COUNSELLORS' EXPERIENCE OF EMPATHIC DIFFICULTY:
A PHENOMENOLOGICAL STUDY

by

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Abstract

The purpose of this study was to capture the lived experience of counsellors, when they encounter empathic difficulties with their clients. Five female counsellors were asked to reflect on situations from their counselling practice where they felt emotionally withdrawing from their clients or felt over-involved with the clients’ concerns.

A phenomenological approach was utilized as methodology to guide this study. The data collection strategies included a 3-hour workshop that introduced the topic to the participants, helped establish trust and rapport with the participants and helped normalize the participants’ experiences. Then, 3 in-depth interviews were carried out with each participant. Each interview was audio-taped and transcribed. Furthermore, data collection was also supplemented by the researcher’s field notes. The participants reviewed each transcript before the next interview, so that the transcripts themselves served as further reflective material for the participants.

The process of thematic analysis yielded 4 major themes. These were: (a) experiencing countertransference reactions; (b) experiencing feelings of inadequacy and professional shame; (c) experiencing the need for self-care and burnout prevention and (d) experiencing psychological growth and transformation. These themes led to a number of implications for counselling practice as well as for future research.

One major implication is that despite their training and competence, counsellors are ultimately as human and as vulnerable as their clients, having their own blind-spots, conflicts and personal experiences and because of this vulnerability, empathic difficulties are inevitable in a therapeutic setting. In this respect, the recognition of countertransference reactions is an important tool for counsellors’ self-care and burnout
prevention. Other implications concern supervision practices and curriculum concerns for counsellors' training programs.
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CHAPTER ONE

Introduction

"My appointment with the client is at 1.00pm. It is now quarter to one and I am
dreading this meeting and wish that he cancels. At five minutes to the hour, I hear his
voice from the waiting room and the secretary's frustrated face as she comes into the
room, non verbally announces that my client has come. The secretary does not like the
client. She finds him a loud person who wants to engage everyone in conversation and
takes a long time to leave the office. I meet him and together we go into one of the
counselling rooms.

Paul (a fictional name) is a client that challenges me. His appearance is that of a
person living on the streets. I try hard not to be overwhelmed by his smell. As he starts
talking, telling me endless stories, I find myself having private conversations with myself,
noting the frustration that is swelling within me and in turn, trying to focus on what he is
saying and trying to show empathic understanding. It is very hard for me to be empathic
with Paul. I find it hard to have compassion for him. I am frustrated with Paul, at his lack of
progress, at his using counselling sessions to have a "break". I also do not know what to
make of his story-telling and wonder whether I should believe what he is saying. I cringe
internally as he describes his violent outbursts of temper, how he not only punches the
door but pulls it away from the hinges, how he wakes his wife by banging on the table and
then expects her to have sex with him.

He tells his story with an air of bravado, as if he expects me to congratulate him.
What shall I make out of it? Any interventions aimed at eliciting his self-awareness are
met with reluctance and resistance. Paul is 35 years old and spends his days sleeping,
drinking beer, smoking marijuana, and watching television. He says that he wants to
change but actually does not make any effort in the direction of change.
Counselling Paul makes me very tired. I also feel very bored and frustrated and feel that I am wasting my time. Lately I have become less involved in the sessions. I let him talk with very few interruptions on my part. I do not like Paul and I cannot understand why my supervisor finds aspects of him endearing. I feel that we are worlds apart. In interaction with Paul, my feelings of frustration, fear for my safety, and boredom get in the way of building a therapeutic relationship with this client. What is strange is that I can feel compassion for this client when I listen to him on tape but not face to face. With Paul, I feel myself becoming judgmental. I feel quite disgusted by him. I am often at a loss what to do with these feelings in the sessions. Most probably, Paul too feels the lack of empathy from my part because he has missed a couple of sessions. I must admit that in some way I felt relieved when my internship hours at the clinic were complete and we terminated our meetings.

In retrospect, I realized that perhaps, as a client, Paul would have been challenging to a number of counsellors: his shabby appearance, his smell, his endless story-telling and his violent temper has the potential to provoke strong reactions in people. The secretary did not like him. Before Paul became my client, he had been seen by 5 other counsellors, who had had similar experiences with him. At the same time, I am also aware of aspects of my personality and my identity as a counsellor that probably play a role in hindering the formation of an empathic contact. The need to feel useful and effective as a counsellor were not being met by this client, who had other plans for our sessions. I was under supervision too and it was important for me to make a good impression on my tutors. Also, I have little respect for men who fly into a temper and lash out at others.”

This vignette is a true depiction of one of my counselling experiences during my internship practice at graduate school. For a number of reasons, I felt that I was unable to
connect with the client and as a counsellor, I was experiencing a gamut of uncomfortable, powerful feelings. Moreover, our encounter did not seem to be very effective, from a therapeutic point of view.

As I reflect on this experience and my past counselling experience, referring specifically to the work as a school counsellor and as a counsellor in a marital and family agency before entering graduate school, I recall observing how sessions with certain clients left a mark on me, both physically and emotionally. At times, the degree of emotional investment that I had to go through, to really grasp the experience of the client, was frightening in itself! Especially with some clients, I felt elements of my experience and personal life surfacing up and making it difficult for me to be there totally for my client. For example, it was hard for me to be there whilst one client was telling me about her grief, disbelief, and terror at having been diagnosed with brain cancer, when this represented (and still represents) one of my worst nightmares. I remember feeling overwhelmed with horror and fear when a client, who was just a few years younger than I was, described in vivid terms the way she was assaulted and raped by an acquaintance. During the time that I was seeing her, I started becoming hyper-vigilant about my safety. I refused to use underground parking-lots and still do when I am alone. Needless to say, such experiences with clients affect one’s life and cannot be easily left behind, at the counselling office.

During my graduate training, such experiences with counselling gave me the impetus to immerse myself in the research literature in the area of counsellors’ reactions in therapy. I wanted to know if my experiences were shared by other counsellors in the field. I wanted to understand what I had gone through with these clients as well as prepare myself for the future, especially because I had chosen the profession of a counsellor as a career.
Before proceeding further, it is important to briefly present my theoretical position of counselling to articulate the way I view therapy, especially the role of the therapist in therapy. My approach is essentially humanistic in orientation, focusing on the attempt to apprehend the client's internal frame of reference and giving importance to creating a working alliance with the client. Bordin (1975) conceptualizes the working alliance as consisting of (a) an emotional bond between the participants, (b) an agreement about the goals of counselling, and (c) agreement about the tasks of the work.

What makes for a good working alliance on the part of the counsellor? Gelso and Carter (1985) suggest that "professional concern and compassion, as well as an abiding willingness to help the client face his or her problems, contribute to the alliance between the participants" (p.163). Gelso and Carter also indicate that the client-centered conditions of empathy, genuineness, and respect are probably central in developing a therapeutic alliance. Corey (1991) has clear definitions for these terms. Empathy is "a deep and subjective understanding of the client with the client. It is a sense of personal identification with the client" (p. 214). "Genuineness" refers to counsellors being "integrated, authentic and real" (p. 213) and "respect" refers to the need for therapists to "communicate to the client a deep and genuine caring for him or her as a client" (p. 213).

As I tried to understand my experience with clients, specifically focusing on my difficulty or inability to empathize with them, I also noticed that I was also experiencing strong reactions to the clients. Literature derived from a humanist perspective helped me understand or examine appropriate and inappropriate counsellor activities and reactions, as well as the role of the counsellor's feelings toward the client (Gelso & Carter, 1985), but this was not satisfactory in understanding my experience. The only perspective that focused more on the therapists' reactions to the clients' material, was the analytic approach, through its focus on countertransference. Countertransference refers to the
therapists' comprehensive subjective experience of their relationship with the clients.
Hence, I concur with Gelso and Carter (1985) who state that "the analytic literature
focuses more on countertransference than do other counseling perspectives" (p. 176).

I thus started becoming familiar with the literature in the analytic field concerning
the process of empathic difficulty and also countertransference reactions from the part of
the therapists. However, I realized that this literature is also limited by the lack of
availability of research studies. As Tansey and Burke (1985) indicate, the literature on
empathy and countertransference is vast, but the literature on empathic failures or
difficulties is very narrow. In fact, most of the literature in the field is almost exclusively
conceptual in nature. In other words, most of what has been published to date tries to
explain the process of empathic difficulty in therapy through theoretical formulations.
Theoretically, I could understand my experience with my clients but theory left me with a
lot of unanswered questions, the most important of which were, "What is this experience
like for other counsellors? What kind of affect did it have on the practitioners' lives? How
did they live through it?"

The purpose of this research study is essentially to obtain an answer to these
questions, to capture the experience of counsellors who are unable to empathize with
their clients, who either feel themselves withdrawing from their clients or feel themselves
getting over-involved with their clients' concerns. The main research question in this study
is "What is the experience of counsellors who encountered empathic difficulties with their
clients?"

To answer this question, I utilize a phenomenological approach as the
methodology in this study, to describe the lived experience of 5 counsellors who were
unable to empathize with their clients and to understand the meaning that this experience
has in their lives. In engaging in this research, I have found an answer to my questions
concerning the experience of therapists who are unable to feel empathy with their clients or who feel too much empathy! It is my hope that this work will be of solace to those therapists who undergo similar experiences in the field, in that they can identify with at least, parts of the participants’ stories, and thus realize that they are not alone in their experiences. I also hope that this work will be a contribution to counsellor-trainees in its message that counsellors are human beings and regardless of how well-therapized, insightful, and integrated we are, the emotionally close and difficult task of doing counselling is bound to trigger reactions in us. These reactions are acceptable and when recognized, they can foster psychological growth in both the therapist and the client.
CHAPTER TWO

Literature review

In this chapter, I present the theoretical framework in which this research is embedded. To date, there is no empirical literature that addresses the experience of counsellors/therapists encountering empathic difficulties with their clients. Literature related to this study comes from writings in the psychoanalytic field of psychology. This literature is almost exclusively conceptual in nature. For this reason I present the theoretical concepts with which I approached the research field and that helped me focus on the counsellors' experience.

Readings in qualitative research designs (Creswell, 1994; Marshall & Rossman, 1995) discuss the role of theory and state how the use of theory in such designs may be problematic. They emphasize how a qualitative researcher does not begin with a theory to test or verify but that a theory may emerge during the data collection and analysis (Creswell, 1994). Thus, it is important that the researcher approaches the subject to be understood not with a preconceived notion or theory of what exists but with an openness that allows a natural unfolding of the phenomenon in order to become revealed and understood. At the same time, if the researcher is to know and understand a phenomenon, it must resonate with what the inquirer already knows and understands from his or her prior experience (Palmer, 1969; Polkinghorne, 1983). The theoretical concepts outlined represent the conceptual framework with which I approached the research and their presentation serve to inform the reader of my theoretical biases, values, and assumptions.

The focus of this research is the experience of counsellors/therapists when they encounter empathic difficulties with their clients. Underlying this research question are a number of assumptions. It is assumed that the relationship between client and counsellor
is the heart of the therapeutic process. Not all schools of psychology give this relationship a place of central importance but most approaches share common ground in accepting the importance of the therapeutic relationship (Corey, 1991). Within this therapeutic relationship, the counsellor’s empathic ability is an important, if not essential condition for successful counselling (Peabody & Gelso, 1982). Empathic understanding as an important condition for therapeutic change is not only notable within the humanistic person-centered approach (Corey, 1991), where it is often seen as a necessary and sufficient condition for successful counselling, but also within a psychoanalytic framework where “empathy on the part of a therapist for his [sic] patient is universally regarded as indispensable for useful psychoanalytic therapy to occur” (Burke & Tansey, 1985, p. 372).

This therapeutic relationship between client and counsellor is founded on basic respect for the person of the client and is organized around the premise that events in therapy have meaning and can be examined in collaboration with clients to facilitate their strivings for connection and meaning in their lives. The relationship exists primarily to address the clients’ needs, their growth, and healing. But counsellors also bring to the relationship their personal background, and experience, as well as their professional training and responsibility. Thus, the emphasis here is that the client and the counsellor are both participants and observers in their interactions (Sullivan, 1953). As participants, both counsellor and client bring to the encounter their life experiences, their beliefs about themselves and others, and their unresolved issues; and each consciously and unconsciously influence the other (McHenry, 1994).

In the context of counselling, especially in the early stages of the client-counsellor encounters, the clients tell their story. Counsellors listen in an empathic, non-judgmental way to the clients’ descriptions and interpretations of what happened to them, with the aim of establishing trust, rapport, and openness. The counsellors’ genuine empathic
understanding enables the clients to feel "held" (Winicott, 1965) in a safe environment. Here, the "clinician's capacity for genuine empathy is the sine qua non for laying the groundwork that enables the patient to perceive that the therapeutic context is a situation of security and protection and a proper place to express anxiety and feelings of vulnerability" (Wilson & Lindy, 1994, p. 6).

Defining Empathic Understanding

It is important to understand that empathy is more than reflecting content to the client. It is not simply objective knowledge ("I understand what your problem is"), which is an evaluative understanding about the client from the outside (Corey, 1991). Instead, empathy is a deep and subjective understanding of the client with the client (Rogers, 1986). Achieving empathy requires the partial identification of the therapist's ability to project herself or himself in the phenomenological world experienced by the other person (Wilson & Lindy, 1994).

Tansey and Burke (1985) consider empathy as being characterized by two components that unfold with varying degrees of awareness across a spectrum of time, across sessions. The initial component involves an identification with the client through which the counsellor becomes receptive and open to the client's material. Fliess (1942) refers to this initial component as "trial identification" with the client. The second component then involves an "oscillation," a shift from thinking and feeling with the client to thinking about the client (Beres & Arlow, 1974). Schafer (1959) refers to this second component of empathy as a movement for the therapist's experiencing ego to the observing ego.

Other writers from the psychoanalytic perspective refer to empathy in similar terms: "Empathy refers to a temporary identification with an aspect of the other's subjective experience which when reflectively understood as such, makes sense to our
emotional responsiveness to the other” (Ivey, 1995, p. 353). Thus, it is assumed that the feelings of the counsellors associated with the trial identification alert them to the inner experience of the client (Tansey & Burke, 1985). Ivey also refers to the counsellors' regression with the client, as well as the therapists needing to attain a self-reflective distance through which they can cognitively grasp the interactional significance of their experience. Similarly, McHenry (1994) emphasizes the need for therapists to participate in the relationship directed by the client and at the same time, step back and understand the meaning of the interaction. Schafer (1959) also describes empathy as an inner experience involving both cognitive and affective components, thus involving the feelings of another but also recognizing the other's separateness and individuality. Finally, Beres and Arlow (1974) emphasize that the identification is transient and is followed by a separation process.

In this regard, the counsellor faces a formidable task with empathic understanding that requires the simultaneous identification with, and distance from the client in order for the counsellor to provide the client with a corrective emotional experience and facilitate the healing process. Thus, sustained empathic understanding at all times, with all clients is a difficult task for counsellors despite their professional training and also because they are human. Mordecai (1991) points out that “in psychotherapeutic encounters...empathic failures occur with regularity. When these failures go unnoticed, they can cause considerable disruption to therapy” (p. 251). Empathic understanding is very hard to maintain in instances where the therapeutic setting and the clients' material become sources of the counsellors' anxiety. This is where countertransference responses from the counsellors will cause in them empathic strain (Wilson & Lindy, 1994), signalling to the therapist that there has been a loss of the therapeutic role. By “empathic strain”, Wilson
and Lindy (1994) refer to “interpersonal events in psychotherapy that weaken, injure, or force beyond due limits a salutary response to a client” (p. 27).

At this point it is interesting to note that “counteridentification” (Slakter, 1987), which is the same process that has been previously referred to as “trial identification,” links empathic understanding and countertransference. According to Slakter, through counteridentification “the analyst both identifies with the patient and at the same time pulls back from that identification so as to view the patient’s conflict with objectivity” (p. 202). He states that empathy is based on counteridentification. However, this identification is also a component of countertransference and "if it operates imperfectly, whereby that objectivity is not achieved, then the analyst’s negative countertransference reactions can cause his [sic] empathy to diminish or vanish altogether” (p. 203). The same point is made by the authors Beres and Arlow (1974):

In both empathy and countertransference, identification is effected with the patient. In empathy the identification is transient, a temporary sharing of derivative expression of the patient unconscious fantasies and wishes ... In the case of countertransference however, the analyst remains fixed at the point of identification with the patient. He [sic] is caught up in conflicts identical to those of the patient. Accordingly, the analyst becomes prone to the vicissitudes of these conflicts and he [sic] may tend to act out a response defensively(p.165).

Defining of Countertransference

Before exploring in more detail the process of empathic failure in therapy, it is important to clarify what is meant by the term “countertransference”. Here, countertransference is taken to be the total emotional reaction of the therapist to the client including the entire range of conscious, preconscious, and unconscious attitudes, beliefs, feelings, and the therapist’s verbal and non-verbal manifestations (Imhoff, 1991). This view of countertransference is classified as a “totalist” view of countertransference as opposed to a “classicist” view. Kernberg (1965) coined the terms “totalist” and “classicist” to differentiate between approaches to countertransference. A classicist point of view
refers to countertransference as restricted to the analyst's unresolved conflicts that are
aroused by the client's transference during therapy and which can hinder and interfere
with the treatment (Mendelsohn, Bucci, & Chouchy, 1992). On the other hand, therapists
from a totalist perspective have a broader definition of countertransference, as including
all the emotional responses that the analyst has during treatment. (Epstein & Feiner, as
cited in Mendelsohn et al., p. 365). Moreover, totalists tend to view the source of
countertransference as originating in the interaction of the client and counsellor and
therefore being comprised of what both of them bring to the session. Finally, according to
this viewpoint, countertransference is considered as the therapists' comprehensive
subjective experience of their relationship with the clients.

Another useful distinction for clinicians between countertransference reactions is
that of objective and subjective or homogenous and idiosyncratic (Giovacchini, 1991)
countertransference. Objective countertransference refers to the therapists' feelings in
response to the clients' emotional communication, uncomplicated by the therapists'
personality. "Objective countertransference reactions are expected [italics added] affective
and cognitive reactions experienced by the therapists in response to the personality,
behavior, and...story of the client" (Wilson & Lindy, 1994, p.15). On the other hand,
subjective countertransference reactions are best understood as a function of the
therapists' unique personal history and unresolved countertransference conflicts.
However, in both cases the counsellors' countertransference needs to be understood
within the context of the clients' interactions with the therapist.

As can be inferred, it is challenging for a clinician to attempt to sort out the relative
contributions of objective and subjective elements in countertransference reactions
(Morrel, 1992). One useful way of conceptualizing this complex situation, as suggested by
Morrel, is to state that all clinicians have delimited areas of vulnerability from their own
developmental histories that manifest themselves as subjective countertransference feelings in the face of a given topic or affect. At the same time, the clients as a result of their psychological make-up induce countertransference feelings in the individuals that they encounter. For example, research addressing therapeutic work with clients having a narcissistic personality disorder make extraordinary demands of their therapists' capacity for understanding, relating, and responding optimally as a result of the clients' sense of entitlement and grandiosity (Ivey, 1995). In this case, counsellors' feelings of hurt, feeling unacknowledged, feeling overlooked, and taken for granted would be considered objective countertransference reactions. These feelings are subjectively experienced by the clinicians depending on their personal past history and vulnerabilities in their personalities.

Having defined in some detail what is meant by countertransference, I now return to the subject of empathic failure or empathic difficulty in a therapeutic encounter. The link between countertransference and empathy has already been discussed, highlighting how the process of identification provokes countertransference responses in therapists especially, if they get stuck at this identification point and are unable to separate themselves from the therapeutic encounter with the clients. A number of authors (amongst whom Burke & Tansey, 1985; Wilson & Lindy, 1994) in the field of empathic failure or empathic disruption present schemas as frameworks to understand these empathic difficulties. Although these models are different in content, one can note that the underlying concepts include the process of trial identification and the need of oscillation from feeling with the client to thinking about the client. This is especially the case when empathic failure comes as a result of subjective countertransference reactions.

Schemas for Understanding Empathic Failures in Therapy

Burke and Tansey (1985) propose a framework that helps pinpoint the varieties of countertransference arrests that can arise in the development of therapists' empathic
understanding of their clients. In their earlier work (Tansey & Burke, 1985), these authors concluded that the mechanism of projective identification is always involved in the process of a therapist achieving empathic contact with a client. According to Tansey and Burke, the "empathic trial identification...is an experiential state which is induced in the therapist through the therapeutic interaction as a consequence of the client's projective identification" (p. 375). Here, the term "projective identification represents an interactional phenomenon in which the projector usually unconsciously attempts to elicit thoughts, feelings, impulses and experiences within another person, which in one way or another resemble his or her own" (p. 374).

Drawing upon and extending the work of several authors (Fliess; Greenson; Malin & Grotstein; Ogden; Olinick, cited in Burke & Tansey, 1985), these authors propose a sequence consisting of three phases: Reception, Internal Processing, and Communication. The first phase (Reception) involves the clinician receiving the client's communication and thus being acted upon and influenced by the client. The second phase (Internal Processing) deals with the therapists' experience and analysis of what has been communicated through the interaction by the client, and the final phase (Communication) entails the therapist giving back to the client what has been internally processed. For the purpose of this research, I focus only on the first two phases of this therapeutic sequence. It is important to note that this sequence involves a continuous dynamic interplay between phases and is here presented in a linear, rigidly defined pattern, only for the sake of clarity. Thus, everything that transpires between client and counsellor builds upon what has come before and similarly, has consequences for what is to follow.

A disruption in the empathic process is defined as a difficulty in any phase or subphase that prevents or impedes further processing by the clinician (Burke & Tansey,
1985). These authors also note that the duration and severity of the impasse depends on the clinician's capacity to tolerate the experience of self associated with the relative strength of the client's projective identification. In other words, therapists' capacity to experience trial identifications corresponds to their tolerance for difficult self-experience and also depends on therapists' degree of conscious awareness of their internal states.

The Reception stage represents the point of contact of empathy towards the client and is the first of the three stages in the empathic processing of the interactional communication. This stage represents the time just prior to and during the session with a particular client. Here there appears to be two categories of disruption in the therapist's achievement of empathic contact. The first set of disruptions may be situational in nature and will inhibit the therapist from fully attending to the client. These intrusions may be due to personal preoccupation, lack of sleep, or over work. Similarly, worrying about previous or upcoming appointments with other clients that may be unusually stressful, constitute disruptions in the empathic process. However, situational disturbances are usually temporary and unless they become a chronic pattern in the interaction with clients, they are not exceedingly disruptive to the empathic process. The other category of disruptions are of a more enduring nature and are described as characterological, resulting from ongoing, unresolved conflicts and concerns with the counsellor's personality. These kinds of disruptions may include "enduring blind spots, extreme sensitivity, or insensitivity to certain issues, prejudicial stereotyping, chronic anxiousness, arrogance..." (p. 381).

Burke and Tansey (1985) point out that these characterological disruptions are not solely intrapsychic events but can be stimulated in reaction to the interactions with the client.

The next subphase within the "Reception stage" involves the clinician sustaining an openness to being emotionally influenced by the client as he or she is expressing his or her story and unconsciously eliciting thoughts, feelings, impulses, and experiences
within the counsellor. At this stage in the empathic process, disruptions can occur if the therapist consciously or unconsciously shuts off the client’s communication in refusing to be emotionally influenced by the client, either by re-directing the client’s conversation through a set of questions, setting limits on a particular form of behavior or denying a client’s perception of behavior, or denying a client’s perception of the therapist, rather than remaining open to the potential impact that a particular client’s interaction might have.

If the empathic sequence has not been disrupted, therapists then open themselves to an identificatory experience with the clients. The clients’ introductory communication exerts a modifying influence on the therapist’s experience of himself or herself in the interaction. Therapists’ affective reaction to the “new” experience of themselves in the client’s interaction serve as “signal affect” (Beres & Arlow; Olinick; Schafer; and Zetzel, cited in Burke & Tansey, 1985). General examples of signal affects would be therapists’ feelings of anger, exhaustion, and powerlessness, in relation to the client. These signal affects lead either to alerting the therapist to the possibility that a projective identification has been made or to a blocking of awareness and cessation of further processing. Therapists unable to tolerate an experience of themselves as being angry towards the clients, as well as exhausted and powerless to help the client, may recommend a termination of treatment or a referral.

Disruptions at this level occur as a consequence of the potency of a client’s communication. Therapists may feel either too uncomfortable or too gratified by the affective experience associated with the projective identification that has taken place. Unconscious defense mechanisms in the therapists may block from consciousness the potential signal value of the emotional impact on the therapist’s self experience. Therapists may find themselves acting “too nice” to compensate for unconscious guilt, or anger toward the client. Or therapists who feel gratified by a client’s idealization may find
themselves taking a stiff and formal approach to block pleasure from awareness. However, unless this critical event of the client's projective identification enters therapists' awareness, they will be unable to understand what is going on between them and the client and may not be able to move forward to the "Internal Processing Stage".

At this second phase, therapists having introjected a projective identification from the client need to tolerate, examine, and use their internal reaction as a tool for understanding the clients' experiences. Thus, therapists need to contain (Bion, 1959) in consciousness, the thoughts, feelings, and impulses having to do with themselves, their clients, and their interaction. Thus, an empathic disruption at this level would again be accompanied by defensive operations within the counsellor blocking from conscious awareness those aspects of their modified self-experiences that they cannot tolerate. Thus, therapists who might be feeling incompetent or hopeless may suppress such feelings. A failure in containment may result in the counsellor simply reacting to the client's experience. For example, a therapist feeling ridiculed by a client may retaliate either through a hostile interpretation, or at the extreme, throw the client out of treatment. When this happens, the clinician is discharging the associated feelings and impulses instilled by the introjected identification and relieving himself or herself from containing the related thoughts and feelings in consciousness.

The second stage of the "Internal Processing" phase involves the process of therapists' separation from their experience in order to begin to observe and understand the underlying sources of their experience in interaction. Burke and Tansey (1985) emphasize three crucial elements in the establishment of this separateness. First, therapists need to suspend potential self-criticism at being seen in an unfavorable light. Second, therapists need to realize that the current self-experience, however uncomfortable, is not an "unmanageable threat to self-esteem especially when viewed in
relation to a predominance of positive self-representations" (p. 387). Third, therapists need to understand that this identification is temporary and not enduring. Therapists, who establish this “psychological distance” (Greenson, 1960), are able to acquire an understanding of what is happening between them and their clients, that helps to reduce the intrapsychic and interactional pressure within the therapist. On the other hand, failure to achieve sufficient separateness results in therapists not being able to “pull back” sufficiently from the clients’ experiences and not being able to observe that what they are experiencing can actually help them understand their clients’ experiences and be deeply empathic with them.

This, in essence is Burke and Tansey’s (1985) schema. The authors present their work in more detail than I have included here but I have limited this review for the purposes of this research. In summary, it seems that a key factor towards a full empathic understanding of what clients are trying to communicate, is the clinicians’ emotional reactions to the clients and the extent to which the therapists are open to experiencing powerful, often uncomfortable feelings, thoughts and impulses.

Another useful framework for understanding disruptions in clinicians’ empathic processes is that by Wilson and Lindy (1994), where they construct a schema for understanding forms of empathic strain in therapy. Wilson and Lindy primarily construct this schema for practitioners working in the field of trauma. However, they also recognize the usefulness and relevance of such a framework to clinical work and research efforts with other client populations (Wilson, Lindy & Raphael, 1994).

Building on the works of Danieli, 1988; Lindy, 1988; Maroda, 1991; Parson, 1988; Scurfield, 1993; Slatker, 1987; and Wilson, 1989; Wilson and Lindy (1994) construct a schema enabling one to distinguish between different forms of empathic failure in terms of countertransference responses. These countertransference reactions (CTR) are
categorized as Type I or Type II reactions. Type I include forms of denial, minimization, distortions, avoidance, detachment, and withdrawal from an empathic stance towards the client. Type II countertransference reactions in contrast involve forms of over-identification, over-idealization, enmeshment, and excessive advocacy for the client, as well as behaviors that elicit guilt reactions.

The authors note that therapists may experience one style more than another. However, it is also possible that they experience any or all modes of empathic strain in therapy. Incidentally it is interesting to mention that the poles of enmeshment versus withdrawal on the continuum of therapists' reactions have also been found in one of the few published empirical studies concerning the manifestation of countertransference. According to Cutler (1958), counsellors may manifest countertransference behavior by (a) over- or under-emphasizing client material that is emotionally-threatening, or (b) by rigidly withdrawing personal involvement in the work.

Type I and Type II countertransference reactions are divided by objective and subjective countertransference processes such that four distinct styles of empathic strain can be identified: (a) empathic withdrawal, (b) empathic repression, (c) empathic enmeshment and, (d) empathic disequilibrium. Figure 1 may help clarify this schema.
Figure 1 Styles of therapists' empathic strain as a function of countertransference reactions, as adapted from Wilson and Lindy, 1994, p.15.

<table>
<thead>
<tr>
<th>OBJECTIVE COUNTERTRANSFERENCE</th>
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<tbody>
<tr>
<td>Empathic Disequilibrium</td>
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<tr>
<td>Empathic Withdrawal</td>
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<tr>
<td>Type II CTR</td>
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<tr>
<td>Overidentification</td>
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<tr>
<td>Type I CTR</td>
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<tr>
<td>Avoidance</td>
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<tr>
<td>Empathic Enmeshment</td>
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<td>Empathic Repression</td>
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SUBJECTIVE COUNTERTRANSFERENCE REACTION

Wilson and Lindy (1994) explain how these countertransference responses can be manifested through a range of physiological, and behavioral symptoms that may be conscious or unconscious. Sleep disturbances, agitation, drowsiness, and recurrent dreams about the client are but a few of the physical and psychological reactions. Excessive irritability, anger, and fear reactions are some emotional reactions indicative of countertransference in the therapists. Denial of feelings and/or denial of the need for supervision/consultation, a narcissistic belief in the role of being a gifted specialist, are examples of behavioral symptoms of countertransference reactions in therapists.
Empathic Withdrawal (Type I CTR): This type or response may occur when therapists are predisposed by defensive style and personality characteristics towards Type I avoidance and detachment. Hearing about client's experiences that commonly evoke horror, dread, fear, and hostility, therapists may unconsciously and in order to avoid pain, distance themselves from these strong emotions through such mechanisms such as denial, disbelief, or isolation. Therapists may deny their response or try to rationalize it on the basis of theory and technique.

Empathic Repression (Type I CTR): Here, the clients' unresolved issues reactivate therapists' unresolved personal concerns in such a way that the clinicians' inward focus on areas of personal conflict may contribute towards their withdrawal from the therapeutic role and also possibly, denying the full significance of the clients' issues.

Empathic Enmeshment (Type II CTR): This third mode of strain is the result of the individual therapist's tendency toward Type II countertransference reactions together with subjective reactions from personal unresolved conflicts. Clinicians here leave their therapeutic role by becoming over-involved or over-identified with the client. As clients repeat their fears in current-day circumstances, they evoke feelings of fright, overprotectiveness, guilt and excessive responsibility in therapists. The therapists make efforts to rescue the client that generally contributes to a loss of boundaries, over-involvement, and reciprocal depending.

Empathic Disequilibrium: This mode is characterized by a therapist's tendency towards Type II CTR coupled with the experience of objective countertransference reactions. Therapists in this mode commonly experience feeling overwhelmed, tense, vulnerable, and uncertain of their ability to adequately treat a particular client even though they might have worked successfully in the past with similar client's concerns. There is only fatigue and despair and over time, this may lead to therapist's burnout and subclinical
depression. According to Wilson and Lindy (1994), empathic disequilibrium is less likely to be a stable state but more often will move toward empathic withdrawal or enmeshment.

It is clear from this review that Wilson and Lindy's (1990) two-dimensional model of a topology of countertransference reaction is valuable for helping therapists to inquire and address their countertransference reactions to the clients. However, the authors also recognize its limitations. Not all countertransference reactions fit neatly into the schema and the static mode of the schema fails to represent the more likely dynamic interplay between the different countertransference reactions. Furthermore, the range of emotional reactions that are part of the countertransference reactions span the continuum of human emotion and varies from one therapist to another depending on the clients' attributes, the therapists' background, and the nature of their experiences. Adequate education and training, years of counselling experiences, supervision, peer support, and particular therapists' personality traits such as resilience, flexibility, and sensitivity are all factors that seem to effect whether or not therapists are able to maintain a empathic stance with challenging clients (Wilson et al., 1994).

Recognizing and Sorting Out One's Countertransference

Countertransference reactions are as varied as individual personalities, and their recognition and sorting out is a challenging task to clinicians especially because of the "intensity of the feelings or the discomfort they engender, [that] has to do with the analyst's own history" (Ernsberger, 1990, p. 16). Similarly, problems arise when clients' material reactivates specific vulnerabilities in therapists that they are aware of but have yet to fully master (Morrel, 1992). Morrel also discusses therapists' tendency to parenthesize countertransference reactions as factors to be resolved in supervision or during one's own therapy. Morrel emphasizes that in real-life clinical situations,
countertransference reactions cannot be easily separated out and handled accordingly. Experience suggests that things are rarely that simple.

To complicate matters further, there are often many variations of subjective countertransference reactions and therapists often need to distinguish among them as falling on a continuum ranging from “general” to “specific” reactions. At the “general” end of the subjective countertransference spectrum are those therapists’ tendencies to respond affectively to a client, irrespective of who that client is or what kind of material he or she brings to the counselling sessions. Examples here would include a therapist’s need to be liked (and hence the avoidance of negative feelings or anger of the clients), or a subtly communicated discomfort with certain subject areas (e.g., sex, aggression) such that they are consistently avoided in all the counsellor’s sessions. At the “specific” pole of the subjective countertransference reactions are those therapists’ feelings in response to some aspect of the clients’ transference, related to the therapists’ areas of vulnerability from their own developmental history. One way of conceptualizing this complex situation is to say that all therapists have their specific areas of vulnerabilities that may manifest themselves as “general” tendencies towards subjective countertransference feelings in relation to a given subject area, affect, or transference phenomenon. At the same time, with certain clients and particularly with certain phases of therapy (for example, termination phase), specific forms of countertransference feelings may re-emerge in the sessions.

Despite the complexity of countertransference reactions, it is possible for counsellors to tune into their behaviors when they suspect that they are experiencing countertransference (Kaufman, 1992). Some behaviors are overt, others are more subtle and therapists could easily deny such signs, perhaps attributing them to busy schedules or to being tired, if they are not alert to countertransference reactions. Overt behaviors
include coming late for sessions, forgetting sessions, wishing that clients cancel, falling asleep during sessions or not returning phone calls (Schoenewolf, 1993).

Countertransference signals could also be manifested as behaviors of over-involvement with clients such as touching, hugging, kissing, sitting very closely, or even prolonged hand shakes (Kaufman, 1992). Kaufman also summarizes somewhat less overt manifestations of countertransference such as rapid shifts in the therapist's behavior, particularly in areas such as being more solicitous or hostile, being self-serving, and making more interpretations that are premature and insecure. Also, covert signs include preoccupation in thought, dream and/or fantasy, and feelings of being stuck. Therapists can tune into their countertransference reactions by being aware of dreams, or preoccupation about a client or a group of clients. Kaufman also suggests being aware of non-verbal behaviors such as not giving eye-contact, shifts to silence, feelings of restlessness, fidgeting, consumption of liquids, glancing at one's own watch, and intensely wishing to have sessions end.

The challenge of recognizing and sorting out countertransference reactions is not only because of the complexity and powerfulness of such affects but also because such reactions are often surrounded by professional shame. It is often the case that therapists feel very disappointed and ashamed of their own personality difficulties encountered in working with clients, once they become professionally established (Franklin 1994). It is as if there is the expectation that education and training "protect" therapists from feeling like the client. In Morrel's (1992) experience as a clinician, as well as those of his colleagues and supervisees, therapists as a rule do acknowledge their own conflicts and limitations but also have a "strong need to believe that these personal issues do not negatively impact our functioning at work" (p. 96). For some therapists, professional competence may symbolize mastering of past trauma, childhood trauma, or working out pain of past
relationships. Thus, when therapists become aware of some recurrent subjective countertransference element in their work, they may be threatened, to some degree, at the core of their professional and personal identity. A typical response is to "feel exposed, often in a shameful or humiliating way" (Morrel, 1992, p. 97). All this has important implications for this research especially for the methodology used to elicit counsellors' experiences of encountering empathic difficulties and experiencing a gamut of countertransference reactions. These implications will be discussed in detail in the next chapter of this project.

Conclusion

It is safe to assume that because psychotherapy is a process of mutual influences in which both participants have an impact on another, and because all therapists have their own vulnerabilities and areas of unresolved issues, countertransference reactions and experiences of empathic difficulties are inevitable in therapy. Therapists face a formidable task with empathic understanding that requires a simultaneous identification and distance from the client in order to provide corrective emotional experience. The range of emotional reactions that are part of countertransference span the continuum of human emotions and varies from one therapist to another. Yet the importance of recognizing and managing countertransference and accepting the fact that we as therapists are unable to feel empathy with all clients' reactions, at all times, is critical to the maintenance of sustained empathic inquiry. "Failure to express or analyze countertransference particularly at critical moments can result in long impasse, untimely termination and treatment that run their course dominated by countertransference" (Maroda, 1991, p. 156). Engaging in the practice of psychotherapy demands that therapists be able to experience an ongoing inner dialogue of what is, at times, painful self scrutiny: "Why am I saying (doing) this right now with this client? How much of my
behavior is a result of my past history? To what extent is the client's affect triggering my reaction?"

Ultimately, the identification and successful management of empathic difficulties will allow therapists to appropriately examine and interpret their own reactive styles and to use them as insights to engage in a therapeutic role with clients. This human process is difficult and requires that counsellors be open to their own feelings and experiences and that they rely on supervision and on peer consultation. In a sense, this process requires of therapists an honest self-scrutiny that parallels clients' struggles with their difficulties.
CHAPTER THREE

Methodology

The research question guiding this study is "What is the lived experience of counsellors, when they encounter empathic difficulties with their clients?" In order to answer this question, a phenomenological approach was utilized as methodology to capture the essence of the counsellors' experiences and to come to a deeper understanding of the meaning of these experiences.

As stated in Chapter 2, there is a dearth of research literature on the phenomenon of empathic difficulties, in the context of a therapeutic encounter. Much of what has been written attempts to explain the phenomenon through theoretical concepts. Thus, this research is innovative in that it asks the practitioners themselves to describe what the experience is like for them. This is an important contribution in the exploration and understanding of the phenomenon of empathic difficulties.

Phenomenology as Methodology

Phenomenology as a human science research approach is a vast subject and it is difficult to give an all-encompassing definition. Van Manen (1994) states that it is "a science of phenomena" (p. 183). A narrower definition of phenomenology is that of a "descriptive method as well as a human science movement based on modes of reflection at the heart of philosophical and human science thought" (Van Manen, 1994, p.184). This chapter focuses on phenomenology as research methodology. However, since phenomenology is rooted in philosophy, it is important to refer back to its philosophical foundations to articulate the epistemological and ontological beliefs that characterize this perspective. In other words, what assumptions about the nature of reality and processes of human understanding shape the paths of the researcher embarking upon the phenomenological research? The following is not an exhaustive discussion on
philosophical concepts but the section expands on essential philosophical principles relevant to the researcher using a phenomenological approach.

Edmund Husserl is generally reputed to be the founding father of phenomenology. However since the time of its inception, phenomenology has undergone a number of transformations especially with the emergence of Existential philosophy and its emphasis on human existence. Initially, Husserl developed phenomenological psychology as a means of finding a basis for the principles of mathematics and logic. Through the method of reflection, he sought to "uncover the necessary universal structures which lie behind particular logical and mathematical acts" (Klein & Westcott, 1994, p.134).

What were the general characteristics of Husserl's thinking with regards to the process of reflection? According to Husserl, cited in Valle and King (1978), phenomenology is a method that allows us to contact phenomena as we live them out and experience them. However, Husserl believed that the researcher or philosopher approaches the notion of experience from a position characterized by a "natural attitude." This refers to a natural science methodology approach concerned with identifying causal relationships between objects. According to Husserl, in order to step outside this "natural attitude" and attempt the description of the psychological act, one must engage in the "epoche" or "phenomenological reduction". In the "epoche" stage, the researcher refrains from assuming the existence of the object or the act under consideration, puts aside the questions about the existence and character of the objects and attends instead to what is present or given in awareness (Klein & Westcott, 1994).

In order to attempt to suspend or "bracket" one's presuppositions and preconceptions, one must first make them explicit--so that these assumptions appear as clear as possible to oneself. For this reason in Chapter 1 and 2, I have made explicit the theoretical biases, assumptions and values with which I approached this research study.
According to Valle and King (1978), the process of bracketing and explicating one's assumptions is a dynamic one and as one brackets one's preconceptions and presuppositions more of these assumptions emerge at the level of reflective awareness. These newly discovered assumptions are then also bracketed. This process of bracketing and re-bracketing is the manner in which the researcher engages in the "eidetic reduction," that is literally reducing the world as it is considered in the "natural attitude" to a world of "pure" phenomena. Now, the purpose of the eidetic reduction is to gain insight into the "essence," that is, the necessary general structure of the object or event under consideration. "Every object including that which is fictitious or ideal has as essence" (Husserl cited in Klein & Westcott, 1994, p.135).

In summary, phenomenological psychology as seen by Edmund Husserl, focuses on conscious (or lived) experiences and on distinguishing those aspects of an experience that are invariant and essential, making the experience show up as the kind it is—that is, the typical way in which a phenomenon presents itself in experience.

Another significant contribution by Husserl to the understanding of consciousness is the notion of "intentionality." This refers to the fact that when speaking of consciousness, one is either implicitly or explicitly referring to its intended object. Even when we think that we are not conscious of anything, we are in fact, conscious of not being conscious of anything. Osborne (1990) sees this concept synonymous to another concept—that of "co-constitutionality," which means that people are not viewed as just objects in nature but that there is an interrelationship between the individual and his or her world. Each individual and his or her world are said to co-constitute one another. Moreover, each individual's existence gives his or her world meaning. Without a person to reveal its sense and meaning, the world would not exist as it does. Each is therefore dependent on the other.
The implications that this has for research follow easily. According to these concepts, reality is both construed by the researcher and the participant. There is no subject-object dualism, or cause and effect relationship. Person and world constitute one unity. Furthermore, this highlights the importance of context and environment. We cannot consider the environment independent of the ways in which people construct their experiences (Osborne, 1990), nor can we consider peoples’ experiences of their environments without considering the ways in which those environments have influenced peoples’ experiences of them. This concept also links to another--the concept of “dialogue,” that is, that people and the world are always in a dialogue with each other. People can be seen as partly acting on the world in a purposeful way but the world also presents situations in which the person must act.

The focus of phenomenology on human existence came about with the emergence and influence of the philosophy of Existentialism, particularly through the work of Martin Heidegger (Klein & Westcott, 1994). For Husserl, the fundamental subject matter of phenomenology was rationality in the form of mathematics and logic, while for Heidegger, the focus was human existence. Joined together, existential-phenomenology can be viewed as that “philosophical discipline which seeks to understand the events of human existence in a way which is free of the pre-suppositions of our cultural heritage especially philosophical dualism” (Valle & King, 1979, p. 7). When one applies this specifically to human psychological phenomena, Existential-phenomenological psychology can then be defined as that “psychological discipline which seeks to explicate the essence, structure or form of both experience and human behaviour as revealed through essentially descriptive technique including disciplined reflection” (Valle & King, 1978, p.7).

As a result of such a philosophical background, one can understand the methodological concepts that characterize existential-phenomenological research. This
section is indebted to readings by Giorgi, Fischer, and Murray (1975) as well as to the article by Klein and Westcott (1994). The latter authors reviewed articles from 1970 to 1990 in phenomenological research and outlined and compared early phenomenological psychology with the contemporary discipline.

Klein and Westcott (1994) point out that contemporary phenomenological psychology still holds experience as central. Lived phenomena are emphasized precisely as they are lived prior to explanation and theoretical interpretation of any kind. Participants in research are encouraged to describe their experiences and not provide explanations of why some event occurred. A focus on the phenomenon as it is lived implies the awareness of the complexities involved with everyday lived experiences and the recognition that, as a researcher one can never capture the totality of the phenomenon. However, those aspects of the phenomenon that are researched need to be understood within the lived context of the participants and within the context of the researcher. Here one can see the notion of co-constitutionality of researcher and participant and their interdependence on each other.

From the researcher's perspective, a researcher is engaged and plays an active role in the constitution of the actual data of the research. According to Husserlian thought, phenomenology's aim is "presuppositionless" description but since this is not possible in an absolute sense, one needs to admit as explicitly as possible the presuppositions that do exist. In the research process, the initial description given by the participant in an open-ended situation is transformed by the researcher in dialogue with the participant according to the aims of the research. This process points to how hermeneutic elements, in the form of interpretation come into play in phenomenological descriptions.

Kvale (1989) offers a useful discussion of the use of hermeneutics in contemporary phenomenological psychology. Hermeneutics is here defined as the "study
of the interpretation of texts" (p.185). The author makes a distinction between these two disciplines, and points to the fact that hermeneutics and phenomenology come from different philosophical traditions. Kvale (1989) also indicates the similarities in these perspectives, particularly in the way they emphasize the implicit understanding of meaning. On the other hand, authors like Van Manen (1994) use the term "description" to include both the interpretative (hermeneutic) element as well as the descriptive (phenomenological) element. Etymologically, "interpretation" means "explaining in the sense of mediating between two parties" (Klein, cited in Van Manen, 1994, p. 26). In the dyad between the researcher and participant, the presence of interpretation is multi-layered—the participants interpret experience and then attempt to express that experience using oral or written forms. The researcher on his or her part attempts to interpret these expressions in terms of meaning structures (Osborne, 1994).

This turn towards hermeneutics is also consonant with the change of location of experience (Klein & Westcott, 1994). The Husserlian perspective mainly considered reflection and description from the perspective of the researcher's private world and expressed by himself or herself. The use of participants and the focus on the meanings of their words as used in contemporary phenomenological research, however, raises the problem of interpreting another person's experience. Usually, the research participants are not trained to carry out the process of phenomenological reduction themselves. Hence, the researcher often has a dominant role in the interpretation of the participants' meaning of their experience.

According to Klein and Westcott (1994), this hermeneutic movement provoked the continuing debate over final authority in determining the participants' experience, over how differences between the interpretations by participants and researchers are to be resolved. This highlights the importance of the need for the researcher to go back and
forth between what is described and what is interpreted in the context of dialogue between the researcher and participants.

In discussing interpretation in contemporary phenomenological research, Osborne (1990) makes an important point: he makes explicit a distinction between Husserlian phenomenology and hermeneutic-existential phenomenology. In contemporary phenomenological research, a compromise seems to have been made between these two approaches in the use of "bracketing" to identify some, if not all of the researcher's presuppositions. Osborne (1990), however, points out that Heidegger believed that "pure" phenomenal description as that propounded by Husserlian phenomenology is limited in its ability to reveal meaning and hence formulated the hermeneutic method in order to interpret meanings that lie beyond descriptive phenomenology. Despite the parallelism and influences of Husserlian phenomenology, the approach in this research project is mainly from a Heideggerian's perspective encompassing an existential-phenomenological perspective that also acknowledges elements of hermeneutics.

From Methodology to Procedures and Method

In the previous section, I present some of the philosophical foundations of phenomenological research and touch upon some of the controversy that surrounds this research methodology. Thus, the term "methodology" refers to the philosophical framework and the fundamental assumption and characteristics of a human science perspective (Van Manen, 1994). I now proceed to outline the practical procedures employed in this research project to answer this project's research question.

What were the steps taken to negotiate entry to the research site? Through personal contacts, I determined that the Alcohol and Drug Agency where I was planning to do my internship training were interested in the research topic that I was investigating. (I do not specify the full name of the site to preserve the anonymity of the research
participants). The Clinic Director was approached through a letter of introduction (Appendix A). I proceeded to give him a detailed account of my research proposal. I was invited to make my first contact with the prospective participants through attending one of the administrative meetings. I introduced myself and the research project to the staff, with the purpose of recruiting participants for the research.

**Selection of participants.** Qualitative inquiry typically focuses on relatively small samples selected purposefully to generate richly varied descriptions of the phenomenon studied (Patton, 1990). The requirement of selection was that a participant had had the experience investigated by this research question and had the capacity to provide a full and sensitive description of the experience under examination (Polkinghorne, 1989).

During my first meeting with the prospective participants, I introduced the research and spoke about the kind of experiences that were going to be explored in this study. I explained that I was interested in incidents during counselling sessions where the counsellors felt unable to empathize with their clients. This could have been a situation where they felt intensely involved with a client or a situation where they felt themselves withdrawing and "shutting off" the client. Thus, the counsellors who identified with this description of the investigated experience were invited to participate. Incidentally, through word of mouth, a colleague and friend also heard about the research topic that I was investigating and volunteered to participate in this research. She is a counsellor within one of the Greater Vancouver Mental Health clinics and as she reported that she had had experiences where she was unable to empathize with her clients, and was willing to describe them, I accepted her as one of the participants.

In total, 5 participants volunteered to participate in this research. Before proceeding with the description of the sample of participants, it is important to comment on the size of the sample within the context of this qualitative research inquiry. According
to Patton (1994), there are no rules for sample size in qualitative research. He states that in-depth information from a small number of people can be very valuable, especially if the cases are information-rich. Less depth from a larger number of people can be especially valuable in exploring the phenomenon and trying to document diversity or understand diversity. In this study, the purpose was to explore in-depth, the experience of empathic difficulty in counsellors and to try to capture the complexity of this lived experience. Hence, in this case, the size of the sample was appropriate to the purpose of this study and proved adequate in providing enough data to draw common themes from the participants' stories and to learn about the phenomenon investigated.

There are no male counsellors at the Alcohol and Drug Agency and so all the participants were all female counsellors, with ages ranging between 32 and 50 years old. They all have a Masters level of training and 4 of the 5 participants have had their graduate training from the Counselling Psychology Department at the University of British Columbia. The other participant graduated from the University of Victoria, British Columbia. As volunteers in this research project, the participants were also invited to complete a “Background information sheet” (Appendix B) which amongst others, helped me determine the theoretical perspectives of the participants and their years of experience within the counselling field. The counsellors are eclectic in their practice of counselling. For most of the participants, the underlying therapeutic framework is client-centered and humanistic in origin. However, many also draw upon cognitive therapy, experiential systems theory, rational-emotive therapy, and solution-focused approaches. Besides their graduate training, many have participated in a number of training workshops involving solution-focused approaches, treatment of survivors of sexual abuse, addiction counselling, and family counselling. The average number of years of experience for the
participants is 8 years in the field. The minimum years spent in counselling is 5 years of experience and the maximum is 11 years of experience.

Data Collection Procedures

In a phenomenological study, there is no such thing as the phenomenological method (Osborne, 1990) for data collection. The particular procedure used in any study depends upon the research question being posed. In this study, the participants were the sources of the data, through their sharing of their experiences and thus, the interview was used as a means of gathering this data. However, a workshop preceded the process of in-depth interviews with the participants. What follows is the rationale for this decision.

In qualitative inquiry, unless rapport and trust are established, the researcher is unlikely to get authentic descriptions of the participants' experiences (Osborne, 1990). By establishing trust and rapport at the beginning of the study, the researcher is better able to capture the nuance and meaning of each participant's life from the participants' point of view, and ensures that "participants will be more willing to share everything, warts and all, with the researcher" (Janesick, 1994, p. 211). In the case of this study, the research literature indicated that therapists often feel very disappointed and ashamed of their own personal difficulties encountered in working with clients, once they become professionally established and hence, in this study it was not only critical to establish trust and rapport with the participants but it was also essential to find the means to help the participants overcome this (expected) sense of professional shame.

For this reason, it was determined that a workshop in the form of a sharing-group setting would precede the interviews. This workshop was facilitated by myself and one of the members of the thesis committee, my supervisor, who is an experienced clinician with 30 years of experience. The workshop was led during a 3-hour segment and was facilitated at the Alcohol and Drug Agency. The format of the workshop consisted of an
informal introduction by the facilitator followed by an exercise in which the participants completed a work-sheet dealing with a list of client characteristics that often are mentioned as problematic by therapists (Appendix C). The aim of the work-sheet was to help participants reflect on the types of clients that they have difficulty with. This activity was then followed by sharing and self-disclosure of participants on what they had written in their work-sheet.

The main facilitator also shared some of her personal encounters with empathic difficulties with clients, thereby contributing to the building of trust in the group as well as giving the message that having empathic difficulties with clients is a "normal" and an expected occurrence in the field of counselling. Thus, her self-disclosure and the participants' self-disclosure about the clients that they find difficulty with, helped to "normalize" the participants' experiences and to create a sense of "universality" (Yalom, 1985) amongst the participants. Universality refers to a perception that the feelings and ideas that one believes are entirely one's own, occur also in other people, that other people share the same problems and participate in the same fears. Later on, during the interviewing process, all the participants remarked that hearing about the other counsellors' difficulties helped them realize that it was acceptable to have difficulties with clients and that having these difficulties were not signs of their own professional incompetence. This enabled them to feel less ashamed of their experience and I think, more willing to be honest and open in their sharing of their stories. Thus, the use of the workshop was successful in reaching its intended purpose.

A week after the workshop, the 5 participants were invited individually to meet the researcher for three one-hour, in-depth interviews so as to share their individual experiences involving an incident where they felt unable to empathize with a client. To encourage the participants to reflect on their own individual experiences they were given a
“Pre-Interview” sheet in preparation for our first interview (Appendix D). The interviews were held in a semi-structured format. Please refer to the interview guide in Appendix E. This guide provided the researcher with the list of questions or issues that were explored during the interviews. At the same time, because the interviews were semi-structured, the researcher remained free to follow and participate in the participants’ conversations, to word questions spontaneously, and to pursue in-depth a particular topic or subject area raised by the participants. At the same time, the conversations were “disciplined” by the use of the interview guide that ensured that the same information was covered with the different participants.

Kahn and Cannell (1957) describe in-depth interviewing as a “conversation with a purpose” (p.149). The purpose here was to access the perspectives of the participants, and to understand the meaning they made of their experiences. As phenomenological studies ask meaning questions (Van Manen, 1994) and the process of meaning-making requires that individuals look at how factors in their lives have interacted to bring them to their present situation (Seidman, 1991), it was decided that three interviews will be held with each participant. The first interview focused on the description of the counsellor’s experience with her client. The second interview focused on the context of the experience, in terms of the counsellor’s personal and professional life. In the third interview participants were asked to reflect on the meaning of their experience, that is, address the intellectual and emotional connections between the experience and their life, in general. Although the third interview focused on the meaning of the counsellors’ experience, all the three interviews, in different ways, focused on the participants’ meaning. As Seidman (1991) points out, when we ask participants to reconstruct details of their experience, they are selecting events from their past and in so doing, they impart meaning to them. In
addition, the very process of putting experience into language is a meaning-making process (Vygotsky, cited in Seidman, 1991).

The interviews were each one hour long and were held in the counsellors’ office at the Drug and Alcohol agency for 4 of the participants who were recruited from the same agency. The Mental Health counsellor was interviewed in one of the rooms at her house. In all of the cases, the rooms afforded a sense of privacy and were comfortable to both the participants and the researcher. The three interviews with each participant took place once a week, in a period of 3 weeks. In between one interview and the other, the participants were given a copy of the transcribed interview and were asked to reflect further on their experience, in order to aim for as much interpretive insight as possible and to determine the deeper meaning of the experience. Thus, the transcribed interviews served as a starting point for further sharing about the lived experience of counsellors, when they encountered empathic difficulties with their clients. Furthermore, before ending each interview session, the participants were given the opportunity to ask questions or to add any information that they judged important.

During the third interview, preliminary themes across all the participants' narratives were identified by the researcher and both the participants and the researcher discussed the significance of these preliminary themes in the light of the research question and weighed the appropriateness of the themes by asking: "Is this what the experience was really like?" Thus, the interviews were "interpretive conversations" (Van Manen, 1994), wherein the participants were co-investigators of the phenomenon of interest and reflected with the researcher upon the significance of their experience. By the end of the third interview, the participants felt that they had no new material to self-disclose about their experience. Thus, three interviews proved to be sufficient time for the
participants to reflect on their experience and an adequate amount of time to capture their experience.

In addition to gathering data from the interviews, detailed field notes were recorded immediately after the interviews, in order to note down observations about the participants' reactions to the interviews, observations about the researcher's own role in the interviews, and any additional information that helped establish a context for interpreting and making sense of the interviews.

Each participant had her own unique reaction to the interviews. One counsellor was very enthusiastic to participate and did not feel inhibited by the recording equipment. Another was very concerned about the length of time of the interview and wondered if she had enough material to keep talking for an hour. However, at the end of the interview, she was amazed that she talked for almost over an hour. In general, during the first interview, the participants were "testing the waters" and checking whether it was going to be safe for them to self-disclose their experiences. At the same time, I was surprised by the depth and intensity of their self-disclosures, even during our first encounter. Initially, whilst I was gathering data during the first interviews with the participants, I found myself becoming distracted with thoughts around the content of the stories that I was listening to, wondering whether what I was listening to matched or was different to what I had already heard from the previous participants. However, I made an effort to focus on the participants' individual stories and to remain open to their disclosures.

Furthermore, I observed that the participants cried during one or two of the three interviews. In-depth interviews have the potential to affect people as they lay open thoughts, feelings, knowledge, and experience. Thus, although the participants had been informed prior to the interviews that the interviews might be emotionally uncomfortable, I was concerned for them and made sure that there was adequate closure at the end of
each interview. One participant reported feeling tired and exhausted after the first interview but was willing to proceed with the rest of the interviews in the coming weeks.

**Ethical Considerations**

The participants had been informed of the potential for discomfort in their consent forms (see Appendix F). Moreover, the form stated that participation was voluntary and that the participants had a right to withdraw from the study at any time. None of the participants withdrew from the study.

Another ethical consideration concerned the distinction between doing a research interview and conducting therapy, especially in this case, where the interviewer is also trained to counsel clients. In fact, I often had to struggle between the role of researcher and counsellor. I needed to remind myself that the meetings with the participants had a clear agenda—that of a research interview and I felt that I did not have the right to probe excessively in the participants' lives. At the same time, I had to have enough flexibility to probe deep enough to explore fully the participants' experience. It helped to keep the following points (Seidman, 1991) in mind: (a) that the goals in therapy and in the research interviews are different. The researcher is there to learn, not to treat the participants; (b) the participants did not seek the researcher and are not clients; and (c) the researcher will see the participants three or four times (including the workshop) after which their connection will substantially end. I was honest and open about my struggle with the different roles that I played and the participants appreciated this disclosure and felt that I was respecting them.

**Data Analysis**

Data-collecting, analysis of the data, and writing cannot be separated from each other, although these are being discussed under separate headings here. In fact, data analysis occurred concurrently with the data collection and the process of writing. Marshall
and Rossman (1995) describe data analysis as a process that entails data reduction as the collected data are brought into manageable chunks and interpretation as the researcher brings meaning to the words of the participants. Within a phenomenological inquiry, data analysis has the purpose to derive a description of the essential features of the experience from the collection of participants' protocols (Polkinghorne, 1989). In this study, the essential structures of the participants' experience were derived through the process of "thematic analysis," that is, through identifying the themes that are embodied in the participants' interviews.

The following procedural steps were used as guidelines to initiate the process of thematic analysis (Giorgi, 1975, pp. 87-95):

1. The researcher reads the entire participants' descriptions in order to get a general sense of the whole.

2. Once the sense of the whole has been grasped, the researcher goes back to the entire text and reads through it with the aim of delineating meaning units, that is, each time a transition in meaning is perceived in terms of the participants' change in psychological meaning of their experience. Thus, a series of meaning units are obtained through this process.

3. In the third step, after having delineated the meaning units, the researcher tries to express in an explicit way, the implicit psychological aspects of the meaning units and then writes out a sentence in his or her own words that expresses this discovery. These meaning units are examined for what they reveal about the phenomenon in question, given the individual's context.

4. Once meaning units have been transformed into psychological language, the researcher works to synthesize a descriptive statement of the essential, nonredundant psychological meanings.
Giorgi's (1975) phenomenological research method was used as a framework for thematic analysis. However, these guidelines were supplemented by more practical steps, as provided by Seidman (1991). Once the interviews were transcribed verbatim, I read the transcripts several times and highlighted the meaning units in each of the three transcripts of the participants. Seidman gives the following advice for delineating meaning units: “Mark what is of interest to you as you read. Do not ponder about the passage. If it catches your attention, mark it. Trust yourself as a reader” (p.90). Keeping the research question in mind, I marked those passages that described the counsellors’ experience and the meaning they ascribed to the experience. Once the passages of interest were marked, I proceeded to develop the profiles of the individual experiences.

This was done by cutting all the highlighted meaning units from the three transcripts and pasting them into a single transcript, leaving the excerpts in the voice of the participants. I used the facility of a word-processor to carry out this procedure that saved considerable time. From these profiles of the participants, emerged the narratives of the participants’ experiences. I decided to represent the participants’ experiences in a narrative form using the voice of the participants, and to write it in such a way that conveys the realism and intensity of their experiences. I also wanted to remain as faithful as possible to the participants’ perspective of their experience.

In the process of making thematic connections, I went back to the cut-and-pasted profiles of each participant’s experiences. These were read again for several times and besides each highlighted passage, I marked down preliminary categories or themes, aided by the following questions: “What is the subject of the passages marked? Are there words or a phrase that seems to describe the meaning units, at least tentatively? Is there a word within the passage itself that suggests a category into which the passage might fit?” (Seidman, 1991, p.99). Once the preliminary themes were validated by the
participants, I proceeded to cut again those marked passages according to the themes they represented, across the participants’ profiles and paste them under the appropriate theme headings. This procedure greatly facilitated the presentation and description of the thematic analysis. Finally, a colleague also acted as a peer-reviewer and after reading the data (before reading my thematic analysis), she proceeded to identify the themes from the participants’ narratives. Her themes were very similar to the ones that emerged in this study. The input of the peer-reviewer helped reduce the influence of subjective bias in the interpretation of the findings, giving this study more credibility and trustworthiness.

In Summary

A phenomenological approach was utilized to capture the experience of counsellors when they encountered empathic difficulties with their clients. Five female counsellors (four from an Alcohol and Drug Agency and one from a Mental Health Agency) volunteered to participate in a 3-hour workshop, followed by three in-depth interviews. The aim of the workshop was to help establish trust and rapport with the researcher and to lessen the (expected) professional shame associated with having therapeutic difficulties with clients.

The data gathered from the interviews and the field observations was represented in a narrative form, in the first person, as if the participants themselves were telling their stories. The process of thematic analysis yielded four major themes. The themes and narratives were validated by the participants and a peer reviewer.
CHAPTER FOUR

Presentation of the Findings

This chapter presents the participants’ accounts of their experience of empathic difficulty with their clients. As explained in chapter 3, I have chosen to represent the participants’ experiences in the form of narrative summaries using the first person, as if the participants themselves are telling their own stories. Following the participants’ narratives, I present a description of common themes that emerged across all the participants’ stories. The use of the participants’ pseudonyms in the narratives and in the thematic analysis as well as the use of excerpts from the narratives will facilitate the transition from the first part of this chapter to the second part.

Phenomenological writings often include biographical information about the participants. As some of this information could easily lead to the identification of these counsellors, the biographical note is excluded here. The participants’ pseudonyms are Belinda, Adrienne, Carol, Joanne and Sarah.

Before proceeding to the participants’ narratives, it is important to give some brief, general information about these counsellors’ work context, that had a bearing on the kind of experience that these participants had with their clients, especially in the case of the 4 counsellors who had volunteered from the Alcohol and Drug Agency. At the time of the interviews, the Alcohol and Drug counsellors were undergoing a number of transitions in their clinic. Their clinical Director was preparing for his retirement and for his departure from the clinic. Moreover, the clinical staff had also been informed that due to new Ministerial policies, the Alcohol and Drug counselling system was no longer going to be a specialty on its own but the service was going to be integrated into a multi-disciplinary service system within a new ministry, the Ministry for Children and Families. This change implied that the clinic team of counsellors were going to be re-located to new clinics and
also separated into two groups. Thus, the counsellors had to deal with a number of losses, not only in terms of the loss of their director and colleagues but also the loss of a known system of service, the Alcohol and Drug system. Within the new system, the counsellors did not know what type of client population they would be mandated to counsel and did not know whether they would still be able to provide Alcohol and Drug counselling, despite the fact that they had been trained as addiction counsellors.

These unknown factors in the counsellors' work situations created considerable anxiety in the practitioners, and I believe that this anxiety was an underlying factor in all the interviews with the Alcohol and Drug participants. Thus, it is important to keep this wider context in mind, when considering the participants' narratives and their experiences with their clients.

The Participants' Narratives

"Encountering a Profound Loss" – Belinda's Experience

Together with this client, I feel that we have been through a horrendous journey. It has been really difficult and emotional and we stumbled a lot together. I guess that it is important to mention that I had not chosen this client. I did not want to face a young woman, 33 years old who came to the clinic because she had lost her baby girl shortly after birth, due to complications of the delivery. This woman had been trying to get pregnant for a long time with her husband and had suffered a miscarriage a year before that. She described herself as very depressed, unable to function, and crying all the time. None of the counsellors wanted to take up this client, perhaps because we all knew that it was going to be a very difficult case.

I arrived for my day at the clinic, not knowing that I had been assigned this case. I found out that she would be coming and that I would be seeing her when I was at the clinic. I was not very happy about it and started to dread the interview with her.
Right away during the first interview she started sobbing and for the entire hour she cried the whole time and told me the story of what had happened. All the details and the story itself were pretty horrific. She told me that the baby got stuck and because of that was injured so badly that she died. Not only that--the client’s body was physically torn apart and she is still suffering the effects of that. The actual experience was horrific. She told me that she (the client) had to wear diapers because of what happened to her body and that she was wearing the diapers that her baby should have been wearing. Another detail that was particularly horrifying to me was that since the client and her husband knew that their baby daughter was going to die soon after the delivery, her husband took pictures of the baby but the film did not turn out!

As the client was telling me her story, I was aware of feeling a bit overwhelmed but I think that I distanced myself from my own process of what was happening to me, to be with her. I do not think that it was a conscious decision from my part--it probably was my way of doing my job. If I had not done that at that point, I do not think that I would have been able to be empathic with her. I would have been consumed by her emotions and would have started crying along with her. It was like an unconscious way of preventing that from happening. I was able to do my job. I was in survival mode. I knew that what she was telling me was horrifying me but I did not know how upsetting it was, how much I was taking it on. I did not know that until she actually left.

As soon as she left the room, I just started shaking, my whole body was shaking and I started crying. I tried talking to myself saying “Calm down…it’s ok,” but I could not stop myself from crying. One of my supervisors came in and saw that I was really upset and I remember just wanting to be alone. I felt too exposed so I told him that I just wanted some time by myself. So I sat in that room and cried and shook, for probably 20 minutes.
My reaction was scaring me because I did not know what was happening to me. It was just happening and I could not stop it. I was saying to myself, "This should not be happening." I did not want the rest of the clinic team to know that this was happening to me. I was thinking, "Well, therapists are supposed to be able to hear this stuff and not start shaking and crying." I felt that I was over-reacting and that somehow I had done something wrong. I think that it shocked me because I had heard lots of terrible things, I had heard abuse stories and I had never had a reaction like this. It was really scaring me. When I finally went out of the room and met the other counsellors, I stared crying again and I did not want to do that. They wanted to support me but funnily enough I did not feel that I wanted it. It did not feel particularly safe crying and so I talked a little bit about what had happened and about what I had heard and cried again and started shaking again.

While driving towards home, I had time to process some of the things that had happened. When I got home my roommate was there and I felt the need to let it all out at that point. I talked about what had happened and remember saying to her, "I can't do this job. I don't want to. Why am I choosing this career? Why do I want to listen to this trauma and this pain that other people are going through?" I was very upset and was questioning whether this was the career that I wanted after all. It felt too much, it was too overwhelming. Sometimes I still think about it and the more I think about it, the more I think it is a really odd career choice in many ways. I do not think that wanting to help people is odd but wanting, choosing to spend your day around people in pain is a bit odd to me.

I was scheduled to meet the client in a week. I felt very strongly that I did not want to be the therapist for this client. I was saying to myself, "I can't do this. I can't handle this client." At the time when I saw this client I was going through a difficult time personally. I was going through my own loss of a love relationship. At that time the loss was just weeks
old. It was a loss of a love relationship that had meant a lot to me, that fell apart in a really awful way and really quickly. It was even hard enough to simple get through my days, to get out of bed and try to lead a normal life. I felt it impossible to be with a client who was in so much pain, let alone help her.

The loss of my love relationship was an experience that left me feeling very hopeless and powerless. I was not feeling confident. I was questioning my abilities and my choices. How could I have misread the situation or allowed myself to be used? I felt like someone had pulled the ground from under my feet. Yet with the client, I was thrust in a situation where I had to be competent and to take risks. As a counsellor, I was in a place where I was impacting on others so I had to somehow keep myself in check because I could not allow what was going on with me to affect these clients who were coming to me believing that I could help them.

It was a difficult week and I felt torn between my needs and the client’s needs. I knew how hard it had been for her to come and share her story with somebody and so I felt responsible to see her through. I did not want to put her in a situation where she had to go through her story with somebody else. I also did not want to be another person on the list who could not be able to handle what she was saying and close the door on her. So I chose to keep seeing her but it felt strange because I really did not want to. I was dreading so much our second session. I did not want to see this client but I felt I had to.

In the second session, I knew what to expect whereas the first time I did not know that I even had the client, till an hour or two before she came. During our second meeting, I still felt shaken inside but at least outwardly it did not seem so traumatic for me. Unconsciously I distanced myself again. When I was with her, I felt more detached and I do not think that I was empathic, as I had been the first time. Yet, physically I was right
beside her, my arm was around her for most of the time. I rubbed her back or held her hand. But I think that I felt more in control of the session.

In fact, over the week I started looking at my own issues through going for my own therapy and getting a better sense of how my personal issues were getting mixed with those of the client. Thus, I was more able to enter the session and keep my issues separate from those of the client's. Moreover, at the time I had no expertise in dealing with women who have lost a child. It occurred to me that one of the tangible things that I could do was read about this and get more of an intellectual understanding of what was happening, even though I knew that this was only a small piece of the puzzle. But at least this was the only thing that I had control over.

Over the next six sessions with this client, there were a number of moments where I felt that I was over-involved or where I was over-identifying with this client. I spent a lot of my time trying to get information, resources and books. I read a lot more than I usually do for my other clients. I think that I went on a quest to relieve this woman's pain. It was really hard for me to see this woman in so much pain week after week. I talked to the therapists that I worked with, to get some ideas of what I could do. In the beginning I felt really helpless because I had this expectation that if I managed to create this special session or the "right session" some of her pain would go away. I felt a deep need to help her. It was a long time before I could see any change. Even though I knew that change was happening, her grief was so profound that she needed a long time to be in her pain. As her therapist, I often felt powerless.

The level of grief that this woman was experiencing was much more encompassing than the one I was experiencing but I felt I related to and connected with parts of her grieving. I felt connected to her as a woman. The story that she described to me represented a woman's worst fear, my fear, too: of not having control over my body or
what happens to my body, or the fact of carrying a child for 9 months in my body and then
losing it. I wondered whether a male counsellor would have had a similar reaction to the
one I was having had he been in the same room as I, listening to her story. To me, the
client's experience was one of those horrific stories that one would not want to think about
or to imagine that this could actually happen. I felt angry at the injustice of life and that
bad things happen to people with the best of intentions. I was angry about what had
happened to her. I also had to face the fear that this could very well have happened, or
could happen to me too. I remember feeling emotionally distraught. I would be feeling
okay and then as soon as I would start talking about the client's experience with someone,
tears would come again. This surprised me because I expected to get over it. However,
the impact of the experience stayed with me for a long time.

This impact expressed itself in various forms including in my dreams. I started
dreaming of babies. In one dream I remember I had a baby girl and I was trying to keep
this baby safe from her parents. I was running and someone who wanted to harm the
baby was chasing us. I was panicking, trying to keep her quiet and trying to hide, ducking
behind the shelves in what looked like a grocery store. Just before I woke up the person
found us, me with the baby and then I woke up. I think that this experience triggered some
of my helpless feelings, of not being able to stop awful things from happening.

We go through life thinking that we are in control of it. We are in charge of
everything and to some extent we are but there are things that can happen which we have
no control over and this is very scary to me. It is not a good feeling to feel that you are
helpless. We are all victims of circumstances. I cannot stop this person from losing their
baby. I cannot stop this parent from abusing their child. I cannot stop bad things from
happening to me. Personally I was feeling less in control, less in charge because of what I
was going through after my love relationship ended and this client’s experience magnified what I was going through.

Throughout our sessions, there were times when I found myself protecting the client from her pain by not asking her questions which I knew would make her cry. I often felt like I was looking over the edge of a cliff, then backing away for fear that she would be in pain again. It was very hard witnessing the pain or feeling that you are the one who is inflicting the pain. My heart would start pounding and I would have this inner battle of whether I should proceed or not.

Around the fifth or sixth session, I remember that she came in a little less distressed than previously and at the end of the session I said something reassuring like, “You’re doing well, you’re doing really well and you are going to be okay”. But I did not say it once but repeated it four or five times! I kept saying it over and over again and as I was doing it, I kept thinking that it was really strange but I kept doing it anyway. As she left, I realized that the reassurance was more for myself than for my client. I was telling myself that everything was going to be okay!

The first time that I actually “jumped off the cliff” and asked the dreaded questions, I felt a sense of relief but the client sobbed and wailed. Yet I knew that this was the right thing to do even though I was afraid. Eventually I started seeing some progress and that felt good. She also regressed for a while and that did not feel good at all. But I was not afraid when that happened. I felt frustrated. Yet I knew that that was the place she needed to go. I realized that grief is not a linear process.

Gradually the client started recognizing the gifts that are attached to losses. It reinforced the idea for me that gifts are attached to even the most painful of experiences and when you are in pain or when you fear that pain of loss, it is easy to forget that part. We framed them as gifts from her daughter. Obviously if it were up to the client she would
not have had the loss of her baby but as time went on, she started being more active in
discovering gifts and she would come to the session talking about another gift she had
discovered.

In retrospect, our journey started with a lot of fear, my own fear, fear of being
overwhelmed and wanting to hide from her experience. Slowly the fear went away. The
longer I stayed with it and the more times that we went through it together the less afraid I
got, then I started seeing that I could have an impact on what her healing looked like and I
could facilitate what she needed to have to happen. It would have been a missed
opportunity for me to learn about myself and what I was capable of doing, had I decided
not to see this client. It helped me regain some confidence and helped me to believe in
myself again. I learned a lot about grief and courage and self-love and self-hate from this
client and it was a mirror for me in many ways.

It also helped me reflect on the fact that in some counsellor training programs, the
expectation is that therapists should be objective and there is no space for your
humanness to come out. Initially, I could not understand my reaction to this client. As a
therapist, I had the expectation that I should have been able to hear such material as this
client's story and not be so traumatized. However, through this experience, I learnt that
ultimately before we are counsellors, we are human beings and sometimes when we are
fragile, client material impacts us in a strong way. So for me, it is important to accept my
feelings around clients but at the same time, it is also important to do my best to be as
emotionally healthy as possible so that the counselling sessions are for the best benefit of
the client.

"Violated boundaries"- Adrienne's Experience

The client is a male, and he is about 54 years old. Initially, he was just like
another client amongst all the other clients in the group. What began to annoy me
about him was his continual focus on his health issues and having to listen to all the details. I found his style of interaction very impenetrable, in a sense, he talks at you and gives you no opportunity to interject or converse. But I thought no more about it, other than that it was annoying to me.

However, by the fourth group session I started experiencing very unpleasant feelings that I am expressing to you now. I feel violated by this client. I feel that he crosses into my physical space and I am sensitive to that. I feel concretely contaminated by him. I have been thinking about my experience and my feelings. It is his darting and penetrating or focusing and mesmerizing eye contact. I feel forced into eye contact. The image that comes to my mind is that of a snake, mesmerizing his prey. In the group, I almost feel like I am a sitting duck in a way. He uses my attention and eye-contact for his own purpose. I feel exploited and feel that while he may be talking to me about things, there is stuff going on, on another level that is exploitative, disrespectful, and angry. As I became aware of this dynamic, I decided, “I am not going to look at you anymore. You’re not going to use me that way.” With other clients, I do not feel used when I listen to them. Usually it feels very comfortable. It feels affirming; it feels like a give-and-take process. I do not feel violated. But I have been feeling violated by this man more and more consistently.

The other group leader who knows this client told me that some of his issues are around shame and denial of sexually abusing his sister and a young girl in the past. This kind of information put me on the alert and made me feel less respectful and more repulsed than I was before. I have strong feelings of revulsion and disapproval towards men who sexually abuse children. These feelings were heightened for me when the counsellor told me that this client is very concerned about his victims not telling anyone. So for me this man has no sense of remorse or regret. He is very glad that his
victims never told anyone. It was a cover up for his sake. I just want to clarify that this client is not my first client who has been involved in sexually abusing other persons but I have never experienced as strong a reaction as I do now with this client.

I experience a very visceral reaction to this client. It is very distressing to me and I feel the anxiety and the contamination as I talk about it. I am aware of parts of my body being assaulted, from my torso up to my knees. I feel assaulted and exposed. It is the feeling of a person being able to come into my physical space and hurt me. I feel it in a concrete way, as a physical pain in my body, gnawing into me.

Actually, the feeling that I get when I think about him or when I experience him face-to-face is very similar to the feeling that I have had all of my life and I get most in touch with, when I feel vulnerable and not safe, not respected, and powerless. It is a very bodily feeling. I believe that this client represents the theme of boundary violation, that is present in my life, a theme that I struggle with, and work on. I believe that this sense of boundary violation comes out of being raised in a family where I felt that I had no boundaries at all. I simply did not count as a person. I was a child to be used and to be expected to perform. Even now, I am the daughter who is expected to do this, that and the other, according to what my family says. The feelings of violation are there and this client flares them up to an acute degree.

My behavior towards this client, that is, not looking at him and not giving him attention raises some ethical quandary within me. It causes me discomfort to consciously choose not to look at him because I wonder what the other group members say, you know, “why isn’t Adrienne looking at him?” I guess that I judge myself about being unfriendly. But at the same time, I want to be able to say that I have my boundaries up, that I personally feel very uncomfortable and I will not engage in these kind of behaviors with him. Yet, it feels uncomfortable or foreign for me to think that I am not the one to help
this client. I still feel that I am labeling myself as being unfriendly or not doing the kind of healing that I should be doing. I should treat him with warmth and a kind of acceptance that I find that I cannot give, that I do not want to give. This client is the first client with whom I experienced such strong, uncomfortable reactions. Right now, I see myself on the extreme side of a continuum of feelings, like the end of the pendulum, where I feel revulsion and unfriendliness, until I find a way to feel that I am protected and that I have enough sense of boundaries that I am able to interact with this client. But until I sort out my reactions, I want to stay away from this client.

It was embarrassing for me to say in front of the Director that I felt that this client was evil. I mean, who wants to use the word evil? I felt that maybe there was something wrong with me for using that word. Thus, it was very reassuring to have my experience validated by the male counsellor who had seen this client for a few sessions. This counsellor told me that the word “evil” may be understandable given that this client uses pornography, which is very demeaning to women, several times a day for his sexual release. He was not surprised that I had picked that up. So I felt less weird and less sensitive. I was very much afraid that there would be a judgement made about me, that perhaps I am too sensitive or inadequate as a counsellor and that I would better get some help for myself. It felt good to have my experience confirmed by that counsellor, that my reactions were not coming out of the blue.

When I am in the presence of this client in the group, I want to place myself within the circle in such a way that I am not sitting across from him. So if I sit more beside him then I could look across the room and he is not within my field of vision. I think that slowly I am becoming more comfortable with the idea that I am not going to give him my undivided attention. I wish very much that I could pull out a shield and have that stand in front of me and that he simply would not look in. At this time I do not
feel that I have all of the protection that I need. I feel that I do not have that in my life; maybe I am starting to get it but maybe I never will.

Upon reflection, I think that I experience many stressors in my life and this client feels like he is one of them. He is not an overriding stressor, just simply because there are so many others, amongst which coping with chronic back pain and the sleeplessness that comes with it. I also realize that as I do more and more counselling, I am having to face the whole world of men abusing children, sexually abusing people, and getting in contact with weird sexual practices. They are much more present in my face than when I was just doing my degree and was not practicing counselling. I tend to think that there is a cumulative effect of hearing stories. I feel that it is quite sickening. Maybe I am beginning to acknowledge that it is sickening and it can be contaminating. I recall that in my second year of counselling, a client confessed to me that he had molested his niece, who was maybe 12 years old and he also confessed to me that he did not feel safe that he would not molest his daughter who was just one years old. Somehow I did not have an empathic block with that client and I did not have the same sense that he was violating me. Looking back, I felt more numbed by what he told me. Perhaps I was not allowing myself to absorb it. But increasingly now, as I hear men who talk about their abuse, I just feel this disgust and revulsion for them.

My reactions are definitely becoming stronger and sometimes I fantasize about having a private practice where I can choose who I would work with. Here, in this government agency I am feeling more and more pressure to work with clients that I would never choose to work with. This leaves me feeling quite unsettled. I sometimes question how much longer I can work in the system, how much longer I want to work with just alcohol and drug clients.
Yet it is curious how reflecting on my experience and talking to you for three meetings about it, helped me feel less victimized. I realized this when I met this client again last night in the group. I felt more detached and safe because of all the action that I had taken. For example, talking with you I feel that I had a chance to articulate my concerns and I followed that up with talking more with other counsellors. I am seeing progress in myself, feeling less disturbed, less personally violated, and feeling that I recognize what I perceive the client to be all about and what I need to do to protect myself. I felt a sense of empowerment yesterday evening, that he was not getting to me as much. I guess that it is illustrative for me of how important it is to sort out my angst with clients and to express my feelings and not isolate myself. If clients bother me and I am very judgmental of them, then that is going to be more of a signal to talk about it as a way to become more accepting of my feelings. It is hard for me to accept my judgement of clients. Perhaps a way to feel more comfortable is not to make a moral judgement that such clients are morally bad or deficient but rather that something has happened in their life, throughout their development and that I cannot reach them. I really do not even want to reach them. I want to let myself off the hook and feel at peace that I do not have to be the counsellor to help them.

In the future, if I find myself feeling uncomfortable with a client, the next step will be to talk to someone and sort it out, whereas before, I would struggle with that more on my own and find it unacceptable to even talk about it. Talking more about these feelings would result in getting more assistance and obtaining feedback as to how to deal with them. It may simply mean deciding not to have those clients on my caseload at that point in time. If I do not have a choice, if the clients are in a group that I lead, then I would struggle with my feelings, process them on a weekly basis and see what comes up.
Finally, this experience and our meetings also helped me re-visit my theory of counselling. I realize that I was quite immersed in the Rogerian approach of counselling, thinking that if you gave people enough empathy, enough unconditional regard and allowed them to talk, then they would grow. I am now moving away for this approach. As a result of such an experience with this client, I have become more aware that the medical model with its diagnoses of mental illness, is a useful concept. So, now I am at the phase where I am trying to articulate to myself what my belief about how people change is, and how I can be open to assessing and responding to what the client shows, or seems to show in the moment, during counselling sessions.

“Fix me...Fix me!” – Sarah’s Experience

This client is in her early twenties but is very young emotionally and intellectually. She strikes me as being very unsure and very needy. She has a long-standing drinking problem and comes from a family who was very abusive to her, both physically and emotionally. She has been raped by a family friend in the past and has also made several attempts to take her life by taking pills. But someone has always been able to rescue her and take her to hospital. She seems very desperate in her situation and comes across as very dependent and almost as if she wants me to take over.

To make matters worse, this client is partially blind and very self-conscious about wearing glasses. She did not wear glasses when she came in to see me and kept bumping into the wall. When I saw her in the session, I started making some judgements about her. I noticed myself thinking, “Oh this person is probably not going to follow through and come to the appointments. She is not going to be the kind of client that I am going to get much satisfaction from working with her. I really have to lower my expectations. I do not have very much hope.” I did not think that I was going to be very successful in the help that I could give her.
Her life was in so much turmoil and she seemed so needy that I felt very overwhelmed. I felt that I could give her so little and she needed so much. I felt overwhelmed, anxious and also desperate that I have to do something for this person. It was very disturbing for me to hear about her life especially when she talked about her boyfriend abusing her physically and justifying his actions by saying that he did not mean it, he was drunk. It was hard for me to have a sense of hope hearing her say, “I just do not want to go on anymore, there is nothing left for me.” My stomach would clench and my mind would start racing. I would say to myself, “Okay, her life is at risk, let us do a safety check here.” So questions that I needed to ask her would start coming to my mind in order to determine how serious she was with following through with her plan to take her life, given that she had attempted suicide several times in the past. This helps me stay focused rather than blank out in my mind. At the same time, I notice that I cannot breathe as deeply as I do normally. I take in shallow breaths, almost as a way of protecting myself from absorbing her pain. This was my way of detaching myself from her and her pain.

However, with this turmoil going on, I am unable to listen to her and be there for her. I constantly have to go back and forth trying to control my anxiety and my breathing and asking her questions. I keep saying to myself, “Calm down, focus on her, on what you need to ask her, and ask her questions about how she can protect herself better from her boyfriend, who she can go to if she is scared and determining how severe the suicidal thoughts are.” So at that time, part of me was thinking rationally and another part of me was saying “Oh God, here is another one.” At the time that I was seeing this client I had a lot of clients who were suicidal. I was also thinking, “Why me?” I was feeling very resentful. I was also feeling torn inside my head. Part of me was saying, “It is her responsibility to follow through.” Another part of me was saying, “Well, if something happens, then you will feel guilty.” So there was an internal struggle going on inside me.
Amidst all this mixture of feelings, I was unable to feel sorry for this client or to feel any empathy for her. I was annoyed at her immaturity or her lack of responsibility. She did not seem very willing to fight to make changes in her life. I felt very tired and drained. The fact that I was annoyed at her rather than feeling compassion for her, made me judge myself, “What is wrong with you?” I started questioning my own competence up to the point where I started wondering whether or not I should be in the counselling field. I know that I have the expectation within me that I should be empathic to my clients. Therefore feeling annoyed, drained, and resentful made me wonder whether I am losing my therapeutic ability.

Upon reflection, I think that when someone comes here to the clinic and they have so many concerns, so many problems and they do not seem to have so many resources, I have a tendency to take on the responsibility and see how I can be helpful. Normally when I am in a counselling situation and the person has taken on some responsibility, I do not feel that I have to do much, other than just listen to them, help them problem-solve, and be a guide in their journey. Whereas, when a person comes to me with no sense of responsibility and totally dependent on me, I feel like I have to somehow fill the void to some degree and offer more than what I feel comfortable with. I take up their sense of urgency. I pick it up and make it my own. I think that I have a tendency to do that, but not all the time. It depends on what is going on in my life at the time, and how many clients I have that I am feeling that I can be effective with. This competence issue relates to how likely I am to take up that person's sense of urgency. If I am feeling competent that the client and I are going somewhere, and that therapeutically we are moving, then it is easier for me not react to that sense of urgency and not to feel overwhelmed. However, when I am feeling uncertain of which direction to go with clients because of the nature of their
disorder or their concerns, then my sense of incompetence or inadequacy comes up and I am scrambling inside, “what can I do? How can I direct this person?”

My behavior probably stems down from my need to help people, my need to fix when I see someone in a desperate situation, my need of wanting to make someone feel better. It comes as a result of my insecurities around my own competence and around my ability to deal with someone who has many problems. In some ways, it feels like I cannot do anything that has any impact because this person is going back to their environment and continue on. So it feels like I am defeated before even starting. If I do not have hope, how can the client possibly have hope? Part of my responsibility as a counsellor is to instill hope in the client and if I am struggling with that, there is no way that client is going to believe in their future. So I feel that I failed in that area. I failed in trying to find some light for that person.

When I leave the clinic at the end of a long day, I feel like I need to go through a ritual of cleansing before resuming my life. I pick the pain of the people that I have difficulty empathizing with. I pick a lot of the pain that they have experienced and the consequences of that pain is sometimes really ugly. Recently, my husband has noticed that I am harder to live with. I am less tolerant of changes in the schedule of whatever is expected to happen. I am less easy-going and less able to go with whatever happens. We have talked about the importance of me telling him when I have had a hard day, particularly around stressful clients and he promised to make more of an effort to ask me about my day and give me more support around that area. Perhaps, he will take our son for a walk so that I can have some time on my own to just reflect on my day rather than getting right into the house cleaning.

I realize that I would like to be able to stay with the clients’ discomfort longer than I have been able to, up to this time and give them more responsibility. I could point it back
to them by saying, "Gees, I am feeling fairly confused right now. I am feeling overwhelmed. What do you think that you need to do?" Obviously taking full responsibility is not being respectful to the clients even though they would be at crossroads and stuck in their life. However with my actions, I am giving them the message that I can do a better job than they can and that does not feel right with my values.

Whilst talking with you, I am also becoming aware of how bored and restless I am feeling in my job at this point because of lack of stimulation. I am in a time in my life where I feel that I am in need of more training, in need of more skills to deal with the kind of difficulties that I am facing with clients. I have been very frustrated lately because help has not been forthcoming. I have applied for training and I have not had any support from management to take the training. It has nothing to do with me personally. It has something to do with the way the regional management structure is being changed right now.

For me, training would stimulate me and boost my confidence level and my sense of competence because I will have more tools to use with any client situation. I have already experienced that to some degree, by taking a couple of courses and it has given me energy. As things stand right now, I am not feeling very fulfilled in my job and thus I get more tired and I put less energy into my client sessions.

In the workshop, it was refreshing to actually hear people acknowledge their difficulties with client. It just seems that it is taboo, that it is not acceptable to acknowledge that. It is almost like talking about suicide in your family. It is almost like if you have these difficulties with clients, then there is something wrong with you. In essence, having empathic difficulties with clients often has to do with your own personal issues but it does not mean that you cannot be a good counsellor. At the time when I was seeing my client, I did not seek support because I thought that having such an experience might suggest that I am not very competent. I knew intellectually that that would not happen but emotionally
that is how I felt. It is not a habit for me to consult with people. It has to be really bad in order for me to do that. Ironically, talking about this experience made me realize that it was really bad. She was one of my most difficult clients. You were the only one I spoke to, about her, whereas if I had spoken to other people in the clinic I might have been able to cope with her and the effect of her situation on me. I need to get in the habit of consulting with people. In fact, if I were to work with her in the future I will try and do that for my protection and to help me stay more detached. It will help me recognize when my need to change someone else’s pain is taking over and affecting my work with clients.

"Contempt from a Client" – Joanne’s Experience

After I read the transcripts of our interviews, I became aware that when I am in uncomfortable situations with clients, there is something in me that shifts into denial or avoidance mode. I do not feel the feelings that I ordinarily feel. It is only after the clients’ files are closed or after the session that I realize what went on inside of me. Perhaps in the sessions I keep a “professional veneer” and I am detached from my own process. In the sessions with the client that I will be talking about, the same thing happened, that is, feelings did not come out until the end of the session or rather after she left counselling.

After terminating my contact with this client, I felt an immense sense of relief. I did not want to work with this client anymore and was glad that I did not have to. During the last session, I was disgusted with her and did not feel any emotional connection with her. It felt like a blunted affect state. There was absolutely nothing on which to base our relationship. She was not moving in her treatment and I would not move from my official government employee position and so the whole thing dropped to the ground. It just seemed so pointless. I did not have enough of an emotional connection with this client to do therapy justice. All I could do was to end the session. It was only after she left that I
started problem-solving and considering which counsellor could take her on, instead of me.

I realize that I need to give you some background information about this client and fill you in about the events that took place between us. The client was a female client, married and had two young school-age children. She and her husband came to our clinic after she had completed residential treatment and after they had been through couples counselling. In spite of the fact that she had completed treatment, she had relapsed already and was drinking again.

I noticed that I was losing compassion for this woman shortly after the assessment process. Usually clients on reflecting on their history, will notice patterns in their life and identify issues that they want to work on. This client never did that. She continued to allude to the idea that she did not know if she wanted to stop drinking and also she did not know if she wanted to stay in the relationship with her husband. She had a lot of blame and anger towards her husband who had been emotionally distant and withholding during her pregnancy 10 years ago. The pregnancy had been a surprise to both of them because she thought that she was unable to have a children. However, they made a commitment to stay together but she received little or no support from him until the child was born. At this point, her husband became very involved with parenting and became more attentive to her as well. Nevertheless, there came a time when her drinking progressed to the point where she needed treatment. Her husband, too started receiving counselling and was getting a lot of insights in terms of his own behaviour and the dynamics in the family and made commitments to change. Yet during the assessment she kept coming back to her anger towards her husband's behavior in the initial stages of the marriage and seemed reluctant to address her own here-and-now drinking issues.
This reluctance spilled into the counselling sessions after the assessment process. As I kept hearing her blaming her husband and being resistant to my suggestions and counselling interventions, I felt somewhat overwhelmed. I started thinking, "Holy smokes, how can we get around this one?" She had this superficial way of getting out of whatever it was that we were discussing and I did not want to be controlling and confrontative. Moreover, she seemed to trust only those people who impressed her and for me this was hard to deal with. To make matters worse, I discovered that this client and I had the same family doctor, who is somewhat of a mentor for me. During my last appointment with my GP, my doctor told me, "Oh, Joanne, you are doing so well with your career. You should write a book!" I was totally flattered and I think that I may have left my feelings of wanting to impress my doctor influence my interactions with this client.

In the sessions the client would come in, be blasé and superficial, blame her husband for a while and act like nothing was happening. At times she would admit that she had had something to drink and once she also came to the session intoxicated. She would superficially acknowledge having goals for counselling and we would begin to explore them but then she would sabotage the depth of the exploration. She would somehow get bored with the line of discussion and have the attitude that this was not going anywhere. We would start to talk about something and then she would drift into this sort of uncomfortable silence and look at me like I am supposed to say something profound and deep to take the session to another level. In such situations, part of me would say, "You think you are kidding me, but you are not. I know what you are up to!" especially when she would have been drinking during the week. Another part of me would be saying, "Oh God, what do I do with this?" I considered it my job as a counsellor to stimulate the client to explore new material. I felt that she was judging my style as a
counsellor. I wished that I had this magic bullet that would get her rolling in a particular direction. Part of me wished that I were more of an artful therapist.

I think that this client brought up my feelings of incompetence, again, not so much in terms of knowledge, but in terms of style. Both this client and her husband were artsy-looking people, very polite and had a very sophisticated way of expressing themselves. In retrospect, I think this was their way of avoiding their issues. For instance, they never told their children that their mother had a drinking problem or even used the words “drinking” or “alcohol.” They had these other sort of euphemistic ways of communicating. However, in their presence and especially in my interactions with this client, I felt horribly blunt and artless--much like a cartoon in comparison with a brilliant, abstract painting. This client brought up feelings of inadequacy and incompetence, very much like how I felt in High School. This client reminded me of attractive, intelligent cutting people in the past who had hurt me. Actually, as a result of working in this field I have had to face an entire conveyor-belt full of aggressive people and I have learned how to handle them quite well. However this client had the ability of making those kinds of statements that make it difficult to find a response to.

There is part of me that would have liked our relationship to fade out and not have to deal with termination. Instead, I decided to confront the client by giving her a handout dealing with a list of symptoms leading to relapse, for her to look at and see whether there were parts that she identified with. I told her that everyone engages in certain behaviors to avoid making changes including myself, for instance, I make excuses to myself about why I do not commit to my exercise program. She came back very angry at me, at the whole Alcoholics Anonymous (A A) treatment and recovery idea. She also said that she was not convinced of the effectiveness of A A and was very embarrassed over the whole idea of being labelled as an “alcoholic.” According to her, I had a one-size-fits-all theory and she
considered it inferior. I told her that I would be glad to discuss her doubts but whatever
issues I acknowledged, or any attempts at being empathic and eliciting her feelings were
discounted. She basically "pooh-poohed" these ideas and "pooh-poohed" me for
presenting them. I recall reminding her about our discussion of the previous session
regarding her needing to have goals for the session. To this she replied that she did not
have any goals. At that point I stated that there was no point in continuing the session and
she walked out of the room looking very dejected and angry.

During the next session when she returned, she tried to make it seem that I had
lost my composure during the previous meeting. She told me, "I questioned your ideas
and you sent me away because you did not know what to do with me. I think you really
lost it." She continued to bait me by commenting on my age, on the fact that I was not
married and I had no children. She said, "I think you are frustrated with me and I am
frustrated with you because you are frustrated with me." I would not confirm or deny this,
even though it presented an opportunity for immediacy. But there was no way that I was
going to get into personal territory with her. I had a feeling that if we had gone deeper than
that, if I had been honest about my feelings the situation would have escalated. I just
wanted to contain the dialogue and have the session end without further ado.

At that point, I felt that any empathy that I might have had for the client totally
broke down. She was expressing contempt for me and I can work with just about any
feeling except with contempt. I have worked with sex offenders before and that was not
nearly as bad. But this client was treating me with sheer contempt and I just could not
work with that. I hated this client at that moment. It was really hard to be attacked on
one's raw spots. Her comments on my age and single life were the worst things that she
could have told me in terms of my personal sensitivities. I think that the worst thing that
anyone can tell me is that I am immature, naive. I am also very small in height and I have
had lots of issues around that, around being thought of as childish. Going back to grade one, I was always the smallest kid in the class. In drawing attention to my age and that fact that I was not married, she was suggesting that I could not function as a counsellor because I did not have the experience of being married and having children and those are the things that I would like to have in my life at the moment.

This client brought up my feelings of envy. (Most of these feelings came after I terminated with this client.) She had two beautiful children, a great husband and she was throwing it away for the bottle. I started feeling that she did not deserve what she had. Ironically I think that she was actually envious of me because she kept fantasizing about wanting to be single, of being away from her husband, away from her kids and living the single, urban life-style that I was living. The unfairness of our mutual situation really bothered me. I felt myself becoming very judgmental towards her as time passed and I reflected on the things that she said to me. What right did she have to throw away something so precious as her husband and her children because she simply had grown tired of them? With this client, it was all about blame--blaming the husband that she is unhappy because he was not making her happy when in fact he was doing everything he could to work on his own issues. After what she said to me, I was pretty disgusted with her and did not want to work with her. I can manage not to judge people for most of the time but when I am attacked I find it hard not to take it personally.

I rarely worry over clients in my life outside work. However, when I feel incompetent or inadequate as the case with this client, I take the worry with me and keep thinking about what happened while I am at home. It is interesting how I actually ran out of gas one morning on my way to work and the session with this client had to be cancelled. I was supposed to meet with this client and her husband for conjoint couples counselling with the husband's counsellor. This was before the confrontation took place. Somehow I
got to know that the husband’s counsellor was sick and it would have just been me doing
the session with the two of them. However, on my way to work I ran out of gas! I was
really worried about what the clients thought of me and I had this horrible picture of them
seeing me walk back from the gas station with the tank of gas in my hand. I kept hoping
that they do not see me as they are driving home. This situation of running out of gas had
never happened to me before. I have never been late for a client. I wonder if there was
some countertransference reactions happening there!

Going back to the last session, as soon as the client left, I went to one of the
counsellors who is married and has children and asked her if she was willing to take on
this client. Luckily for me, she accepted. I could hardly wait for the client to get home to
phone her and tell her. Recently I have found out that the client is still not committing to
her individual sessions with the new counsellor and her husband is talking with his
counsellor about leaving the marriage because she is drinking daily and continuing to
blame him. I think that her husband is planning to give her an ultimatum. You are probably
wondering how I know this. Well, I must admit that in the weeks following termination with
this client I was looking in her file and seeing how sessions were progressing with the new
counsellor. I was also asking her counsellor and the husband’s counsellor how things
were going. I was curious and quite keen to see whether things were going to work out for
her. I needed to have the reassurance of whether I had done the right thing with her. I
kept asking myself, "Were my insights correct?" I have to admit that knowing that the
counsellors are going to confront her about the need for her to commit to doing individual
work leaves me feeling very relieved. Regardless of my style of confrontation, the client
chose not to make use of anything that I offered her.

Another part of me felt vindicated that her husband was going to leave her. I have
to admit that I had hoped that this would happen. As I have already said, there was a part-
of me that felt that she did not deserve this man and these children. She was just walking away from him caught in her own arrogance and no-one and nothing was good enough for her.

Upon reflection, I realize that my instincts were right with this client and I feel myself becoming more confident in my role as a counsellor. I realized that being a counsellor means that you do have to make decisions about where the therapy is going. A lot of these decisions are completely arbitrary and maybe the decision that you make might not be the best possible decision. However, I learned to stand by my decisions whatever they are. By sending her to another counsellor I risked professional embarrassment because it could have worked with the new counsellor. However, my instincts were right. I guess that what I am learning is that I can live with the eventual outcome of my decisions and not have to sit there worry intensely, full of uncertainty. For the first time in my life, I feel that I am becoming an adult. As I said, I have a lot of insecurities about being small and feeling small, feeling that I am no longer a teenager but neither fitting in with the adults. I think that that is changing. I can have an opinion, and I have attained a certain degree of professional standing. I can withstand the criticism of my clients, of my peers. Perhaps my identity as an adult is solidifying.

"Weariness in the Therapeutic Relationship"- Carol's Experience

I started seeing this client in the beginning of '96 and since then, I have seen her for 17 sessions. At the time when she had come to our clinic, she and her partner had been on the methadone maintenance program for about 3 months. She told me that she had been addicted to heroin for about 3 months and prior to that had been an alcoholic and also had other problems. She had been to a number of residential treatment centers none of which met with great success. If you were to see her, you would notice that she looks very wasted, much like the stereotypical drug-addict. At the same time she dresses
very flamboyantly and speaks with some sort of British accent that makes her sound high-
class and sophisticated.

Invariably I am struck by her appearance, that is, the blackened teeth, the
blackened finger-nails, the wasted look and the way she comes across. She is very
educated, very intelligent, and articulate and seems very together and yet you know that
her life is totally falling apart and has fallen apart. But, whenever I talk to her, I do not feel
like I am connecting with the person whose life is falling apart and this has been ongoing
more or less since I started meeting her. I am not sure when was the first time that I
started noticing that I was not connecting with her. In the first few sessions, I was trying to
get to know her and I was open to what she was telling me. Gradually I started to sense
that the sessions were not moving forward and that we were covering material already
covered before.

As time went by, I started not looking forward to her coming, almost like having a
sense of dread; not that something bad was going to happen but that nothing was going
to happen. She is not a silent client and neither is she resistant nor does she come across
as having a superior attitude. What I dread is that I do not know what to do with her. I feel
very exasperated and frustrated. I think that part of the dread is because we come close
at times to my feeling emotionally connected with this person, to the point where we would
have gotten to how she actually feels and then this emotional connection is gone again.
The next time she comes in, she is all over the place, emotionally and psychologically. I
find it frustrating working with her. I am not seeing much progress, although when I look at
our past sessions, I know that she is closer to being able to return to work of some sort
and she is telling me that she is less depressed and less suicidal.

I guess that in terms of progress she is doing okay because her goal is to get back
to work and to maintain the methadone as prescribed and eventually taper it off. But in
terms of the actual sessions, I do not know what the sessions have to do with the progress that she is making. I do not feel that what we are doing here is making any difference.

From my part, I sometimes try very hard to elicit feeling statements from her in the hope that I will be able to connect with her as a person. At other times, I feel myself shutting down in the sessions, when I am with her, like I do not even want to make the effort. How do I do this? Well, at times I hand over the session to her, meaning that she will talk and I will just sit and do nothing. I sit back and do nothing. At other times I become more focused, more-goal-oriented, which is not in my style but at least I feel that something got accomplished in the session. I am finding it hard to put into words my experience because it is not that there is anything definite that is going on. She does not remind me of anyone that I know in my life or anything like that. To be honest, I feel like I do not care for her and it is not that I expect myself to care deeply about all my clients. Yet I can still work with them. I can still relate to them as human beings. In the case of this client, I really find it hard to relate to her as a human being and I do not know why that is so.

It is somewhat disturbing to me that I cannot relate to her. I know that I cannot relate to her being a heroin addict and being on welfare. There are a lot of things about her life that I cannot relate to but I know that I can relate to what is happening to her when she talks about losing her sense of self since she has become addicted to heroin, and being depressed. Yet even though I can identify with that, I still feel unable to connect with her. It is very frustrating. All her issues are issues that I have dealt with, with other clients: the extreme dependency on her boyfriend, the feeling that she would not live if he is not in her life and her feeling that the best thing that she could do is get away from him. I also know that she has been sexually abused. Everything I know about her I can relate to but
there is something within her that blocks me out and I find myself going numb when she is here. I do not feel much. I shut down and I know she shuts down too. Body-wise, when I am with her, my head feels fuzzy and I get very tense around my legs. I think that this is more of a reaction to going numb in my head. I tense up and say to myself. “Oh no, I do not want to be doing this.” So I engage in an internal battle within myself. I go numb spontaneously and then I fight myself during the whole session trying to not feel numb.

While I am talking here, I almost caught myself saying that maybe her sense of hopelessness rubs off me. Yet again it is that paradox, that she does not come across as being hopeless. I think that really she is hopeless. I get the feeling that I am not seeing the real person. I am not getting to the real person who is here for help. I am getting this person who is just on the surface. It is very demoralizing and frustrating. I feel a little bit relieved when the session is over, though not always. I usually open the window, and put the fan on because she wears a perfume. After we end the session, I often feel that nagging frustration that I have spent an hour with my legs tight and my head fuzzy. Usually I just want to clear myself somehow and so I will actually go over to the shopping mall or anywhere, just as long as I get out of the office for a while.

There is part of me that feels annoyed with her. It is like, “let’s get down to the brass tacks here.” Oddly enough, I think that I am less confrontative with her than I am with other clients! I do not know what that is about either. I do not understand this relationship and I guess that this is fairly obvious. The process has kept going on because she keeps coming back. If she has not shown up for sessions for a while and I am just at the point where I am going to close her file, she will call and resume coming at a regular basis. I also think that part of what keeps this process going is that I am trusting her report that she is doing better as a result of something that we are doing even though I cannot put my finger to it!
For me, having such a client has been emotionally wearing. It is one of those things that I do because I am supposed to, because it is my job. I am here and I have this client who is asking for a service, and she is not complaining. I do not dislike her enough to say to someone that I cannot work with this client and so it has turned out to be one of the things that I have to do. I find her very tedious to work with. It is like pushing through clouds and every now and again you get a glimpse of something solid but as soon as you reach for it, it recedes into the background so you are constantly groping around.

I question my ability quite often with her. Maybe if I understood more about borderlines (the client came up with the idea that she might have a borderline personality disorder) then I could maybe find the key that unlocks the therapy. I had some research articles using a cognitive approach with borderlines and I tried exploring the underlying schema that this person might operate on, that is, I am not fit to be in society or to be around people. I thought that if we could get at that basic belief, then we could make some progress but I found that she avoided it.

I do not feel like I am doing therapy with her. I feel like I am putting in time and then all the while I am going numb in my head. Sometimes I feel that nothing is good enough for this client. She has been through so many different counsellors and through so many different treatment centers that I carry a little bit of my own insecurity of being compared to others and wonder whether I am worse or better that the other counsellors? I wonder if I would succeed where others have failed. I actually think that I will not find the key to unlock her and the therapy but what keeps me pushing on is the work ethic. I do not feel good about myself if I stop trying in the sessions. I feel better when I try even though I fail.

What I can probably do with this client is settle for less, that is, settle for what we are doing now, monitoring her methadone, monitoring how she is doing with the job
search, monitoring where things are with her and her boyfriend and not exploring the deeper issues like the eating disorder, the abuse that has been there in her life, her nightmares, and her fears. Somewhere in there, there is the key but both she and I are settling for less. There is a blockage somewhere and sometimes I feel like it is coming from her, sometimes I feel it is coming from me. I question whether I really want to get into the deep issues with her. Time is limited and there is the fact that I do not feel a lot of connection with this client. Part of what enables me to explore core issues with clients is that I care for them. In this case, my lack of feeling for her inhibits me from doing deeper exploration. Will I be able to be there for her if I do not really care for her?

At this point I want to talk about the context in which I have been seeing this client as I think that it has influenced my experience with this client. Looking at the larger picture, for these last couple of years, I have definitely been feeling that I need to get out of addiction work, out of this government agency-run-of-the-mill churning out clients. I realize that I am bored. I find it tedious working with almost 60% of my clients and even with the other 40%, I do not find much satisfaction. This is not to say that they are not making progress. It is just that for me, it is not interesting. I am very drawn to working with survivors of abuse with post-traumatic stress. Obviously, I do get to do some of that here but probably not as much as I would like to. For me the difference in the work is between someone who is on an assembly line putting furniture together versus someone who gets to do cabinet-making, using their own creativity. With 60% of the clients that I see, I feel like I am putting the pieces together and they look fine, the furniture is turning out but it is not particularly satisfying and does not reach my soul.

In terms of the work environment, I have been feeling very disillusioned. My hope was that in working with a group of people such as in this clinic we would actually have had a voice within the alcohol and drug system to change it and make a difference. It has
proved not to be the case. Moreover, just in terms of the general overall bureaucratic system, we have been threatened with regionalisation of one form of the other. So there has always been the hovering uncertainty in the back of everybody's mind that we are going to be split up as a clinic and that we are going to lose each other's support. I have been here for eight years and even though we have had our differences, we are pretty much of a unit and I feel very supported here. I know that I am cared for and that means a lot to me. So this situation of uncertainty has been wearing on everybody and has probably impacted me in terms of working with clients.

Moreover, this last year has probably been one of the hardest, not in terms of being emotionally upsetting but just in terms of becoming more and more aware that I cannot work in the addiction field much longer and having a growing sense of "I-have-to-get-out-of-here." This fact has not helped very much in working with clients who are frustrating and in terms of this client, I think that given the mind set that I have been in the last couple of years has probably detracted from my work with her. Perhaps I did not explore as many resources as I could. I did not want to put a lot of effort into this client and I think that showed. Personally, I was also trying to cope with resuming work after a psychological breakdown and that was not easy. Furthermore, with this client there was a certain lack of commitment to the process from her part. She was only putting out so much so I was not going to put out more.

In essence, I think that this experience with this client is a microcosm of myself and my feelings about working in this setting. I noticed my lack of motivation to explore various avenues and in some ways it is a kind of signal to listen to myself, listen to what is happening and to take note. I am not comfortable working in this way. It is a sign of weariness that I am feeling and that if I do not want wear myself out, I need to make a change. I also realized that there are some clients that probably I will never be able to
work with and that is okay and I am also accepting the fact that there are a lot of clients that I will never like working with. What is important for me is that I realized that I need to do something different in order to survive and that it is okay not to get along with every client.

Description and Analysis of the Common Themes

The process of data analysis yielded common themes that characterised the experience of counsellors encountering empathic difficulty with their clients. It is important to note that although the themes are discussed separately, these were intricately woven into each story and frequently overlapped in a manner that reflects the complexity of the participants' lived experiences, embedded within the participants' specific social and psychological contexts. Four major themes emerged from the in-depth interviews. These themes often include sub-themes that are part and parcel of the main theme. Excerpts from the participants' transcripts are included to link the participants' stories (presented in the first part of this chapter) to the themes discussed in the second part of the chapter.

Experiencing Countertransference Reactions

This theme explores the way countertransference reactions were manifested in the participants' experience in terms of their feelings, the physical and physiological reactions they experienced, as well as the behavioural reactions that took place within the context of their experiences.

In the case of the participants in the study, feelings were experienced either during the session with their clients or after the clients left the room, or even after terminating with their clients. In the initial contact with their clients, the participants experienced a range of feelings that felt uncomfortable to them but as counsellors they were still able to maintain a therapeutic relationship with their clients. As the contact with the clients
increased, the participants’ emotional reactions intensified and hindered or took over the counsellors’ feelings of empathy for the clients.

For instance, initially Belinda had not wanted her client on her case-load. She was dreading meeting her as she had already foreseen that it was going to be emotionally difficult for her to listen to the woman’s story concerning the death of her baby. After the counsellor heard the client's material, she was horrified and felt very overwhelmed, powerless, and hopeless. Similarly, Sarah was initially annoyed with the clumsiness and neediness of the client as she presented herself to the counsellor. She felt herself becoming judgmental towards the client. With further contact with the client, Sarah felt very overwhelmed, anxious, and desperate to help the client. She also felt very hopeless. “It felt overwhelming to me, very overwhelming. I felt that I could give her so little and she needed so much. I felt a sense of desperation that I have to do something.” Sarah felt disturbed by what the client was saying especially when she talked about her suicidal wishes and about deserving the physical assault by the client’s boyfriend. As Sarah experienced these powerful feelings, she felt resentful towards the client. She was annoyed that the client was so helpless and so dependent on her help. After having a session with this client, Sarah often felt emotionally drained and very tired.

Adrienne too, experienced annoyance with the client in her group and she felt unfriendly towards him. She did not acknowledge his presence as she saw him near the clinic one time and this was not typical of her behaviour with other clients. After the fourth session, Adrienne’s feelings of annoyance transformed themselves into feelings of being manipulated, exploited, and violated by the client:

I feel violated. I feel that he crosses into my physical space and I am sensitive to that. I tend to feel concretely contaminated...I feel exploited... while he may be talking to me about things, there's stuff going on another level which is exploitative and disrespectful and angry. And evil in a way. It is perverted.
Adrienne felt very disturbed by her experience and cried during the interview. She felt victimised, powerless, and unable to protect herself from the “darting, penetrating...and mesmerising eye-contact” of this male client. She would have liked to have a protective shield behind which she could hide and feel protected. “I could pull out my shield and stand that in front of me and he simply could not look in.”

In the same way, it was difficult for Carol to talk about her experience with her client. She felt disturbed and frustrated with her experience of her client. She could not fathom why she was unable to connect with her client and felt like she had failed as a counsellor: “It is hard to talk [about this experience]. It is hard to put my finger on what is going on and to talk about something that has felt so consistently like a failure...that is the hard part.” As time went by, Carol started dreading the sessions with this client and did not look forward to her coming. She felt demoralised and constantly questioned why she could not relate to this client. The sense of dread for Carol was that nothing happened during the session and she felt that she was just putting time in the sessions and not doing therapy. She also felt that this experience was emotionally-wearing and that working with this client was very tedious and boring. Moreover, she often felt numb in the presence of this client and battled within herself to stop feeling this numbness. In essence, Carol felt that she did not care for her client but often tried to focus on the client's wasted appearance to feel sad for the client. However, this did not work all the time.

Initially, Joanne felt overwhelmed by the client’s sophisticated arguments and resistance to the counselling: “Holy smokes! How do I get around this one?! Because this is a more intelligent, more sophisticated client...she had this glib, superficial way of getting out of whatever it was we were discussing.” As the client kept avoiding discussing her own
issues and blaming her husband instead, Joanne felt increasingly exasperated and frustrated with the lack of co-operation of the client. The therapeutic relationship totally broke down at least from Joanne's perspective, when the client attacked her personally. The client questioned her competence as a counsellor because Joanne was not married and did not have children. The client also brought to attention Joanne's age and the fact she is short in height and looks young and naive. After this incident, Joanne felt disgusted with this client and hated her. She became angry and bitter but contained these feelings within her. In retrospect, Joanne realized that she also experienced envy for the client, too: "meanwhile, she's married to a nice guy, has two great kids and is throwing it all away in exchange for a bottle of Liebfraumilch...she doesn't deserve what she has...she brings up my feelings of envy...the unfairness of our mutual situations really bothered me!"

Many of Joanne's powerful feelings emerged into awareness only after she terminated the relationship with her clients. During her interviews with me, Joanne realized that when she is in uncomfortable situations with clients, she somehow "shifts into denial or avoidance mode" and is unable to feel any feelings. This is what Joanne thinks has helped her "contain" the client's attack on her. Joanne called this mode a "professional veneer." This "avoidance mode" is probably reflected in an incident that occurred while the counsellor was driving to work one day, for an appointment with her client and the husband together with the counsellor's husband in a couples counselling session. Incidentally, Joanne discovered that the husband's counsellor was sick and so Joanne was going to be the one to face the clients. To her surprise, she ran out of gas, could not get to work in time and the session had to be cancelled. This was very unusual for Joanne: "that never happens to me. I am never late for a client. I never miss out. I never no-show on a client" and in retrospect wondered whether there were some countertransference reactions going on.
Similarly, during her first session with the client Belinda felt that she was cut off from what was happening inside her and thought that this helped her not be consumed by the client's emotions:

I think that I detached from my own process, of what was happening for me. I do not think that it was a conscious decision. It was probably just my way of doing what I had to do because if I had not done that at that point... I would have been consumed by her emotions and would have started crying along with her... I was able to do my job.

In the presence of her client, Belinda was aware that what the client was telling her was horrifying to her but she did not know how much upsetting the client's material was for her, the extent to which she was absorbing it. In the presence of her client, Belinda described herself as being in survival mode. However, after the client left the room, it seems that she allowed herself to experience the client's impact and the “shutting-out” mechanism was no longer in function. Her whole body started shaking and she started crying. She realized that she could not control her reactions and cried and shook for a considerable long period of time:

As soon as she left the room, I remember I just started to shake. I was shaking, my whole body was shaking and then I started to cry... I couldn't stop myself from shaking and crying. One of my supervisors came in and saw that I was really upset and I remember just wanting to be alone... I think that I felt too exposed so I told him that I just wanted some time by myself. So I sat in that room and cried and shook for probably 20 minutes.

During Carol's encounters with her client she too experienced a “shutting-out” of the client. For this counsellor, the experience had conscious and unconscious dimensions. Consciously, Carol would sit back and let the client take over the session: “I feel myself shutting down [with this client] like I do not even want to make the effort. I give her the session... she will talk and I will just sit back and do nothing.” Spontaneously, at the same time, Carol would experience a feeling of numbness, which she felt physically in her head and legs: “When I mentioned the word numb, two parts of my body leap to mind... I feel
sort of fuzzy in my head and I get tenser in my legs." The more numb Carol felt, the more she fought that feeling through out the whole session with the client.

This same physiological or physical component in the "shutting-out" mechanism was also apparent in Sarah's experience. As Sarah felt more and more overwhelmed, she noticed that she was not breathing as deeply as she normally does. This was Sarah's protective mechanism: "I was shallow-breathing and protecting myself from being able to absorb her and her pain." This "protective" mechanism was absent in Adrienne's experience of this client. In fact, Adrienne was so disturbed and anxious in the presence of this client because she felt she had no protection from the presence of this male client. She felt him invade her physical space and felt his impact in a very visceral manner: "I guess that I am just aware of how...I do feel most of the contamination around my heart and chest [cries]...I am aware of my torso, probably up to my knees being [more] assaulted and exposed."

In describing their countertransference reactions, all the participants described the way their experience with their clients touched upon personal, unresolved issues in their life. These counsellors could not be "blank screen" objective professionals in interaction with their clients but were professionals impacted by their clients as much as they were impacting their clients in the context of their encounter. As Belinda said, "when you have an experience like this, you realize how closely your experience mirrors the client's in a lot of ways and...there really isn't anything that separates you from them."

For Adrienne, her experience with her male client represented an illustration of one of the issues that she struggles with in her personal life, that is, the issue of boundaries, and becoming aware of the need and the importance of setting limits in her life:

I believe that the theme represented by this client is the sense of boundary violation that I struggle with, address, work on--this sense of boundary violation that comes out of being raised in a family where I felt that I had no boundaries at
all; I experienced a lot of boundary violation through words, more psychological abuse and this is what I got in touch with during our last interview and that is why I started crying...it is not as if this theme is not there. It is there and the client flares it up to that degree.

For Adrienne, this experience with her client was not an overriding stressor in her life. He was one of the many stressors she was experiencing at the time of the interviews, which included coping with physical pain and the sleeplessness that accompanied her chronic back pain. I think that Adrienne explained the impact of the client in a very apt manner, with the use of the words “flares it up”—“it” referring to the theme of boundary violation that is present in her life. Her experience with this client touched upon one of her vulnerable spots. To Adrienne, this experience was another intense and painful reminder of the issues that she works on, with her personal therapist.

Belinda, too, was struggling with her own personal issues at the time she was seeing her client. She was going through her own loss of a love relationship that had meant a lot to her, that had fallen apart very suddenly and in an awful way. Belinda felt herself relating and connecting to the woman’s grieving. However, their interactions hit Belinda at a deeper level than this. She often felt helpless and unable to help this woman with her grief. Belinda felt that she needed to help her and she needed to start recovering and feeling hopeful again. This counsellor remembered times when she did not want to ask the client questions that she knew would make her cry. She would protect the client from feeling the pain that she needed to feel to work through her grief because it was very hard for Belinda to be in the presence of someone who was going through so much pain while she herself was in pain.

The counsellor also described an incident during the fourth or fifth session through which she realized that she was over-identifying with this client. During this particular session the client had come in and seemed a “little less, tiny, minuscule, less distressed
than usual." At the end of the session, Belinda told the client, "You're doing well, you're
doing really well and you're going to be okay." Belinda kept saying these words over and over again and as she was doing this, she kept thinking that she was acting in a strange manner but kept doing it anyway. As the client left the room, Belinda realized that those reassuring statements had actually been for herself. She had been reassuring herself that everything was going to be okay and that she was going to be all right.

Belinda's over-identification with her client was manifested in other ways too. During supervision, Belinda would only talk about this client even though she had difficulties with other clients. She consulted with other therapists at her work-place in the hope that she could, find this "special" session that would heal the client's pain and she read all the books that she could get hold of about grief and loss. In retrospect, Belinda realized that through this client, and through personal work with her therapist, she became in touch with issues of loss and fear of loss--issues that she had already confronted at other times but never felt so intensely and so deeply. Belinda believed that with her client she touched a core part of her self, that part which is scared of death. Belinda had to confront her fear around profound losses and how to recover from such losses. She confronted the reality and injustice that life offers, that bad things happen to good people too, and that no-one or nothing has control over these things. As with Adrienne, Belinda's client touched her in a profound way.

Sarah's client brought to the counsellor's awareness her need to help and her need to take away people's pain when she sees someone in a desperate situation. She was reminded of instances when she was growing up and how she would often try to listen to people as a way of getting them to like her. There were times during her twenties were Sarah felt so insecure and so inadequate that she blanked out when listening to people. She did not think she was worth people liking her for what she was. The
experience with this client brought up again the feelings of incompetence, of feeling a
great need to help and not knowing from where to start. Sarah's client situation was so
desperate that she felt defeated before starting to work with this client and this was
overwhelming for her.

Yes, it was overwhelming to me and I just did not know where I should focus on,
although the suicide and the safety issue were always at the back of my mind. It
was just I did not feel like I could do anything, or have any impact because this
person was going back to her own environment and continue on. I felt defeated
before even starting.

Joanne's client attacked her on her weak spots, that is, on the fact that she was
not married, did not have kids, and looked young and naive. These were issues that
Joanne battled with, in her life. This client brought back memories from Joanne's past, of
instances where she had been hurt and demeaned, especially because of her small size.
Moreover, the fact that Joanne and her client had the same family physician had an
impact on the therapeutic relationship. Joanne wanted to impress the client and to
impress her doctor in the process and this had a bearing on how she related to her client.
Moreover, Joanne perceived this client as being very sophisticated and arsty-looking,
qualities that the counsellor seemed to wish to possess. Instead, in the presence of this
client, she felt "horribly blunt," "artless" and "especially incompetent not in terms of
knowledge, but in terms of style." Compared to her client, Joanne felt like a "cartoon",
while her client was "this brilliant, abstract painting."

Finally for Carol, the impact of this client's experience and her overriding feeling of
being emotionally-worn out represented a microcosm of this counsellor's feelings
regarding her work at the Drug and Alcohol agency, the type of counselling she was doing
and the type of clients she was interacting with. Carol was disillusioned at work and felt
bored working with almost all her clients. In essence, for Carol, this frustrating experience
with this client and the weariness she continuously felt were a signal to listen to herself, to
what is happening to her, to take note, and to make some changes in her life to prevent herself from wearing out completely. Thus, what the counsellor was feeling about the relationship with her client resonated with her feelings about her work and the changes she needs to do to keep herself emotionally healthy.

The Experience of Feeling Inadequate, Incompetent as a Counsellor

When the counsellors in this study were unable to feel empathy for their clients, they all started to question their therapeutic abilities and their competence as counsellors. For these professionals, feeling compassion and empathy for their clients is an essential element of the therapeutic process and when this did not happen, they blamed themselves and questioned their competence. As Sarah stated,

The end result was that I judged myself, “what is wrong with you?” I questioned my competence and it spiralled to the point where I was saying to myself, “Maybe I should not be in this field”. I had the expectation that I should be empathic to all my clients and this was not happening.

In a similar manner, Adrienne felt uncomfortable with the powerful feelings of revulsion and disgust that she had towards her client. She was hesitant to use the word “evil” with her Director to describe the man. She feared that she would be judged by others as being “too emotional, fussing too much and being too sensitive.” Only after her experience was validated by another counsellor who had seen this client on an individual basis did she feel “less weird, less too sensitive,” in expressing what she felt towards this client.

When Belinda started shaking and crying after her client left, she felt that she was overreacting and thought that somehow she had done something wrong in the session. She could not make sense of her reactions and was scared:

I was thinking that this shouldn’t be happening and I didn’t want the rest of the group to know that this was happening. Like it was okay I think to be upset but I really felt traumatised by the material that I had heard and I was thinking, “therapists are supposed to be able to hear this stuff and not start shaking and
crying"...like somehow I had done something wrong and I think that it shocked me because I had heard lots of terrible things, you know I had heard abuse stories and I never had a reaction like I had to this material.

On Carol's part, the counsellor often felt that she was continually searching for the key that would unlock the therapy with this client. She often questioned her ability and wished that she had more knowledge about people with borderline personality disorder. Moreover, the client had been through so many different counsellors and through so many treatment centres, that Carol often wondered if she were better or worse than the other professionals that had come in contact with this client. She wished that somehow one day she would "crack the code" of the client and succeed where others have failed.

These feelings of incompetence and inadequacy that accompanied the counsellor's experience of empathic strain with their clients often hindered the professionals from consulting with peers or from seeking supervision, if this latter was available. For instance, Sarah did not ask for support as “that might suggest that I am not very competent. I know intellectually that this would not happen but emotionally this is not how I felt.” In the same way, Adrienne was reluctant to ask for support as she feared that this would reflect negatively on her personality and professional reputation. Moreover, when Joanne terminated with her client and referred her to another counsellor (who was married and had children) in the same agency, Joanne felt that she risked professional embarrassment especially if this new counsellor was successful with this client:

You know what would have been a horrible, worst case scenario for me, is to get to know that the new counsellor had done some really empathic work with her and really non-confrontational and that the client just sort of blossomed from that...I would have egg all over my face.

As a result, she kept worrying and wondering how the sessions were going. She frequently asked the new counsellor about the client and also looked into the client's file to see how the sessions were progressing. She badly needed some reassurance regarding
her abilities as a counsellor. Joanne kept wondering, "Did I do the right thing? Were my insights correct or were they incorrect?" Joanne felt guilty about having confronted her client and felt immensely relieved when she read in the client's file that the client was not doing any individual work and that the new counsellor was planning on confronting her too.

To Carol and her colleagues who participated in the study, seeking support and sharing feelings about clients in the agency seemed an unsafe intervention to do. Moreover, there did not seem to be the space for the counsellors' feelings. Sarah stated that she rarely took the time to speak about how clients were affecting her. She was not in the habit of doing so: "It was as if it wasn't an acceptable thing to do. I usually deal with people and just leave it." Things had to be really bad for her to seek support. Carol related the same feelings:

I think that with rare exceptions, my stuff does not get dealt with here unless... I mean... I had a client who died of an overdose and even then I had to actually grab someone to sit down and say I need to talk about this. I had to make time to do that.

In effect, this experience was one of the most difficult experiences that Sarah and Carol had had with their clients, and they realized that they needed not only to get into the habit of seeking support, but actually make time to get that support in the future.

In this respect, the use of the workshop as a research methodology before the in-depth interviews took place, was successful in normalizing the counsellors' experiences and in helping them lessen the professional shame that they felt as a result of their experiences with their clients. Sarah commented the following:

Well, it was the first time that I heard people acknowledging the difficult clients they have had, although I had known that. It just seems like a taboo thing...to talk about that...it is not acceptable to acknowledge that...it is funny how that is...it is almost like talking about suicide...it is almost like the message is that if you have these difficulties [with clients], there is something wrong with you, which there is...a lot of countertransference that takes place and in essence it is often is about you
(laughter). But that does not mean that you can't be a good counsellor...it was good to break the silence.

Adrienne similarly felt that her experience was being validated by the workshop and it helped her to hear the workshop facilitator legitimise "empathic strain" as a valid area for research. It helped her feel more empowered and more able to take the risk to participate in the in-depth interviews.

**Experiencing the Need for Self-care and Burn-out Prevention**

This theme consistently emerged in all the participants' narratives. The counsellors' experiences with their clients as well as the process of talking about their experiences as participants in the study brought to their awareness the extent of the impact that their clients were having on them and the need to give more importance to their self-care if they wanted to continue practising their profession while remaining emotionally healthy and satisfied with their work.

All the counsellors worked in a government agency and repeatedly stated that they do not have either the time nor the space, to process and make sense of what happens to them during their engagement with their clients. A statement from Belinda's interviews will provide the reader with a glimpse of this situation:

> We're so busy putting out other people's needs before our own and putting out fires, that you really don't take the time to get in touch with what's happening to you along the way...I mean your focus has to be on helping these people who are often in a crisis; and you have to be calm and you have to be together and you have to be empathic and you have to do all these things to get through a crisis and while you're doing that you don't pay attention to what's going on for yourself...I think it is a definite hazard of our profession and somehow we have to find a way to take care of ourselves, at the same time it is not easy.

During her interview, Carol uttered almost the same words as Belinda:

> I think that this is reflective of just working in this office setting and the number of clients that we see...I do not know about anybody else but I probably tend to underrate how much I feel or gloss over my own reactions a bit more because you're in this work mode and you keep going...it's kind of like an acceptance of this 'wear and tear' of being a counsellor and not really looking at it.
What often helped the participants jolt out of this “wear-and-tear” resignation was talking to other counsellors from different counselling fields. Only when these other counsellors would remark at how much more stressful such clients were as compared to their client group, would the participants become aware of the challenges of their client population. Thus, feedback from other professionals brought into awareness the difficulties these participants faced. In actual fact, for all the counsellors except one, participating in this study was their first opportunity at talking at length about their experience and at realizing how clients had strongly impacted them in their professional and personal lives.

At the time of the interviews, there seems to have been no ongoing supervision meetings in the counsellors’ agencies. What was available, at times, was peer consultation often in the form of case-presentations. However, these counsellors did not consider this setting psychologically safe for them to disclose their feelings towards their clients, especially when considering the feelings of inadequacy and shame that accompanied all of their experiences.

The participants also reflected on their career pathway and how their approach to clients and work differed since the time they had started counselling, fresh and full of enthusiasm after completing graduate school. Adrienne stated that:

Eager beaver, like I was after graduating, I was happy to get a job and any job was great but now the honeymoon is over and when you see certain kind of clients with certain difficulties 30, 40, 50, 100, 200, times over, it starts getting old.

Belinda too stated that when she had started counselling she somehow saw herself as a saviour for the clients who were suffering. However, it did not take long for her to realize that she had to reframe her expectation as she was setting herself up to be “knocked down time and time again.” She decided that all that she could do was to be this
one person in the clients' life that they can count on to be respected and cared for and hopefully if this did not make a difference in the present circumstances, she hoped that it will have an impact on their future, in the choices they make, and who they become.

Some of the participants wondered how much longer they could stay in their present work setting. Adrienne noticed that recently she has been experiencing what she termed as a “cumulative effect” of seeing certain kinds of clients over and over again. She has noticed that as time goes by, she is having stronger reactions to hearing stories of men abusing children and now she is finding it “sickening” and “contaminating.” In the first few years that she started counselling, she remembers feeling numbed by the abuse stories that she heard. Now she is noticing that her reactions are becoming stronger and more “coalesced...more definitive...increasingly as I hear men who talk about abusing children...I just feel like feel like telling them ‘you bastards’ and I just feel this.” These feelings unsettle Adrienne and set her wondering about her future and how much she will be able to work with these type of clients.

Two of the participants stated that they do not see themselves working in the same setting in the future. Ideally they would like to work in private practice where they would have more choice over the type of clients that they would work with, not be constrained by time limits regarding counselling sessions and have more say in the type of service provided. The ideal working place for Carol would be a private practice with a few colleagues where there will still be opportunities to case-conference, do some teaching, socialize, and where “the time restriction is off my mind.” For Carol, knowing that she can give only a limited service to her clients (a total of 30 sessions) wears her out and she feels that she is pressured by “this constant countdown.” In Belinda’s experience, bureaucratic systems often disempower clients and she finds this quite offensive. Ideally she would like to work in an agency that has principles that she can believe in and that
together with other workers, she could provide a service that truly respects clients.

Adrienne fantasizes “about having a private practice where I can just say, [pointing to the imaginary clients] ‘yes, yes, no, no – I won't work with you; I won't work with you; I will work with you; I will work with you’, “which would give her a choice as to whom she will work with and not be constrained to take on the next person on the waiting list as mandated by government service.

In summary, the participants’ experience with their clients as well as participating in the workshop and the in-depth interviews helped these counsellors evaluate the impact of clients and the work-setting upon their personal and professional lives, reflect on their career decisions made in the past and also to consider what changes they need to do for themselves to prevent burnout.

**Experiencing Transformation and Psychological Growth**

From the transcripts, it was clear that the participants and researcher were involved in a reflective process that engendered mutual growth, increased self-awareness, and learning, not only on a professional level but also on a personal level. This theme summarizes the change and the growth experienced by the counsellors and what this whole experience meant to them.

On a personal level, the participants reframed their experience with their clients as an opportunity for personal growth. Belinda realized that through her encounter with her client, she had to confront herself and some of the issues that had always been a core part of herself. In her life, Belinda experienced innumerable losses over which she had no control. With this client, Belinda had no choice but to re-encounter these profound personal losses in her life even whilst actively grieving the recent loss of a very important relationship. Belinda believes that even though she had done personal work every time
the losses had taken place, she only came in touch with the core part of her issues because of her experience with the client.

Through and with her client, she learned that one can recover from one's losses and also find gifts that come with such losses. Belinda vicariously received the gifts that the client received. One gift that she received was “just how sacred life is, and how important it is to honour that...and in our relationships with people, to make every day count with them.” This experience with the client reinforced Belinda’s beliefs in the resiliency of the human spirit and that even the most unbelievable grief and pain can heal. The counsellor also felt that she regained confidence in herself as a therapist and in her ability to make a difference in the lives of her clients. This is how Belinda described her journey:

It started with a lot of fear, my own fear; fear of being overwhelmed and wanting to hide from her [client’s] experience and slowly feeling, like the fear slowly went away; it didn’t happen quickly...the longer I stayed in it, the more times that we went through it together, the less afraid I got...and then I started seeing that I could have an impact on what her healing looked like, what her journey looked like and that I could facilitate what she needed to have happen.

In Adrienne’s case, the process of growth and change was apparent during the research process itself. By the third interview, which took place after an interval of 2 weeks after the first interview, Adrienne was feeling less victimised, more detached and safe. The process of engaging in a conversation as part of the research project empowered her to becoming proactive in her approach rather than a recipient of uncomfortable, powerful feelings:

I was reflecting on my experience last night [while counsellor was in the group with the client] and I was feeling less victimised...I was feeling more detachment and safety because of all the proactive things that I have done. For example, just even talking...well not just even, but especially talking with you and having a chance to articulate my concerns and following that up with talking with staff more, I feel that by engaging in that process...I feel less disturbed, less personally violated...I feel a sense of empowerment, actually that he isn’t getting to me as much.
As a result of her experience with her client, Adrienne learnt that it was important for her to pay attention to what her body is telling her as her “body pain is a strong signal to pay attention to what’s happening in the moment.” Thus, if in the future she were to re-experience uncomfortable, strong reactions towards a client, this would be a signal for her to consult with someone so as to be able to sort out her feelings and make sense of the experience, whereas in the past she would struggle with her feelings on her own and find it unacceptable to talk about it. This emphasis on the importance of reaching out was also expressed by Sarah:

It reminds me of how important it is to talk about clients that I have difficulty with, with other people. You were to only person I spoke to about her...whereas if I had spoken to other people...I might be better able to deal with her when the next situation comes up

Sarah also stated that this experience helped her appreciate the fact that she is human, has limitations and that she needs to prioritize her professional and personal growth. As a professional she requires more training and as counsellor she realized that it is important for her to increasingly recognize how her need to help, and her need to change someone’s pain takes over and affects her work with clients. She also believes that she has acquired a greater capacity to be compassionate with clients because she is more in touch with her own feelings as a result of having her own personal issues triggered by her work.

Joanne’s experience with her client as well as participating in the research process taught her that it is inevitable at times to have empathic difficulties with clients and that as a therapist she can fail at times. Joanne felt that she was becoming more confident in her role as counsellor and in her ability to stand by her decisions. This counsellor realized that she “doesn’t have to be all things to all people” – it was useless trying to impress clients or peers.
Carol too, came to the realization that empathic strains with clients are sometimes inevitable. She realized that there will always be clients who she will not enjoy working with and that there will always be clients who she will not be able to work with. According to this counsellor, talking about her experience had a powerful impact on her. It provided time for her to reflect and to evaluate herself professionally and personally. A number of points regarding her experience with her client became clearer. In this respect, she realized that after all it does matter to her that she emotionally connects with clients. On another level, Carol was reminded of the broader contexts of her life, of the period in her life when she had to cope with her psychological breakdown, the emotional weariness that she was feeling then, and is feeling now, as reflected in the work with her client and also in her feelings regarding her work in the drug and alcohol setting.

The participants also reflected upon how their view of themselves as counsellors and their theoretical perspective had changed. Adrienne found herself revisiting her personal theory of counselling. Coming from a predominantly humanistic Rogerian background, this counsellor questioned whether empathic understanding, unconditional positive regard, and genuineness were truly sufficient (and necessary) conditions for change to occur in clients:

I realized that I was quite immersed in the Rogerian concept that we were taught. It really made an impact. I felt that it was the way, the right way: if you just gave people enough empathy, enough unconditional positive regard and you allowed them to talk, they would grow and I probably envisioned that they would grow as I should see them grow, right? (Sarcastic tone)...so I'm moving away from the methodology of the Rogerian concept, like that positive regard is enough

This experience with this client helped her start realizing that clients are at different places on the road of change and no amount of empathy however great would enable the client to change unless he or she is ready to do so. Adrienne started becoming more accepting of the idea that as a counsellor it is not her sole responsibility and her
duty to change the client so that he or she becomes healthier and more respectful and that it is not her responsibility to help everybody that comes through her door. She started becoming more comfortable with the notion that some clients may not be ready to change and that they may never be ready. Moreover she became more appreciative of the medical model of illness and view of psychopathology than she had been in the past.

At the same time, [I am] seeing that some people may be diagnosed with a mental illness and that's actually a useful concept; so like the psychopath, I'm happy to let the medical model diagnose that person as having these kinds of limits and needing this kind of setting and this kind of therapy to function; if you set them loose out in the world again, they're going to...re-commit a crime; if you provide them with empathic kind of counselling, they're going to use those as tricks. So I am at the phase now where I'm trying to articulate to myself what is my belief about how people change and...to be open to assessing and really responding to what the client seems to show in the moment.

For Adrienne, coming to the above realizations and questioning her view of herself as a counsellor and how people change, was a sign of growth. At the same time, she still struggled with accepting these newly acquired concepts and at times felt guilty expressing herself in this way as she felt that she was judging these clients as being deficient or bad. However, participating in the research process helped her affirm her growth with me as the researcher and it “turned out a very positive experience.”

Belinda reflected upon her training at graduate school. In this case, this counsellor stated that most counselling programs urge the trainees to be as objective as possible and not to allow any personal material to intrude upon the therapy. She thinks that in essence, programs still subscribe to the notion of the therapist as an expert and educator of the client and thus there is no space for the therapists’ humanity in the therapeutic relationship. Moreover, as far as having empathic difficulties with clients, Belinda thought that such experiences should not happen, if she is a good therapist.

However, as a result of her experience, she came to the conclusion that “you realize how closely your experience mirrors the client's...and there’s really nothing that
separates you from them. You’re just human beings.” Belinda thus sees herself becoming more accepting of being first and foremost, a human being and then a counsellor, and that she is less judging of herself as an incompetent therapist because she has had such an experience of empathic difficulty with her client. At the same time, she is aware of the need for a balance between accepting her experience and her feelings around clients, and making sure that she is as emotionally healthy as possible to be able to work with clients. Through the research process, Belinda felt that she further consolidated her growth and journey with her client. Our conversations helped her to examine the process that she went through and brought a sense of closure to her experience.

In Conclusion

The participants’ experience of encountering empathic difficulties with their clients had several dimensions. The counsellors’ often experienced feelings of anxiety, horror, of feeling overwhelmed, desperate, bored and weary. These feelings were often accompanied by physiological reactions such as shallow-breathing, shaking, and psychic numbing. The counsellors often felt that they were shutting-off the clients’ material or going into “avoidance mode”. At other instances, the participants over-identified with the clients as opposed to avoiding the clients’ material. However, this still inhibited the counsellors’ empathic understanding and their therapeutic role with the clients.

Such an experience of empathic difficulty provoked an immense sense of professional inadequacy and shame. The participants questioned their competence and their therapeutic ability. At the same time, through the process of reflecting and participating in the research process, the counsellors experienced a transformation of their experience into an opportunity of professional and personal growth.
CHAPTER FIVE

Discussion of the findings

The purpose of this study was to capture the lived experiences of counsellors who encounter empathic difficulties with their clients, using a phenomenological-hermeneutic approach. Such an approach aims at gaining a deeper understanding of the nature and meaning of our everyday experiences. In this study, I attempted to explore the essence and the meaning of the lived experience of 5 female counsellors by asking these professionals to reflect retrospectively on what the experience was like for them, how they made sense of this experience and what significance it had for their personal and professional life. The research question that guided this study was “What is the lived experience of counsellors who encounter empathic difficulties with their clients?”

The process of reflection is an intrinsic component of phenomenological research. The participants reflect on their experience and disclose their experience to the researcher who in turn, reflects on these experiences and tries to grasp the essential meaning of the participants' experience. According to Van Manen (1994), phenomenological human science research attempts to articulate the structures of meaning embedded in lived experiences through language, that is, through the content and form of the text. In this study, thematic analysis was used to come to grips with the structure of meaning of the participants' experience. In this case, four major themes emerged from the participants' narratives, themes that can be understood as the structures, which make up the experience. These were: (a) Experiencing countertransference reactions; (b) Experiencing feelings of inadequacy and incompetence as a counsellor; (c) Experiencing the need for self-care and the need for burnout prevention and, (d) Experiencing transformation and personal growth.
Thus, these themes were the findings of this research. However at this point, it is also important to reflect in a critical manner on these findings. In what way are these findings important? What is the significance of this work? How do these findings compare with professional literature? What does this work contribute or enunciate to the field? What are the implications for the practice of counselling psychology? What are the implications for future research? I discuss these questions in this chapter.

Before embarking on these questions, it is important to clarify that the strength of phenomenology is not to offer us the possibility of theory through which we can explain and/or control the world. Rather, it offers us "the possibility of plausible insights that brings us in more direct contact with the world" (Van Manen, 1994, p. 9). Van Manen also refers to a good phenomenological description as one that "resonates with our sense of lived life," as "something we can nod to, recognising it as an experience that we have had or could have had" (p. 27). Furthermore, when phenomenological research results in a "rich and deep" text, it invites readers to a dialogue "where they involve themselves in the text, reflect on their own experiences, make comparisons, discern differences and use imagination to extend their understanding to other similar experiences" (Hunnisett, 1986, p. 266). It is hoped that such a text has already engaged the reader in dialogue and reflection about his or her own experiences in counselling.

Research Findings in the Context of Professional Literature

As stated in Chapter 2, in the literature section of this thesis, there are no published research studies on the experience of counsellors encountering empathic difficulties with their clients, using a phenomenological approach. The only background literature that dealt with this phenomenon was mainly conceptual in nature and coming exclusively from a psychodynamic perspective. Some of the findings of this research study were consistent with the theoretical framework with which the researcher
approached the field and thus are compared to the professional literature discussed in the “Literature review” chapter. Other findings however, were “surprises” to the researcher, themes that I had not anticipated. In this regard, these findings are compared to new research literature, which has not been previously discussed in this work.

The first theme that emerged was the theme of “Experiencing countertransference reactions.” In describing their experiences, the participants noticed how their encounters with the clients often touched upon personal unresolved issues in their life. In this respect, it seems that experiencing subjective countertransference reactions (Giovancchini, 1991), that is, countertransference reactions that result as a function of the therapist’s unique personal history and unresolved personal conflicts, is an important element in the experience of counsellors when they encounter empathic difficulties with clients. The participants’ countertransference reactions involved their feelings, the physical and physiological reactions they experienced, as well as the behavioural reactions that took place within the context of their experiences. These different dimensions of the counsellors’ experience were very similar to the types of reactions experienced by psychotherapists who work with trauma survivors, as derived by Wilson and Lindy (1994) and that were indicators of countertransference reactions taking place in the therapy. Some of these reactions were the following: “irritability,” “agitation,” “anger,” “disdain toward client,” “feeling overwhelmed,” “relief when a client missed an appointment,” “horror,” “disgust,” “dread,” and “numbing reactions” (p. 26). These feelings, physiological reactions, and behavioural reactions are strikingly similar to the choice of words that the participants used to describe their experiences.

In looking at the participants’ experiences in detail, through utilizing Tansey and Burke’s (1985) three-stage therapeutic sequence for understanding empathic failures, one can realize that the presence of these countertransference reactions of the participants
could have served as "signal affects," alerting the therapists to the possibility that a
projective identification might taken place, from the client into the therapist, causing the
empathic difficulty. Tansey and Burke (1985) point out, that unless the critical event of the
client's projective identification enters the therapists' awareness, they will be unable to
understand what is going on between them and the client. Perhaps, in the case of this
study, the participants had not been trained to consider the influence of clients' projective
identification and therefore, this has implications for counsellor training programs as well
as for counselling practice. On the other hand, as Tansey and Burke (1985) indicate,
unconscious mechanisms in the therapists may block from conscious awareness the
potential value of the emotional impact of the therapists' self-experience, as a
consequence of the potency of these affects.

Tansey and Burke (1985) also point out that therapists need to contain in
consciousness, the thoughts, feelings, and impulses having to do with themselves, their
clients, and their interactions. A failure in containment may result in the counsellor simply
reacting to the client's experience. For example, a therapist may retaliate either through a
hostile interpretation or at the extreme abruptly end the client's treatment. One of the
participants, Joanne strove to contain her client's comments. However, the attempt at
containment failed at the point when the counsellor terminated her client's contact. The
client "attacked" the counsellor, criticizing her life-style and the fact that she was not
married and had no children. At that point, for the counsellor, the therapeutic relationship
broke down completely. As Pearlman and Saakvitne (1995) explain: "When therapists are
devaluated and discounted, their capacity to empathize with their patients is thwarted
because their psychological energy is directed toward the preservation of their sense of
therapist-self, and their [italics added] need for empathic understanding and appreciation
is heightened" (Elkind, as cited in Pearlman & Saakvitne, 1995, p. 213).
The participants' experiences were also further complicated by an overall feeling of inadequacy and incompetence at experiencing empathic failure with their clients. Experiencing the inability to empathize with their clients was ego-dystonic to the counsellors, that is, incompatible with feelings about themselves as therapists and clashing with their ego ideal and deeply held values about how therapists should be in therapy. As Belinda, one of the participants stated, "Therapists should be able to hear this stuff and not start shaking and crying." Sarah, similarly voiced what being a therapist meant to her, in terms of providing empathic understanding: "I had the expectation that I should be empathic to all my clients and this was not happening." The therapists' experience of feeling unable to empathize with their clients impacted them in deep ways. It affected their professional identity. They doubted their competence as professionals and experienced professional shame. In her article "Unearthing Shame in the Supervisory relationship", Talbot (1995) states "interpersonally, shame is the emotion associated with the humiliating revelation of personal failure to another" (Nathanson, cited in Talbot, 1995, p. 339). However, she continues by saying that "intrapsychically, shame is felt when the individual painfully experiences a discrepancy between the actual self and the ideal self" (Broucek; Morrison, as cited in Talbot, 1995, p. 339).

Burke and Tansey (1985) emphasize that for therapists to begin to observe and understand the underlying sources of their experiences with their clients they need to separate from their experience, shifting from their "experiencing ego" to their "observing ego" (Schafer, 1959). In order for this to happen, Burke and Tansey state that therapists need to suspend self-criticism at being seen in an unfavorable light; therapists need to realize that current experiences, however uncomfortable are not a threat to one's self-esteem and that therapists need to understand that what they are experiencing is temporary and not enduring. However, this lack of insight in the participants, coupled with
the challenges of the intense countertransference reactions and the feelings of inadequacy and professional shame hindered them from "pulling back" sufficiently from the clients' experiences. They could not establish "psychological distance" (Greenson, 1960) and acquire an understanding of what was happening between them and their clients.

In addition to Tansey and Burke's (1985) framework, Wilson and Lindy (1994) provide a schema that aims to distinguish between different forms of empathic failures, in terms of reactions ranging on a continuum between avoidance reactions to overidentification reactions as discussed in the literature review. If one compares this schema to the participants' experience, one will realise that the reported experiences contained avoidance reactions, (as for example: the feelings of detachment and the act of withdrawing from the empathic stance) and/or overidentification reactions (as in Belinda's experience with her client), from the part of the counsellors' to the clients' material, presented in the therapy. Thus, this findings of this study are consistent with the literature. At the same time, one can note that the counsellors' experiences were more than this range of reactions as presented in the participants' narratives. Thus, research that aims to capture lived experiences adds richness to the phenomenon studied and contributes to the further understanding of this phenomenon. In essence, as a researcher I have gained a richer and deeper perspective of what it is like to encounter empathic difficulties through eliciting the participants' experiences than what I had learnt through reading the background literature.

Another consistent theme present in all the participants' interviews was the realization of their need to prioritize their self-care in order for them to prevent burnout in their lives. The most widely used definition of burnout in the literature comes from Maslach and Jackson (1986): "Burnout is a syndrome of emotional exhaustion,
depersonalisation, and reduced personal accomplishment that can occur among individuals who do ‘people work’ of some kind” (p.1). Through participating in this study and talking about the impact that clients had in their lives, counsellors realized that they rarely have the time, or take the time to process and make sense of what happens to them with their clients and the end result of that is very often, feeling emotionally depleted, unstimulated at work and unable to make any progress with the client, in counselling. Empirical research shows that a lack of therapeutic success (in this case, as a result of being unable to empathize with clients) was perceived by psychotherapists as the single most stressful aspect of their work (Farber & Heifetz, 1982). In this same study by Farber and Heifetz, the majority of the therapists interviewed felt that burnout resulted from the nonreciprocated attentiveness, giving, and responsibility demanded by the therapeutic relationship.

At the same time, when the participants’ feelings, physiological reactions, and behaviours were addressed, when their experience was given priority and validated, the participants encountered a transformation of their experience and experienced psychological growth. The process of talking about their experience gave the participants an opportunity to reflect on their work, to become in touch with the totality of their experience and also to find ways of making meaning of what they went through with their clients.

How can conversations become vehicles for transformation? Anderson (1997) distinguishes between two kinds of conversations: those in which new meaning emerges and those in which it does not. She refers to the former type of conversations as “dialogical conversations.” Anderson defines dialogical conversations as “shared inquiry” (p.112), a process in which “the participants are in a fluid mode characterized by an in-there-together, two-way, give-and-take exchange” (p.112). In these conversations, the
participants do not assume they know what the other person is saying, or means but each
tries to learn and understand the other by negotiating meanings using language. In this
way, meanings that emerge in the conversation urge each participant toward
understandings that were “not foreseen or intended” (Wachterhauser, cited in Anderson,

According to this perspective which comes from a post-modern, narrative
approach, conversation becomes a meaning-generating phenomenon in itself. It is
transformative in its capacity to situate events in people’s lives in the context of new and
different meanings that emerge from the exchange of conversation. Change occurs in and
through the “redescriptions that result from the telling and retelling of familiar stories. In
the telling and retelling, not only do new stories emerge, but a person changes in

In this study, the participants reframed their “frustrating,” “horrific,” “desperate”
experiences as opportunities that resulted in their growth as persons and as counsellors.
This transformation was not anticipated by the researcher. However, it was clear that by
the second interview, all the participants were experiencing a shift in their feelings, and in
their thoughts especially in the way they were reframing their experiences. Research
findings in the area of psychological growth that occurs after trauma indicate that
“emotional growth” is a positive outcome experienced by individuals who deal with their
difficulties (Affleck, Allen, Tennen, McGrade, & Ratzan, 1985; Affleck, Tennen, &
Gershman, 1985).

This “emotional growth” was present in especially two of the participants, Belinda
and Adrienne. Belinda came in touch with one of her worst fears, the fear of experiencing
a profound loss in one’s life. She confronted it and the longer she stayed with the fear, the
less afraid she felt. She regained confidence in her ability to make a difference in clients’
lives and learnt that it is possible to survive great losses in life. Furthermore, she vicariously experienced "the gifts that came from loss" appreciating the "resiliency of human spirit," and the "sacredness of relationships." On reflecting upon the interviews, Adrienne felt less victimised, more detached from her experience and thus empowered to act, to set limits and protect herself from her client. She felt able to seek help and support whereas in the past she would have struggled on her own.

Surviving trauma may also lead to an enhanced appreciation of one's vulnerability, sensitivity, and emotional experience (Tedeschi & Calhoun, 1995). For most of the participants, participating in this study brought into their awareness, that even though they are professionals, they are human too, with their own vulnerabilities, needs, and wants and that they cannot afford to ignore "themselves" and assume that they are not being impacted and influenced by their clients. Moreover, this enhanced appreciation of one's vulnerability is also associated with a changed sense of relationship with others (Tedeschi & Calhoun, 1995). As a result of her experience, both Sarah and Adrienne realized the importance of reaching out for help and support from others and stated that this is what they will do when they will re-experience uncomfortable emotions in their encounter with clients.

Another benefit reported by people coping with life traumas, in Tedeschi and Calhoun (1995) is that of a changed philosophy of life. The participants did not specifically reflect on their philosophy of life. However, some of the participants revisited their personal theories of counselling. They also pondered about their view of how people change in therapy, about the complexity of change and about human nature in general. In their journey, the participants struggled with living through their experiences. Very often, their journey with their clients touched upon painful, personal issues and touched upon
their core identities as counsellors and persons. Yet with the struggles, they also made
discoveries about themselves and were transformed in the process.

Limitations of the Research Project

As has been already stated, the purpose of doing a phenomenological study is to
attempt to construct a full interpretative description of some aspect of the lived world. Yet
lived life is always more complex than any description of meaning can reveal (Van Manen,
1994). In this sense, this study is limited by the fact that no single description of the
experience of counsellors who encounter empathic difficulties with their clients, can
capture the complexity and totality of the experience, no matter how thick the description
and no matter how close the description is to the participants’ experience.

In addition, the narratives presented have come about as a result of the
researcher’s interaction with the participants. Perhaps another interviewer would have told
a different story of the participant’s experiences. However, it is interesting to note that a
peer reviewer who read the narratives came out with almost the same themes and sub-
themes from the data provided to her. In addition, the transcripts, the themes, and the
narratives were shared with the participants and they considered them accurate
representations of their experiences. All this further enhances the credibility and
trustworthiness of this study especially in balancing out subjective bias in the interpretative
process.

This research study focused on the retrospective reflection of the participants’
experiences. As the counsellors had to recall their experiences, this study may have been
limited by memory recall and by the fact that some material may have been distorted by
the participants. Furthermore, as the participants knew that I was interested in specific
types of experiences around the topic of empathic difficulty, the issue of social desirability
and the need for social approval could have come into play with the way the participants
responded to the research (Borg & Gall, 1989). This issue came up with one of the participants. As she reviewed her first transcript, she commented that during the first interview she was very much aware of the "demand characteristics" of the research and she was aware that during the interview her feelings were much more intense than they had been in reality. However, she felt that by the third interview we had got to how she actually felt with respect to her client. In effect, the use of three interviews in this study contributed greatly towards the consistency and validity of the participants' experiences.

This study was dependent on the context of the participants. In this sense, it was limited to the experiences of 5 female, Caucasian counsellors of age range from 32 years to 45 years old, working in government agencies and having a range of counselling experience from a minimum of 5 years to a maximum of 11 years. A different sample, larger in size, mixed gender, of a wider range of ages and work experience, working in different settings as well as one encompassing a multi-cultural representation may have resulted in different findings. All these factors have implications for future research, which will be discussed later in this chapter.

Finally, one of the challenges of doing phenomenological study is that there is no "primer" on "how to" do this type of research. There are no definitive set of procedures and a lot of the research process depends on the "interpretative sensitivity, inventive thoughtfulness, scholarly tact and writing talent" (Van Manen, 1994, p. 34) of the human researcher. At times, the research process appeared an intimidating and endless task that stretched one's abilities. At times, it was very easy to lose the focus of the research study, especially when faced with the volume of data that is characteristic of qualitative studies. Thus, it was often necessary to go back and forth between the results, the thematic analysis and to the research question, to re-orient one's sense of purpose in this study. At the same time, it was also an exciting and stimulating endeavour!
Implications for Counselling Practice

The participants' narratives were powerful reminders or revelations that counselling and psychotherapy need be understood in a relational context. In the context of the therapeutic encounter, there is the interaction of complicated feelings, needs, beliefs, and interpersonal styles of two people engaged in a complex, intimate process together. The participants' stories underscored the fact that despite their training and competence as professionals, counsellors are ultimately as human and as vulnerable as their clients, with their own blind spots, conflicts, and personal experiences and that because of this vulnerability as humans, empathic difficulties are inevitable in a profession that is so dependent on the therapeutic relationship.

In this respect, if we accept that therapy needs to be viewed from a relational context, then as therapists we will accept that we will be affected by what we hear from our clients and that with every new client, there is the possibility that we will be touched, that our vulnerabilities will be elicited, and that we will also be transformed in the process. In a certain sense, it seems almost illogical to think that we would be involved in a transformative process whereby our clients often undertake life-changing decisions, and not be transformed ourselves.

The findings of this study also have implications for counsellors' burnout prevention and self-care. I think that recognising the signs of empathic difficulties with clients, especially the recognition of countertransference reactions is an important tool in the self-care of therapists. These reactions can hopefully be understood as "normal," albeit often very powerful and painful components of doing therapy, and not pointers of the professionals' incompetence or inadequacy to do therapy. At the same time, these reactions also can be "alert calls" for professionals to seek peer support, consultation, and supervision. In fact, counsellors are ethically obliged to be "cognizant of client-elicited
emotions, countertransference and other issues that impact counselling relationships and must obtain appropriate assistance to deal with such in their personal lives” (Standards for the Clinical Practice of Mental Health Counseling, as cited in Schultz 1994, p. 180).

The participants’ experiences were transformed into opportunities for growth as the counsellors reflected on their experience and made sense of what happened. In this respect, this study has important implications for supervision practices. Research has already indicated that the presence of a safe, positive, and mutually respectful supervisory relationship is crucial to the learning, receptivity, and satisfaction of supervisees (Hanson & Barker; Friedlander, Siegal, & Brenock; Karr & Geist; Schact, Howe, & Berman; Worthington & Roeehkle, as cited in Cornfield, 1997). Thus, it is recommended that supervisors find constructive ways of including the vulnerabilities of therapists in supervision, without discrediting their capacity to help clients. It is important that supervisors help supervisees identify what is going on in the therapeutic relationship and use the countertransference reactions as opportunities for further learning and growth.

In the same way, graduate training programs, particularly counsellors-educators need to teach students about the inevitability of countertransference reactions with clients and provide the necessary supportive structures to enable the counsellors-trainees to go through the process and learn from it. In writing about the dynamics of countertransference, Gelso and Carter (1985) state the following: “Counsellor countertransference occurs in counselling of every [italics added] theoretical orientation” (p. 181). Moreover, they also state that:

...facing, and indeed inspecting, countertransference-based feelings is one of the most difficult tasks of the therapist. It requires considerable courage and a willingness to deal with one’s own painful feelings for the sake of the therapeutic work. There are no easy answers to the question of how to accomplish this, but at the same time doing so is a crucial aspect of effective therapy (pp. 182-183).
It is important that such professional issues are acknowledged and brought to the surface and not be considered "taboo," as one of the participants stated. Furthermore, it is recommended that the subject area of countertransference, its recognition and management is included in the curriculum of counsellors' training programs, perhaps being incorporated with the teaching of the basic therapeutic skills.

Finally, I think that this research study has also something to offer to the field at large, in terms of the administrators of service-providing agencies. These would benefit from reading the participants' narratives as this would give them insight into the complexity of doing therapeutic work as well as help them increasingly recognize the importance of making supportive and effective supervision or consultation available on a regular basis to the service-providers themselves. The participants' narratives would also help them understand the implications that such experiences have on clients' turn-over as well as on the therapists' mental health and satisfaction at work.

**Implications for Future Research**

In trying to capture the complexity of lived experiences, one of this study's contribution is in its provoking and stimulating the research field to ask more questions and, perhaps to make new connections between different phenomena. One of the questions that came to mind concerns the role of individual variables. What role does gender play in the experience of counsellors when they encounter empathic difficulties with clients? Given the same clients, would male counsellors have reacted differently to the same material? Does age of the counsellor make a difference? For future research, it is interesting to note Pearlman and Saakvitne's (1995) discussion on countertransference issues across the therapist's age and professional development.
Moreover, what role does education and training play? Would the counsellors have had the same experiences had they been trained to recognize countertransference reactions? Wilson and Lindy (1994) conclude that adequate education and training, years of counselling experience, supervision, peer support, and particular therapists' personality traits such as resilience, flexibility, and sensitivity are all factors that seem to affect whether or not therapists are able to maintain an empathic stance with challenging clients. It would be beneficial to the field if future research projects would employ quantitative methodologies to investigate the relationship of these factors and the phenomenon of interest.

Future research could also focus on the clients' perspectives. Wilson and Lindy (1994) suggest a number of client variables that could be relevant to the understanding of countertransference reactions in therapists. Some of these client variables include the following: “Age, race, gender, ethnicity, personality characteristics and family dynamics” (p. 21). Thus, future research could indicate which of these client variables, if not all contribute to empathic difficulties in therapists. It would also be useful to the field to focus on the experience of clients when they encounter their therapist’s difficulty at empathizing with them as this would give counsellors further insight of what it means to be their client, enabling them to hopefully extend or stretch their empathic ability in situations that challenge even the most experienced of clinicians.

Conclusion

In the course of the interviewing process, I asked the participants what their experience meant to them. To complete this phenomenological research project, I have put the same question to myself, that is, what was the experience of doing this research like and what did this research mean to me? The most meaningful part of the research process was interviewing the participants. In-depth interviewing has led me to have a
deep respect for these counsellors, for their risk-taking in sharing often, very painful experiences, and for being a “witness” to their psychological growth and transformation.

The research process itself was not without struggles. During the data analysis process, I believed that I needed to be as faithful as possible to the participants’ words and intrude as little as possible in the stories. This would have been disrespectful to the participants as well as ineffective research! Thus, this is why I chose to represent the data in the first person, in the voices of the participants.

Furthermore, during the interviews, I struggled in the different roles that I played. I was primarily an interviewer but sometimes I also felt like I was a counsellor and there were instances where I felt like a supervisor. I tried to keep in mind that our meetings had a purpose and that the interview guide was my agenda and yet I needed to have enough flexibility to give the participants the space to narrate their stories.

Finally, through engaging in this research study, I have gained a lot of insight into the intricacies and complexities of counselling and psychotherapy. As a counsellor, I have started to accept that knowledge and insight into people’s behaviour does not make me invulnerable to emotional pain, at least not in this profession. I learned that I need to be continually aware of my feelings, reactions, and experiences while counselling clients. It is important that this awareness is used constructively, not to determine pathology in either myself as the counsellor or in my clients but to encourage reflection on how two individuals, with their own unique complexities and vulnerabilities interact in their journey towards growth, recovery, and change.
References


APPENDIX A

Letter of Introduction

c/o 321, 6040 Iona Drive
Vancouver, B.C.
V6T 2E8
9th January, 1997

Clinical Director
(Address not disclosed to
preserve participants' confidentiality.)

Dear Mr. W. Moy,

I wish to thank you for considering the possibility of allowing me to access your agency and to collaboratively engage in research with your counsellors. Through this letter, I wish to introduce myself and to take the opportunity to describe briefly my research proposal.

As a topic for my graduate thesis topic, I aim to explore the process that goes on when therapists encounter empathic difficulties with their clients, when they feel themselves either withdrawing from the clients' issues or feel over-involved in the clients' concerns. The emphasis here will be on capturing this experience through feedback from professionals in the field, in daily contact with clients.

In my experience as a counsellor working in a school setting and marital agency before deciding to attend graduate school, I have encountered situations where I have felt very affected by what the client was telling me. In some situations I have felt myself withdrawing, not wanting to hear about the pain nor the graphic, often horrific details. At other times, I felt very personally involved in a client's life almost to the extent of forgetting that this is a client and not a friend and needing to remind myself of the importance of maintaining professional boundaries as a necessity for client change. All this had physical and emotional effects on me. Such experiences led me towards choosing to investigate this area as a research topic for my Masters' thesis.
I now wish to outline in some detail, the procedures involved in this research. The following procedures have also been submitted to the U.B.C. Ethical Review Board for approval purposes. During my first meeting with the potential participants, I will introduce the research proposal to the counsellors and the procedures involved in this project. It is envisaged that this meeting will have recruitment purposes too. The number of participants required for this research is 5-6 participants.

The first stage of this project will involve a 3-hour workshop facilitated by myself and my supervisor on the topic of “Empathic difficulties during therapy.” Volunteers interested in this research project will fill in a work sheet on the topic that will help them identify which types of clients and client situations are likely to provoke empathic difficulties, in the case of each participant. A discussion and sharing will follow from this work sheet.

The second stage of the project will involve 3 one hour in-depth interviews with each volunteer. The time during which the interviews will take place will be negotiated according to the convenience of the participants so that my presence as a researcher at the agency will be as minimally intrusive as possible to the work of the counsellors and to the agency as a whole. These interviews will be guided by the following research question: “What is the experience of therapists who encounter empathic difficulties with their clients?”

Data collection will include collecting field notes and audio-taping the interviews with the therapists. These interviews will be transcribed and copies of each transcripts will be presented to the participants so that they can check that what I have recorded is consistent to the therapists’ experiences. From the data collected I will delimit the underlying meaning units in the texts to draw out the central themes of the participants’ experiences.

With regards to issues of confidentiality, the identities of all the participants will remain anonymous and will be kept confidential. No real names will be used during the interviews and no identifying information will be included in the final thesis, in any future journal articles or conference presentations or released to any persons. Information gathered during the interviews will remain confidential and will be accessible only to myself, my supervisor and to the two other members of the thesis committees. The audio-tapes will be erased after the project is complete. Furthermore, I wish to clarify to the potential
participants in the team, that participation in this study will be entirely voluntary and participants also have the right to withdraw from the study at any time.

Finally, there are no known risks involved in participating in this study. However some participants might experience if at all, some psychological discomfort related to personal disclosure. Having said this I also wish to emphasize the number of benefits tied to this research. The participants will be given the opportunity to disclose their experiences in a safe, confidential environment to a researcher who will listen attentively and provide empathic understanding. This study will aid the participants come to the realization that such experiences as the ones investigated by my research question, are common experiences in the work of counsellors. Furthermore, this research can provide the context for personal reflection and evaluation of one’s work.

This, in essence, is my research project. At this point I wish to make a request, namely that if the agency and its members are willing to participate in my research, I would require a letter showing that the agency has given its consent. The UBC Ethical review Board require written proof of the Agency consent. Should further information or clarification be desired, please do not hesitate to contact me at phone no: (604) 822-0154 or my supervisor at (604) 822-5259.

I look forward to hearing from you and hope that I will be given the opportunity to engage in research with the members of your staff.

Yours sincerely,
Clarissa Sammut Scerri
APPENDIX B

Participant Information sheet

Thank you for agreeing to participate with me in my research. As you know the material that you discuss in your interviews will remain confidential and the data presented in my M.A. thesis will refer to you anonymously. However I do need some background information and I would appreciate your taking time to answer the questions below.

Name ___________________________  Age ___________

Preferred Pseudonym ______________________________

Tel no: (work) _________ (home)__________ (Time)___________________

(Please indicate at which phone number you prefer me to call you as well as the preferred time at which I can reach you).

Type of Education & degree ____________________________________________

Years spent Counselling (Please include the setting where you have counselled, if different than present)

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________
Briefly, describe your theoretical orientation in counselling.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Please, specify any kind of significant training that you may have had in counselling, beside graduate school.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Thank you for your time!
APPENDIX C

"Empathic Difficulty" Worksheet

The following is a partial list of client types, characteristics or diagnoses that often are mentioned as problematic by therapists. The list is purposely overlapping in categories of the descriptors and diagnoses given here.

Instructions

• Choose 15 that you feel are often most problematic for you.
• Reorder the first 15 starting with the least preferred and most problematic (1-15).
• Choose 5 that would be least problematic for you.
• Add any descriptors, categories or diagnoses that are problematic for you that have not been included here.
• Re-examine the descriptors and categories and describe any commonalties you see in the least preferred clients.
• Describe your ideal client.
• Think of a client that is troublesome to work with and answer A-E. Which clients do you have the most trouble working with? Choose 15.
1. The literal, concrete client
2. The abrasive client
3. The belligerent adolescent
4. The hostile client
5. The boring client
6. The passively resistant client
7. The lonely client
8. The silent client
9. The manipulative client
10. The seductive client
11. The dependent-helpless client
12. The help seeking-complainer client
13. The unsophisticated client
14. The non-complying client
15. The unmotivated client
16. The neglectful parent
17. The poor impulse control client
18. The empty client
19. The compliant client
20. The abuser-physical
21. The abuser-psychological
22. The violent client
23. The elderly client
24. The physiological disorder client
25. The chronic pain client
26. The client who blames
27. The client who refuses to take responsibility
28. The argumentative client
29. The client who fears intimacy
30. The client with inappropriate boundaries
31. The critical, impatient client
32. The narcissistic client
33. The sociopath client
34. The alcohol/drug addicted client
35. The suicidal depressed client
36. The severely disturbed client
37. The borderline client
38. The masochistic, self-defeating client
39. The survivor of childhood sexual abuse
40. The dissociative, identity disorder client
41. The paranoid client
42. The manic-depressive client
(1) Most problematic, least preferred clients, rank ordered.

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<tr>
<th>Type</th>
<th>No.</th>
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<th>Type</th>
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<tr>
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<td>6.</td>
<td></td>
<td>11.</td>
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<td>2.</td>
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<td>12.</td>
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<tr>
<td>3.</td>
<td></td>
<td>8.</td>
<td></td>
<td>13.</td>
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<tr>
<td>5.</td>
<td></td>
<td>10.</td>
<td></td>
<td>15.</td>
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</table>

(2) Of the types of clients described in items 1-42 which ones are least problematic for you?

<table>
<thead>
<tr>
<th>Type</th>
<th>No.</th>
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<tbody>
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<td>1.</td>
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(3) Add any descriptors, categories, diagnoses that have been problematic for you that are not included here.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

(4) Re-examine your client descriptors and note any commonalties you see in least preferred clients.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

(5) Describe your ideal client.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Who Gets You and Why

A. What am I doing to create or exacerbate problems in the therapeutic alliance?

B. What unresolved personal issues are being triggered by the conflict I am experiencing?

C. Who does the client remind me of?

D. What expectations am I demanding of this client?

E. What needs of mine are not being met in this relationship.
Please read the following and write down any words or phrases that come to mind in thinking about your experience with your clients and the empathic difficulties you encountered, that will help you in relating your experience during the first interview.

Think of an incident during counselling where you felt unable to empathize with your client. This could be a situation where you felt intensely involved with your client or a situation where you felt yourself withdrawing and “shutting off” the client.

During our first interview, I will ask you to describe your encounter, how you behaved and what you felt. I will ask you to describe it in such a way that someone who has never had the experience would be able to “see” the experience in your description.
APPENDIX E

Interview Guide

(Semi-structured format)

Guiding question: “What is the experience of therapists encountering empathic
difficulties with clients?”

First interview

I will ask the participants to refer to the “Pre-Interview Sheet” given to them earlier
and ask them to describe in as much detail as possible an experience with a client where
they have felt unable to empathize with their client. The incident could be a situation
where they have felt intensely involved with a client or a situation where they have felt
themselves withdrawing and “shutting off” the client.

I will ask the participants to describe their encounter, how they behaved and what
they felt, as opposed to explaining their encounter with the client. I will ask them to
describe their experience in such a way that someone who has never had the experience
would be able to “see” the experience in their description.

Second interview

Here, I will present to the participants my preliminary understanding of the
description of the first interview. I will ask the participants to clarify any material that
appears vague and ask them to provide me with any additional information that will help
me further understand their experience with the clients.

The remainder of the interview will focus on getting a sense of the context of the
participants’ experience in terms of their professional and personal life through the use the
following questions as a guide.
As an introduction, I will state the following: Now that we have gone through the description of your experience, I would like us to put this experience into the context of a bigger picture, that is, in the context of your professional and personal life.

a) After the client left the room when the session had ended, what did you say to yourself?

b) Did you share your experience with this client with anyone at work? If you chose to seek support was there a network of colleagues/friends to help you? Supervision? Peer consultation?

c) If you did seek consultation from others, in what way was this useful in helping you make sense of what had happened with your client?

d) Give me a sense of what was it like at work for you in general, at the time of the experience.

-----------------------------------

Let's go back to the time when you decided to become a counsellor

a) What were the salient experiences that influenced you to choose this profession?

b) What would you say as you look back now on your motivation to become a counsellor?

c) If you were to look in the future and see yourself in the same job, what would your gut reaction be? What concerns does the prospect of continuing bring up?

-----------------------------------

d) Which areas of your life do you think are affected by your experience with your clients and in what ways are they affected?

Possible prompts include sleeping patterns? Ability to relax and unwind? Sense of humour? Social activities? Ability to relate and work with other clients?.

e) In terms of your personal life and personal development what kind of transitions where you going through that would helpful for me to know in the context of your experience with your client.

Third interview.

Similar to the second interview, I will present participants with my preliminary understanding of the previous interview for clarification purposes, and ask for any addition of other information that the participants may want to add to the previous interview data.

The interview will then focus on consolidating the meaning and significance that this experience has for the participants.

a) Given what you described in the previous two interviews, what does it mean for you to have had the experience of encountering empathic difficulties with your client? What is the significance of the event for you?

b) After having had this experience are you aware of any changes in the way you look at: yourself as a counsellor; yourself as a person; how you view the world; how you view relationships in general; in the way you deal with change and the unexpected?

Prompts that will be used across the three interviews:-

Tell me more about that?

What were your feelings when that happened?

What went through your mind when that happened?

What did you do when that happened?

What did that mean to you? How did that affect you?
APPENDIX F

INFORMED CONSENT FORM

RESEARCH FOR A MASTERS DEGREE
IN COUNSELLING PSYCHOLOGY
ENTITLED

COUNSELLORS' EXPERIENCE OF EMPATHIC DIFFICULTY-
A PHENOMENOLOGICAL STUDY

Thesis Committee Supervisor
Dr. Pamela Cramond-Malkin
Counselling Psychology Dept
Psychology Dept
Telephone: 822 - 5259

Investigator
Clarissa Sammut Scerri
Graduate Student
Counselling
Telephone : 822-0154

Purpose of this study:

This project will focus on what happens when counsellors encounters situations where they are unable to provide empathic understanding to clients and feel themselves either withdrawing from the client's issues or feel over-involved in the client's concerns. The emphasis here will be on capturing this experience through feedback from professionals in the field, in daily contact with clients.

Study Procedures

As a person who voluntarily agrees to participate in this research study, you are invited to meet the investigator for three interviews lasting one hour each, thus for a total of three hours, at a time convenient for you. To provide a temporary, detailed record the interviews will be audio-taped and during the second and third interview, you will be presented with a transcript of the previous interview so that you will be able to check that what I have recorded is consistent with what has been disclosed by you. The transcript will also be used for further reflection between the interviews.

Confidentiality

Your identity as a participant will remain anonymous and will be kept confidential. No real names will be used during the interviews, and no identifying information will be included in the final thesis, in any future journal articles, conference presentations or released to any persons. Information gathered during the interviews will remain confidential and will be accessible only to myself, my supervisor and to the two other members of my thesis committee. The audio-tapes will be erased after the project is complete.
Participation in this study is entirely voluntary. If you decide not to participate, or choose to withdraw from the study at any time in the future, your position in the agency will not be jeopardized nor any relationship with the investigator or the University of British Columbia. There are no risks involved in participating in this study. However, there is a possibility of some psychological discomfort related to self-disclosure. Should this be a concern for you, please feel free to contact my Supervisor or myself at the above telephone numbers. We will be pleased to discuss any concerns in this regard, answer any questions that might arise during the project period or refer appropriately if more in-depth help is necessary. Moreover, should you have any concerns about your rights as a research participant, you may contact the Director of Research Services at the University of British Columbia, Dr. Richard Spratley at 822-8598.

To confirm that you consent to participate in this study and that you have received a copy of this consent form for your own records, please sign in the space provided below.

Participant's signature__________________________ Date ________________
Signature of a Witness__________________________ Date ________________

Sincerely,
Dr. Pamela Cramond-Malkin
Clarissa Sammut Scerri