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ABSTRACT

The current study examined how clinicians practicing relational psychotherapy experience their own vulnerability in the therapeutic relationship with clients. The study followed a qualitative, phenomenological research methodology. The researcher interviewed ten experienced clinicians who practice relational psychotherapy. Four major themes emerged as significant findings. First, vulnerability was described as a quality of engagement in the therapeutic relationship that is open, engaged, and resonant. Second, participants expressed a sense of risk associated with mutual vulnerability. Third, participants emphasized the importance of mutual vulnerability for client's healing. Fourth, participants described vulnerability as a developmental capacity. These findings have significance for the field of relational psychotherapy, especially training of new clinicians.

**CLINICIAN VULNERABILITY:
OPENNESS TO INFLUENCE IN RELATIONAL THERAPY**

A project based upon independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2017

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CHAPTER I

Introduction

In order to foster a meaningful therapeutic relationship, it is a common assumption that the client must agree to be vulnerable in the presence of the therapist. Clients are asked to disclose their personal thoughts, feelings, longings, and fears to a therapist who has historically remained largely unknown to the client. Although vulnerability in psychotherapy has long been viewed as a task residing solely with the client, contemporary research has begun to conceptualize vulnerability as a relational process. In a qualitative study of clients' experiences of vulnerability in psychotherapy, Leroux, Sperlinger, and Worrell (2007) found that clients often experienced vulnerability as a moment of either opening or closing to the possibility of a relational encounter with their therapist in treatment. Leroux et al. (2007) concluded that, "...to be vulnerable is always to be vulnerable *in relation*. As such vulnerability is a relational phenomenon occurring in a relational context and is not essentially a private, inner experience" (p. 316). Recognizing the relational quality of vulnerability, Slavin (1998) described a process of reciprocal vulnerability in therapeutic relationships. Slavin argued that in order for therapeutic change to occur, both parties must be open to the deep impact the relationship may have on them. Slavin defined vulnerability as an openness to being influenced by the other, as "the potential for being touched, changed, and possibly wounded in unexpected ways" (p. 237). According to Slavin, only within a therapeutic relationship of mutual vulnerability can patients feel safe, feel seen as unique individuals, and accept the influence of their therapist for growth and change.

The importance of mutual participation in therapeutic relationships is further recognized in the contemporary theory of relational psychotherapy. Relational theory is the most contemporary form of psychoanalytic treatment that focuses primarily on the relationship between the client and the therapist as the healing element of treatment (Ornstein & Ganzer, 2005). In contrast to earlier psychodynamic theories, relational theory recognizes the ways that the therapist's unique subjectivity influences the client and the therapeutic relationship (Aron & Lechich, 2012). The relational therapist is an active participant in the therapeutic relationship, interpreting her own participation in the relationship as well as the thoughts, feelings, and behaviors of her client (Ornstein & Ganzer, 2005).

If, as in relational treatment, the relationship between the client and the clinician is integral to therapeutic growth, and, as research shows, vulnerability is required of both parties in intimate relationships, it follows that clinicians, too, are required to be vulnerable in their work with clients. The purpose of this study is to explore that conclusion. This study seeks to answer the question - *How do clinicians practicing relational psychotherapy experience their own vulnerability in their work with clients?*

Literature Overview

Although few researchers or theoreticians have used the term clinician vulnerability to describe the phenomenon of clinicians' experience of being influenced by their work with clients, many have approached the phenomenon with different language. Some such categories of thought that shed light on the topic of clinician vulnerability include countertransference in relational theory (Hayes et al., 1998), clinician subjectivity (Aron, 1991; Bass, 2001), the archetype of the wounded healer (Martin, 2011; Zerubavel & Wright, 2012), change in the therapist (Gibbons, Murphy & Joseph, 2011; Kahn & Harkavy-Friedman, 1997; Lazar &

Gottmann, 2003), and mutual transformation (Schamess, 2012). Each of these topics reflects a different approach to conceptualizing clinician vulnerability and begin to illuminate the different types of influence a clinician may experience in the treatment relationship with a client. Each of these topics will be explored further in the literature review and will serve as the foundation for this study.

Study Methodology

In order to answer this research question, I conducted an exploratory, qualitative research study following an interpretative phenomenological analysis research methodology. I conducted interviews with 10 experienced clinicians who self-identified as practicing relational psychotherapy and who had five or more years of experience practicing post-graduate school training. Participants were recruited using purposive and snowball sampling techniques in the greater Boston area and across the United States. The interviews were conducted either in person or through Skype or FaceTime. Each interview was audio-recorded, transcribed verbatim, and analyzed for themes.

Personal and Professional Interest

As a clinical social work graduate student, my interest in the topic of clinician vulnerability is both professional and personal. As I explore the topic of clinician vulnerability, I begin with the assumption that all therapists are wounded healers. Everyone experiences pain and suffering at various points in their life, including therapists. These personal experiences of pain and suffering are often what enable therapists to empathize with their clients, enhancing their clinical work (Celenza, 2010). However, this process of revisiting painful experiences and emotions in their clinical work can also be potentially draining and destabilizing for clinicians. Part of my interest in exploring the topic of clinician vulnerability in the therapeutic relationship

is to explore the ways in which clinicians' personal experiences of woundedness potentially impact their clinical work and their experience of the therapeutic relationship.

As a clinical social worker in training, I come to this research with my own experiences as a clinician in therapeutic relationships with clients. As a social work student, I have also recently experienced the ways in which clinical social work and relational psychotherapy are taught to new clinicians. In this process of clinical education, I have sometimes felt that training programs and supervisors, in an effort to train clinicians in appropriate and necessary therapeutic boundaries, overemphasize therapeutic boundaries for new clinicians who are presumed to be naturally inclined to trespass those boundaries. This emphasis on therapeutic boundaries sometimes comes at the cost of recognition and discussion of the ways that clinicians may appropriately and therapeutically allow themselves to engage in the therapeutic relationship in a way that is engaged and reflective of their unique subjectivities. Part of my motivation to explore clinicians' experiences of mutual vulnerability in their clinical work is to better understand the ways in which clinicians are mutually engaged in and impacted by the therapeutic relationship with clients.

I am particularly interested in the ways in which clinicians are positively impacted by their engagement in a mutually vulnerable therapeutic relationship with clients. In my experience as a social work student, when the impact of therapeutic work on clinicians is mentioned, it is usually mentioned in the context of negative consequences such as vicarious traumatization and secondary stress. This is likely reflective of an effort to protect students from the potentially negative impacts of their work and to alert students to the signs and symptoms of these conditions. However, the exclusive mention of negative consequences of therapeutic work in training programs does not reflect the potentially beneficial aspects of therapeutic work. As a

result, I am particularly interested in exploring the ways in which clinicians benefit from their participation in the therapeutic relationship and potentially grow and change alongside their clients throughout their careers.

Contribution to the Field

As psychotherapists, we make a career out of witnessing other people's struggles and facilitating their growth, healing, and change. As such, it can sometimes be uncomfortable to acknowledge our own needs and processes of growth and transformation. The concern among many clinicians is that to focus on the clinician's process of growth and transformation in his work is to risk de-emphasizing the needs of the client (Schamess, 2012). While it is true that relational theory requires greater self-understanding to maintain appropriate boundaries in treatment, mutual participation in the therapeutic relationship is often inevitable and necessary for therapeutic growth (Schamess, 2012). Acknowledging the therapist's participation in the therapeutic relationship and the personal impact of his work with clients ensures that this process is given greater attention and clients are potentially protected from unconscious processes unfolding in treatment (Schamess, 2012).

Interestingly, far more attention has been paid to the negative impacts on clinicians in their work with clients than on positive impacts and benefits of clinical work (Schamess, 2012). Although this difference in the amount of research may be due to a desire to protect clinicians from harmful effects of their work with clients, it may also reflect a reluctance of clinicians to admit personal gain from their work. It can feel as though the clinician's needs and the client's needs are at odds with one another, and to focus on one is to take away from the other. It is my belief that this is a false dichotomy. My hope in conducting this research is to allow clinicians to acknowledge and explore the different ways their work impacts them, both positively and

negatively, and to begin to challenge the assumption that in order for clinicians to be of service to their clients their own needs and experiences of growth must be ignored or deemphasized.

Although this study focused primarily on clinicians who identify as practicing relational theory, the results of this study are relevant for all practicing psychotherapists. Research has shown that across various theoretical orientations and treatment modalities, the therapeutic relationship between therapist and client accounts for the greatest percentage of client change within the therapeutic process (Asay & Lambert, 1999). Given the significant impact of the relationship between the therapist and the client on the therapeutic process, understanding more about how clinicians experience their own vulnerability within the therapeutic relationship will benefit clinicians practicing with a variety of theoretical perspectives.

Conclusion

Contemporary research and theory has found vulnerability to be a relational not an individual process (Leroux et al., 2007). Describing a process of reciprocal vulnerability in psychotherapy relationships, Slavin (1998) argued that only within a relationship of mutual vulnerability can clients feel safe, seen, and open to therapeutic influence. This study seeks to explore the conclusion that, as participants in the therapeutic relationship, clinicians, too, are called to be vulnerable in their work with clients. Further, as participants in the therapeutic relationship who are open to the influence of their clients, the clinician's own vulnerability may contribute to experiences of personal and professional growth and development. This study seeks to explore these conclusions through a phenomenological qualitative research study, which will be discussed in more detail in subsequent chapters. The following chapter provides a thorough overview of the historical and contemporary research and theory that serves as a foundation for this study.

CHAPTER II

Literature Review

In his article “Influence and Vulnerability,” Slavin (1998) argues that therapeutic change can only occur within a relationship of mutual vulnerability and safety. According to Slavin, in order for clients to feel safe in the therapeutic relationship they must feel as though their therapist has an investment in them as a person, beyond any therapeutic agenda, and that the therapist is open to being influenced and personally impacted by the therapeutic relationship. In order for the client to feel safe in the therapeutic relationship and accept the therapist’s influence, the therapist must agree to be vulnerable. This vulnerability is characterized by an “openness to being influenced” by the client, including “the potential for being touched, changed, and possibly wounded in unexpected ways” (Slavin, 1998, p. 237). As such, Slavin’s definition of vulnerability extends beyond the potential to be harmed and includes the potential to be positively changed and impacted by the relationship. Slavin’s process of mutual vulnerability in therapeutic relationships builds on foundational ideas within contemporary relational theory, including mutuality in therapeutic relationships and the bidirectional process of change.

Citing Slavin’s theory on mutual vulnerability, Leroux et al. (2007) conducted a phenomenological qualitative research study with six participants who had engaged in regular, weekly psychotherapy with clinical psychologists. Leroux et al. sought to explore participants’ experiences of vulnerability in psychotherapy. Participants described vulnerability in psychotherapy as “an embodied sense of tension or dilemma” (p. 323) in which participants are presented with the opportunity to be open to or to avoid or deny a relational encounter with their

therapist in treatment. Either option, opening or closing oneself in reaction to a moment of vulnerability, has risks and consequences. In moments of closing to the possibility of vulnerability in treatment, participants described feelings of anxiety, apprehension, discomfort, isolation, and a disconnect from their therapists. In contrast, in moments of openness to vulnerability, participants described feeling understood and met by their therapist in the therapeutic encounter. As the findings of Leroux et al.'s study seem to indicate, "vulnerability is a relational phenomenon occurring in a relational context" (p. 316), involving both the client and the therapist.

The purpose of this study is to expand upon Leroux et al.'s study of clients' experiences of vulnerability in therapeutic relationships and focus on clinicians' experiences of vulnerability in their work with clients. As Slavin (1998) argues, vulnerability is required of both clinicians and clients within therapeutic relationships. However, previous research has not explored clinicians' experiences of vulnerability and has focused primarily on clients' experiences in treatment. Although there is strong theoretical support within relational psychoanalysis for the concept of mutuality within therapeutic relationships, no prior empirical study has explored therapists' experience of mutual vulnerability in the therapeutic relationship in relational psychotherapy. This study seeks to fill that gap in the research and answer the question - *How do clinicians practicing relational psychotherapy experience their own vulnerability in their work with clients?*

The literature review will provide an overview of the current theory and research that supports the concept of mutual vulnerability in relational psychotherapy. Core concepts within relational psychoanalysis, including mutuality and intersubjectivity, will be reviewed as the theoretical foundation for this study. As a unique subject in the therapeutic relationship,

clinicians' personal history of suffering and adversity impacts their experience of the therapeutic relationship. The concept of the wounded healer will explore how clinicians' personal experiences of pain and suffering may impact their experience of vulnerability in their work with clients, including their ability to extend empathy to their clients. Within relational psychotherapy, clinicians are also called to use themselves and their own emotional reactions in the therapeutic relationship in service of their clients. Theory and research related to concepts of enactments, projective identification, countertransference, and self-disclosure will be reviewed and discussed. As clinicians remain open to the influences of their clients, they may experience positive and negative impacts from their work. In order to understand the potentially harmful effects of clinician vulnerability in therapeutic relationships, research and theory on vicarious trauma, secondary posttraumatic stress, and boundary violations will be presented. In addition to harmful effects of their work with clients, clinicians may also experience benefits and positive effects from their work. Research on the potential benefits of clinicians' work with clients, including vicarious posttraumatic growth and mutual transformation, will also be reviewed. Each of these areas of theory and research will provide a better understanding of the experience of clinician vulnerability in relational psychotherapy.

Relational Theory

History. The field of psychoanalysis has long debated the role of the clinician in the treatment relationship with clients. Indeed, the first major theoretical divide in the field of psychoanalysis, that between Freud and his friend, mentee, and analysand Sandor Ferenczi, reflected drastically opposing views about the possibility and desirability of analytic neutrality. Freud believed that analysts must remain detached and neutral observers of the client's process, reflecting and interpreting the client's transference, projected desires, and unconscious resistance

(Mitchell & Black, 1995). As he famously instructed, “The analyst should be impenetrable to his patients and, like a mirror, should show them nothing but what is shown to him” (Freud, 1912, as cited in Bass, 2001, p. 687). Freud’s analytic stance required that the analyst suspend his own thoughts and feelings about the analysand and focus exclusively on reflecting back to the analysand his own projected material. Freud instructed analysts never to indulge a client’s transference wish, but instead to rely on frustration of that wish in order to bring unconscious material into consciousness. The analyst’s failure to remain an objective and neutral interpreter of the analysand’s transference was viewed as a distraction from the analytic work resulting from the analyst’s own unresolved internal conflicts (Mitchell, 1988). Although this stance of objectivity may be difficult for both analyst and analysand, it was deemed to be necessary for therapeutic growth (Mitchell, 1988).

Challenging this notion of analytic neutrality, Ferenczi argued that the analysand is attuned to the analyst’s subjectivity despite the analyst’s attempts to suspend and withhold his own thoughts and feelings within the therapeutic relationship (Ferenczi, 1932). Ferenczi argued that analytic neutrality is impossible and potentially damaging for clients. The analyst’s aloof, cold demeanor and refusal to engage with the client may be experienced by the patient as a repetition of cold, neglectful experiences with caregivers in the patient’s childhood and serve as a reenactment of the original conditions that led to their current psychological defenses (Ferenczi, 1932, p. 159). Further, the analyst’s refusal to admit or acknowledge subjective thoughts and feelings about the patient despite the patient’s awareness of such feelings may be experienced by the patient as a lie that prohibits honest disclosure within the therapeutic relationship. Ferenczi argued that presuming the clinician does not have an emotional reaction to the client is impossible, prevents the clinician from accessing the useful information about the

client that may be gained from attending to his emotional response to the client, and may contribute to an unsafe and unsupportive environment for clients.

Contemporary relational theory. Although Ferenczi's ideas were largely discredited during his lifetime, he is now considered the original relational theorist in psychoanalysis and his work has served as the foundation for many contemporary relational theorists (Aron, 1996). Contemporary relational theory was developed in an atmosphere of theoretical pluralism and incorporates ideas from multiple psychoanalytic traditions including self-psychology, object relations, intersubjectivity, feminist and queer theory (Aron & Lechich, 2012). The foundational premise of relational theory is that human behavior is informed and motivated by human relationships (Mitchell, 1988). According to relational theory, all humans are formed into being in correspondence with their early significant relationships (Mitchell, 1988). As Mitchell (1988) writes, "Embeddedness is endemic to the human experience – I become the person I am in interaction with specific others. The way I feel it necessary to be with them is the person I take myself to be" (p. 276). Early relational experiences with significant others are internalized in the form of a relational matrix, which includes one's sense of self, one's internalized representations of others, and the interactional patterns of relationship resulting from past and present relational experiences (Aron & Lechich, 2012). Understanding the relationship between the self and significant others, relational theory seeks to understand not just the client's individual, intrapsychic processes, but the interpersonal, intersubjective field of experience.

As such, one of the major contributions of relational theory is its acknowledgement of the inevitability of mutuality in the therapeutic relationship (Aron, 1996). Relational theory recognizes the ways that the therapist's unique subjectivity influences the client and the therapeutic relationship. In contrast to earlier psychodynamic theories, the client's transference

in no longer solely the client's projection of past feeling states and experiences onto the therapist, rather the client's transference and the therapist's countertransference are co-created in a complex interplay of both the client's and the therapist's unique subjectivity (Aron & Lechich, 2012). The therapist's own affect and behavior in the therapeutic relationship, her countertransference, is no longer considered an obstruction to the therapeutic process but is regarded as a source of important clinical information (Aron & Lechich, 2012). According to relational theory, it is precisely this relationship between the therapist and the client and the client's probing for a personal relationship with the therapist that is the healing element of treatment (Aron, 1991). However, it is important to note that although relational theory recognizes the inevitability of a mutual influence between patient and analyst in treatment, this mutuality does not imply a symmetry or equality of therapeutic influence (Aron & Lechich, 2012).

Intersubjectivity. Integral to the concept of mutuality within the school of contemporary relational theory is the idea of intersubjectivity. Jessica Benjamin captured the idea of intersubjectivity with the line, "Where objects were, subjects must be" (Benjamin, 1990, as cited in Aron & Lechich, 2012, p. 216). According to Benjamin, a baby's ability to recognize its mother as more than an object designed for the gratification of its needs and as a unique subject is a developmental achievement (Benjamin, 1988, as cited in Aron, 1991). Intersubjectivity refers to this developmental capacity to "recognize another person as a separate center of subjective experience" (Aron, 1991, p. 31). Relational theorists have employed the concept of intersubjectivity to describe the relationship between the unique subjectivities of patient and analyst in the therapeutic relationship (Stolorow & Atwood, 1996). Similarly to the increased developmental awareness of intersubjectivity between baby and mother, the patient's experience

of the analyst must also transform from one of object usage to one of subject recognition (Aron, 1991). The therapeutic relationship then becomes an intersubjective interaction of two mutually influential subjects. As both relational and intersubjective theory regard conflicting and constricting internalized relational models as the source of psychopathology, the intersubjective therapeutic relationship becomes the means of healing as the patient is able to experience and internalize alternate ways of relating to others (Stolorow & Atwood, 1996). Through the therapeutic relationship, “the patient’s experiential repertoire becomes enlarged, enriched, more flexible, and more complex” (Stolorow & Atwood, 1996, p. 183).

Relational psychoanalytic theory provides an ideal theoretical foundation for the study of mutual vulnerability as it recognizes and values the inherent mutuality and intersubjectivity between clients and therapists in therapeutic relationships. Relational theory acknowledges the unique subjectivity of the therapist within the therapeutic encounter and attends to the complex ways that the subjectivity of both the therapist and the client respond to one another in treatment. As both relational theory and the concept of mutual vulnerability recognize the ways that the person of the therapist influences and is influenced by the therapeutic relationship, it is worth exploring the research on therapists’ personal histories and their motivations for pursuing clinical work. Clinicians’ personal histories of suffering and adversity impact their work with clients, both enhancing and potentially limiting their ability to be empathic and attuned to their clients’ suffering. Clinicians’ personal histories may also impact their unique vulnerabilities and the ways in which they are open to being personally influenced by their work with clients. The next section will explore the research on clinicians’ personal histories and experiences of suffering in the context of their work with clients.

Person of the Therapist

Motivation to pursue clinical work. To some degree, all clinicians have experienced suffering and adversity in their life and likely utilize those personal experiences of suffering in their work with clients. Indeed, many therapists are motivated to pursue a career in psychotherapy because of experiences of personal suffering (Ivey & Partington, 2014). As Celenza (2010) wrote about therapists' desire to pursue clinical work, "What is this need? On the surface, it is a need to help others heal their wounds, but this is a thin disguise for our own need to heal ourselves" (p. 60). In a qualitative study, Barnett (2007) sought to explore this theoretical hypothesis and investigate the unconscious motivations of therapists for their choice of profession. Barnett interviewed 9 experienced, psychodynamically-oriented clinicians about their professional and personal histories. Through her research, Barnett found that all of the participants had experienced an early loss or sense of deprivation in their relationships. Seven of the participants spoke of experiences of depression earlier in their lives, either their own or a loved one's (Barnett, 2007). Further, Barnett found that all of the participants in the study had experienced shame for various reasons, including parental disapproval, trauma, and difficulties with adapting to their environment. The findings of Barnett's study add empirical support to theoretical suspicions that clinicians' need and desire to help others heal and grow is intimately connected with clinicians' own histories of suffering and a desire to heal their own wounds in their work with clients.

The wounded healer. The wounded healer is a construct that has existed in many different contexts including religion, philosophy, art, medicine, and psychology. Jung was the first psychoanalyst to describe the archetype of the wounded healer within the context of a therapeutic relationship (Zerubavel & Wright, 2012). The archetype of the wounded healer

suggests that the capacity to heal another results from the healer's own woundedness. Although woundedness lies on a continuum with greater or lesser degrees of severity, the focus of the wounded healer archetype is on the ability to utilize experiences of wounding in the service of healing (Zerubavel & Wright, 2012). It is not the wound in itself that provides the healing capacity but the process of recovery. Therefore, within the context of psychotherapy, the more a clinician is aware of his own wounds and process of recovery, the better able he will be at guiding his clients through a similar process (Zerubavel & Wright, 2012).

The dilemma for the field of psychotherapy is discerning when a clinician is recovered enough for his wounds to be an asset in his clinical practice rather than a detriment. This discernment between a wounded healer and an impaired professional is made more difficult by the lack of open discussion within the field of psychotherapy of therapists' own wounds for fear of personal and professional judgment. Further, there are varying trajectories of growth and healing from woundedness and growth is not static (Zerubavel & Wright, 2012). This dilemma between woundedness as an asset or a detriment to clinical work can be seen in the process of application and acceptance to psychotherapy training programs. In a qualitative study, Ivey and Partington (2014) sought to investigate whether program selectors for a clinical psychology graduate program would identify woundedness as a salient feature in applicants' biographies and, if so, how that evaluation of woundedness would impact selectors' appraisal of the applicant's clinical potential. Ivey and Partington found that 9 out of the 10 participants designated applicants who evidenced woundedness in their biography as most suitable for clinical training. Further, almost all participants designated applicants who did not evidence woundedness as least suitable for practice (Ivey & Partington, 2014). Participants were

suspicious of applicants who had a “conspicuous absence” of woundedness or described an “implausible triumph” (Ivey & Partington, 2014, p. 170) over negative life events.

These results showed that personal experiences of woundedness are seen as an important element of a clinician’s clinical potential. However, it was not merely the presence of woundedness that led participants to assess applicants as suitable for practice, but the degree to which the woundedness was found to be “facilitative” rather than “obstructive” (Ivey & Partington, 2014, p.174) to the applicant. Applicants were deemed to have facilitative woundedness if they were consciously aware of the wound, were able to discuss the wound without defensiveness, made conscious connections between their wound and their desire to pursue clinical work, and were able to comment on the transformative process of healing that had occurred after the wounding (Ivey & Partington, 2014). As this study found, what is important for clinical practice is the degree to which wounds are engaged in a process of reflection and healing. Ivey and Partington concluded, “Authentic wounded healers, it would seem, embody a paradox: they must be healed yet continue to suffer, and their suffering must be transmuted without being transcended” (p. 174).

Empathy. One important benefit of the therapist’s own experiences of suffering is his increased capacity to empathize and connect with the suffering of his clients (Celenza, 2010). Although empathy is a multifaceted process, clinicians’ ability to find emotional resonance within themselves for the emotion of their clients is a significant aspect of clinical work (Gerdes & Segal, 2011). Research has found that clients’ perceptions of empathy from their therapists correlates with therapeutic outcomes (Elliott, Bohart, Watson, & Greenberg, 2011). Despite the clinical importance of empathy in therapeutic work, this process of empathic attunement with clients’ suffering is draining for therapists. Therapists are repeatedly asked to revisit experiences

of personal pain and suffering in service of empathic attunement to their clients, along with the challenge of returning to a place of psychological balance, in order to facilitate clients' healing (Celenza, 2010). As Harris (2009) writes, "...the need to have open access to unbearable affects in ourselves is one of the challenges that makes psychoanalytic work so difficult" (p. 8).

The difficulty of remaining open to the affective resonance of their own and their clients' suffering can lead clinicians to adopt a stance of omnipotence that defends against feelings of doubt, sadness, and shame (Harris, 2009). While clinical omnipotence protects clinicians from unbearable feelings of pain and sadness, it also interferes with both clinicians' and clients' process of growth and healing (Harris, 2009). Remaining open to empathic attunement with their own and their clients' suffering requires therapists to come to their work centered and fortified with their own needs well attended to (Celenza, 2010). For Martin (2011), clinicians' acceptance of their own woundedness is what allows them to remain connected to their shared humanity with clients. This recognition of the shared reality of suffering for all humans is what facilitates clinicians' ability to sit with their clients' suffering without trying to fix or alter it (Martin, 2011). As Nouwen (1972) says, "Making one's own wounds a source of healing, therefore, does not call for a sharing of superficial personal pains, but for a constant willingness to see one's own pain and suffering as rising from the depth of the human condition that we all share" (p. 94). Empathy for the wounded healer is a willingness to see ourselves in our clients and share the common humanity of suffering.

As the research and theory on the concept of the wounded healer indicates, clinicians come to their work with clients with their own experiences of pain and suffering. These experiences contribute to clinicians' ability to extend their clients empathy, but also require significant emotional strength and endurance in the therapist as their own pain is continually

provoked and elicited in their work with clients. These personal experiences of pain and suffering may contribute to therapists' experiences of vulnerability in their work with clients, potentially impacting therapists' willingness and ability to be open to a relational encounter with their clients in treatment. These personal experiences may also impact therapists' engagement with their clients in the therapeutic relationship. As relational psychoanalytic theory posits, the therapeutic relationship is a complex interplay between the subjectivity of both the clinician and the client. As such, clinicians are also vulnerable to the influences of their clients in the therapeutic relationship. The next section will explore ways in which clinicians are personally impacted and influenced by their work with clients, including through processes of enactments, projective identification, countertransference, and questions about self-disclosure.

Therapist in Relationship

Mutuality in relational treatment. According to relational treatment, the source of psychopathology is not repressed instinctual drives, but constricting and conflicting internalized relational patterns (Stolorow & Atwood, 1996). As the self is formed in early significant relationships, the child learns that some behaviors elicit positive responses from others and some behaviors elicit rejection. The parts of the self that elicit rejection or negative responses from the environment are then separated from the rest of the self (Aron & Lechich, 2012). Dissociation becomes the primary defense as certain unacceptable and anxiety-provoking aspects of the self are kept separate and unknown from the rest of the self (Aron & Lechich, 2012). Enactments in the therapeutic relationship become the "interpersonalization of dissociation" as the patient externalizes the anxiety-provoking self-states and attaches them to the analyst (Aron & Lechich, 2012, p. 218). In an enactment, the therapist is unconsciously pulled to participate in the client's relational matrix in ways that allow engagement with and expression of the client's dissociated

self-states (Aron & Lechich, 2012). As an unconscious process between clinician and client, enactment requires that the clinician become both a participant in the relational pattern being expressed and an observer of the enactment with a focus on interpretation and reflection (Aron & Lechich, 2012). When the dissociated self-state is experienced in the therapeutic relationship, explored, and interpreted without judgment, the client can begin to reflect and integrate the self-state into consciousness. The transformative potential of enactments in relational treatment comes from the exploration and insight following the enactment, as well as the new interpersonal experience generated for the client within the therapeutic relationship (Aron & Lechich, 2012).

Another defensive process similar to enactment is projective identification. Projective identification is an important defensive process within relational treatment as it is one of the only defensive processes that is both intrapsychic and interpersonal (Ogden, 1992). Projective identification is a three-part process in which unconscious, unwanted aspects of the self are projected onto another person and then reengaged and reintegrated into the self (Ogden, 1992). Similar to relational theory's concept of dissociation, the first phase of projective identification involves the unconscious rejection of parts of the self that are deemed dangerous or threatening to the self. These unwanted parts are then expelled onto another person who experiences pressure to accept the unwanted parts as their own (Ogden, 1992). In therapy, therapists may feel intense pressure to accept patients' projected self-states and respond to the patient from the unwanted self-state. Although these self-states are unwanted by the patient, the patient seeks and desires the other's acceptance of the unwanted self-state as confirmation that the self-state is both expelled from the self and preserved in the other (Ogden, 1992). The third phase of projective identification involves the self's reintegration of the unwanted self-state after it has been processed by the recipient. In therapy, if the therapist can process the projected feeling

differently than the client expects, the client can internalize a different relationship and engagement with the unwanted self-state.

In order to accommodate this reinternalization of the projected, unwanted aspect of the self, the therapist has to be able to accept, tolerate, and bear the client's projected material (Ogden, 1992). This requires the therapist to receive and feel in himself the client's unwanted feeling states and tolerate those feelings without denying them, defending against them, or acting on them (Ogden, 1992). As such, "the therapist must be sufficiently open to receive the patient's projective identification and yet maintain sufficient psychological distance from the process to allow for effective analysis of the therapeutic interaction" (Ogden, 1992, p. 33). This process requires a great deal of vulnerability, psychological maturity and strength of the therapist to feel and hold the patient's unwanted feelings in treatment. If the therapist is unable to tolerate or accept the patient's unwanted self states, those self-states remain dissociated and repressed and the patient is unable to grow and integrate those parts of the self into a cohesive whole (Ogden, 1992). As such, it is necessary that therapists remain open to the influence of their clients and allow themselves to be used for the safe containment of unprocessed parts of the self, despite the difficulty of that task. Therapists' willingness to accept the projective influence of their clients in the therapeutic relationship may represent one aspect of clinician vulnerability in the therapeutic encounter.

Countertransference. Within relational treatment, countertransference, the therapist's thoughts, feelings, and fantasies about the client, is regarded as important clinical information. Attending to countertransference reactions allows clinicians to gain insight into the conscious and unconscious dynamics within the therapeutic relationship (Aron, 1991). For example, only by recognizing and exploring their countertransference can clinicians interpret a therapeutic

process of projective identification or enactment and make use of the experience for therapeutic change. As such, countertransference reactions can originate from the clinician's own history and subjectivity as well as the clinician's reactions and experiences within the therapeutic encounter. Hayes et al. (1998) conducted a qualitative research study with eight psychologists to explore clinicians' experiences of countertransference in therapy. Common sources of countertransference reactions in therapists included family issues, such as parenting, partners, and family of origin issues; personal needs and values, such as the therapist's need to be needed by the client; and therapy specific events such as termination. Therapists also described common countertransference reactions when they compared themselves or someone they knew to their client. These countertransference reactions often led to certain behavioral and affective manifestations in treatment including the therapist either drawing closer to the client through compassion and nurturance or withdrawing from the client through blocked understanding or lack of empathy (Hayes et al., 1998). This research highlights some of the ways that clinicians' personal histories and reactions in the therapeutic encounter can impact their thoughts, feelings, and actions with clients in treatment. Clinicians' experiences of countertransference and their countertransferential responses to clients in treatment may represent another area of potential vulnerability for clinicians in their work with clients.

Further research on countertransference in therapy has found that clinicians' reactions to their clients and management of those reactions can impact the therapeutic process and outcome (Hayes, Nelson, & Fauth, 2015). Hayes et al. (2015) conducted a qualitative study and interviewed 18 therapists about their experiences of countertransference in cases that they considered successful or unsuccessful. Therapists who described successful therapy outcomes provided much more detailed descriptions of their process of managing their countertransference

reactions, both within and outside their sessions with clients. Further, clinicians' awareness of their countertransference feelings toward clients was negatively related with manifestations of countertransference behaviors in treatment (Hayes et al., 2015). Participants reporting on successful cases were better able to recognize and manage their countertransference and maintain a broader awareness of how their countertransference may be indicative of an enactment in the therapeutic relationship and adjust their behavior accordingly. This research highlights the importance of clinicians attending to their own emotional and behavioral reactions to clients in treatment to better understand and manage their countertransferential responses.

Self-disclosure. The debate about the appropriate use of clinician self-disclosure in therapy dates back to Freud and Ferenczi's original disagreement about the possibility and desirability of clinical anonymity. Ferenczi argued that patients are sensitive to their analyst's thoughts, wishes, and tendencies even without the analyst's awareness of this sensitivity (Ferenczi, 1932). Ferenczi described a "dialogue of unconscious" (Bass, 2001, p. 687) that occurs when two people meet, acknowledging that an exchange takes place on both an unconscious and conscious level during interpersonal interactions. Following in Ferenczi's footsteps, many contemporary relational theorists have argued that clinician anonymity is impossible (Aron, 1991; Bass, 2001; Singer, 1997). As Aron (1991) writes, "Self-revelation is not an option; it is an inevitability" (p. 40). Therapists often reveal things about themselves inadvertently. Patients glean information about their therapist from their therapist's appearance and dress, office decor, and manner of speaking (Frank, 1997). Even therapists' interpretations of clients' associations in treatment reveal something about the therapist's own internal values and organizing principles, the therapist's "private religion" (Singer, 1977, p. 183). Just as the client reveals his inner workings by what he says in treatment, so, too, does the therapist (Singer,

1977). Further theorists have argued that a clinician's ability to empathize with his clients reveals to his client a personal knowledge of a similar experience (Bass, 2001). As Bass (2001) writes, "If it is yours, and I recognize it, mustn't it be mine as well? And if it is mine, you will know that soon enough as you come to know your own" (p. 685). In this way, Bass argues that as the clinician empathizes with the suffering of his client and fosters insight into this suffering in his client, he also fosters insight into the clinician's own suffering. The patient's self-awareness is then intimately linked with awareness of the therapist (Singer, 1977).

This mutual process of awareness and understanding between client and analyst is encouraged in relational therapy as an important element of healing and growth (Aron & Lechich, 2012). Aron (1991) argues that clients probe for information about their analyst because they want to connect with another person in an authentic and emotionally intimate way. This desire for connection is part of clients' therapeutic growth. As such, Aron argues that relational therapists should engage clients on their thoughts and fantasies about the therapist's inner world and encourage clients to share their observations and insights into the therapist's behavior and affect. Self-disclosure becomes less important in terms of what it reveals about the therapist than whether it fosters or prevents further exploration of association in the therapeutic relationship (Aron, 1992). If warranted to foster greater exploration and insight, relational therapy does not prohibit self-disclosure as a legitimate technique to promote interpersonal engagement in the therapeutic relationship (Aron & Lechich, 2012). Although relational therapy acknowledges the mutual engagement and influence of therapist and client in the therapeutic relationship, it also emphasizes that the relationship is not symmetrical (Aron, 1992). Clinician self-disclosure remains far less frequent and more limited than client disclosure in the therapeutic relationship.

Recent research on the use of clinician self-disclosure in psychotherapy reinforces relational therapy's allowance of self-disclosure as a means toward greater engagement and understanding in the therapeutic relationship. In a meta-analysis of 53 studies on the use of clinician self-disclosure versus nondisclosure, Henretty, Currier, Berman, and Levitt (2014) found that clinician self-disclosure had a positive impact on clients on many measures. Clinician self-disclosure led clients to have increased favorable perceptions of their clinicians and increased the likelihood of clients disclosing to their clinicians. Clinician self-disclosure also increased clients' participation in therapy. As Henretty et al. hypothesized, clinician self-disclosure may generate trust, a shared sense of vulnerability, and shared empathy and understanding in treatment. As both research and theory reinforce, clinicians cannot avoid some measure of self-disclosure even if they wanted to withhold this information from their clients. Clinicians are therefore known and engaged with on a personal level by the clients in ways that clinicians cannot always control or dictate. This degree of self-disclosure may reflect an aspect of clinician vulnerability in treatment as clinicians are probed for a more personal and intimate relationship with their clients. The degree to which clinicians are open or closed to the possibility of a personal disclosure in their work with clients may reflect clinicians' experiences of vulnerability in treatment.

As clinicians open themselves to complex intersubjective processes in the therapeutic relationship, including relational enactments, projective identification, and countertransference, they become vulnerable to the varied influences of their clients. As clinicians remain open to the painful experiences of their clients, this vulnerability may lead to detrimental effects and influences on the clinician's own subjectivity. Some potentially negative influences may include vicarious trauma, secondary traumatic stress, burnout, and boundary violations. The following

section gives an overview of the literature on some of the potential negative influences clinicians are susceptible to in their work with clients.

Negative Influences

Vicarious trauma. Experiences of trauma are common in the populations that therapists serve (Bride, 2007). Therapists across multiple disciplines serve survivors of childhood abuse, domestic violence, violent crime, sexual assault, natural disasters, and war (Bride, 2007). Working with survivors of trauma is emotionally and psychologically draining for direct service providers, potentially leading to conditions such as vicarious trauma, secondary traumatic stress, compassion fatigue, and burnout (Newell & MacNeil, 2010). Although these conditions have some similarities and overlaps, they are conceptually different. Vicarious traumatization refers to “the transformation that occurs within the therapist as a result of empathic engagement with clients’ trauma experiences and their sequelae” (Pearlman & Mac Ian, 1995, p. 558). This transformation includes changes in the therapist’s experience of self, others, and perceptions of the world (Pearlman & Mac Ian, 1995). The therapist may have an altered sense of identity, spirituality, safety, trust, intimacy with others, and view of humanity (Rasmussen, 2005).

Similar to experiences of vicarious traumatization are experiences of secondary traumatic stress in trauma therapists. Secondary traumatic stress (STS) refers to, “the natural and consequential behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other [or client] and the stress resulting from helping or wanting to help a traumatized or suffering person” (Figley, 1995, as cited in Newell & MacNeil, 2010, p. 60). Symptoms of STS can parallel those of people directly exposed to trauma including intrusive thoughts, avoidance behavior, and physiological arousal (Bride, 2007). In a survey of 294 master’s-level social workers that work with trauma victims, Bride (2007) found that 70% of

participants had experienced at least one symptom of secondary traumatic stress within the past week. Further, 15% met the core criteria for a diagnosis of post-traumatic stress disorder. The most common individual symptoms cited were intrusive thoughts, avoidance of reminders of clients, and emotional numbing. Bride's research suggests that engaging in an empathic relationship with clients who have suffered trauma can contribute to emotional symptoms and vulnerabilities in therapists who absorb and process client's pain.

Working from an intersubjective perspective, Rasmussen (2005) described the process and impact of vicarious trauma within the therapeutic relationship. A core element of traumatic experiences is the affective experience that accompanies the trauma. Citing the work of Stolorow and Atwood (1992), Rasmussen describes a process in which painful and frightening affect becomes traumatic when the environment fails to tolerate, contain, and alleviate the affect. In order to facilitate healing after trauma, therapists must be able to provide the empathic affective container that the client lacked at the time of the trauma. This, however, implies that the therapist is able to contain the client's painful and unbearable affect. Rasmussen argues that as a result of vicarious trauma, "the therapist may also feel vulnerable, weakened, hopeless, or depleted, in which case the client, sensing this vulnerability, may consciously or unconsciously edit or alter their stories" (p. 26). Therapists' willingness and ability to act as an affective container for their clients may be another aspect of clinicians' experiences of vulnerability in their work with clients. Therapists may not be willing to open themselves to a relational encounter with clients who are traumatized and may therefore limit the degree of mutual vulnerability within the therapeutic relationship.

This intersubjective interplay between clients and therapists in trauma work may apply to all cases of psychoanalysis in which both client and therapist are consistently exposed to painful and unbearable affect. As Harris (2009) writes,

Always we produce and are exposed to more than we can master, know, or manage...that mix of powerlessness, shame, and insistent demand is actually a terrible combination, a prescription for dissociation and trauma. I think this may be one of the indissoluble, irreducible conditions of analytic work (p. 8).

Indeed, research has found that the largest risk factor for professional burnout is human service work in general (Newell & MacNeil, 2010). Interestingly, research has also found that empathy may be a mitigating factor for burnout and secondary traumatic stress in social workers (Wagaman, Geiger, Shockley, & Segal, 2015). Researchers surveyed 173 social workers and asked them to complete measures of empathy, burnout, compassion satisfaction, and secondary traumatic stress. Their results found that two components of empathy, self-other awareness and emotion regulation, were correlated with compassion satisfaction, potentially lowering rates of burnout and STS (Wagaman et al., 2015). This empathic ability to be attuned to clients' emotions while maintaining awareness of the self as distinct from the other, may allow therapists to be exposed to intense affect without experiencing burnout.

Boundary violations. As this research on empathy and burnout suggests, personal and professional boundaries are integral to the development and maintenance of a therapeutic relationship. The therapeutic frame includes both the structural elements of the relationship including time, place, and fees as well as the content in terms of what will be discussed (Smith & Fitzpatrick, 1995). The therapeutic frame, and the boundaries that are implied in that frame, are based on core guidelines in psychotherapy and are designed to create a sense of safety in the

therapeutic encounter by allowing both client and therapist to know what is expected and condoned in the therapeutic relationship. However, these boundaries are not always rigidly enforced, and at times either client or therapist may step beyond the therapeutic frame. These instances of going beyond the therapeutic frame may be described as either boundary crossings or boundary violations (Smith & Fitzpatrick, 1995). Boundary crossings are considered minor transgressions of common clinical practice that may or may not benefit the client, whereas boundary violations are considered departures from accepted clinical practice that put the therapeutic relationship at serious risk (Smith & Fitzpatrick, 1995). While debate about what constitutes a boundary crossing or violation continues in the field of psychotherapy, the one boundary violation that is most universally agreed upon for its damaging effects on clients is sexual contact between therapists and clients (McNulty, Ogden, & Warren, 2013).

Clinicians who commit sexual boundary violations with clients are often regarded by the psychotherapy community as “psychopathic” “bad apples” who are distinct from the broader psychotherapy community in their capacity to commit such a violation (Gabbard, 1996). However, as Gabbard (1996) writes after spending much of his career studying sexual boundary violations between therapists and their patients, “The majority of those that I have seen over the years are more *similar* to the rest of us than different” (p. 312). Studies that have sought to estimate the number of clinicians who have had a sexual relationship with a client have estimated between 5% and 25% of clinicians (Smith & Fitzpatrick, 1995). Lessening the distinction between “us versus them” allows for broader discussion of the vulnerabilities that may contribute to sexual boundary violations even in well-intending clinicians (Gabbard, 1996).

In a qualitative study with three clinicians who committed sexual boundary violations with clients, two themes emerged from their narratives (McNulty, Ogden, & Warren, 2013). In

order for violating clinicians to move beyond the therapeutic boundaries in their relationship with a client, they first had to lessen the distinction between the clinician and the client. Violating clinicians had to “neutralize the client’s *patientness*” (McNulty et al., 2013, p. 192) by lessening their assessment of the client’s mental health problems. By lowering their assessment of the client’s mental health concerns, violating clinicians experienced a sense of clinical competence and skill. However, when the client’s mental health concerns reemerged in the course of their sexual relationship, the violating clinician felt a sense of loss of professional confidence (McNulty et al., 2013). This research seems to reveal some of the psychological processes that contribute to sexual boundary violations, including an appeal to the clinician’s sense of clinical omnipotence and skill. As Gabbard concludes from his research with sexual boundary violators, the best defense for clinicians against boundary violations is a willingness to acknowledge and reflect on countertransference with the support of colleagues and supervisors (Gabbard, 1996). The very thoughts, feelings, and actions that clinicians want to keep secret in their work with clients are what most needs to be shared and openly discussed in order to prevent boundary violations (Gabbard, 1996).

As the research on vicarious trauma, burnout, and boundary violations suggest, by remaining open to the influence of their clients in the therapeutic relationship, by being vulnerable, clinicians may become susceptible to harmful processes that may impact themselves and their clients. However, by remaining open to the influence of their clients in the therapeutic relationship, clinicians may also experience personal growth as a result of their mutual vulnerability. Just as clinicians may be negatively impacted by their work with trauma survivors, clinicians may also benefit from witnessing and participating in clients’ processes of growth and recovery. The following section will explore potential positive impacts of clinician’s experiences

of vulnerability in their work with clients including vicarious post-traumatic growth, mutual transformation, and change in the therapist research.

Positive Influences

Vicarious posttraumatic growth. As research has shown, therapists who work with trauma victims are susceptible to symptoms of vicarious trauma that include changes to their perceptions of themselves, of others, and of their environment (Pearlman & Mac Ian, 1995). This research, while important in its promotion of awareness of the potentially harmful impacts of trauma work on therapists, has tended to overlook some of the perceived rewards therapists also report from their work with trauma survivors (Arnold, Calhoun, Tedeschi, & Cann, 2005). Recent research on the impact of trauma work on therapists has broadened its focus to include both the potentially harmful effects of vicarious trauma as well as perceived benefits. In a phenomenon described as vicarious posttraumatic growth, therapists may experience positive, personal changes after working with clients who experience growth after a trauma (Arnold et al., 2005). Similar to vicarious trauma, vicarious posttraumatic growth may include changes to the therapist's self-perception, interpersonal relationships, and outlook on life (Arnold et al., 2005).

In a qualitative study with 21 trauma therapists, Arnold et al. (2005) found that all of the participants reported some sort of positive response to the work in addition to negative responses. In fact, when asked an open-ended question about their work with traumatized clients, 76% of participants first reported positive responses from their work over negative responses (Arnold et al., 2005). The most frequently reported positive outcome of their work was having the opportunity to observe and encourage clients' own growth and recovery from trauma (Arnold et al., 2005). The majority of participants also cited positive personal changes including increased levels of compassion, understanding, insight, tolerance, and empathy (Arnold et al.,

2005). Other positive changes reported included a deepening of spiritual beliefs, an increased awareness of their own life circumstances, and a greater appreciation for the resilience of the human spirit (Arnold et al., 2005).

Further research on both the positive and negative impacts of trauma work on therapists has found that many clinicians experience symptoms associated with both vicarious trauma and vicarious posttraumatic growth (Barrington & Shakespeare-Finch, 2013; Cohen & Collens, 2013; Hyatt-Burkhart, 2014). In a qualitative study with staff of a non-profit working with refugees, participants reported symptoms of vicarious trauma, including intrusive thoughts and strong emotional reactions (Barrington & Shakespeare-Finch, 2013). Participants also reported symptoms of vicarious posttraumatic growth including being less judgmental of others, increased gratitude, an increased sense of personal strength, and an increased desire to be connected with others who share similar beliefs and values (Barrington & Shakespeare-Finch, 2013). As researchers conclude, experiences of vicarious trauma and vicarious posttraumatic growth are not binary (Cohen & Collens, 2013), and experiences of vicarious posttraumatic growth do not lessen the symptoms of distress therapists may also experience in their work (Barrington & Shakespeare-Finch, 2013). Recognizing this duality, it is important to acknowledge and attend to trauma therapists' experience of positive personal changes in response to their work. Acknowledging that positive growth may result from experiences of trauma may contribute to a sense of empowerment for both clinicians and clients working with the effects of trauma and lessen the pathologizing nature of trauma work (Arnold et al., 2005).

Change in the therapist. The phenomenon of positive change and growth in therapists as a result of their work with clients is not distinct to trauma therapists. Research on therapists' perceived benefits from their work with clients has found numerous positive effects across

multiple dimensions of the therapist's life (Kahn & Harkavy-Friedman, 1997; Kantrowitz, 1996; Lazar & Guttman, 2003). Lazar and Guttman (2003) divided clinicians' personal gains derived from their work with clients into four categories: vocational benefits, self-improvement, fulfillment needs, and narcissistic gains. In a survey of 113 clinical social workers, Lazar and Guttman found that 100% of participants reported that their work with clients helped them learn more about and improve themselves (Lazar & Guttman, 2003). Further, almost all participants reported that they gained self-confidence, self-approval, and improved interpersonal skills through their work with clients (Lazar & Guttman, 2003).

One of the most commonly cited benefits of work with clients is increased self-understanding (Kahn & Harkavy-Friedman, 1997; Kantrowitz, 1996; Lazar & Guttman, 2003). In a survey of 84 clinical social workers, Kahn and Harkavy-Friedman (1997) found that the most frequently cited personal change in therapists as a result of their work with clients was personal growth and emotional development. Similarly, in a survey of 399 analysts' perceived personal change as a result of their work with clients, participants strongly agreed with the idea that their work with clients led to personal changes in themselves (Kantrowitz, 1996). When asked what prompted these personal changes, participants reported increased self-reflection as well as increased openness to new and diverse experiences in their work with clients (Kantrowitz, 1996). Through self-reflection, participants reported developing increased self-acceptance, increased understanding of countertransference reactions, and positive changes in their work with clients (Kantrowitz, 1996). Research on therapists' perceived benefits of their work with clients clearly recognizes the unique opportunity therapists are provided in their work with clients for increased self-reflection, self-understanding, and self-improvement. By

remaining open to the personal influence of their work with clients, clinicians experienced increased self-awareness and personal growth.

Mutual transformation. Emphasizing the intersubjectivity and mutuality of the therapeutic relationship, relational theory recognizes the bidirectional nature of therapeutic change (Schamess, 2012). As Bass (2001) wrote about the therapist and client's engagement in treatment,

Our psychic experience interpenetrates with that of our patients; we become entangled in transference-countertransference matrices replete with dense processes of projection and introjection; we experience various forms of identification and merger, processes with effects we see and experience but cannot always understand; and our shifting states of self and affect shift in a stunning choreography that becomes the medium of analytic work. Through it all, we simultaneously transform and become transformed by our patient. Can my patient change, and I remain the same? Can I change, and my patient remain the same? (p. 695)

Schamess (2012) refers to this process of bidirectional therapeutic changes as mutual transformation. In a powerful personal case study, Schamess and his client describe the process of change each underwent in their clinical work together. Schamess describes the ways in which his own struggles with abandonment anxiety and difficulties exerting personal agency were reflected in his work with his client R. Schamess was forced to confront these personal areas of growth and acknowledge R's accurate perception of Schamess' need for growth. As Schamess and R reflected on the ways in which these mutual areas of growth impacted each of them individually and in the context of their therapeutic relationship, both Schamess and R grew through their work together.

This clinical case study highlights the powerful process of mutual transformation and growth that can occur in a therapeutic relationship in which both clinician and client are willing to reflect on their unique subjectivities and personal weaknesses in a process of mutual vulnerability. As Aron (1991) argues, clients seek and desire a relationship with their therapist. As such, relational therapists can gain valuable clinical information by fostering an open dialogue with the client about the client's perceptions and observations of the therapist. However, this process is only beneficial to the client if the therapist is willing to be open to the possibility that the client may observe something about the therapist about which the therapist was not aware (Aron, 1991). In this case study, Schammes models a therapist's willingness to be open to his client's observations of his behavior in the therapeutic relationship. Schammes allowed R's observations to prompt self-reflection, which then led to greater self-awareness and growth. After reading Schammes' narrative of his growth and change through their work together, R reflected on how powerful it was to hear that he had contributed to his therapist's growth. R doubted his ability to be of value to others and felt validated by his experience of mutual transformation in the therapeutic relationship with Schammes. Schammes' case study, as well as others' accounts of personal growth through their work with clients, highlights the ways that therapists' willingness to be vulnerable to the influence of their clients in treatment can lead to processes of mutual transformation in both clients and therapists (Levine, 2009).

Conclusion

As Slavin (1998) argues, only within a relationship of mutual vulnerability and safety can therapeutic change occur. Therapists must be open to the influence of their clients and allow the therapeutic relationship to impact them in the same way that any intimate relationship impacts those involved. Although previous research has not explored clinicians' experiences of

vulnerability in their work with clients directly, much theory and research has explored potential aspects of clinicians' experiences of vulnerability in their work with clients. Clinicians' personal histories of pain and suffering may reflect potential areas of vulnerability for clinicians in their work with clients, especially as clinicians strive to empathize with their clients. Clinicians also experience the influences of their clients in the dynamics within the interpersonal relationship, including in processes such as enactments, projective identification, and countertransference. As clinicians are enlisted in their clients' emotional and interpersonal dynamics, they allow themselves to be used for the client's eventual growth and healing. Clinicians' experiences of receiving, holding, and reflecting clients' emotional content may reflect an aspect of clinician vulnerability in their work with clients. As clinicians allow themselves to be influenced by their work with clients, they open themselves to both the harmful and inspiring impacts of intimate contact with their clients in treatment. Clinicians' experiences of vicarious trauma and secondary stress may reflect the harmful impacts of clinician vulnerability in their work with clients. In contrast, clinicians also open themselves to positive influences in their vulnerability with clients in treatment. By witnessing their clients' growth and allowing their work with clients to foster increased self-awareness, clinicians experience personal growth and transformation within the therapeutic relationship. All of these areas of previous research inform the exploration of clinicians' experiences of vulnerability in their work with clients.

Although these areas of research shed light on what clinicians may hypothetically describe as their experience of vulnerability in their work with clients, no research has yet focused directly on clinicians' experiences of mutual vulnerability in therapeutic relationships. While previous research on vicarious trauma and vicarious posttraumatic growth explored clinicians' experiences in their work with clients, the phenomenon clinicians described was

limited by the research focus on experiences of trauma. The current study seeks to explore the phenomenon of clinician vulnerability within the context of intimate therapeutic relationships more generally without limiting the phenomenon to a certain client population or presenting problem. Because the current study seeks to explore vulnerability within the context of an intimate therapeutic relationship, relational theory provides the most appropriate theoretical foundation as a psychoanalytic approach that values and recognizes the importance of relationships for therapeutic growth. The phenomenon of clinician vulnerability in relational psychoanalysis has not yet been adequately explored and understood. This study seeks to address the gap in the research and add to the existing research. The following chapter describes the methodology used in the current study.

CHAPTER III

Methodology

The purpose of this study is to explore the question - *How do clinicians practicing relational psychotherapy experience their own vulnerability in their work with clients?* This study is an exploratory investigation into the lived-experience of vulnerability as felt, understood, and described by relational clinicians in their work with clients. Previous research has explored clients' experiences of vulnerability in the therapeutic relationship, however no prior empirical study has explored clinicians' experiences of mutual vulnerability in the therapeutic relationship in relational psychotherapy. This study seeks to fill that gap in the research and broaden the clinical understanding of the experience of vulnerability in the therapeutic relationship.

Research Design

In order to investigate this research question, a qualitative, phenomenological research study was conducted. This research method was selected for multiple reasons. Qualitative research methods are often used for exploratory research in which the goal of the study is to explore a phenomenon in-depth with a focus on the meanings associated with the phenomenon for participants (Engel & Schutt, 2013). Qualitative research often follows inductive reasoning processes as the researcher discovers important information about phenomenon without predetermined hypotheses or categories (Engel & Schutt, 2013). Qualitative research methods are appropriate for this study as the purpose of the study is to explore relational clinicians' experiences of vulnerability in their work with clients and the meaning associated with those

experiences. Within the broad umbrella of qualitative research methods, a phenomenological research method was selected for this study. Phenomenological research seeks to discover and understand the lived experience of phenomenon in its complexity, richness, and novelty (Finlay, 2012). Phenomenological research asks the question, “What is this kind of experience like?” (Finlay, 2012, p. 173). A phenomenological research method is fitting for this study as the purpose of this study is to better understand the experience of vulnerability as lived and understood by relational clinicians in their work with clients.

A phenomenological research method is also fitting for this study because, in many ways, the phenomenological research process is similar to the process of mutual vulnerability in relational psychotherapy that this study seeks to explore. Similar to relational psychotherapy’s acceptance of the ways in which the therapist’s unique subjectivity influences the therapeutic relationship, phenomenological research understands and allows for the presence of the researcher’s unique subjectivity in the research process. As Finlay (2008) writes, “The phenomenological process, in this view, does not involve a researcher who is striving to be objectivistic, distanced or detached. Instead, the researcher is fully involved, interested and open to what may appear” (p. 3). Within phenomenological research, the researcher is actively involved in engaging with and interpreting the phenomenon as participants describe it. Further, just as Slavin (1998) defined vulnerability as an openness to being influenced by the other in the therapeutic relationship, phenomenological research requires a similar openness in the researcher to the experience of the phenomenon being encountered. Finlay describes the phenomenological attitude that a researcher adopts in the course of the research as, “a process in which the researcher opens themselves to being moved by an Other, where evolving understandings are managed in a relational context” (p. 3). These similarities between the process of mutual

vulnerability in the therapeutic relationship and the phenomenological research method are striking and lend greater support to the argument for the appropriateness of a phenomenological research method for the exploration of this research question.

Within the umbrella of phenomenological qualitative research methods, interpretative phenomenological analysis (IPA) was selected as the research method for this study. IPA is a form of phenomenological research that is concerned with, “capturing the individual nuance of experience” (Smith & Shinebourne, 2012, p. 74). IPA is also an accessible research method with clearly defined processes of data collection and analysis. As a graduate student with limited experience with qualitative research, a research methodology with a clearly defined research process increases the trustworthiness of the findings.

Sample

Participants in this study were required to meet the following criteria: be a licensed practicing psychotherapist, either a social worker, psychologist, or mental health counselor; self-identify as using a relational theoretical approach in their work with clients; and have five or more years of experience practicing relational therapy post-graduate school training. As stated in the literature review, relational psychotherapy is the most contemporary form of psychoanalytic treatment that focuses primarily on the relationship between the client and the therapist as the healing element of treatment (Ornstein & Ganzer, 2005). The sample was restricted to relational psychotherapists because relational theory values mutuality in the therapeutic relationship. As such, relational psychotherapists may be more likely to have experienced mutual vulnerability in their work with clients. Further, clinicians with five or more years of clinical experience postgraduate school training may have a deeper understanding of relational processes in treatment than newer clinicians, potentially enhancing the findings of this study.

Following an IPA research method, “participants are selected purposively because they can offer access to a particular perspective on the phenomena being studied” (Smith & Shinebourne, 2012, p. 75). The sample frame was designed to increase the likelihood that participants would have an experience of vulnerability in their work with clients that they could describe in the research. IPA research studies are typically conducted with small, relatively homogenous samples (Smith & Shinebourne, 2012). Detailed, in-depth analysis of interview transcripts is time-consuming and intensive, often necessitating smaller sample sizes. A sample size of six to eight participants is recommended for graduate and doctoral level IPA researchers to provide sufficient cases to find similarities and differences across participants while not overwhelming the researcher with the data collected (Smith & Shinebourne, 2012). This study used a sample of 10 participants. The researcher was not able to meet the minimum sample of 12 participants that is required by the Smith College School for Social Work due to difficulties with recruitment.

Recruitment

Prior to recruitment of participants for this study, the study design was reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (Appendix A). Nonprobability, purposive sampling procedures were utilized to increase the likelihood that participants had an experience of the phenomena being studied. A combination of convenience and snowball sampling techniques were used to recruit participants for this study. Convenience, or availability, sampling methods were used to recruit participants based on the ease of access and availability (Engel & Schutt, 2013). I began the recruitment process by utilizing convenience sampling techniques and contacting personally known therapists in the Boston area who may know colleagues who would be eligible and willing to participate in the

study. To begin the recruitment process, I contacted an alumna of Smith SSW who had completed a postgraduate research fellowship at the former Boston Institute of Psychoanalysis (BIP) and requested that she forward the recruitment flyer (Appendix C) to her colleagues from the BIP. I also contacted a Smith SSW alumna who is a member of the Massachusetts Institute of Psychoanalysis (MIP) to request that she forward my recruitment flyer to members of MIP who may be eligible and willing to participate in the study. In addition, I posted my recruitment email and flyer on the Facebook page for Smith SSW students and alumni in the Boston area.

When these initial recruitment efforts did not yield many participants, I continued my recruitment efforts by contacting professionals in the Boston area and across the country. I shared my recruitment information with my supervisor and the director at my field placement for each to share with their private practice groups and professional contacts. I emailed my recruitment information to the online listservs for The Mitchell Center in New York City, the NYU Postdoctoral Program for Psychotherapy and Psychoanalysis, and the American Psychological Association Division 39, both the New York and the Massachusetts chapters. I shared my recruitment information with a colleague from my graduate program that was working in a psychoanalytic treatment center in New York City and requested that he share my materials with his colleagues and contacts. I also emailed my recruitment information to two professors from Smith SSW that work with clients in private practice. Lastly, I emailed professional contacts of my research adviser whose names and contact information were provided to me by my research adviser. After identifying participants through these convenience sampling methods, I utilized snowball sampling methods and requested that participants forward the recruitment information to colleagues that may be eligible to participate in the study. These recruitment efforts yielded 10 participants.

After participants contacted me to express their interest in the study, I exchanged emails to determine their eligibility in the study and, if eligible, scheduled a meeting time to conduct the interview in-person in Boston or through FaceTime or Skype. After the interview was scheduled, I emailed participants a copy of the informed consent form (Appendix D) for them to review beforehand. I ensured that participants signed a copy of the informed consent form, either in person or by submitting a scanned copy via email, before conducting the interview.

Data Collection

IPA is a research method designed to better understand the lived experience of a phenomenon as described by participants. As such, IPA requires a data collection method that invites participants to share “rich, detailed, first-person accounts of experiences and phenomena” (Smith & Shinebourne, 2012, pp. 75-76). In order to facilitate a deep exploration of the research question, I conducted semi-structured, one-on-one, in-person or Skype interviews with participants. One-on-one, in-person interviews allow the researcher to engage the phenomena more deeply through dialogue with participants (Smith & Shinebourne, 2012). When in-person interviews were not possible, I conducted FaceTime or Skype interviews that allowed for visual representation of both the participant and myself. Each interview lasted 45-60 minutes.

In order to gain a better understanding of the lived experience of phenomena, IPA interview questions are open-ended and encourage participants to speak from their own experience (Smith & Shinebourne, 2012). A semi-structured interview guide helps to keep the interview focused while also allowing the researcher flexibility to adjust the timing and phrasing of questions to meet the participant and facilitate dialogue (Smith & Shinebourne, 2012). IPA research is often concerned with sensitive, personal experiences for participants and requires that researchers build rapport with participants quickly and are aware of signs of participants’

potential discomfort during interviews (Smith & Shinebourne, 2012). It is important to begin with questions that build rapport and comfort between the researcher and the participant before moving to more personal questions.

In order to address the need for sensitivity in the progression of the interview, the interview guide for this study was developed to gradually increase the sensitivity level of questions as the interview progressed. The interview guide started with questions about the participant's demographic information and career as a relational therapist. Once an initial sense of rapport was built, the interview then moved to more personal, open-ended questions about the experience of vulnerability in clinical work, including, "How would you describe your experience of vulnerability in your work with clients?" and "How has your vulnerability in your work with clients impacted you personally?" See Appendix E for the full interview guide.

To allow for thorough data analysis in IPA research, it was necessary to audio record and transcribe each interview verbatim in its entirety (Smith & Shinebourne, 2012). During this research study, each interview was audio recorded with two forms of recording devices – one was the Voice Memos application on my iPhone and the other was a digital audio recorder device. After each interview, I reviewed the digital audio recording to ensure that the interview had been recorded. Once I ensured that the recorder captured the interview, I deleted the audio recording from my iPhone. The audio recording was then imported onto my computer and then transcribed into a Word text document. When conducting interviews by Skype or FaceTime, I utilized the recording function included with the Macbook Quicktime software and the digital audio recorder device. I then followed the same research methodology as in-person interviews. I transcribed the audio-recordings into Word transcripts that were then stored on my personal, password-protected computer.

Data Analysis

IPA provides guidelines for data analysis following a five-step process. This process is described in detail as follows.

1. The researcher must become immersed in the data through multiple, close readings of the verbatim transcript of the interview. After each reading, the researcher makes notes and observations about the language used, emotional content, and significant dialogue.
2. After multiple readings of the transcript, the researcher begins to discern emerging themes from the notes. Each theme is a, “concise phrase at a slightly higher level of abstraction that may refer to a more psychological conceptualization” (Smith & Shinebourne, 2012, p. 77).
3. The researcher then looks for connections between the emerging themes based on conceptual connections and commonalities. A new label is generated for each thematic grouping.
4. The researcher then repeats the first three steps with each subsequent transcript. The researcher allows the analysis of the first case to inform the analysis of subsequent transcripts, while also remaining open to new themes as they emerge. The researcher then reviews earlier transcripts with the new themes that emerge in later transcripts in an iterative process of continual review and adjustment (Smith & Shinebourne, 2012).
5. The final compilation of themes is discussed one by one in the findings section of the paper with illustrative extracts from participant transcripts. These narrative accounts in the participant’s own words allow the research to retain “the *voice* of the participants’ personal experience” (Smith & Shinebourne, 2012, p. 80) and increase the trustworthiness of the study by providing direct data to bolster thematic findings.

In order to increase immersion in the data, I transcribed the first five interviews from the audio recording into a Word document myself. I then hired a transcriptionist to transcribe the last five interviews from the audio recording into a Word document. After each interview was transcribed into a Word document, I printed each interview and coded the data by hand. I then captured the themes and major findings of each interview in individual analysis Word documents to facilitate analysis of the interviews as a whole. I also took some written notes during the interviews, which were also transcribed and stored in the individual analysis Word documents for each interview.

Reflexivity and Trustworthiness

As Giorgi (2002) writes about validity in phenomenological research, “Knowledge, as a phenomenon in the world, is strictly correlated with subjectivity. Perhaps there are things or events ‘in-themselves’, but there is no ‘knowledge-in-itself’. There is only knowledge for a human subject who apprehends it” (p. 9). Phenomenological research attempts to get as close to the “things themselves” (Finlay, 2012, p. 180) as possible, but recognizes that descriptions of experiences of phenomena are always translations and approximations of the phenomena itself. This process of engagement with and translation of experiences of phenomena is inherently subjective, involving the unique subjectivities of both the researcher and the participant. Phenomenological researchers try to make sense of the ways participants make sense of their experiences in the world. Within phenomenological qualitative research, then, the researcher’s subjectivity is integral to the research process and the ultimate findings deduced from the data.

While recognizing the inevitability of the influence of the researcher’s unique subjectivity in the research process, phenomenological research also requires that researchers strive to encounter phenomena without preconceived understanding (Finlay, 2008). In order for

researchers to be open to new understandings of phenomena they must recognize and attempt to distance themselves from their own biases and presuppositions. This process of bracketing one's pre-understandings, as described in phenomenological research methods, allows the researcher to dwell more fully in the experience of the phenomena as described by the participant. As Finlay (2008) writes, "This process of mentally transposing oneself into another's world is realizable only if the researcher is open to the possibility and they can let go of habitual routes; in other words, engage the epoché" (p. 26). Attempting to bracket or distance oneself from one's presuppositions about phenomena is only possible after first recognizing and acknowledging one's presuppositions.

In an effort to acknowledge the ways that my unique subjectivity and position as the researcher may influence the research process and findings, I attempted to be transparent with my own biases and presuppositions about the phenomena of clinician vulnerability in therapeutic relationships. I came to this research as a clinician in training with a strong interest in relational psychotherapy. As such, I have a personal interest in the phenomenon of clinician vulnerability in relational psychotherapy, as it is a phenomenon that I will likely experience in the course of my work with clients. While a personal interest in the research subject is not discouraged in phenomenological research, as Finlay (2012) writes, "We can only understand when we care" (p. 175), it becomes especially important that my personal biases be recognized and acknowledged.

After I identified clinician vulnerability in relational psychotherapy as a topic that intrigued and inspired me, I began to read literature by relational clinicians describing processes of mutual transformation and personal growth through their work with clients. I was further inspired in my research after reading accounts of personal transformation and positive change through clinicians' engagement with clients in relational psychotherapy. Throughout the process

of researching and completing the literature review section of this study, I became aware of a desire to focus more directly on the positive, transformational potential of clinical work and clinician vulnerability than on the potentially negative impacts of clinician vulnerability in relational psychotherapy. This resistance may represent a personal desire to avoid confronting the potentially harmful effects of the career choice I am just beginning.

After becoming aware of my own bias toward emphasizing the positive effects of clinician vulnerability, I attempted to remain aware of this bias throughout the research process and bracketed any personal resistance I felt toward acknowledging the harmful effects of clinician vulnerability in relational psychotherapy. In my interviews with participants, I attempted to adopt an appropriate phenomenological attitude by bracketing my preconceived notions of what the experience of vulnerability in relational psychotherapy may be like and remain open to the lived experience as described by participants. I also attempted to be conscious of the ways in which I might have inadvertently guided participants to discuss positive elements of their experience of vulnerability in their work with clients as opposed to negative aspects of their experience. By acknowledging this bias both to myself and to the reader, I hope I increased the trustworthiness of the findings and the research process as a whole. With that being said, I also acknowledge that this research process and findings have been translated through my particular, subjective lens and cannot be entirely replicable or generalizable. Despite these limitations, I continue to find this research study informative and useful for expanding the understanding of clinicians' experience of vulnerability in relational psychotherapy.

Ethical Considerations

Voluntary participation. To protect against the possibility for coercion or influence in the recruitment process, I did not interview individuals with whom I had a personal relationship,

such as current or former supervisors or colleagues. After initial contact, all participants were emailed a copy of the informed consent form to review prior to the interview date. On the interview date, I reviewed the informed consent form with the participant and requested the participant sign the informed consent prior to beginning the interview. Participants were also reminded prior to beginning the interview that they could refuse to answer any question for any reason throughout the interview and could withdraw from the research study for any reason up until April 1, 2017.

Confidentiality. Participation in this study was confidential. Only I was informed of participants' identifying information and I was the primary handler of all data collected. Interviews were conducted in locations that ensured privacy. Following the interview, each participant was assigned a pseudonym, which was placed on all materials. The signed informed consent forms were kept separate from all other notes and transcripts. Participant identity was kept confidential throughout the research process and all direct quotations were de-identified and anonymous. Only after all identifying information was removed did my research advisor have access to the data collected, including transcripts and summaries of the interviews, in order to assist in the analysis of the data. All electronic data was stored on my secure, personal computer and was password protected. According to Federal regulations, all research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period.

Participants were reminded before the interview to keep all client information de-identified if they mentioned specific case examples. In the findings and discussion chapters of

this study, the data was presented as a whole and when short, illustrative vignettes were used, all identifying information was removed and disguised with a pseudonym. I did not include any information in any report of this study that would make it possible to identify a participant or a participant's client.

Risks and benefits. This study involved minimal risk to participants. To address the possibility that participants could be uncomfortable describing their experience of vulnerability in their work with clients, the interview guide was designed to build rapport between the participant and myself before the participant was asked to describe their experience of vulnerability in detail. As a clinician in training, I was aware of non-verbal signals of distress and discomfort and was attentive to these signals throughout the interview to avoid participant discomfort. If participants appeared to require post-interview support, I directed participants to appropriate supports. Participants in this study may have experienced certain benefits from their participation, including the opportunity to reflect on their experiences in their work with clients, potentially leading to enhanced insight and clinical awareness. Participants may also have experienced a sense of personal fulfillment by contributing their experience and knowledge to the development of the field as well as by contributing to the education of a clinician in training.

Conclusion

This study sought to explore clinicians' experiences of vulnerability in relational psychotherapy. In order to capture the lived experience of vulnerability as felt and described by clinicians, a phenomenological, qualitative research method was used. Participants were selected purposively to increase the likelihood that participants had experienced vulnerability in their work with clients. I conducted semi-structured, one-on-one, in person, Skype, or FaceTime interviews with participants that lasted 45-60 minutes. Each interview was audio recorded and

transcribed verbatim for subsequent analysis. I followed an interpretative phenomenological analysis (IPA) research methodology, which provided a clear process for data analysis. In order to enhance the trustworthiness of the data and findings of this study, I attempted to acknowledge and bracket all preconceived understandings about the phenomenon of clinician vulnerability and actively engaged with participants' descriptions of their experiences of vulnerability. Throughout the research process, I adhered to the social work research ethics and took measures to ensure voluntary participation, confidentiality, and minimal risk for participants. The next chapter will present the findings of this study and will review both my interpretation of the data and participants' descriptions of the experience of vulnerability in their own words.

CHAPTER IV

Findings

The purpose of this study was to explore the question – *How do clinicians practicing relational psychotherapy experience their own vulnerability in their work with clients?* In order to address this question, the researcher conducted a qualitative, phenomenological study by conducting semi-structured interviews with relational psychotherapists in-person and through Skype or FaceTime. Participants in this study were required to meet the following criteria: be a licensed practicing psychotherapist, either a social worker, psychologist, or mental health counselor; self-identify as using a relational theoretical approach in their work with clients; and have five or more years of experience practicing relational therapy post-graduate school training. Participants were selected purposefully using convenience and snowball sampling techniques. The researcher conducted interviews with 10 participants. Eight of participants were female, and all identified racially as Caucasian or White. Nine participants were social workers who had completed MSW degrees and had also participated in post-graduate school psychoanalytic training programs. One participant was a clinical psychologist. The participants ranged in age from 39 to 73 years old, with an average age of 58. Participants had been practicing as psychotherapists for an average of 24 years, with years of practice ranging from 7 to 45.

Research based on interpretative phenomenological analysis (IPA) seeks to understand the lived experience of a phenomenon as described by participants. This study sought to explore clinicians' lived experiences of vulnerability in their work with clients. Following an IPA research methodology, each interview was audio-recorded, transcribed verbatim, and analyzed

for themes. Through an in-depth analysis of the data, four major themes emerged from participants' experiences and descriptions of vulnerability in their work with clients. These four themes were the predominant discussions with the majority of participants. First, vulnerability was often experienced by participants as a quality of engagement with clients that is affectively open, resonant, and attuned, often marked by profound moments of connection in the therapeutic relationship. Second, participants experienced a sense of risk and fear in their vulnerability with clients, which required that participants felt safe in the therapeutic relationship before allowing themselves to be open with their clients. Third, participants emphasized the importance of mutual vulnerability in the therapeutic relationship for healing and growth through engagement in a clinical relationship in which both members are vulnerable, human, and fallible. Fourth, vulnerability is a capacity that develops over the course of clinicians' careers. Each of these themes will be discussed in more detail in the following sections.

Quality of Engagement

Felt experience. Many participants referred to their vulnerability in the therapeutic relationship as an internal state in which they were open to being affectively touched and impacted by the experience of the client. One participant (B) described vulnerability as a quality of presence in which the clinician is "available, present, and responsive." Another participant (E) described vulnerability in the therapeutic relationship as a "mindset" or a "way of listening" in which she actively seeks to find a corresponding emotion or experience within herself that allows her to better understand and empathize with the experience of her client. Participant (C) described it by saying, "It's an empathy. It's a sympathy; but it's also a kind of connection...I think of it as when what they're feeling, I feel." For many participants, vulnerability in the therapeutic relationship was a willingness to be open to the client's experience, to feel in some

measure what the client is feeling, and to seek out corresponding experiences within themselves that would allow them to better understand what the client is experiencing in that moment.

In an effort to describe moments of shared vulnerability and emotional attunement, many participants spoke about times in which they had become tearful or cried with a client. One participant (D) described crying with a client by saying,

There was just something about that disclosure that was so touching and poignant about how little care she had that I just started to cry. I think, especially in a relational frame, that those moments are really moments of connection.

Another participant (J) described it as a moment of shared humanity saying, “If a patient is telling me something really sad and I’m deeply affected, I’m crying because I’m a human.” There was a sense that for many participants, allowing themselves to cry in front of a client was a moment of shared vulnerability not only because they were willing to allow themselves to be deeply impacted by the client’s experience but also because they were willing to allow the client to see them in that moment of emotional expression. As participant (C) described, “It’s very easy to stay removed from that place because to tear up in front of a client you’re very vulnerable. I’m feeling something. I’m flushed.” Despite the risk of being seen in that moment of connection, participant (C) went on to say, “I find it incredibly enlivening in my work. I find those moments very healing where somebody just feels that I get it.” Many participants found moments of shared vulnerability in the therapeutic relationship to be moments of profound connection and mutual understanding that facilitated a deeper sense of intimacy in the relationship.

Many participants expressed that the clinician’s vulnerability and openness to the client’s experience was a necessary aspect of the therapeutic relationship for the client’s healing and growth. As participant (I) described, clients need a “relational home” for the painful affect and

experiences that they've been unable to process and integrate on their own or in previous relationships. Participant (I) described this process of creating a relational home for client's pain saying,

And so I think it's just being able to bear the pain, you know? Just being with myself and saying, "I need to understand and be with that this is how this person feels. And for right now, I am helpless to change it."

As participant (I) describes, it is vulnerable for clinicians to hold clients' painful feelings and resist trying to change or deny those feelings. Participant (C) spoke to a similar process saying, "Sometimes you're not in there with them in experiencing it, you're just kind of holding. You're just present." She added, "I think what goes through my mind in those moments is, 'I'm just witnessing. I'm present. I'm here. I'm available to you now, but I'm still protected.'" In moments in which a client's experience may be too painful or too intense to be fully joined by the clinician, participants continued to describe a type of openness and vulnerability to the client's experience by holding and witnessing that emotion in the relationship.

Resistance to vulnerability. Although many participants described this quality of openness and presence as the ideal state for healing and growth in the therapeutic relationship, many also spoke of ways in which they struggled to be vulnerable in the therapeutic relationship with clients. Many participants spoke about the difficulty of being vulnerable with clients that present with issues that are personally significant to them as the clinician. Participant (A) had personal experiences of loss of family members to suicide and described the process of working with a chronically suicidal client, saying "I think she touched probably some of the most profound issues in me, so it made her both hard to work with but also a huge opportunity to

rework some things.” She continued, “It’s like your issues are sitting right in front of you, you know?” Participant (C) spoke of a similar resistance to clients by saying,

It can be difficult for me, given my history, when I have a client that walks in that is mirroring something that’s going on in my own life that I don’t want to be vulnerable with and I have a hard time with.

In these cases of similar issues and struggles, many participants described a difficulty in being vulnerable and open to the client’s experience in the therapeutic relationship. While working with the chronically suicidal client, participant (A) described the difficulty of staying emotionally available, saying “I thought I was rallying and rising above it. I was really kind of shutting down and shutting her out.” Participants struggled to remain open to their clients’ in the therapeutic relationship when they were unable to process or reflect on corresponding experiences within themselves that were triggered by their work.

Participants also described times in which their personal circumstances outside of their work impacted their ability to be vulnerable in the therapeutic relationship. Participant (B) was diagnosed with a chronic illness and experienced a period of depression following treatment of his condition. He spoke about the difficulty of being emotionally available or present with his clients during that time, saying “I was just trying to get through the hour...and that’s not so good in the vulnerability quotient.” He continued, “I could try to give myself over and do the mirroring, but I did not have much to offer of myself and my usual level of responsivity.”

Participants described feeling overwhelmed or saturated with emotion during particularly straining or challenging times in their personal lives and consequently having a hard time being open to their clients’ emotional experiences in their work. Many participants also spoke of the difficulty of being vulnerable and available to clients who presented with certain affect states or

interpersonal dynamics that were difficult for them as clinicians, such as clients who are angry with them in sessions. Participant (J) described having a hard time regaining her balance when she feels “attacked” by patients. Participant (E) spoke of her difficulty remaining open to feelings of erotic transference with clients in the therapeutic relationship. Participant (H) spoke of her inability to join a client in feelings of disgust about his sexual orientation because of her personal experiences advocating for a daughter who is homosexual. In these examples, participants struggled to remain open to certain affect states or interpersonal dynamics that were personally difficult for them because of their past or current personal lives and values.

In contrast to the state of openness and availability participants experienced in the therapeutic relationship when inhabiting a quality of vulnerability, participants described a feeling of tension, constriction, and blockage in the therapeutic relationship when they were unable to be open to the client’s experience. Participant (J) described the feeling of tension saying, “I lose my ability to think...I can feel myself going into a kind of a freeze where I don’t have access to words...I can just feel kind of a numb.” Participant (G) described a feeling of anxiety and a “collapse” of the sense of openness and vulnerability that was previously in the therapeutic relationship. Participant (F) described it as a sense of “distance” between herself and the client that feels “profound” and noticeable to both her and the client. Participant (E) described her process of sensing her resistance to her client’s experience, saying

I’ve had moments where I can feel my resistance. I can feel my guard go up while I say all the right things to the patient about welcoming this, let’s be with this, let’s think about this. You know? Not saying anything that I think would sort of put someone off or shame them, but still feeling not vulnerable, not sort of receptive to that experience.

In moments in which they experienced a difficulty being open or present with their clients, a few participants described continuing to say the appropriate clinical words but without an internal resonance with what they were saying. In those moments, participants may continue to strive for openness and continue to invite their clients to share their experience but struggle to allow themselves to be affectively available to those experiences. Many participants expressed a sense that their clients could tell the difference between words they spoke in a state of vulnerability versus a state resistance. As participant (B) said, “people may not consciously notice it, but I also feel that the impact is made regardless.” For some participants, this unconscious or undisclosed resistance to inhabiting a vulnerable presence with clients led to conflict and disruption in the therapeutic relationship.

Returning to vulnerability. In many cases in which the client’s issue triggered a corresponding experience in the clinician, participants described needing to do a deeper layer of personal work and self-reflection in order to reengage in the therapeutic relationship with a renewed vulnerability and presence. Participant (E) described working with a client for whom a transition of offices left the client feeling hurt and enraged. Participant (E) described her resistance to acknowledging the disruption in the relationship and her own process of self-reflection on her experience of abandonment following her parent’s divorce as a child.

Participant (E) described this process saying,

I had to do this other piece of work that this patient, this treatment, just called me to do around my experience of being left and feeling furious and confused around that, and I did. I got to this place, I don’t know if we can call it empathy or what, but this corresponding place in me. I didn’t need to say anything about it to my patient, but something shifted in me internally and there was this session where I began to say the

same things to her that I had been saying about how hard, how painful, this is and how humiliated you must feel, how abandoned you're feeling, how furious you are with me. When I had shifted something in me to really get that, I could say it in a way that like, transformed, how she was feeling.

After engaging with her own experience of being left as a child, participant (E) was better able to be open and receptive to that feeling in her client. Participant (E) experienced that without needing to disclose her internal process, by returning to a place of vulnerability and openness in the therapeutic relationship, the work was “transformed.”

Many participants spoke about the moments of transformation that occurred in their therapeutic relationships when the clinician was able to return to a stance of vulnerability and openness to the client's experience. Participant (E) described that moment of transformation in her work with this client saying, “It just felt like...a relief...a new level of intimacy... She was so relieved, like the lid had come off the pressure cooker or something. I think we just both felt freer, more relaxed, but in a profound way.” Participant (A) spoke of a similar process of deepening in the therapeutic relationship through her process of personal work on her experience of loss. Participant (A) described the change in the relationship, saying

It went from terrifying to scary to...then when it would work, it was...what would be the word for that? I felt like it was a privilege. She then let me in, and I let her in... It was that back and forth, and that felt extraordinarily...almost sacred. That's not a feeling exactly, but deeply intimate.

Participant (B) described the moment of disclosure about his illness as “liberating” and that it “really opened things up” and was “facilitative of the process.” For many participants, it was as though the tension and conflict that had been created in the therapeutic relationship through the

clinician's resistance to being open and vulnerable with the client's experience was released and both the client and the clinician experienced a sense of connection and deepened intimacy.

In different ways, all of the participants discussed a process of vulnerability and resistance that was ongoing in the therapeutic relationship. Many participants described varying degrees of awareness of their own vulnerability in the therapeutic relationship and varying degrees of control over their vulnerability within a session, a day, or a period of life. Participant (A) described the continual process of vulnerability and resistance in her work with her client saying, "And it wasn't like, and then we fixed it and we were fine. You know? It would happen again. But we could talk about it." Many participants described having these moments of deepened awareness and understanding in the therapeutic relationship with clients and then repeating the cycle of resistance and renewed vulnerability in their relationship with clients.

For many participants, this cycle was not something that they were always consciously aware of or in control over. Participant (B) described the difficulty of capturing the quality of openness he experiences in words by comparing it to a Supreme Court Justice description of pornography, saying "I don't know how to define it, but I know it when I see it." He continued, "It's sort of the same with feeling like you're in sync or in tune or really present. It's nothing I think you can urgently demand or insist of oneself...but you can certainly be aware of it." Other participants expressed a similar difficulty in fully capturing the quality of vulnerability and presence they experience with clients. In some instances participants seemed to have an awareness of their lack of vulnerability and in others were unaware and relied on their clients' feedback to gauge their openness. Most participants seemed to accept that their own vulnerability in the therapeutic relationship is something that is continually shifting within a session, within a day, or within different periods of their life. It is not always within their conscious or willful

control to demand a greater degree of vulnerability of themselves, despite always aspiring to deeper levels of connection and understanding with their clients.

Risk of Vulnerability

Self-disclosure. While many participants agreed that an internal state of openness and receptivity was ideal in the therapeutic relationship, participants often struggled with the degree of self-disclosure that felt appropriate with clients. When participants described moments of vulnerability in which they felt affectively attuned or connected with their clients, many shifted quickly from a description of this experience of vulnerability to comments about whether or how they might share that experience with their client in the form of a disclosure. Participants seemed to struggle with questions of what to disclose, when to disclose, and whether disclosure was necessary for a client to understand and appreciate the clinician's vulnerability. A few participants seemed to feel a tension between recognition of the importance of mutual vulnerability in the therapeutic relationship and fear of blurring the lines between client and therapist and trespassing on the client's therapeutic space. Participant (B) spoke of this struggle to discern how much to disclose of himself in his work with clients, saying "I think it feels like a slippery slope at times. If you reveal this thing, what else do you reveal? And how much control do you have? And how much should one reveal?"

Questions of self-disclosure seemed to center on the clinician's own degree of comfort and readiness to talk about a certain topic or experience with clients. Participant (G) described his process of discernment with self-disclosure in the therapeutic relationship, saying "Where do I wanna go? What am I comfortable talking about?" Some participants seemed to hope that even without an explicit disclosure, the client would feel the clinician's quality of openness and receptivity in the therapeutic relationship through an emotional connection and understanding.

Participant (B) seemed to reconcile his struggle around self-disclosure and the importance of vulnerability by commenting, “I don’t think it, for the most part, really depends on disclosing all that much about your personal life... It’s much more of an emotional exchange than a content.”

Underlying many of the participants’ comments about self-disclosure were feelings of fear that clinicians experience in the process of becoming vulnerable in the therapeutic relationship. One of the initial fears associated with self-disclosure and mutual vulnerability was a fear that the clinician will trespass a professional boundary. When asked about their training in relational psychotherapy, most of the participants spoke of a process of moving away from traditional psychoanalytic theory that stressed clinician neutrality and toward relational theory’s emphasis on mutuality and intersubjectivity. However, despite a theoretical foundation in relational psychotherapy, some of the participants spoke of a residual fear of transgressing a professional value when allowing themselves to enter into the therapeutic relationship in a more full, authentic, and vulnerable way. As participant (I) described, “I think all of us in the field who are older live under the umbrella of a lot of those old assumptions. It’s like the therapy police are gonna get you...It’s inevitable, it’s part of the culture.” Despite feeling drawn to relational therapy’s emphasis on mutual subjectivity and co-creation, many participants continued to question how much of themselves they could bring to the therapeutic relationship.

A few participants spoke of how much more difficult they believed relational therapy is as opposed to forms of therapy in which the clinician is less personally engaged. Participant (H) attended a relational post-graduate training program mid-way through her career and experienced a shift in her approach to the therapeutic relationship that was initially very difficult for her. She spoke of the transition in her work by saying,

Well it was interesting, at the beginning I found it very frightening. I grew up in a home that was far too loose in terms of certain boundaries, and so a world that said a therapist must not do this and must not do that felt very comfortable for me. When they said, “Well, with some patients you can and with some patients you shouldn’t” then it was much more complicated, and I was very anxious from the beginning of being seen as seductive, being all sorts of things. So it really was a process for me working out what was okay and what wasn’t and being really attuned to how the patient was taking in what I was saying. And, so that was a lot harder to do.

The anxiety and fear that participant (H) experienced in the transition to a relational form of psychotherapy highlights an underlying sense of fear and anxiety that all of the participants spoke about in different ways in their discussion of vulnerability and self-disclosure. Those fears included risks of harm to themselves personally, harm to the client, and disruption in the therapeutic relationship.

Fear of vulnerability. For some participants, loosening the boundaries of traditional psychotherapy and adopting a more relational theoretical approach in their work with clients triggered fears about their role as the therapist. A few participants spoke of fears of self-disclosures being burdensome to their clients, forcing the client to have to attend to the clinician and encroaching on the client’s therapeutic space. Participant (B) spoke about his struggle to discern whether to disclose his diagnosis of a chronic illness to his patients. He ultimately decided to disclose the information once he had undergone treatment and his health was stable, but he continued to fear what the disclosure would mean to his clients. He said, “You get into this work to help people not to burden them and so there was some concern about how I might burden them with this information.” In this comment, participant (B) seems to express a contrast

between his role as the therapist to treat his clients and his experience of a personal illness. Participant (B) seems to indicate a belief that as a clinician, he should not acknowledge or burden his clients with his own experiences of hardship or struggle. Participant (D) echoed this idea saying, “I think most of us still hold a value that it’s not about us, it’s about the client.” These comments highlight clinicians’ struggles to reconcile their need not to burden their clients with personal information while also recognizing the importance of being fully present in the therapeutic relationship with clients.

As the clinician inhabits a space of openness and vulnerability in the therapeutic relationship, they also make themselves more visible to their clients in ways that may be experienced as anxiety-provoking and uncomfortable. A few participants described the fear of being seen by clients in intimate and vulnerable ways that were deeply personal to them. Participant (D) spoke about the vulnerability she felt in her work during the pregnancies of her three children. Participant (D) described feeling especially vulnerable as a pregnant woman outside of her work and vulnerable in her therapeutic relationships as clients felt more comfortable commenting on the change in her physical form and the reality of her pregnancy. Participant (D) described the experience as “really uncomfortable,” saying “I think that’s a uniquely vulnerable time because you become the focus in a way that we’re not usually the focus, right?” Participant (D)’s pregnancies and the change her in physical form led to a degree of personal exposure that she was uncomfortable with in her role as the therapist. She continued, “I’ve got this giant belly and it’s in the room with us and it’s not like I can...pretend that’s not happening.” The change in her physical form led to a disclosure that she was not in control over, making her vulnerable to the varied reactions of her clients to this information.

In another example of the clinician being seen in the therapeutic relationship, participant (G) talked about a moment of connection with one of his clients in which the client commented on a shared history of childhood abuse despite the participant never disclosing that information. Participant (G) described that moment saying, “So there was this knowing that occurred without me even really having to say it.” Again, participant (G) felt seen and known by his client in that moment of recognition despite not disclosing that information about himself to the client explicitly. He described his reaction to that disclosure by saying, “ It felt - I-I felt a little anxious, 'cause I felt like I'd been seen.” In this way, despite being open to the therapeutic relationship, clinicians may continue to feel a degree of discomfort or anxiety when they feel seen and exposed to their clients in ways that they may not be in control of or with personal information that is particularly sensitive.

Participants also spoke of a fear of being seen by clients as flawed, human, or bad. Participants seemed to feel a risk that if the client saw their limitations, shortcomings, and weaknesses the client would leave treatment. As participant (B) described in his decision to disclose his personal illness, “Well, I was worried in part that people would flee. I mean, you know, all of a sudden I've got an incurable blood cancer, and who wants a dying therapist?” Participant (B) seemed to struggle with his own sense of value in the therapeutic relationship following his diagnosis and a fear that clients would no longer want to work with a “dying therapist.” Many clinicians seemed to experience a similar sense of uncertainty in their relationship with clients as they allowed themselves to become more vulnerable in the therapeutic relationship and more exposed in their own limitations and flaws. A few participants described fears of being abandoned by their clients if they exposed their limitations or made mistakes in the therapeutic relationships. Participant (I) described this fear saying, “I think that

the fear that the treatment will fall apart and that I'll be left, I'll be abandoned, and I will be...it'll be a failure, the treatment, is very scary to me." Some participants seemed to experience a tension between the value of being open and vulnerable with clients in the therapeutic relationship and fears of how much vulnerability is tolerable, either to themselves or the client.

A few participants described cases in which a client did leave treatment following a disruption in the therapeutic relationship and the impact that termination had on them. Participant (H) described a therapeutic relationship that ended following a comment she made in treatment that was particularly difficult for her. Participant (H) described the termination by saying,

And he wasn't ready. And he left the session after five minutes and he never came back and it never got repaired. I tried calling him and it never got repaired and it was so horrible for me. So sometimes you don't guess right and sometimes you could lose somebody and that was awful. I mean, I still remember him all these years later when I would have bet any amount of money that he and I would be able to deal with whatever came up, and we weren't. So sometimes you put it on the line and you're wrong and you don't do good. And that's hard.

The fear of losing a client or breaking the therapeutic relationship seemed to underlie many of the participants' concerns about self-disclosure and about allowing themselves to make more provocative or challenging comments with clients. In this example, participant (H) struggled to make sense of the termination of a relationship that she thought was strong enough to sustain a disruption, further reinforcing the fear that any comment or conflict may end the relationship. As a few participants acknowledged, as they allow themselves to be more vulnerable and personally invested in the therapeutic relationship with clients, they also risk feeling pain and disappointment when that relationship ends. As participant (H) continued, "So you sort of give of

yourself and then at some point they're gone. So that's part of the deal. It is a hard part of the deal." As participants become more personally invested in the therapeutic relationship, they also open themselves to greater disappointment if or when that relationship ends.

A few participants expressed the pain, confusion, and shame that they continued to feel as a result of relationships that terminated unexpectedly. Participant (I) described feeling "ashamed" of herself following a disruption in a therapeutic relationship in which the client became enraged at her for not being fully present in the therapeutic relationship. She described her reaction to the client terminating treatment by saying,

I still feel sad and upset, and then I wonder, "Could I have handled it in any other way? Would some other therapist have said just the right thing?" Maybe I didn't, I mean, who knows, right? 'Cause the truth of the matter is, there's no knowing the answer to something like that if there is something else I could have done. But I was very, I was hurt. I was angry. I had done, from my perspective, I had given this patient a lot, a lot. And okay she's enraged with me, but she wouldn't... she just couldn't, she just couldn't, she couldn't do it. I still think about her."

As participant (I) acknowledges, she felt like she had invested a lot in this client and therefore felt sad, hurt, and angry when the client was unable to work toward a repair following a disruption in the therapeutic relationship. She describes feeling ashamed and self-critical, wondering if she could have done something differently or if a different therapist could have navigated the situation better. She concludes saying, "I could only be who I was, the best I could be, and it didn't work for her, and that hurts." Participant (I) seems to express the fear that many participants described of wanting to allow themselves to be vulnerable with their clients and trust that their clients would accept and appreciate that vulnerability, while also being afraid of being

hurt by their clients' reactions to their own limitations and capacity to make mistakes. As participant (F) says, "I'm at risk all the time of being injured... I mess up constantly. My unconscious is out there poking, making problems, saying the wrong thing. It's horrifying to work from this perspective." As participant (F) describes, engaging in the therapeutic relationship from a relational perspective that requires the clinician to be open, available, and impacted by the relationship can be threatening for the clinician when there is conflict and disruption in the work.

Safety and deepened intimacy. In order to address their fears of vulnerability in the therapeutic relationship, participants described needing to feel a sense of safety in the relationship with clients. Participants described needing to have a sense of understanding, rapport, and connection built with a client before they would allow themselves to be more vulnerable and open in the therapeutic relationship. Participant (D) described the ways in which small moments of rupture and repair enhance her ability to be vulnerable in the therapeutic relationship, saying

I have that confidence that I can be a little more real with them and they can tolerate it.

They're not so fragile that it's going to be distressing or distracting to them or it's going to break the relationship.

Participant (H) described feeling more comfortable making spontaneous comments with clients once she feels she knows them well enough to trust that the comment is relevant. She shared, "I mean if I want to do something totally weird or say something totally weird the first month I'm with a patient, I don't. I feel like I don't know them well enough." In these ways, participants described needing to feel a degree of safety, trust, and rapport with clients before allowing themselves to be more open, spontaneous, and vulnerable in the therapeutic relationship.

Despite the multiple cases participants described of a treatment ending, many participants also described cases in which their willingness to be vulnerable, flawed, and open with their clients deepened a sense of connection in the relationship. Participant (G) described his relationship with his client deepening following the moment of connection surrounding their shared history of abuse. He described a “level playing field” in which the distinction between himself and his client was lessened and the work became less “rigid and constricted” with more freedom to have a “certain spontaneity” in the relationship. Participant (A) described learning that both she and her client could survive their mutual vulnerability in the therapeutic relationship by saying,

I had the experience of screwing up with her, big time, and having her hang in there.

And trusting that process, that I can really be vulnerable and the other person isn't gonna die. And they can be vulnerable and I'm not gonna die. And they're not gonna leave me...

So for me that was huge. That was a very different experience for me.

Participant (A) described the way in which that process of mutual vulnerability allowed her to know on a deeper level that rupture and repair is possible and that both the client and the therapist can grow and heal in that experience. Following the disclosure of his illness, participant (B) described how important it was for his clients to realize that he could “really understand from the inside” the experience of being depressed. When participants had the experience of being vulnerable in the therapeutic relationship and being met with appreciation and acceptance from their clients, many described a greater sense of mutual safety, connection, and freedom in the therapeutic relationship. Clients seemed to learn that it was okay to see and acknowledge their therapist’s flaws and limitations, and clinicians learned that it was okay to allow their flaws and limitations to be seen by their clients. Despite clinicians’ fears of vulnerability in the therapeutic

relationship, when they had the experience of being met with acceptance in that vulnerability, their willingness to be vulnerable increased.

A Real Relationship

All of the participants described the importance of being in a full, authentic, human relationship with clients. For many, engaging in a real relationship with clients was the only way to promote healing and growth for the client. As participant (D) shared,

I think we can't change folks' template of relationships unless you're willing to be in a relationship with them, and if you're not engaged enough, if you don't have enough skin in the game so to speak, then you're not getting at that deeper level of work.

Many of the participants spoke to the idea that unless the clinician is willing to engage in the therapeutic relationship in a way that is real, vulnerable, and authentic the work will not be deeply transformative for either the client or the clinician. Participant (A) described this process, saying "You have to open yourself up to both your own pain and also a growing involvement with someone, caring about someone. There's nothing detached about this. And when you care about someone, vulnerability and pain is going to happen." Engaging with the client in a mutually vulnerable therapeutic relationship inevitably requires that the clinician be open to both their own painful experiences and the pain that can result from caring deeply about another person. Participant (A) went on to describe a therapeutic relationship in which she had been deeply impacted by the client and moved by the relationship. She described the quality of that relationship saying, "It really created a space where I was human...it felt like we were in it together. In an incredibly vulnerable, intimate, and healing way, actually, for both of us, quite frankly." As participant (A) describes, engaging in a real relationship with clients often led to a sense of mutual humanity, vulnerability, intimacy, and healing in the therapeutic relationship. As

she concludes, “So that’s the pain and that’s the joy.” By participating in a real human relationship with clients, clinicians make themselves vulnerable to both the pain of caring about another person and the joy of a mutually intimate and healing relationship.

One of the ways that participants described the importance of offering a real relationship with clients was as a way to model for clients the potential for healing in a mutually vulnerable relationship. By allowing themselves to be vulnerable and authentic in the therapeutic relationship, participants expressed that they were modeling for clients that it was okay for them to do the same. Whenever participant (H) allowed herself to talk about something that was uncomfortable for her in the therapeutic relationship, she felt like she modeled for her client that, “the world is not gonna end if you show some part of yourself that's sort of weird.” Participants felt that their own vulnerability and authenticity in the therapeutic relationship helped their clients see that it was okay to expose and reveal parts of themselves that were less desirable or comfortable for them and it would be safe to do so. Participant (H) also described an example in which acknowledging an angry response with a client allowed the client to appreciate the impact he had on her. Participant (H) described how that moment of anger allowed the client to understand that, “this is not a pretend relationship, this is actually two real people in the room.”

In contrast, some of the participants described the harm that can be caused in the therapeutic relationship when the clinician is not willing or able to offer a full human connection. Participant (B) described a therapeutic relationship in which the clinician is not fully present as hollow and likened the clinician to “Harlow’s wire mothers.” He described the potential harm to clients in these relationships saying, “If you’re not offering a human relationship with them, if you’re not offering a full range of an emotional interaction, it’s inhuman...it’s fundamentally destructive and depriving and neglectful.” Similarly, participant (F) described a clinician who is

not fully available to his client as wearing “the suit” and likened it to a “hideout” in which the clinician is able to avoid engaging with his own “messiness, unpredictability, and defensiveness.” Most participants expressed a belief that clinicians who do not engage in therapeutic relationships from a place of vulnerability and openness are engaging in a relationship that is distant, unaffected, and self-protective and which is damaging to the client. Although many of the participants inhabited different degrees of vulnerability and openness in the therapeutic relationship, all of them agreed that some measure of vulnerability, openness, and presence was necessary for healing and growth in the therapeutic relationship.

Engaging in a mutually vulnerable and intimate therapeutic relationship with clients ultimately led to participants’ experiences of mutual change and growth in their work with clients. Many participants spoke about the ways in which they were prompted to do personal work and self-reflection in order to alleviate a resistance in the therapeutic relationship and deepen the work. Participant (H) acknowledged the need for personal reflection and change in the therapeutic relationship by saying,

A very wise analyst said that when somebody comes to you to do intensive therapy, there will be some part of you that needs to change in order for them to be able to do that. So if you're not prepared to change, then you're in the wrong profession.

Participant (J) agreed, saying “If I'm doing any work that's worth anything with anybody who's coming in to see me, I'm really changing just as much as they are.” For all participants, there was an understanding that the clinician’s own personal growth and reflection was an integral part of the therapeutic process. Participant (A) spoke to the deep connection and intimacy that can be built in a therapeutic relationship when both parties are willing to grow and change, saying

What we went through together really forged a kind of love, I think, that superseded...I don't think it's like therapy-love. I think that kind of trivializes what it is. I think it's really a kind of a love between two people who've been through a lot together and who have come out the other side both of them as better people.

By allowing themselves to be transformed in the work alongside their clients, participants seemed to experience a deeper sense of connection, intimacy, and vulnerability with their clients. Participants seemed to view the process of mutual change and growth to be integral to the therapeutic process.

In addition to being open to personal growth in the therapeutic relationship, participants described the importance of accepting their own limitations in the therapeutic relationship. All of the participants spoke about the difficult process of accepting a client's feedback about the ways in which they had hurt, disappointed, or upset the client in the therapeutic relationship. Participants seemed to struggle to resist their own self-protective, defensive processes and to accept that they had hurt the client in some way. Some participants spoke of a desire to remain a good, nurturing, and healing presence for their clients and their personal resistance to accepting the ways in which they have hurt their clients in the therapeutic relationship. Participant (E) described this process by saying, "I mean it's a vulnerable thing... to not keep the focus defensively on the other, on the patient, and to really look at your own participation in an enactment with the patient that's hurtful for the patient." She continued, "That ultimately is gonna be good if you can think about it and work it through, but still it's painful." Although it may be painful for the clinician to acknowledge their role in a client's experience of hurt or anger, many participants described the importance of accepting and acknowledging their role in the therapeutic relationship as a way of validating clients' experiences and emotions. A few

participants discussed a fear of “gas-lighting” their clients by denying or rejecting clients’ feedback about their experience of the therapeutic relationship. Participant (B) spoke to this fear in his decision to disclose his illness and depression to his clients by saying, “It just felt like it would have been almost gas-lighting them otherwise. To not reveal that information.” He went on to say, “Here I was prior to that undergoing very significant cancer treatment and doing all the rest of it, and here I was with these patients talking about their deepest, intimate most secrets and concealing that from them.” Participant (B) seemed to feel unsettled withholding significant information about himself while his clients were discussing some of their most vulnerable and intimate thoughts and experiences. He seemed to have a sense that his clients may have sensed his lack of presence, therefore not to share the information of his illness would be misleading. Some participants also expressed that for many clients, the therapeutic relationship may be the first relationship they’ve experienced in which the other person is willing to accept and acknowledge their role in a disruption in the relationship.

Acknowledging and accepting the ways in which participants hurt their clients in the therapeutic relationship also led to a sense of humility about their own limitations as professionals. Participant (F) described the importance of accepting limitations by saying, “You have to not be ashamed of your humanness, and your humanness is messy.” She continued, “We can have these great ideas - we need to do no harm and take these vows. Fine, but you won’t be able to live up to it. It’s a great goal.” Participant (H) described her process of having to accept that she will not be able to meet all of her clients’ needs, saying

That’s part of the struggle - when you can’t be what a patient needs you to be. We’re disappointing in all kinds of ways, and sometimes it’s good ways we’re disappointing and sometimes it’s bad ways we’re disappointing. It just is part of relationships.

For many participants, accepting one's limitations as a clinician was a vulnerable process that required them to confront the ways in which they cannot always be good and healing providers for their clients.

One way that many participants came to accept their limitations in the therapeutic relationship was by adopting a stance of not knowing. A few participants described the pressure they experience from clients to know the right answers or to use their expertise to cure or heal their clients. Adopting a stance of not knowing and mutual exploration in the therapeutic relationship required that both the clinician and the client accept the anxiety of not having answers and agreeing to find them together. Participant (B) described this process by saying, "I think the vulnerability is to not know. There's some pressure on us to know, but the real vulnerability, and it's a shared vulnerability, is to be able to tolerate not knowing and to not have the answers." Participant (G) also spoke about the discomfort of working from a relational perspective of not knowing saying, "You don't get to sort of sit on your throne making proclamations. You don't get to say, 'I think that's your projection,' right? You also have to stay in a place of not having all the answers." By adopting a stance of not knowing and tolerating their own and their clients' anxiety about not knowing, participants seemed to accept their own limitations as providers and adopt a perspective of mutual exploration in their work.

Developmental Capacity

When asked if their capacity to be vulnerable with clients had changed over the course of their career, all of the participants agreed that their capacity to be vulnerable had grown and deepened throughout their careers. Many of the participants described a process of becoming more comfortable being themselves in their work with clients. Participant (B) said, "There's been enormous influence over the years in just being much more comfortable being myself."

Participant (J) agreed saying, “It’s easier for me to be both my funky self but also to be more casual but also to be more disciplined.” Participants seemed to describe a process of relaxing into an ability to be authentic in the therapeutic relationship as they developed greater trust in their clinical knowledge and skill. Participant (H) described feeling more confident in herself as a clinician by saying,

I wasn't constantly second-guessing myself...in a way that I did when I was a novice therapist. I knew that I knew enough that if something wasn't exactly right we would be able to work it out and get past it.

As participants gained greater clinical experience, they were better able to trust themselves and trust their ability to navigate their clients’ varied responses within the therapeutic relationship. Participant (I) described gaining confidence in her internal sense as a clinician by saying, “You kind of know inside yourself if something really feels off or wrong.” Similarly, participant (H) described a process of internal discernment in her work saying, “When it feels okay, I do it, and when it doesn't feel okay, I don't do it. But I've noticed over time that I feel more okay about more things than I would have ten years ago.” Participant (H) described her increased capacity for discernment within the therapeutic relationship as a process of “getting to trust your own insides.” Participant (G) described feeling more solid in his ability to, “roll with it” in his work. Participant (F) described gaining a greater ability to, “take some risks and rely on my instinct” as her career progressed. As participants gained a greater sense of confidence in themselves and in their clinical abilities, their capacity to be vulnerable and authentic in the therapeutic relationship seemed to increase.

In addition to gaining greater confidence in their clinical abilities, a few participants also described ways in which they grew personally through their work with clients. Participant (B)

described becoming “a much calmer, more patient person over the years.” Participant (I) described an experience with a client in which the client became enraged with her following a therapeutic rupture. She described the experience as “growth-producing” as she learned that she could “survive” her client’s rage and “use it” for healing and repair. A few participants described feeling less defensive and less reactive with clients over the course of their careers as they continued to grow and develop personally. Participant (G) described this process saying, “I’m not as defensive, which makes it easier. I’m not defending as much.” As participants gained acceptance for the parts of themselves that are triggered in their work with clients, they were better able to remain vulnerable and present with their clients in the therapeutic relationship. Participant (F) described feeling more comfortable with her own vulnerability in the therapeutic relationship saying, “My vulnerability feels less vulnerable now. I’m more comfortable with my vulnerability than I was in the beginning.” Being open and present in the therapeutic relationship began to feel less personally risky and threatening to participants over the course of their careers as they continued to grow as individuals and gained greater trust in themselves as clinicians.

Throughout their careers, a few participants also described gaining greater trust in the clinical process and trust in the value of mutual vulnerability in the therapeutic relationship. Participant (E) described having greater “faith in the process” as she learned to “believe in the importance” of vulnerability and feel “less overwhelmed” when she does allow herself to be vulnerable and open in the therapeutic relationship. Participant (H) described gaining greater trust in her experience of vulnerability in the therapeutic relationship, saying “What I’ve learned to trust is not so much what I’m feeling but that what I’m feeling can be relevant and can be useful.” Participants seemed to gain a greater trust not only in the therapeutic process but in the value of their own vulnerability within the therapeutic relationship. Participant (A) described the

confidence she gained in the process of rupture and repair in therapeutic relationships through an experience with a client in which a disruption was able to be healed. Participant (A) described how this confidence impacted her ability to engage with clients later in her career by saying, “We can have big disruption here. It's inevitable. It's how this works. And if we both hang in there, we can absolutely get through this and be in a better place.” As participants had experiences with clients of disruption in the therapeutic relationship that were able to be resolved, they gained a greater trust in their capacity as clinicians. In turn, a few participants described gaining greater trust in their ability to be open and vulnerable in the therapeutic relationship as they began to trust that they could recover the relationship no matter how the client responded.

Along with the importance of clinical experience, all of the participants expressed the importance of continued training, supervision, and personal therapy for professional development. All of the participants had engaged in post-graduate training programs in psychoanalytic theory and had continued to stay involved and engaged with those training programs for continued learning. In addition, all of the participants described the importance of personal therapy as a tool for self-reflection and personal support throughout their careers. Participant (I) described her process of individual therapy as a process of discovering her own vulnerability and “knowing” herself “in and out.” Participant (E) described feeling more open and vulnerable in the therapeutic relationship with her clients after she returns to work from her own therapy. She described the way in which her personal therapy allows her to “get in touch with the patient position” and “be less of an other” with her clients. A few participants discussed returning to personal therapy during times of personal depression or to unpack a resistance they felt in their work with clients. Continuing to engage in personal therapy throughout their career

allowed participants to continue to grow as individuals, self-reflect, and gain appreciation for the position of the client in the therapeutic relationship. Many of the participants also described the importance of supervision, both individual and peer, as a way to gain important feedback about areas of practice in which they may be unaware of their subjectivity in the therapeutic relationship.

For many participants, continued participation in training programs, personal therapy, and supervision reflected their understanding of clinical learning as a developmental process throughout one's career. Participant (C) described her process of learning new clinical interventions as a continual process of practicing and assessment. She described the process saying,

And then you try them enough times until it starts to feel like, "Okay I can try this and be vulnerable, but not too vulnerable." It's a tricky line and you cross it too much on this side and then you cross it too much on this side, and you kind of bounce around. You don't ever hit a perfect place. You're constantly working at it. But I think that's the training, is to have a community around you helping you figure this out and failing a lot of times.

Many participants described a process of development throughout their careers that continued to grow and deepen and which allowed them to inhabit greater degrees of vulnerability in their work with clients. Participant (J) likened clinical training to "weight-lifting and working out" implying that clinical skill requires continual strengthening and practice. A few participants described ways in which continued clinical training allowed them to feel more comfortable being vulnerable in their work with clients. Participant (H) described gaining greater trust in herself as a clinician and in her ability to be vulnerable saying,

It helped me to trust myself that I was a good enough therapist that I wouldn't do something that was really horrible. That my right brain would know enough not to do something really terrible, and that if it was a little bit terrible, we would be able to deal with it.

Continued education, supervision, and personal therapy seemed to allow participants to trust that they knew enough as clinicians to allow themselves to be vulnerable in the therapeutic relationship with less risk of disrupting the treatment or the therapeutic relationship.

Conclusion

The purpose of this study was to explore relational clinicians' lived experiences of vulnerability in the therapeutic relationship. Following an interpretative phenomenological analysis methodology, interviews with 10 participants were transcribed and analyzed for themes. The majority of participants discussed four main themes in their descriptions of their experiences of vulnerability in the therapeutic relationship. Participants described their vulnerability in the therapeutic relationship as a quality of engagement that is open, present, and affective attuned. Participants experienced limitations to their ability to be vulnerable, including personal resonance with the presenting issues of their clients, fears of transgressing professional boundaries, and fears of that their vulnerability would threaten or disrupt the therapeutic relationship. Despite these fears, all participants expressed an understanding that the clinician's willingness to engage in a real, authentic, and human relationship with clients is crucial to the client's healing and growth. Lastly, all participants described ways in which their capacity to be vulnerable in their work and in their clinical relationships had changed and grown over the course of their careers. The following chapter will discuss these findings in relation to the literature as well as the potential significance and implications of these findings.

CHAPTER V

Discussion

This study explored how clinicians practicing relational psychotherapy experience their own vulnerability in their work with clients. Following an interpretative phenomenological analysis research methodology, interviews with 10 participants were transcribed and analyzed for themes. Four major themes emerged from the data and analysis. First, participants described their vulnerability as a quality of engagement in the therapeutic relationship that is open, engaged, and attuned to their client. Second, participants described a sense of risk associated with their vulnerability in the therapeutic relationship, which required that participants felt safe in the therapeutic relationship with clients before allowing themselves to be vulnerable. Third, participants emphasized the importance of mutual vulnerability in the therapeutic relationship and participation in a full, authentic, human relationship for the client's healing and growth. Fourth, participants described their own vulnerability in the therapeutic relationship as a capacity that developed over the course of their career. Each of these themes will be discussed in relation to the literature in the following sections. The strengths and limitations of this study, my reflexivity throughout the research process, as well as the implications for future practice and research will also be discussed.

Discussion of Themes

Quality of engagement. Many participants described their experience of vulnerability in the therapeutic relationship as a quality of engagement that is present, open, receptive, and emotionally attuned. Vulnerability was experienced as a quality of being in the therapeutic

relationship rather than a certain intervention, theory, or behavior. This quality of being was often experienced as a sense of internal grounding and spaciousness, sometimes described as a bodily sensation of attentive ease. By describing vulnerability as a quality of engagement that is open, present, and engaged, participants seemed to be describing a clinical stance that is open to both their own internal experience within the therapeutic relationship and their clients' thoughts, feelings, and reactions within the relationship. This description of vulnerability as an experience of openness and willingness to explore and encounter aspects of both themselves and their clients is similar to clients' experiences of vulnerability described by Leroux et al. (2007). Leroux et al. described clients' experiences of vulnerability in the therapeutic relationship as a process of, "becoming aware, through an openness to explore self and other, of truths about self and other" (p. 324). The similarity between the findings of this study and those of Leroux et al. (2007) suggest that clinicians and clients experience vulnerability in the therapeutic relationship in similar ways.

In contrast to the quality of engagement that is open, present, and attuned, participants described a lack of vulnerability in the therapeutic relationship as a feeling of constriction, blockage, and resistance. Participants described feeling tense, anxious, or unaffected in the therapeutic relationship, as though the previous sensation of ease and spaciousness in the relationship had collapsed. Leroux et al. (2007) found a similar contrast between clients' experiences of vulnerability and lack of vulnerability in the therapeutic relationship saying, "Two possibilities are experienced in the same moment: the possibility for remaining open to a relational encounter with the therapist or to an aspect of their own inner experience, and the possibility of closing down or avoiding relational contact with the therapist or an aspect of their own experience" (p. 323-324). Again, the similarity of these findings suggest that both the

clinician and the client can sense a shift, within themselves and within the therapeutic relationship, from a quality of openness and mutual vulnerability to one of constriction and resistance to vulnerability.

Many participants described a process of resistance and restriction in their ability to be vulnerable in the therapeutic relationship as a response to an experience or emotion within themselves that they were unwilling or unable to process. Participants resisted their own experience of vulnerability in the therapeutic relationship when a painful aspect of their personal history or an aspect of their present life was overwhelming or straining their emotional resources. As a result, participants seemed to engage in various defensive processes, sometimes unconsciously, to guard against the emotional response elicited by the therapeutic relationship. The defensive process had the effect of distancing the clinician from the unwanted emotional experience but also distanced the clinician from the client's experience, thus resulting in a feeling of blockage in the therapeutic relationship and a lack of openness and understanding between the clinician and the client. Leroux et al. (2007) described this experience for the client as a "mis-meeting," in which clients feel "misunderstood, rejected, and not sufficiently heard or seen" (p. 323).

In order to return to a state of vulnerability, participants first needed to become aware of their resistance to being open and vulnerable to the client's experience in the therapeutic relationship, either through a process of reflection on their countertransference or as a result of feedback from the client. Many participants then needed to do personal work to engage with the experience triggered by the engagement with the client in order to access and process their own emotional reactions. Following this process of personal work and reflection, the clinician could then return to the therapeutic relationship with renewed openness and vulnerability, both to their

own internal experience and to the client's experience. In some situations in which the participant's personal circumstances outside of the therapeutic relationship were straining their emotional resources, for example the experience of a personal illness, the participant needed to undergo a process of personal integration and understanding of that experience before being willing to be open about that experience with clients in the therapeutic relationship. Sometimes a certain passage of time or emotional distance from the difficult circumstances seemed necessary for resolution of the emotional strain and a return to vulnerability and openness in the therapeutic relationship.

Participants' difficulty remaining open and vulnerable with clients who triggered personal experiences of pain and struggle was congruent with the literature on the difficulty of empathic attunement in relational psychotherapy. As Harris (2009) said, "...the need to have open access to unbearable affects in ourselves is one of the challenges that makes psychoanalytic work so difficult" (p. 8). Indeed, it was participants' lack of open access to unbearable affect within themselves or their clients that prohibited mutual vulnerability in the therapeutic relationship. Participants' struggle to remain open and vulnerable clients who trigger their personal histories is also congruent with the literature and research on the construct of the wounded healer. As the research and literature on the wounded healer argues, it is the process of recovery that enables wounded healers to utilize their own woundedness in service of others. As the study of Ivey and Partington (2014) argued, "Authentic wounded healers, it would seem, embody a paradox: they must be healed yet continue to suffer, and their suffering must be transmuted without being transcended" (p. 174). Interestingly, participants in this study seemed to describe a similar optimal window of engagement with their own experiences of wounding and their personal histories. Participants described a way in which they were unable to feel

comfortable engaging with an emotional experience within the therapeutic relationship if they were saturated with their own experience and emotional response. It was only after a process of personal reflection and greater integration of their own emotional experience that participants felt comfortable remaining open to that experience within themselves and with their client in the therapeutic relationship. However, following this process of processing and integration of their own wounds and histories, many participants described moments of profound transformation and mutual understanding in the therapeutic relationship as clients felt that participants understood their experience in a deeper way. In this way, participants' experiences of woundedness could enable a process of empathy and mutual vulnerability within the therapeutic relationship, but only if the participant was sufficiently healed to allow themselves to make use of that experience in their clinical work.

Risk of vulnerability. As participants described an internal quality of openness, vulnerability, and emotional attunement in the therapeutic relationship with clients, many moved quickly to questions of how and when they might make this mutual vulnerability known to the client in the form of a disclosure. Questions about self-disclosure became the focal point in many of the interviews as participants struggled to reconcile competing values of openness and mutual vulnerability in the therapeutic relationship and the need for professional boundaries and a therapeutic framework that prioritized the experience of the client. Interestingly, participants did not seem to question the relational tenets of the co-constructed nature of the therapeutic relationship, intersubjectivity, or the importance of countertransference as useful clinical information. However, they continued to struggle with questions of how much to allow themselves to make their shared participation in the therapeutic relationship known to the client in the form of disclosures.

I was surprised that despite participants' extensive training, experience, and knowledge of relational psychotherapy, many continued to struggle with the legacy of analytic neutrality advanced by classical psychoanalysis. Many participants voiced fears of transgressing professional boundaries by allowing themselves to be more fully present and known in the therapeutic relationship. As such, many participants described their experience of self-disclosure in the therapeutic relationship as liberating or freeing, as if they had previously constricted and restrained. Despite participants' fears about self-disclosure, many participants found that their clients were appreciative of their honesty and felt respected, trusted, and valued by the participants' disclosure. This finding is supported by the research of Henretty et al. (2014) which found that clinician self-disclosure had a positive impact on clients, including generating trust in the therapeutic relationship, a shared sense of vulnerability, and shared empathy and understanding. Further, as Aron (1991) argued, clients probe for information from their analyst because they want to connect with another person in an authentic and emotionally intimate way. This connection is an integral part of the client's therapeutic growth. It is interesting that despite the theoretical and empirical support for thoughtful self-disclosure in the therapeutic relationship, many participants continued to struggle with questions of how and when to disclose their own vulnerability to their clients in treatment.

As one participant described, there is a sense of risk associated with stepping outside the known boundaries of classical psychoanalysis and entering into a therapeutic relationship in which the clinician is more personally engaged, invested, and known. In addition to a desire to protect and observe appropriate therapeutic boundaries, clinicians' continued fear and resistance to trespassing the boundary of self-disclosure in the therapeutic relationship might also represent a personal fear of greater involvement in the therapeutic relationship. As participants allowed

themselves to be vulnerable in the therapeutic relationship, they also experienced greater potential to be hurt by conflict or rupture in the therapeutic relationship. Interestingly, the risks of mutual vulnerability described by participants were not what were described by the literature of vicarious traumatization, burnout, or secondary traumatic stress. The literature on vicarious traumatization, burnout, and secondary traumatic stress seems to describe the potential risks that clinicians may experience from intimate engagement with the client and the client's history. In the current study, participants described risks to themselves, the client, or the relationship that resulted from greater involvement in the therapeutic relationship itself. The risk did not result from the clinician's engagement with the client's history but from engagement in a mutually intimate, vulnerable, and influential therapeutic relationship.

Participants described personal fears associated with increased investment and engagement in the therapeutic relationship including fears of abandonment, rejection, and being seen and known by the client. Participants also experienced a resistance to feeling helpless, bad, or ashamed in the therapeutic relationship. Many of the risks participants experienced in the process of mutual vulnerability were similar to the risks clients described regarding their experience of vulnerability in the therapeutic relationship. Leroux et al. (2007) found that clients, too, fear being seen by the therapist in the therapeutic relationship and fear being rejected when unacceptable parts of themselves are acknowledged and known by the therapist. Clients also experienced fears of being left by the therapist following moments of vulnerability and had to hold experiences on their own that they do not know how to manage (Leroux et al., 2007). In this way, both clinicians and clients seem to experience mutual fears associated with increased vulnerability and personal investment in the therapeutic relationship. In many ways, the fears and risks participants described in the process of mutual vulnerability in the therapeutic relationship

are risks inherent to any intimate relationship. Although not included in the literature review for this study, literature on the attachment style of clinicians and the impact of that attachment style on their therapeutic relationship with clients may further explore clinicians' experiences of risk in their clinical work.

Real relationship. All of the participants stressed the importance of being in a full, human, authentic relationship with clients. For many, the therapeutic relationship was integral to the client's ability to heal and grow. Participants' emphasis on the importance of a full, authentic therapeutic relationship for clients' healing is consistent with the literature and theory of relational psychotherapy. According to relational theory, it is the relationship between the therapist and the client and the client's probing for a personal relationship with the therapist that is the healing element of treatment (Aron, 1991). In the therapeutic relationship, the client experiences and internalizes alternate ways of relating to others (Stolorow & Atwood, 1996). As participants described, unless they were willing to engage with their clients in a full, authentic, human relationship, the client would not be able to experience an alternate relationship that could challenge and modify their existing, constricting relational frameworks. Further, by allowing themselves to be authentic and genuine in their response to clients in the therapeutic relationship, participants described their clients gaining an increased understanding of their unique subjectivity in the relationship. For example, one participant's genuine response of anger toward her client reinforced her client's understanding of her as a real person in the therapeutic relationship who is influenced by the client in authentic ways.

The importance of a full, human relationship is further reinforced by Slavin's (1998) research on mutual influence in therapeutic and supervisory relationships. According to Slavin, therapeutic change can only occur within a relationship of mutual influence and vulnerability. As

such, Slavin defines vulnerability as “an analytic readiness to be affected deeply” (p. 237). He argues that the analyst is inevitably going to be impacted and influenced by the client, but the difference is the analyst’s readiness and willingness to accept that influence.

One way that participants described being open to the influence of their clients in the therapeutic relationship was by accepting client feedback. Participants expressed the importance of being willing to reflect on themselves and their participation in the therapeutic relationship honestly and not react defensively to clients’ feedback. Many participants experienced a difficulty acknowledging their own limitations, failures, and weaknesses in the therapeutic relationship. Participants’ difficulty accepting their own limitations in their clinical work seemed to correspond with Harris’ (2009) description of the tendency for clinicians to defend against feelings of doubt, sadness, and shame with a stance of clinical omnipotence. Although this sense of omnipotence is effective in defending against feelings of helplessness, uncertainty, and fear, it also interferes with the process of growth and healing in the therapeutic relationship. For many participants, accepting one’s limitations as a clinician was a vulnerable process that required them to confront the ways in which they cannot always be good and healing providers for their clients. For many participants, accepting their limitations as professionals resulted from a process of self-acceptance. By adopting a stance of not knowing and tolerating their own and their clients’ anxiety about that not knowing, participants seemed to accept their own limitations as providers and adopt a perspective of humility in their work. Through this process of self-acceptance and shared humility, many participants described experiences of mutual growth and transformation in their clinical work.

In contrast to this process of self-acceptance, humility, and mutual vulnerability, many participants described the potential danger and harm that could be caused to clients if a clinician

is not willing to engage in a full human relationship with clients. Participants expressed a strong belief that clinicians who are not willing to engage in a full relationship with clients are withholding, defensive, and destructive. Participants' belief in the importance of authenticity and full engagement in the therapeutic relationship corresponds with Ferenczi's description of the potential dangers of a neutral analyst. Ferenczi (1932) argued that an analyst's distanced and cold demeanor could be experienced by the patient as a repetition of neglectful experiences with caregivers and a reenactment of the original conditions that led to the patient's current relational framework. Further, participants' fear of potentially gas-lighting their clients by denying or rejecting their clients' feedback seems to correspond with Ferenczi's concern that clients will experience the analyst's supposed neutrality as a lie and denial of what they are perceiving of the analyst's reactions. In these ways, the findings of the current study seem to correspond with the literature and theory in relational psychotherapy that describe the importance of accepting and embracing the intersubjectivity of the therapeutic relationship and mutual participation in a full, human, and engaged therapeutic relationship.

Developmental capacity. All of the participants agreed that their capacity to be vulnerable in the therapeutic relationship had grown and deepened throughout their careers. Participants described a process of becoming more comfortable with themselves in their work with clients, as if over time they were better able to merge their professional identities with their personal selves. Participants experienced greater trust in themselves as clinicians and in the clinical process throughout their careers, which seemed to enable greater trust in their capacity to be vulnerable in the therapeutic relationship. Participants learned that mutual vulnerability could facilitate the clinical process rather than detract from it. As participants gained greater trust in their theoretical and experiential clinical knowledge, they experienced an increased ability to

take risks in the therapeutic relationship and inhabit a space of mutual exploration and not knowing. Just as writers say one must learn the rules of grammar before one can bend the rules, so it seemed that participants felt they must learn the rules of psychotherapy before they could adopt a more personally authentic and exploratory form of practice with clients. As such, participants emphasized the importance of continued training, supervision, and personal therapy for continued learning and self-reflection.

Participants' description of their increased capacity for vulnerability throughout their careers is supported by the literature and research on clinicians' personal growth through their work with clients. Research has found that clinicians experience increased self-understanding, self-confidence, and self-reflection as a result of their work with clients (Kahn & Harkavy-Friedman, 1997; Kantrowitz, 1996; Lazar & Guttman, 2003). This research was supported by the findings of the current study, in which participants described increased self-understanding throughout the course of their career. However, one difference emerged in participants' discussion of their increased capacity for vulnerability throughout their career. While the existing literature focuses on clinicians' personal benefits as a result of their clinical work, the participants in the current study seemed to focus on the personal benefits of this work as it related to their increased professional capacity throughout their careers. The literature does not speak as directly to clinicians' career-long growth and development or the various ways clinicians experience themselves at different stages of professional development. The literature on mutual transformation seemed to most closely capture participants' descriptions of mutual change and influence over the course of their careers. In contrast, the literature on vicarious posttraumatic growth seemed least fitting for participants' descriptions of growth and change through their work with clients. Whereas the research on vicarious posttraumatic growth

describes the benefits that clinicians experience through a process of witnessing growth and change in their clients, participants in the current study described a process of change that resulted from active participation in a mutually influential and transformation relationship with clients.

Vulnerability as a developmental capacity has interesting implications for the training of new clinicians in relational psychotherapy. Slavin (1998) discusses the difficulty of teaching mutual vulnerability to new clinicians saying, “A major difficulty that beginning psychotherapists consistently have is in believing that what emerges spontaneously from them will indeed be therapeutically relevant and useful. Most often, unconsciously derived, seemingly ‘unplanned’ responses quickly become mistrusted as problematic, intrusive countertransferences” (p. 236). To address this difficulty, Slavin describes a process of supervision in which the supervisor models for the supervisee a process of mutual vulnerability and trust in the relational process that enables new clinicians to have greater trust in themselves in their own work with clients. Exploring the literature on the training of relational psychotherapy may further elucidate the developmental capacity of mutual vulnerability in the therapeutic relationship and the ways in which clinicians can be supported in that capacity throughout their careers.

Strengths and Limitations

Strengths. The current study exhibits many of the criteria for assessing rigor in qualitative research by demonstrating sensitivity to the context of the research, commitment to the research process, transparency and coherence, and significance for the field (Yardley, 2000, as cited in Smith et al., 2009). In order to create a research question that was reflective of the existing literature, I conducted a thorough literature review that informed the creation of the

interview schedule. I demonstrated sensitivity to the personal nature of the research question by conducting interviews in a way that attempted to build trust, rapport, and connection between the participant and myself prior to discussing the participant's more personal thoughts and experiences. In each of the research interviews, I followed the interview guide through the first set of questions about demographics and personal history and then adopted a more interactional style of engagement that was responsive to what the participant shared as primary to their experience of vulnerability. I frequently asked follow up questions that attempted to deepen the conversation and the participants' description of their experience of vulnerability, such as, "Can you say more about that?" and "How did that make you feel?" In the majority of interviews, the participants spoke at length with occasional prompts for deepening and exploration. Feedback from a few of the participants indicated that they felt my interview style was engaged and conversational. My clinical training was helpful in providing me with some of the foundational skills of qualitative research, including active listening and attunement.

I demonstrated commitment and rigor throughout the research process by engaging with each phase of the research process thoroughly and thoughtfully. I was attentive and engaged with each participant throughout each interview and analyzed each transcript in depth. Further, the sample for the study included 10 experienced clinicians, all of whom had direct experiences of the phenomenon being explored. In the writing of this report, I attempted to be transparent about the research process and my own reflexivity. I centered the voices of the participants in the findings to ensure that the lived experience of the participant was represented in the final report. Lastly, because clinicians' experiences of mutual vulnerability in the therapeutic relationship have not been explored in the existing literature, the current study makes a significant contribution to the literature and to the field of psychotherapy. Throughout the current study, I

strove to ensure rigor in the research process through sensitivity to context, commitment, transparency, and importance (Yardley, 2000, as cited in Smith, Flowers, & Larkin, 2009).

Limitations. As described in the methodology section of this report, one limitation of this study was my inability to recruit a full participant sample of 12 participants as required by the Smith School for Social Work Human Subjects Review Board. Instead, I interviewed 10 participants. Further, I was only able to interview each participant for one 45-60 minute interview and was not able to complete second interviews to facilitate a deeper engagement with the phenomenon being described. One possible explanation for the difficulty in recruiting participants was the sensitive and personal nature of the research question. Participants had to agree to be vulnerable in the research interview in order to discuss their experience of vulnerability in their work with clients. One potential participant, a social work psychoanalyst who practices relationally, decided not to be interviewed because she was uncomfortable with the degree of vulnerability required by the research interview. Another participant who did agree to be interviewed shared at the end of the interview that he was not surprised I was having a difficult time with recruitment. He suspected it was the sensitive nature of the research question that was preventing more participation.

As a result of this limitation, the participants who agreed to be interviewed may represent a population of clinicians who are the most comfortable with their vulnerability, both as research participants and as clinicians. As a result, the findings of this study may represent one end of the vulnerability spectrum as experienced by clinicians in their work with clients. As with all qualitative research studies, the findings of this study cannot be generalized beyond this particular sample. Further limiting the generalizability of the findings is the homogeneity of the research sample in terms of race, gender, and education. The majority of the participants were

White, female, and social workers. These research findings may not be generalized to clinicians with different identities and educational backgrounds.

Although I originally hoped to conduct most of the interviews in person, the difficulty with recruitment required that I expand my sample to include participants from across the United States. As a result, the majority of interviews were conducted remotely via Skype or FaceTime. In these remote interviews, I sometimes experienced an increased difficulty establishing trust and rapport quickly in the research interview. Although the virtual platform did allow for visual representation of the participant and myself, we were unable to rely on the foundation of interpersonal information that is shared by meeting someone in person and sharing physical space. Establishing a sense of connection between the participant and myself required me to be thoughtful about the need to pace the research questions in a way that allowed the participant to gain comfort and trust in the interview process. In order to communicate presence and sustained attention, I attempted to provide greater verbal and expressive feedback throughout the interview. Despite these challenges, in the majority of interviews, I felt that a connection was established and the platform did not interfere with the ability to engage deeply with the research question.

Reflexivity. As a future clinical social worker that aspires to practice relationally, this study was personally and professionally rewarding for me. I enjoyed each phase of the research process, including the formulation of the research question, the literature review, the research interviews, and the data analysis. As a clinician in training, it was inspiring for me to have the opportunity to speak with seasoned clinicians about their experiences with clients throughout their careers, especially through the lens of their own experiences of vulnerability in their clinical

work. I often felt grateful and privileged by participants' willingness to share such intimate and personal aspects of themselves and their clinical work with me in interviews.

As participants described, vulnerability is a capacity that develops over the course of one's career and may not be easily or readily available for new clinicians to inhabit early in their careers. As a new clinician who is interested in the phenomenon of clinician vulnerability, I often resonated with the difficulty of inhabiting mutual vulnerability early in one's career. However, I was also intrigued and inspired to hear more about the ways in which the capacity for vulnerability deepens with greater clinical training, experience, and practice. It was often refreshing and enlivening for me to hear participants speak of the ways that they gained greater trust and capacity to bring themselves more fully to their clinical work throughout their careers. Through this research process, I am excited to begin my own career as a clinician and to continue to explore and discuss both my own and my colleagues' experiences of vulnerability in our clinical work.

Despite the personal resonance of the research question, throughout the interview process, I attempted to bracket any preconceived understandings of the phenomenon of clinician vulnerability and to be open and willing to encounter the phenomenon as described by each participant. I was aware of my potential resistance to exploring the painful or negative aspects of clinician vulnerability and attempted to counteract that resistance by being mindful of what I chose to engage more deeply in my conversations with participants. I attempted to keep an open mind during each interview and allow the previous interviews to inform my conversations with subsequent participants without precluding new or contrasting information. Further, I strove not to lead participants to any certain understanding or description of their experience of vulnerability but allow participants to discuss what felt most relevant to them.

Understandably, this research has been impacted by my own subjectivity as the researcher. The data, findings, and analysis of this research study are a unique combination of my own subjectivity as the researcher and those of the participants of this study. Despite the inevitability of the subjective nature of this study, my rigorous attempt to follow an IPA research methodology as closely as possible and my attempt to acknowledge my own subjectivity in the research process should lend greater trustworthiness to the findings of this study.

Implications for Practice and Research

Many participants stated in the interview process that they were not sure what they were going to talk about in the interview or what my research question meant by vulnerability. However, most participants found that as the interview progressed, they had a great deal to discuss on the topic of vulnerability. This suggests that the concept of clinician vulnerability in relational psychotherapy is not well conceptualized. Although many of the supporting categories of literature surveyed as a foundation for this study were relevant to the discussion of clinician vulnerability, very few studies have presented clinician vulnerability in the therapeutic relationship as a phenomenon experienced by clinicians in their clinical work. The lack of a coherent and unified definition of mutual vulnerability in the therapeutic relationship seems to leave both clinicians and the field of psychotherapy without the language necessary to talk about the phenomenon as it is experienced by clinicians. Participants in the current study seemed to be putting words to the phenomenon of their mutual vulnerability in their clinical work, potentially for the first time. They seemed to have discussed various aspects of the experience of vulnerability, such as their experiences of countertransference, questions about self-disclosure, and empathic attunement. However, these elements of clinician vulnerability seemed disparate

and unconnected because the language of clinician vulnerability had not yet unified the experience as one, overarching phenomenon.

Clinicians' lack of coherent language to describe the phenomenon of mutual vulnerability in the therapeutic relationship may have implications for the field of psychotherapy. Without language to describe the experience of vulnerability in the therapeutic relationship, that experience remains only vaguely understood, communicated, or discussed within the field of psychotherapy and among clinicians. Just as countertransference needs to be acknowledged and discussed in order to be managed in the therapeutic relationship, so, too, do clinicians' experiences of mutual vulnerability need be understood in order to be recognized as a process that is impacting the quality of the therapeutic relationship and treatment with clients. As a phenomenon, clinician vulnerability in the therapeutic relationship has not yet been fully explored or understood.

In order to better understand the phenomenon of clinician vulnerability, further studies should continue to examine how clinicians experience their own vulnerability in their clinical work. This study selected a sample of experienced clinicians practicing relational psychotherapy in an attempt to interview a population of clinicians who may be most fluent in discussing their own experience of vulnerability in the therapeutic relationship. Ideally, future qualitative and quantitative studies should focus on clinicians at different stages of their professional careers, which would further the exploration of the developmental progression of vulnerability in the therapeutic relationship. Future studies could also focus on clinicians practicing from different theoretical frameworks. These studies would further illuminate the experience of clinician vulnerability at different stages of professional development and within different treatment modalities.

The findings of the current study also have implications for the education of new clinicians, especially clinicians who are practicing relational psychotherapy. As Slavin (1998) asks, “How can supervisees be taught to trust themselves and to trust in the usefulness of their unpreconceived, seemingly countertransferential responsiveness?” (p. 236). If mutual vulnerability in the therapeutic relationship is a developmental capacity that deepens over the course of clinicians’ careers, what degree of vulnerability should be expected or is desirable for new clinicians? Is vulnerability a capacity that can be taught to early clinicians or should the emphasis in training programs remain on providing strong theoretical foundations and clinical skills that will later be adapted and enhanced with increased vulnerability? This research also has implications for supervisory relationships. How might supervisors encourage and facilitate a process of mutual vulnerability in the therapeutic relationship that enables supervisees to trust their capacity to be vulnerable in their work with clients? These are important questions for both social work and psychotherapy educators to consider in training new clinicians.

Conclusion

This study sought to explore the question - *How do clinicians practicing relational psychotherapy experience their own vulnerability in their work with clients?* In order to address this research question, a qualitative, phenomenological research study was conducted to better understand the lived experience of clinician vulnerability in relational psychotherapy. Following an interpretative phenomenological analysis research methodology, 10 experienced, relational clinicians were interviewed, and each interview was transcribed and analyzed for themes. Through the process of data analysis, four major themes emerged from the majority of interviews. First, participants described their experience of vulnerability in the therapeutic relationship as a quality of engagement that is open, resonant, and attuned. Second, participants

described a sense of risk associated with mutual vulnerability in the therapeutic relationship, requiring that participants felt safe in the therapeutic relationship before allowing themselves to be vulnerable. Third, participants stressed the importance of mutual vulnerability and participation in a full, human, and authentic relationship for clients' growth and healing. Fourth, participants described their own vulnerability in the therapeutic relationship as a developmental capacity that deepened throughout their career.

The findings of this study have broad ranging implications for clinicians practicing at various stages of their professional careers and from a variety of treatment modalities. As research has shown, across various theoretical orientations and treatment modalities, the quality of the therapeutic relationship accounts for the greatest percentage of client change in the therapeutic process (Asay & Lambert, 1999). As the findings of the current study indicate, clinicians' experiences of mutual vulnerability within the therapeutic relationship impact their participation and engagement with clients in the therapeutic relationship. As such, clinicians' experiences of mutual vulnerability may impact the quality of the therapeutic relationship and may, in turn, impact the potential for client growth and change. Better understanding of clinicians' experiences of vulnerability in their clinical work may have potentially significant implications for the field of psychotherapy across treatment modalities and orientations. Further research should continue to explore the lived experience of clinician vulnerability across treatment modalities and at different stages of professional development. Further research should also explore the potential connection between mutual vulnerability in the therapeutic relationship and client change. In order to understand the potential implications for the quality of the therapeutic relationship and the impact on client change, the phenomenon of clinician vulnerability in therapeutic relationship must continue to be explored, discussed, and studied.

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Appendix A – HSRB Approval Letter



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

January 11, 2017

Christine Powers

Dear Christine,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Susanne Bennett, Research Advisor

Appendix B - HSRB Response to Amedments



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

January 19, 2017

Christine Powers

Dear Christine:

Your requested amendments have been reviewed. We do not approve your request for a decrease in sample size. You are approved to add the use of Skype for data collection interviews. Thank you and best of luck with your project.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Susanne Bennett, Research Advisor



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

April 3, 2017

Christine Powers

Dear Christine,

I have reviewed your amendment and it looks fine. The amendment to your study is therefore approved. Thank you and best of luck with your project.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Susanne Bennett, Research Advisor

Appendix C – Recruitment Email and Flyer

Dear Friends and Colleagues,

I am writing to let you know that I am conducting a research study as part of my Masters thesis for the Smith College School for Social Work. For my thesis, I am conducting interviews with relational psychotherapists in the Boston area to explore clinicians' experiences of vulnerability in their work with clients. Previous research has defined vulnerability as an openness to influence in intimate relationships. This study seeks to explore the ways in which clinicians are open to the influence of their clients in the therapeutic relationship.

I am looking for participants who:

- Are licensed practicing psychotherapists (social workers, psychologists, or mental health counselors)
- Self-identify as using a relational theoretical approach in their work with clients
- Have five or more years of experience practicing relational therapy post-graduate school training

If you or anyone you know would be eligible and willing to participate in this study, I would be so appreciative. The interview will last 45-60 minutes and will be conducted in person at a location most convenient for the participant. This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee.

I have included a flyer below that can be forwarded to friends, colleagues, and anyone else you think may be interested in this study.

If you're interested in participating in this study or you have any questions, please contact me by email at cpowers@smith.edu.

Thank you so much for your time and assistance with this project!

Sincerely,

Christine Powers

MSW Candidate, Smith College School for Social Work



RESEARCH STUDY

ARE YOU A LICENSED PRACTICING PSYCHOTHERAPIST?
(SOCIAL WORKER, PSYCHOLOGIST, OR MENTAL HEALTH COUNSELOR)

DO YOU IDENTIFY AS USING A RELATIONAL THEORETICAL APPROACH IN
YOUR WORK WITH CLIENTS?

DO YOU HAVE FIVE OR MORE YEARS OF EXPERIENCE PRACTICING
RELATIONAL THERAPY POST-GRADUATE SCHOOL TRAINING?

**If you meet the above criteria, you may be able to participate
in a study designed to explore relational psychotherapists'
experience of vulnerability in their work with clients.**

The interview will last 45-60 minutes and will be conducted in person at a location most
convenient for the participant.

TO PARTICIPATE, PLEASE CONTACT CHRISTINE POWERS AT:

C P O W E R S @ S M I T H . E D U

This study is being conducted as part of the researcher's Masters thesis.

This study protocol has been reviewed and approved by the
Smith College School for Social Work Human Subjects Review Committee.



2016-2017

Consent to Participate in a Research Study

Smith College School for Social Work • Northampton, MA

.....
Title of Study: Clinician Vulnerability: Openness to Influence in Relational Therapy

Investigator(s): Powers, Christine; cpowers@smith.edu

.....
Introduction

My name is Christine Powers and I am a graduate student at Smith College School for Social Work. I am conducting a research project about clinicians’ experiences of vulnerability in their work with clients. You are being asked to participate in this study because you are a licensed practicing psychotherapist (social worker, psychologist, or mental health counselor) who self-identifies as using a relational theoretical approach in your work with clients and who has five or more years of experience practicing relational therapy post-graduate school training.

I ask that you read this form and ask any questions that you may have before agreeing to be in this study.

Purpose of Study

The purpose of this study is to explore how clinicians practicing relational psychotherapy experience their own vulnerability in their work with clients. Previous research has defined vulnerability as an openness to influence in intimate relationships. This study seeks to explore the ways in which clinicians are open to the influence of their clients in the therapeutic relationship. This study is being conducted as a research requirement for my master’s in social work degree. This research may be published or presented at professional conferences.

Description of the Study Procedures

My research will be gathered through exploratory interviews with participants who are willing to share in-depth accounts of their experience of vulnerability in their work with clients, including their experiences of countertransference and enactments within the therapeutic relationship as well as the personal impacts of their work with clients. If you agree to be in this study, you will

be asked to read and sign this informed consent form and participate in one 45-60-minute interview.

To begin the interview, I will ask for basic demographic information such as your age, race, ethnicity, and gender. Any identifying information that is gathered in the interview will later be changed to protect your confidentiality. The interview will then consist of open-ended questions to facilitate engagement with the over-arching questions regarding vulnerability in relational treatment.

I will personally conduct the interview and I may take a few notes during the interview process. I will audio record the interview in order to transcribe your responses at a later point. In order to conduct the interview, we will meet at a location most convenient for you, either a public place that affords some privacy or at your office.

Risks/Discomforts of Being in this Study

It is possible that at times during the interview you may feel uncomfortable describing your experience of vulnerability in your work with clients. To address this possibility, the researcher has designed the interview to foster greater comfort and understanding between yourself and the researcher before you are asked to relay details of your experience of vulnerability. If at any time you are uncomfortable answering a question during the interview, you may decline to answer any question for any reason. You may also withdraw from the study at any time for any reason.

Benefits of Being in the Study

As a participant in this study, you may benefit from the opportunity to reflect on your experiences in your work with clients, potentially leading to enhanced insight and clinical awareness. You will be contributing your clinical experience for the development of the field of clinical social work and relational psychotherapy, potentially resulting in a sense of fulfillment and gratification.

Your participation in this study will benefit the field of psychotherapy by expanding the existing empirical literature on clinicians' personal experiences of vulnerability within the therapeutic relationship. Understanding more about how clinicians experience their own vulnerability within the therapeutic relationship will benefit clinicians practicing with a variety of theoretical perspectives.

Confidentiality

Your participation in this study will be kept confidential. Interviews will be conducted in locations that ensure privacy and only the researcher will be informed of your participation. The researcher will be the primary handler of all data collected. Following the interview, each participant will be assigned a pseudonym, which will be placed on all materials. This informed consent form will be kept separate from all other researcher notes and transcripts. After all

identifying information has been removed, my research advisor will have access to the data collected, including any transcripts or summaries of the interview and may assist in the analysis of the data.

All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to Federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period.

Should this study be presented or published at any time, the data will be presented as a whole and when short, illustrative vignettes are used, all identifying information will be removed and disguised with a pseudonym. The researcher will not include any information in any report she may publish that would make it possible to identify you.

Payments/gift

You will not receive any financial payment for your participation.

Right to Refuse or Withdraw

The decision to participate in this study is entirely up to you. You may refuse to answer any question or withdraw from the study *at any time* up to April 1, 2017 without effecting your relationship with the researchers of this study or Smith College. If this is an interview and you choose to withdraw, I will not use any of your information collected for this study. You must notify me of your decision to withdraw by email or phone by April 1, 2017. After that date, your information will be part of the thesis, dissertation or final report.

Right to Ask Questions and Report Concerns

You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study at any time, feel free to contact me, Christine Powers, at cpowers@smith.edu. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent

Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep.

.....

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

.....

1. I agree to be audio taped for this interview:

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

2. I agree to be interviewed, but I do not want the interview to be taped:

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

Appendix E – Interview Guide

Introduction Paragraph for Participants:

“Hello, thank you for agreeing to be a part of this research study. The purpose of this study is to explore how clinicians practicing relational psychotherapy experience their own vulnerability in their work with clients. Previous research has defined vulnerability as an openness to influence in intimate relationships. This study seeks to explore the ways in which clinicians are open to the influence of their clients in the therapeutic relationship.

You have been asked to participate in this study because you are a licensed practicing psychotherapist (social worker, psychologist, or mental health counselor) who self-identifies as using a relational theoretical approach in your work with clients and who has five or more years of experience practicing relational therapy post-graduate school training. The interview will last for approximately one hour and will consist of open-ended questions to facilitate engagement with the over-arching questions regarding vulnerability in relational treatment. You may decline to answer any question at any time. You may also withdraw from the study at any time. If you mention specific case examples in your answers, please remember to de-identify all client information. The interview will be audio recorded in order to transcribe your responses at a later point.

I appreciate your time and assistance with this research and hope you will gain insight and a sense of fulfillment from your participation. Before we begin, do you have any questions about your participation in this study or the informed consent form?” (If yes, I’ll answer questions. If not, I’ll direct the participant to sign the informed consent form before beginning the interview.)

Interview Questions:

Demographic Information

- 1) What is your gender?
- 2) What is your age?
- 3) How do you identify racially?

- 4) How do you identify ethnically?
- 5) Where and when did you receive your MSW degree?
- 6) How long have you been practicing as a psychotherapist?

Career as a Relational Therapist

- 7) What led you to pursue a career as a psychotherapist?
- 8) What led you to adopt a relational theoretical approach in your work with clients? What drew you to relational psychotherapy?
- 9) How do you define relational psychotherapy?

Prompt questions –

- How is relational therapy different from other forms of therapy?
- How do you conceptualize mutuality and intersubjectivity in your work with clients?
- How do you conceptualize enactments in relational psychotherapy?

Vulnerability in the Therapeutic Relationship

- 10) How would you describe your experience of vulnerability in your work with clients?
- 11) How does your vulnerability in the therapeutic relationship impact your work with clients?

Prompt questions –

- What role does transference and countertransference play in your relational work with clients?
- How comfortable are you with self-disclosure in your therapeutic relationships?
- How do you experience empathy in your work with clients?
- What enhances or enables your experience of vulnerability in your work with clients?
- In contrast, what limits or inhibits your experience of vulnerability in your work with clients?

Personal Impact of Vulnerability

- 12) How has your vulnerability in your work with clients impacted you personally?

13) As you're beginning to think about your experience of vulnerability in your work with clients, what does it evoke for you?

Prompt questions -

- How would you describe that experience of vulnerability as it feels in your body?
- What kind of imagery or other sensory experience does it evoke for you?

14) In what ways have you been negatively impacted by your work with clients?

15) In what ways have you experienced personal growth through your work with clients?

Prompt question –

- Are there times in which areas of personal sensitivity for you, perhaps experiences of suffering or adversity, may overlap with the presenting concerns of your client in treatment? If so, how have you managed those experiences of personal resonance with the suffering of your client?

16) How has your experience of vulnerability in the therapeutic relationship changed over the course of your career?