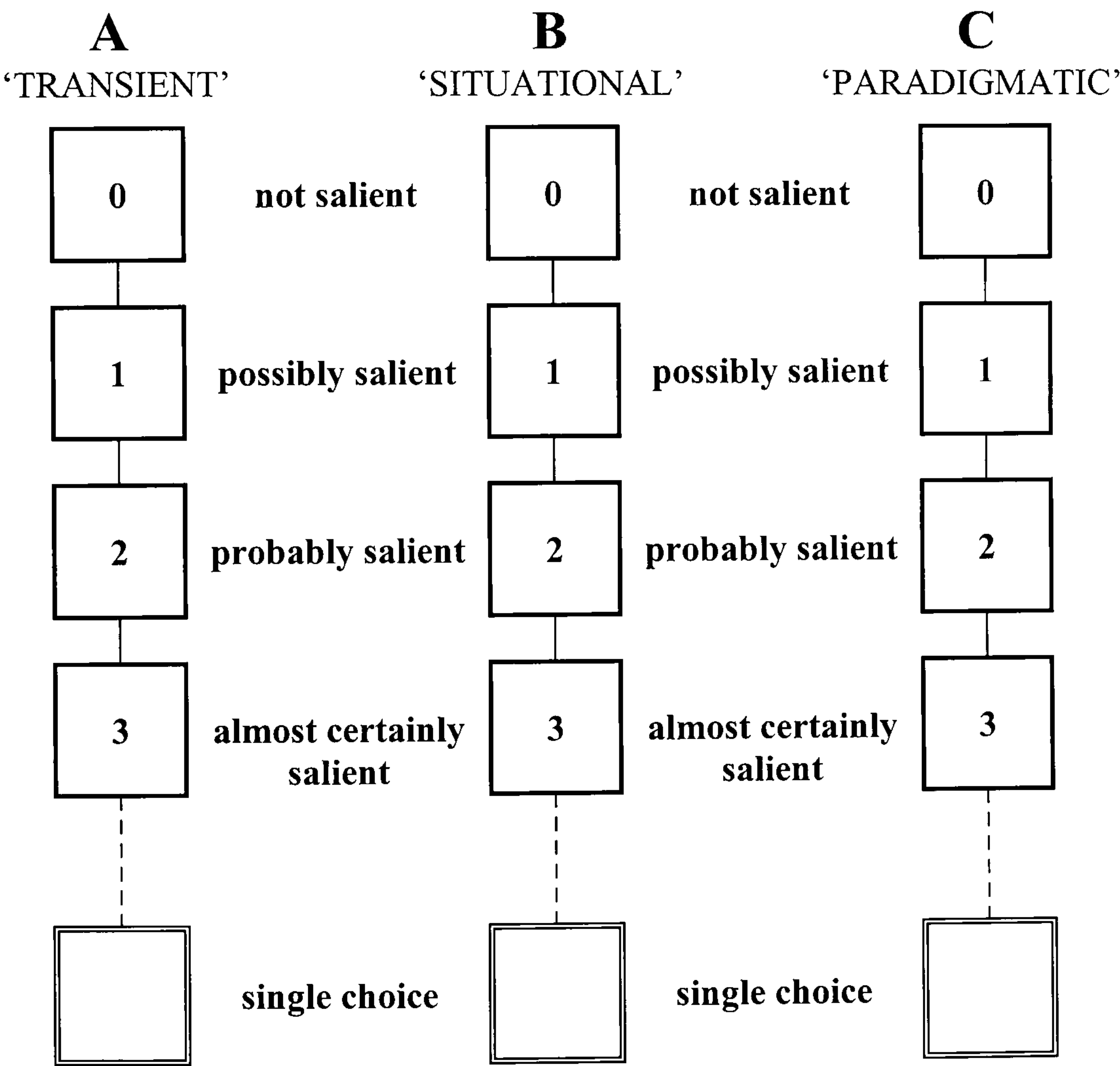
My way of dealing with this situation at first was to acknowledge that I had actually enacted something and that this was my failure, and over the next few sessions she was able to see something of her own contribution.







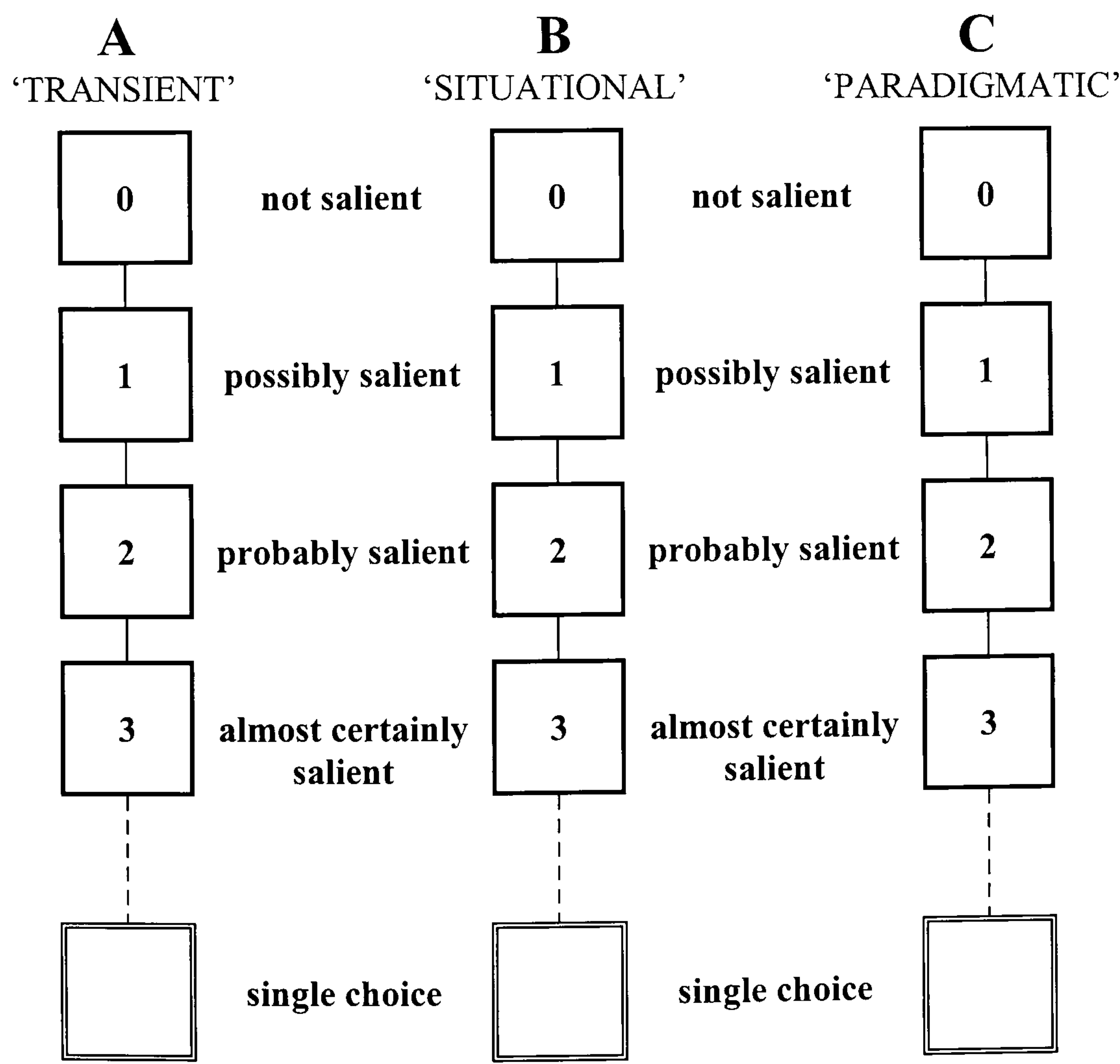
I wrote a letter to the GP which partially broke confidentiality.  
Felt as though repeated a "letting down" of the patient. Patient was extremely angry and for weeks afterwards let me know how useless I was, and untrustworthy.  
Tried to be honest about the situation, admit the 'mistake' and see if I could in any way use it to help the patient and therapy.  
Patient eventually came to trust me again and able to reform therapeutic alliance and go on to do further work which helped in a positive outcome for the therapy.



At the same time as patient one *[described in the other account]* I was seeing another female patient, aged about 40, overweight, with long-standing problems of depression, anxiety, moderate alcohol abuse, fairly severe Bulimia. She had been unemployed for a considerable time, wanted to become an opera singer (I suspect she had a fine singing voice, probably not professional quality though).

She was an only child of very rigid parents, father probably rather psychopathic/autistic but very repressed and repressive. I was seeing her three times a week. She never used the couch and was often late and missed some sessions from time to time. On the occasion in question she turned up after 30 minutes (for a 50 minute sessions) and extremely inebriated, hardly able to stand. She was in the room before I realised and I sensed that rejection would probably terminate the treatment.

We had a strained twenty minutes toward the end of which I said I thought this had to be a one off as she would be unable to remember and process what we'd covered. She was clearly hurt and embarrassed and I thought the action was overcontrolling (afterwards). Much later we were able to look at how vital it had been for her that I really experienced her depths of despair and self-destructiveness through this - and also her need of me.



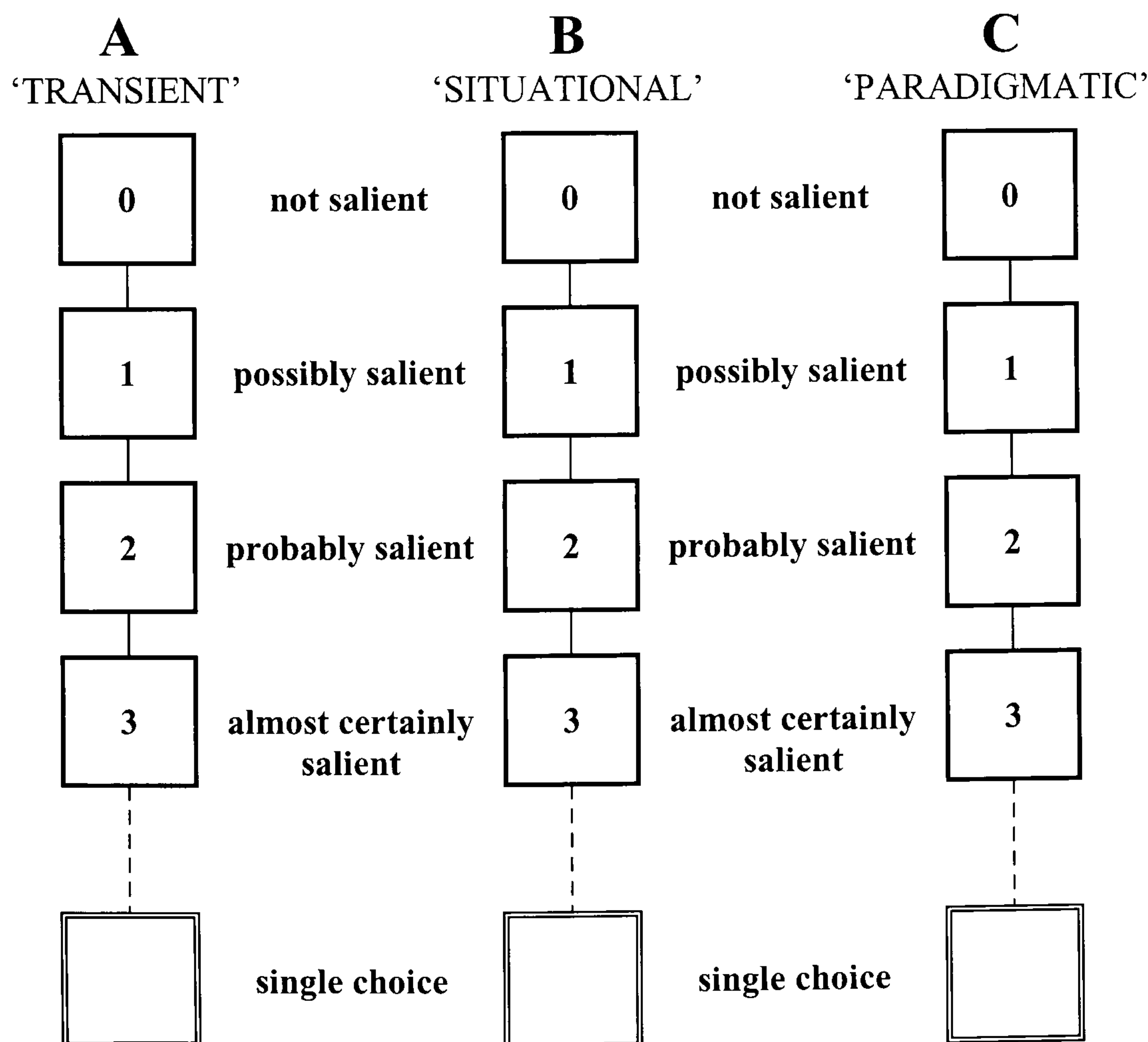
He was my first client on returning to the hospital after doing a year long course in psychotherapy. He knew me as a nurse before leaving. He was prone to a psychotic type breakdown often and indeed throughout the year we worked together often presented endless reams of psychotic symptomatology. He would retreat into this state within the session when any attempt at exploration of his internal state was made. I became very frustrated, annoyed and often felt as 'mad' as he. After all, I wanted to produce my new skills.

I backed right off, listened and empathised and stayed with him. His psychotic presentation reduced only to return time and time again.

I recall the development of the treatment alliance was difficult due to our past experiences of each other. Though I struggled to remember him, he seemed to be able to recall at will comments or situations we had been in together. I could only agree and work with it in the here and now.

He is a restricted patient under the Mental Health Act but slowly made progress gaining increasing amounts of parole within the hospital. He stopped assaulting staff and made contact with his family again but unfortunately the psychotic presentation, whilst reduced for some nine months, took him again and after 18 months without warning he stopped coming. All attempts - writing, meeting on the ward - failed to get him back.

I spent many long hours with my supervisor and therapist wondering and thinking why it turned out the way it did.





My difficulty arose from having to deal with the client's issues about her religious beliefs after a fairly damaging experience of intense "Christian training" during which brainwashing techniques were used. Her fairly insecure religious beliefs did not sustain her during this and it was followed up by some "Christian counselling" which had left her with a sense of falling apart.

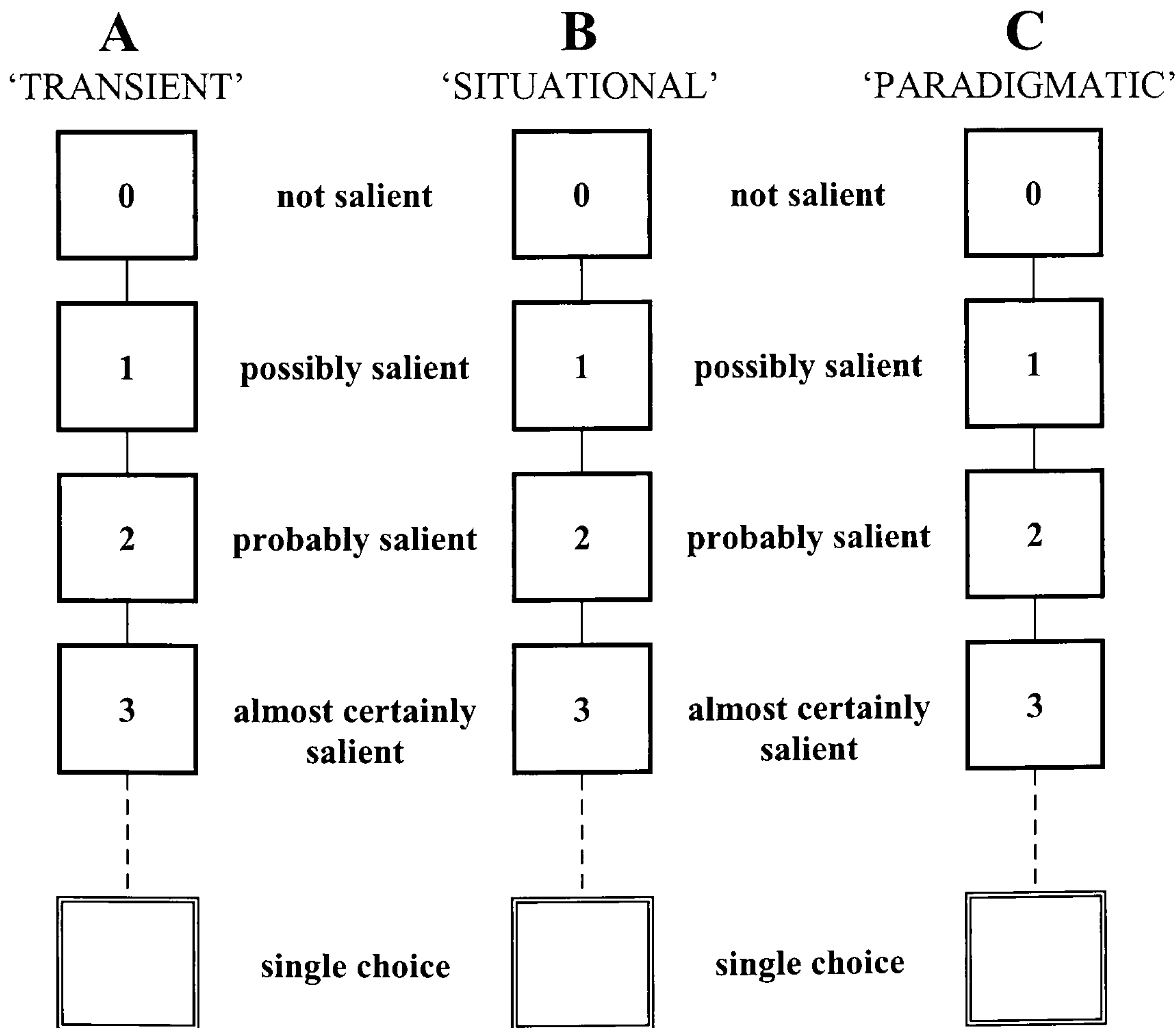
My problem was to preserve a boundary of anonymity when the client seemed to have every opportunity to discover my personal connections with a Church. I was concerned that discovering this would prove unhelpful to her and put me in a quandary not least of which was my own feelings about these kinds of evangelist techniques.

What the client did was to attempt to reinstate or patch up a rigid system of beliefs which make her feel securer. I found it difficult not to confront this too bluntly, because my own objectives were to increase her ability to use and view her religious faith more flexibly. It was a fine line to walk to allow her to find her security again but not to shore up all the old defences again. She was facing an imminent bereavement and I was preparing her for this loss.

How it turned out was that half way through I was too challenging and the client showed increased distress and considerable mistrust. She would have liked to know that I was of the same religious persuasion as her but I declined to reveal might personal views.

She wrote to me after the death in the family to say that she had found the therapy helpful, found talking with her relative frankly and openly about the impending death very rewarding and reassuring. She felt able to grieve. She had had several unresolved losses when she entered therapy.

She also made a guess about my religious beliefs and Church attachment which was accepting of me but actually incorrect.



The difficulty arose when I reviewed a patient for a possible course of psychotherapy one month after my initial assessment.

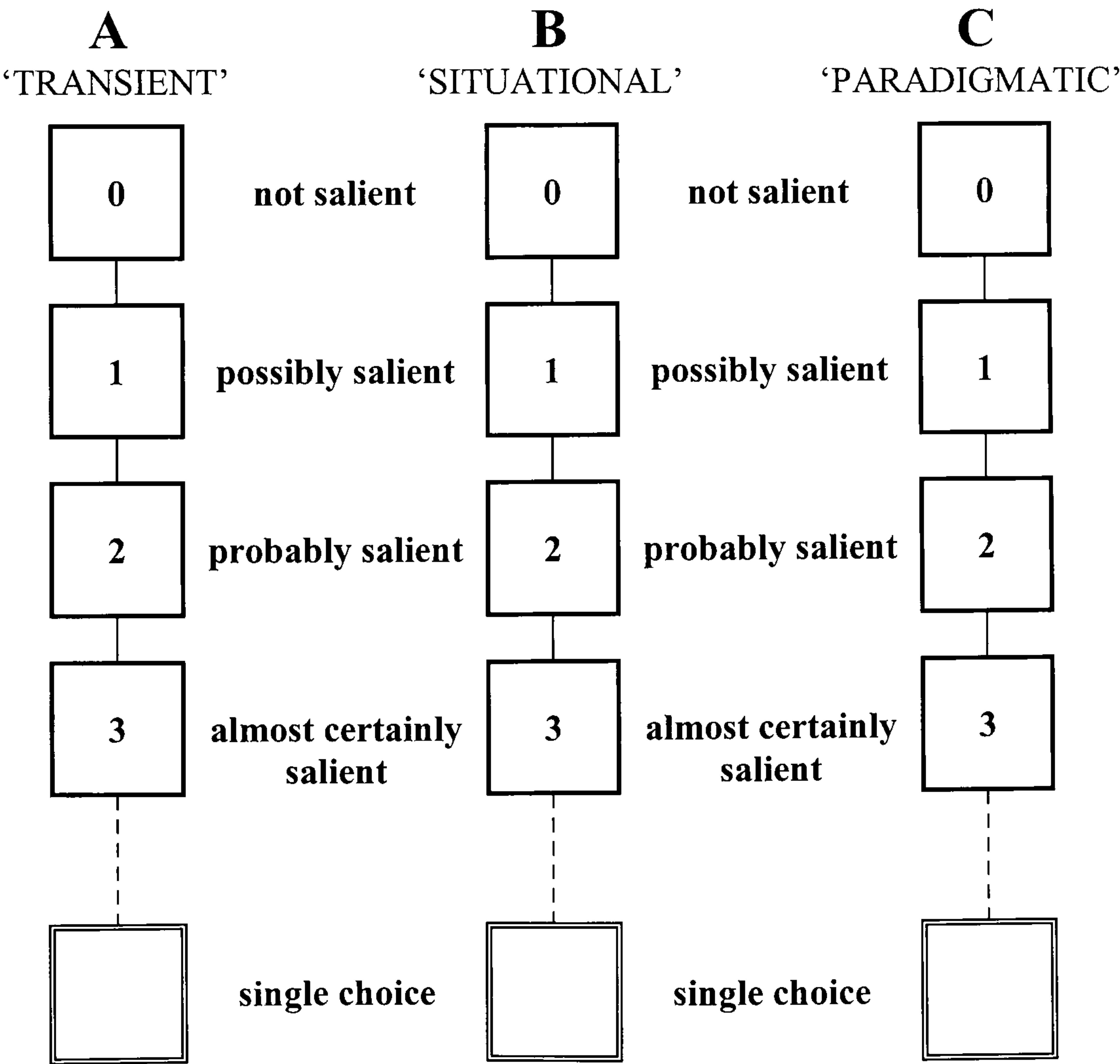
In the intervening months, she had become significantly depressed and hopeless. Towards the end of the session, she spoke of serious suicidal thoughts.

I offered her a further review in two days (which happened to be on a Friday afternoon). The patient remained a serious suicide risk but unwilling to come into hospital for an informal admission. I tried to persuade her to accept admission or a GP visit at home the following day. She refused both.

I felt helpless, powerless, frustrated and anxious both for her safety and that I should do "the right thing".

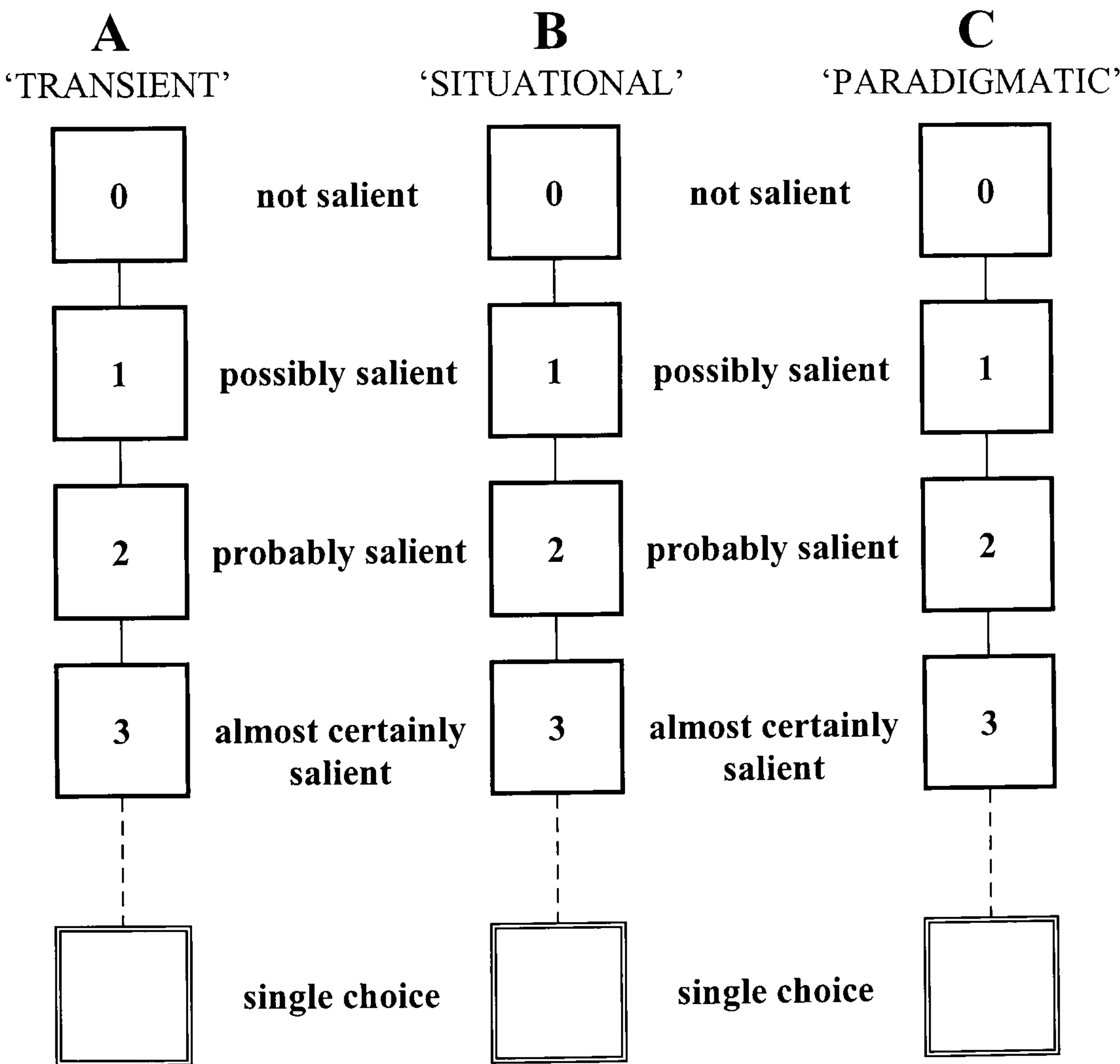
I decided to ask a consultant colleague to come and interview her in my office. He did so and we finally persuaded her to be admitted that evening as a voluntary patient, after a brief return home to collect belongings and make arrangements for the children.

I returned home late that evening, still anxious about her well-being and I remained so all weekend until returning to work on the Monday to hear that she was an in-patient. I experienced enormous relief that she was still alive.



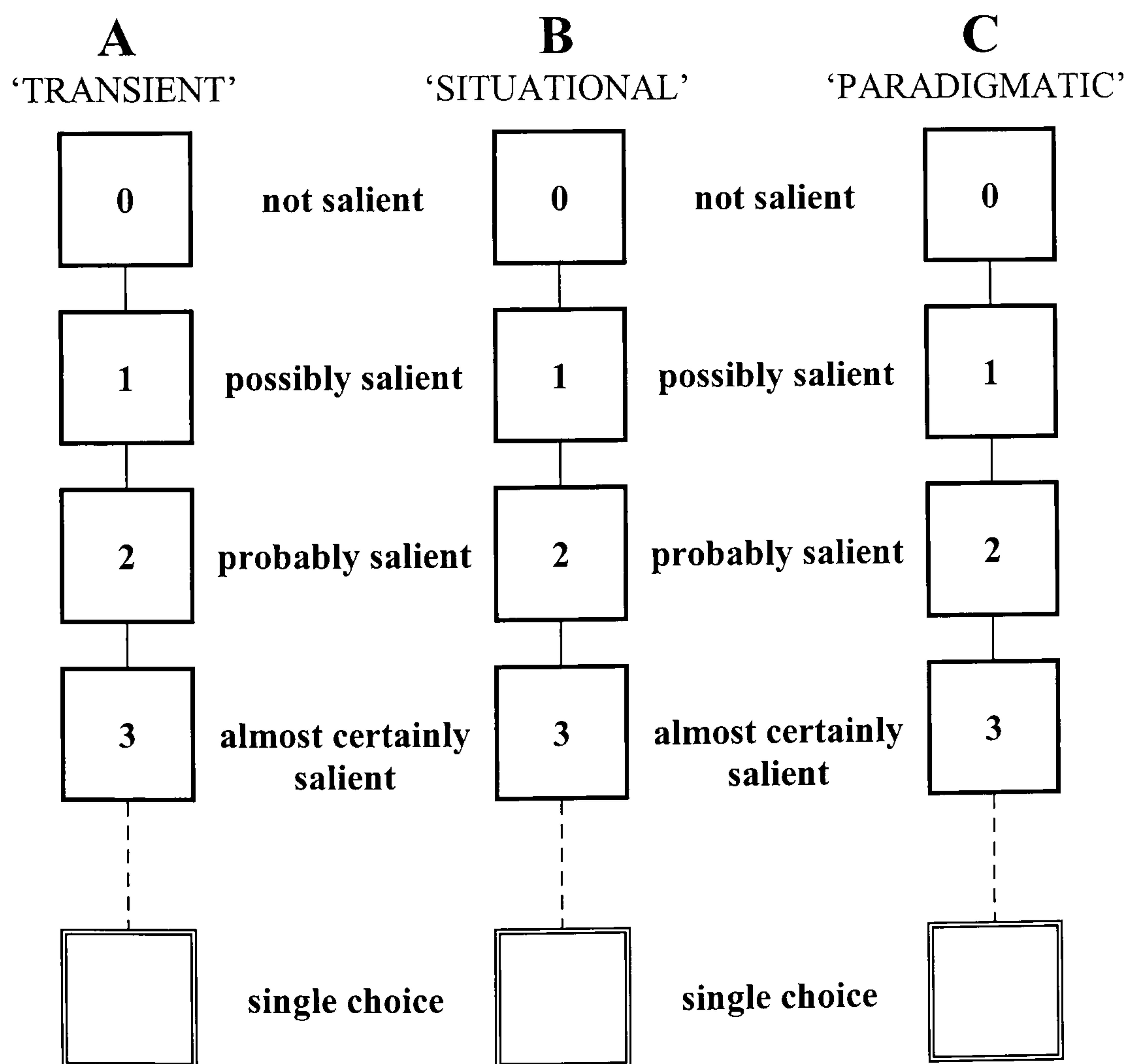
**MALE PSYCHOLOGIST**  
**PSYCHODYNAMIC / COGNITIVE / HUMANISTIC ORIENTATION**

A female patient who suddenly announced she was planning to leave her husband and stared at me in a way that made me panic that she was going to pack her bags and turn up at the clinic expecting to come and live with me / be my partner or lover. I felt panicked, fearful that I didn't have control and wouldn't be able to stop her. Despite this I muddled through and later in the session clearly stated the boundaries of our relationship (we only meet at the clinic for one hour to work together on her presenting problem (hypochondriacal/obsessive thoughts about being terminally ill)). She was angry with me for weeks, which we were able to work through (a bit). Supervision helped.





- 1) Client disclosed own {?} sexual abuse in childhood, incest - father alleged perpetrator -, at beginning of session and prior to that in letter from GP (referral letter).  
Confidentiality was fully discussed. However, at end of therapy session 1, client disclosed her own children spent 2/3 hours per day with her father (alleged perpetrator) while she worked.
- 2) My own feelings - anxiety, which I confronted with client regarding the potential for her children's danger.
- 3) Confrontation one-to-one did not work. The client refused to accept her children may be in danger (denial). I informed once again need to break confidentiality unless other arrangements could be made for their care.
- 4) Outcome, after several days and consultation with GP and health visitor, client agreed to make new child care arrangements which were carried out and monitored by GP and health visitor.



The situation which came immediately to mind was of [a] difficulty arising for myself, not so much at the time I was working with my client, but how I subsequently processed that work before taking it to supervision. The session which gives rise to my experience of difficulty had been taken up with my client taking up the previous week's theme of struggle between being fiercely independent and acknowledging her feelings of dependence on me to. Although very articulate she was also brimming with emotion. She blamed me for inviting her dependence and encouraging it by use of touch. (early on [in] our work together we had discussed and agreed on a parting hug, my putting my hand between her shoulderblades when working on breathing and occasional hand to hand contact for emphasis or reassurance. I was also aware she had been badly let down in a lesbian affair in late adolescence and we had discussed that in relationship to her therapeutic relationship with me.) The previous week we had done some experimental (Gestalt based) work exploring her conflicting needs to hide from me and to reach out. I had invited her to reach out her hand to me and had met the stretched out hand with my own and followed it with a hug. This had brought back a memory of standing in a cot at the age of three, in hospital, calling for a nurse who ignored her and then smacked her for wetting herself. This memory brought up powerful feelings of ambivalence towards women, particularly those who offer support and care and don't deliver. (At this point I was glad I had met her request for care the previous week.) We talked again about her 'loving' mother from whom there had been "no free hugs" and the importance her family placed on "proper good-byes" - hugs at bedtime and when going away - and being physically held. She asked if I would hold her so we sat on the floor, she leaned against me and I put my arms round her for ten minutes. During this time she 'dry sobbed' against my shoulder while I spoke soothingly and reassuringly that it was OK to feel 'little' and alone and ask for help. When her time was up I checked she was feeling able to re-enter her world, we had our usual goodbye hug and she went off.

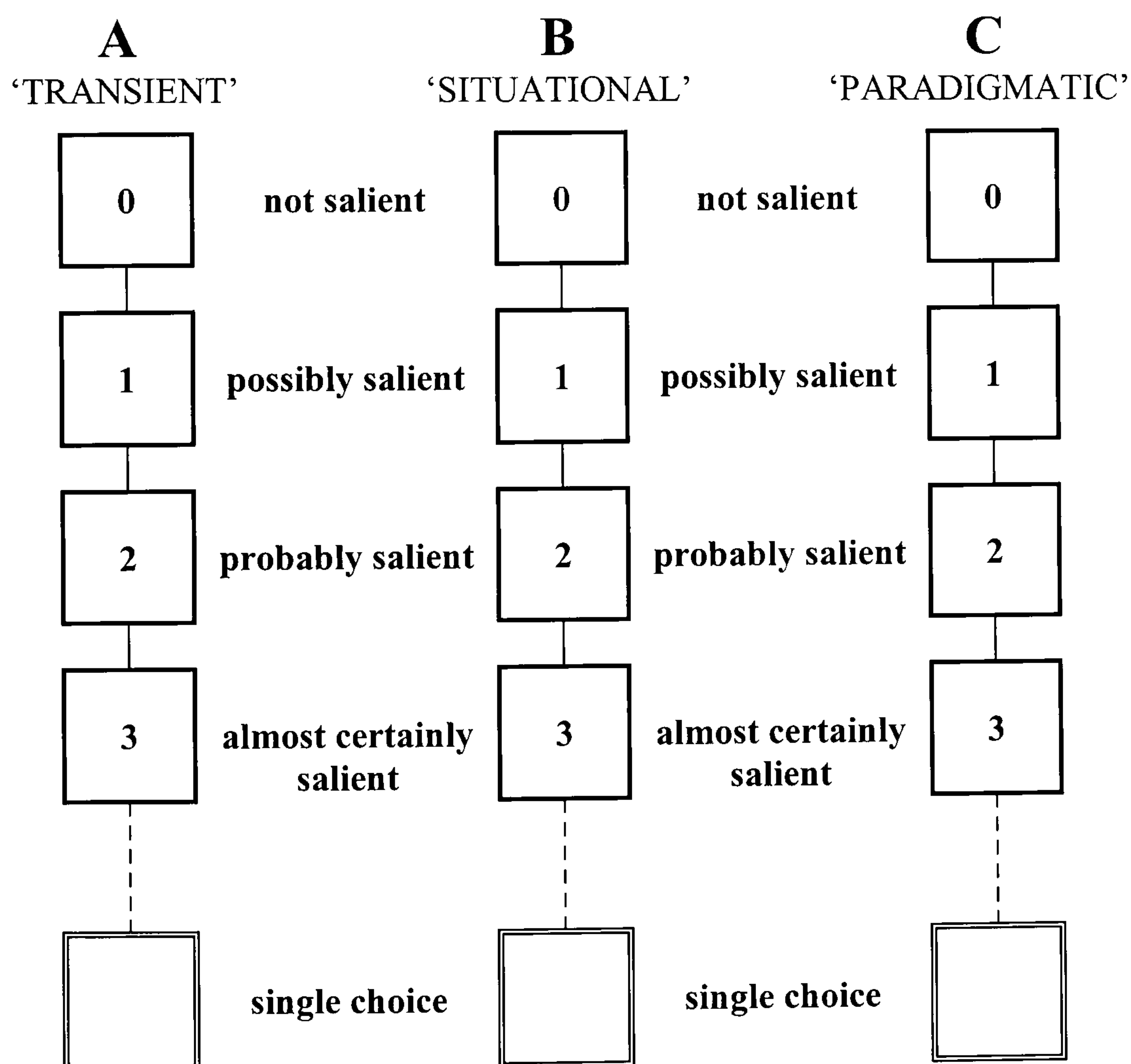
During that session I was aware of the intensity of her emotions and some power in her needs and demands but I don't recall doubting my reactions or what I offered. I was very clear about why I intervened as and when I did and I was also very clear about my boundaries. After the session I felt emotionally exhausted. As the day went on I kept returning to the session questioning what had happened. I think the difficulty really began when talking with a supervisee who was using me as a subject in her research into the use of touch in therapy! I recalled much earlier psychodynamic prohibitions about ever touching clients and despite subsequent training in the use of therapeutic touch, "permission" from supervisors and my own experience of being held in therapy, became very anxious and confused about whether in some way or another I had abused my client by 'giving in to her demands to be held'. For a couple of days I worried, fretted, returned to various texts and re-examined myself and my actions. My supervisor was away that week and it didn't feel appropriate to check out with other colleagues. Then, by coincidence, a paper on projective identification was given to me and a weight shifted as I reconsidered my experience as that of my client - confused, guilty, "too much", inappropriate, "doing something wrong", needing reassurance etc. I felt I could wait until I saw my client again.

*PLEASE CONTINUE ON THE NEXT PAGE*



The following session she came on time, considerably less tense and a little less emotionally intense. She reported that something important and shifted for her and she had experienced less acute anxiety, the image of the three-year-old was still with her but more removed and causing less direct pain. We talked about what was happening, its meanings and I again held her - as a mother holds a child who has been frightened. I felt no further anxiety about what I was doing. I took it to supervision and felt psychologically 'held'.

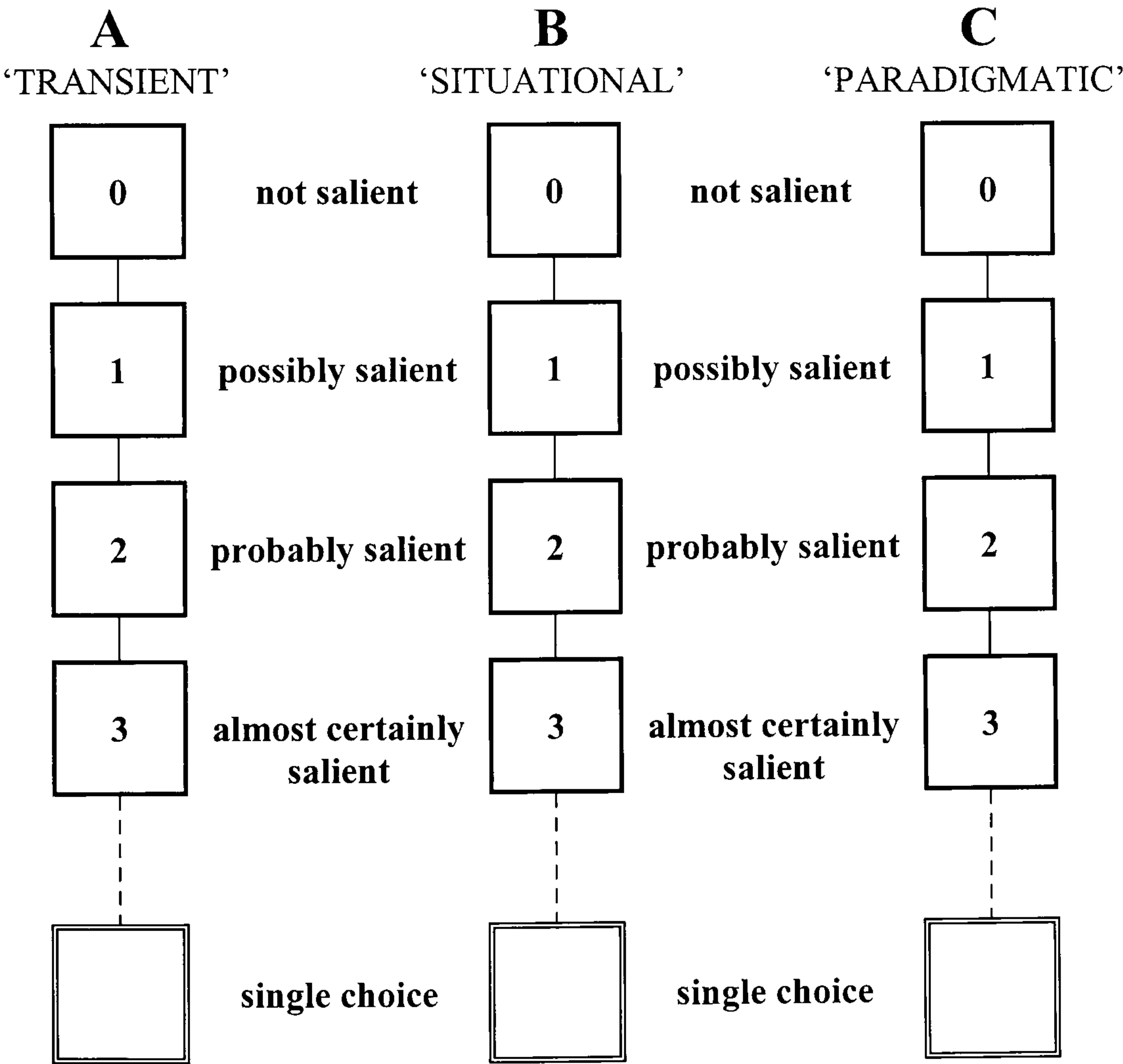
I believe my difficulty arose with my identification with my client's feelings translated into old childhood concerns about what I felt right in doing being considered 'wrong' (? Bad) by parent/authority figures. Although it did not actually last long my concern at potentially harming my client was intense enough to disturb my sleep for a couple of nights. This intensity is also a reflection of my clients ways of being.





I have chosen to write about an experience which was difficult since it involved intense sexual feelings

- My patient stated his intense feelings for me after several sessions.
- I felt a reciprocal feeling for him as we had grown close during the therapy
- I was as ‘professional’ as I could be and of course took the issue to supervision
- We talked it through and I was able to maintain his trust while still being ethical to him and his {?}.



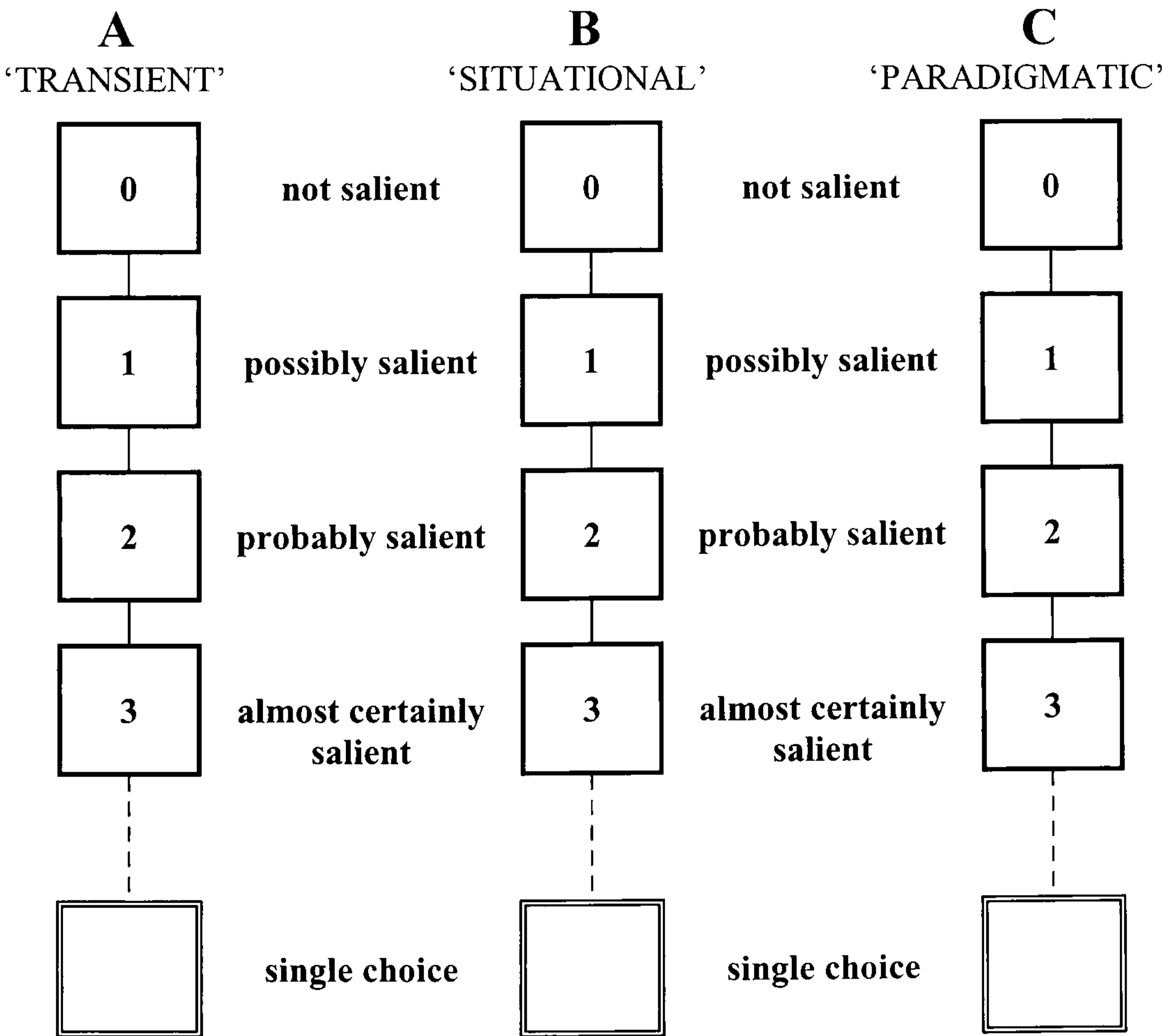
My client is a woman in her early fifties, married with a teenage daughter and working in a professional rôle. In child-hood she experienced bereavement and an emotionally neglectful and controlling parental relationship and was sexually abused within her family and outside the home. In adolescence and very early adult life she was bullied into a sexual relationship with a female boss. Despite being well informed about therapy she has been surprised by the strength of her emotional response towards me as a therapist and the enormity of the emotions she had previously held in check. We work together twice a week - and she is getting close to dealing with (allowing to surface) the fury she often feels with men - or felt with her early abusers.

The “difficulty” in this situation is helping her to get to and express unfamiliar feelings in a way that feels safe - we both know that she wants to express her feelings very physically and violently and yet is afraid to even say she is cross. This difficulty was exacerbated when I hurt my back which prevented me from sitting beside her and being in physical contact with her while we talk (which has been our practice for some weeks since she got into her most miserable and upset material).

I felt that I handled the physical change well and was transparent without burdening her and that the face-to-face exchanges which followed were helpful although different - in part we negotiated boundaries again, particularly how she might behave if she did get angry. I made it clear that feelings were welcome but that I could not tolerate being struck (“you may not hurt me”). It transpired at the next session that she had found this very hurtful (“of course I wouldn’t”) and she was then angry (in the room) for a very brief flash. Progress? Manipulation? Etc. I had mixed responses both to her present anger and to her pain about my attempted clarity.

I was able to remain warm and accepting and to apologise for handling the situation badly - whilst also saying that I thought that what had been clarified was helpful. She was able to tell me how angry she had felt all week and how she thought she could not continue to work if it felt like this - she was shaking fairly uncontrollably at the time. Nevertheless she had brought me a present (for a forthcoming holiday) and although I have no great problem with receiving/accepting gifts from clients we talked about this and its timing and may need to explore it further. The apology/exploration and acceptance returned us to a more normal state - but then I worry that this also shortened her opportunity to be angry (with me).

The situation is on-going and clearly contains much ambivalence for both of us. I am generally confident of a positive outcome in this case, but have found this incident quite difficult.

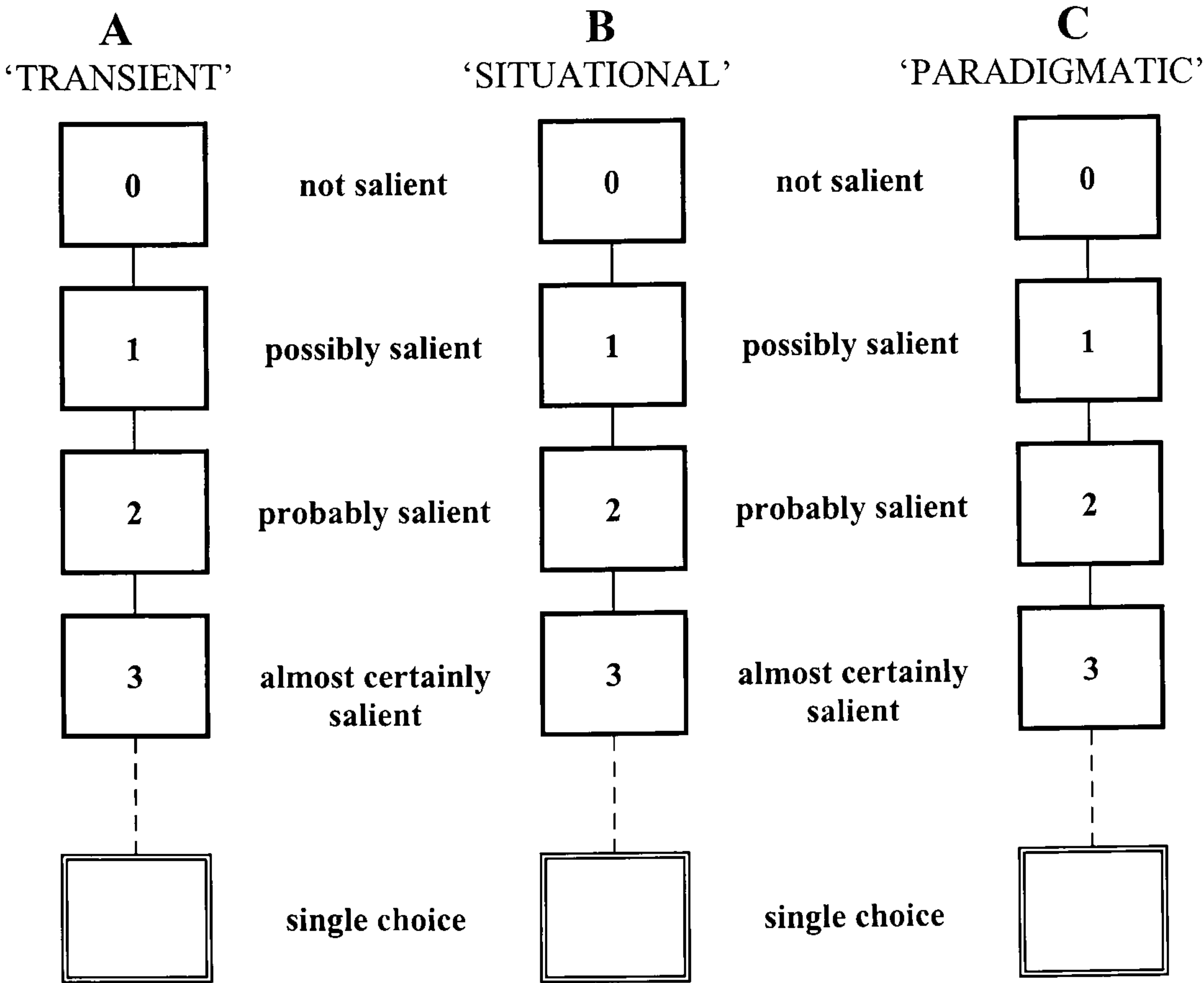




The greatest difficulty I experience is not with very emotive or aggressive clients/situations, but with avoidant once. The client I have in mind is a young man with a learning disability and has been sexually abused by care workers and teachers at school. He has also experienced rejection from his family and been severely bullied in many different situations. He is highly obsessional, has had violent outbursts, talks to strangers on inappropriate sexual matters, cross dresses, is considering a sex change operation, experiences uncertainty around his sexual orientation and is very vulnerable. In therapy he is often avoidant and talks at great length and in great detail about his preoccupations with transport and certain television programmes. He also recounts irrelevant parts of his days in minute detail. He does this to an extent that is overwhelming and is very difficult to sway. Interpretations are frequently talked over and not listened to. Many conversations of also very grandiose and unrealistic. He ascribes himself superhuman strengths and describes actions of retribution (very unrealistic) against wrongdoers to his person from past and future. He takes silence as reinforcement of these fantasies and refuses to acknowledge any challenges. Infrequently he does accept very insightful interpretations and will talk about his real fears behind the fantasy, but will often suddenly retreated back behind the fantasy. Therapy with him is extremely frustrating and often very boring (I sometimes have difficulty staying awake in sessions). I frequently ask myself whether I am doing him any good at all, but on reflection realise that he has achieved substantial improvements in his life and has gained many insights. Day to day he is, however, very frustrating and I sometimes even have violent fantasies towards him in the session. At other times I feel very positive towards him.

One of the problems lies in the glimmers of hope he offers for insight and improvement, only to be snatched away a moment later by a fantasy about how, for example, he beat up three men wielding large knives whom he had challenged for dropping litter. Given his stature and personality this is certainly not reality based, but he will insist that it is. At other times he will acknowledge that he actually feels very vulnerable, weak and frightened and that his ideas of superhuman strengths are wishes rather than realities. He ascribes all blame for wrongdoing to others and does not acknowledge any himself. For example, he was sacked from his job for stealing though he plainly denies this and only talks about his desire for retribution and anger towards the manager. I have acknowledged these feelings but also tried to get him to acknowledge his wrongdoing (his accounts are not plausible as he has changed his story several times).

In therapy I experience his hidden rage, frustration and despondency and I believe it is this that leaves me feeling bad. What makes him difficult is the subtle ways in which he communicates these feelings to me, making it very difficult to interpret.



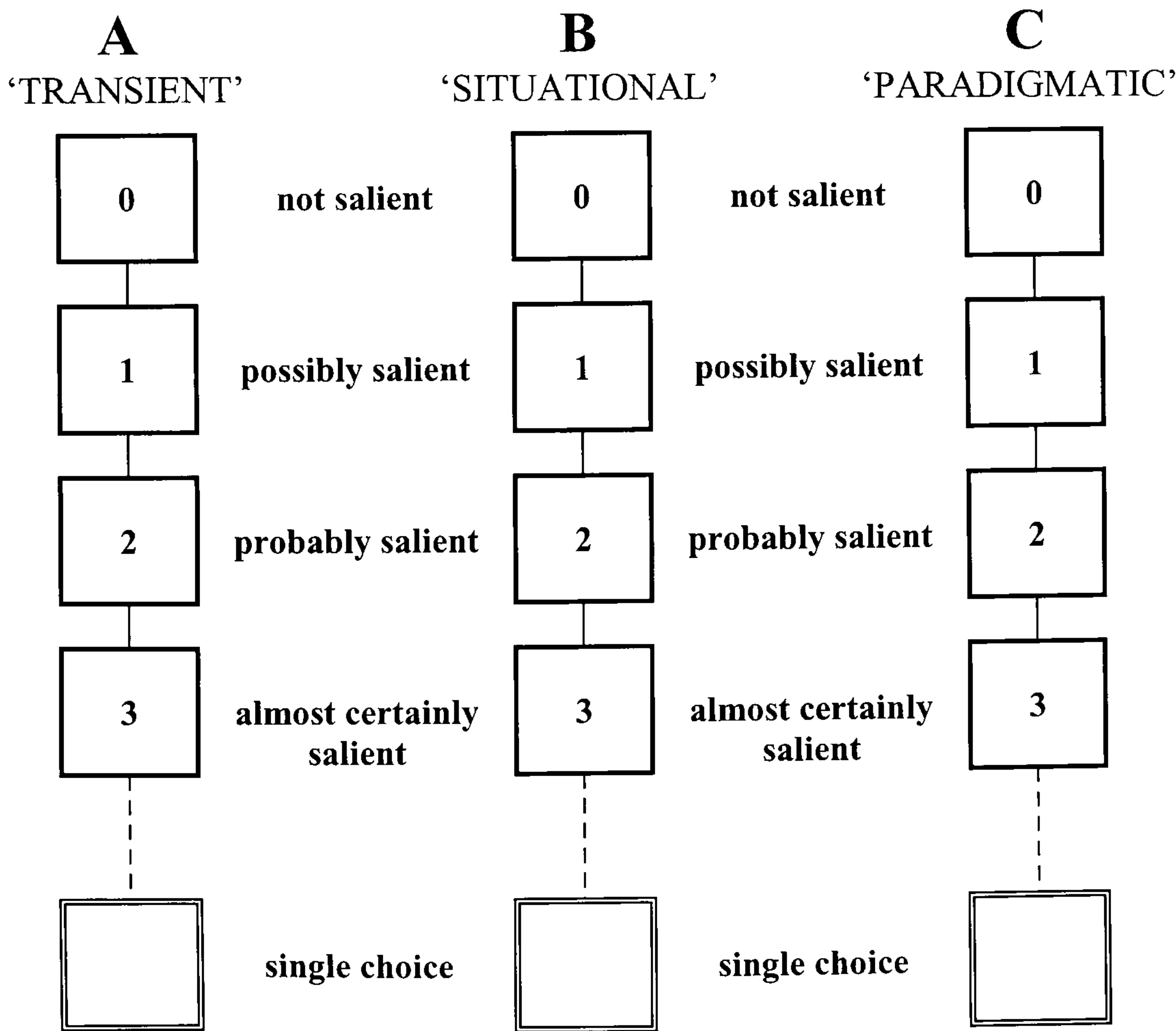


The patient is a 29-year-old divorcee who I have been seeing once a week for two years. Generally I found her not too difficult but the difficulty I've had is around silence in the sessions. Over the past six months longer periods of silence became more frequent. Prior to that there were silences that would last approximately 3 to 5 minutes, but lately these silences could last 15 minutes to half an hour. During the silence my mind tended to wander off and I would find myself thinking about all sorts of things from domestic business to holidays, partner, etc. Then I would become aware of what I was doing and begin to feel guilty and try to concentrate on the patient. Often I would skip back into this {?} wandering. Meanwhile the patient sat there with little eye contact, looking glum. In an attempt to engage her I might say something like "its hard to talk today". She wouldn't respond and I would wander off again. In some ways I was happy to wander off in my head. I suppose it was part of my ambivalence towards the patient. Again I would return to her and try again and often the second interpretation would elicit a response. She would talk about how hard it was for her to talk and she wished she didn't have to come.

Prior to this period there was much happening in her life. She was busy changing jobs from one that was demanding to one that was much less demanding. She went through a separation from her husband. So, there was enough material to fill the sessions. Now it seemed as if she was bringing herself and this she found much more difficult. She talked of not wanting to come and wishing that she could run away - as I was doing in my mind.

This then led to some work on her fears and anxieties about bringing herself. Her fears about trusting me, about confronting me, as well as her indifference to me. She was never bothered about breaks it seemed, although in childhood her father was always going abroad for long periods due to his work (another going away).

Therapy continues with much more work to be done but I now feel much more engaged in that process than I did when I was wandering off.



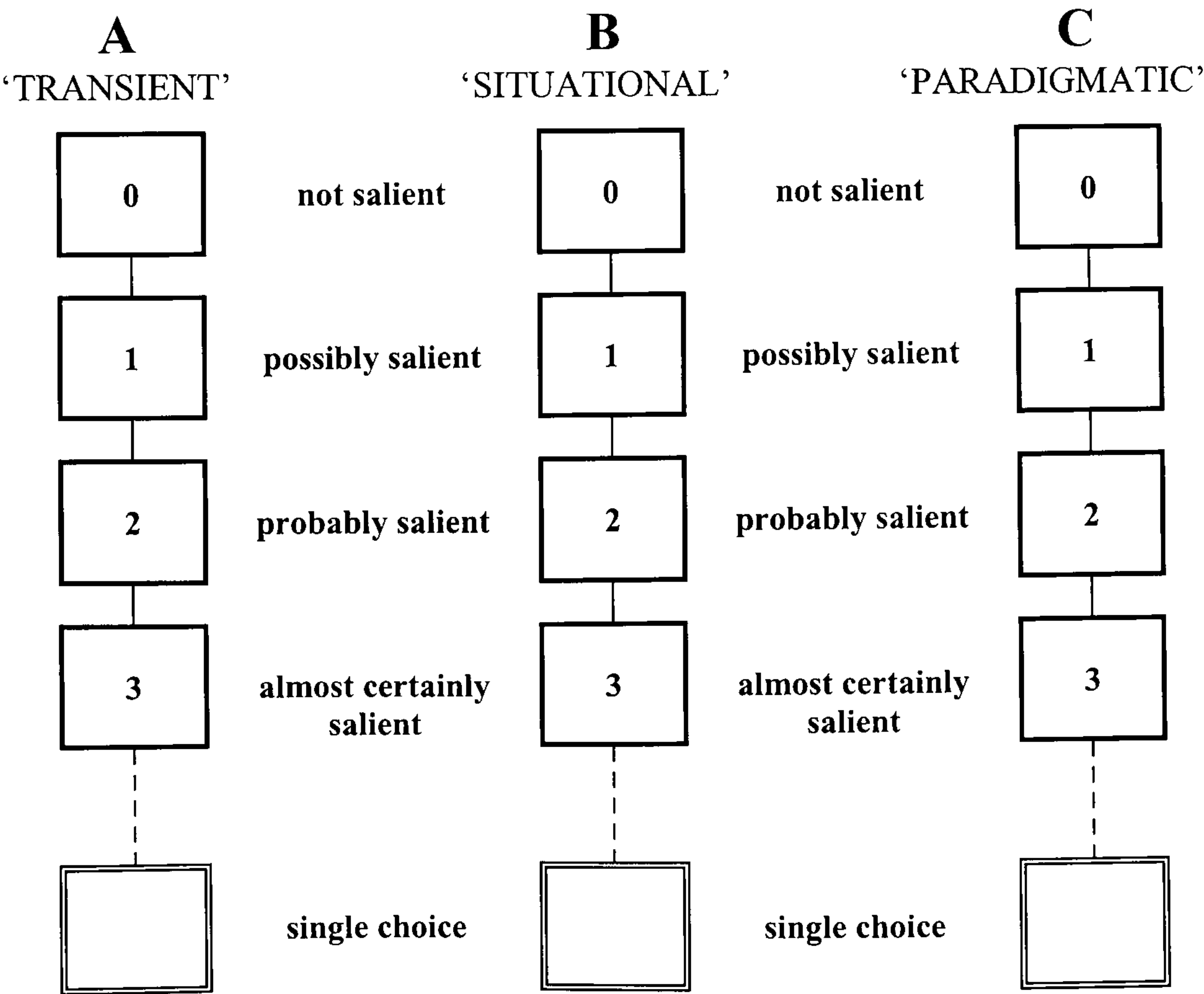
‘B’ was a 33-year-old single woman whose father had divorced her mother during B’s infancy, and whose mother was unrelentingly manipulative of B’s affections, as well as ego-destroying by way of constant criticisms and disparaging comparisons with other female children. B attended an all-girls boarding school from the age of 11 years, which she claimed to enjoy for all the vices [she] was able to indulge there, whilst providing other evidence of emotional abuse and blighted academic potential. She had had numerous short-term relationships and one-night-stands to the point of promiscuity, and had a long-standing refractory depressive illness with more recent self-harm (cutting). Her preference was for work in media, but she rarely lasted in any job for more than a few months before real or imagined difficulties with colleagues or (more often) with senior personnel led to her quitting.

B was experiencing some current adversities; she was jobless, had recently re-located, and her boyfriend was treating her too casually, in her view. She sought help following a brief affair, after which she made herself the victim of her boyfriend’s unconcern - the implication being that his unconcern somehow compelled her to indulge in the affair.

Early in therapy, she began to arrive late or to cancel sessions at short notice, with specious reasons such as having overslept, having a hangover, needing to visit the DSS office, and similar. In sessions, she seemed desperately needy, often crying for long periods. I was over-accommodating of her tardiness, and let this continue for some months, repeatedly re-arranging appointments to suit her, sometimes for later the same day, and provided extra sessions when she was particularly distressed. Inwardly, I experienced anger at the manipulation of our time boundaries, and hopelessness at B’s predicament, as she depicted it.

It was about five months into therapy before I properly challenged B on her time-keeping, and I did so with much trepidation. The trigger to doing so was my supervisor’s observation that I was unable to perceive the narcissism in B’s personality and relationship with me, due to my own projective identification.

In an emotionally-charged session, B revealed that she had seen a London-based psychotherapist for 18 months, four years earlier, and “all he ever did was ask me why I was late - does it matter...” She was highly indignant and angry, and had no sense of the inequability of her poor compliance with time boundaries. She threatened to abuse me verbally, and seemed ready to swing a heavy handbag at me, at any moment. I insisted that for therapy to continue, she would have to attend regularly and promptly. She eventually left in high dudgeon, after I specified the nature of her leaving as being occasioned by her conscious choice, and not by my rejection. This effective withdrawal by B marked the end of therapy.





**FEMALE COUNSELLOR, PSYCHOLOGIST, PSYCHOTHERAPIST  
PSYCHODYNAMIC / COGNITIVE ORIENTATION**

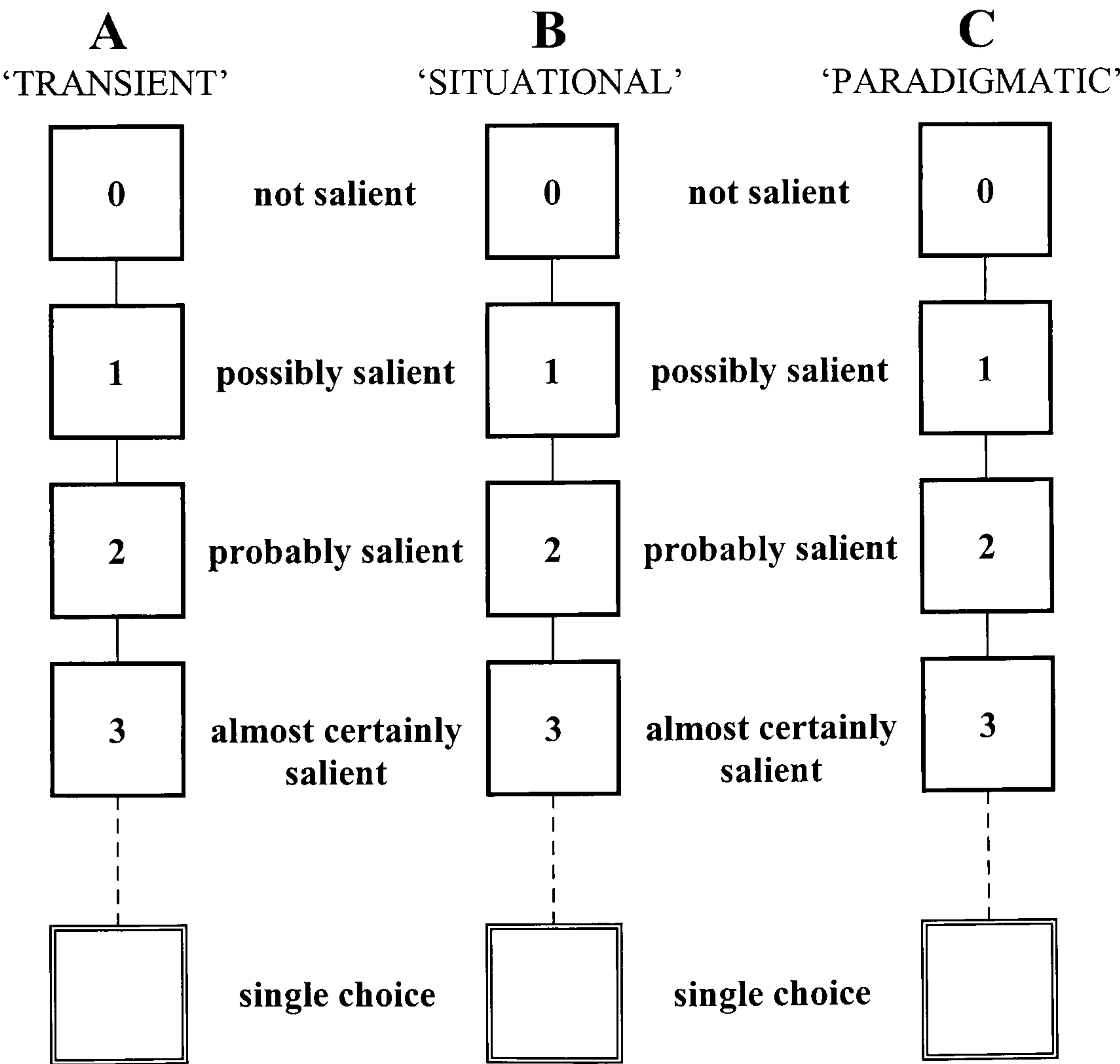
Returned from supervision one evening to find a long-term client (who I had just discussed in supervision) sitting on my doorstep, waiting - 10 minutes before her appointment time.

She is a professional woman, and normally she came to my office exactly on time.

I immediately felt guilty, as if in some way I had been remiss - and found wanting. I felt awkward and embarrassed as I unlocked the door. This was directly linked with the content of the supervision session where I had talked about [what] seemed to be the countertransference of inadequate mother.

In the session I enabled the client to talk about what it had felt like for her to come and find my door locked - which led to her acknowledging how much she felt she needed me just now and the terror she had experienced as she thought I might have forgotten - or mistaken the day...

Proved to be useful for further exploration of the transference and countertransference at that point in the therapy.



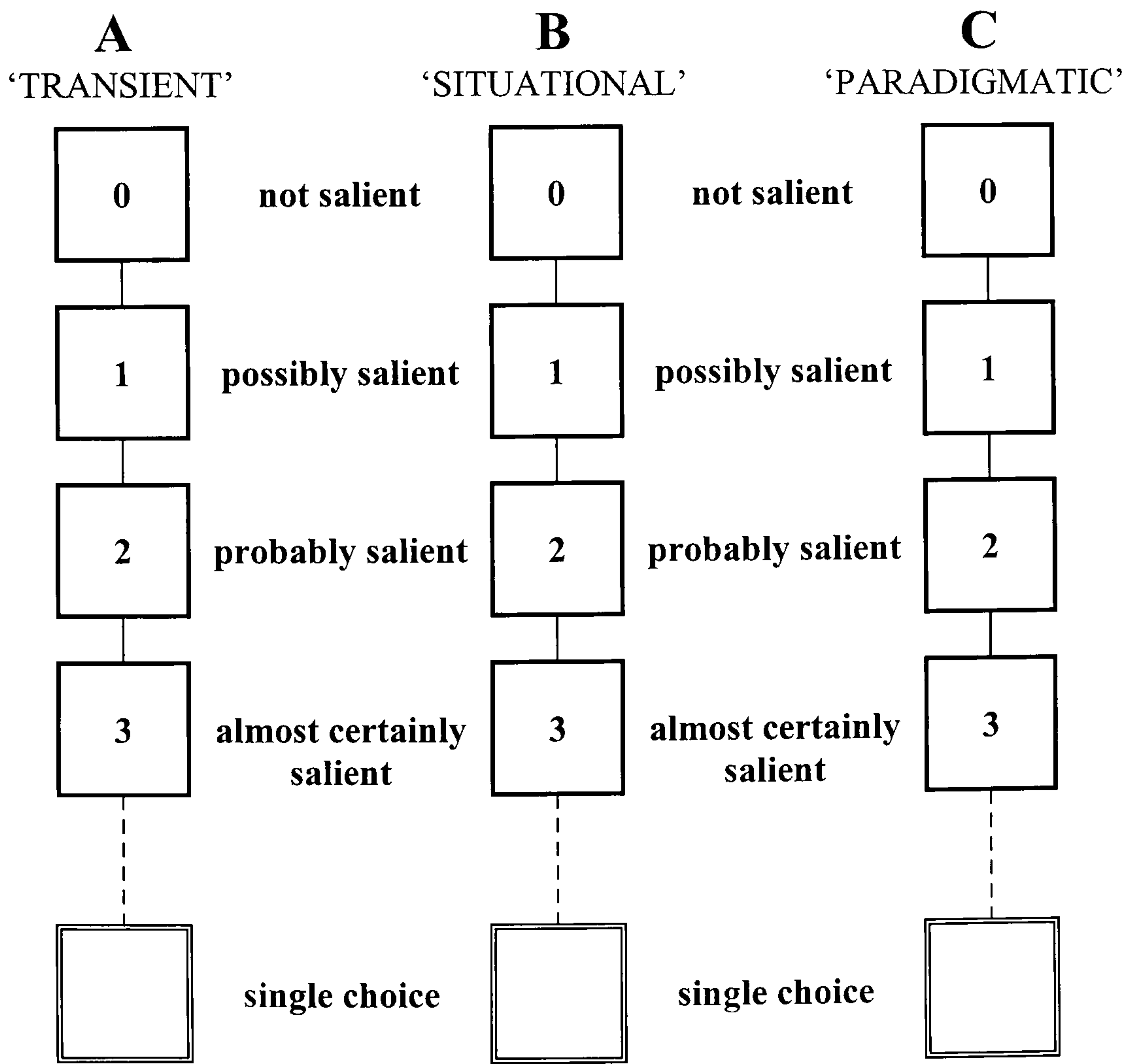


Working with ex-military personnel with PTSD/combat stress. At the request of the psychiatrist, I had two sessions with three Falklands war veterans, one of whom was verbally very aggressive, shouting and swearing.

I was very new to this particular form of PTSD, having worked mainly with women before (two of the three where the first clients in this group I had worked with) but I learned fast!

The aggressive client raised memories in my life of experiences of violent men. I contained the situation by staying calm, working with the aggression, bringing it back to the present / here-and-now, focusing on the difference between the effect of aggression and the desired outcome. I dealt with the effects on me 1) in supervision 2) by using the experience to further my understanding of myself and of PTSD 3) through aroma therapy and Tai Chi.

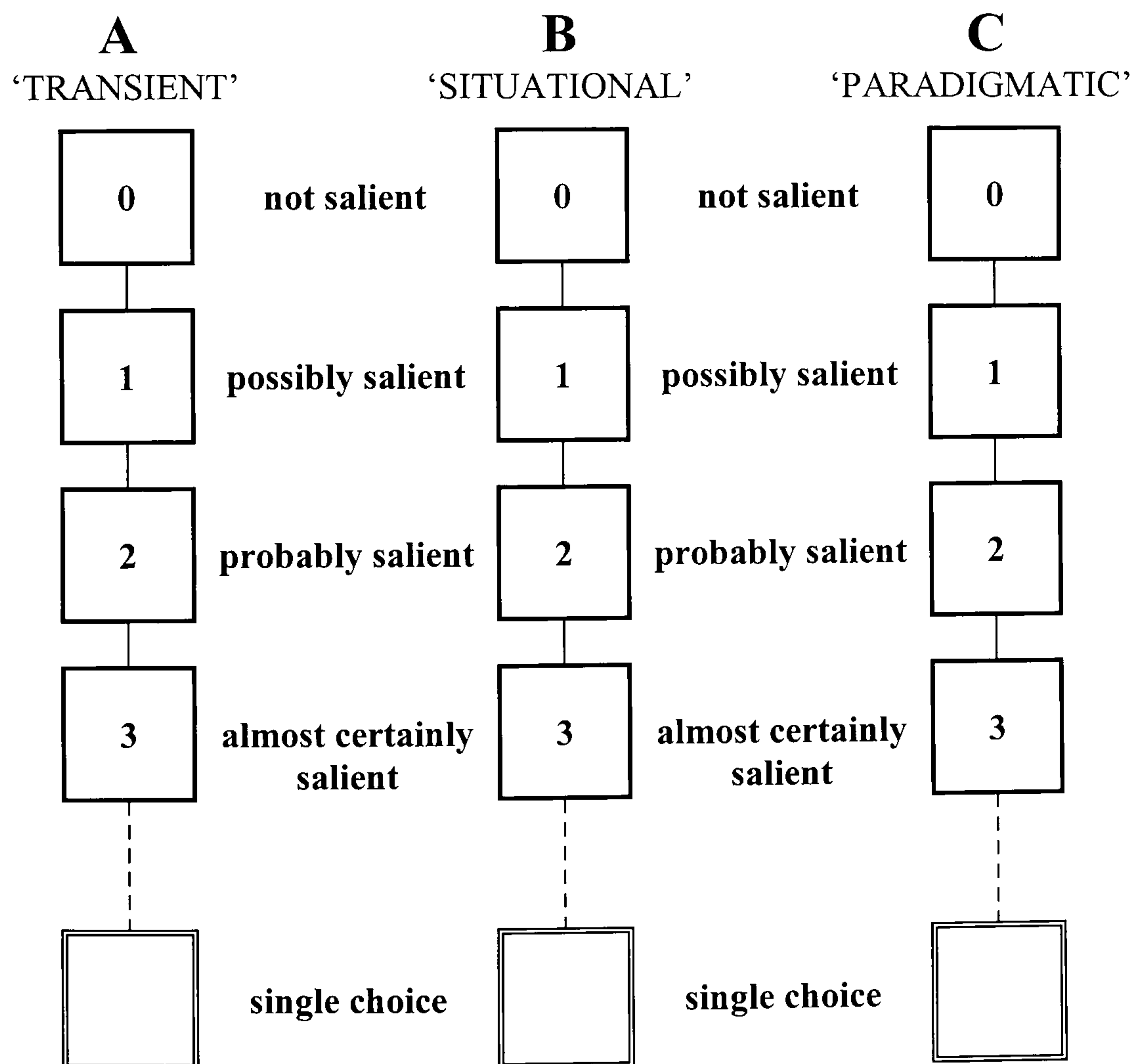
The other two participants said that the experience had shown them the futility of anger as a means of dealing with their condition and started to work in therapy from that time. They also expressed respect for my courage in facing them. The aggressive client resisted therapeutic input from every member of staff who agreed to work with him to including my supervisor.



When she got to the point where she felt able to tell me the story I found it difficult to concentrate as she spoke of feelings of guilt and also of her distress and seeing her father 'all mixed up'. My father had died 10 years earlier also with heart attack and also in hospital. I don't think she did anything to make the situation more difficult but my loss of concentration and focus on her made it harder.

Before the next session I talked through my feelings with myself and also with a friend (supervision not due and I believed I could manage it). The next session I was able to separate the two events.

She continued in counselling for a while until her feelings of grief resolved - we also were able to look at other issues and the outcome was in the end good (for us both!).







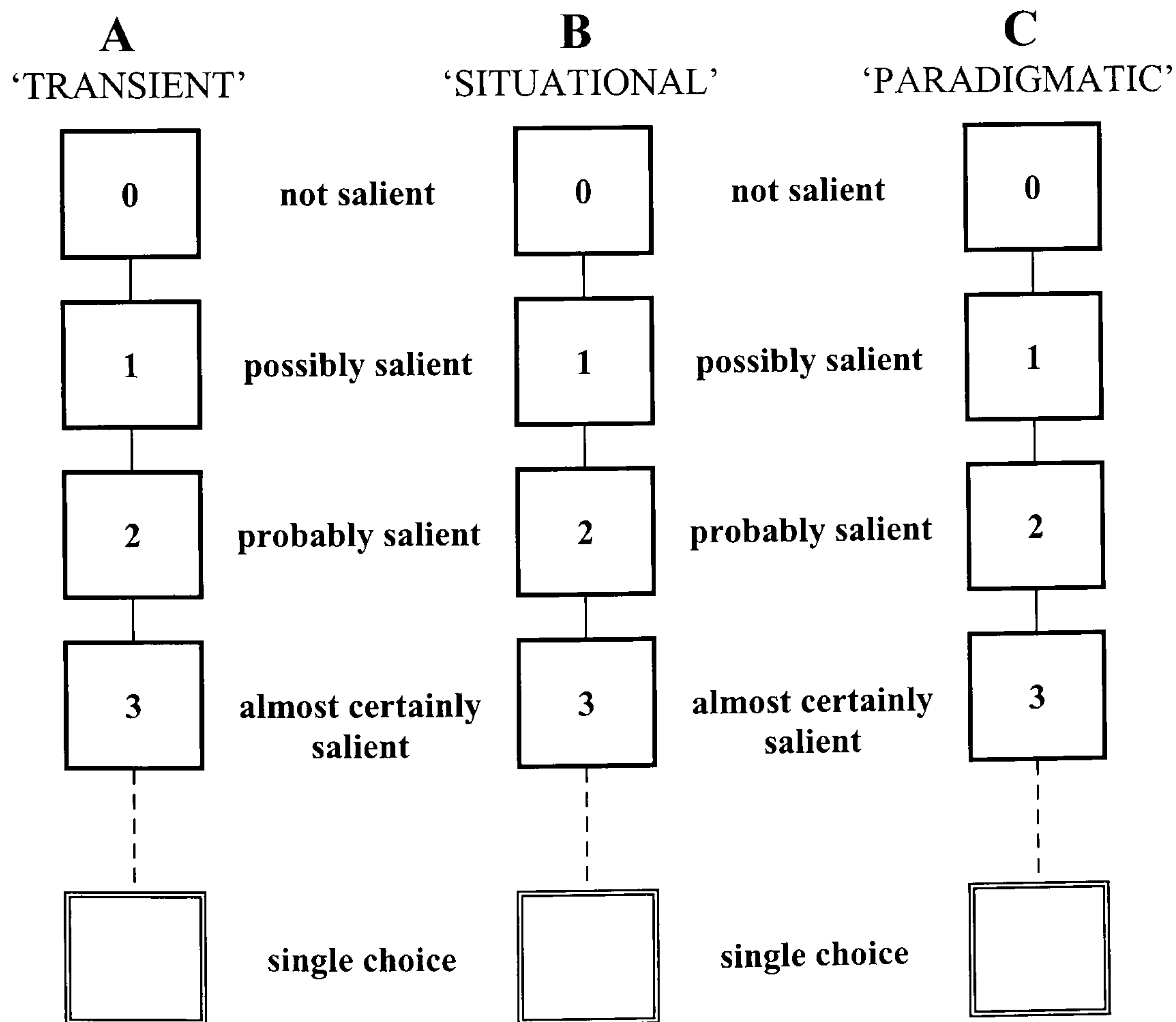


This example comes from my work with a client which has lasted over several years. She is German, speaks fluent English and wanted to work on her depression and separation issues arising from leaving an Eastern spiritual movement in which she had been initiated as a nun. It took a long time to build a therapeutic relationship between us because she did not find it easy to trust, had a profound fear of rejection and [found it]difficult to reveal her deepest feelings about her sense of betrayal by the movement which she had been involved with for so long.

However, our work did develop slowly until I received a letter from her in the second year. She said she felt very angry with me as she had felt that I hurried the end of the session and also that she felt abandoned by me for not responding appropriately to her when she felt so much deep pain. She thought I had looked very sleepy in the session and this increased her fear of abandonment.

I was distressed to receive this letter and was very undecided how to respond to her. I was unsure whether to wait until our next session to discuss the matters she had raised, and thought this might increase her anxiety. After careful reflection, I decided to write to her to offer an apology and an explanation of what I thought had happened in the session. I validated her openness in expressing her anger and fear of abandonment and assured her that I would not abandon her. I also said that my apparent sleepiness was due not to tiredness, but to a headache at the time, for which I had taken a painkiller whose effects began to take place sometime after we started the session.

The next time we met, she seemed much less fearful and mistrustful and we talked about what had happened in more depth. I felt that I had made the right decision in writing to her in advance of our meeting. In this case the exchange of letters gave us both time to think about what had been going on and helped to pave the way for what has become a deep and trusting therapeutic relationship.





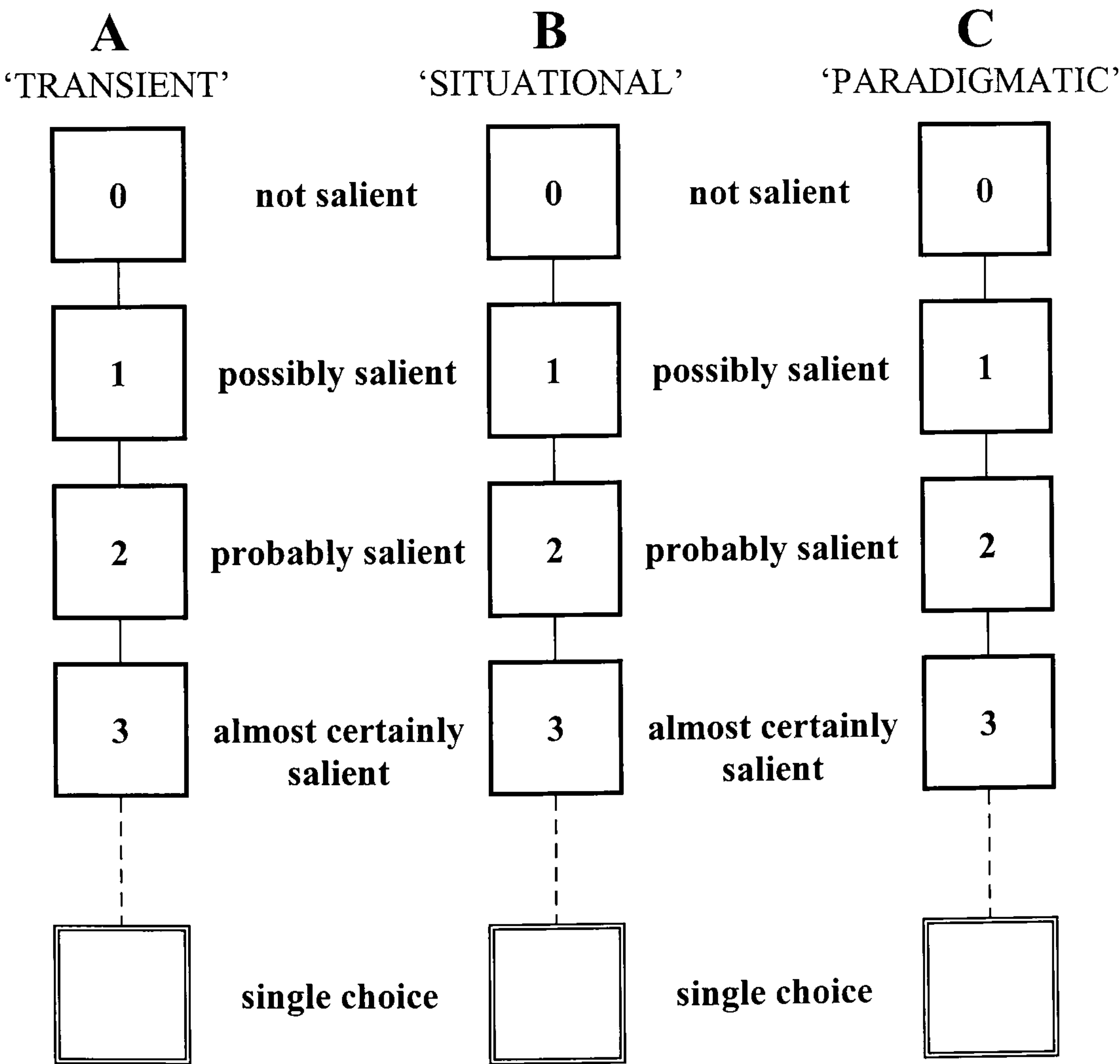
**MALE COUNSELLOR, PSYCHOLOGIST, PSYCHOTHERAPIST  
PSYCHODYNAMIC ORIENTATION**

This was a client in her late twenties with a history of childhood sexual and physical abuse, plus convictions for drug offences and for harming her own children, who were in the process of being permanently removed from her by Social Services.

I had seen a for around a year, working on issues from her own abuse and on her subsequent behaviour, as well as the trauma of the removal of her children. In addition I had arranged for her to attend a survivors' group for 10 weeks.

During our work there were numerous times when she felt close to falling apart or unable to cope, or would fail to turn up because of her depth of depression, but she managed to keep going each time and seemed to be making progress.

Then she came to an appointment with her mother, who has been in and out of psychiatric hospitals, and demanded that she be admitted herself. I felt that she would be able to cope with this crisis and tried to talk it through with her, but it became clear that under her mother's influence she had made her mind up and that the therapeutic rapport that we had had to was not sufficient to combat that. She left angrily, with her mother, and has not been in contact since.





This patient was referred to me about six months ago because she had recently embarked on a training course which required her to be in weekly therapy. She had received weekly therapy for about four to five months from someone whom her training body felt was not appropriately qualified. The patient delayed finding another therapist until her trainers put on the pressure.

During our first few sessions, much time was spent in discussing her feelings of resentment at having to make this change. She found difficulty in producing material because as she said she'd "told it all before to someone else".

Initially I experienced sympathy and understanding of her feelings of loss, and her fears that I would not be any better than her previous therapist, and probably not as good. But her resentment was such that she began to come late to sessions complaining that 9 am was too early; Monday was a bad day after a strenuous weekend; the journey was too far (it is about three to four miles); public transport was unreliable; etc etc. When challenged, her response was somewhat sulky.

After receiving a cancellation because this patient "overslept", I challenged her behaviour head on. Initially there was silence - not sulkiness but considerable muted anger. I commented on this but it was, not surprisingly, denied. That session was not a 'good' one - it ended with the patient leaving early because of "pressure of college work".

The next session started on time but with protracted silence. When I drew attention to this and said I realised how angry she appeared to be feeling that I resisted her wish to "rubbish" me because I am not her previous therapist, she burst forth with an account of how much she hated me, and how her dreams were about throttling me and trampling on my dead body.

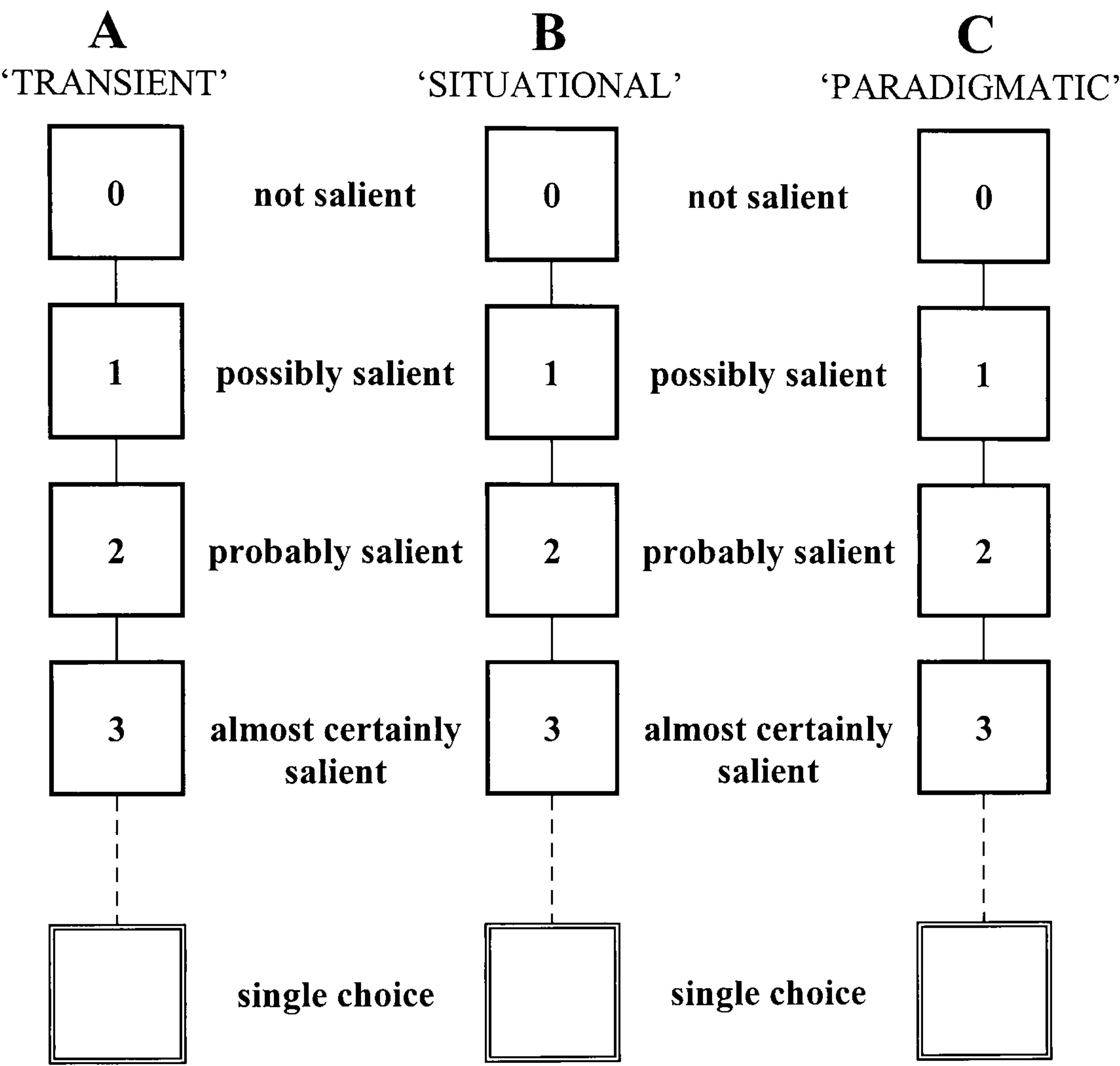
Although I could see that these angry feelings, so close to the surface, could be analysed readily, I was surprisingly disturbed to witness this "red faced, furious child" who clearly felt cornered and cheated. Whilst I inwardly struggled with quite powerful feelings of not being a good enough therapist; of being too old; too formal, etc, I nevertheless avoided any apology for my behaviour: I had at all times with her been calm and courteous.

I checked that she knew she had to change therapists before accepting a place on her training course, and reminded her that she must have wanted the training place more than she wanted to remain with her first therapist. She burst into tears and attempted to point out some failings in that person which I said were *not*\* something I needed to hear since the issue was about her relationship to me.

Whilst not nearly fully resolved, there has since been quite a positive change in this patient's attitude to her therapy. I was quite taken aback at how much her hatred for me left me in such discomfort. Although I tried in the countertransference not to show this, I felt for some time quite reduced in confidence and skill.

\* I note, somewhat wily, that I inadvertently left out the word "not"!

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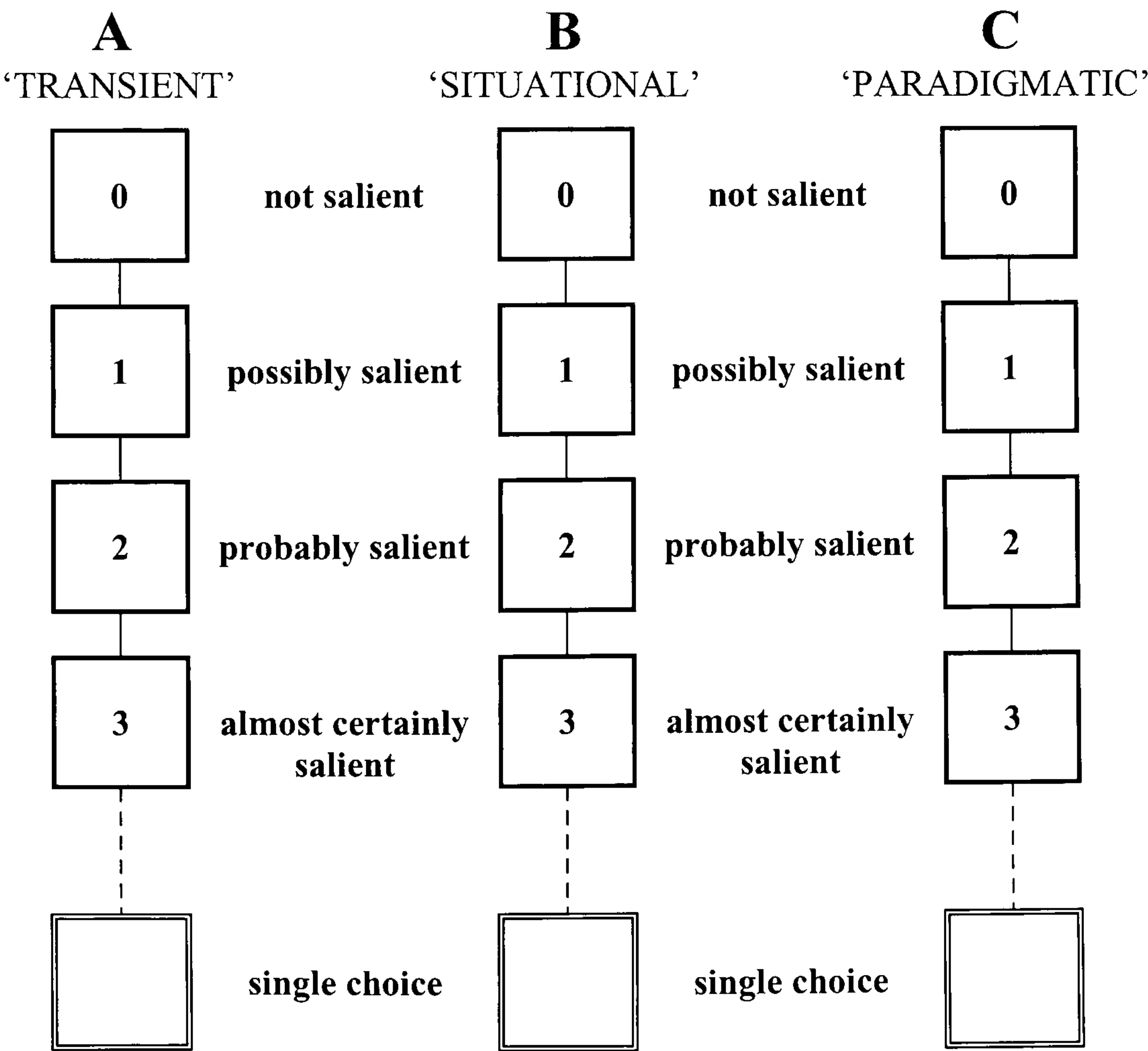
About 18 months ago - this was the second meeting of three with a supervisee - a Health Visitor who was disturbed about her relationships at work. (This private client visited me at my home). A short time into our second session agreeing whole-heartedly with her, concerning something she had observed in a relationship, I said "of course! - of course!". Her angry reaction astonished me - she left her chair - " I have never being spoken to like that before!"

Striding across to the door she announced "I am going!". Shocked, I had said "I am sorry if I have offended you". Her rejoinder was "I am never coming back!".

I reminded her that she had already paid for her next session but she stomped out, as I followed to let her out of the front door. I was really confused by her reactions - but then recalled how she had spoken about the sense of being "put down by colleagues at work" - I realised that she might have taken my vehemently agreeing response for sarcasm\* (which I deplore - and would never allow).

So at once I computed a brief note - saying that if I had given some offence it was unintentional, and that I apologised. As she wished to terminate I enclosed the fee paid for session three. However, before I could go out to post it my client telephoned me, to apologise, and to confirm our next meeting! This she attended much more settled having meantime been successful at a new job interview - taking her to another country to work.

\* ie "the meaning of the message is the response it elicits ".



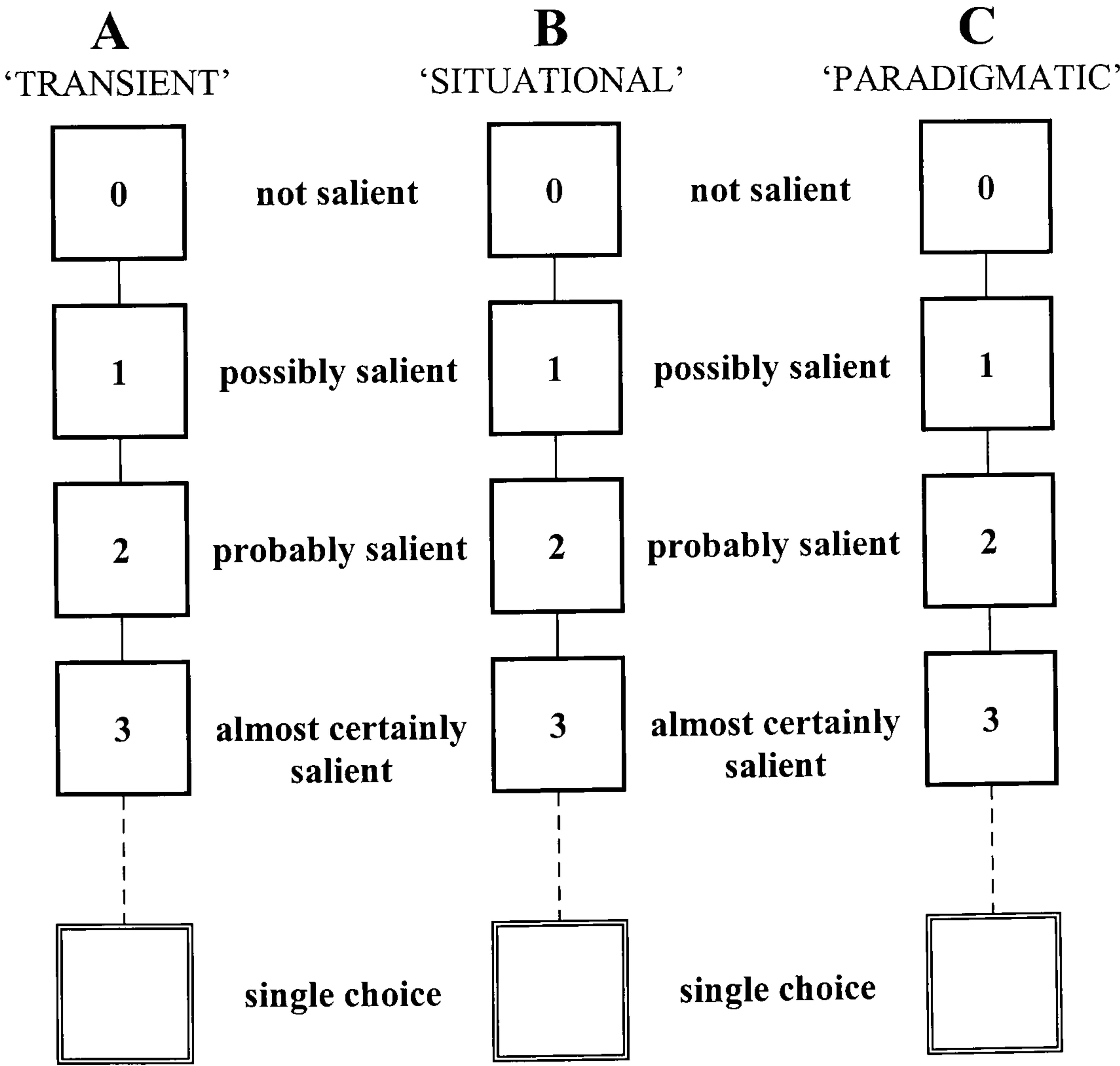


**FEMALE COUNSELLOR, PSYCHOLOGIST, PSYCHOTHERAPIST**  
**TRANSACTIONAL ANALYSIS / HUMANISTIC ORIENTATION**

Client began relating story of her colleague and during the telling, I began to recognise the main character in the plot as someone else who I was working with. At almost the same time, my client said "...and then, because he works with you...". At this point I asked her to stop her story, and focus on the issues that were directly pertinent to her. I knew that I felt uncomfortable, but didn't immediately know what to do - if she hadn't said that she knew of our (his and my) working alliance, I think I might well have let her finish and then taken the issue to supervision for a bit of help.

I explained to the client facing me that I was being given information that I was not feeling good about hearing, but that I felt that she would know that I was doing my best to protect everybody's confidentiality but asking her to focus on her issues in the situation. She surprised me by saying that she felt safer in our relationship - she'd been fantasising that 'he' had been talking about her. This was now put to rest for her.

I believe our relationship improved as as result of this encounter.



The "event" occurred in and between the two sessions leading up to my annual August break - though in retrospect I can see that the process was in place for some weeks/months before. Mr B had been in therapy almost nine months and these months had proceeded rather benignly. He had commenced six months after a rather unexpected separation from his wife of five years and was feeling utterly lacklustre in his approach to life. He was diabetic and unwilling to take responsibility for managing his insulin - had a history of self harm - and relationships with women who similarly harmed themselves.

During the penultimate session he came wearing socks unlike any he had ever worn before. I commented. He told me they were his wife's socks and he had found them while he was "clearing out" her belongings. He said she had cruelly deceived him and loosely linked her "behaviour" with me. I wondered if our impending break was the link.

With my comment he grew very angry - began to shout and began to say that I was crushing him - likening his experience to being an insect being trodden on. For some ten minutes (felt like longer) I felt bombarded by a fury of words and unable to respond. He left the session in a fury. I felt depleted, exhausted by him - aware of death, dying or wanting to be dead myself. Actually I wish in those moments after the session that I could just slip away and die. For some days (whole weekend) after, thoughts of my own death just spun around in my head. I even imagined how I would die and felt shocked by how calmly I contemplated the whole issue. I wished I could see my therapist - but she was on holiday too! And just being able to think about this help[ed] relieve some of the pressure. Being able to link my therapists' unavailability with a very significant personal loss of my own just twelve months prior to this time somehow helped me know the place I was in with Mr B. I got hold of Thomas Ogden's book on projective identification, had a supervision session and returned to the next session in a very different frame of mind. So also did Mr B. He said that he had been "obsessed" with seeing/searching for dead animals on the roadsides. Somehow being able to locate them helped him believe that they had actually existed. I felt very clear that I was identifying with this 'dead' or "near dead" state that it appeared he also knew/felt a lot about also. He went on to say that since his wife left he felt like his life was just slipping away from him. He felt closer to or even dead himself.

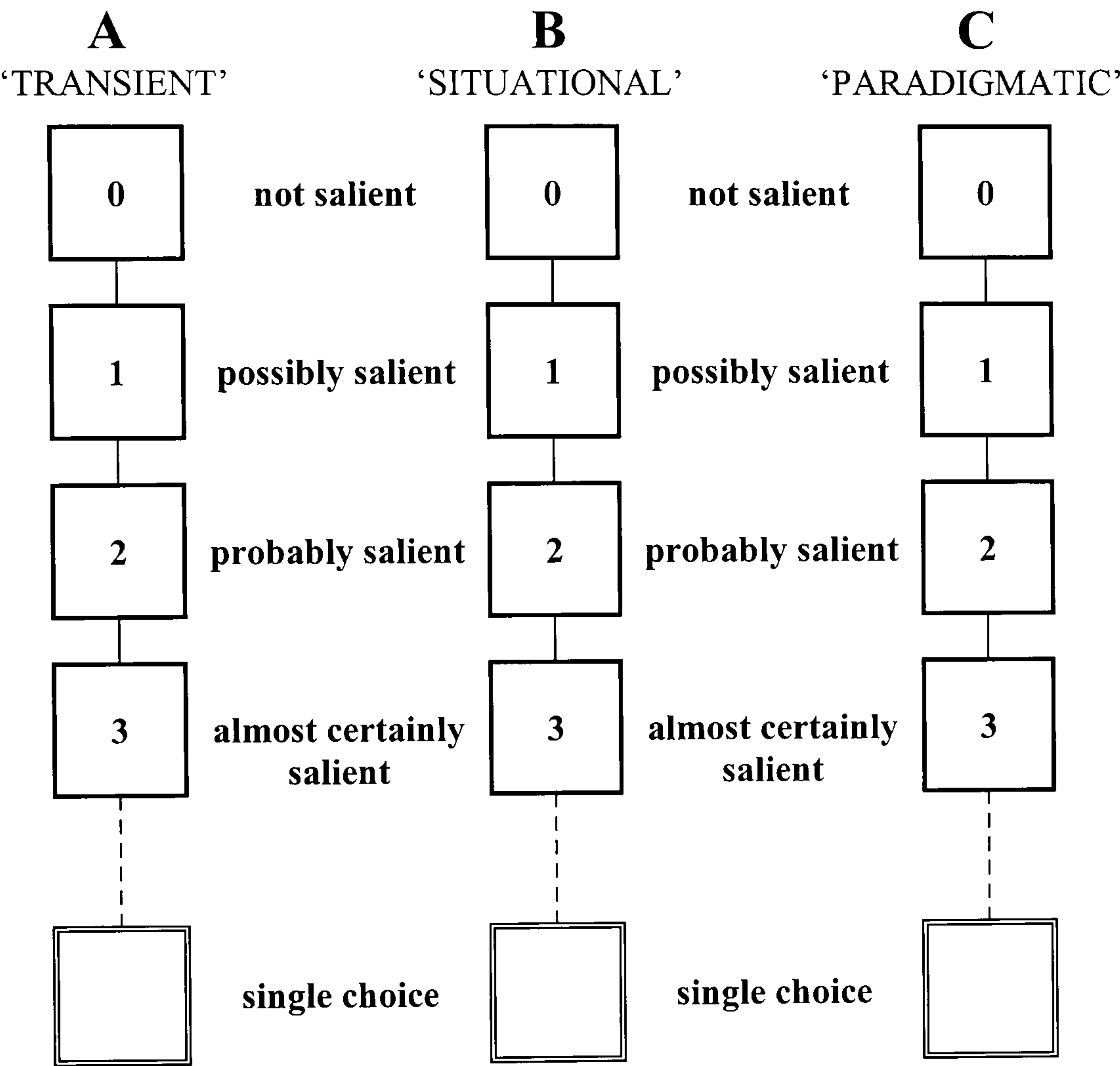
#### How the situation turned out

This moment of insight was short-lived. Mr B returned after the break - continued to be furious with me. By now I had taken my own identifications with his material further back in my developmental history but unfortunately I suspect I wasn't 'on top of it' enough to manage the situation with Mr B. He stormed out of a session soon after and never returned.

I guess I discovered that I'm not the best in the world dealing with communication at this level. I'm a 'thinking' therapist and when I am not able to think I know less about how/what to do. That includes managing my own stuff though I suspect that I'm getting better at this with time, therapy and experience.

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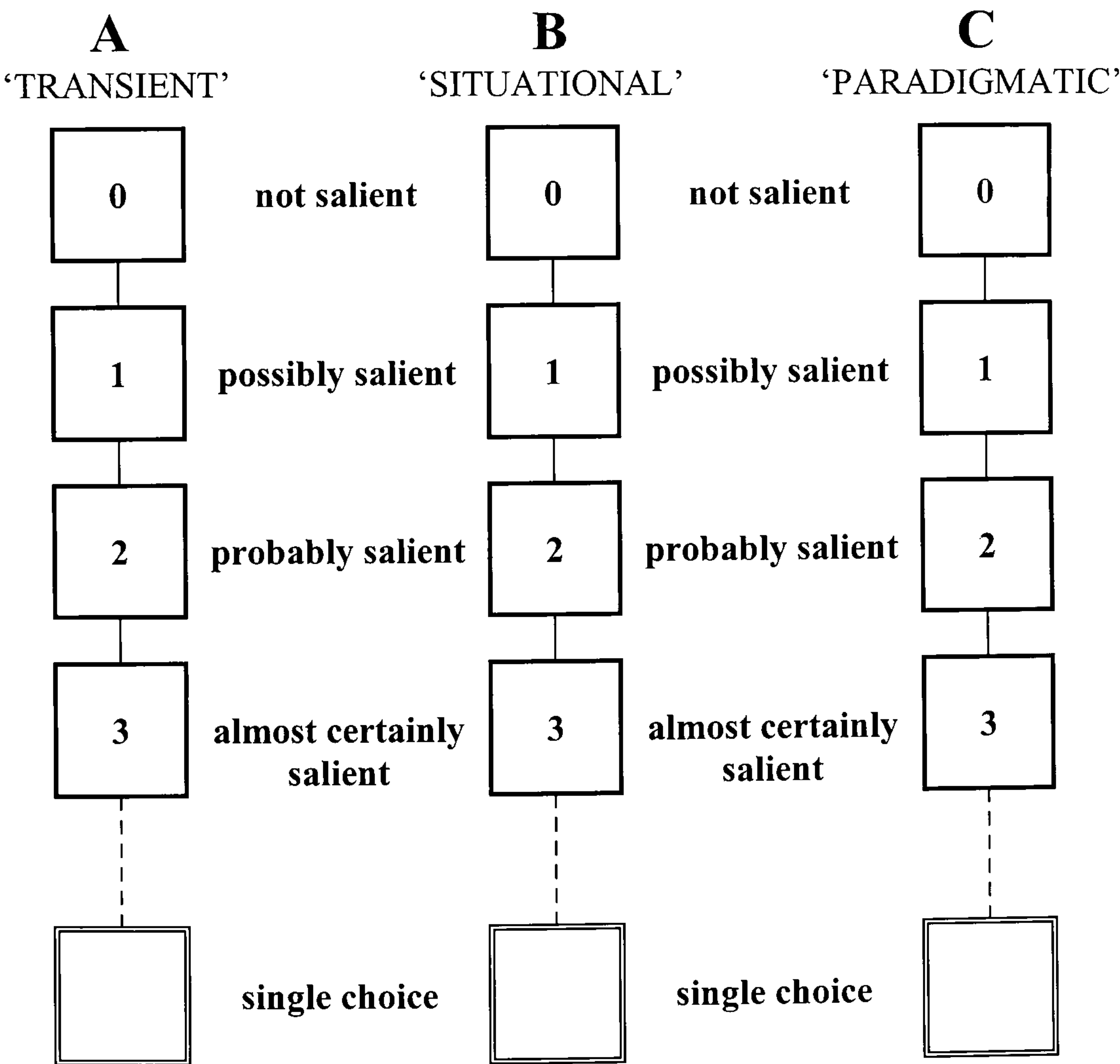




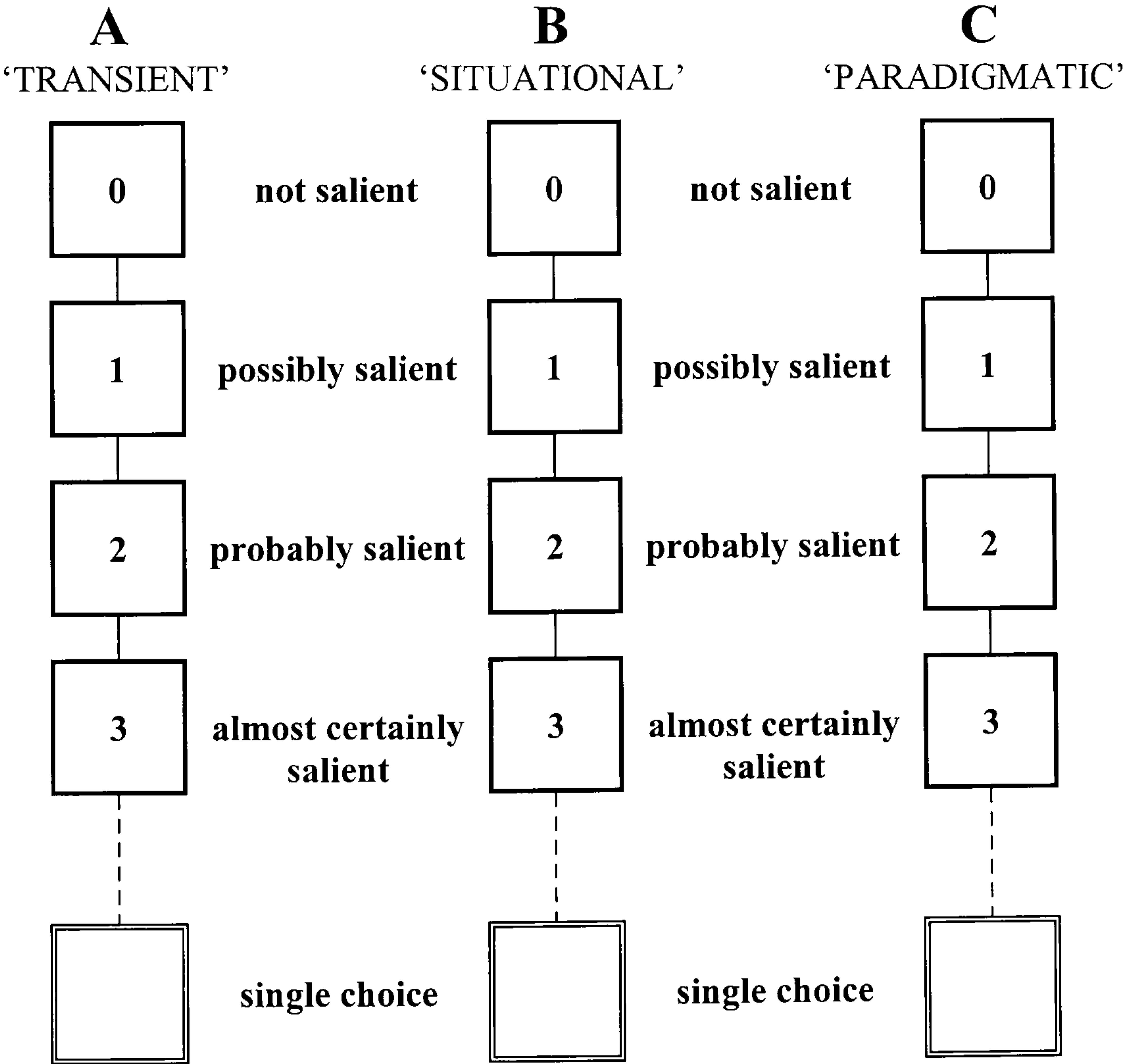


I am having difficulty disengaging my patient from what feels like a successful therapy of approximately 18 months duration. The presenting difficulties have diminished, work and personal relationships have improved but she fends off an ending; "it's not yet time, still very uncertain, worried about recurrence of symptoms etc". We talk over her fears and reflect on her wish to make therapy her 'home' but she still holds on to the sessions. Part of me is drawn to give her a push, and an opportunity arises when she unusually defaults on two consecutive appointments. I draft and send a carefully worded "perhaps it's time to discontinue/break..." letter.

The letter crosses in the post with her note, apologising for her absence, and informing me that her father had taken ill and died very suddenly. She was obliged to return home at short notice and had only now found space to contact me. She asked for a further appointment. I feel a certain guilt that my 'shove' was annoyance based and perhaps precipitate. A second letter is drafted and sent and I'm due to meet the patient again shortly.



The patient told me she was un able to come to her session the following week because of a professional commitment outside her control, and asked if I could see her on another day. I agreed to see her on a different day, and a different time. I actually forgot the arrangement we had made and although I was in, I was not expecting her when she arrived and had to keep her waiting a couple of minutes while I got the room ready. It was clear to her that I had forgotten, and she was quite upset and angry when she came in. We had a difficult session because she could not easily voice her feelings. These only emerged after she left the session and for a few weeks after that she was very distrustful and hostile, feeling I had abandoned her, and was punishing her for the change in session which I had agreed to. I felt very bad about the mistake in the first session, and found it difficult to think about what it might mean in terms of the transference. In time I was able to relate it to her own early experience and a deeper layer of mistrust which was there all the time. I "became" her neglectful (as she felt) mother, who was too busy attending to other children to give her the attention she wanted and needed. In the end it was helpful, but at the time I felt I had done her some awful injury and wondered if we would recover from it.



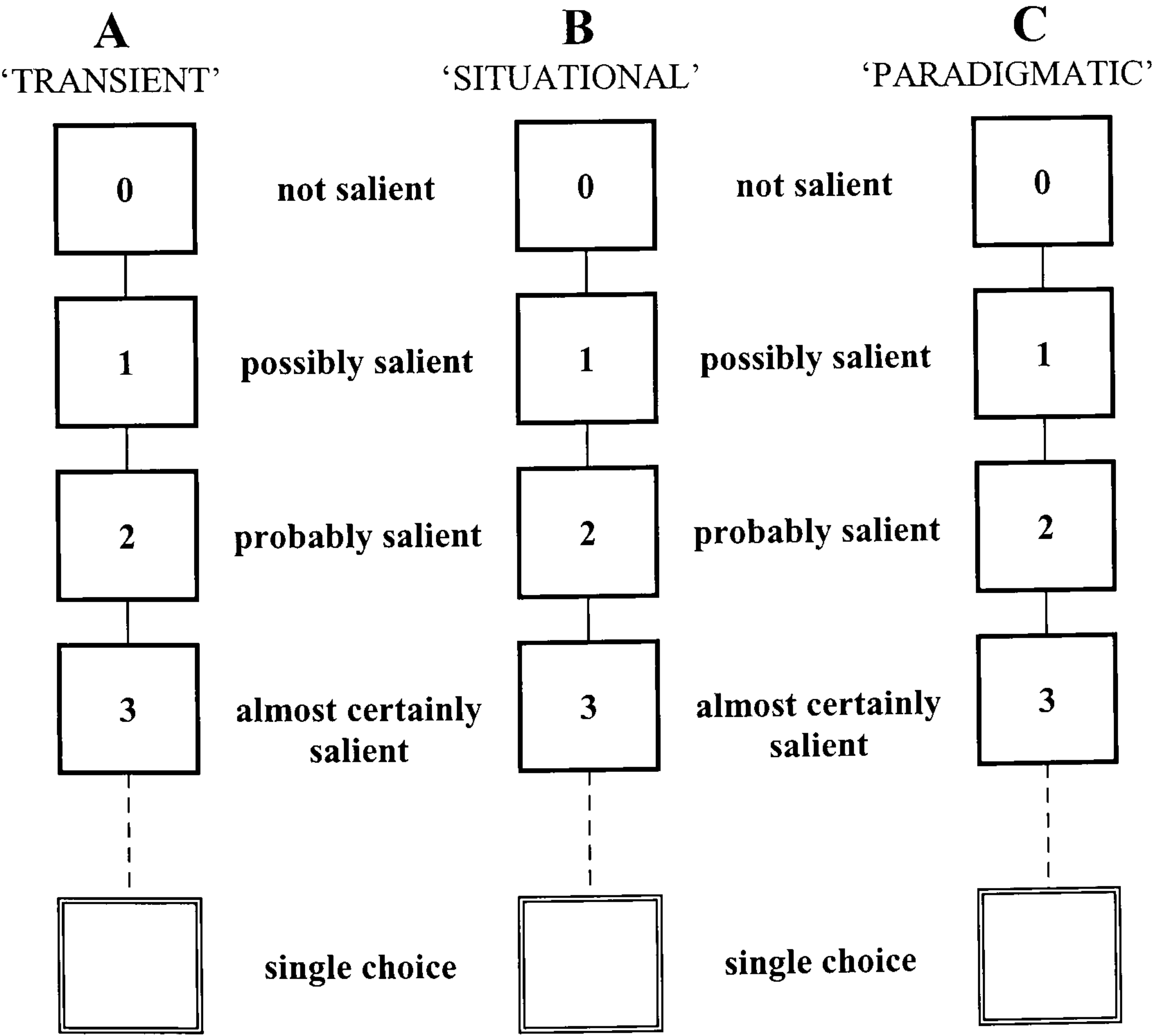


I had been seeing the client for long-term, three times per week, therapy. She had developed an intense transference towards me. She was threatening self harm on a regular basis and was often very very angry in the sessions.

In this particular session, she was very upset. She said she felt suicidal and I was incompetent and unable to help her. She launched into this tirade against me, saying that I was completely useless and was actively undermining her, getting at her and deliberately saying things that would make her feel worse. She said that I was not experienced enough to deal with her problems.

I had begun to dread sessions with her. At the time, they seemed like a terrible ordeal that I would have to go through. They loomed up in the week and I felt anxious and sickly before them. I felt completely abused by her, kicked around and battered. I felt angry with my supervisor and felt inadequate as a therapist. I had been seeing her once a week but my supervisor suggested I would be better able to contain things if I saw her three times per week. She constantly made complaints and tried to contact me outside the session.

In the particular session, I felt overwhelmed, I was concentrating on trying not to respond in a negative way - but inside - I hated and loathed her. She suddenly stood up - took the tape out of the machine - said she was going to take it to the press and the hospital authorities to complain about how awful I was. She was a minister of the Church and in a powerful position. I was stunned. Upset, sick all weekend. I felt useless. She came back on the Monday, bringing the tape. She had played it to friends. They had commented that I sounded 'nice' and as if I was trying to help her, but that she was too busy shouting at me. She apologised and the sessions continued. They were still difficult but never as bad.







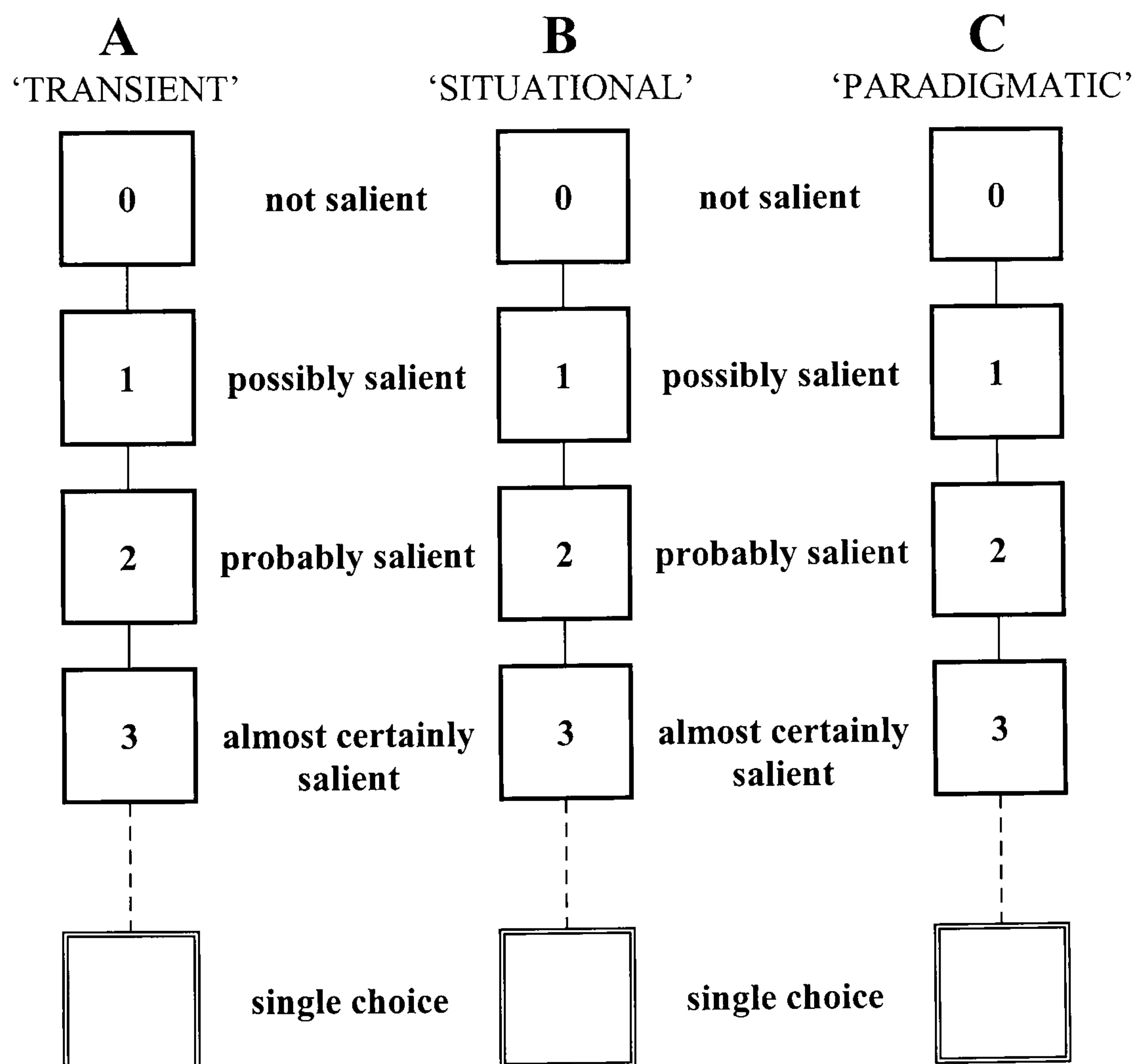
A taciturn, near to silent client.  
Uttered statements with little consequence.  
"Sent" by his wife.

My approach of empathy: frame-working came to naught.

His sense of motivation was, to me, grounded and I felt impotent and speechless

My unconscious, inner world started to unfold into rage, shame and hurt - towards him.

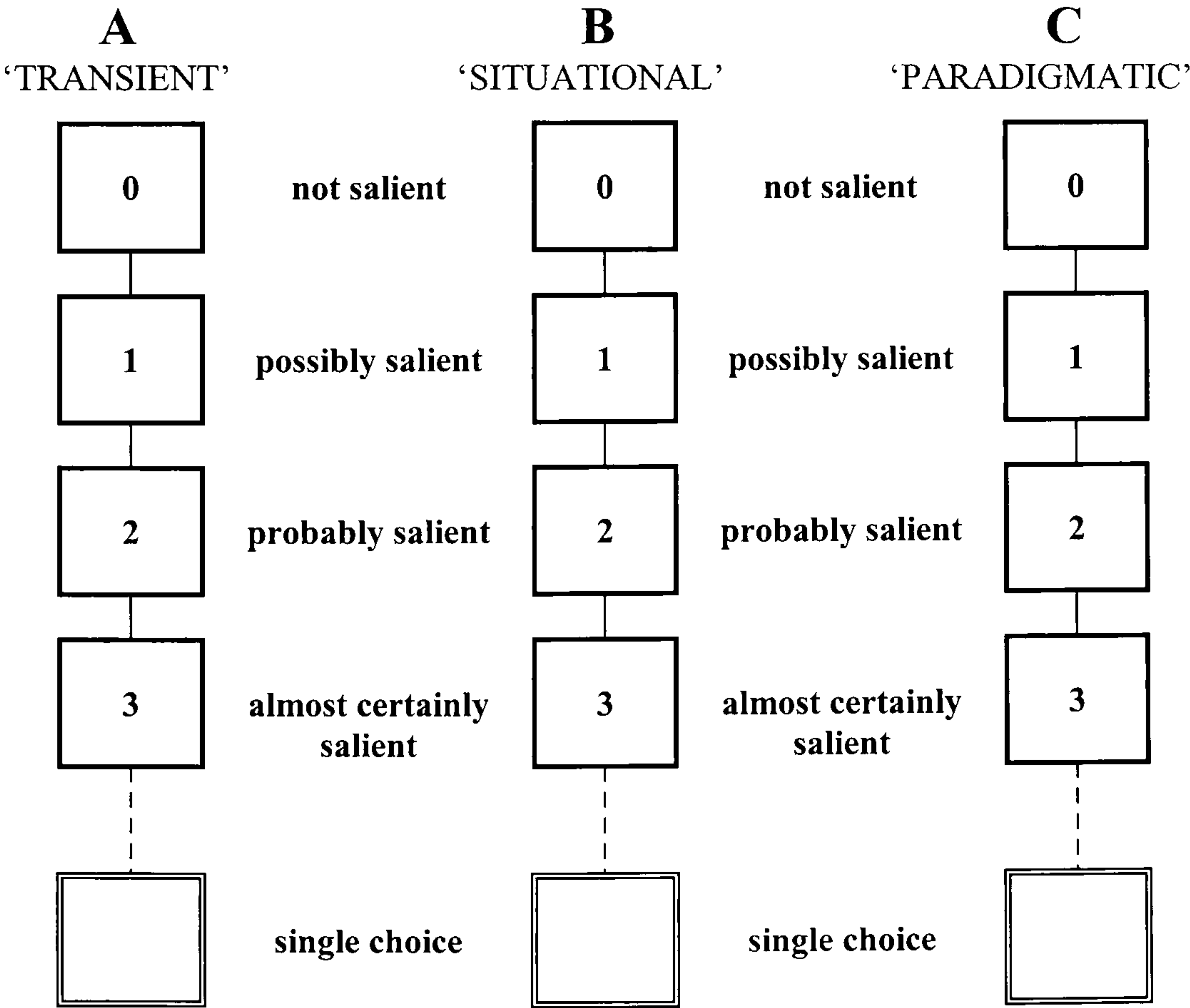
Supervision was my safeguard and boundary-zone. A writing/reading of Winnicott's "Hate and love in the counter-transference" proved an anchor.



The young woman I was asked to counsel had recently experienced a Crown Court case as a witness. The defendant had allegedly and with much substantive evidence sexually assaulted her for many years. The case was dismissed and she felt crushed and vulnerable. However, during the trial, she developed a strong relationship with a man, 10 years her senior, (she was 18) who championed her and gave statements supporting her case. The difficulty which arose was his constant attempts to intervene/interfere in the process of the therapy. My client was loyal to his views and interpretations of what was going on in her psychological make-up. She was emotionally exhausted and felt unable to do anything. He protected her from reflecting about the past.

It was very frustrating for me to engage my client in any meaningful work at first. She dissociated or showed signs of inertia.

I decided to use psychometric testing to get her to focus on her feelings and anger which she denied. I explained to her partner the importance of enabling her to be more autonomous and decisive as no doubt the responsibilities for him of undertaking these tasks must be restricting for him. He agreed. My client expressed her feelings of anger once she felt able to identify them and attribute them appropriately. In this way we worked through the various areas of concern, and she felt able to assert herself with members of her family and her partner's. She found it hard to do the testing - as it forced her to focus and think but she persevered. She realised she did not have to please everybody and that after the initial surprise, her family began to take her seriously. Gradually her boyfriend relaxed his control as he accepted I was not trying to separate them or reduce his image in her eyes. They moved into a place together - her choice - and at a distance from her mother. My client learnt to set personal boundaries and to use her increasing energy to return to her previous interests. She had lost any confidence she had when her case was found in favour of the defendant, but she learned to accommodate her traumatic past and is now focusing on her new life and relationship which fulfils her current needs.





This client - I'll call her Anna - was referred to the psychology service in which I work with the informally conveyed information that she had been 'through the system' with little change over the years.

The incident I am going to recount was brief, and at the end of our third (therapy) meeting. (After assessing Anna for our service, and discussing her with my peers, I decided to offer her therapy with the clear boundary of 12 sessions.)

At the end of our pre-therapy assessment meeting Anna had shaken me by the hand. At the end of her first therapy session, she had shaken me warmly by the hand.

At the end of her second therapy session, Anna had taken my hand in both of hers, looked into my eyes, and held my hand warmly and long, saying 'THANK YOU'.

At the end of her third therapy session (which constitutes the incident in question) she took my hand and drew me into an embrace. I managed to release from this hug/clinch, and said - I hope both sensitively and firmly - that although shaking hands was in itself an acceptable way to end therapy, generally I saw physical contact as outside the remit of therapy as I engaged in it. Anna was clearly upset; but I in no way retracted from what I had said - and the therapy session ended there.

My feelings were strongly that: my professional boundaries had been overridden; and that this was a 'dangerous' client, able to manipulate situations and people, and that I would be at strong risk of losing the effectiveness of therapy if I did not stand my ground on my professional boundaries, and keep to focused therapy.

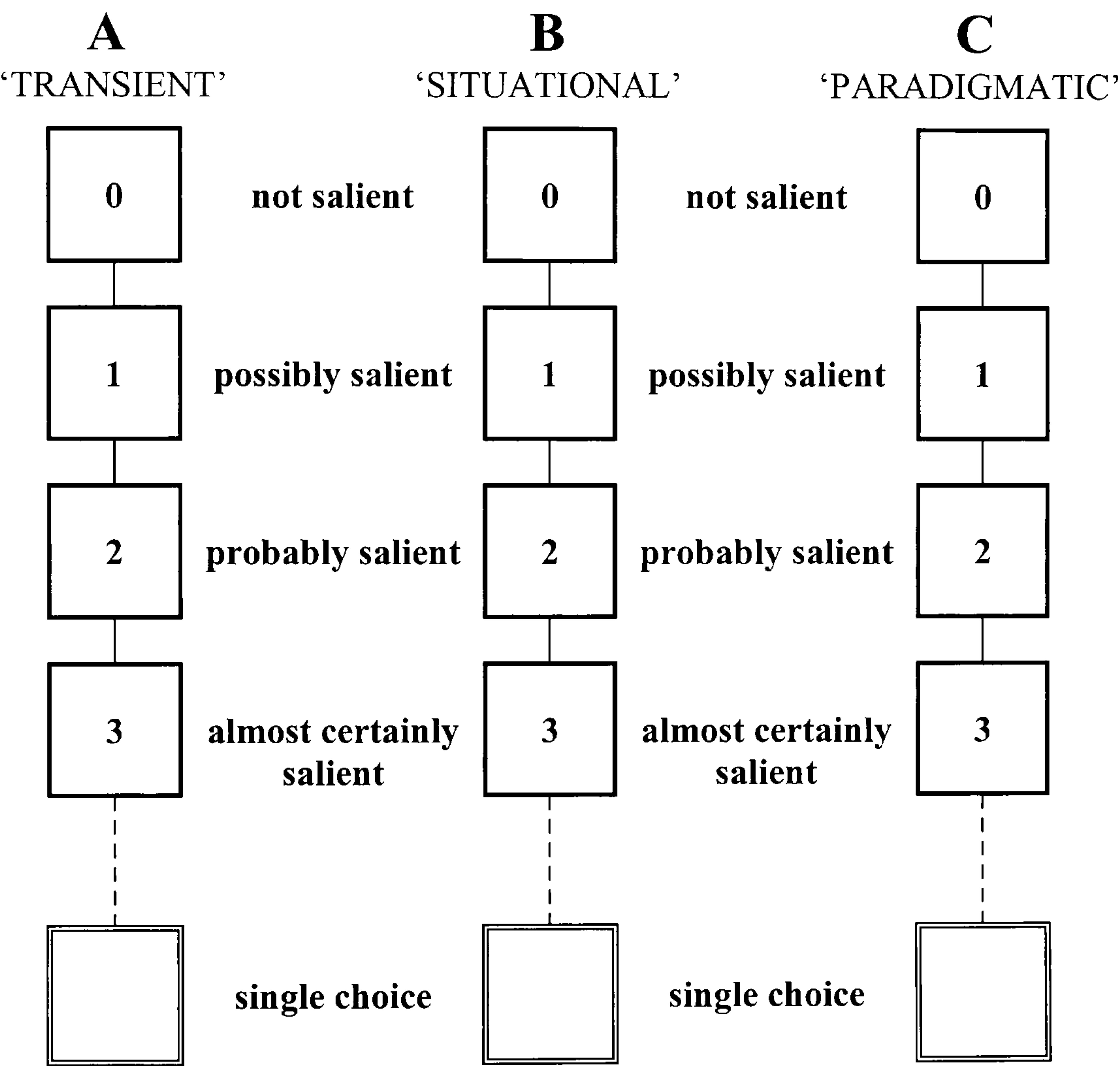
The way I dealt with the difficulty was to state clearly to the client that, in my frame of reference, her actions were outside the remit of therapy.

I, of course, discussed this incident informally with colleagues, and more formally in our peer supervision group

I began my next session with Anna by saying that I realised that she had been upset when she left the previous session. She acknowledged this, and told me that sessions with her previous therapist/s had always ended with a hug (and I don't disbelieve this!). We then went on with therapy.

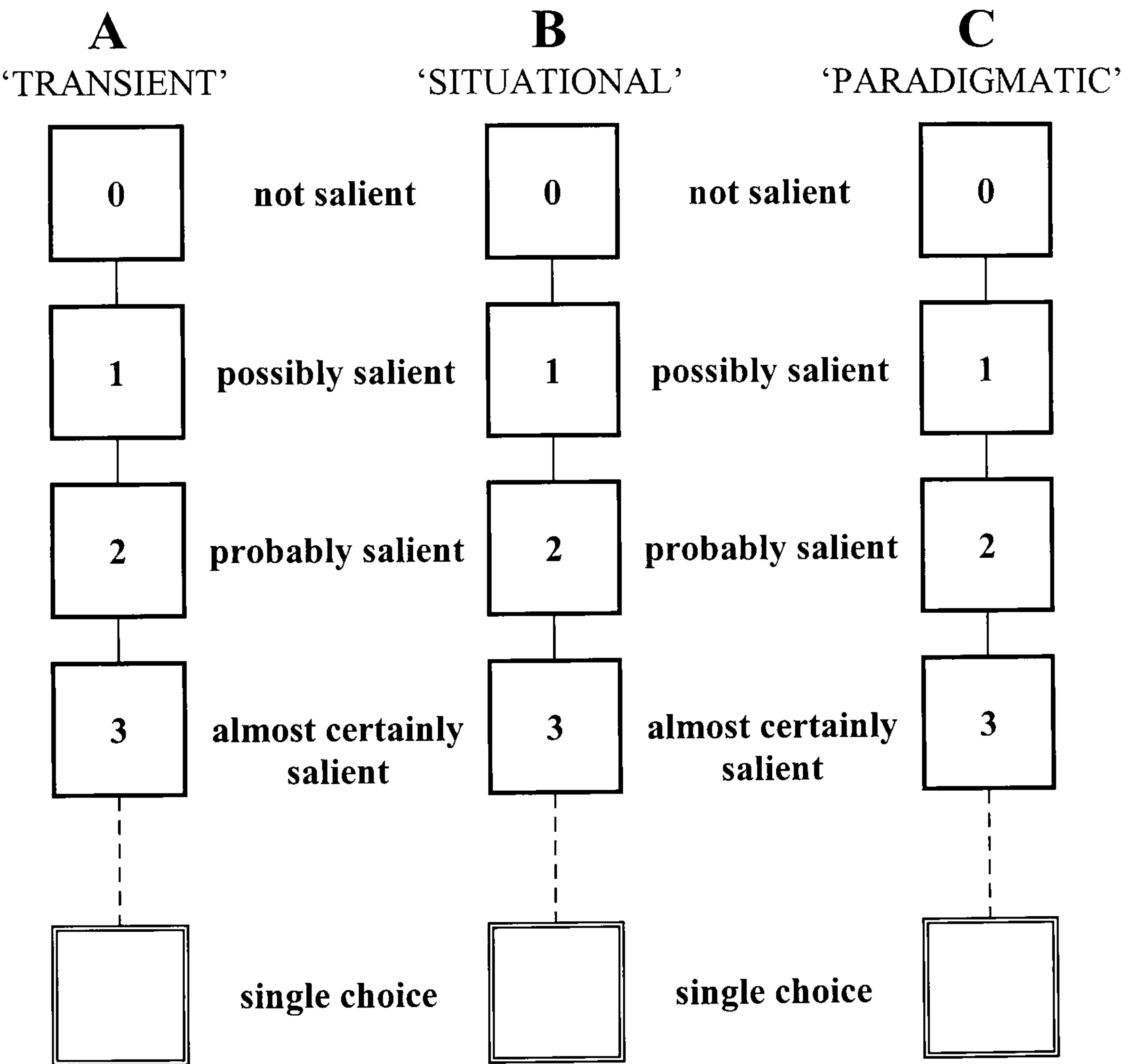
Anna has now had eleven of our sessions of therapy and seems (to my multidisciplinary colleagues' amazement) to have used the brief, focused, time-limited format well. Boundaries, of course, are crucial to this process; and this (uncomfortable) incident provided a very clear in vivo example!

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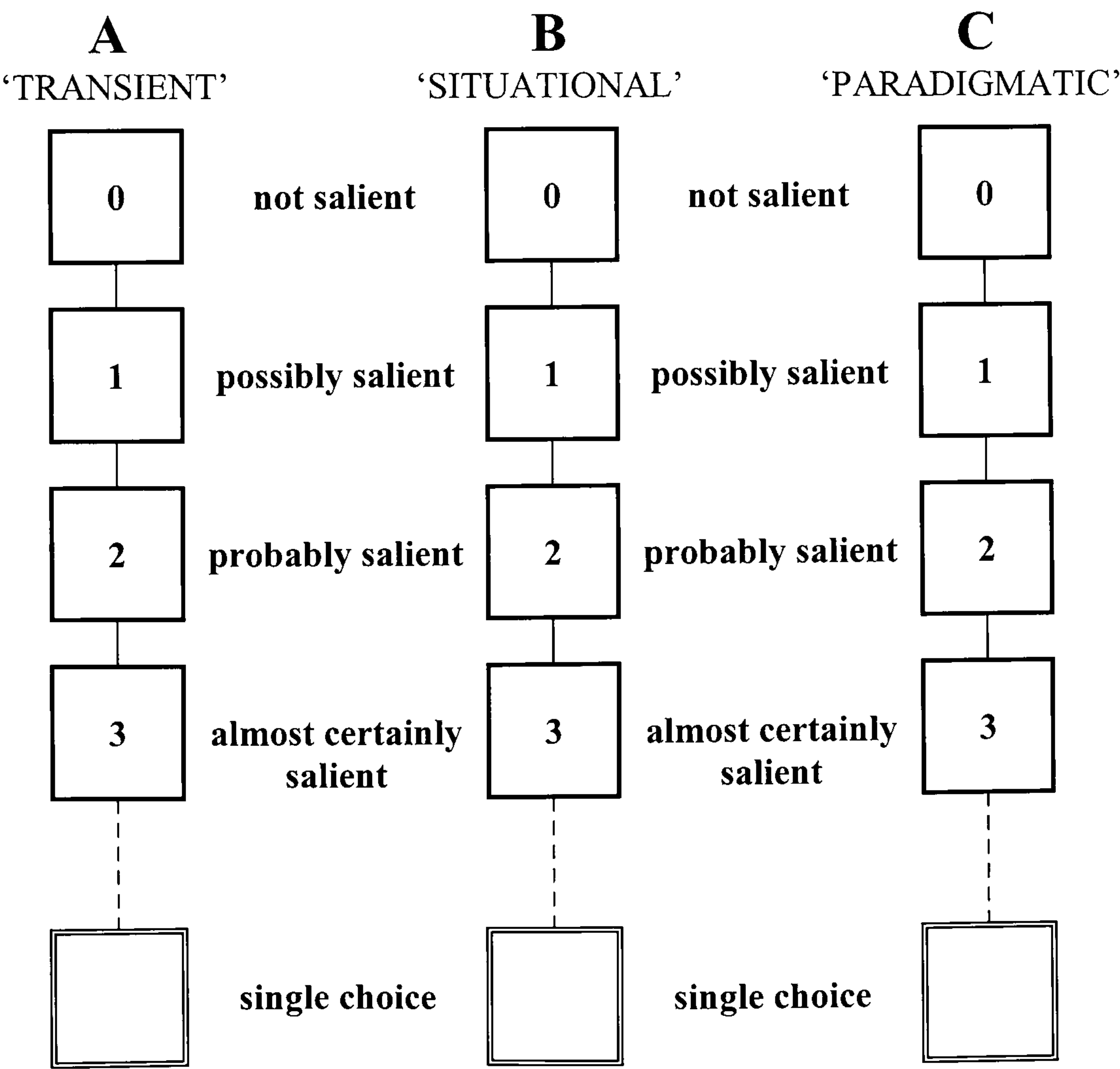
War veteran with chronic PTSD and alcohol abuse. Frustration at cycle of remissions and relapses. Difficult to unearth the "softer" side to his personality, but was a likeable chap which allowed me to continue. Used much confrontation and "straight talk". Outcome successful largely - although he will always be disposed to the use of alcohol to "solve" or hide his problems.

Also involved wife which helped greatly.



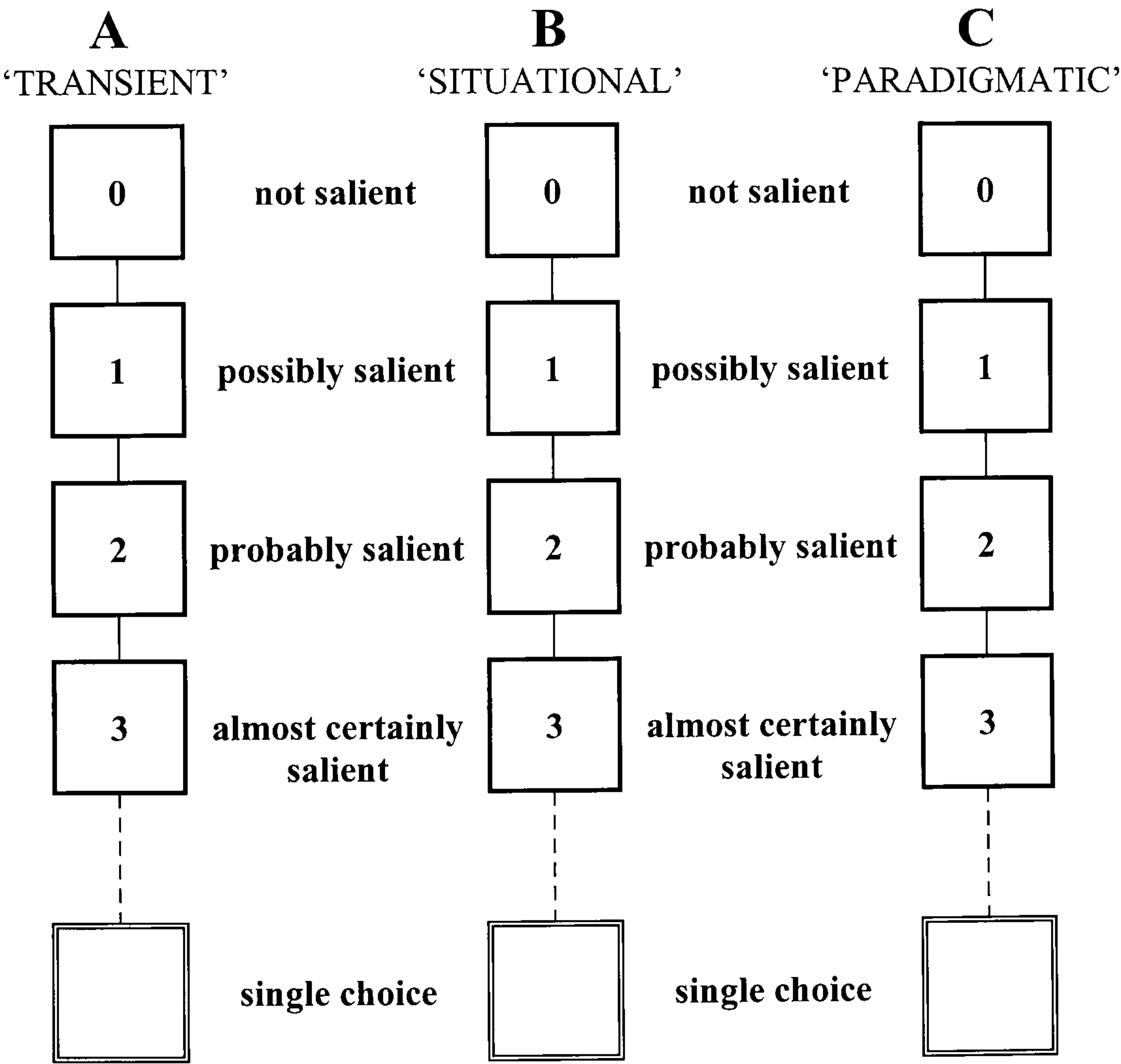


The person who comes to mind is one of the first patients I saw, soon after starting in a psychotherapy job in the NHS. She was a lady whose diagnosis was Borderline Personality Organisation/Disorder and she was the first patient I had seen for twice weekly therapy. Although she sustained denigrating attacks on me for the four years I saw her, it was not those that I had the problem with. The occurrence that made the situation difficult were her repeated attempts to physically hug me, along with demands that I hugged her. These demands and attempts at physical closeness came at the end of sessions as we stood up. At this time, I was not a very experienced psychotherapist and felt anxious and somewhat overwhelmed by this lady's constant need, attempts and demands to breach the physical boundaries of the therapy. Although her childhood experiences made this behaviour understandable, insight did not help. My feelings at the time were also accompanied by fears of failing as a psychotherapist if I couldn't contain her. How I dealt and coped with these experiences was influenced by my supervisor who was a very experienced and supportive consultant psychotherapist. She helped me find words and ways to address this lady's needs and, eventually, the physical displays stopped, although the verbal attacks continued throughout the four years.

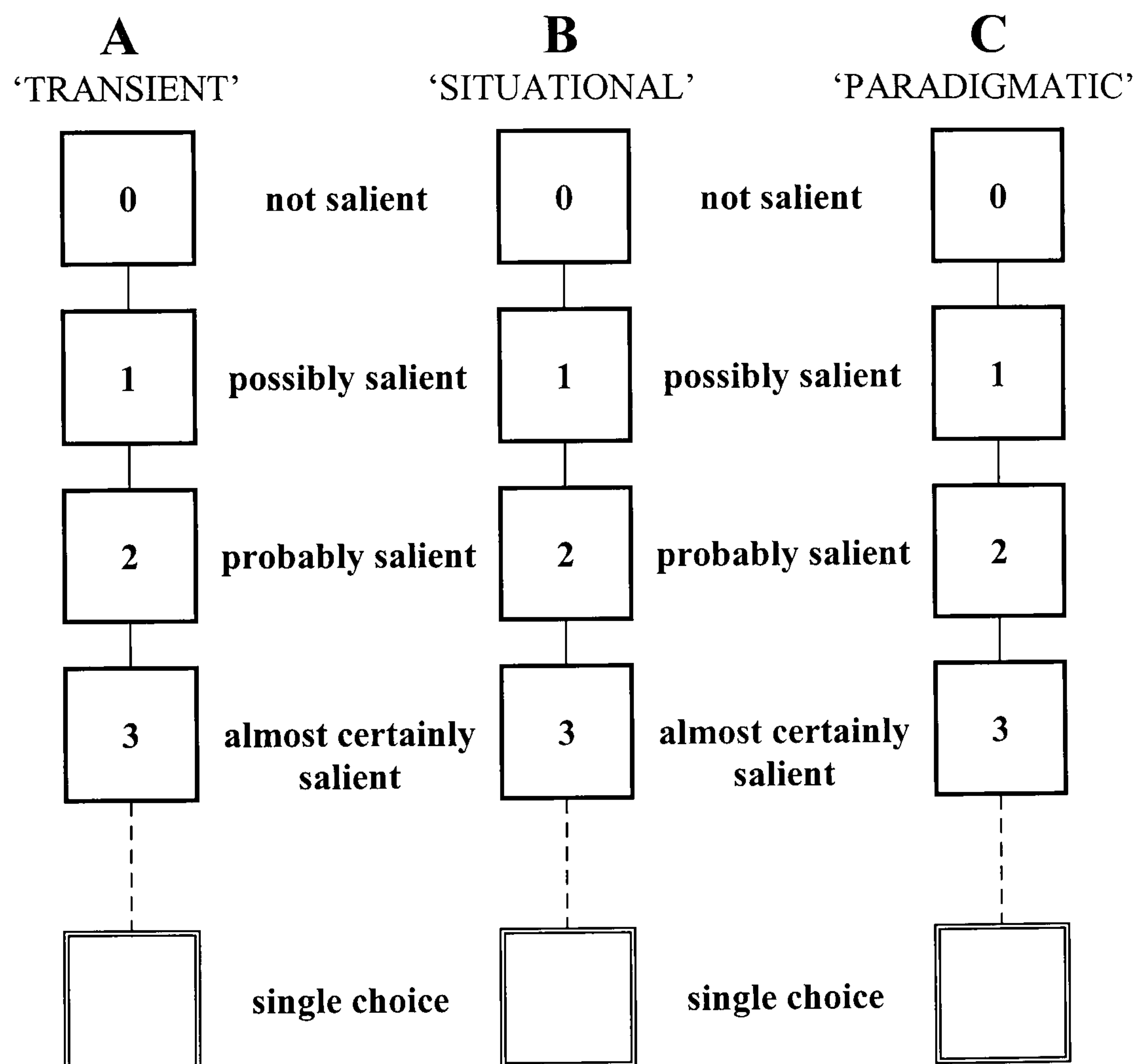


This (current) case has some similarities with the other. The client has low self-esteem (in some areas only), depression, constant tension and fear of mental illness. He is afraid of showing vulnerability to others and of being 'destroyed' by them - and is therefore apt to back off and distance whenever we look too directly at the distress he feels.

The work is difficult but I find it - and him - less difficult because I have become more confident and experienced at working with process and at 'metacommunication'



The client was referred for depression. However, in addition to this he described life events as causing him difficulty eg loss of job and relationship. Described himself as bisexual which was not a problem but then described finding young boys attractive. This was not discussed in detail. I felt he was deliberately trying to shock me. We focused on CBT for his depression but I felt uncomfortable in the same room as him and felt like washing my hands after he left. He defaulted after three to four appointments.



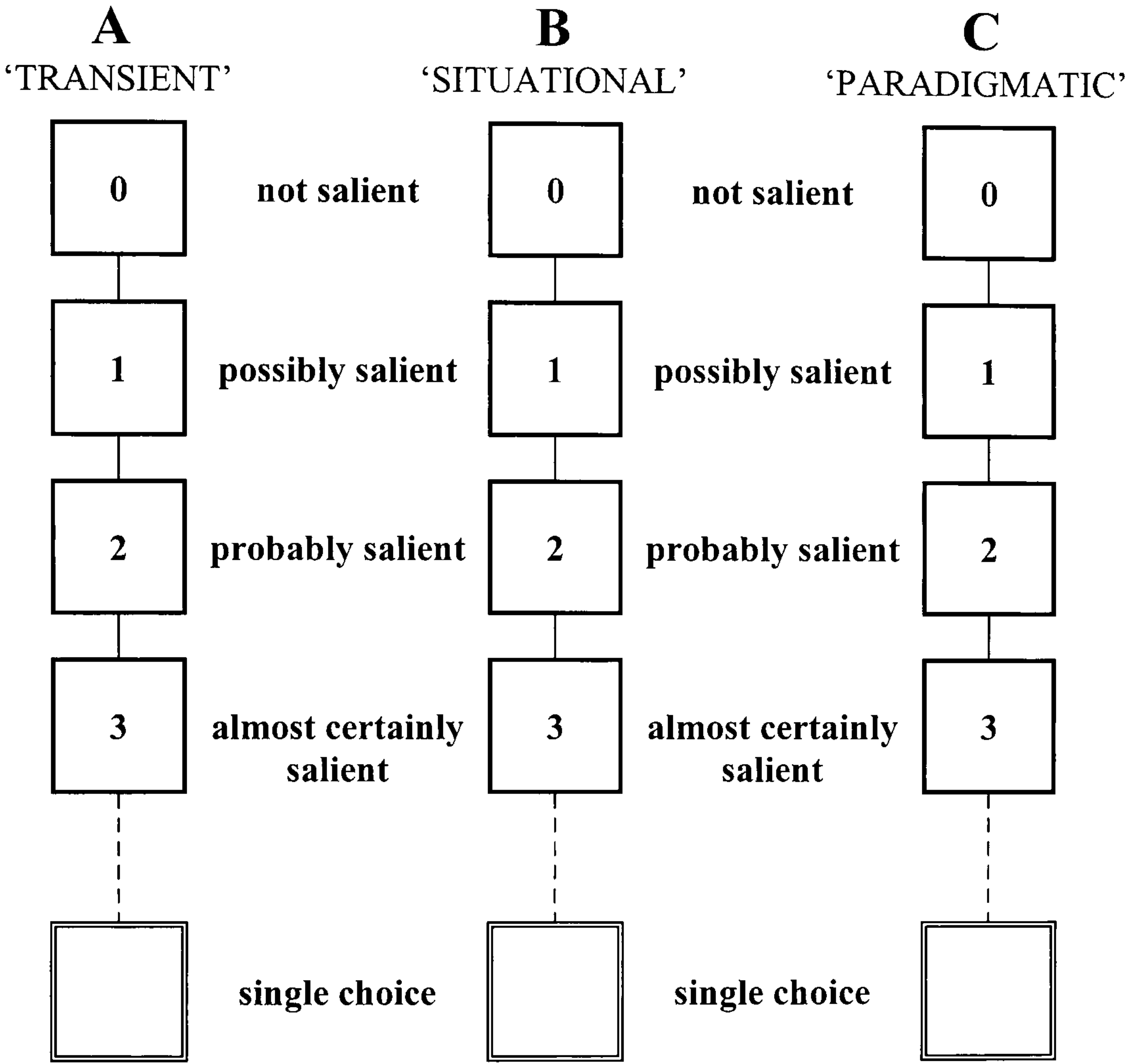


This concerns a single parent called Sonia. I saw her as an NHS patient over a long period, weekly at first, then less frequently. Probably more than two years. She was about 49 when I started seeing her. She was miserable, lonely and ridden with guilt and a sense of failure. She had two failed marriages. She had three sons, the oldest two being drug addicts and very unpleasant characters. She lived with her youngest son, Stephen, aged 19 years who was quite bright and a gentle sort but had not so far succeeded in anything, was misused by others, occasionally got into trouble because of others, and had never worked. During all the time I saw Sonia I made no headway at all. Everything I could suggest to try to improve her life she had tried; every way I tried to help her take a different perspective on things she argued against. I felt quite hopeless and at times angry with her, but we both kept on meeting. I saw Stephen about three times to no avail. I left the NHS in 1992 and have a small private practice. On the occasions I thought about Sonia I felt relieved that I did not have to see patients like her. However a few years on I got a phone call and I immediately recognised her voice. She told me that about eight months earlier, Stephen had died of an overdose of Methadone. She wanted to see me to try to understand why this had happened and why his life went so wrong. I had no hesitation in arranging an early appointment as I was very sad about this. I saw her at the University where I work as it was easier for her to get there and there was no question of my charging any fee.

The session was difficult because of the pain involved; I had liked Steven and cared about him even in the brief time I had known him. Either then or later I was angry with him for making such a mess of his life and causing his mother such grief (as Sonia herself was to reveal later). Towards the end of the session Sonia asked if she could see me privately and I immediately felt depressed and hopeless. I did not wish to see her because I felt that I had escaped from all this and was free to choose whom I wanted to see. At the same time I felt very selfish and rejecting of Sonia. I am sure, however, that I could still act in her best interests. I was certain that the same thing would happen as before. One of the issues had been that Sonia felt guilty about Steven's inability to make a go of anything and it seemed that she had assumed too much sense of responsibility for him and unable to let go of him. The reason why she wanted to see me was that I had known Steven and she wanted to understand what she did and didn't do to cause him to fail at so many things. I felt she was perpetuating her 'holding on' of Stephen and this was not helpful for her. I also abhorred the idea of taking money from her as she was on benefits. I suggested to her that she has a fresh start with another therapist and I could suggest the names of some colleagues. I sensed that she felt rejected by this. I really did not feel it would be any help at all to see me but in the end I relented.

I saw Sonia for about six sessions. (It turned out that her oldest son had also died.) Exactly what I predicted happened. After the last session she wrote to say that she had decided not to attend again. I was relieved at this.

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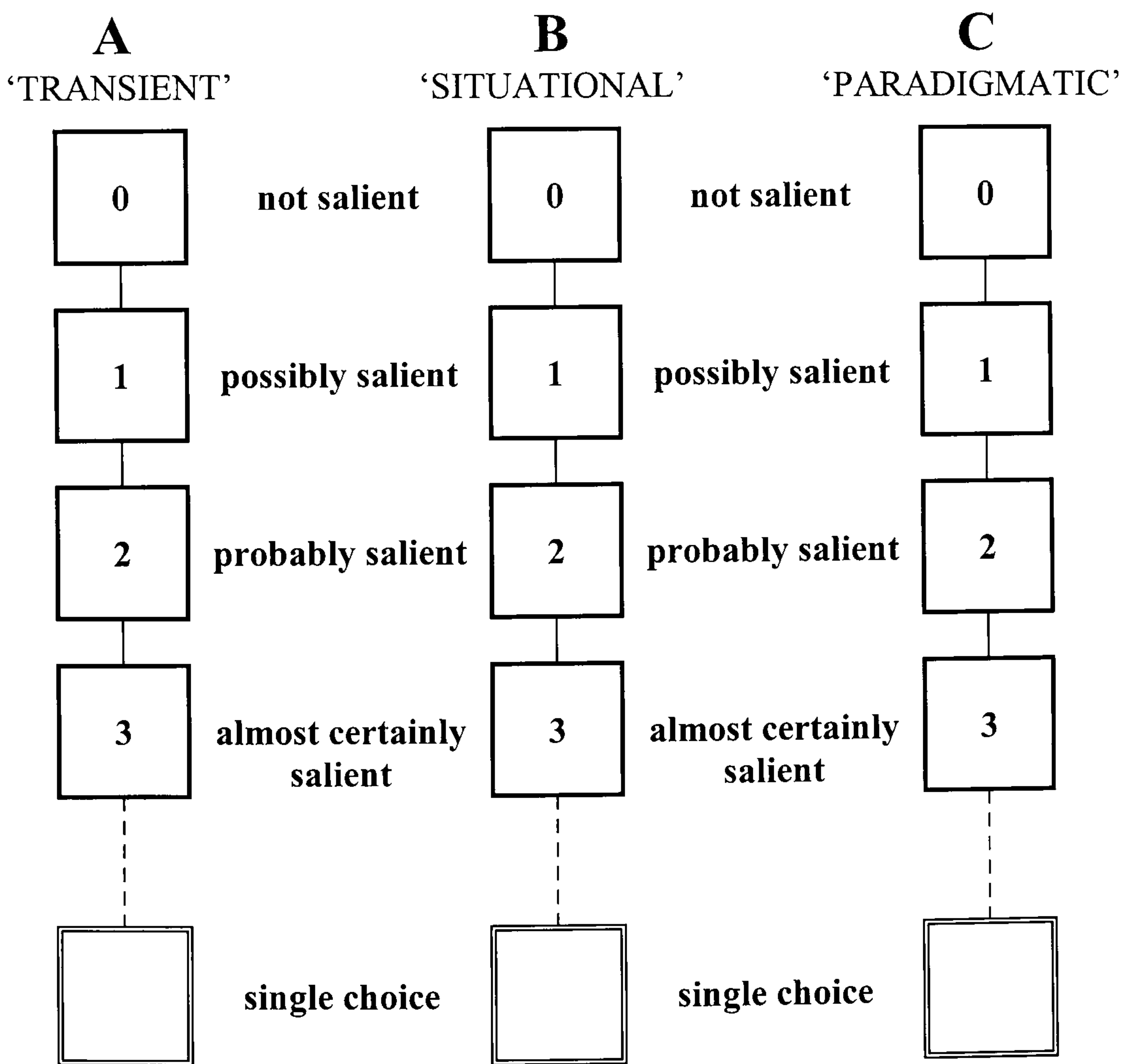




My immediate thought on reading what is requested, is that patients are "not so difficult" as colleagues or managers - .

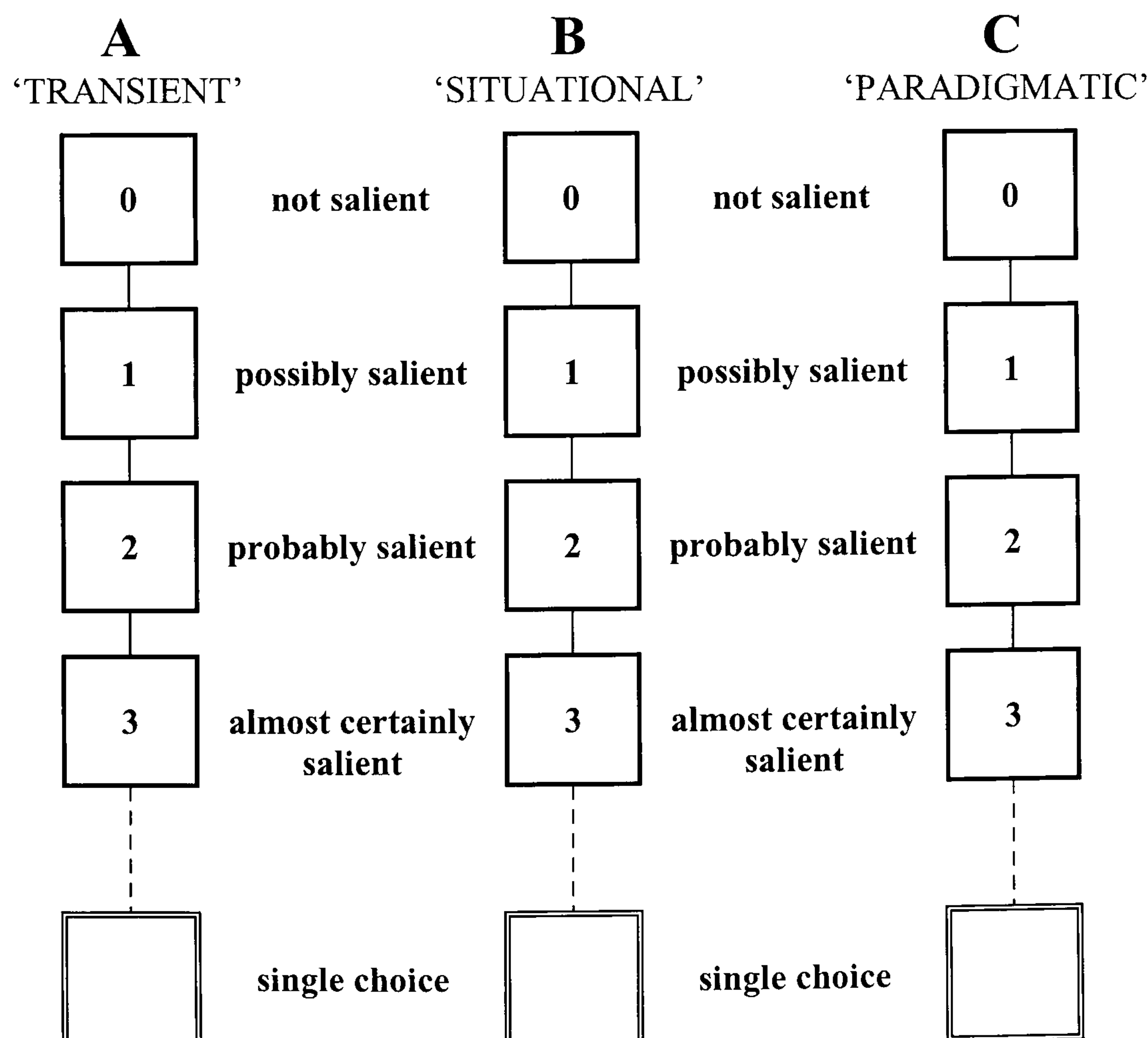
However the patient (not so difficult) a likeable man early Forties in brief therapy - six sessions - referred by GP. Client wanted help to restart his life, had not worked for many years because of tinnitus and fear of failure, wanting what he did undertake to be perfect so did nothing. Conversely there was a fear of intimacy for my client and "I invited" unintentionally more "disclosure"/ intimacy than the client retrospectively could comfortably within the brief therapy could be tolerated. I experienced great regret when talking about it in supervision that I had possibly intensified the clients difficulty rather than alleviated.

The incident/difficulty was in the third session the client came having shaved off his beard saying "he had decided to allow me closer" - (and to use the sessions) - by lowering defences rather than maintaining them to arm himself for the less than perfect therapy/world/relationship/etc. I was left feeling/carrying the failure of being a very much less than perfect counsellor. He was able to smash and break his sculpture for not being perfect - I felt the regret for this which he then owned. By the time the ending came - having offered another six sessions - the beard was well grown again.

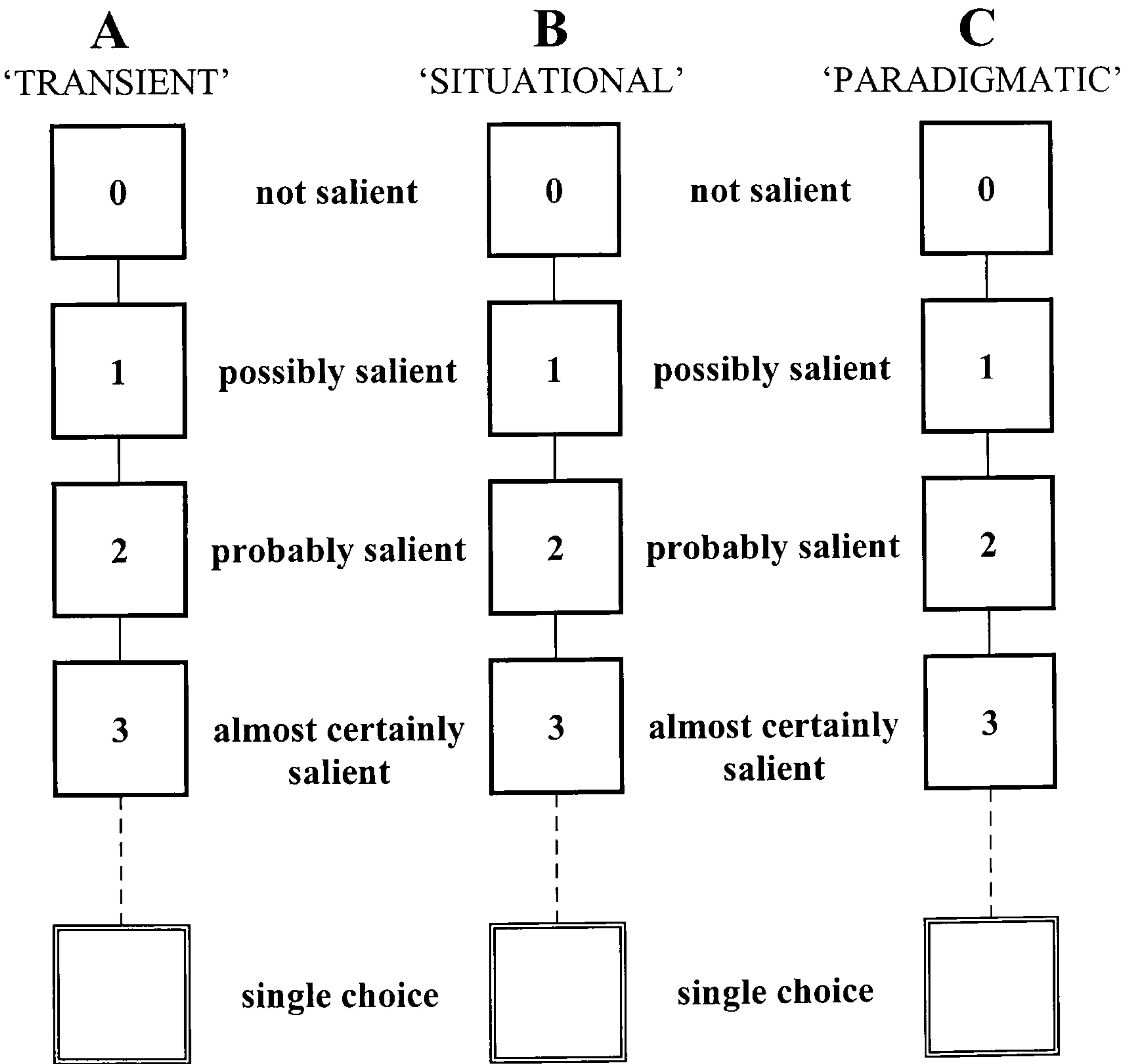




At the end of the session I felt exhausted.

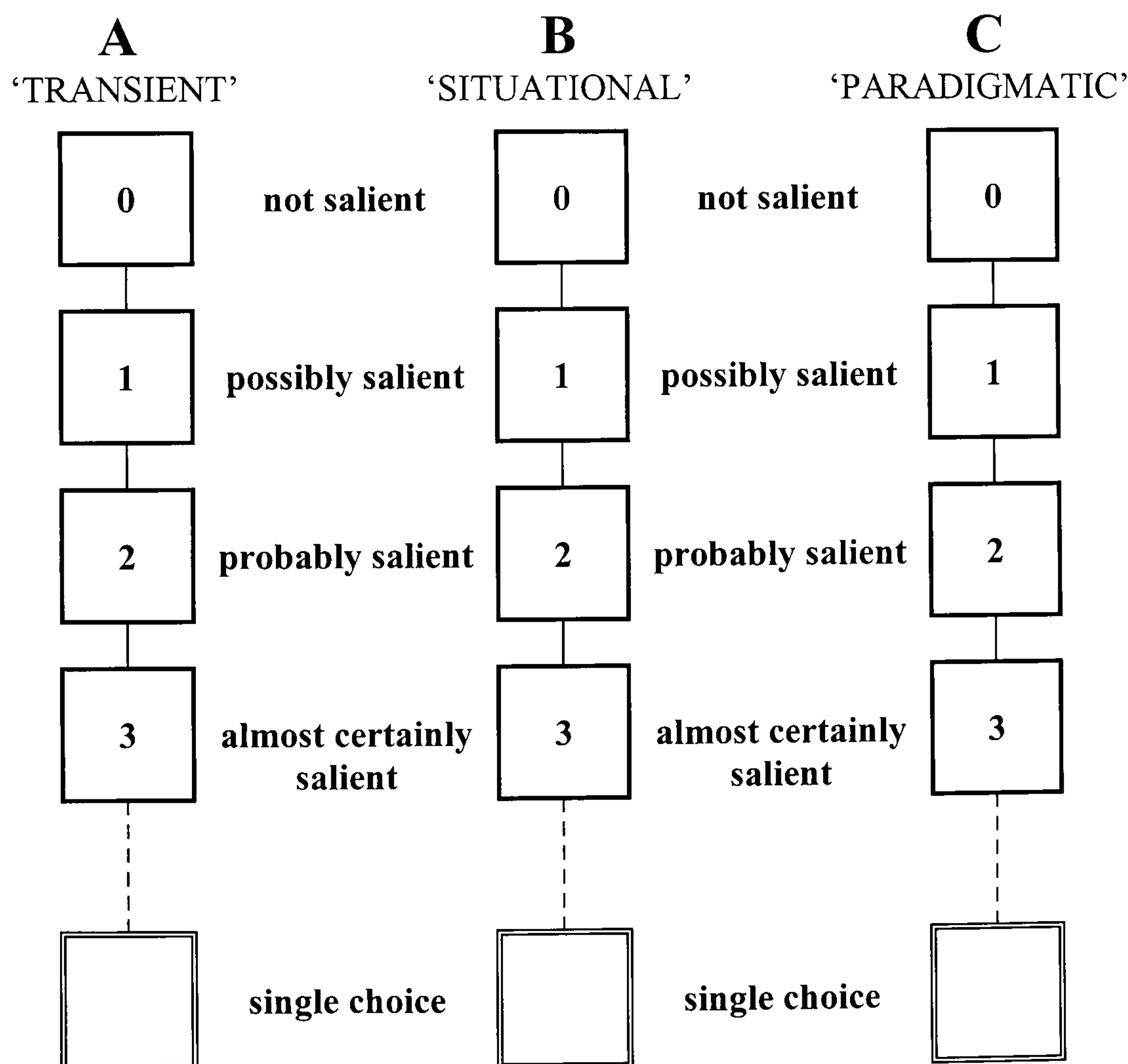


My patient, M, is a woman of 44 years. She is a professional in a senior position. She is very attractive, and personable. I am aware that she is the sort of person I would choose as a friend, - interesting, witty, clever, outgoing etc. She came to see me when her husband (of ten years) suddenly left her to go off with another woman. She was very distressed. M has had considerable health problems. She has had her large bowel removed and has an artificial bowel. She had had several near death experiences on the operating table. After approx 8 months of therapy, she became seriously ill again, which resulted in an operation for gallstones. She would be missing 4 sessions. She was very frightened and felt very alone. She relapsed into feeling as depressed and distressed as she had been when I first saw her. I felt very tempted to abandon my therapist role and be her friend. This I had no intention of doing, but I did wonder how to manage her hospitalisation. In the end I visited her for 15 minutes, taking her some flowers. She was pleased to see me but I kept the visit quite formal. We resumed therapy and worked to a conclusion. She expressed her desire to be close to me.



What I found difficult about this lady was that she presented as an intelligent, verbal person for was able to quickly grasp concepts and appeared to be enthusiastic to work. However, quickly I got into a powerful experience where she constantly questioned me about every aspect of the therapy. Kept asking impossible questions about the process and I ended up feeling deskilled and persecutory when I didn't answer the questions. I felt like I was failing at all levels to provide what she needed and that I was being punished accordingly. This lady would also not leave the room at the end of therapy and constantly complained that the time was too short. On one occasion I had to open the door and ask her to leave and still she tried to re-engage me in conversation on the door step. This made me feel like I was rejecting her and I became afraid of my own ability and desire to persecute her in return.

I dealt with this by taking it to supervision with a colleague and looking at the dynamic and transference. As a result I began to interpret my feelings towards this lady and most of the questions have stopped and she is able to relax enough to get into the therapy and work and only questions me at the very end as a race into omnipotence.







The patient is an anorexic. She was admitted to the ward weighing just over four stone. I was asked to see her on the ward by the consultant. She was there for about three months and I saw her weekly with her weight increasing to 6.5 stone when she was discharged with the idea of continuing to see me weekly. So I now see her weekly as an out-patient. Since discharge about eight weeks ago her weight has increased, but only by about 3 lbs.

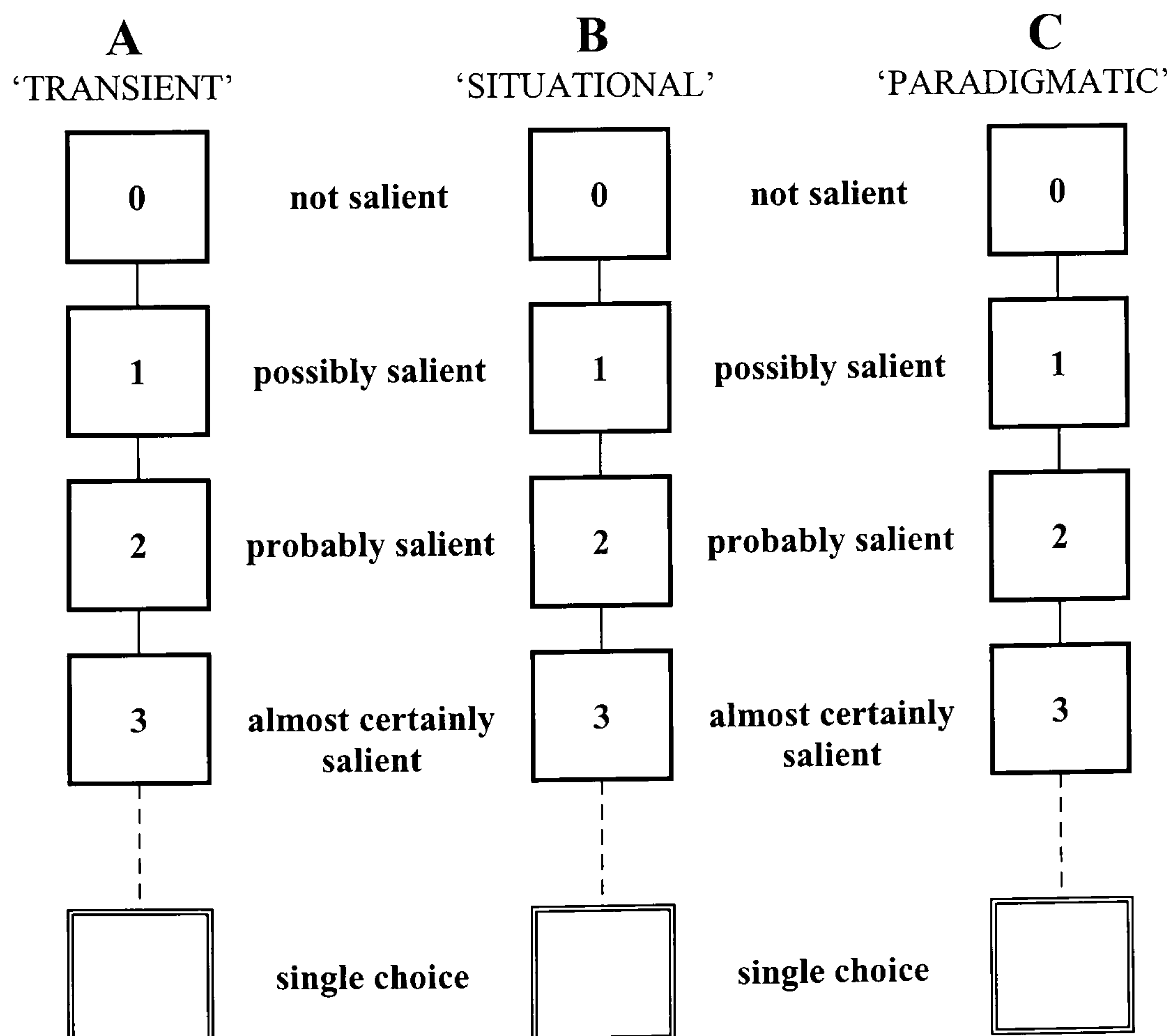
In the sessions she presents the same every time. Everything is fine. She has no problems. There is nothing to work on. She talks easily but says nothing. She stares all the time - her eyes are very wide and she looks directly at me the whole time - even when she is talking. I find it quite unnerving. I feel frustrated at having nothing to do other than pay attention.

The most powerful feeling I have is boredom. She is a person living, apparently, without conflict and stress. She is very good at separating other people's problems from her own. Yet she ended up close to death.

How do I cope or deal with it? Try to directly challenge her over the lack of conflict, excitement (hence my boredom) and emotion in her life. She understands my comments. She tells me that, nevertheless, she is happy with her partner, her family, her friends. She has interests and she is pacing her life well.

I guess the bottom line is that her weight has at least maintained itself but I feel that there is an intense denial and perhaps I have a feeling of being pushed out.

I continue to see her.



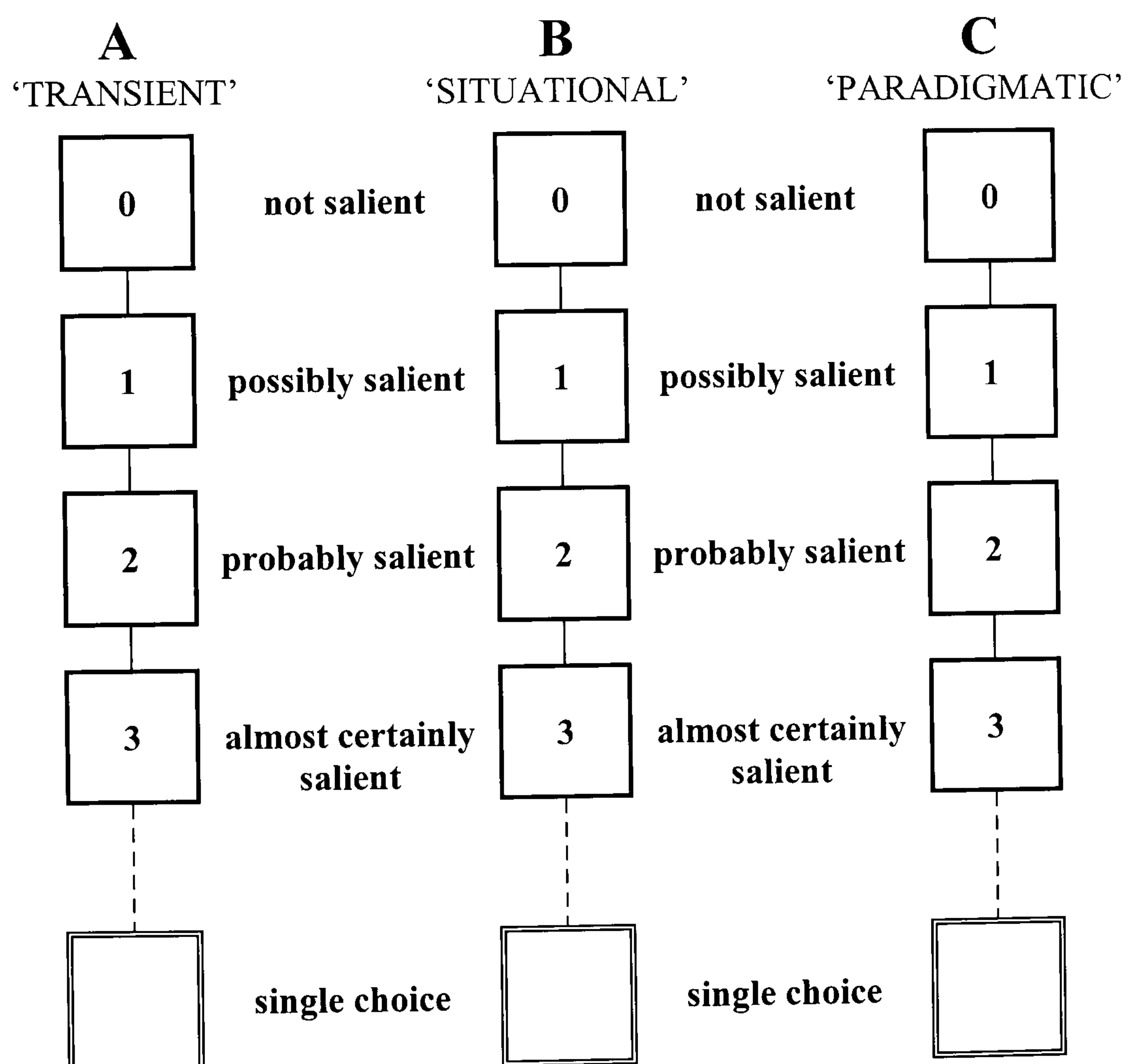


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The patient was describing a recent incident where he had gone to the house of a work colleague who had allegedly stolen some of his tools. He said he had kicked the door in and consequently the villagers had all turned against him. He said the villagers had taken strong exception to his behaviour because the man's mother and daughter were indoors. He expressed his views thus: "Who the hell is his mum anyway? Queen Nefer-bloody-titi? She's an old hag. It was his fault anyway because he wouldn't come out. It was only a council house anyway."

I felt furious and had to draw the session to a close. Sessions have continued, but I have ignored this issue.



(As I am a psychologist working in a department including counsellors, I consider all my clients to be difficult, as 'not so difficult' clients are referred on to the counselling service. For this reason, it is difficult to select an appropriate client. The client I have chosen is one who I saw before the counselling service was available, and therefore more faded from memory.)

The client was referred for depression, and I felt it was due to a delayed grief reaction to her father eight years previously. She was happy with this formulation, and 'grief therapy' was generally straightforward (or felt to be). Despite the client working well, us having a time-limited contract which seemed adequate for the work to be done, and our focus (as it was grief therapy) always including endings of some sort, I found it difficult to end therapy with the client. I had generally found myself to be 'good' at working with endings and termination, so this client left me feeling quite helpless and frustrated.

We extended our work twice beyond the original contract, once immediately, and once after a break.

The client would generally work quite well, but as the end of therapy became close, she became very childish and 'stupid-like' and often seemed like she was proud and clever, amused by the fact that she couldn't understand what was happening. She stopped listening to what I was saying and seemed to be mocking me. It felt as if she was being deliberately 'disobedient'. Knowing that she could get away with it because she was just like a child. It felt like she was a child who had just discovered how to control and manipulate their parents.

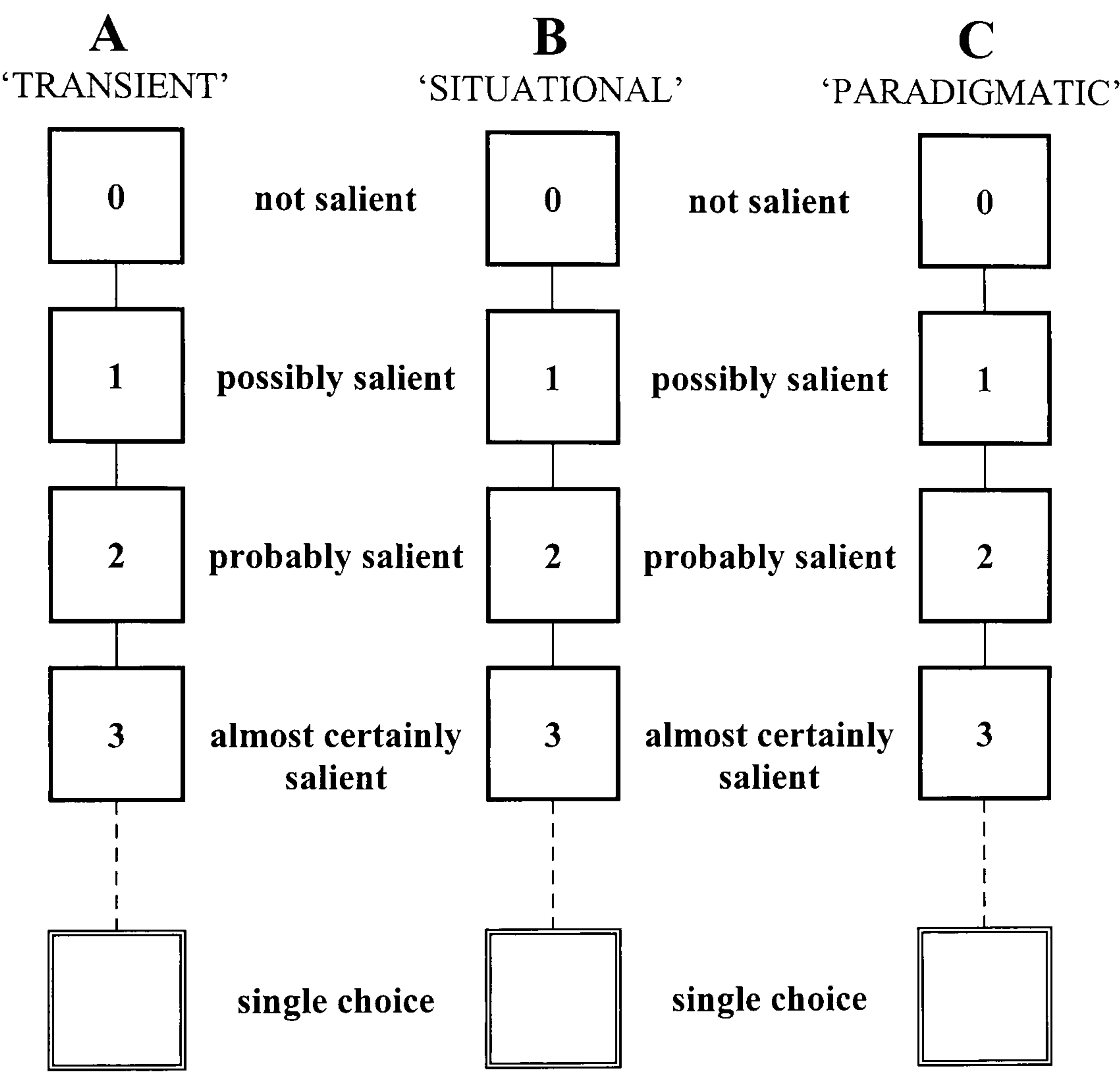
This obviously left me feeling angry and that it was an impossible situation. I felt hopeless, but enraged. I could not end therapy, as this felt like it was abandoning a child and therefore I could be disciplined for neglect. I therefore felt manipulated into continuing and it felt as if my client felt smug in the knowledge she had complete control over me.

On the second time, we came close to the end of the contract, she developed hallucinations and again I felt as if she was smug with the knowledge that I couldn't abandon her as she was 'sick' and couldn't fend for herself.

In both instances, I tried to explore more fully why it was difficult to let go for the client and for myself (again - lots of supervision). I found it difficult to empathise. It seemed again that she found pleasure in seeing me struggle with my helplessness.

Eventually, I was due to leave the surgery to which this client belonged and therefore termination with this client was inevitable (with me at least). The third attempt at termination seemed successful (although I am unaware if her symptoms returned at follow-up). I felt, however, that the success on the third occasion was something to do with the fact that I was actually/literally leaving and therefore could no longer be manipulated into staying (the client knew I was leaving the surgery). I am unsure as to how it would have turned out otherwise. I was enormously relieved at being able to end therapy with this client.

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**PSYCHODYNAMIC / COGNITIVE / HUMANISTIC ORIENTATION**

This is a woman in middle-age. Her children have grown up and are about to leave. She had ECT when the children were small and took an antidepressant for 20 years till she came off them to have a minor operation. She has since developed 'derealisation and depersonalisation': essentially, whenever she thinks about anything or remembers anyone/anything, she asks herself 'are the feelings there that should be there?'- these feelings are not there and then she seems to panic.

The patient focused totally on the symptoms of derealisation. She was demanding help and I found myself working very hard - trying my level best to help her. Nothing I tried helped. I tried to formulate things with her in some detail - all my hard work and no appreciation, no benefit. Left me feeling impotent and, worse still, I didn't see how I could ever escape from her.

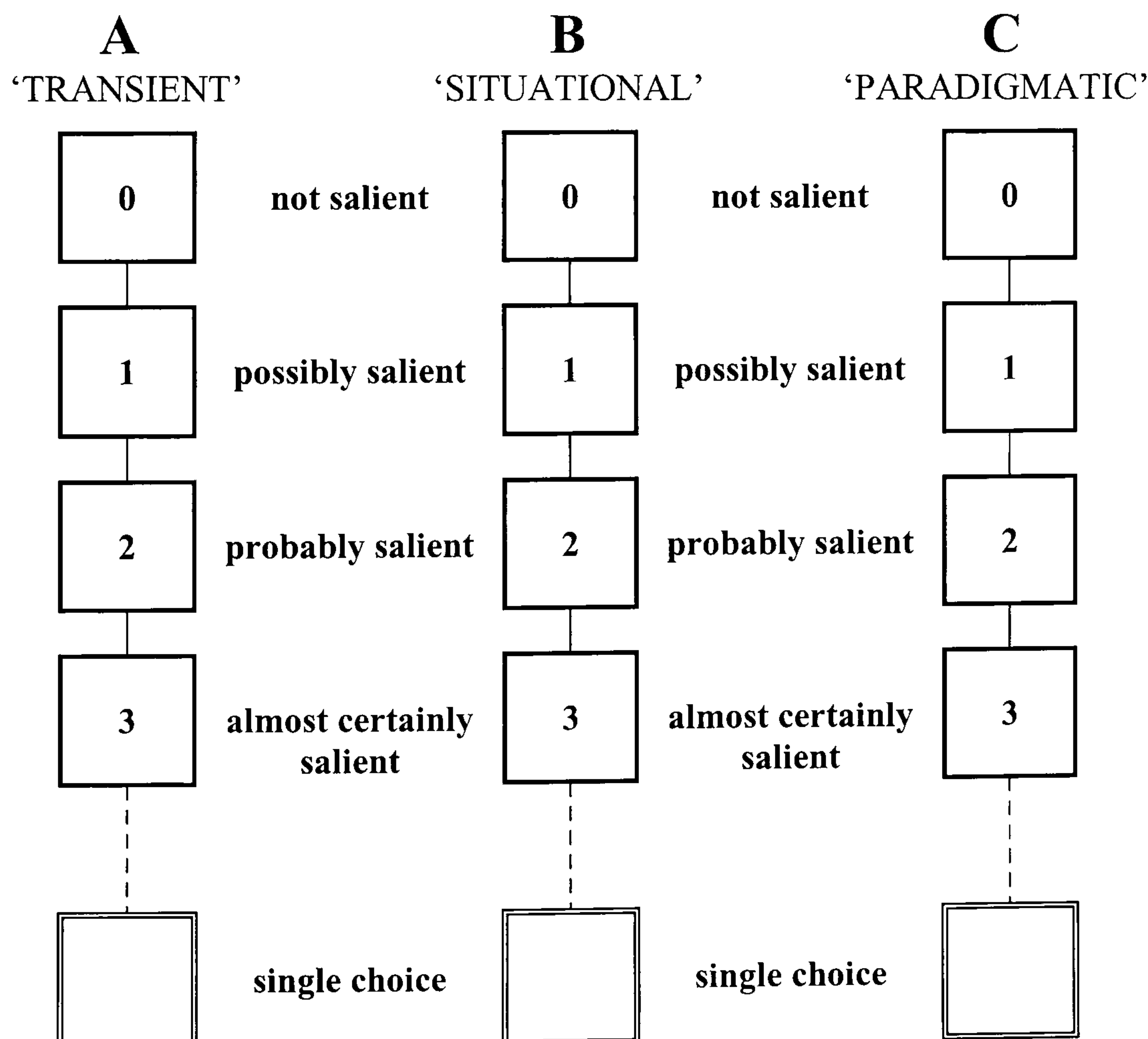
At the end of each session she would say " Tell me what to think/do " - I couldn't.

How I coped:

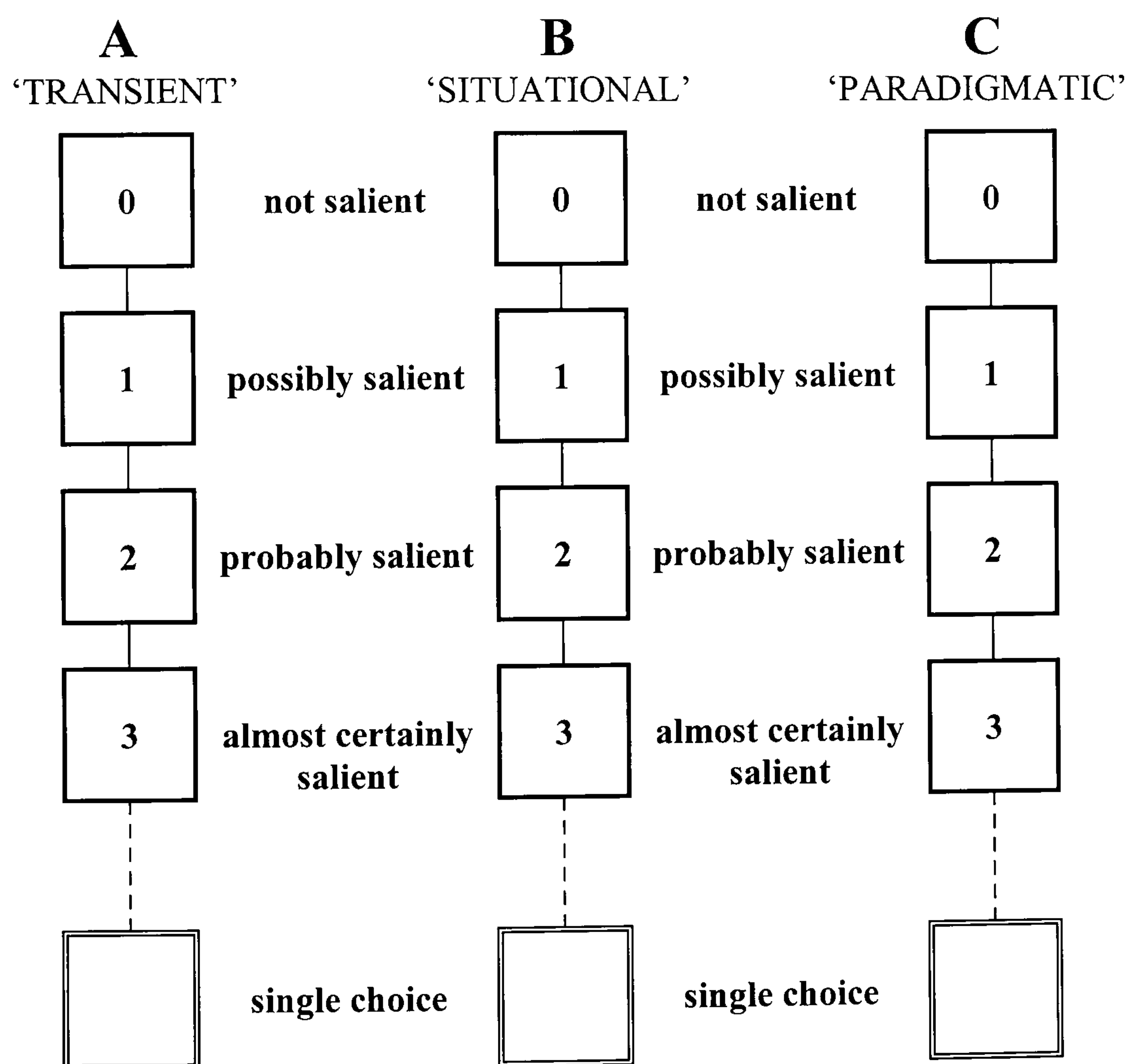
1. Sticking to my model so as almost to blame the model, not me.
2. Gather evidence of her failure to benefit so that I could discharge her.
3. Jump on the statement that she was having some reflexology as an opportunity to have a break from her.
4. Take the whole thing to supervision and realise that she treats everyone this way (or was treated in this way by people in the past).
5. Suggest that active therapy isn't helping So offer 'supportive sessions' to take focus off relief from symptoms but really hoping that she would say no to this.

Outcome.

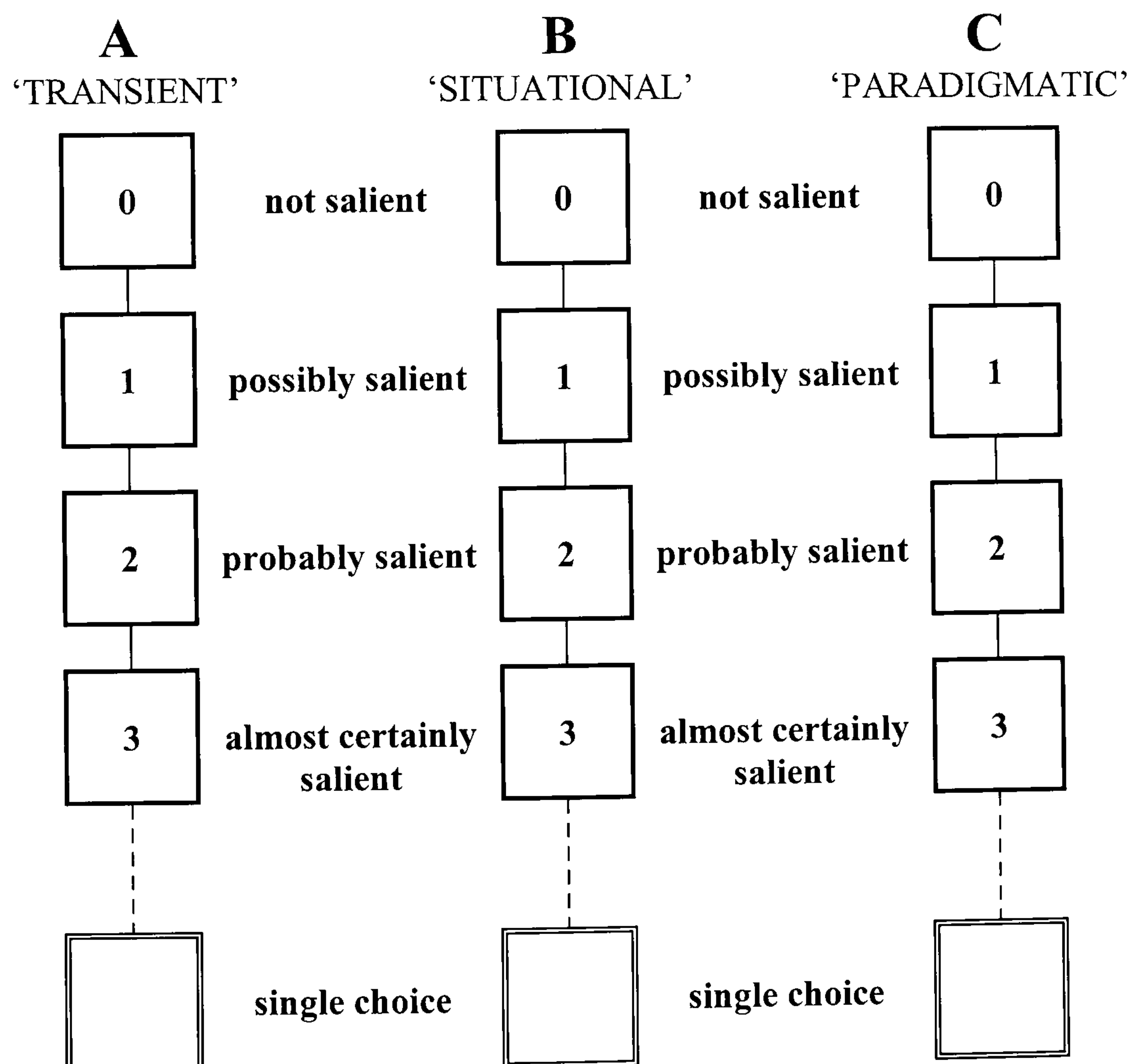
I hear from consultant colleague that she has said 'yes' to supportive sessions but I haven't yet arranged an appointment to see her! (I will now I remember).



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The patient caused herself harming by pouring boiling water over her forearms causing extensive burning. She showed me the wounds which caused me to feel shock, deep concern and defensiveness. I showed her some of my concern but unfortunately I was not able to hide some of my shock reaction. The patient came to realise the seriousness of what she was doing. Much of what is happening to her has to do with her husband's preoccupations and inability to respond to her needs. Somehow she needs to receive a more human response from others. As a service we have managed to keep our response to a minimum. My own response as a therapist was more intense and she (the patient) clearly came to realise my inability to cope with this kind of acting out behaviour. She has become more confrontative towards her husband. The self harm has continued but in a much milder form.





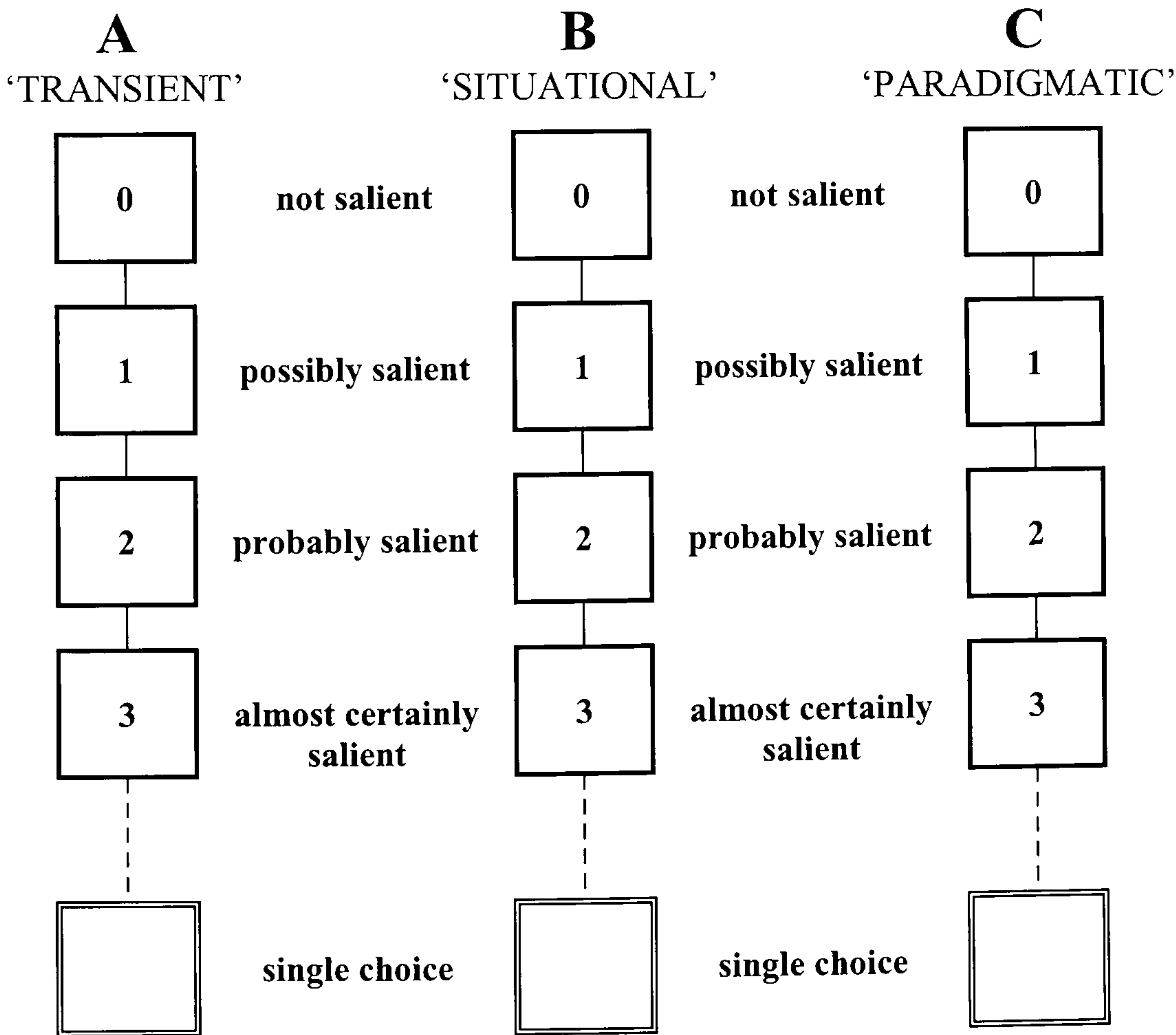
Having been in supportive therapy for nine months or so, one session in August, the patient announced that she was suicidal and had seriously questioned the value of life. A significant relationship had ended in a nebulous sort of way: the male partner was giving ambiguous messages; maybe I've ended things, maybe I haven't. In the August, the message became for the first time unambiguous: he became engaged to someone else. The extent of the patient's depression was significant and caused me to stop in my tracks. On the one hand, I wanted to contain feelings within the session, maintaining boundaries. On the other hand, to what extent had we moved beyond my expertise? To what extent did my patient need psychiatric intervention? I wanted to convey to the patient a sense of containment and safety within the session. My own reaction was one of worry, fear that I could be misjudging, sadness, a gutted feeling when the patient first mentioned her own emptiness. Perhaps, not for the first time in therapy, I asked myself what I was doing here!

Towards the end of the session, we discussed the reality of her suicidal intent especially over the following weekend which was going to be devoid of any social contact. I acknowledged that I wanted to keep her feelings within the session, and had confidence in her personal resilience (did I honestly have such confidence? - not sure!).

We explored practicalities who she might contact if she became desperate (out of hours mental health teams, friend etc). We also explored why she had become so desperate, going back over the course of the therapy and acknowledging the extent of the loss she had so far minimised.

By the next session, the patient began shily. The intervening weekend, she had taken herself out with a friend to a party. She'd met someone ...

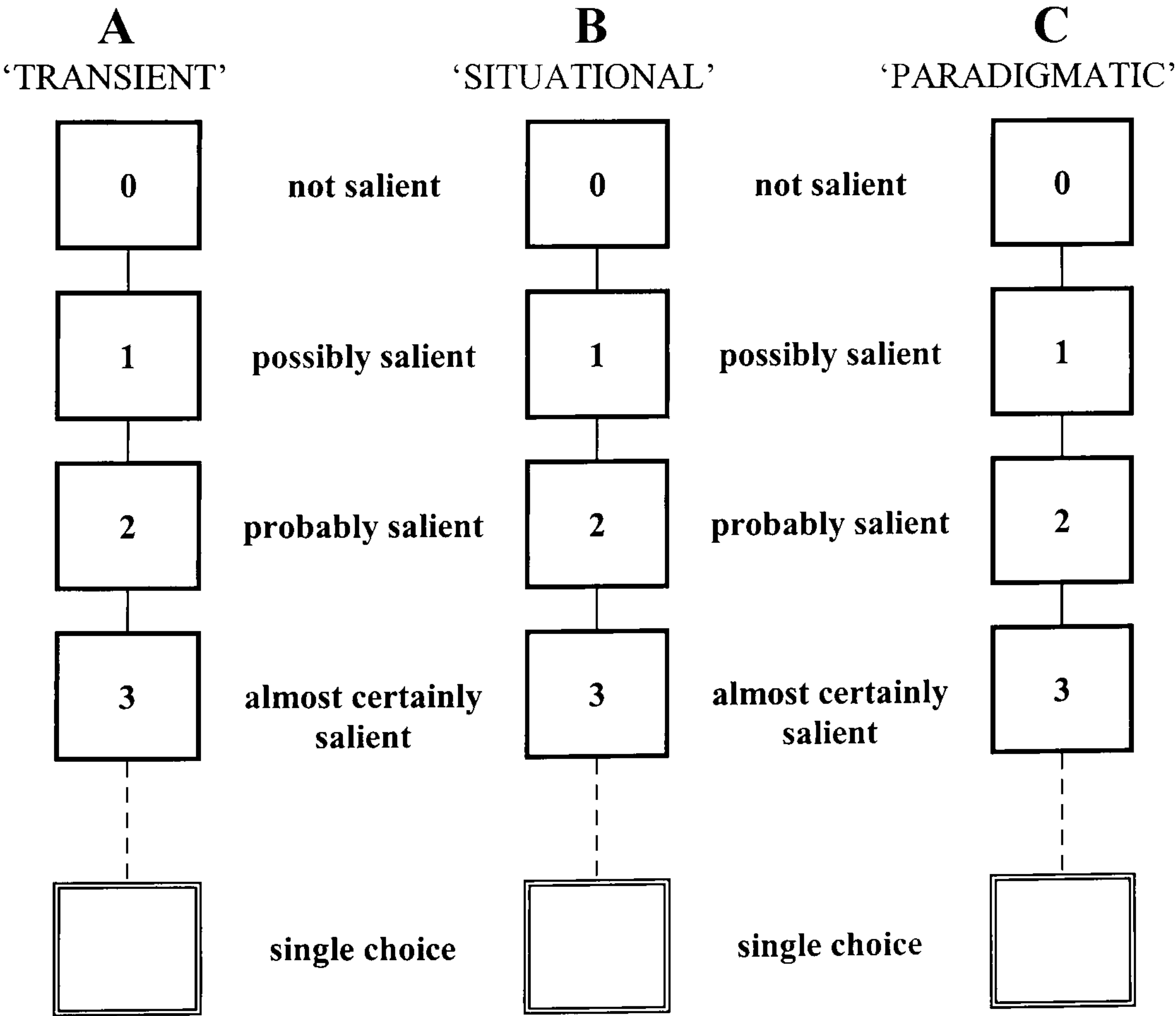
This relationship developed over the subsequent months. Yes it may have been a flight response - flying into the safety of another relationship. Or it may have been the release of the previous relationships - now there was no ambiguity.



I was telephoned at 5 pm at the end of my clinic by a patient whom I had seen on two or three occasions. She told me that she didn't feel there was any point in continuing her life and was going to kill herself. She demanded from me one good reason for her to live and said that I wouldn't care if she lived or died. In a calm voice she announced that she had been steadily taking paracetamol throughout the telephone call and then proceeded to make a series of swallowing sounds. I felt a sweep of nausea come over me and felt dizzy and faint with the horror of what she was doing. I then felt extremely angry as if I had been abused by her. I kept thinking, why is she doing such an awful thing to me? I felt that she was challenging me to keep her alive with some specific words, but I did not know what they were, and that if I wouldn't find them she would have to kill herself to demonstrate what a failure I was as a therapist.

I was stumped as to how to get out of or end this situation. If I rang off I believed she would take the whole bottle of paracetamol, if I stayed on she was slowly killing herself for me to hear and I didn't want to be abused any longer. I then said that I would be ringing off in five minutes and gave her a countdown. I also told her I would be contacting her GP or psychiatrist. At the end of the five minutes she said "well I suppose you must go and carry on with your life, you don't need to worry about me any longer".

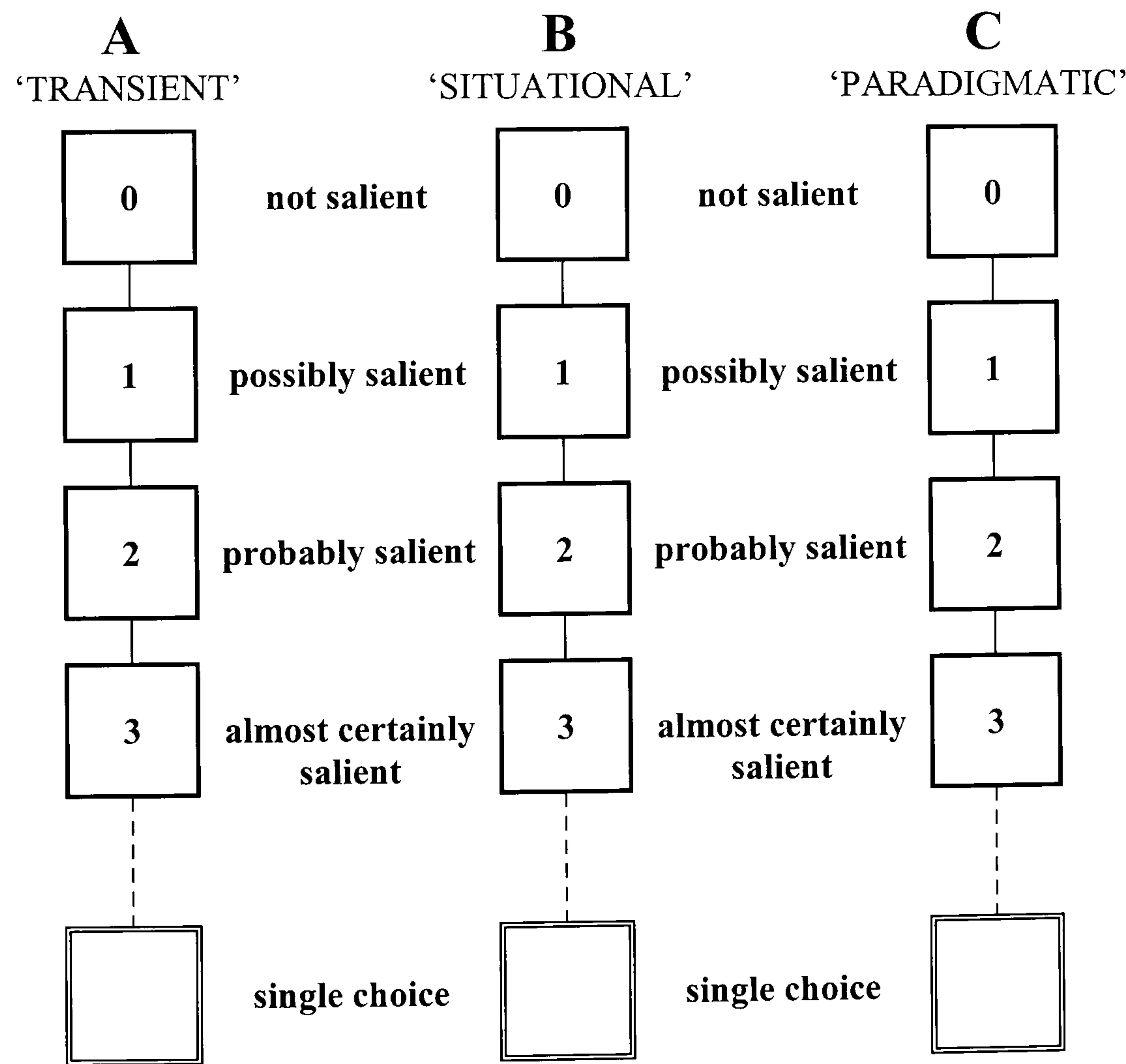
After I put the phone down I felt devastated and physically sick. For a number of days I had flashbacks to the sound of her swallowing. I then tried to get hold of a psychiatrist to go and see her but they insisted the GP should go. The GP insisted the psychiatrist should go. The psychiatrist refused and the GP said I should go and do a home visit! I said this was inappropriate and the GP eventually took the details. I eventually went home two hours late from work, completely shaken up. Feeling angry, abused, let down by the system, haunted by this client and unable to escape her. I did not feel able to continue working with this client as I could not find any way in to be able to connect with her. She has since been passed around a number of therapists, and has become notorious in both the physical and mental health system. This eases my conscience re being a 'bad' therapist - at least I am not the only one to find her so difficult!





Patient had traumatic phantom limb pain - progress was slow but being made. We reached a point at which we were both ruminating over the same themes. The patient would repeat his history of work, emphasising his virtues pre-accident, and I found it hard to think at all... I became concerned that we were stuck and that I had lost control over the session. His pain ceased to improve and I became anxious that the patient would lose faith in me, that I could not contain his anxiety or challenge what I thought was a destructive/inhibitory process - his nostalgic rumination. Began to dread the sessions in advance and wonder, in anticipation, what we would fill the time with.

I then took the case to supervision - supervisor asked the simple question "what do we know about him" and I realised I knew very little - but had assumed I knew him quite extensively. Pain and the accident had dominated the picture - distracting me from a full history. The next session I asked him about his childhood. He said "my father never loved me" and we were off.





## GESTALT-INTEGRATIVE / PSYCHODYNAMIC ORIENTATION

(This dates back two years, but the sequelae remain with me personally/professionally)

This was a young, single woman in her very early twenties, who lived on and off with a series of male partners.

I had "inherited" her from a succession of other mental health workers who had tried to offer individual counselling based intervention. She had also briefly been in a group for people with Bulimia, but was considered still too fragile for survivor group work. She had experience of being in care as a young teenager when out of control, injecting illicit drugs from age 12 years, showing a degree of 'promiscuity', eating disorder, self mutilation, and overdosing behaviours.

Part of me felt quite nervous about taking on such an apparently very disturbed and damaged patient.

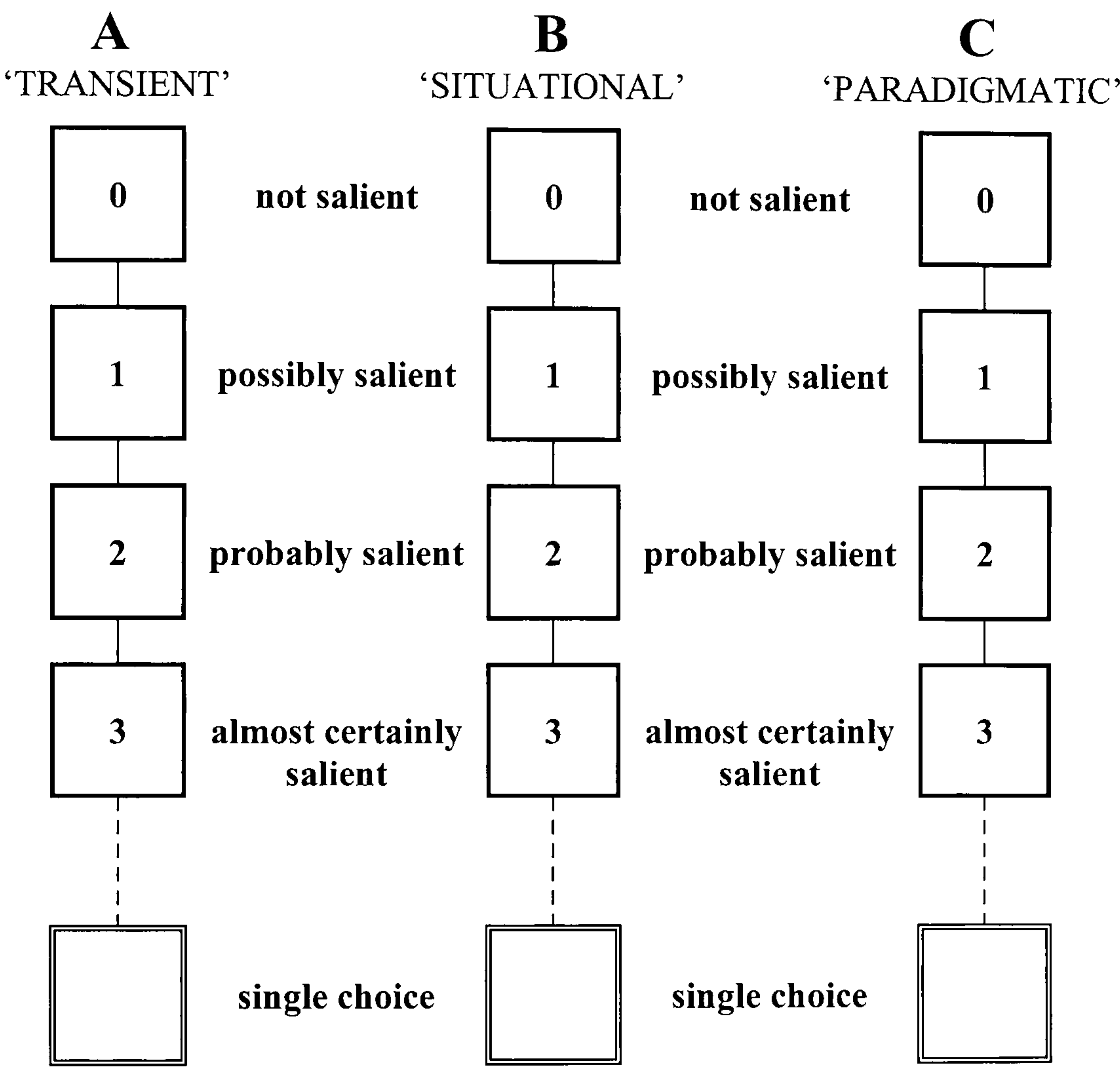
She came with a long history of alleged abuse - from family members, and later also was asked by local police, investigating multiple allegations of abuse by care workers in a variety of local children's homes, to provide testimony of her own in their inquiry. This was based on other residents' describing abuse they had alleged happened to her in one of the homes.

As I worked with her this young woman began expanding upon more and more elaborately overwhelming abuse, some of which bordered on the extreme polarity. She had been well versed in a number of spiritual healing and alternative techniques prior to seeing me, and I felt the influence of these was something very confusing and indeed even quite malign for her as it did not aid a gradual integrative processing and moving on development. She tended also to be capable of very sudden and overwhelming regression type reactions to about the level of a highly out of control and terrified two-year-old. Trying to contain her within the confines of even twice a week out-patient sessions at the centre was becoming ever more difficult. In-patient holding was deemed 'unsuitable' by other team members, however. A more conjoint input (ie daily attendance at the centre) was set up to try to keep her grounded and able to stay in touch with her more adult state, she actually decompensated further.

I had grave misgivings by then about the wisdom of continuing with any depth exploration - (I wish I had read James Kepner: 'Healing Tasks' then, and spent much more early time and work on supportive grounding and 'instilling' coping strategies!). However, this young woman would turn up to see me, both on days we were due to meet, and on others, already in a highly charged up state of arousal, and beyond being able to be held at a less intense level of working. So I felt precipitated into the regression work.

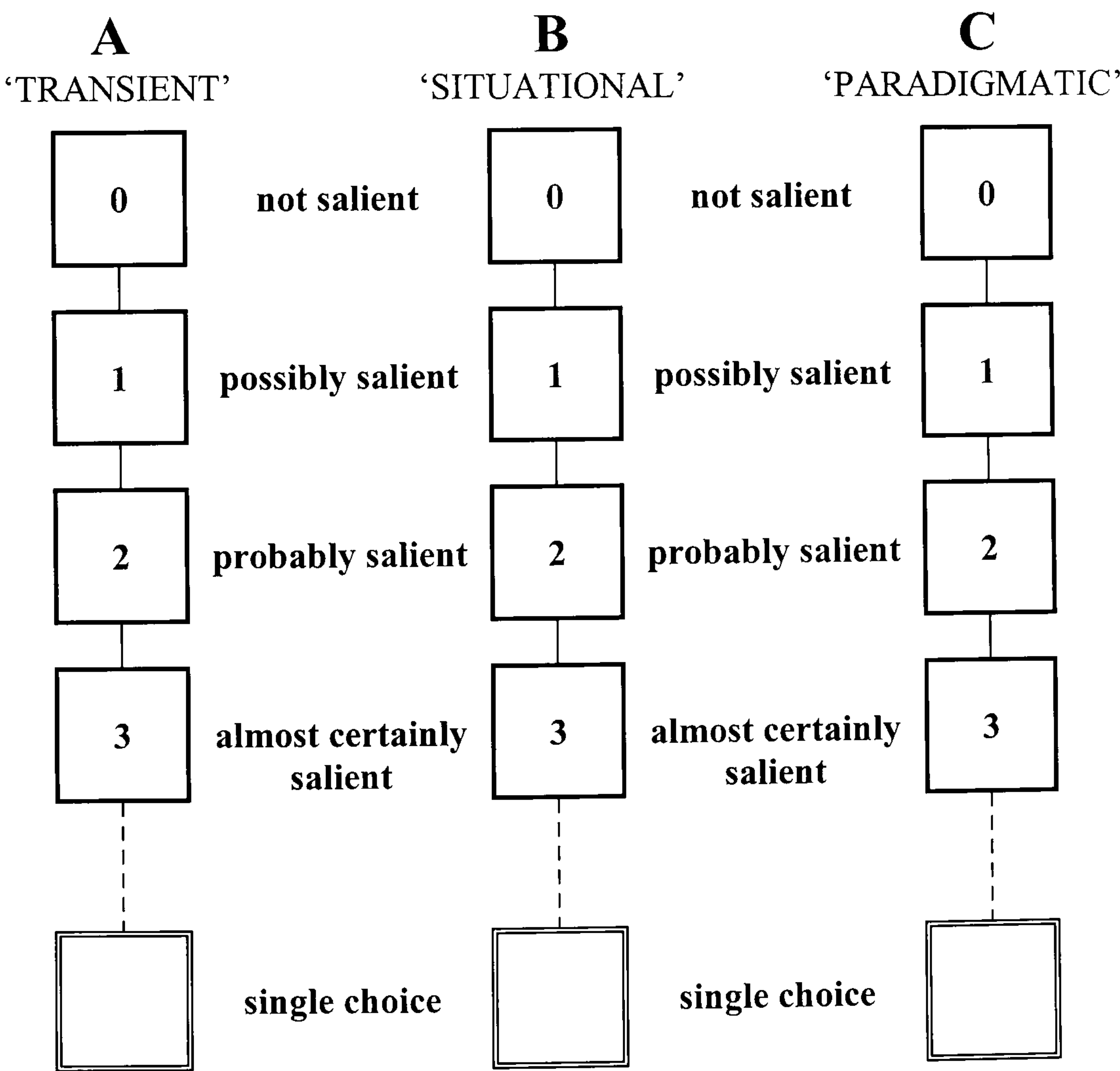
It was not so much a single incident of difficulty that I recall, as a general emergence, over three or four sessions, of her becoming even more acutely angry than usual. She accused me (and other staff) of betraying her even more by believing all her statements and allegations, as these "were all made up to test us out". She was aware of the topical controversies surrounding false memory retrieval, and said we'd had all been party to these. Moreover, she felt I had thereby wrecked any residual relationship with her family of origin (from whom she had been taken into care). While realising that much of her retraction was, I felt, due to her terror and denial (though no prosecution was occurring), I felt she spoke a degree of truth as I had allured her into ever spiralling accounts. Sadly she discontinued contact shortly after this stage and though she has gradually since settled more, I do harbour many qualms about the mishandling of her case.

*PLEASE CONTINUE ON THE NEXT PAGE*





- The patient decided to terminate the therapy when I felt she was not ready to do so. However, one of her initial presenting difficulties had been her lack of assertiveness after many years in institutions. She had become quite assertive over the period of therapy (about two years or so), and was determined to terminate the sessions.
- On the one hand I was pleased that she felt able to assert her feelings, and on the other hand I was angry with her because she was not listening to me. I felt like a mother with an adolescent child and at times felt I wanted to punish her.
- As a "mother"/therapist I agreed to let go and the therapy sessions ended. However, I did not fully let go and offered the patient the opportunity to ask for further sessions if she needed them in the future.
- The woman still occasionally asks to see me for "one off" sessions when she has a problem. However, she says she does not want regular therapy sessions again. The woman has continued to grow and change in lots of positive ways, but I feel that terminations are still difficult for her.





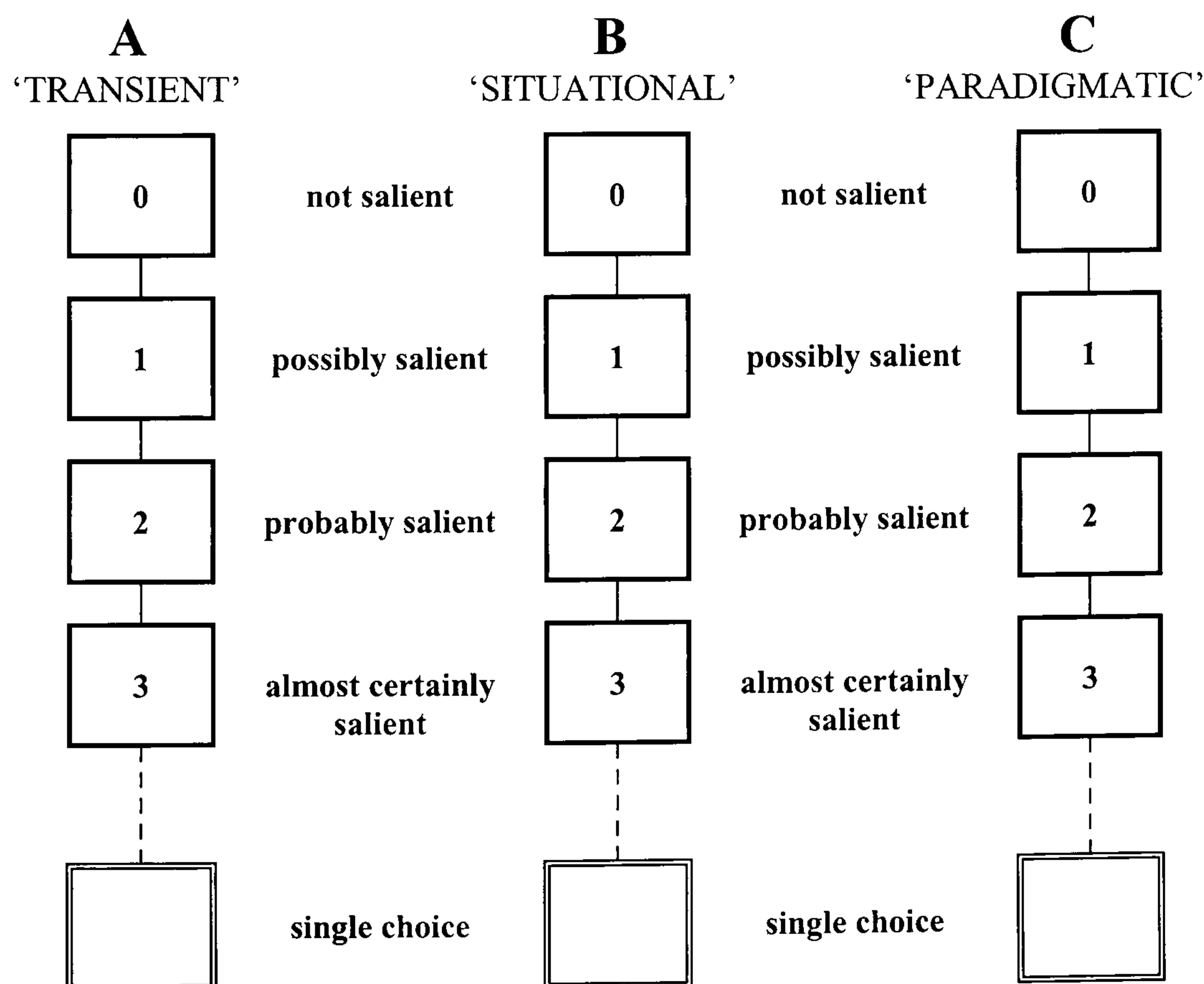
The young woman had had a protracted hospital stay for ?Anorexia under section having gone to her GP saying she wanted to die and was going to starve herself to death. This came some 12 months after her husband had died from a brain tumour after they had been married for only one or two years.

I saw her after her discharge from hospital after a junior doctor had seen her for six months' psychotherapy, which he had contracted as a deal to ensure that she wouldn't starve herself again. My arrangement had no such control aspect. Therapy was very difficult with her regressing to being a small child, hiding behind a chair in a corner of the room. It was the ending which was particular difficult - as she started 'acting out' more. She had returned to work (she was a health visitor) but sold her house and was staying in Bed and Breakfasts.

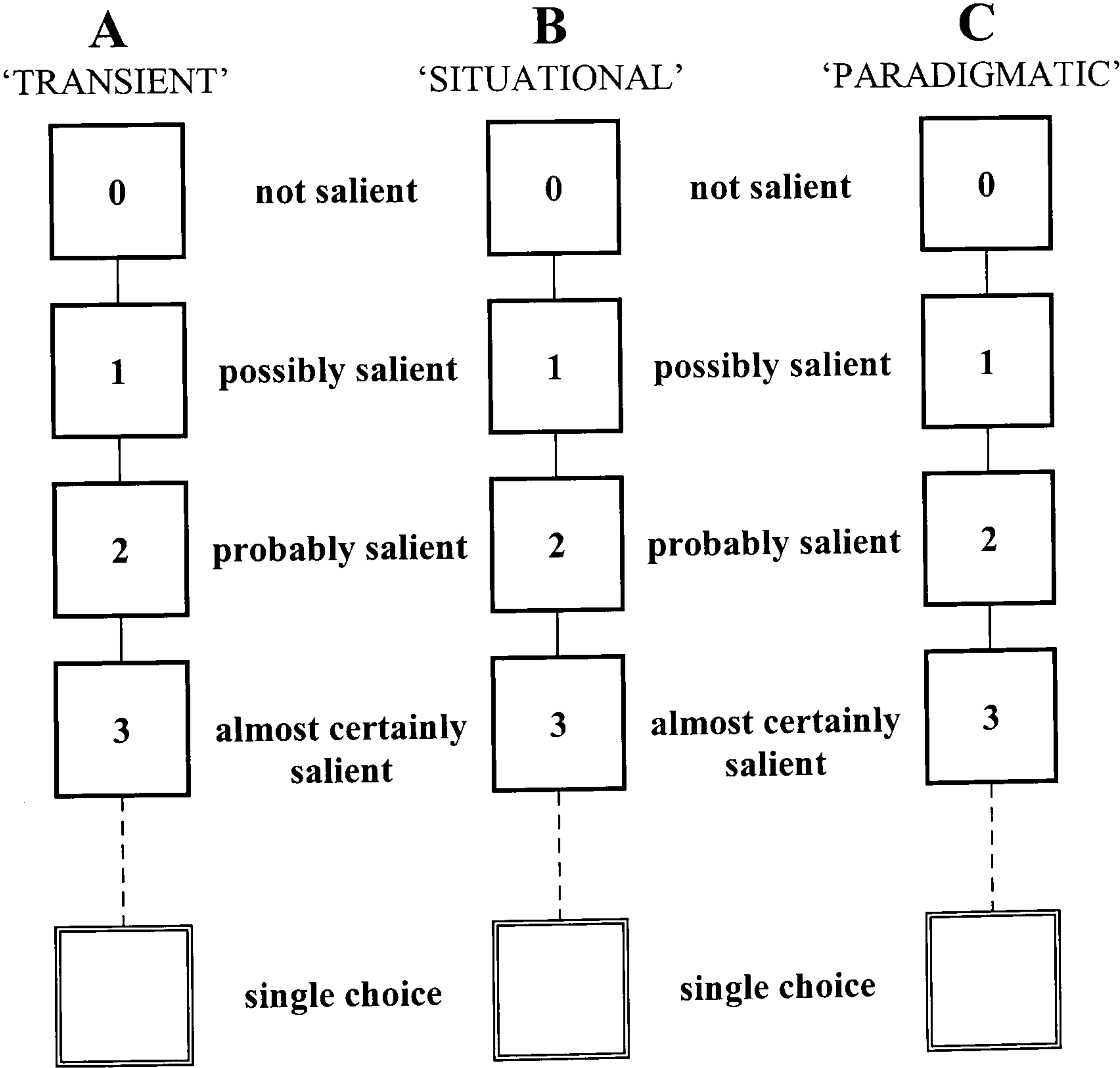
She had some contact with her family but there were clearly problems there. I knew I could contact her through her brother if she did not attend but she did. The ending came because I was changing jobs (guilt and relief). As our ending date was agreed, she started to disclose more and it became clear that she was taking risks in 'picking up' men (strangers) for sexual favours in the hotels near her Bed and Breakfast - she moved around a bit. I was very anxious for her. She also refused to have further contact with the mental health team and I was not going to coerce her.

So the ending came with this very disturbed woman back at work, no longer showing signs of depression and not wanting further help. I was extremely anxious, and felt guilty about leaving. I talked to a colleague about it, mostly to confirm my views on the individual's rights to freedom and autonomy. I was confused by the 'leaving gift' she gave me which was a boxed set of glasses which didn't look new and I wondered if it was one of her wedding presents that I knew she had been getting rid of along with most of her other possessions. There seemed like no resolution was possible, simply a my containment of my anxiety and eventually (until now) I forgot about it. I never heard about her again.

Anxiety about ending was not new but the fact that she cut herself off from most normal stable bases, except work and the sexual aspect of her behaviour was new. She hated it when she enjoyed our sessions and was desperate to keep me away.



Patient got very upset in final session of therapy with me (I was finishing working with the patient because my placement was coming to an end - not because therapy had reached an end point). Became very tearful and distressed. It was difficult to bring the session to an end - especially as he continued talking and recounting stories - as if to keep the session going. I felt very pained. My personal feelings were that I also was sad that therapy was ending with this client. I felt guilty that I was somehow ‘letting him down’ because I was not available to follow through what we had started. I also felt very bad that I had not pre-empted the situation and done more work with the client previously with working around endings. I attempted to cope by keeping strong boundaries and containing my client’s emotions. I tried to contain my emotional response to deal with in supervision after the meeting.  
Session overran by thirty minutes. I felt left with a lot of sadness and guilt and regret.





During my internship (on my way to private practice) I began seeing a young woman who had been diagnosed by a hospital psychiatrist as having a borderline personality disorder. She had been seeing a colleague at the agency where I was doing my internship but had moved to seeing me for individual therapy after attending a women's group I was facilitating. She was difficult! But I was stubborn and determined to contain her and not (over)react to her bombs and attacks - nor to her initial over-idealization. I felt quite protective of her and resisted agency encouragement to refer her elsewhere (agency support policy being "you don't have to see this woman..."). I was also a bit naive - and consumed by this case, reading everything I could lay my hands on about borderline personality disorder in a somewhat vain attempt to keep one step ahead of her - she researched mental illness, medications, and borderline personality disorder in great depth, constantly challenging me, my knowledge, my effectiveness. I knew she was in a great deal of psychic pain and I really did try to help. The incident in question occurred when she was telling me about an acquaintance who had implied doubts about my patient's sexual orientation. Knowing (because I had just re-read about it!) that borderline personality disorder patients often manifest a sexual ambivalence, and not knowing where else to go with this topic that we had discussed and discussed and discussed, I foolishly asked "do you have questions about your sexuality?" she didn't erupt - the hurt and anger set in slowly - but deeply. She couldn't see that by asking the question I was not necessarily implying my doubts about her sexuality. And in fact, I wasn't. Her intense reaction surprised me - but was also welcome in one way because it gave me something to work with (I thought) in the future. My mistake though obviously was broaching the idea before she was ready.

She said she would quit - that I wasn't doing her any good. As I didn't have a patient following her I kept her 20 to 30 minutes over time. I showed her the passage in a book she already owns (DSM III R - an American diagnostic manual) that refers to sexual ambivalence, and reassured her that I was not implying such in her, but only asking so that I could reassure her if necessary. (Another, smaller, error!)

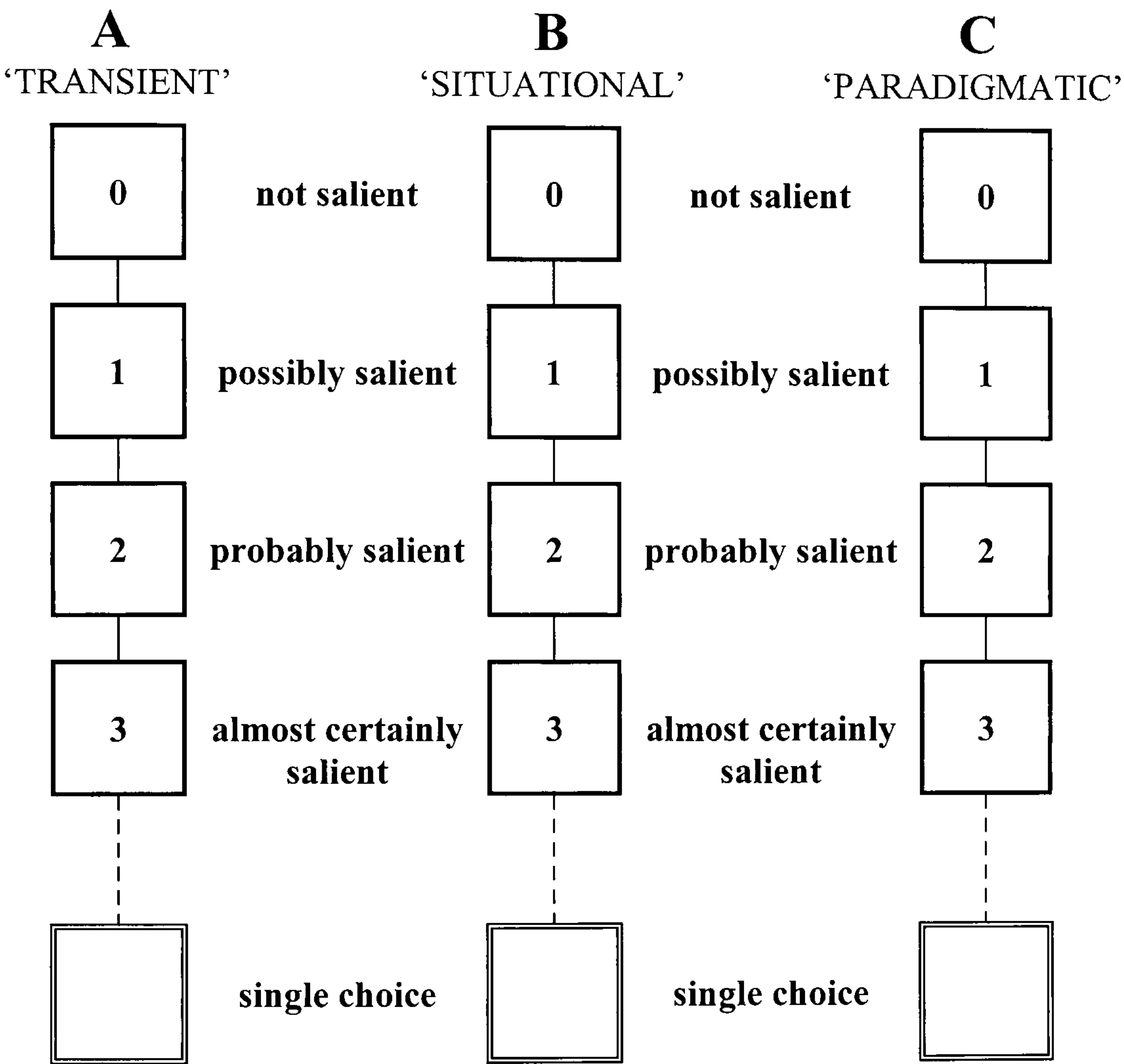
Eventually she left, saying she'd think about coming back. Half of me would have been enormously relieved not to see her again, but I didn't want it to end that way.

Because of her suicidal ideation whenever upset, I rang her the next day to check in with her. Predictably she had told all and sundry that I had impugned her sexuality and all and sundry had urged her to quit seeing me.

She didn't - then. Somehow we went on and some months later she was able to see that it was only a question I'd asked, not a statement I'd made. Some months later she did quit, but fairly amicably. We both recognised the futility of continuing I think, and I did tell her the door was always open. Sixteen months later she rang for an appointment in which she acknowledged that I had helped her and she wished she could return. Unfortunately, I was about to leave both the agency and the area so I saw her only two to three more times to clear up old business. I send her an occasional postcard and she once phoned "to keep in touch".

*PLEASE CONTINUE ON THE NEXT PAGE*





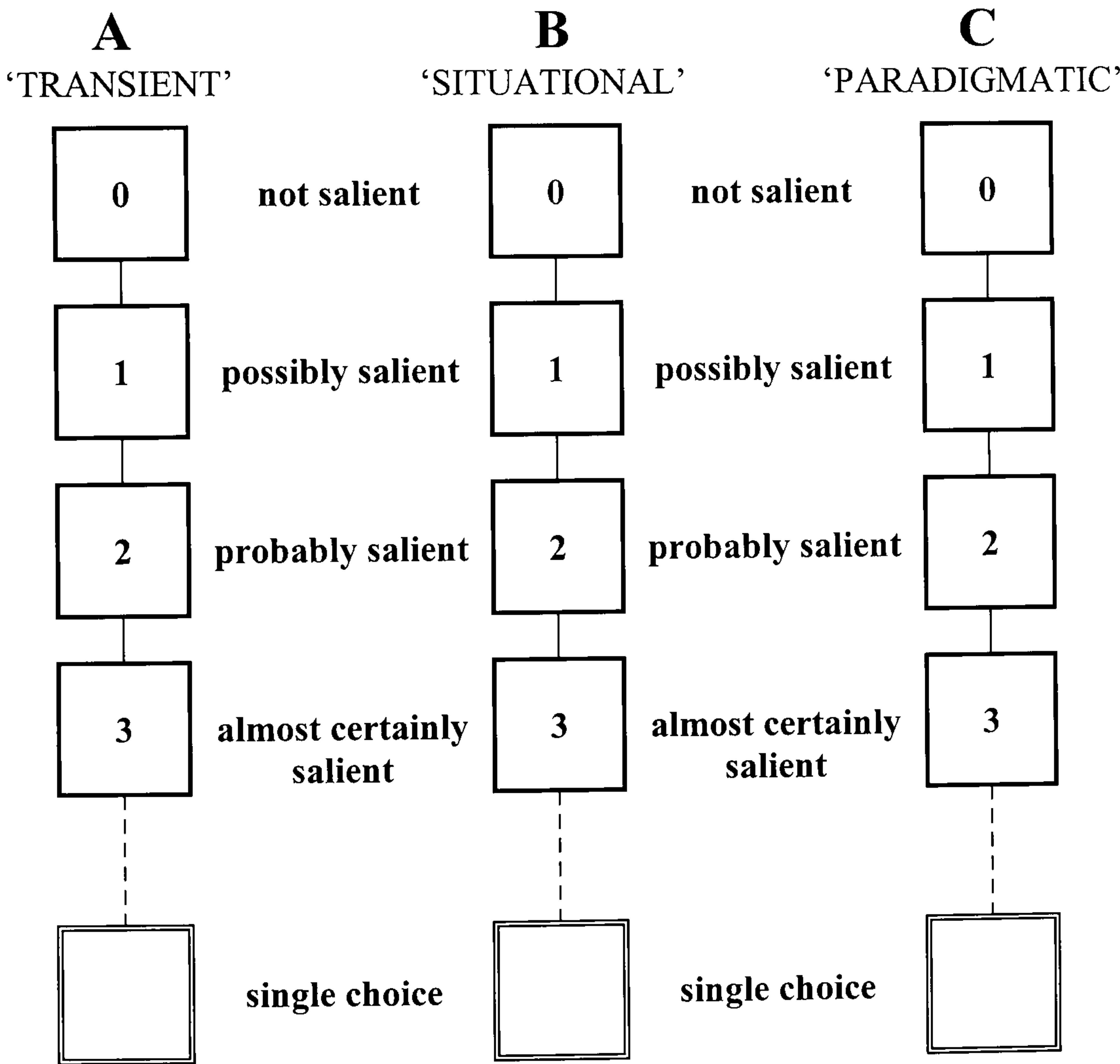






A GP in his late forties with three-year history of depressive illness only partially responsive to antidepressants. Therapy was ongoing - a little over 12 months. He is a passive man, indecisive, not interesting in presentation. He regularly brings his dreams but rather is a ‘good boy’ and there is little free association to them or in response to my comments or interpretations. There is hardly any sense of liveliness. Sessions are dull most of the time and time passes slowly.

The problem seems to me a common one in therapy - repression to the point of near-extinction of emotional life. I know if therapy is going to be at all successful it will take a long time and probably needs to be more intensive than once a week, but its all I’ve got. The fact that he is a local GP and one of his partners is a leading political figure in fundholding practice adds to the pressure - the reputation of the department and psychoanalytic psychotherapy is at stake!



**NOTE TO READERS: PLEASE RESPECT THE WISHES OF THIS RESPONDENT!**

**99      MALE PSYCHOLOGIST, PSYCHOTHERAPIST  
PSYCHODYNAMIC/COGNITIVE, ORIENTATION**

234

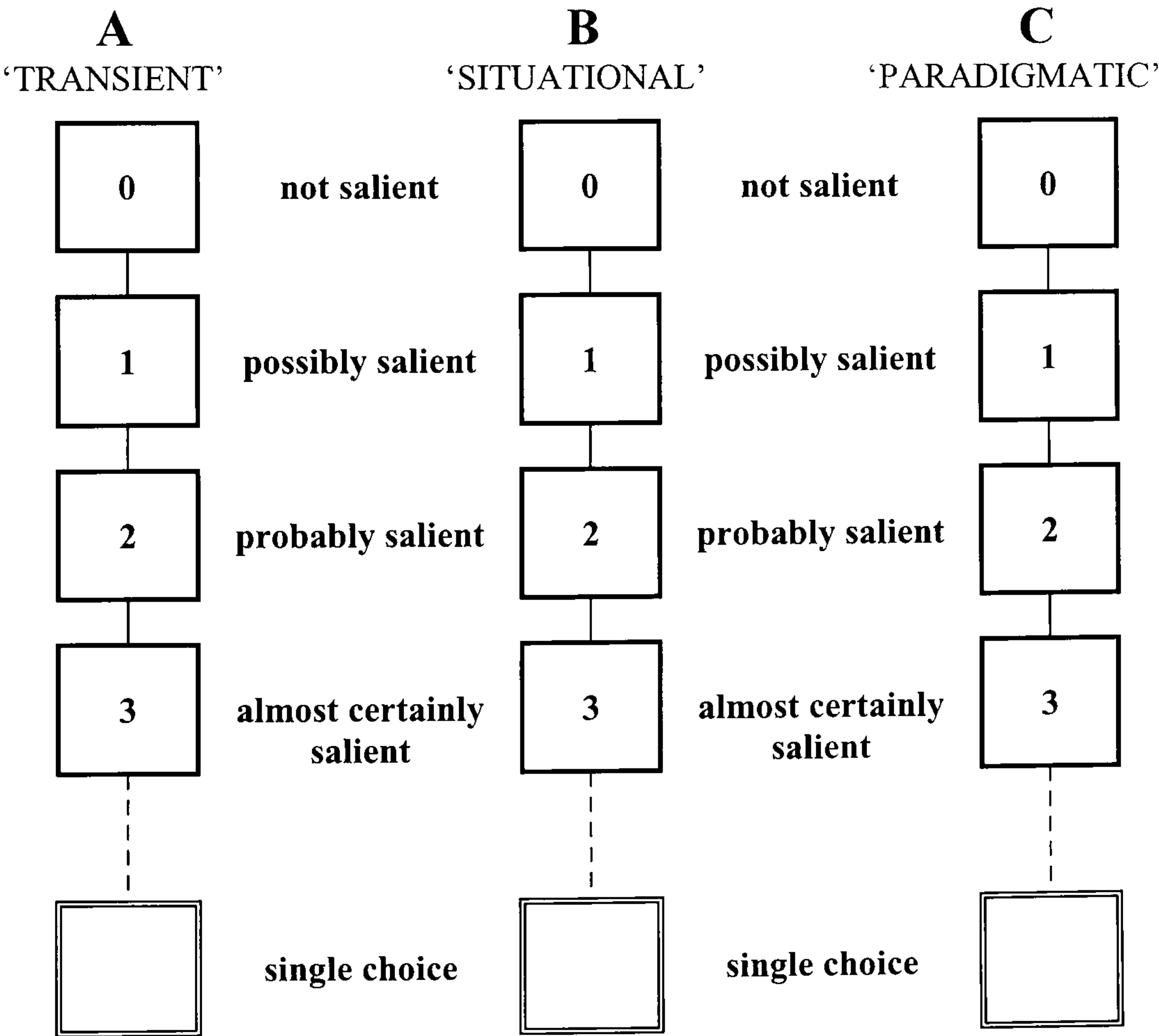
The patient began shouting at me at the top of their voice, screaming and yelling “I want to kill your father, I want to kill you”. At this moment a youth living in the adjacent property to the one in which I work as a psychotherapist yelled through the wall an abusive response to my patient’s outburst.

I was already somewhat surprised by the intensity of the patient’s transference. The added and totally unexpected intrusion of a neighbour caused me to feel some panic internally (it had never happened before). I stayed outwardly calm (I think) and decided to use the developing situation ‘in’ the work.

The situation initially went from bad to worse with the patient and the neighbour escalating and yelling through the wall. As I write this, my principal thought is of great concern that this experience not be published as an anecdote within the research papers you publish as it is such an unusual experience. I fear it would be repeated as a good ‘trade’ story by other therapists. (This one happened to me before with an equally memorable account of an unusual session I gave in a paper to a group of doctors at a conference. Somehow it got back to the patient concerned.

Anyway, I ask that this story not be published or ‘passed on’.

The eventual outcome was useful. After the session I wrote to the neighbour.



12. Appendix 12: TDQ1 Accounts used for Rater Training

Criterion scores (which had not been supplied to raters) are displayed in the shaded single-choice boxes.

The text of the first training account (X03) has already been reproduced in Appendix 6 on page 47 above

X03     PAST Difficulty 315

Female Therapist.*Difficulty occured seven years ago. No other information available.*

TRANSIENT		SITUATIONAL		PARADIGMATIC
<div>0</div>	not salient	<div>0</div>	not salient	<div>0</div>
<div>1</div>	possibly salient	<div>1</div>	possibly salient	<div>1</div>
<div>2</div>	probably salient	<div>2</div>	probably salient	<div>2</div>
<div>3</div>	almost certainly salient	<div>3</div>	almost certainly salient	<div>3</div>
<div>3.0</div>	single choice	<div>2.57</div>	single choice	<div>.67</div>



1.

*[What did you or your patient (client) do which made the situation difficult?]*

Client told me voices were talking about severed heads impaled on sticks and that made him think of my head on a stick. He wanted me to leave him because otherwise he was afraid he would attack me although he did not want to.

Client was chronically deluded, had schizoaffective diagnosis, had made several recent suicide attempts, was kept under close supervision on a locked ward, occasionally attacked staff. I was attempting to do cognitive belief modification.
2.

*[What feelings or personal reactions did you experience in the situation?]*

Some horror, some anxiety.
3.

*[How did you attempt to deal or cope with this difficulty?]*

Stayed put despite his threats. Uncrossed my legs so I would be ready to defend myself. Expostulated with him : - I ignored what he said about his voices and treated it as a direct threat from him for which I expected him to take responsibility. He calmed down and I left at the scheduled time.

Sought peer supervision later.
- 1.4

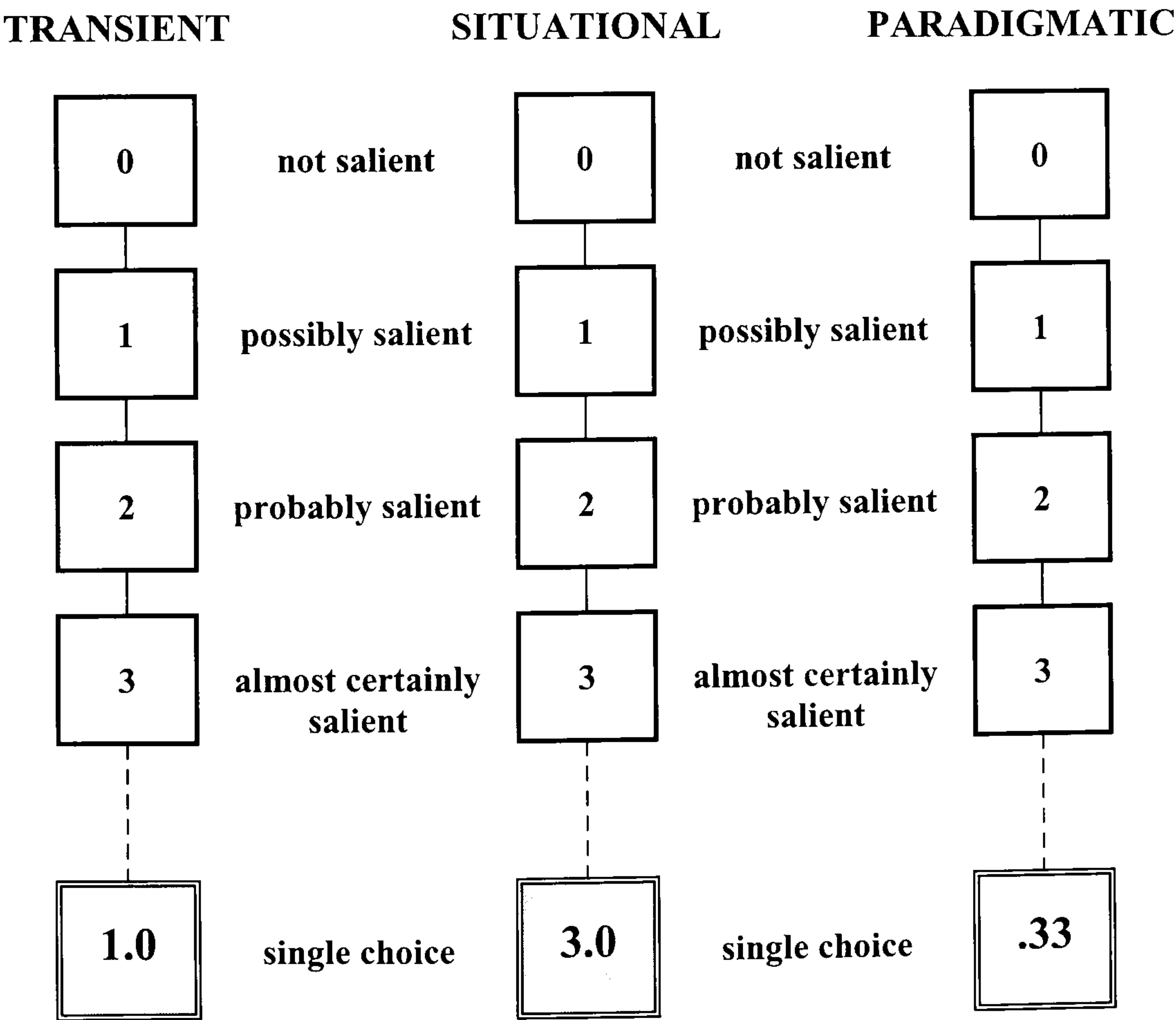
*[How did this situation turn out?]*

I continued to see him each week for individual work and managed to maintain reasonable relationship. While I was away on leave, he was moved to a different ward where he succeeded in killing himself.

Male Therapist

9 Years Experience

Psychodynamic / Behavioural / Cognitive Orientation



1.1 [What did you or your patient (client) do which made the situation difficult?]

Male client said he was physically unwell; after sighing a lot he then 'fainted' for 5(?) minutes. I didn't believe that he had really fainted. When he 'woke', he told me (unprompted) "not to worry", in what I felt to be a patronizing manner, and proceeded to continue the session in a cheerful manner, whilst I was furious!

He then avoided all discussion of what had happened, whilst I continued to try to address it.

1.2 [What feelings or personal reactions did you experience in the situation?]

Fury! I felt he was 'acting' (literally, not just 'psychologically') as his sighs had felt, to me, to be ungenune and when he 'fainted' his body hadn't slumped in the way I'd expected from someone unconscious (e.g. his head had conveniently come to stop before hitting the radiator at his side). I felt controlled and manipulated into 'holding' his feelings of inadequacy (telling me not to worry, whilst he was cheerful and avoiding discussing it). At the same time, I felt guilty about the intensity of my anger and dislike, and that I might be wrong and he was really unwell and I was not coming to his aid by just sitting there!

1.3 [How did you attempt to deal or cope with this difficulty?]

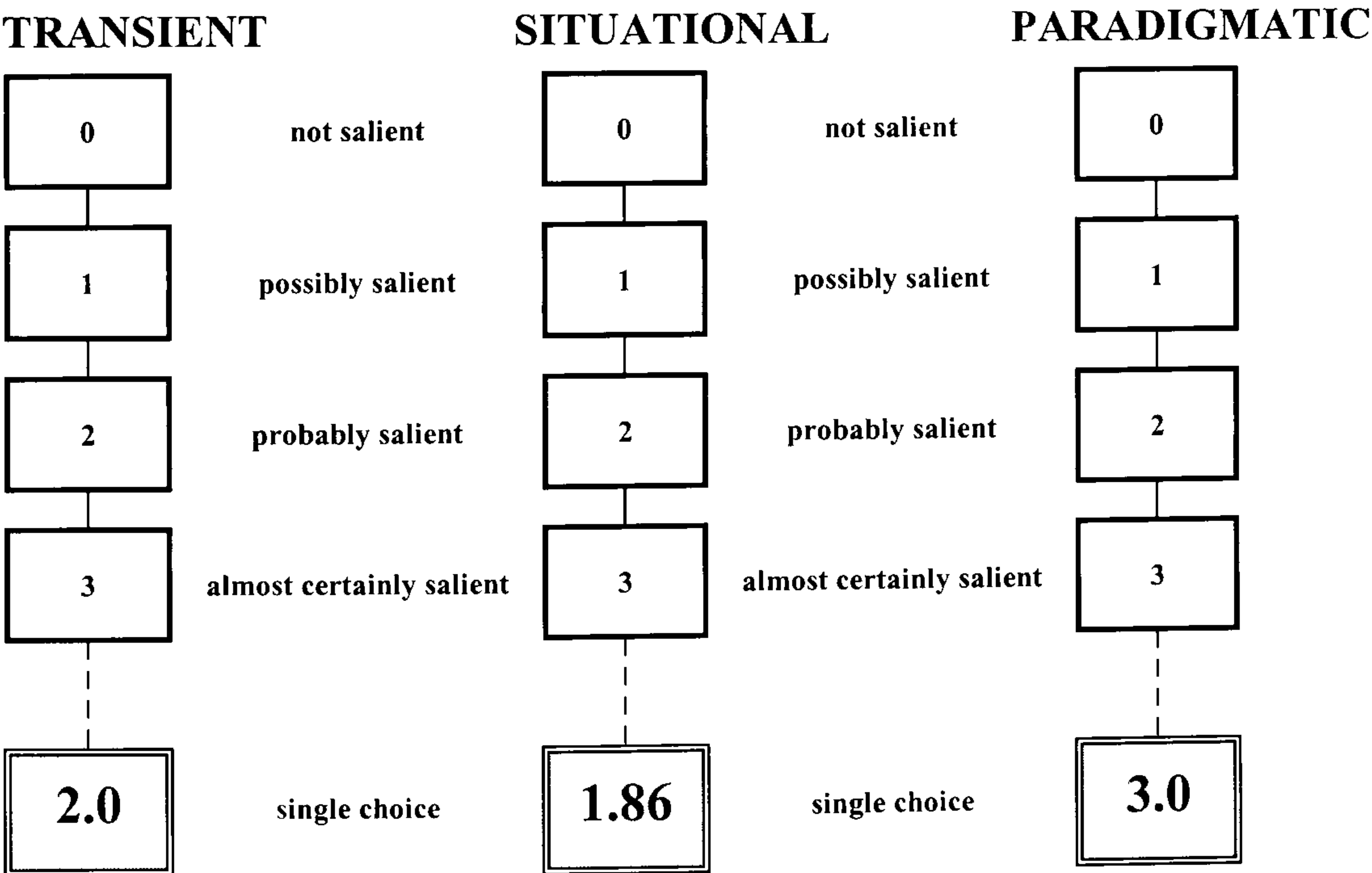
I expressed some anger, but I (dishonestly) related it to anger that he wasn't taking care of himself by being here when he was saying he was so unwell. I had attempted to interpret his 'fainting' as relating to his (usual) difficulty in being with me, but this was ignored by him and I gave up. Mostly, I 'coped' unsuccessfully with my anger and I feel I was cold towards him. After the session, I vented my fury on the office door (!) and sought out a colleague to help me make sense of what had happened, particularly regards projected anger.

1.4 [How did this situation turn out?]

Talking with my colleague helped a great deal in making sense of his probable anger, and helped me to re-focus on the fact that this was a typical situation given the reason why he'd been referred (the only client I've ever picked up with the referral diagnosis of classic 'hysterical' paralysis and fits) which my anger had made me completely forget! I also realized I'd been irritated with him from the outset and it helped me to examine the case in general. For the next few sessions I was better able to control and understand my feelings in relation to him, and our later sessions were much more productive.

[Don't know where else to put this, but it feels important - I still feel great embarassment about my behaviour (which is why I probably recall it) as it feels like a situation I didn't 'cope' with at all well. So even though it was about 2 years ago, it still 'goes to the core of me'.

Female Therapist      4 Years Experience NOW      Psychodynamic\ Humanistic\ Systemic\ Integrative Orientation





1.

*[What did you or your patient (client) do which made the situation difficult?]*

Patient describes some events she had organised in a manic phase which I found amusing. She detected my amusement and was hurt by this.
2.

*[What feelings or personal reactions did you experience in the situation?]*

Sadness and guilt at her hurt - some surprise that I had conveyed my 'private' response.
3.

*[How did you attempt to deal or cope with this difficulty?]*

Acknowledged the correctness of her perception - apologised for her hurt.  
Related scenario to other instances when patient was misunderstood, not taken seriously.
4.

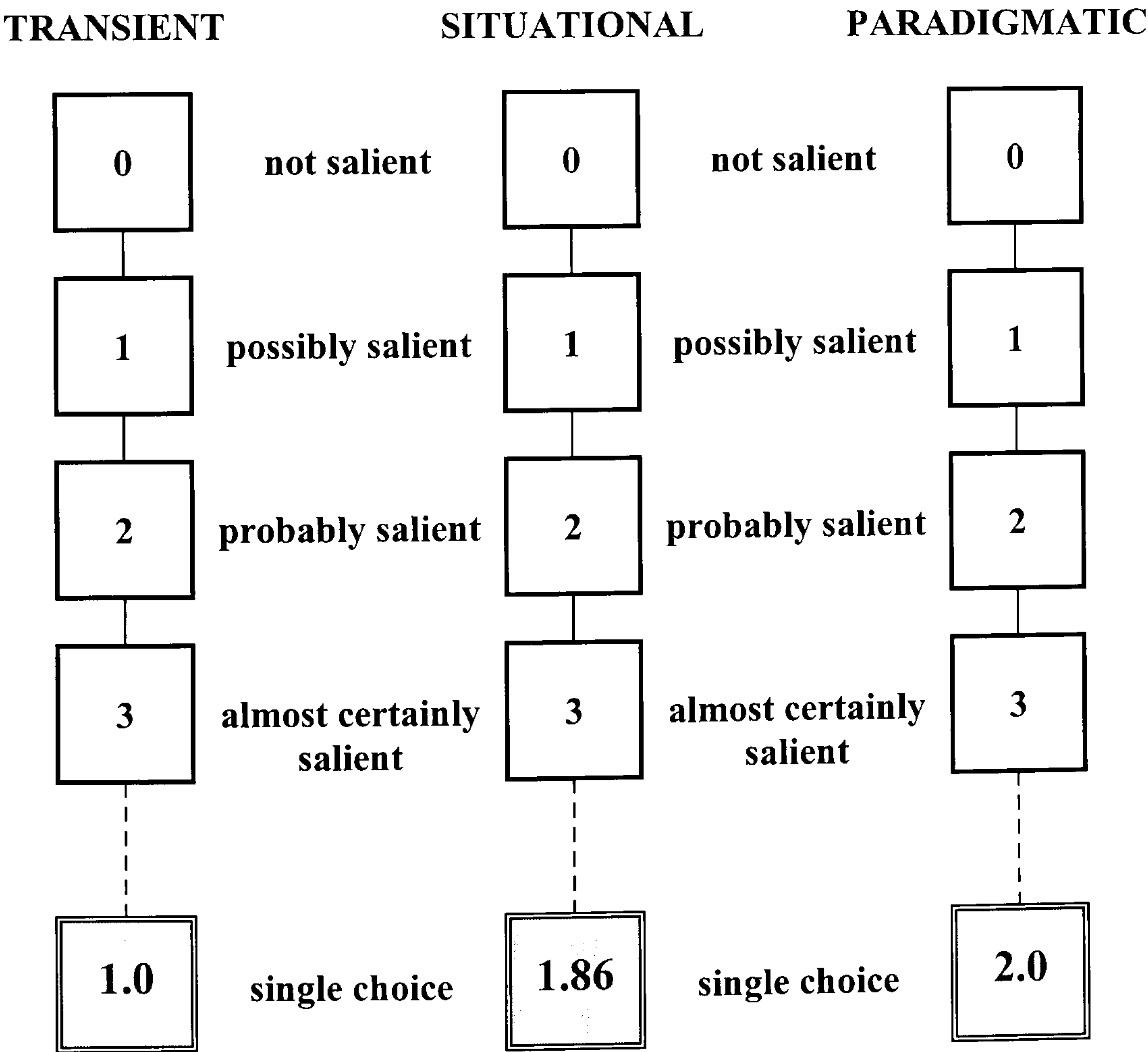
*[How did this situation turn out?]*

Raised some important issues, but too early & I think the alliance is somewhat shaken.

Female Therapist

15 Years Experience

Psychodynamic/Cognitive Orientation





1.

[What did you or your patient (client) do which made the situation difficult?]

He showed intense anger.

Misinterpreted everything I said.

At end of therapy took out a complaint against me which was investigated by the Health Authority, (?) Ombudsman and BPS Disciplinary Committee.
2.

[What feelings or personal reactions did you experience in the situation?]

Anxiety

Loss of confidence

Apprehension
3.

[How did you attempt to deal or cope with this difficulty?]

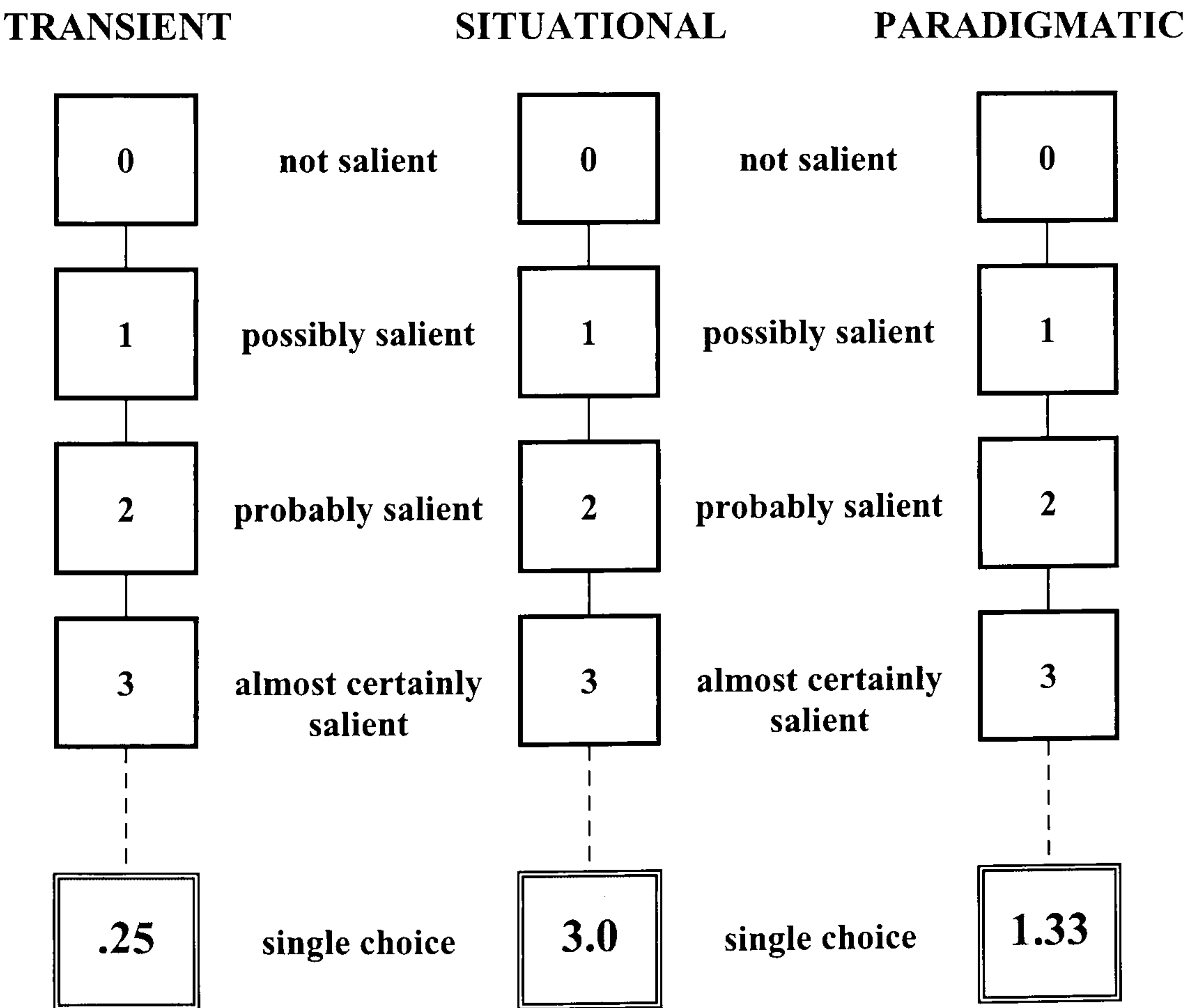
Saw a counsellor

Spiritual Guidance
4.

[How did this situation turn out?]

Various bodies found that patient had no cause for complaint. He hasn't given up trying though. Solicitor involved.

Female Therapist    17 Years Experience NOW    Psychodynamic Orientation



1.

[What did you or your patient (client) do which made the situation difficult?]

Patient invited me out socially - later admitted to having sexual phantasies about me.
2.

[What feelings or personal reactions did you experience in the situation?]

Initially I felt flattered, then embarrassed, then confused, then worried. Of most concern to me was my automatic reaction to his seduction - what a thrill I got from being fancied (no matter by whom).
3.

[How did you attempt to deal or cope with this difficulty?]

Talked to Head of Speciality - asked for individual supervision (not then available on a regular basis). Eventually entered personal therapy for myself as I knew this situation could re-occur.
4.

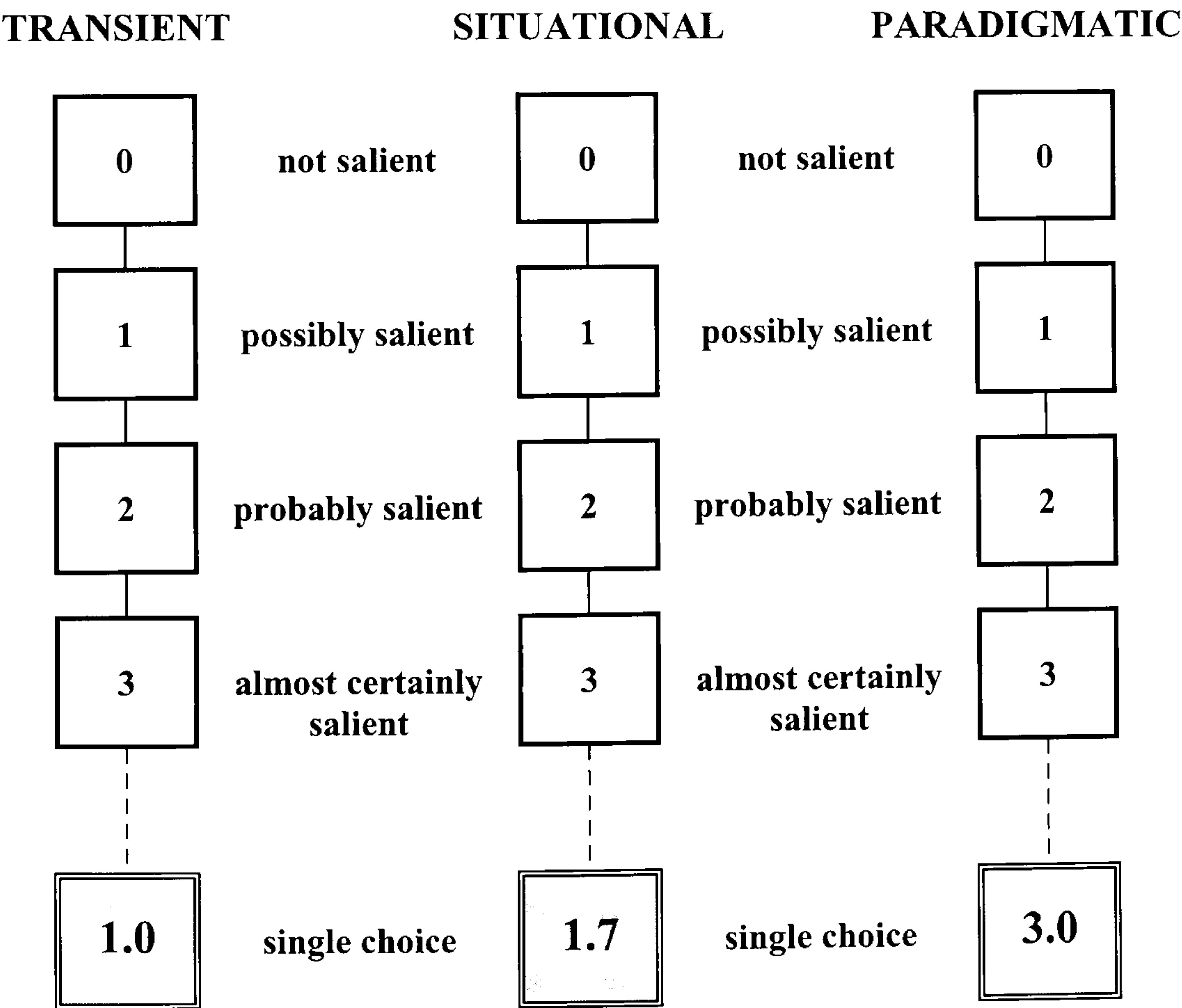
[How did this situation turn out?]

He was jailed (for perjury) (for lying in a previous court case) - I visited him and was distant & “professional”. Made clear that the therapeutic contract was over and he was not to make contact again. Upon release he wrote me one letter - factual details of his plans - and I never heard from him again.

Female Therapist

13 Years Experience NOW

Humanistic/Gestalt Orientation



- 27

**CURRENT (or very recent) Difficulty**

112
1.

*[What did you or your patient (client) do which made the situation difficult?]*  
Report a feeling of deadness in addition to almost hallucinatory flashbacks of torture/abuse over a sustained ten year period. The deadness was accompanied by a feeling of fatigue and a disengagement from therapy in the session.
2.

*[What feelings or personal reactions did you experience in the situation?]*  
Despair, a feeling that a very distressed/disturbed client was somehow slipping from any help I could give her.  
Fear that she might take her life as she was expressing a desire to die though not through her own actions.
3.

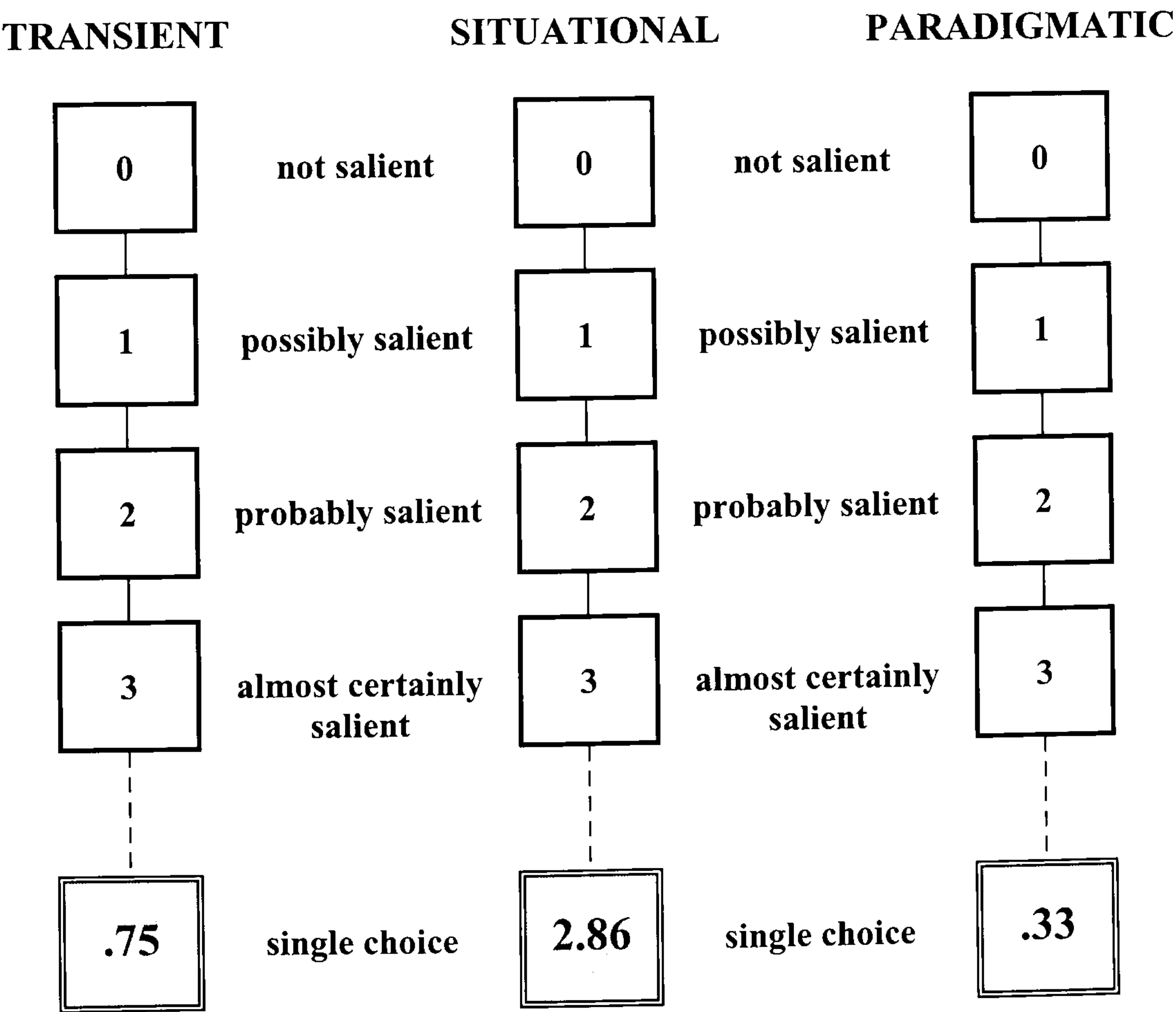
*[How did you attempt to deal or cope with this difficulty?]*  
Contain the anxiety as I perceived that for her I needed to show I could contain her despair, anger and her "madness".
4.

*[How did this situation turn out?]*  
A gradual resumption of therapeutic work although the situation is still fraught.

Male Therapist

10 Years Experience

Psychodynamic\Systemic Orientation





1.

[What did you or your patient (client) do which made the situation difficult?]

Client drew attention to me being 5 minutes late for session. Client angry.
2.

[What feelings or personal reactions did you experience in the situation?]

Worried that I was failing to create safe setting. Client angry.
3.

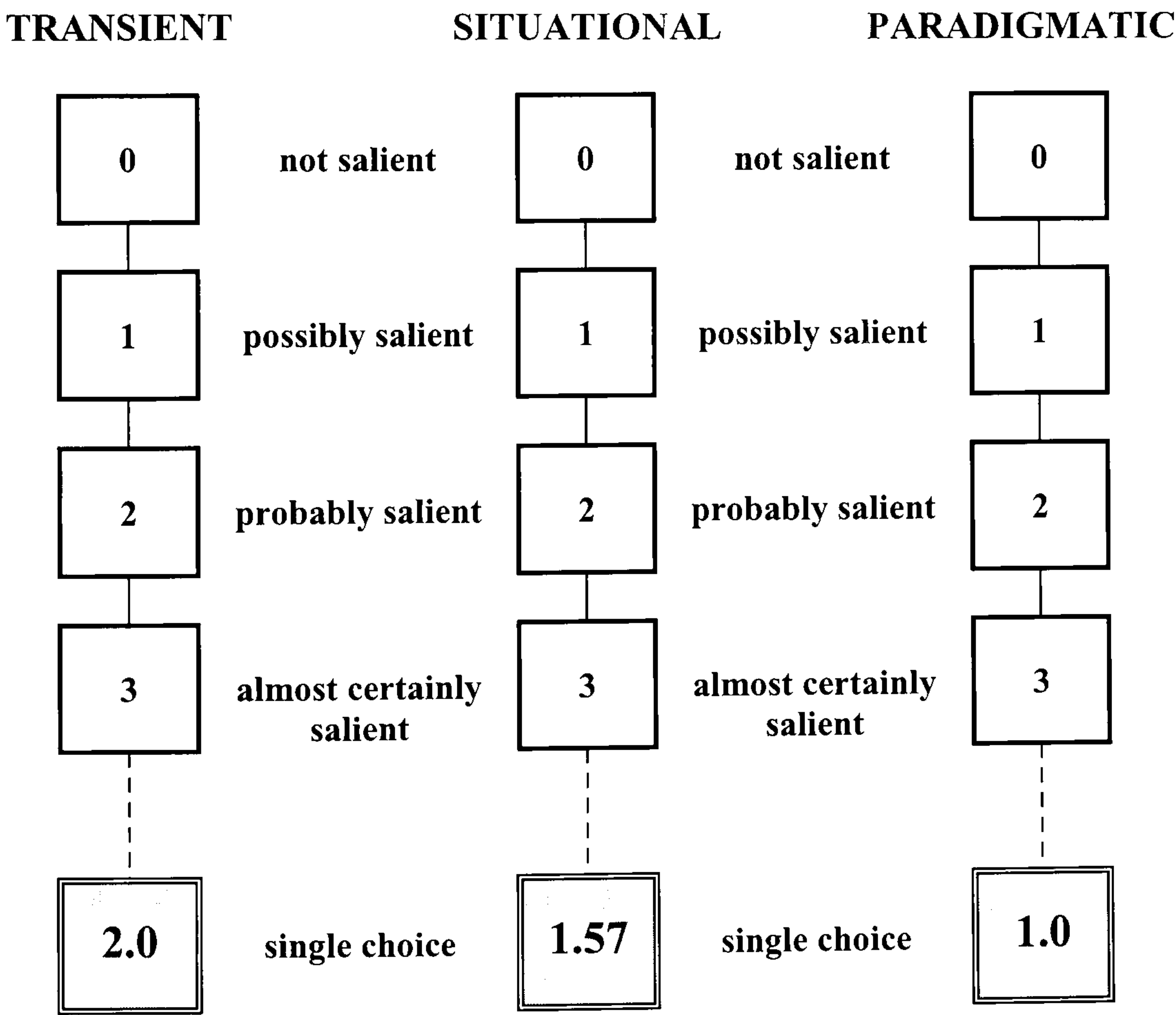
[How did you attempt to deal or cope with this difficulty?]

Tried to talk with client about their thoughts and feelings.  
Apologised for keeping person waiting.
4.

[How did this situation turn out?]

Over course of therapy and supervision addressed issue of rejection  
and abandonment and used relationship with me to frame this.

Female Therapist    6 Years Experience NOW    Psychodynamic Orientation



1.

[What did you or your patient (client) do which made the situation difficult?]

The client became suddenly very upset at the end of a session. I felt that in my surprise I contributed to her feeling of being not understood & of being isolated.
2.

[What feelings or personal reactions did you experience in the situation?]

I felt sad & puzzled & felt as though I had tactlessly mismanaged the moments prior to her tears.
3.

[How did you attempt to deal or cope with this difficulty?]

I tried to allow her time to cry & an opportunity to talk about her feelings & to be critical of me if that was how she was feeling.
4.

[How did this situation turn out?]

We ended the session with the client still upset & me still confused.  
This happened late last week. I'll see her for a subsequent appointment this week.

SEX

Male

Female

(tick one box only)

EXPERIENCE

less than 6 years

6 - 12 years

more than 12 years

(tick one box only)

ORIENTATION(S)

Psychodynamic

Behavioural

Cognitive

Humanistic

Systemic

(tick as many boxes as apply)

TRANSIENT

0

1

2

3

1.0

not salient

possibly salient

probably salient

almost certainly salient

single choice

SITUATIONAL

0

1

2

3

1.25

not salient

possibly salient

probably salient

almost certainly salient

single choice

PARADIGMATIC

0

1

2

3

2.0

not salient

possibly salient

probably salient

almost certainly salient

single choice

1.

[What did you or your patient (client) do which made the situation difficult?]

Nothing specific - I merely felt helpless to help the patient
2.

[What feelings or personal reactions did you experience in the situation?]

Helpless  
Panicky  
Inadequate
3.

[How did this situation turn out?]

Became more directive, I'm afraid
4.

[How did this situation turn out?]

N/A

SEX

Male

Female

(tick one box only)

EXPERIENCE

less than 6 years

6 - 12 years

more than 12 years

(tick one box only)

ORIENTATION(S)

Psychodynamic

Behavioural

Cognitive

Humanistic

Systemic

(tick as many boxes as apply)

TRANSIENT

0

not salient

1

possibly salient

2

probably salient

3

almost certainly salient

2.0

single choice

SITUATIONAL

0

not salient

1

possibly salient

2

probably salient

3

almost certainly salient

.75

single choice

PARADIGMATIC

0

not salient

1

possibly salient

2

probably salient

3

almost certainly salient

2.0

single choice

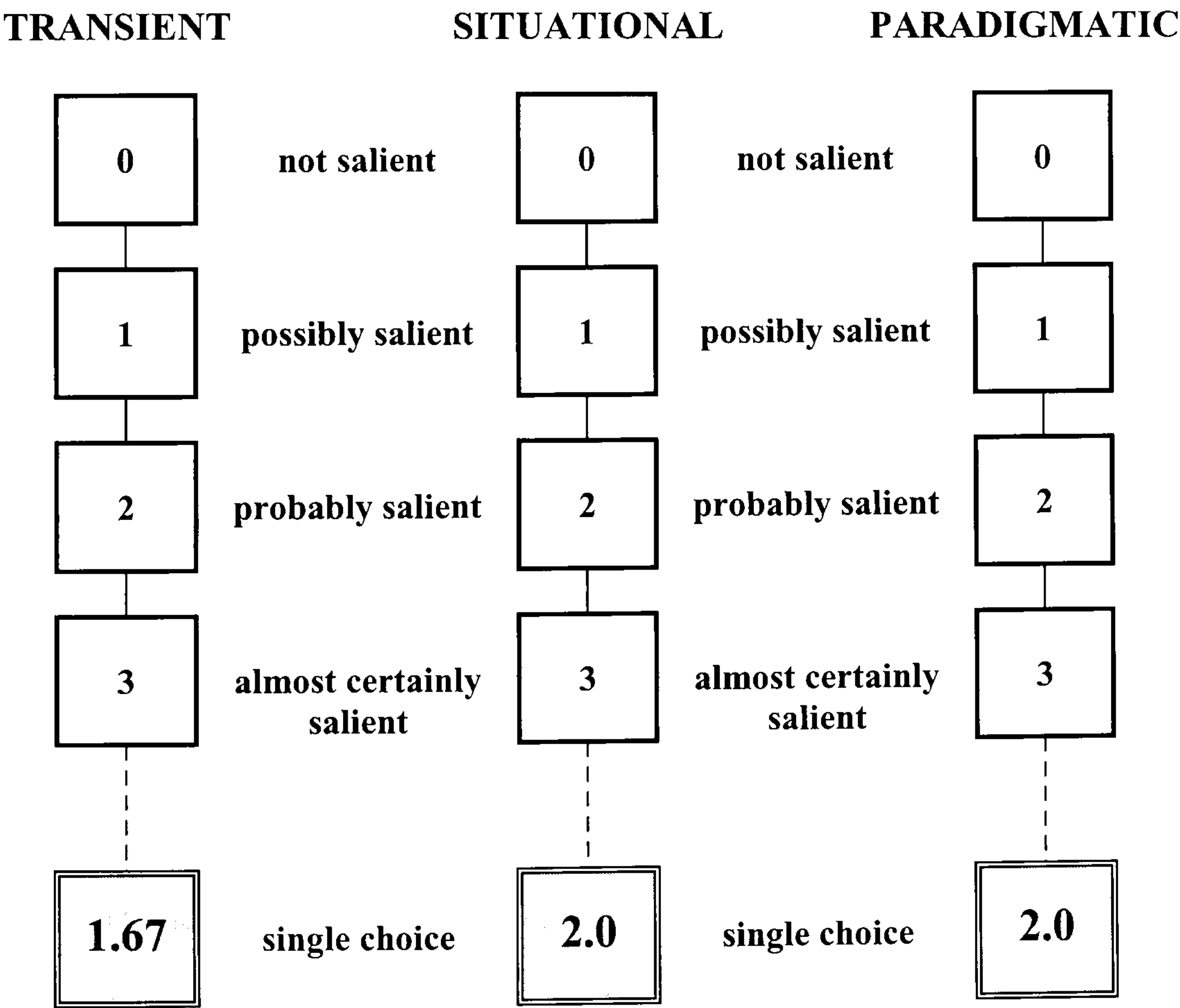


1.     *[What did you or your patient (client) do which made the situation difficult?]*  
A female client was enraged and hurt by my standing at the end of the session as she left the room.
2.     *[What feelings or personal reactions did you experience in the situation?]*  
I felt I should not change my practise in response to this reaction but it left me feeling cruel, abusive, inflexible and at times angry.
3.     *[How did you attempt to deal or cope with this difficulty?]*  
I took it to supervision to get support for my decision & help to understand what prompted her reaction.
4.     *[How did this situation turn out?]*  
The patient came to see my standing formalised a relationship that she had different fantasies about. The hurt & rage subsided.

Male Therapist

8 Years Experience

Psychodynamic Orientation



1.

*[What did you or your patient (client) do which made the situation difficult?]*

Patient had been drinking; told me of her intentions to harm her brother (who had sexually abused her as a child) - her explicit plans to catch the 8.00am train - then realised she had to hold me prisoner over-night so I could not call the police or prevent her. She barricaded the room and threatened to harm me if I stopped her.
2.

*[What feelings or personal reactions did you experience in the situation?]*

I felt very cool and calm. I knew I had to make very good contact with this person and not let her drift into fantasy.  
I felt concerned for her safety when she began hitting her hands against the window panes -  
I remember thinking over first aid procedures for lacerated wrists and cut arteries.
3.

*[How did you attempt to deal or cope with this difficulty?]*

I kept insisting she look at me - look at the reality of the situation - look at the consequences of her action - how she would not be able to continue in therapy, she would be in jail!
4.

*[How did this situation turn out?]*

A C.P.N. returned to the building and the patient allowed me to ask him to arrange for overnight voluntary admittance to Psychiatric Hospital while I sat with her.

SEX

Male

Female

(tick one box only)

EXPERIENCE

less than 6 years

6 - 12 years

more than 12 years

(tick one box only)

ORIENTATION(S)

Psychodynamic

Behavioural

Cognitive

Humanistic

Systemic

(tick as many boxes as apply)

TRANSIENT

0

1

2

3

0

not salient

possibly salient

probably salient

almost certainly salient

single choice

SITUATIONAL

0

1

2

3

2.75

not salient

possibly salient

probably salient

almost certainly salient

single choice

PARADIGMATIC

0

1

2

3

0

not salient

possibly salient

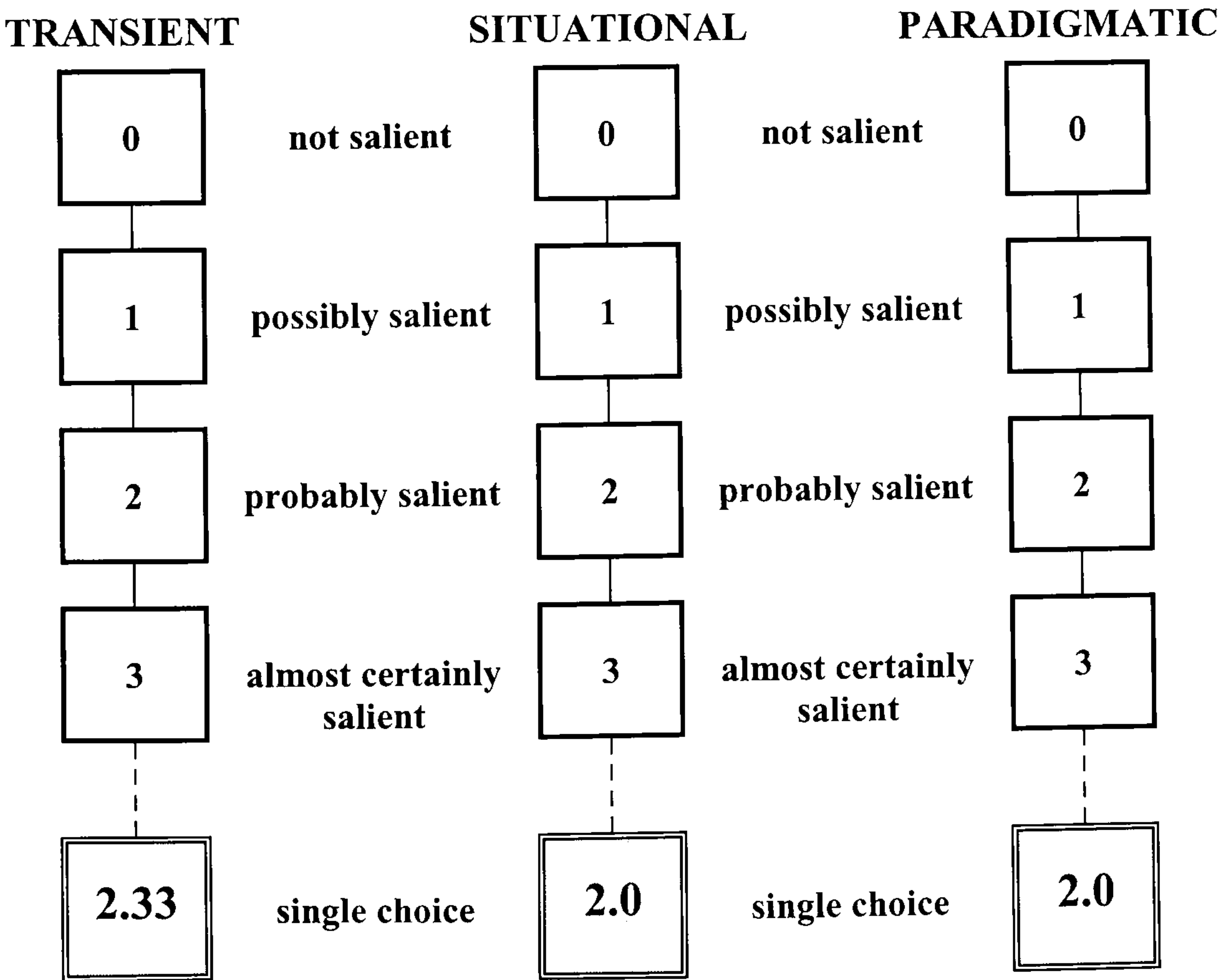
probably salient

almost certainly salient

single choice

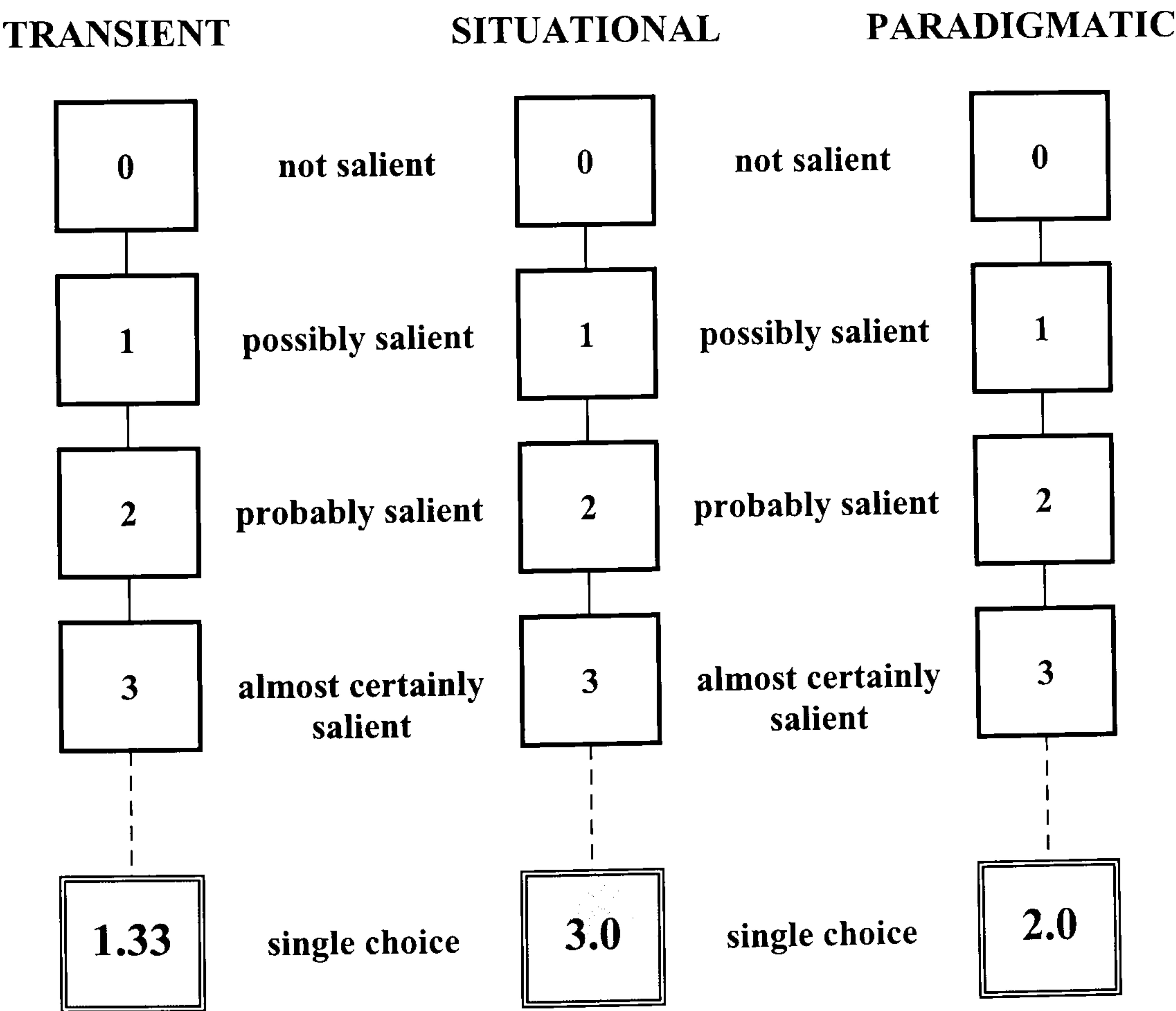


1. *[What did you or your patient (client) do which made the situation difficult?]*  
I would like to refer to the same problem [as in the CURRENT Difficulty], but cast my eyes 10 years back when, although adhering to a psychodynamic framework, I had no access to either good personal psychoanalysis or good psychoanalytic supervision as in London. I worked then in Cape Town and was guided by books rather than experienced seniors.  
*[I am referring to a dynamic which I've found in a variety of patients usually with a narcissistic character structure. I can also think of any one of these patients in particular. It is not a single event in therapy but a continuous attitude throughout therapy. The attitude is a negative one, which asserts truth openly at times, but usually more covertly and in an insidious function. The attitude is that of subtle denigration, devaluation of whatever therapy has given e.g, a good, alive, rich session is turned into a nothing session as if any gains made are valueless, on a par with anything else (subtle but powerful terms of "rubbishing").]*
2. *[What feelings or personal reactions did you experience in the situation?]*  
I think I did not allow myself to recognise fully the reality of this denigrating and subtly attacking state of the patient towards me. Perhaps used an intellectual stance and saw patient as a victim of oppressive parental figures, encouraged their expression of hostile feelings towards others under the aegis of "self-assertion" i.e sided with them in much extra-transference work. i.e.avoid the negative transference and thereby lose the opportunity of working with what troubles the patient a great deal.
3. *[How did you attempt to deal or cope with this difficulty?]*  
See above - Personal Reactions most probably the one of anxiety and devaluation (as in the first part). But this aspect of my countertransference not fully used, worked with. On reflection working in a political climate of oppression as under apartheid leads to favouring an oppressor/oppressed grid, coloniser/colonised in terms of which the patients problems are seen through the grid of being primarily a victim.
4. *[How did this situation turn out?]*  
I don't think I helped my patients much with the part of them which was destructive and in fact caused them much psychotic pain and despair.





1. *[What did you or your patient (client) do which made the situation difficult?]*  
PURSUED ME (LITERALLY), WOULD NOT LEAVE ME ALONE.  
FOLLOWED AND SOUGHT ME OUT. WROTE SEVERAL TIMES A WEEK.  
REWROTE HISTORY. NEVER SAW ME AS A PERSON OR AS A THERAPIST.  
USED ME INSATIABLY AS AN OBJECT OF FANTASIES WHICH, THE CRUX,  
I NEVER UNDERSTOOD.
2. *[What feelings or personal reactions did you experience in the situation?]*  
WORRIED (AS IN ANXIOUS, BUT ALSO AS IN BONE WORRIED  
BY DOG). INCOMPETENT. ABUSED. INVADED.
3. *[How did you attempt to deal or cope with this difficulty?]*  
1) PEER SUPERVISION.  
2) CAME INTO MY OWN PERSONAL THERAPY SESSIONS.  
3) TALKED TO MY BOSS.  
4) INDIVIDUAL SUPERVISION WITH ANALYST.  
5) THOUGHT, READ ETC.  
ALL POINTED TO ENDING THERAPY.
4. *[How did this situation turn out?]*  
THERAPY ENDED STORMILY. PATIENT AND THERAPIST SURVIVED.



1.

[What did you or your patient (client) do which made the situation difficult?]

Patient (female) became quite withdrawn and also sarcastic when she spoke. Quite denigrating of therapy. Long silences and staring out of window.
2.

[What feelings or personal reactions did you experience in the situation?]

Anger towards her rubbishing of what I was offering and allowing no dialogue with me. Frustration with her and venting feelings after she left.
3.

[How did you attempt to deal or cope with this difficulty?]

Interpret it as pattern she can recognise  
Check retaliation on my part when also describing situation.  
Survive it and still be there for her  
Provide some “more obvious” unconditional positive regard as I sensed insecurity lay behind this defensive rubbishing
4.

[How did this situation turn out?]

Became clearer in time she retreats into this stance when unsure if she is cared about. After several sticky sessions I offered more support and help and she responded with more openness. Ongoing situation and a replay of a central dilemma in her life.

SEX

Male

Female

EXPERIENCE

less than 6 years

6 - 12 years

more than 12 years

ORIENTATION(S)

Psychodynamic

Behavioural

Cognitive

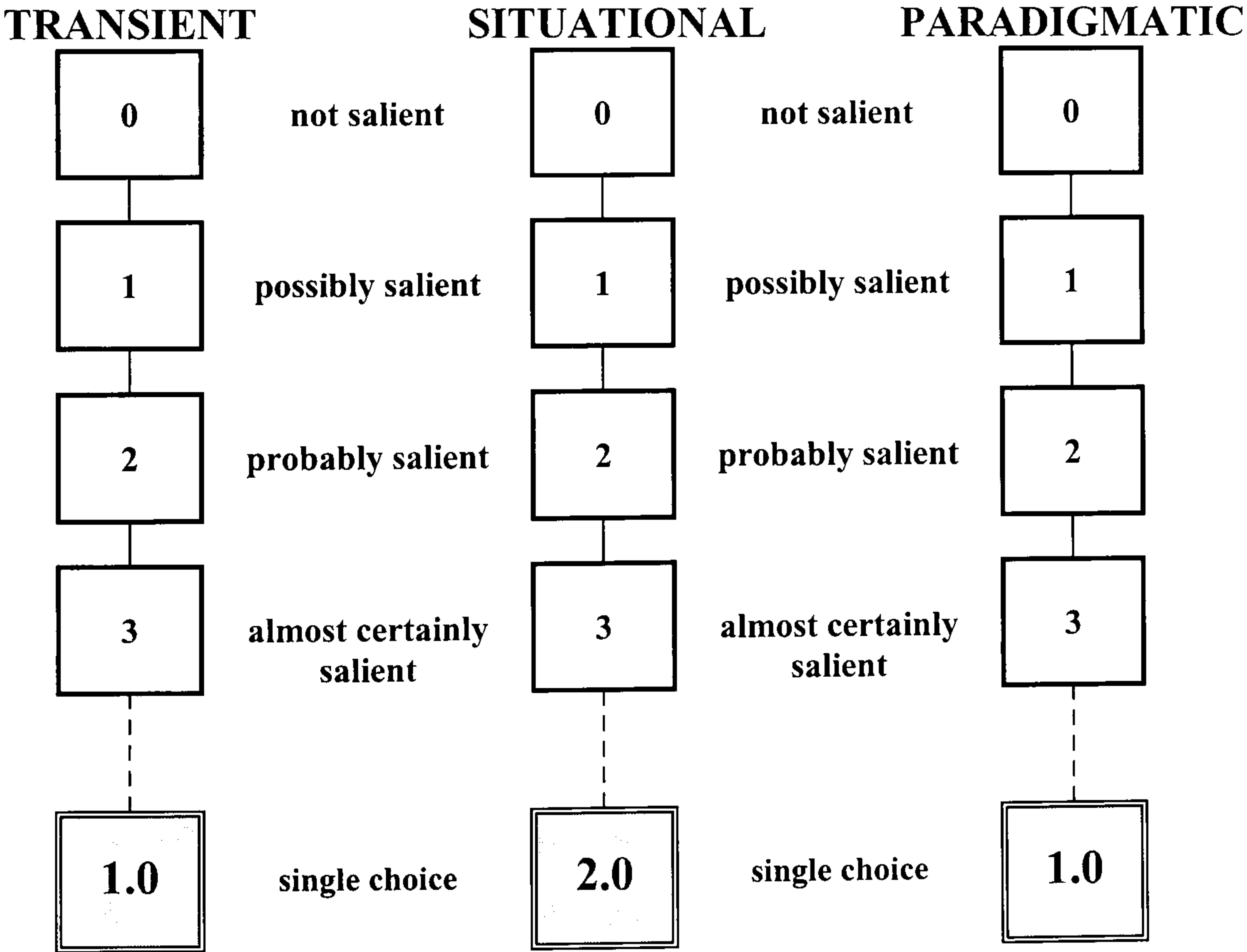
Humanistic

Systemic

(tick one box only)

(tick one box only)

(tick as many boxes as apply)



1.

[What did you or your patient (client) do which made the situation difficult?]

I mentioned various matters for illustration. Patient could not bear me to say anything ‘nonanalytical’ and became increasingly insecure and anxious, questioning my competence etc., idealizing previous therapist.
2.

[What feelings or personal reactions did you experience in the situation?]

I wished I had not taken the patient on.
3.

[How did you attempt to deal or cope with this difficulty?]

I carefully monitored my interventions, while saying I had no objection to the (threatened) seeking of an external consultation.
4.

[How did this situation turn out?]

Patient defaulted (by letter) in a break.  
I replied (by letter) but I have heard nothing more.

SEX

Male  
 Female

(tick one box only)

EXPERIENCE

less than 6 years  
 6 - 12 years  
 more than 12 years

(tick one box only)

ORIENTATION(S)

Psychodynamic  
 Behavioural  
 Cognitive  
 Humanistic  
 Systemic

(tick as many boxes as apply)

TRANSIENT

0

not salient

1

possibly salient

2

probably salient

3

almost certainly salient

1.0

single choice

SITUATIONAL

0

not salient

1

possibly salient

2

probably salient

3

almost certainly salient

1.75

single choice

PARADIGMATIC

0

not salient

1

possibly salient

2

probably salient

3

almost certainly salient

2.0

single choice



1.

[What did you or your patient (client) do which made the situation difficult?]

He projected very abusive feelings into me.
2.

[What feelings or personal reactions did you experience in the situation?]

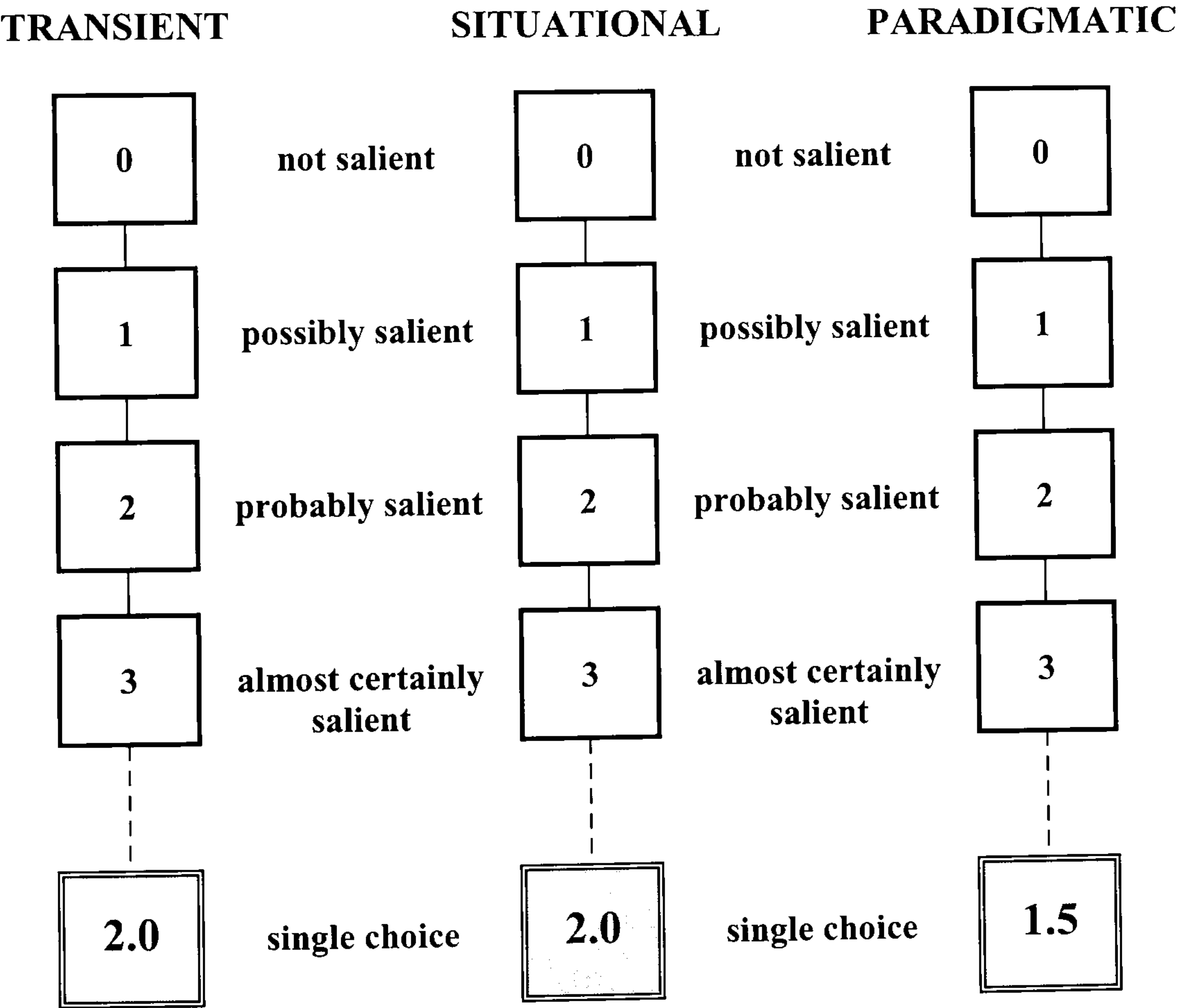
I carried him around with me - he sat on my shoulder in the bath, he inhibited me from making love, he kept me awake at night, he breached my boundaries.
3.

[How did you attempt to deal or cope with this difficulty?]

I shared my difficulties with both my supervision group and individual supervisor: interpreted his need to make me feel as bad as he had as a child when he had been sexually abused.
4.

[How did this situation turn out?]

He regarded this as a turning point in his therapy and from then on was able to show vulnerability and work with his child parts, and through this 2 metaphorical characters emerged which we worked with. He's now in litigation.



### 13. Appendix 13: ‘Training Link’ Supervision Paper and Insert

Supervision - A Personal View

Thomas A. Schröder, Head of Psychotherapy Specialty, S. D. M. H. T.

Writing this, I realise with some consternation that nearly eleven years have passed since I was appointed to my current post. I came to Derby after a relatively brief, quite intensive, but ultimately unsatisfying dalliance with RELATE. (Friends and colleagues had been recognising all along that this relationship was going nowhere, but were too polite to say. I was, as is usual, the last to know.) Since then, it seems, I have been gathering moss.

Supervising and being supervised has been a substantial part of my professional life since 1979 and has brought me into contact with different kinds of folks: voluntary and professional counsellors; clinical psychology practitioners and trainees; specialist and generalist psychotherapists in and out of training. They have been requiring different kinds of strokes - contracts ranging from a few months to many years; individual, conjoint or group settings; peer, consultative or training arrangements - but despite these differences I am struck by the common features which have been emerging as important for me over the years. Of course, getting longer in the tooth as a supervisor is not necessarily an advantage. Worthington’s (1987) review of the research literature led to the conclusion - as yet unchallenged empirically - that “supervisors do not become more competent as they gain experience” (p.203). Although this makes somewhat uncomfortable reading for practitioners, it probably comes as no surprise to those of my supervisees who have been working with me for long periods. However, if the passage of time has failed to make me more proficient, it has at least made me more opinionated.

The aspects of supervision which have become particularly important to me fall into two sets, those specifically informed by psychodynamic theory and those drawing on a wider framework. I will start with the latter:

- Thinking of the supervisory setting as a *facilitating environment*. The image I have in mind is essentially horticultural (I spent formative years as a student in a staunchly Rogerian university department in Hamburg), where capabilities grow if the right conditions are provided. The corollaries to this view are a) that supervisees bring the most important prerequisites for good practice already with them (including their genuine traumata) and b) that supervisors need to avoid having too exact an anticipation of the eventual outcome of their efforts.
- Recognising the central *importance of the supervisory relationship*, not simply as a vehicle for imparting skills, but as instrumental in facilitating change. The supervisor’s main contributions to this are empathic relatedness (requiring a capacity for trial identification with the supervisee) combined with a facility for standing back and monitoring tactfully. Supervision has necessarily a judgmental component, though it is always easier to specify to therapists how **not** to be and what **not** to do, rather than **how** to conduct themselves.
- Focusing on *learning from experience*. By this I mean the capacity to first let something happen and then to reflect on it. Reflection requires *tolerating not knowing* and avoiding premature closure. Succumbing to interpersonal pressures for action in therapy and losing space for reflection happens to us all from time to time. Supervision recovers the reflective space, albeit after the event, and reminds us of the maxim



“don’t just do something, sit there!”. Conversely, the desire to be prepared for all eventualities may prevent us from letting something worthy of reflection happen in the first place. I recall preparing myself for running my very first psychotherapy group by reading a well-known textbook cover to cover, so that I would not encounter anything unforeseen. My supervisor regarded my efforts with mild amusement and, wisely, asked me to think about how I would be in the first minute of the new group. This proved sufficient to ease my anxieties and to enable me to be receptive to the unforeseen happenings in the group which occurred from the second minute onwards.

- Paying close attention to *setting and boundaries*, both in the therapy being supervised and in the supervisory arrangement. Security of time boundaries and regularity of supervisory meetings in a constant setting not only provide me with an external holding frame (possibly by resonating with early experiences of regular good feeds), but also encourage me to present for reflection those therapies which ostensibly are ‘going well’ at the moment but which often benefit more from being thought about than those which trouble me overtly.
- Linked to the previous point is the necessity of *reminding supervisees of their obligation to look after themselves* before trying to attend to clients. I would be hard pushed to listen to anyone’s troubles if I was sitting in a wonky chair, worrying that I might be toppling over at any time. It is equally difficult to be available to others in the face of weighty and lasting insecurities regarding health, mental state, professional context or private life. At worst, we need to guard against the risk of expecting our clients to provide the gratifications which elude us in the rest of our lives. Taking this responsibility seriously is particularly onerous during training, though the motivations which have brought many of us into a helping career in the first place often continue to militate against taking care of ourselves before caring for others. In the interest of the client, supervision needs to address this issue.

The four specifically psychodynamic features of supervision important to me are:

- Grappling with *negative transference*. Most of us like a positive climate in therapy, where clients progress and are grateful and therapists are privately pleased and openly encouraging. If however, as I believe, all relationships are based on ambivalence, then the acknowledgement of negative feelings in therapy becomes vital, lest they emerge after termination when they cannot be jointly processed any more. If supervisors can tolerate feeling occasionally like spoilsports, negative transference becomes thinkable in supervision and addressable in therapy.
- Attending to *countertransference* - using the therapist’s emotional reactions as a source of information about the client - which leads to the familiar dilemma of how to disentangle those aspects of the response originating in the therapist from those arising from the client and those due to situational factors. Supervision helps in this by facilitating sameness/difference comparisons between clients (do I react to other clients in the same way?) and between therapists (would others react to the same client in the way I do?). Personal therapy can then help to illuminate those parts which supervision can’t (and should not) reach.
- Understanding *re-enactments* provides direct access to those aspects of the client’s experience which currently cannot be spoken of (symbolised) - a sort of playtherapy for adults with the therapist as the main toy. How come, for instance, that I find myself repeatedly writing everybody else’s reports before that of the client whose, as yet



unvoiced, complaint is that she is always bottom of the heap? Something informative has happened without me noticing it - supervision helps me to reflect on it.

- Being alert to *parallel process*, which is an extension of the above. Relationships in supervision become a direct source of information, reflecting aspects of therapeutic relationships and thus pervasive themes in clients' lives. Parallel process occurs regularly in individual supervision but is particularly powerful in groups. I recall, for instance, an occasion where a supervision group split into two camps, one convinced that the therapy they were discussing was doomed and should be terminated, the other imbued with therapeutic optimism. Only after a polarised debate were we able to recognise that the group process had mirrored the alternating states of mind of the therapist who was working with a manic-depressive client. The most convincing theoretical accounts for this phenomenon derive from the psychodynamic concept of "projective identification". Empirical evidence has mainly been supplied by the interpersonal tradition. (In case you, gentle reader, are presently in a mood to be edified as well as diverted, I refer you to Kiesler's (1996) concise review.)

Turning again to a general point, I do believe that ongoing supervision is an essential part of good practice. This is currently more readily acknowledged in the world of counselling than in clinical psychology or in psychotherapy, though things may at last be changing. Peer supervision is a perfectly adequate modality, especially at later career stages. Reflective space is opened up by the very presence of third parties and I trust my colleagues to have blind-spots slightly different from my own.

Finally, I want to say something about therapists' experiences of difficulties, an area which has preoccupied me for quite some time now and which supervision helps to acknowledge. Conducting therapy is intermittently difficult: working with distressed people can be distressing, attending to disturbed people is often disturbing and the mental pain of others frequently reminds us of our own. I believe the only way of avoiding experiencing difficulties in therapy is not to engage in it fully (this it has in common with other activities, such as parenting). Similarly, I expect supervisory relationships to have their difficult aspects and have learned to mistrust those which become too cosy. They seem to me to indicate the presence of a collusion between supervisor and supervisee to screen out painful aspects of reality. And if supervision is not about at least the attempt to be honest with myself and to stay in touch with my own and my clients' realities, I need not have bothered embarking on it.

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# Research Project

## Therapists' Experiences of Difficulties in their Practice

### DEAR COLLEAGUE, CAN YOU HELP WITH THIS INQUIRY?

#### *What is it about?*

The study aims to examine the kinds of experiences which psychological therapists have when meeting difficulties in the course of their work. It has its roots in a collaborative research programme - investigating therapists' difficulties and coping strategies - previously conducted by practising clinicians meeting at the University of Warwick. The current study constitutes the final part of work I am undertaking for a doctoral dissertation and a parallel survey is presently being conducted among German speaking therapists.

#### *Who can participate?*

Anyone who is currently engaged in the practice of individual psychological therapy or counselling, whatever their theoretical orientation, professional setting, or length of experience.

#### *What are you letting yourself in for?*

Participants are asked to complete a confidential questionnaire about their own experiences. The total time commitment is approx. 90 minutes, however, as the questionnaire consists of several independent sections, you can arrange its completion to suit your personal circumstances.

#### *What can you get out of it?*

*[Apart from the virtuous feeling of having contributed to the emerging field of psychotherapist research, increased the sum total of human knowledge etc....]*

Many previous participants have found the questionnaire useful as providing a reflective space, like an exercise in self-supervision (look up the article in this issue of Training Link if you want my views on this subject).

If you are willing to take part, please complete and return the tear-off slip. Alternatively, you could contact me by **phone (01332 364 512)** or **fax (01332 293 316)** or via **e-mail** on **<psrah@csv.warwick.ac.uk>** or **<thomas@tythebarn.u-net.com>**.

Many thanks for your help!

Thomas A. Schröder, Clinical Psychologist, Specialist in Psychotherapy

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Name: \_\_\_\_\_

Contact Address: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

*Please return to::*  
**Thomas A. Schröder**  
**Psychotherapy Dept.,**  
**Temple House,**  
**Mill Hill Lane,**  
**DERBY DE23 6SA**

## **14. Appendix 14: Advertisements**

### **UKCP Newsletter**

#### Research Project

#### THERAPISTS' EXPERIENCE OF DIFFICULTIES IN PRACTICE

This is an investigation into the kinds of experiences psychotherapists have when meeting difficulties in the course of their work. It builds on a previous study, collaboratively undertaken by practising clinicians meeting at Warwick University, and is currently conducted among German and English speaking psychotherapists. Participants are asked to complete a confidential questionnaire about their own experiences. Total time commitment is approx. 90 mins.

If you are willing to help, please contact me, Thomas A. Schröder, at the Psychotherapy Dept., Temple House, Mill Hill Lane, Derby DE23 6SA, Tel.: 01332 364 512, Fax: 01332 293 316; or on e-mail: [psrah@csv.warwick.ac.uk](mailto:psrah@csv.warwick.ac.uk). Replies are very welcome from members of all sections of UKCP.

### **CPCT Newsletter**

#### Research Project

#### THERAPISTS' EXPERIENCE OF DIFFICULTIES IN PRACTICE

This is an investigation into the kinds of experiences counsellors and psychotherapists have when meeting difficulties in the course of their work. It builds on a previous study, collaboratively undertaken by practising clinicians meeting at Warwick University, and is currently conducted among German and English speaking counsellors and psychotherapists. If you would like to participate, you will be asked to complete a confidential questionnaire about your own experiences. Your total time commitment would be approx. 90 mins.

If you are willing to help, please contact me, Thomas A. Schröder, at the Psychotherapy Dept., Temple House, Mill Hill Lane, Derby DE23 6SA, Tel.: 01332 364 512, Fax: 01332 293 316; or on e-mail: [psrah@csv.warwick.ac.uk](mailto:psrah@csv.warwick.ac.uk).



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Thomas Schröder

## Was lange währt, wird auch nicht leichter Schwierigkeiten und Bewältigungsstrategien in der psychotherapeutischen Arbeit

Die Geschichte, die ich Ihnen im folgenden darstellen möchte, beginnt im Jahre 1984, ist aber bis heute noch nicht beendet. Sie umfaßt drei Kapitel, die von zwei Leitmotiven durchzogen sind.

Der erste Abschnitt befaßt sich mit der Arbeit einer Gruppe englischsprachiger Kliniker, die sich in einer Forschungskollaboration zusammengeschlossen hatten, um – ausgehend von ihren eigenen Erfahrungen – Schwierigkeiten und Bewältigungsstrategien in der therapeutischen Arbeit systematisch zu untersuchen. Der zweite Abschnitt berichtet über die Ergebnisse einer Umfrage unter britischen Psychotherapeuten, die zu diesem Thema von derselben Forschungsgruppe durchgeführt wurde.

Im dritten Abschnitt werden Resultate vom »Collaborative Research Network« (CRN) im Rahmen der Internationalen Studie zur Beruflichen Entwicklung von PsychotherapeutenInnen (ISDP) vorgestellt, die auf der Auswertung eines entsprechenden Abschnittes des Basisfragebogens, den viele von Ihnen ja auch hier in Lindau ausgefüllt haben, beruhen.

Das eine Leitmotiv ist *inhaltsbezogen* und besteht aus der Phänomenologie der Empfindung von Schwierigkeiten, die aus verschiedenen Blickwinkeln betrachtet wird; das andere Leitmotiv ist *prozeßorientiert* und bezieht sich auf die Vorgehensweise in gemeinschaftlichen und praxisnahen Forschungsansätzen.

Meine Kollegen in der ursprünglichen kollaborativen Forschungsgruppe waren:

Marc Binns	(Carlton Hayes Hospital, Leicester),
John Davis	(University of Warwick),
Marcia Davis	(Walsgrave Hospital, Coventry),
Robert Elliott	(University of Toledo, Ohio),
Val Francis	(Ransom Hospital, Mansfield) und
James Kelman	(Uffculme Clinic, Birmingham).



Obwohl zwei unserer Mitarbeiter Universitätsstellen innehatten, handelte es sich hier im wesentlichen um eine Gruppe von Klinikern, also von Psychotherapeutinnen und -therapeuten, die in der allgemeinen Gesundheitsversorgung praktizierten und denen ein Interesse an der Psychotherapieforschung gemeinsam war. Zum einen wußten wir aus früheren Erfahrungen, besonders von der Ausbildung in der Klinischen Psychologie her, wie isolierend eine Forschungstätigkeit sein kann, und wir waren daher zu einem gemeinschaftlichen Vorgehen entschlossen, welches uns die beste Chance zu bieten schien, Enthusiasmus und Energie zu bewahren. Zum anderen waren wir davon überzeugt, daß es nützlich ist, die Funktionen des Praktikers und des Forschers zu verbinden. Diese Kombination vorgegenwärtigt einem nicht nur die praktischen Probleme der Forschung, die man als Kliniker ja oft unterschätzen kann, sondern auch etwas über die Notwendigkeit, praxisnah zu bleiben, die einem als Forscher doch leicht abhanden kommen kann.

### Die Entwicklung zweier Taxonomien

Welche Fragestellung stand am Anfang unserer Untersuchung? Da wir von unserer eigenen Praxiserfahrung ausgingen, war es uns am naheliegendsten, das zu wählen, was sowieso Gegenstand vieler unserer Diskussionen war: nämlich die Schwierigkeiten, denen wir in unserer täglichen Arbeit als Psychotherapeuten immer wieder begegneten und die uns in unseren Rollen als Supervisoren auch von anderen berichtet wurden. Es wurde uns erst später bewußt, daß Schwierigkeiten an sich in der psychotherapeutischen Literatur kaum Beachtung gefunden hatten, obwohl natürlich manche verwandte Phänomene, wie zum Beispiel das der Gegenübertragung, ausführlich beschrieben worden sind. (Ein Ansatz, der mit dem unseren einige Gemeinsamkeiten hat, ist seither von Plutchik, Conte u. Karasu 1994, veröffentlicht worden.)

Zwei Grundsätze leiteten uns in unseren Überlegungen. Zum einen wollten wir den Abstand zwischen Forschern und »Subjekten« (»Versuchsleitern« und »Versuchspersonen«) möglichst gering halten, indem wir uns im Anfangsstadium selbst zum Gegenstand unserer Untersuchung machten. Zum anderen wollten wir uns von unseren theoretischen Grundpositionen soweit wie möglich freimachen, um einen direkteren Zugang zur Qualität unserer Erfahrung zu finden – mit anderen Worten, wir wählten einen phänomenologischen Ansatz. (Dies reflektierte übrigens auch die Realität in unserer Gruppe, in der die verschiedensten theoretischen Orientierungen vertreten waren – psychodynamisch, kognitiv, interpersonell

und integrativ – während uns allen eine Ausbildung in der Verhaltenstherapie gemeinsam war.)

Konkret begannen wir mit den ausführlichen Beschreibungen einzelner Schwierigkeiten, denen wir persönlich begegnet waren. Wir tauschten die Darstellungen dann untereinander aus, um gemeinsame Gesichtspunkte herauszuarbeiten. Dies führte zum Beispiel zu einer Übereinkunft, Situationen und Empfindungen zu beschreiben. Im nächsten Schritt sammelten wir neues Material und begannen damit, es vorläufig zu klassifizieren. Danach beschrieben wir weitere Schwierigkeiten aus unserer eigenen Praxis und versuchten, diese in unsere Kategorien einzuordnen, was wiederum zu deren Abänderung und Verfeinerung führte; und so fort, in einem Verfahren, das unter dem Namen »grounded theory« (Glaser u. Strauss 1967) in den letzten 30 Jahren bekannt geworden ist. Traditioneller läßt es sich vielleicht am besten charakterisieren als ein hermeneutischer Zirkel: ein »Kanon der wechselseitigen Erhellung des Ganzen und seiner Teile«. So gingen wir von unseren eigenen Schwierigkeiten (den Teilen) zum Ganzen (zur Klassifizierung), dann wieder zurück zum Speziellen (weiteren Schwierigkeiten), und weiter zum Allgemeinen (dem Kategoriensystem), um zu ergründen, wie sie sich gegenseitig aufklären. Dies war für uns ein sehr aufregender und lehrreicher Prozeß, denn er gab uns die Möglichkeit, durch unseren Forschungsansatz unsere eigene Praxis besser aufzuklären und zu verstehen, sowohl als Klinikerinnen und Kliniker wie auch als Supervisorinnen und Supervisoren. Das Endergebnis dieser ersten Phase war dann eine Taxonomie, die darauf abstellt, welche *Empfindungen* Psychotherapeuten haben, wenn sie in ihrer Arbeit Schwierigkeiten begegnen. Wir hatten den Gedanken, auf *Verhaltensbeschreibungen* abzustellen, frühzeitig verworfen, da unterschiedliche Psychotherapeuten dem gleichen Verhalten grundverschiedene Bedeutungen zuordnen können. Die Kategorien in der Endfassung der Taxonomie sind in Tabelle 1 aufgeführt.

Tabelle 1: Taxonomie der Schwierigkeiten

1. Therapeut(in) fühlt sich unfähig
2. Therapeut(in) erlebt sich als schädlich
3. Therapeut(in) verblüfft (fachliches Rätseln)
4. Therapeut(in) fühlt sich bedroht
5. Therapeut(in) fühlt sich ohne Rapport
6. Persönliche Angelegenheiten
7. Schmerzliche Realität
8. Ethisches/moralisches Dilemma
9. Therapeut(in) fühlt sich festgefahren
10. Therapeut(in) fühlt sich vereitelt

(Zur Definition der jeweiligen Kategorien vgl. Davis et al. 1987)



Da wir uns in diesem Teil der Untersuchung auf unsere eigenen Schwierigkeiten konzentriert hatten, stellte sich weiterhin natürlich die Frage, ob die daraus abgeleitete Taxonomie idiosynkratisch war und nur die Auffassungen und Gedankengänge unserer Forschungsgruppe reflektierte, oder ob sie verallgemeinert werden konnte und auch mit den Erfahrungen anderer Therapeutinnen und Therapeuten im Zusammenhang stand. Aus diesem Grunde führten wir zwei weitere unterstützende Studien durch. In der ersten dieser Nebenstudien untersuchten wir, ob sich unsere Taxonomie auch auf Schwierigkeitsdarstellungen anderer Psychotherapeutinnen und -therapeuten anwenden ließ. In der zweiten Nebenstudie suchten wir festzustellen, ob Kollegen, die keine Psychotherapeuten waren, jedoch Erfahrungen auf dem Gebiet der Mental Health hatten, – in diesem Falle psychiatrische Krankenschwestern und -pfleger – unser Kategoriensystem verläßlich anzuwenden vermochten. Die Ergebnisse waren zufriedenstellend und überzeugten uns, daß die Taxonomie gut genug war, um sie für weitere Forschungszwecke zu verwenden.

Eine parallele Untersuchung, die auf der gleichen Vorgehensweise beruhte, befaßte sich mit der Frage, wie wir und andere Psychotherapeuten versuchten, mit den so beschriebenen Schwierigkeiten in unserer Arbeit nun umzugehen oder fertigzuwerden. (Der entsprechende englische Ausdruck »coping« läßt sich nicht präzise übersetzen.) Nach Durchlaufen der verschiedenen Phasen des »grounded theory«-Verfahrens – von der ausführlichen Beschreibung einer einzelnen Begebenheit über die vorläufige

Tabelle 2: Taxonomie der Bewältigungsstrategien

- 1. Therapeut(in) wendet sich an sich selbst
  - 1.1. Neueinschätzung
  - 1.2. Selbstregulierung
- 2. Therapeut(in) wendet sich an den Patienten
- 3. Therapeut(in) wendet sich an andere(s)
  - 3.1. Ratsuche
  - 3.2. Weiterbildung
  - 3.3. Diffusion der Verantwortlichkeit
  - 3.4. Suche nach Befriedigung
- 4. Therapeut(in) wendet sich an die Praxis
  - 4.1. Fachliches Eingreifen
  - 4.2. Außerfachliches Eingreifen
  - 4.3. Kursänderung
- 5. Therapeut(in) wendet sich von der Schwierigkeit ab
- 6. Therapeut(in) wendet sich gegen den Patienten
- 7. Therapeut(in) wendet sich vom Patienten ab

(Davis et al. 1989)

Zuordnung zu Kategorien bis zur wiederholten Revision des Kategoriensystems – gelangten wir im Endergebnis dieser Arbeit zu einer Taxonomie der »Bewältigungsstrategien« (»coping strategies«). Diese stellte im Wesentlichen auf die *Quellen* ab, an die sich Psychotherapeuten wenden, um Hilfe bei ihren Bemühungen mit einer Schwierigkeit fertigzuwerden, zu suchen. Die Kategorien der endgültigen Version sind in Tabelle 2 aufgeführt.

Die ersten vier dieser Kategorien beschreiben aktive Lösungsversuche (»approach«), die letzten drei benennen Vermeidungsstrategien (»avoidance«).

### Eine Umfrage unter britischen Psychotherapeuten und Psychotherapeuten

Der nächste Abschnitt handelt von der Erweiterung unserer Fragestellung über unsere eigene Gruppe hinaus auf einen Kreis von knapp 100 britischen Psychotherapeutinnen und -therapeuten. Diese Umfrage fand in den Jahren 1985/86 statt, und bisher ist nur in geringem Umfang darüber berichtet worden (Schröder et al. 1987a;b). Wir benutzten wiederum die Ressourcen innerhalb unserer Gruppe, um eine Liste von rund 150 Kolleginnen und Kollegen zusammenzustellen, die uns gut genug bekannt waren, um sie persönlich anzuschreiben und um ihre Mithilfe zu bitten. Jede(r) der insgesamt 96 Antwortenden trug drei Schilderungen von schwierigen Situationen in der Einzeltherapie zu der Studie bei, unter den Fragestellungen:

- 1. Was taten Sie oder Ihr(e) Patient(in), das zu der Schwierigkeit in dieser Situation geführt hat?
- 2. Welche persönlichen Reaktionen oder Gefühle hat diese Situation bei Ihnen ausgelöst?
- 3. Wie haben Sie versucht, mit dieser Schwierigkeit zurechtzukommen oder fertigzuwerden?
- 4. Wie hat sich die Situation dann schließlich entwickelt?

Außerdem wurden Informationen über eine Reihe von Therapeuten-, Patienten- und situationsbedingten Variablen erfragt.

Die Beschreibungen wurden von allen Mitgliedern unserer Gruppe unabhängig voneinander den Schwierigkeitskategorien und Bewältigungsstrategien zugeordnet, wobei für jede Kategorie ein Urteil auf einer vierstufigen Skala getroffen wurde (von »0 = in dieser Schilderung nicht vorhanden« bis »3 = in dieser Schilderung klar vorhanden«). Als Maß der



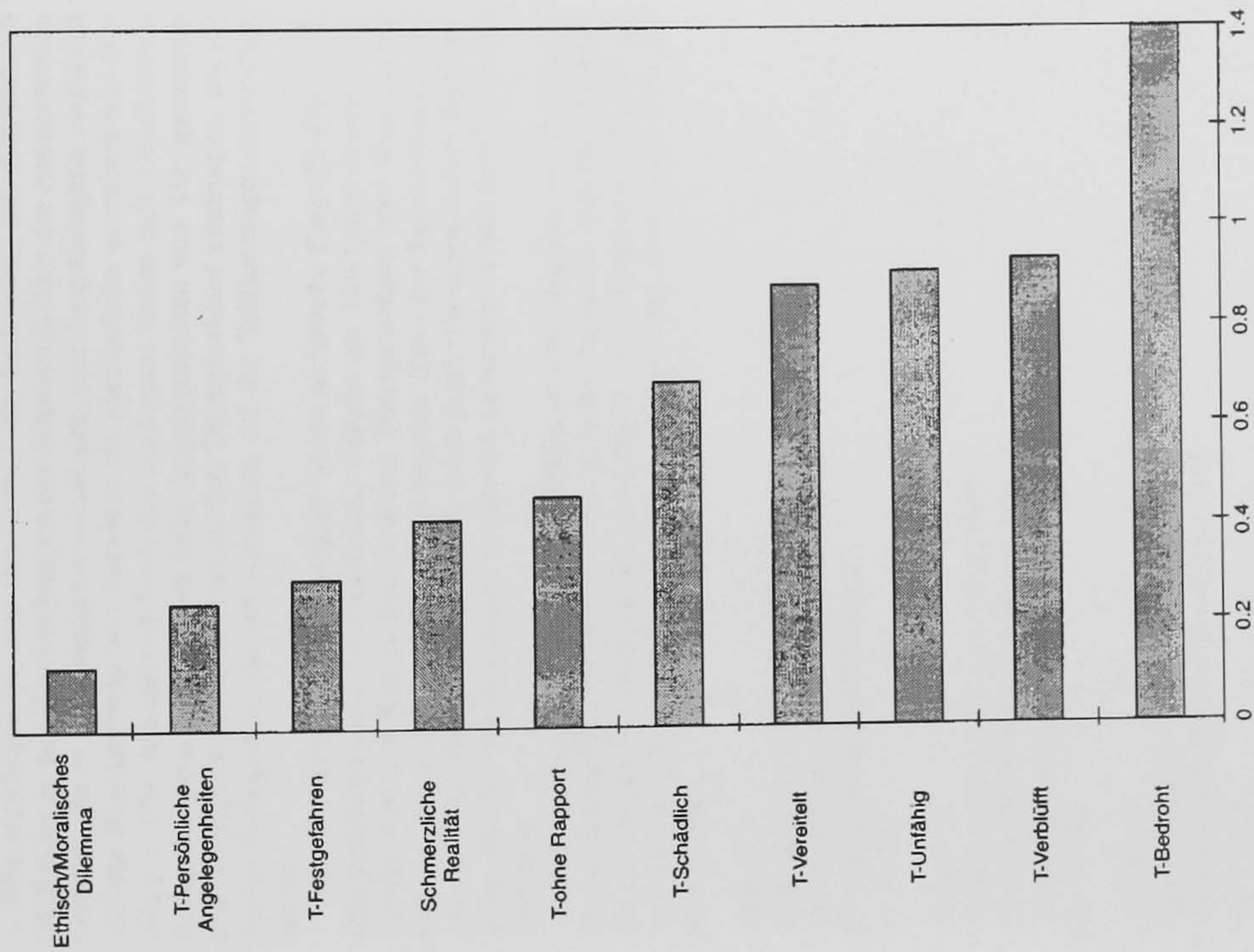


Abbildung 1: Schwierigkeiten in der therapeutischen Arbeit, Häufigkeitsmittelwerte

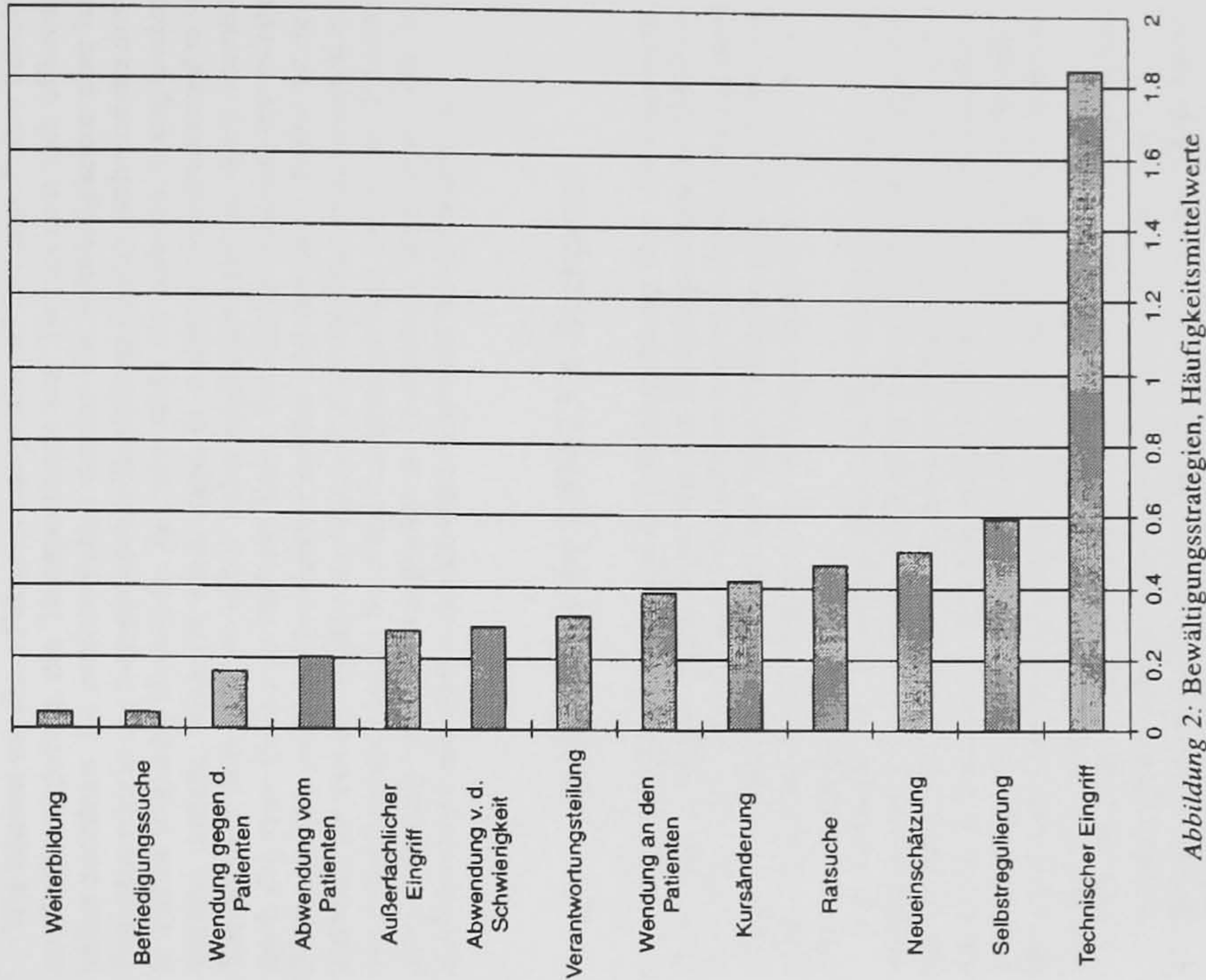


Abbildung 2: Bewältigungsstrategien, Häufigkeitsmittelwerte

Übereinstimmung wurden Reliabilitätskoeffizienten berechnet, die im Bereich von 0.81 bis 0.99 lagen (wobei »0.0« bedeutet, daß zwischen den Beurteilungen kein Zusammenhang besteht und »1.0« eine perfekte Übereinstimmung anzeigt) und daher sehr zufriedenstellend waren.

Die Prävalenz der einzelnen Kategorien in den insgesamt 288 Schilderungen, ausgedrückt als Häufigkeitsmittelwerte unserer Beurteilungen, ist in den Abbildungen 1 und 2 wiedergegeben.



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<p>Wie ersichtlich ist, war das Gefühl der Bedrohung mit Abstand am häufigsten in den Beschreibungen der Schwierigkeiten der Antwortenden vertreten. Es ist auch wenig verwunderlich, daß diese Kategorie verläßlich mit der Beschreibung von Patienten als »borderline« assoziiert war (<math>r = .40</math>, <math>p &lt; .05</math>). Am anderen Ende des Spektrums finden sich ethisch/moralische Dilemmata und persönliche Angelegenheiten von Therapeutinnen und Therapeuten, die störend in den Therapieablauf eindringen, als die beiden Kategorien, die am wenigsten auf die Schilderungen anwendbar waren.</p> <p>Von den Bewältigungsstrategien waren <i>technische Eingriffe</i> (wie z. B. Interpretationen oder Reflektionen) weitaus am häufigsten beschrieben, gefolgt von den Kategorien, in denen Therapeutinnen oder Therapeuten sich <i>an sich selber</i> als Hilfsquelle wenden. Zwei der <i>Vermeidungsstrategien</i> und die Kategorien <i>der Suche nach (außertherapeutischer) Befriedigung</i> und der <i>Weiterbildung</i> waren am seltensten in den Schilderungen vertreten.</p> <p>Wenn wir die Schwierigkeiten (summiert über alle drei Schilderungen) einer Faktorenanalyse unterziehen, das heißt, wenn wir statistisch feststellen, ob einige Schwierigkeiten miteinander so zusammenhängen, daß sie auf wenige Dimensionen reduziert werden können, dann ergibt sich folgendes Bild:</p> <p><i>Faktor 1:</i> Therapeut(in) fühlt sich unfähig Therapeut(in) erlebt sich als schädlich Persönliche Angelegenheiten (<math>\alpha = .62</math>)</p> <p><i>Faktor 2:</i> Therapeut(in) fühlt sich festgefahren Therapeut(in) fühlt sich ohne Rapport Therapeut(in) fühlt sich vereitelt (<math>\alpha = .56</math>)</p> <p><i>Faktor 3:</i> Schmerzliche Realität Therapeut(in) fühlt sich nicht bedroht (<math>\alpha = .41</math>)</p> <p>(Die <math>\alpha</math>-Werte sind Maßzahlen der internen Konsistenz eines Faktors; ein Wert von »1« bedeutet, daß alle Komponenten eines Faktors vollkommen miteinander kongruent sind; ein Wert von »0« bedeutet, daß die Komponenten voneinander völlig unabhängig sind.)</p>	<p>Wie können wir diese Faktoren interpretieren? Der erste Faktor besteht aus Schwierigkeiten, die Therapeutinnen und Therapeuten sich offenbar selbst zuordnen. Im zweiten Faktor werden die Schwierigkeiten eher im Patienten oder in der therapeutischen Beziehung geortet, während der dritte Faktor tragische Umstände, die aber nicht als bedrohlich empfunden werden, umfaßt. Wenn ich mich frage, in welchem Gemütszustand sich Therapeuten befinden, die diese Schwierigkeiten erleben, dann erinnert mich der erste Faktor an Melanie Klein <i>Depressive Position</i>, der zweite Faktor an ihre <i>paranoid-schizoide Position</i> und der dritte Faktor an den Zustand, der von Symington als <i>tragische Position</i> bezeichnet worden ist. Sie mögen andere Namen für diese Faktoren im Sinn haben, die Tatsache der Zuweisung von Schwierigkeiten zu bestimmten Bereichen bleibt jedoch bestehen und wird uns im letzten Abschnitt wiederbegegnen.</p>	<p>Resultate aus der CRN-2376-Stichprobe</p> <p>Der letzte Abschnitt gibt Ihnen eine Rückmeldung über die Ergebnisse Ihrer eigenen Bemühungen, sofern Sie den Basisfragebogen der ISDP bereits ausgefüllt haben. Diese Untersuchung nimmt ja ihren Ausgang auch wieder vom Prinzip des kollektiven Selbststudiums praktizierender Psychotherapeutinnen und -therapeuten, wenngleich auch im viel größeren, internationalen Rahmen.</p> <p>Die Konzepte der Schwierigkeiten und Bewältigungsstrategien in der therapeutischen Arbeit sind in den Basisfragebogen miteingegangen. Bevor sie jedoch für dieses Format relevant und verwendbar waren, mußten die Taxonomien zunächst in Skalen umgeschrieben werden. Die deutschen Übersetzungen beider Skalen sind im Anhang dieses Beitrags wiedergegeben. Jede Kategorie ist mit jeweils zwei Fragen vertreten. So repräsentieren zum Beispiel in der Schwierigkeiten-Skala die Fragen</p> <p>5. Wie oft empfinden bzw. erleben Sie <i>derzeit</i> Schwierigkeiten, sich emotionalisch in die Erfahrungen eines Patienten einzufühlen? und</p> <p>15. Wie oft empfinden bzw. erleben Sie <i>derzeit</i> sich als nicht fähig, einem Patienten Sympathie oder Achtung entgegenzubringen?</p> <p>die Kategorie <i>Therapeut(in) fühlt sich ohne Rapport</i>. In gleicher Weise ist die Bewältigungsstrategie <i>Diffusion der Verantwortlichkeit</i> durch die Fragen</p> <p>6. Wenn Sie <i>Schwierigkeiten</i> haben, wie oft ziehen Sie andere Fachleute oder Einrichtungen hinzu? und</p> <p>19. Wenn Sie <i>Schwierigkeiten</i> haben, wie oft suchen Sie die Zusammenarbeit mit Freunden oder Verwandten des Patienten?</p>



232	Empirische Forschungsergebnisse	T. Schröder: Bewältigungsstrategien in der psychotherapeutischen Arbeit 233																								
<p>in der entsprechenden Skala vertreten. Demzufolge beinhaltet die Schwierigkeiten-Skala 20 Fragen, die zusammen 10 Taxonomie-Kategorien repräsentieren, während die 13 Kategorien der Bewältigungsstrategien-Taxonomie durch insgesamt 26 Fragen in der entsprechenden Skala vertreten sind.</p> <p>Die folgenden Ergebnisse stammen von der derzeit aktuellen Stichprobe der Internationalen Studie zur Beruflichen Entwicklung von PsychotherapeutenInnen, die auf einem Rücklauf von 2376 Basisfragebögen beruht. Eine der Fragen, die für uns von Interesse war, betrifft die Häufigkeit, mit der bestimmte Schwierigkeiten und Bewältigungsstrategien berichtet werden, und die Stabilität einer solchen Verteilung im Vergleich verschiedener Untergruppen.</p> <p>Die folgenden drei Schwierigkeiten wurden am häufigsten berichtet:</p>		<p>weiter oben beschriebenen britischen Umfrage fallen sowohl die Ähnlichkeiten auf wie auch ein bemerkenswerter Unterschied: <i>Das Gefühl der Bedrohung</i>, das so klar aus den konkreten Schilderungen hervortritt, spielt in der Selbsteinschätzung von Therapeutinnen und Therapeuten nur eine untergeordnete Rolle.)</p> <p>Dieses Bild, das sich aus der gesamten Stichprobe ergibt, zeigt auch eine bemerkenswerte Stabilität im Vergleich von Untergruppen. Ganz gleich, ob man die Gesamtstichprobe nach Geschlecht, Sprache, Berufsgruppen oder theoretischen Orientierungen aufteilt, erhält man immer wieder eine ähnliche Verteilung (die koreanische Stichprobe ist die Ausnahme zu dieser Regel, aus bisher ungeklärten Gründen, die aber wahrscheinlich eher in kulturellen Unterschieden als in Übersetzungsschwierigkeiten zu finden sein werden). Die Allgemeingültigkeit der Taxonomie scheint damit bestätigt zu sein, und als praktizierende Psychotherapeuten mögen wir in dem Gedanken Trost finden, daß unsere Kollegen, wo immer sie sich befinden, sich mit ganz ähnlichen Schwierigkeiten auseinandersetzen, wie wir selber.</p> <p>Für die Bewältigungsstrategien ergibt sich das folgende Bild. Die drei am häufigsten genannten Strategien waren:</p>																								
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unsere persönlichen Ressourcen und auf Kollegen. Die am seltensten berichteten Arten der Bewältigung fallen in die Kategorien des außerfachlichen Eingreifens und (wie man erwarten oder zumindest hoffen würde) der Vermeidungsstrategien.

Nun zu unserem letzten Ergebnis: Wenn wir alle Fragen der Schwierigkeiten-Skala wieder einer Faktorenanalyse unterziehen, erhalten wir die folgenden Faktoren, die auch mit dem Entwicklungsstand von Psychotherapeutinnen und -therapeuten im Zusammenhang stehen:

#### Faktor 1: (Der »schlechte« Therapeut)

- Wenig Vertrauen darauf, daß Sie einen günstigen Einfluß auf einen Patienten bzw. eine Patientin haben.
- Angst, daß Sie dem Patienten mit Ihrer Behandlung mehr schaden als nützen.
- Zweifel, wie Sie in einem bestimmten Fall am besten vorgehen sollten.
- Die Gefahr, die Kontrolle über die therapeutische Situation an einen Patienten zu verlieren.
- Nicht in der Lage, genügend Kraft aufzubringen, um die Therapie mit einem Patienten in einer konstruktiven Richtung voranzutreiben.
- Entmutigt, weil Sie keine Möglichkeit finden, dem Patienten zu helfen.
- Nicht in der Lage, das Wesentliche an den Problemen eines Patienten zu erfassen.

( $\alpha = .80$ )

Der Ursprung der Schwierigkeiten ist wieder ganz klar dem Therapeuten/der Therapeutin zugeordnet. Natürlich handelt es sich hier nicht um objektiv schlechte Therapeutinnen und Therapeuten, sondern um diejenigen, die sich im Moment als unzulänglich empfinden. Es kann aber gut sein, daß derartige Selbstzweifel Therapeuten davor bewahren, wirklich Schaden anzurichten und daß die objektiv schlechtesten Therapeuten eher diejenigen sind, die sich nie als unzulänglich empfinden

#### Faktor 2: (Der »schlechte« Patient)

- Schwierigkeiten, sich empathisch in die Erfahrungen eines Patienten einzufühlen.
- Gereizt, weil ein Patient Ihre Bemühungen aktiv blockiert.
- Nicht in der Lage, die emotionalen Bedürfnisse eines Patienten zu tragen.
- Nicht fähig, einem Patienten Sympathie oder Achtung entgegenzubringen.
- Festgefahren in einer Beziehung zu einem Patienten, die nicht voranzukommen scheint.

- Frustriert mit einem Patienten, der Ihre Zeit verschwendet.  
( $\alpha = .77$ )

Das Gemeinsame der in diesem Faktor zusammengefaßten Schwierigkeiten ist, daß ihre Herkunft den Patienten zugewiesen wird. Während es der Grundhaltung vieler Therapeuten zuwiderlaufen mag, Patienten für ihre Schwierigkeiten verantwortlich zu machen, werden diese in den hier aufgeführten Fällen doch, zumindest zeitweilig, als unzulänglich empfunden.

#### Faktor 3: (Die »schlechte« Welt)

- Schmerzlich berührt über Ihre Macht- und Einflußlosigkeit gegenüber der tragischen Lebenssituation eines Patienten.
- Beunruhigt durch moralische oder ethische Probleme, die in Ihrer Arbeit mit einem Patienten aufgetreten sind.
- Zornig, weil bestimmte Faktoren im Leben eines Patienten einen günstigen Therapieausgang unmöglich machen.
- In einem Konflikt zwischen gleichwertigen Verpflichtungen gegenüber einem Patienten einerseits und anderen Personen andererseits.

( $\alpha = .67$ )

Der Ursprung der Schwierigkeiten, die zu diesem Faktor beitragen, liegt eindeutig in äußeren Umständen. Die Realitäten müssen so ertragen werden, wie sie sind und die Welt erscheint, zumindest im Augenblick, als frustrierend, vielleicht sogar als ein Jammerthal.

Fragen Sie sich nun einmal für sich selbst: Welcher dieser Faktoren wird am ehesten mit der Entwicklung von Psychotherapeutinnen und -therapeuten zusammenhängen? Was würden Sie erwarten?

Unsere Ergebnisse zeigen (wenn man die Länge der Praxiserfahrung als groben Index des Entwicklungsstandes benutzt), daß die schlechte Welt auch mit zunehmender Praxiserfahrung schlecht bleibt. Auch »schlechte« Patienten werden nicht besser, je länger man praktiziert. Die Erfahrung der eigenen Unzulänglichkeit nimmt jedoch mit zunehmender Erfahrung ab ( $r = -0.23$ ,  $p < 0.001$ ). Es muß natürlich dahingestellt bleiben ob dieses Ergebnis tatsächlich auf professioneller Weiterentwicklung beruht oder darauf, daß Psychotherapeuten, die sich ständig als unzulänglich empfinden, andere Möglichkeiten finden, ihren Lebensunterhalt zu verdienen, oder lediglich auf dem zunehmenden Verfall selbstkritischer Fähigkeiten. Sie werden dazu sicher Ihre eigenen Gedanken haben.



Schlußbemerkung

Wir haben Schwierigkeiten und Bewältigungsstrategien in der psychotherapeutischen Arbeit unter verschiedenen Blickwinkeln betrachtet. Insbesondere für die Schwierigkeiten ist eine Konvergenz der verschiedenartigen Ergebnisse zu beobachten, die Konsequenzen für Therapie und Supervision hat. Kurz gesagt, gibt es einige Schwierigkeiten, die aus äußeren Umständen herrühren, die wir *akzeptieren* müssen; andere Schwierigkeiten, die von problematischen Patienten herrühren, die wir *tolerieren* müssen; und letztlich jene Schwierigkeiten, die in uns selbst ihren Ursprung haben und die uns herausfordern, sie zu *modifizieren*.

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Anhang

Schwierigkeiten-Skala  
(J. Davis u. D. Orlinsky/Deutsche Version:  
U. Willutzki u. H. Ambühl)

- Wie oft empfinden bzw. erleben Sie *derzeit* ...? [0 = nie – 5 = sehr oft]
- |  |   |   |   |   |   |   |
|--|---|---|---|---|---|---|
| 1. Wenig Vertrauen darauf, daß Sie einen günstigen Einfluß auf einen Patienten bzw. eine Patientin haben?  | 0 | 1 | 2 | 3 | 4 | 5 |
| 2. Angst, daß Sie dem Patienten mit Ihrer Behandlung mehr schaden als nützen?  | 0 | 1 | 2 | 3 | 4 | 5 |
| 3. Zweifel, wie Sie in einem bestimmten Fall am besten vorgehen sollten?   | 0 | 1 | 2 | 3 | 4 | 5 |
| 4. Die Gefahr, die Kontrolle über die therapeutische Situation an einen Patienten zu verlieren?  | 0 | 1 | 2 | 3 | 4 | 5 |
| 5. Schwierigkeiten, sich empathisch in die Erfahrungen eines Patienten einzufühlen?  | 0 | 1 | 2 | 3 | 4 | 5 |
| 6. Unbehaglich, weil Ihre persönlichen Wertvorstellungen es Ihnen erschweren, dem Patienten bzw. der Patientin gegenüber eine angemessene Einstellung beizubehalten? | 0 | 1 | 2 | 3 | 4 | 5 |
| 7. Schmerzlich berührt über Ihre Macht- und Einflußlosigkeit gegenüber der tragischen Lebenssituation eines Patienten?   | 0 | 1 | 2 | 3 | 4 | 5 |
| 8. Beunruhigt durch moralische oder ethische Probleme, die in Ihrer Arbeit mit einem Patienten aufgetreten sind?   | 0 | 1 | 2 | 3 | 4 | 5 |
| 9. Nicht in der Lage, genügend Kraft aufzubringen, um die Therapie mit einem Patienten in einer konstruktiven Richtung voranzutreiben?                               | 0 | 1 | 2 | 3 | 4 | 5 |
| 10. Gereizt, weil ein Patient Ihre Bemühungen aktiv blockiert?   | 0 | 1 | 2 | 3 | 4 | 5 |
| 11. Entnützt, weil Sie keine Möglichkeit finden, dem Patienten zu helfen?  | 0 | 1 | 2 | 3 | 4 | 5 |
| 12. Schuldig, weil Sie in einer kritischen Situation mit einem Patienten falsch vorgegangen sind?  | 0 | 1 | 2 | 3 | 4 | 5 |
| 13. Nicht in der Lage, das Wesentliche an den Problemen eines Patienten zu erfassen?   | 0 | 1 | 2 | 3 | 4 | 5 |
| 14. Nicht in der Lage, die emotionalen Bedürfnisse eines Patienten zu ertragen?  | 0 | 1 | 2 | 3 | 4 | 5 |
| 15. Nicht fähig, einem Patienten Sympathie oder Achtung entgegenzubringen?   | 0 | 1 | 2 | 3 | 4 | 5 |
| 16. Besorgt, daß Ihre persönlichen Lebensumstände die Arbeit mit einem Patienten beeinträchtigen?  | 0 | 1 | 2 | 3 | 4 | 5 |
| 17. Zornig, weil bestimmte Faktoren im Leben eines Patienten einen günstigen Therapieausgang unmöglich machen?   | 0 | 1 | 2 | 3 | 4 | 5 |

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18. In einem Konflikt zwischen gleichwertigen Verpflichtungen gegenüber einem Patienten einerseits und anderen Personen andererseits?	0 1 2 3 4 5	19. Suchen Sie die Zusammenarbeit mit Freunden oder Verwandten des Patienten?	0 1 2 3 4 5
19. Festfahren in einer Beziehung zu einem Patienten, die nicht voranzukommen scheint?	0 1 2 3 4 5	20. Teilen Sie Ihre beunruhigenden Gefühle einer Ihnen nahestehenden Person mit?	0 1 2 3 4 5
20. Frustriert mit einem Patienten, der Ihre Zeit verschwendet?	0 1 2 3 4 5	21. Interpretieren Sie den Widerstand bzw. das beunruhigende Verhalten des Patienten?	0 1 2 3 4 5
<p style="text-align: center;"><b>Bewältigungsstrategien-Skala</b> (J. Davis u. D. Orlinsky/Deutsche Version: U. Willutzki u. H. Ambühl)</p>		22. Verschieben Sie die therapeutische Arbeit, um sich mit den unmittelbaren Bedürfnissen des Patienten zu befassen?	0 1 2 3 4 5
<p><b>Wenn Sie Schwierigkeiten haben, wie oft?</b> [0 = nie – 5 = sehr oft]</p>		23. Verändern Sie Ihre therapeutische Einstellung oder Ihren therapeutischen Ansatz gegenüber dem Patienten?	0 1 2 3 4 5
1. Versuchen Sie, das Problem aus einer anderen Perspektive zu sehen?	0 1 2 3 4 5	24. Vermeiden Sie es, das Problem sofort anzugehen?	0 1 2 3 4 5
2. Versuchen Sie, Ihre beunruhigenden Gefühle innerlich zu verarbeiten?	0 1 2 3 4 5	25. Zeigen Sie dem Patienten Ihre Frustration?	0 1 2 3 4 5
3. Besprechen Sie Ihre Schwierigkeit mit dem Patienten?	0 1 2 3 4 5	26. Überlegen Sie, den Patienten einem anderen Therapeuten bzw. einer anderen Therapeutin zu überweisen?	0 1 2 3 4 5
4. Besprechen Sie das Problem mit einem Kollegen?	0 1 2 3 4 5		
5. Konsultieren Sie die Fachliteratur?	0 1 2 3 4 5		
6. Ziehen Sie andere Fachleute oder Einrichtungen hinzu?	0 1 2 3 4 5		
7. Suchen Sie andere befriedigende Erfahrungen außerhalb der Therapie?	0 1 2 3 4 5		
8. Setzen Sie Grenzen, um den Patienten in einem angemessenen therapeutischen Rahmen zu halten?	0 1 2 3 4 5		
9. Verlassen Sie die Therapeutenrolle, um Ihrem Patienten eine dringende Hilfestellung zu geben?	0 1 2 3 4 5		
10. Ändern Sie Ihre Therapievereinbarungen mit dem Patienten?	0 1 2 3 4 5		
11. Hoffen Sie einfach auf eine günstige Wendung irgendwann einmal?	0 1 2 3 4 5		
12. Kritisieren Sie einen Patienten, weil er Ihnen Schwierigkeiten macht?	0 1 2 3 4 5		
13. Ziehen Sie ernsthaft einen Abbruch der Therapie in Betracht?	0 1 2 3 4 5		
14. Überlegen Sie für sich allein, wie das Problem entstanden ist?	0 1 2 3 4 5		
15. Lassen Sie einfach die Erfahrung schwieriger oder beunruhigender Gefühle zu?	0 1 2 3 4 5		
16. Versuchen Sie, das Problem gemeinsam mit dem Patienten anzugehen?	0 1 2 3 4 5		
17. Konsultieren Sie einen erfahrenen Therapeuten?	0 1 2 3 4 5		
18. Melden Sie sich zur Teilnahme an einem Kongreß oder Workshop an, der mit dem betreffenden Problem zu tun haben könnte?	0 1 2 3 4 5		



16. Appendix 16: Additional Table

**CORRELATIONS OF AUTONOMY SCORES WITH DIFFICULTY TYPES:**

	MEAN SALIENCE SCORES					
	PARADIGMATIC		SITUATIONAL		TRANSIENT	
	B1	B2	B1	B2	B1	B2
<b>Therapist Introject</b>	<i>-.17</i>	<i>-.13</i>	<b>-.21</b>	<b>-.15</b>	<i>.12</i>	<i>.12</i>
<b>Therapist active with patient</b>	<i>.05</i>	<i>.23</i>	<b>-.13</b>	<b>-.30</b>	<i>.19</i>	<i>-.08</i>
<b>Therapist reactive with patient</b>	<b>-.20</b>	<b>-.39</b>	<i>.27</i>	<i>.22</i>	<i>-.12</i>	<i>.00</i>
<b>Patient active with therapist</b>	<i>.08</i>	<i>-.19</i>	<b>-.25</b>	<b>-.18</b>	<i>.26</i>	<i>.05</i>
<b>Patient reactive with therapist</b>	<i>-.09</i>	<i>.23</i>	<i>.05</i>	<i>.02</i>	<i>-.05</i>	<i>.02</i>

Table 7: 1