Commitment under pressure: Experienced therapists’ inner work during difficult therapeutic impasses

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(Received 30 April 2009; accepted 3 November 2009)

Abstract
Interviews were conducted to explore the recall of impasse experiences of 12 highly skilled and experienced therapists. Participants were interviewed in depth individually about a specific impasse from their experience that resolved successfully. The transcribed interviews were analysed using qualitative methodology. The authors found that participants understood their reported impasse experiences as important for their professional development. The category of “helpful subjective presence” describes the mode of being with patients that the participants found therapeutic. The categories of “losing hope” and “difficult feelings in the therapist in the here and now” are processes that threaten the helpful presence. The participants’ inner work on the two latter categories is identified as a key to the successful resolution of impasses.

Keywords: inner work; impasses; psychotherapy process; rupture; qualitative research methods; philosophical/theoretical issues in therapy research; psychoanalytic/psychodynamic therapy; experiential/existential/humanistic psychotherapy

Psychotherapists sometimes experience their work as emotionally demanding. In long-term psychotherapy, especially with patients with heavy suffering, the relationship can turn into phases of stagnation and impasse. Such impasses often activate strong emotional states in both members of the therapeutic dyad (Bachelor & Horvath, 2006; Hill, Nutt-Williams, Heaton, Thompson, & Rhodes, 1996). There are long traditions within psychotherapy theory that regard the therapist’s way of relating to his or her own feelings and how he or she relates emotionally to the patient as central factors in the change process. This understanding of therapy is concordant with perspectives that give prominence to the emotional interaction between therapist and patient, among others the humanistic tradition (Rogers, 1957), the therapeutic alliance tradition (Bordin, 1979; Safran & Muran, 2000), and the relational and intersubjective traditions within psychoanalysis (Aron, 1996; Benjamin, 1995; Mitchell, 2000). In these traditions, the person of the therapist within the interpersonal relationship with the patient is assumed to have an effect on process and outcome. In this study we wanted to explore how esteemed therapists experience and give meaning to therapeutic impasses, that is, situations where the interaction in therapy has developed into a stalemate. Our hypothesis was that by studying these experiences and the way they were given meaning, we could contribute to knowledge about how therapists can be constructive during such instances.

In a meta-analysis, Wampold (2001) found significant individual differences between therapists, with some being consistently more able to facilitate productive therapeutic processes and positive outcome in their patients than others. He stated that “the essence of therapy is embodied in the therapist” (Wampold, 2001, p. 202). Kim, Wampold, and Bolt (2006) analyzed data from the National Institute of Mental Health Treatment for Depression Collaborative Research Program and found that 8% of the variance in outcome was attributable to therapists. Elkin, Falconnier, Martinovich, and Mahoney (2006) analysed the same data employing different strategies.
for modeling and found no significant therapist effect. Reviewing their own results and the research literature, Elkin et al. suggest that therapist effects are unevenly distributed and that effect sizes are attributable to positive and negative outliers. Although obtaining a higher level of certainty about the size and internal distribution of the therapist factor calls for large-scale studies with optimal sample sizes and statistical models (Soldz, 2006), the observed variation between therapists’ ability to produce good outcome has motivated qualitative research on therapist variables.

Summarizing empirical research on therapist effects, Skovholt and Jennings (2005) argue that it is important to stimulate more research on therapeutic mastery and competencies. They formulate four principles for the personal development into professional mastery: (a) tolerance for taking sufficient time, (b) intrapsychic essentials of the will to grow, reflection, and openness to experience, (c) tolerance of uncertainty and focus to details, and (d) acceptance of own developmental phase (Sullivan, Skovholt, & Jennings, 2005). However, meta-studies and reviews are often on a level of abstraction that makes them informative as guiding principles (Jennings, Goh, Hanson, & Banerjee-Stevens, 2003; Skovholt & Jennings, 2005) but also risk leaving the reader with a somewhat unanswered question: How do experienced and well-trained therapists actually act, feel, and think in the often ragged and untidy here and now of difficult therapies?

Efforts to research therapist effects empirically have been undertaken from different perspectives, focusing, for instance, on therapist interpersonal style and skills or intrapsychic variables and processes. Sullivan et al. (2005) explored master therapists’ construction of the therapeutic relationship, conceptualizing domains of interaction connected with mastery, and categories of therapist action within these domains. Jennings et al. (2003) reviewed the role of experience, personal characteristics, cultural competence, and comfort with ambiguity in relation to the development of therapeutic mastery. They concluded that experience in itself does not lead to expertise. In addition, an affinity for complexity and ambiguity, the ability to form quality relationships, being open to change and being emotionally mature, as well as being constantly curious are aspects needed to turn experience into expertise. Maharer, White, Howard, Gagnon, and MacPhee (1992) researched distinguished therapists through a different approach. They analysed videotapes of sessions, focusing on what therapists did to bring about really good moments of therapy. Their approach was in line with the moment-to-moment phenomenology of Stern (2004). They concluded that therapists’ sensitivity to their patients’ immediate state, along with an intention to help patients to experience this state more deeply, facilitated expression of feelings in the session. Their categories of good moments all entail the therapist being in the relation with openness to the patient’s experience, a way of being that they regard as fostering problem acceptance and expression of self. This is in line with theoretical accounts building on clinical experience (see, e.g., Bugental, 1987). Therapist variables are also researched in relation to ruptures and repairs of impasses (Bachelor & Horvath, 2006; Safran & Muran, 2000). Hill et al. (1996) studied therapists’ retrospective recall of impasses leading to premature ending of therapy. They found that therapist mistakes, problems within the transference/countertransference matrix, severity of pathology, and disagreement over tasks and goals were understood as important contributors to poor outcome.

The aim of the current study was to explore how experienced and esteemed therapists of different theoretical and therapeutic affiliations experience and interpret ruptures or problematic relational processes in therapies that later developed well. To achieve this, we invited participants to retrospectively recall specific experiences with difficult impasses in therapies that later led to positive progression and outcome. This represents a different approach from that of Hill et al. (1996) while still addressing similar issues. Whereas Hill et al.’s participants were invited to retrospectively recall what they understood as important when their therapies went bad, we wanted to explore our participants’ recall of their experience from difficult therapies that ended well. By developing criteria to sample highly skilled and dedicated therapists, and by interviewing these therapists about experiences in difficult but constructive processes, we hoped to gain access to valuable experiences from instances where they functioned as good therapists.

Method

Participants

Therapists. The participants were 12 experienced clinicians (six women and six men). All were practicing clinicians, and most also held positions as teachers and supervisors for candidates within their respective clinical traditions. Collected demographics include years of practice (mean years of experience as individual therapists = 26.6; SD = 10.9) and formal education (two medical doctors specialised in psychiatry and 10 psychologists with a specialist licence in clinical psychology). Theoretical affiliations were as follows: cognitive behavioural therapy, n = 4; psychodynamic therapy, n = 4; psychoanalysis, n = 1; body-oriented therapy, n = 3. Because education and
theoretical affiliation were part of our sampling strategy, these variables are further discussed in the Sampling subsection.

Patients. To contextualize the findings that we present, some common descriptions of the patient group can be useful. Participants described high symptomatic distress, social withdrawal, severe relationship problems, recurrent suicidality issues, and loss of function as patient characteristics. Because this is a study of the therapists’ experiences of impasses, no patients were directly involved in the study. However, as the participants were invited to present recollections of therapeutic experiences, we were careful not to obtain information that might identify patients. No registration of patients’ formal diagnosis was made.

Researchers. The study originated from the Bergen Relational Theory and Psychotherapy Research Group (RTPR). Christian Moltu, a practicing clinical psychologist within the Norwegian public health services, holds a particular interest in relational and intersubjective processes in therapy and has published within this field in Scandinavian professional journals. Per-Einar Binder is a professor of clinical psychology and has training in long-term psychodynamic therapy with children, adolescents, and adults. Geir Høstmark Nielsen is also a professor of clinical psychology and is a pioneer in short-term dynamic psychotherapy with adults. Both Binder and Nielsen have been broadly engaged and visible in the professional field of psychotherapy in Norway, academically and in clinical settings. All three authors have an interest in interpersonal and relational psychodynamic approaches and in psychotherapy integration. Binder is also working with humanistic-existential and mindfulness-informed approaches.

Procedures for Collecting Data

Sampling. Our aim was to compose a strategic sample of participants who, as a group, were representative of the variation of therapeutic practices within the field and who could be considered able and willing to articulate therapeutic experience. Sampling was started by obtaining lists of therapists who had completed formal education at the highest level of the five main psychotherapy and counselling training institutes in Norway: Norwegian Psychoanalytic Institute, Institute of Psychotherapy, Institute of Active Psychotherapy, Institute of Cognitive Therapy, and Norwegian Character Analytic Institute. Candidates accepted at these institutions have a formal basic training as either clinical psychologists or medical doctors. From these lists we strategically chose 18 therapists who were nationally held as dedicated proponents of their respective affiliation, who were clinically active, and who we assumed would be articulate about their therapeutic experience on basis of their activities as lecturers and speakers at seminars. In the process of purposefully sampling 18 participants for invitation, there were therapists on the lists who equally fulfilled our criteria of dedication, clinical activity, and verbal articulation. In such instances, participants were chosen at random. In a letter presenting the researchers and the study objective, these 18 therapists were invited to participate. About a week after receiving the letter, the therapists were contacted by telephone. Of the 18 invited, six men and six women agreed to take part in the study. Those invited who did not want to take part in the study maintained that it would be too time consuming for their schedule. As a group, these participants reflect the diversity of practice in the field of psychotherapy in Norway. We consider our sampling strategy as being in line with the recommendations of Sullivan et al. (2005), that studies like this one make use of information-rich participants, because our sampling strategy is directed toward dedication and willingness to articulate.

Data. In the letter of invitation, participants were invited to select from their experience one specific and extraordinarily difficult therapy impasse that had resolved in a productive way. We did this in order to give the participants a chance to prepare themselves, to establish security in the interview situation, and to create a situation for providing rich narrative material and reflections upon it. An approach without this preparation might have given more immediate and spontaneous responses but perhaps less in-depth exploration of the individual participant’s accumulated practical knowledge of handling impasses. Semi-structured in-depth interviews were chosen to facilitate a flexible, explorative dialogue about each participant’s chosen therapy incident. The interview protocol was developed in cooperation with the research group, before it was taken to an independent group of experts on qualitative health research for discussion and revision. It was then tested in a pilot interview and partly revised. The resulting interview guide had a brief introduction and four broad questions (Table I). Follow-up strategies for each question were used when participants gave descriptions on a too general or abstract level. In those cases, we asked for experiences of specific episodes to get “mininarratives” about the therapy process. The interviews were conducted face to face by Moltu in each participant’s office. Most interviews lasted about
Introduction: “In the invitation letter, I asked you to think of one specific therapy where you experienced that the process at a particular point was very difficult but later on turned into productive development and change. I am interested in your personal experiences facing this impasse.”

Question A: “Can you briefly describe what you did together until it got difficult?”

Question B: “How did you experience the difficult phase?”

Question C: “What did you experience that you might do and had to do facing this difficulty?”

Question D: “How did you experience the later positive change and that the process again developed positively?”

60 min (range 45–80). The interviews were recorded and transcribed verbatim for analysis.

Biases. The study’s affiliation with Binder, Nielsen, and RTPR may evoke a particular expectation in participants as to what the study finds relevant. The relational and humanistic clinical and theoretical orientation of all three authors yields both opportunities and possible biases: It gives a preunderstanding that opens up opportunities for in-depth exploration through a rich vocabulary and curiosity for relational phenomena. On the other hand, this preunderstanding can also take the form of a “relational bias” in both the interviews and in the analysis of data. Being aware of such potential biases, we made efforts to keep a high degree of reflexivity (Alvesson & Sköldberg, 2000; Finlay & Gough, 2003) through the processes of designing, performing, and analysing. How we specifically carried out this work is further detailed in the Discussion section.

Data Analysis

Following Giorgi and Giorgi (2003), Finlay (2003), and Smith (2007), we were especially attentive to the experiential horizon of the participants. Experiential horizon refers to the point of reference from which one gives meaning to experiences. Gadamer (1975) emphasizes that “when we try to understand a text … we try to transpose ourselves into the perspective within which [the author] has formed his views” (p. 292). We worked to have our own preestablished understanding challenged and transformed through a dialogue with the perspectives in the material. By comparing the individual participants’ accounts, we wanted to identify patterns of commonalities and differences in the way they had experienced and handled impasses. For this aim, we used a hermeneutically modified method of systematic text condensation (Malterud, 1993, 2001). This method proceeded through the steps presented in Table II. Analyses of the interview transcripts were technically carried out with the assistance of NVivo 8 software (QSR International, 2008).

The themes that present from our analysis can also be described as “meaning patterns.” A meaning pattern appears when we condense the content of meaning units of relevance for a particular theme and compare the experiences inherent in the narratives of several participants. That is, a pattern emerges when there is convergence between the experiences of different participants and when there is a moderate degree of divergence between them that makes the pattern thematically rich. The themes were named in a way that tried to stay as close as possible to the participant’s own language; for instance, the participants used the phrase “being present” in a way that was helpful to their patients, and we coined this theme as “being helpfully present.” The analyses were conducted by Moltu and Binder. Because of his intimate knowledge of the material as an interviewer, Moltu took a leading role in Steps 2, 3, and 4 of the analysis. Binder, knowing the material only by transcriptions, performed the role of a critical examiner and validated these steps of the analysis. In this process, multiple meetings were held for Binder to engage critically in dialogue with Moltu and in reviewing the participants’ perspectives, aiming to reach consensus in interpretation. In Steps 2 and 3, for example, this process of validation resulted in some of the units of meaning being merged into larger units. In Step 4, the process led to a reorganization of a category initially labelled “inner reflection” by Moltu, because, on reexamining the interviews, we agreed that these phenomena were inseparable from the experiential categories of “difficult feelings” and “threatened hope.” This reorganization necessitated working through Steps 2 and 3 of the analysis again. Step 5 was conducted by Moltu and Binder together, with Moltu taking a leading role. Although the meaning patterns and concepts were developed from the interview data, with theoretical concepts set aside, both the research question that initiated the dialogue with the participants and the reading of the data will necessarily be affected by the particular experiential horizon of each individual researcher.
We, therefore, used a reflexive hermeneutic approach (Alvesson & Sko¨ldberg, 2000) in the discussion of the researchers’ interpretive role and the specific context of the data. To provide the reader with quotes exemplifying the meaning of our categories and to enhance transparency of our interpretive process, we adopt the presentation style of thick descriptions (Geertz, 1973).

Results

The participants indicated that the incidences they had selected for the interview were important to their professional development, and that they represented important principles guiding their work in therapy today. Our analyses indicate that participants, across therapeutic traditions, experienced a large portion of similar phenomena when facing difficult therapeutic impasses and that the way they relate to their inner experiences is important to the therapy process. We present here three core categories that we consider strong, meaning that they were common across our participants. The first category is “the a priori commitment to being helpfully present.” Our interview guide focused the interviews toward the experience of impasses. Within this frame, our participants chose to use large parts of the interviews to talk about those modes of interaction or therapist presence that they regarded as helpful and therapeutic. We interpreted this as motivated by the participants’ experience with how an impasse situation has the power to move them out of this preferred therapeutic stance. We found two categories or processes that seem to have the power to destabilize the participants’ mode of being in therapy: “threatened hope” and “difficult feeling states in the therapist in the here and now.” The participants experienced that their inner work facing these challenges were of high importance to the resolution of the impasse. See Figure I for a summary of findings.

The A Priori Commitment to Being Helpfully Present

An overarching theme common across all participants was the experience of being committed to a professional imperative. A formulation that sums this up is: “I will do my best to stay psychologically present and be helpful to my patient even when it gets hard.” This a priori commitment to being helpfully present seems to be both a deep personal investment in their professional identity and an ethical commitment to the patient and his or her growth process. We consider this category important because it forms a background for our understand-

![Figure I. Summary of findings.](image_url)
therapist as well in order to be a good process” (psychodynamic).

The category of “helpful subjective presence” in our material consists of two different but related themes. We find that for presence to be helpful the intention for emotional availability and openness as we have presented must be balanced with recognition of the separateness of the patient. This can be understood as being emotionally present within the context of I-Thou relating. In line with Rogers’s (1980) conceptualisation of empathy, Buber’s (1958) “I-Thou” relationship, and Benjamin’s (2004) “thirdness,” the recognition and confirmation of the subjective “otherness” of the patient is also an essential component of emotional presence.

Alongside with staying present with their own feelings, there is the need for recognising the borders and differences between therapists’ own experience and that of their patient, to recognise and confirm the patient as an “other.” The participants emphasise that this helps them to enhance the patient’s autonomy. The feeling of difference or distance between therapist and patient also helps the former stay emotionally present, without being overwhelmed by despair when the patient experiences states of severe emotional pain. The “otherness” aspect of the presence makes it possible for the therapist to keep a vision of a possible future with less suffering for the patient. According to one participant,

“I feel I have a special responsibility for carrying hope, for believing that we can come through ... I think it is more the belief that we can make this through, and not acting on potential feelings of despair, or shortcoming, or anger” (psychodynamic).

This participant verbalises the understanding that he will be present to the patient’s pain but that he is also separate. He has his separate perspective that makes possible a developmental process. The category “the a priori commitment to being helpfully present” seems to tap the participants’ understanding of how suffering is handled and alleviated in the relationship. For their presence to be therapeutic, they need to balance emotional sameness and subjective otherness in relation to the patient.

What motivates the therapists to being helpfully present? This vantage point seems to serve both as a general therapeutic ethos that guides modes of entering the therapeutic setting and thinking and also a strong personal investment in their role as therapist, that is, a strong commitment to the patients and to themselves to be the one who can “be there” and be helpful during hardship. This duality is illustrated in another comment:

“Well, there is something—in that I, as a therapist, I have made a choice. I have said to myself that I am her therapist. I have chosen it. I don’t ask her if she wants me to be her therapist. I have chosen, for myself. So I will take my position accordingly” (cognitive).

So, when the stage is set, the therapist is deeply committed, and an impasse occurs, what happens? Our key finding is that the therapists experienced a sequence of challenges in two domains to stay helpfully present when the process got difficult. In our material, we found that the participants, across psychotherapeutic affiliations, consider the inner work when faced with such challenges as an important contribution to therapeutic change in the patients. In the following, the two domains of experience that follow this sequential development are presented and discussed. The two processes that we found to have the power to move the therapists out of helpful presence are (a) threatened hope and (b) difficult emotional states in the therapist in the here and now.

### Threatened Hope

All the participants set out from an initial state of hopefulness, based on their general belief in their therapeutic method and in themselves as therapists. When experiencing the full extent of the patients’ difficulties and suffering, this initial stance is threatened, and the participants experienced a strong pull toward self-doubt and doubt in one’s method. A comment from one of the participants illustrates this sequence:

“For good or bad I have quite a high faith in my own ... in what I believe is my ability to find a way out of these things ... but it was really ... it was really stuck, and how can I put it? I started seriously doubting it” (body oriented).

In our analysis, we have identified this category as “threatened hope,” although its meaning seems to be derived from two overlapping phenomena: Trust or trust in the psychotherapy process is understood as an inner evaluation of earlier successes that gives rise to a professional confidence. Entering therapy, our participants felt confident that their mode of therapy could be helpful to their patients. The concept of hope entails a focus on the temporal dimension, that therapy is a developmental process. We understand hope as a mind-set where a possible good future is envisioned as a context for understanding the here and now, the applied trust in interpreting the here-and-now situation, so to speak. This mind-set...
enables therapists to be helpfully present in the patients’ suffering without being overwhelmed, because they envision the suffering alleviated at some point in time. For this discussion, we consider the two slightly different phenomena of trust and hope under the same heading: threatened hope.

The experience of being stuck and losing hope is a common theme across the sample. Threatened trust in the process is broadly experienced on two levels: losing patience with the process and then starting to doubt oneself, because patience is part of one’s therapeutic ideals. One participant says:

“I would say it is feeling impatient in the body. I could call it being annoyed, or fed up, like ‘Oh, I can’t stand listening to this.’ And, well, if I get … these tendencies alert me. Such reactions … are challenges for me as a therapist” (body oriented).

A noticeable paradox seems to be that when participants could recognize parts of themselves feeling hopelessness and a lack of trust in the process but without feeling the need to make changes, this helped them regain a position of hope and trust. Experiencing threatened hope in the possible positive outcome of therapy can also be described as “losing faith in one’s methodological approach to therapy”:

“And then I got … from time to time I really started doubting and … well yes, I felt great doubt whether they [his therapeutic tools] could accomplish anything good when it came to compulsive states. Maybe it was right what the man [the patient] said … and what the literature said, that it wasn’t … that it couldn’t … help … so I got … I was so much in doubt! Had I started something that was completely hopeless?” (psychodynamic).

In retrospect, the participants describe the process of losing trust and hope as very painful, and that the sequential move from trust and hope to doubt happened multiple times as the therapy progressed. In line with the experienced a priori commitment described previously, we understand the strength of this experience as being linked both to a personal need to be “good” and to stay present with compassion.

**Difficult Emotional States in the Therapist in the Here and Now**

As we have shown, therapists enter the process with emotional presence, availability, and helpfulness as an imperative. During difficult therapeutic encounters, the participants experienced strong negative feelings. These encounters can be divided into two subsets: (a) when the therapist experiences aggression directed at him or her during the impasse and (b) when the therapist experiences that the patient withdraws emotionally. The general theme that we found was that both these kinds of situations interrupt the therapist’s initial experience of relative emotional freedom and negatively transform his or her experience toward feeling trapped in emotional reactivity.

**Staying helpfully present with the angry patient—being able to tolerate the full range of negative emotions.** In those cases where the patient directs aggression, explicitly or implicitly, at the therapist, the outset of emotional freedom is followed by discomfort. One participant illustrates the experience of discomfort in this way:

“Well, and then I felt like … a more frightened therapist and pretty cold and things like that … what made me feel like that … well, it started coming more and more” (psychoanalytic).

Generally, most participants described the initial emotional discomfort as manageable, suggesting that it can be made a focus for therapeutic exploration and dialogue based on each therapist’s clinical experience. One participant’s comment illustrates this:

“It has something to do with the intensity, and this was … this was a moderate level of intensity … workable level you could say” (psychodynamic).

In the extraordinarily difficult processes described in the interviews, however, therapists found their usual personal and technical skills for handling difficult emotions in the therapeutic relationship less helpful. One participant says:

“You could say she was acting out … and I got a little uneasy, because I got that feeling, what is this? Am I doing something that can make her situation worse? And what can I do? And, first and foremost, how can I manage this?” (body oriented).

In situations where patients directed anger at them, the participants experienced themselves as increasingly emotionally reactive, as in this example:

“Well, I felt like he was like a vibrating … he was vibrating out of aggression and contempt and devaluation of me … and as I remember it, I
was . . . well, I felt very tense and I felt very guarded” (psychoanalytic).

A common theme among participants who described events and processes with aggressive impasses is the power of such interactions to pull the therapist into an emotional reactivity: The therapists feel trapped in their own emotional state. This is progressively burdening the therapist to a degree where the risk of acting out the negative feelings is experienced as high. The following is a condensation of one participant’s description that can serve as a proto-narrative for this sequential move:

“It was constantly unpleasant, and that was a tough challenge, it was something with the . . . well, to place it, to handle it, because the content of the attacks, most people would find them fairly unreasonable . . . I felt it both like a big hard lump and a pressure in my stomach. And little by little I felt that I . . . I kept on ruminating after the sessions . . . I had problems with getting rid of, or put the feelings aside before the next session and in my spare time as well . . . and then I felt like I had to compromise my therapeutic stance. I guess that was the dilemma I faced, when I realized what I can do and what I really mustn’t do, to avoid unleashing this rage in her” (psychodynamic).

This illustrates a therapist’s experience of being trapped both in his own emotional state and what is then perhaps experienced as a too rigid role and his searching for a constructive way out of this. This proto-narrative describes a theme that we find across the sample when summing up common patterns of experience. It can be interpreted as an example of the sequence from (a) an initial feeling of emotional discomfort with the patient’s aggressive feelings within the sessions to (b) a progressing feeling of being more and more trapped in emotional reactivity to (c) the therapist feeling his or her therapeutic autonomy restricted and, finally, to (d) the point at which the ability to regulate and handle difficult feeling states in the therapist without nontherapeutically acting them out is threatened. The experience of increased risk of acting out is described in a variety of manners, from the explicit anger to a more subtle dismissing stance. One participant says:

“I thought a lot about having a technique inside your head, a sort of a method, and if you only have that . . . well . . . then you can isolate that from what’s human and really push the method and say it is so and so . . . what is that? It is being a bit mechanical . . . so I really had to keep constantly in mind that . . . eh . . . that I didn’t use my habitual technique or method in an aggressive way, like I at times really felt inclined to. It stirs up the potential of being cold and inhuman, even when we talk about it now, I can still feel it, and it is pretty scary” (psychoanalytic).

**Staying helpfully present when the patient withdraws.**

The second general subtype of difficulty with emotional presence described by the participants is when therapists experience that the patients are withdrawing from contact during the session and become increasingly difficult to reach emotionally. This situation tends to give therapists a feeling of being left out and of progressively experiencing helplessness and self-doubt. In the words of one participant:

“It was increasingly . . . well, I tried to put to use all my therapeutic tools, and when I couldn’t get to him, I felt more and more despair . . . because I didn’t experience that he consciously tried to boycott, so I didn’t feel irritated, it was more like despair, like, will I be able to get to you and help you?” (cognitive).

The situation when the patient withdraws seems to pull the therapist into less helpful ways of relating. Several participants described this process along the lines of “leaning toward” the patient and “overwhelming” him or her with demands. One participant told about her experiencing herself as being pushy in relation to the patient:

“I was sitting at the edge of my chair here, leaning forward, like this, I did that, and my gaze was directed outward only, directed at her, I was very much in her, looking for the answers inside her” (body oriented).

Impasses characterised by patient withdrawal seem to evoke the possibility for a similar type of emotional reactivity as the one characterised by aggressive ones. In the narratives, we find a sequence where the therapist (a) becomes aware of experiencing the emotional contact as veining and (b) is becoming more and more trapped in an emotional reactivity where he or she (c) experiences feelings of personal despair and irritation with the patient. This experience increases the risk of the nontherapeutic acting out of these feelings, by “leaning toward” and “overwhelming” the patient, which is generally experienced as not helpful. We find that the level of personal investment in the role of being a therapist and personal commitment to therapeutic ideals explains some of pull toward emotional reactivity. The following proto-narrative is a condensation of
one participant’s description of the experience with a withdrawal situation:

“I think this is about me being a little too rushed about doing something. It’s like ‘Right, let us help this woman with her anxiety and social difficulties’ . . . and then, it doesn’t develop like that. That is, I experienced more and more that it was all standing completely still between us . . . And then, then you start taking these rounds with yourself, that I am incompetent as a therapist, that I am no good at my job, can’t do it and things like that . . . we carry it with us, right, no matter how experienced we get. . . . I got so . . . Well, I really had to come to terms with impatience. It sounds strange that I, with my experience, couldn’t see that in the beginning, but we get so blinded by these situations . . . we get so caught up” (cognitive).

Discussion

A Generic Description

How do therapists manage to land on their feet and handle difficult impasses in ways that lead to constructive development? Although coming from very different therapy traditions and theoretical affiliations, our participants were quite unison in seeing their inner work on sustaining hope and handling their own difficult feeling states as crucial for later successful resolution of an impasse. Put very simply, they seem to share the experience of a mode of being together in therapy that they understand as helpful and two domains of experience that can force them out of this mode. Succeeding to be helpful in difficult therapies, then, depends on therapists’ inner work in the areas of hope and difficult feelings in the here and now. We have shown how the participants experienced the power of the impasse to pull them into emotional reactivity in which they experienced their ability to feel and think freely severely threatened. But how is it that highly experienced therapists can get so trapped in feelings of hopelessness during an impasse? It seems that their level of personal commitment and dedication explains some of this. When doing psychotherapy also serves the personal need to be good, or the need to be the one who can help, personal and professional experiences of hopelessness and helplessness are inseparable.

The Category of “Helpful Subjective Presence”

The participants use large parts of the interview to talk about their experience of what kind of therapist presence they see as helpful to the patient. Bugental (1987) defined availability and openness to the patient’s and one’s own experience and the capacity to respond as the key features of presence. Geller and Greenberg (2002) offer a theoretical model of therapeutic presence based on their qualitative interview study of seven eminent therapists with special interest in the topic. They found that “therapeutic presence involves a careful balancing of contact with the therapist’s own experience and contact with the client’s experience” (p. 83), and argue that presence involves a being with rather than a doing to mode of interaction. Our participants’ understanding of helpful subjective presence supports these conclusions from Geller and Greenberg (2002), emphasizing the dual qualities of staying open for what comes up in the experiential world and at the same time recognizing the otherness of the patient. The participants put much emphasis on recognising, listening to, and being able to accept difficult emotional states that arose in them and at the same time use the information that these feelings provided to find ways to help and communicate with the patient as another human subject. We find it interesting that this category is so strongly represented in our material, because the interviews were focused on the experience of impasses.

Benjamin’s (2004) work on complimentary twoness and intersubjective thirdness offers a rich conceptualization of interaction in therapy. She claims that the potential for growth through relationships lies within the intersubjective process of thirdness, a way of being together in mutual recognition of the others’ subjective presence. In therapy impasses, she argues, this mutuality breaks down into twoness of complementarity, where one part is doing something, which the other is reactively experiencing being done to (Benjamin, 2004). This is generally considered a less therapeutic mode of interaction. Although Benjamin’s (1995, 2004) work is on a level of high theoretical abstraction, we find that it can contribute to the understanding of our findings. Through its concept of twoness, it provides a framework for understanding phenomena of reactivity in the therapeutic interaction during impasses. In Geller and Greenberg’s (2002) category “preparing the ground for presence,” they found that an important aspect for their informants was the a priori intention to bring in their whole self and meet the patient receptively. Our finding that the participants experience an a priori commitment to helpful presence resonates with this intention. They want to meet their patients with an open, receptive, and warm presence. In impasses, however, this gets troublesome. Our categories of “threatened hope” and “difficult emotional states in the here and now” can be interpreted as the forces that work against the therapist’s presence or, in Benjamin’s (2004) terms,
threaten to break down the interaction into twoness. Indeed, during difficult impasses the participants report the experience of becoming reactively trapped in difficult feelings and hopelessness, a position from where they find it difficult to be helpfully present. That is, to use Geller and Greenberg’s (2002) and Benjamin’s (2004) formulations together, a move from being with to being done to.

In addition to being part of psychotherapy theory, presence as well as bodily and emotional groundedness in the here and now are seen as essential parts of psychological growth in the mindfulness tradition (Kornfield, 2008). Santorelli (2000) describes this as being present and attentive to emotional wounds in both oneself and the patient. Quoting Rumi: “Don’t turn your head. Keep looking at the bandaged place. That’s where the Light enters you.” The participants in our study chose to stay present with what was most painful, both in themselves and their patients, and they experienced that the intention to stay present was also a basic aspect of staying helpful.

But why do the participants highlight helpful subjective presence in the way they do? In addition to being a central part of their knowledge about working with therapeutic impasses acquired through experience, it is also a focus that is important within psychotherapy as an oral tradition (through supervision). Our findings suggest that this focus has proven helpful for the participants when encountering difficult phases of the therapy process. Our findings also point to the possibility that the intersubjective here-and-now aspect of psychotherapy should be given more theoretical attention within traditions that tend to emphasise the transferential or technical aspects of therapy. Therapeutic presence is, as are the often cited therapist factors of interpersonal style and capacity for empathy, a complex construct (Bachelor & Horvath, 2006; Geller & Greenberg, 2002). Our study adds reasons for further work toward conceptual consensus and for continued efforts to research the phenomenon empirically. We find that cross-references between the intersubjective thinking in the relational tradition and the humanistic/existential tradition are relatively rare, and our study suggests that theoretical dialogue and integration could be mutually beneficial.

The Therapists’ Difficult Feeling States

Hill et al. (1996) found that problems in the transference/countertransference matrix were an important reason for premature termination in impasse situations. Bachelor and Horvath (2006) summarize that personal vulnerabilities in the therapist when it comes to dealing with negative affect are contributing factors to unsuccessful impasse resolution. We address the flip side of this issue, studying therapist experiences in impasses successfully resolved. Our participants highlight their experience of having to work hard on their own difficult feeling states to be able to be helpfully present. They tell about points in time during the process where they experienced strong impulses to act out negative affect or withdraw. In a totalistic conception of countertransference, all feelings that arise in the therapist during the therapeutic interaction are considered countertransferential, while more moderate conceptions of countertransference focus on the relationship between scenarios worked on in therapy and vulnerabilities in the therapist’s self structure (Gelso & Hayes, 2007). In a totalistic conception all the difficult feelings present in our material would be considered countertransferential, whereas in a more moderate conception only some of them would be. Several, but not a majority, of the participants explicitly tied experiences of difficult feelings to the patient triggering personal conflicts in the therapist, for example, feeling vulnerable at the verbal display of aggression or feeling personally threatened by lack of therapeutic success.

Whatever the origin of the difficult feelings in the here and now, our participants speak strongly to the need for their management in the therapy situation, supporting Jennings et al.’s (2003) claim that the ability to relate to emotionally charged situations is a characteristic of good therapists. Gelso and Hayes (2007) offer a model for countertransference origins, triggers, manifestations, and management. Management factors in this model are “therapist behaviours and characteristics that help therapists regulate and productively use their countertransference reactions” (Hayes et al., 1998, p. 469), specified by self-insight, conceptualizing ability, empathy, self-integration, and anxiety management (Gelso & Hayes, 2007). The present study does not discriminate between countertransferential reactions and personal negative feelings, but our category “difficult feeling states in the therapist in the here and now” supports the characteristics of management proposed by Gelso and Hayes (2007) and Hayes et al. (1998). Our findings show that negative feelings toward the patient occurred in all the impasses we studied, across all the different approaches to therapy, supporting that this is a normal and common phenomenon during impasses.

Is inner regulatory work on negative emotional states always the best thing to do during impasses? The participants largely agree that it was very important for the further process of treatment that they regulated and tolerated the difficult feelings without acting them out in the relationship. There was consensus in the material that allowing oneself
to stay with the difficult feelings, and to try to create a meaningful understanding of the experience, is a core component of regulating and managing situations of impasses. The more intense the difficulty gets, the more idiosyncratic strategies for tolerating difficult feelings are displayed, including such activities as meditation, workout, reading novels, and consulting colleagues or supervision. However, some participants also describe instances where they somehow “slipped” without the slip having a damaging and irreparable effect on the relationship. We find it difficult to make a perfectly clear distinction between reparable and harmful acting out of the therapist’s negative feelings. In this area, our data only allow us to hypothesize, and they suggest interesting questions for further research. It seems that it depends on the origin of the therapist’s negative emotional states. For example, in withdrawal situations where the therapist is experiencing personal vulnerability or perhaps narcissistic injury, he or she can be so overwhelmed that the risk of acting out in potentially severely damaging ways increases. The less involved, professional impatience often seems to result in actions with reparable consequences that can even be fuelling development.

A study from the therapist perspective focusing on differences between acting on feelings of different origins might yield interesting findings.

**Reflexivity: Limitations, Biases, and Possibilities**

Malterud (2001) and Alvesson and Sköldberg (2000) maintain that a researcher will unavoidably have an impact on the findings of a study. In quantitative as well as in qualitative research, the researcher’s intentions and preconceptions will give direction to the way in which research is performed and findings are understood. We have utilized reflexivity as a guiding methodological principle in designing, performing, and analysing this study (Alvesson & Sköldberg, 2000; Finlay & Gough, 2003; Malterud, 2001). More specifically, we have chosen to make explicit our preconceptions and to present these to an independent group of professional health researchers. With this group we considered possible biases and discussed questions important to the qualitative research process: For instance, how do the dynamics of the interview situation give prominence to some stories over others? Because all the interviews were done by Moltu, the interview situation consisted of a relatively young clinical psychologist and therapists who were 10 to 40 years older. The participants appeared to be relatively open and nondefensive in their accounts. Perhaps being interviewed by a much younger colleague contributed to an atmosphere of safety and nonrivalry. The fact that both interviewer and participants were practicing therapists may also have contributed to an experience of having something in common, which made sharing and deep exploration of the participants’ clinical experiences possible. One might also consider the possibility that being interviewed by a novice colleague made the esteemed therapists reluctant to show themselves as truly vulnerable out of a need to be seen as impressive or skilled. However, the content of the interviews as well as the emotional tone in the interview interaction speak against this. A number of participants spontaneously said that it felt good to have the chance to sit down and reflect on and understand their experiences.

From what perspective and with what intentions were the research questions posed? An interest in relationships and intersubjectivity is far from a neutral motivational stance. This suggests the possibility for a relationship bias in the way psychotherapy is being described. To meet this particular challenge, we chose to also include participants with a more “technical” orientation to therapy than our own. And we discovered that perhaps our most significant preconception was that these therapists typically would handle impasses with more use of technical interventions than what we would prefer ourselves. In fact, their stories showed that they did not. A research interest specifically directed toward relationship issues also gives certain advantages in this kind of studies; it makes it possible to invite participants into deeper exploration of different aspects of relational phenomena.

Another question is how the theoretical profile of the research group may have influenced the stories told. This perhaps represents the greatest danger of a relationship bias in our research. Our research group and its members have a rather well-known relational profile with regard to theoretical views on therapy processes. The level of experience and confidence in our sample may also counter this potential bias. Two of the participants referred explicitly to Moltu’s previous publications, stating, for example, “I know that you are interested in Sternian moments and the like, but I don’t think it is like that, it is much more a fleeting process.” Such comments emphasise at least two important matters: (a) that interview situations inevitably contain and are influenced by expectations of what the interviewer finds relevant and (b) that the level of experience among our participants enabled them to break with such experienced expectations when they deemed it pertinent. It is difficult for a researcher not to have a visible profile, because publishing and lecturing are a part of academic life. A possible solution might be that
researchers with different orientations than ours also perform qualitative studies of the topic in question.

Conclusion
We have studied what esteemed therapists experience when therapy processes move from hopeless impasse to constructive resolution and development. We interviewed 12 highly competent therapists from different therapeutic traditions about one specific impasse experience of their own choice. We found that the theme of commitment to helpful presence guided their work. Their understanding of presence built on their professional and clinical understanding of suffering as well as on a personal investment in the process. Two domains of experience made being helpfully present difficult during the impasse. Therapists progressively experienced a loss of hope and emotional reactivity during the growing manifestations of the impasse. The participants regarded their inner work in these two areas as important for staying present and as the key to successfully resolving impasses in the therapeutic relationship and process.

References