REFLECTIONS ON COUNTER TRANSFERENCE: AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS OF THERAPISTS' EXPERIENCES OF THEIR WORK WITH BEREAVED CHILDREN.

by

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DECLARATION

I declare that the dissertation entitled “Reflections on Counter Transference: an Interpretative Phenomenological Analysis of Therapists’ Experiences of Their Work with Bereaved Children” is the result of my own work except as cited in the references and that it has never been presented anywhere else for a similar purpose. It is submitted to the University of Johannesburg (Department of Psychology) in partial fulfilment of the requirements of the degree Master of Arts in Clinical Psychology.

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SUMMARY

The aim of this study was to explore and gain a deeper understanding into the lived experiences of therapist's encounters of counter transference when working with bereaved children. The topic developed when the researcher came across such a case in her own psychotherapy masters training and addressed it within her supervision sessions.

A qualitative paradigm was utilised and an interpretative phenomenological analysis strategy was applied. This study drew on the experiences of a small participant sample that comprised of three psychotherapists. The data gathered was based on semi-structured interviews that yielded rich narratives. The data was analysed for units of meaning. These units of meaning were then approached from a hermeneutic stance of inductive interpretation. This allowed for the categorisation of the data into superordinate themes.

Three superordinate themes emerged based on the participants' experiences of counter transference when working with a bereaved child, namely: 'the myth of neutrality: the dual role of the psychotherapist'; 'ethical dilemmas: the "pity lens" in bereaved child psychotherapy'; and 'containing the therapeutic frame: avoiding the blind spots'.

This study was able to contribute to the existing reservoir of knowledge and provide up-to-date themes on the phenomenon of counter transference when working therapeutically with bereaved children. It has enabled an in-depth analysis and exploration of the experiences of psychotherapists who have encountered counter transference when working with a bereaved child within the South African context.

The findings of this research confirmed the perspective that counter transference can be utilised as a therapeutic and clinical tool within the psychological field. The importance of remaining ethically aware of one's counter transference was significant for all the participants as it enabled the participants to avoid unethical behaviour. Paramount to remaining conscious of counter transference was the role of self-care

and self-analysis for the psychotherapist, as well as the importance of attending some form of supervision in order to receive an objective perspective. Furthermore, a noteworthy result was the intensity and amplification of the psychotherapist's counter transference reaction and impact when working specifically with a bereaved child. The bereaved child client creates significant ethical complications for the psychotherapist due to the complex and intense emotional connection that develops in the therapeutic relationship.

It is hoped that this study will encourage additional research into this phenomenon as it is considered an area of interest for exploratory studies for the training psychotherapist.

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CHAPTER 1
INTRODUCTION, AIM AND ORIENTATION

1.1 Area of investigation

The primary aim of this minor dissertation was to explore the reflections on counter transference by utilising an Interpretative Phenomenological Analysis (IPA) paradigm to explore therapists' experiences of their work with bereaved children.

Given the therapist's position as an active participant in the therapeutic process this research study focused on the therapist's lived experience and own understanding of counter transference within therapy. Thus, the study's focus was not on counter transference directly but rather on the therapist's lived experience of counter transference. In addition, this research study focused specifically on the therapist's experiences of counter transference when working with bereaved children. Within this research study each therapist was the author of their own experiences of counter transference when working with bereaved children. Through narrating these individual experiences this research study aimed to gain deeper insight into the psychological phenomenon of counter transference.

Bereavement in children was focused on as it can occur as a result of various circumstances, including war, violence and accidents. In addition, South Africa has been particularly severely impacted by the AIDS epidemic, with UNAIDS (2010) estimating that 1.9 million South African children have had one or both parents die as a result of AIDS related illnesses. Children's responses to grief vary and are dependent on variables such as age, the relationship with the disease and the cause of death (Goldman, 1994; Worden, 1996). Given these circumstances, it is likely that most South African psychologists will need to provide therapy to a bereaved child at some point in their career.

In the context of this study a bereaved child was defined as a child who has lost one or both of his or her primary caregiver figures, but still has an available family support system. It is possible that these bereaved children may look to the therapist to fulfil a

parental void. Children are traditionally seen as vulnerable and in need of protection, and therapy with bereaved children may therefore provoke anxiety and a parental role in the therapist's counter transference.

1.2 Need for the research

At the outset of this research, it was considered that the study could potentially contribute to existing knowledge in several ways. A review of existing literature indicated that the phenomenon of counter transference has been under-researched in recent years. Much of the literature is more than a decade old. Since Winnicott's 1949 publication of *Hate and the Counter Transference,* child therapists have had little to say about counter transference issues (Shopper, 1998). It is as though Winnicott's conclusive study of the topic effectively closed the door on further exploration. The lack of empirical consideration given to counter transference can be mirrored in the irregular history of theoretical attention to the topic (Rackner, 1957). Rackner continues to comment that this collective resistance to self-awareness on the part of the research-practitioner is a reaction to Freud's influence, whereby counter transference was considered to be a frailty on behalf of the psychotherapist (1957). Furthermore, counter transference as a research topic may be avoided as it is a difficult construct to understand in its entirety. This is due to the fact that many definitions exist within each different theoretical school of thought and that is a process that is not easily defined or captured. This study hopes to rise above these challenges and capture the lived experiences of counter transference from the psychotherapists' perspectives.

Discussion around this topic needs to be resurrected and new information should be discovered that was not included in Winnicott's work. Therefore, it was hoped that this project would increase practical awareness and reawaken theoretical exploration of issues surrounding counter transference as a therapeutic experience.

Much of the previous research provides fairly superficial descriptions of counter transference. This research aimed to contribute an in-depth analysis of therapists' experiences with this phenomenon. The study also has practical implications as it

can help student psychologists become more aware of the process of counter transference and help them to use it collaboratively with the client as a useful therapeutic tool.

This research project sought to make the issue of counter transference with bereaved children more tangible for psychology professionals, to increase awareness of the phenomenon, and to contribute to the reservoir of knowledge relating to counter transference within a South African context. In addition, this study was based on actual experiences and is thus more practical than it is philosophical. Findings will enhance the psychological field by establishing common and up-to-date themes of therapists' experience and insight into their counter transference.

1.3 Aim and method

The aim of this research was to explore the lived experiences of the therapists in their work with bereaved children in order to understand thoughts and feelings around counter transference that develop during the therapeutic relationship. Furthermore, the research was aimed at gaining a deeper understanding of the impact of counter transference both within therapy and the therapist's personal life. The research question is: What will an exploration into the child therapist's thoughts and feelings around counter transference yield?

This researcher made use of a qualitative method called Interpretative Phenomenological Analysis (IPA). IPA is based on two elements: phenomenology and interpretation (Willig, 2001). The method is advantageous as its philosophical underpinnings seek to gain information from an insider's perspective as opposed to collecting numerical data. Thus, the data gathered was based on the therapists' own lived experiences and interpretations of their counter transference when working with bereaved children. IPA is an idiographic method of inquiry and focuses on specific in-depth cases that are detailed and individually orientated (Porta & Keating, 2008). According to Smith and Osborn (2003), three participants in this type of study is sufficient to obtain rich and descriptive data and for comparison of themes.

1.4 Use of the terms ‘transference’ and ‘counter transference’

The twin concepts of transference and counter transference lie at the core of every psychotherapeutic relationship (Rao, Meinzer, & Berman, 1997). On the one hand, the term transference refers to how “the patient experiences the analyst as someone else… [and] "displaces" or "transfers" infantile and internal conflicts to current situations and objects which are out of place and inappropriate" (Racker, 1982, p. 15). On the other hand, counter transference is seen as the therapist’s unconscious reaction to the client’s transference (Waska, 1999). Although the concept of counter transference originated within the psychodynamic theoretical framework, the concept has been integrated into various therapeutic and theoretical modalities, and is believed to impact on the therapeutic process and on the private life of the therapist (Rao, Meinzer, & Berman, 1997). The concept of counter transference positions the therapist as an active participant in the therapeutic process instead of as a neutral observer, and in this way the therapist is seen to be affected by and affecting the client’s experience (Mohr, Gelso, & Hill, 2005).

Counter transference occurs as a result of the therapist-client attachment relationship (Ekamparam, 2008), which is unique to the professional and ethical role of the therapist. Within this role the therapist is neither the client’s friend nor advisor. Instead, the therapist creates a stable and secure base for the client to seek comfort and security (Ekamparam, 2008). Gabbard (2001) states that clients will predictably try to transform the therapist into a transference object. The result will be counter transference that is a co-creation between the client and therapist. In traditional psychotherapy the therapist was seen as a neutral and detached individual who was able to receive the client’s transference. However, therapists are human beings who experience unconscious thoughts and feelings (White, 2011). As a result, it is not possible for the therapist to be an objective and neutral bystander. Goldner (1993) put it well in stating that “…psychotherapists cannot help beaming their version of the ‘truth’ to their clients, no matter how committed they are to a stance of neutrality” (p. 60).

The phenomenon of counter transference enables the therapist to bring thoughts and feelings into consciousness in order to remain professional. Haber (1994) describes this predicament by stating that "[t]he professional therapist, like an actor, has a role. Inside, in between, and beyond the role is a person without a clearly defined script" (p. 269). Despite the guidelines of the therapeutic space, the therapist will experience feelings of counter transference that are not a part of the script.

1.5 Chapter review

In Chapter 2 the pertinent literature is reviewed and it contextualises the research. The emphasis is on the definition and examination of the relevant terms and concepts to this study. The nature of counter transference, counter transference theories and the development of the phenomenon are explored and discussed. The literature review will also investigate the myth of the neutral bystander, as well as the different kinds of attachment styles that manifest in the therapeutic relationship. Ethical considerations with regard to counter transference will also be examined.

In Chapter 3 the methodology will be discussed. This includes the chosen methodology of IPA, reasons for utilising IPA, the IPA framework, the research design, the data analysis procedure, as well as ethical considerations of the study.

In Chapter 4 the results of the study are presented. Thus, the superordinate themes are identified and evidence is provided from the data. This is to depict the lived experiences of the participants with regard to the research question.

Chapter 5 is a discussion of the findings. An attempt will be made to relate the themes to existing theory and research as evidenced by the literature review.

The focus of chapter 6 is the conclusion of this research. This will also include limitations of the study, as well as recommendations for future research and reflections.

1.6 Chapter summary

The aim of this chapter was to orientate the reader to the research that was conducted. The need for this study was discussed, as well as the chosen methodology and the aims of the study. The term ‘counter transference’ was explored with the intention of contextualising the phenomenon being researched.

The following chapter will explore existing literature on the subject matter.

CHAPTER 2
LITERATURE REVIEW

2.1 Introduction

The complementary terms of ‘transference’ and ‘counter transference’ are a phenomenon that can be observed and acted out in day-to-day life and commonplace situations. However, these factors are emphasised and more commonly acknowledged within the caregiving profession, such as that of the medical and psychological professions (Rao, Meinzer, & Berman, 1997). It is therefore an implausible scenario whereby a psychologist will not experience counter transference in reaction to their client’s transference within the therapeutic relationship. It is a phenomenon that is on-going throughout the duration of the therapeutic alliance and it is unavoidable. This research seeks to explore this phenomenon from the lived experience of three psychologists. However, this study was not focused exclusively on the experience of counter transference, but rather, specifically on the counter transference experience when engaging in therapeutic sessions with a bereaved child.

Bearing the above in mind, chapter 2 will seek to review existing literature on this topic. The definition of ‘transference’ and ‘counter transference’ will be discussed. A brief overview of the history of counter transference will be explored in terms of theoretical mind shifts that have occurred and the different schools of thought about this phenomenon. The chapter will then focus on the bereaved child and how this client presents within the therapeutic space. A consideration of factors that affect the therapeutic relationship with regard to counter transference will be investigated, including the role of the psychotherapist and attachment. The chapter’s attention will then shift toward the impact of counter transference on the psychotherapist’s personal well-being, as well as the ethical implications that arise when counter transference is not adequately addressed by the psychotherapist, and how it can become detrimental if left in the psychotherapist’s unconscious. Throughout the chapter, previous research will be referred to when relevant to the subject matter under discussion.

A few considerations with regards to terminology must be addressed from the inception of this literature review. The therapeutic relationship involves two distinct parties. The first is the professional in the therapeutic relationship. To address this first party, the terms *psychotherapist* and *psychologist* have been used inter-changeably. The second party is referred to as the *client* or *the bereaved child*. The therapeutic exchange between the two parties will be referred to as *therapeutic/therapy session/s*. The connection between the psychotherapist and client will be used inter-changeably as the *therapeutic relationship* or the *therapeutic alliance.* Much of the theoretical history is entrenched in psychoanalytical jargon as can be seen in direct quotes. The researcher will endeavour to use the above mentioned lexis as generic terminology throughout this study.

2.2 Counter transference

Langsley and Yager (1988) undertook a quantitative survey of skills required in the mental health field. Rated second most important out of the 48 required skills, was "…the ability to recognise counter transference problems and personal idiosyncrasies as they influence interactions with patients and…deal with them constructively" (p. 471). Thus, one can determine the extreme value and importance that is placed on this phenomenon of counter transference. It is at the core of the therapeutic process, the therapeutic relationship and therapeutic well-being of both client and psychotherapist. Counter transference occurs in all therapeutic situations and has fundamental consequences for the therapeutic alliance, clinical decision-making and even clinical outcomes (Gabbard, 2005; Gelso, Latts, Gomez, & Fassinger, 2002).To gain a deeper understanding of this concept, the definition as well as the evolution of its history will be discussed.

The subject of counter transference in relation to the child and adolescent field is reasonably scarce and neglected (Brandell, 1992; & Showalter, 1985). According to Rasic (2010), previous authors have hypothesised two main reasons for this. Firstly, that the natures of counter transference and counter transference reactions are such that they cannot be empirically measured. Thus, the research cannot be purely evidence based and it is therefore not popular to study as a quantitative topic (Rasic,

2010). Secondly, that the topic of counter transference requires honest self-examination on behalf of the psychotherapist. This may cause anxiety in that the participant must truthfully acknowledge either their overly positive or overly negative feelings toward their vulnerable child client. Consequently, this may cause the psychotherapist to experience shame, discomfort or social awkwardness (Showalter, 1985). This makes it a difficult topic to explore in a qualitative manner as willing participants are not easily identified.

2.2.1 Defining and understanding the term 'transference' and 'counter transference'

The terms 'transference' and 'counter transference' go hand-in-hand with one another. They are complementary terms that frequently occur as a paired phenomenon within the therapeutic sessions between a psychotherapist and client. Counter transference as a term cannot be fully comprehended without being compared to its counterpart, transference. These two terms transpire as a result of the therapeutic relationship that develops between the psychotherapist and client. One could liken it to the 'yin and yang' of the therapeutic alliance; thus, complementary influences that interrelate to create a dynamic organisation.

Transference can be defined as: "universal in human interpersonal relationships… an unconscious repetition or replication in a more or less crystallised or fossilised way; of impulse, pain, defence, internal and external object relationships, as they have occurred in the past" (Cilliers, Rothmann, & Struwig, 2004, p.73). Thus, within the therapeutic relationship, the client will bring their own dynamics into the therapy session. The dynamics will then be unconsciously acted out within the session. This may be in the form of the client's emotions, the client's fantasies or the client placing the psychotherapist into a certain desired role. The client's transference will create a dynamic within the therapeutic relationship. How the psychotherapist chooses to react to this dynamic is dependent upon their counter transference reaction. Waska (1999) stated: "Therapists are inevitably touched, contaminated, and seduced by these dynamics" (p.156). Moore and Fine (1990) eloquently described the process of transference to be the displacement of thoughts, feelings and behaviours. These factors are usually associations from childhood that are then placed onto the

psychotherapist during the therapeutic sessions. Hence, it is the displacement of the client's emotional state and needs onto the psychotherapist.

Counter transference is not easily defined within the psychological community. It has different connotations depending on the different schools of thought. For example, the classical stance of counter transference is derived from the views of Freud. This is the belief that counter transference is the psychotherapist's unconscious emotional reactions to the client and that these are a reflection of the psychotherapist's unresolved conflicts. This classical view depicts counter transference to be undesirable, pathological and something that has to be overcome (Kernberg, 1985). This view of Freud from 1910 remained unopposed for nearly 40 years (Racker, 1957). The totalistic stance is a more recent viewpoint on the debate of counter transference (Miles, 1993). This school of thought entails both the unconscious and conscious emotional reactions of the psychotherapist. This perspective believes counter transference to be a potential therapeutic tool. Thus, as depicted above, the definition is not fixed for this phenomenon. It is largely influenced by what ideology one follows. This will be further explored in the brief history of counter transference within this literature review.

Samuels (1985) noted two categories of counter transference that may help to define counter transference. The first category is the reflective, where the analyst's feelings closely reflect the patient's unconscious inner state. The second category is the embodied, where the analyst feels like a particular "person" (i.e. a "complex", internal object or object representation) who inhabits the patient's inner world.

Therefore, the terms 'transference' and 'counter transference' are involved in a mutual and reciprocal process between the client and the psychotherapist: "Therapist and patient constantly struggle to make meaning and sense out of what takes place in the therapeutic relationship. However, both parties are constantly tempted to act out these meanings…" (Waska, 1999, p. 156). It is the psychotherapist's responsibility to ethically handle this two-way process within the therapeutic environment.

2.3 A brief historical review of counter transference

As mentioned previously, the concept of counter transference is laden with connotations and various perspectives based on the school of thought that one adopts. A brief review of the evolution of the term 'counter transference' will be discussed in order to gain a deeper understanding of this phenomenon.

2.3.1 The classical stance

The first mention of counter transference in literature is made by Freud in 1910. Freud stated, "We have become aware of the 'countertransference,' which arises in the physician as a result of the patient's influence on his unconscious feelings, and we are almost inclined to insist that he shall recognise his counter transference and overcome it" (pp.144-145). Freud created a negative stigma toward the term and this was not questioned by psychotherapists for a few decades. Freud deemed counter transference to be of no benefit therapeutically (Freud, 1910). Furthermore, it was inferred that counter transference was abnormal and could create a 'phobic' reaction to one's own counter transference (Kernberg, 1965). As noted previously, this stance is a classical one.

2.3.2 The totalistic stance

The totalistic stance is a more modern take on counter transference. This perspective extends the classical understanding of counter transference. It takes into account the psychotherapist's reaction in its entirety within the therapeutic setting (Brandell, 1992; Ens, 1998; Gabbard, 2004; Heimann, 1960). The reaction of counter transference is a result of the psychotherapist's intrapsychic processing of the client's behaviour and personality. The process is then complicated by the psychotherapist's previous experiences. The psychotherapist will have either a conscious or unconscious reaction that can be emotional or cognitive (Bemporad & Gabel, 1992; Betan, Heim, Zittel Conklin, & Westen, 2005). Freud deemed counter transference to be an encumbrance in the therapeutic experience. The totalistic view encourages the use of counter transference as a therapeutic and clinical tool. It facilitates momentous

insight into the client's intrapsychic world, their interpersonal patterns, as well as their emotions and cognitions and how these dynamics influence others (Gabbard, 2004; Heimann, 1960).

The totalistic view encourages counter transference and normalises this phenomenon within the psychological field as a natural and common occurrence. The totalistic stance is more in keeping with current practices, as well as the experiences of the three participants for this research study.

2.3.3 Objective/homogenous and subjective/idiosyncratic counter transference

An additional embellishment of the term came into being when counter transference was divided into two categories (Rasic, 2010). These categories include objective/homogenous counter transference and subjective/idiosyncratic counter transference (Giovacchini, 1981; Marshall, 1979; Winnicott, 1949). The term objective counter transference is used when describing a reaction that a psychotherapist would have that would be universal amongst psychotherapists; for example, feeling helpless when a client commits suicide. Subjective counter transference would be based within the psychotherapist's own unresolved intrapsychic conflicts (Marshall, 1979; Ritvo & Ritvo, 2002). Both types of counter transference are useful sources of information for the psychotherapist and both can be utilised as a therapeutic tool within the therapeutic setting. These two described categories were both established within the participants' narratives within this specific study.

2.3.4 Counter transference as a therapeutic tool

Modern psychology looks toward counter transference as a therapeutic tool; a clinical tool that can help in the diagnostic assessment and treatment plan for clients. Ethical practice of counter transference is that the psychotherapist remains aware and insightful of their counter transference reactions. This ethical use of the phenomenon enables it to be used as an important factor for psychotherapeutic change for the client (Gelso et al., 2002). Counter transference can lead to the "verbalisation,

exploration, and understanding [that] provide a vehicle to work through the various conflicts, fears and pains associated with those fantasies" (Waska, 1999, p.160). Thus, the transference and counter transference provide clues as to what needs to be addressed in psychotherapy sessions in order to promote healthy and positive change into the client's life.

Heimann (1949) recognised this as well in his understanding of counter transference when he was working therapeutically with children clients, stating "The analyst's counter transference is not only part and parcel of the analytic relationship, but it is the patient's creation, it is part of the patient's personality. The emotions roused in the analyst will be of value to his patient, if used as one more source of insight into the patient's unconscious" (p.77).

Heimann (1949) thereby identified that transference and counter transference are dynamic and circular processes that exist between the client and the psychotherapist within the therapeutic environment. Heimann recognised counter transference to be invaluable for providing access into the client's unconscious which in turn will enable the psychotherapist to better aid their client in psychotherapy. It is a tool that can bring the unconscious into the consciousness of the psychotherapist and vice versa the client.

2.4 Counter transference with a bereaved child client

For the purposes of the present study, the term "bereaved child" refers specifically to a child who is twelve years of age or younger. The child must have lost at least one primary caregiver. The term 'bereavement' is defined as: "the complex reactions of survivors following the experience of separation by death from a significant person" (Epstein, Weitz, Roback & McKee, 1975, p.537).

Lang (2010) reviews the work of Henry Kroenengold's "Hey toy man" which demonstrates the role of counter transference between a therapist and a child client. This is an example of how therapists have written of this phenomenon within their private practice. Kroenengold (2010) explored the role of control in therapy and how

the child client was able to manipulate the sessions and Kroenengold. The therapist may over identify with the child and the child's needs and this will co-create countertransference (Lang, 2010). The child client was able to exert control over Kroenengold and was able to transfer her anxieties onto Kroenengold who internalised them as counter transference. The present study will be similar to the in-depth exploration of Kroenengold's single case; but will enhance and explore three additional recent experiences.

2.4.1 Developmental grieving model

Pannells and Smith (1995) investigated the ways in which children grieve and how they respond to death. By examining the children's thought processes and coping behaviours, they were able to develop a basic developmental framework for how children grieve. Children under the age of two will experience loss, but will not grasp the permanence of this loss. Between the age of two and four, the child will have a better grasp on the notion of death, but may still be confused and believe death to be temporary. Children from the ages of five to nine will demonstrate curiosity about death and become more aware of others' grief. From the age of nine to twelve years the child will be able to comprehend that death is permanent and this will lead to thoughts, fears and anxiety surrounding the child's own mortality (Pannells & Smith, 1995).

This is an important framework to bear in mind when working therapeutically with a bereaved child and what transference the child will display with regard to their beliefs surrounding death. This age-related framework demonstrates that children are developmentally incompetent to care for themselves and it is therefore conceivable that the death of a primary caregiver will render the child exceedingly vulnerable and emotionally exposed.

2.4.2 Counter transference with child clients in comparison to adult clients

Therapeutic work differs greatly when working with child clients in contrast to adult clients. Children create more complex and confusing emotions within the

psychotherapist and these can significantly influence clinical judgment (Rasic, 2010). Consider the impact of a child who is grieving and who has lost a primary caregiver; naturally, the counter transference of the psychotherapist will increase further. Thus, a child's transference is different to an adult's as child and adolescent psychiatry is unique in terms of the quality and intensity of the psychotherapist's counter transference, and the recurrent contradictory emotions that arise as a result of this (Abbate, 1964; Showalter, 1985).

Lang (2010) describes working therapeutically with children as "…intriguing, frustrating, fun, moving, sad, and ultimately deeply satisfying. We are drawn into a life and world totally separate from our own. For the period of time we are working with them, their world and our world overlap" (p.33). Lang effectively depicts the exceptional and penetrating impact that children can have on the adult psychotherapist. The overlapping of worlds that Lang describes is the psychotherapist getting in touch with their own inner child. Their personal inner child will have a history complete with emotional connotations and these will integrate into the psychotherapist's counter transference.

Shopper's (1998) comments coincide with the stance that counter transference is enhanced with child clients as she observes that children like to use action, have a closeness to primary process thinking and the therapist plays a role of play participant (Lang, 2010). These factors create a trap for issues of counter transference. Therefore, highlighting and re-emphasising the notion that counter transference has a greater impact when working with children.

Moody (1955) published a case study on his counter transference with a child client. This was a transparent and honest case study that he attributed to Jung's influence of acknowledging and using one's counter transference. Moody (1955), like Shopper and Lang, noted the delicate situation of embracing counter transference when working with children. He stated that:

> It is never easy to know what other child analysts do. But from what I have seen, I strongly suspect that many of them work within a transference

> relationship that is far more reciprocal than they are prepared publicly to admit. For children themselves, as well as the informal setting in which they are treated, encourage the spontaneity of the analyst to a degree that stands in marked contrast to the adult patient in the formal setting of the consulting room. One cannot help wondering whether a theory built primarily on the basis of experience with children would not have accepted more readily the reciprocal nature of the analytical relationship. But it seems that, in regard to the function of counter transference, theory has lagged behind practice and that practice has been impeded by inadequate theory (pp. 57 & 58).

Moody (1955) notes the extreme transference and counter transference dynamics that arise in the therapeutic alliance between the child client and the psychotherapist. He is of the opinion that perhaps this is more easily accepted than it would be in adult psychological theory. He also notes that this is a topic that is under-researched and this is likely due to psychotherapist's not wanting to admit to, or share, their counter transference narratives. The present study will take a personal and in-depth look into the experience of counter transference work with children, similar to how Moody did in his case study. This study hopes to encourage transparency amongst professionals in the field with regard to embracing and discussing counter transference work with children in order to bridge the gap between research and current available theories.

2.4.3 Displacement of roles

Ekstein, Wallerstein and Mandelbaum (1959) explored the role of counter transference in psychotherapy with children and adolescents in America. They also recognised the extreme impact that the younger client populations' transference has on the psychotherapist's counter transference. They state that:

> It has been understood for some time that transference manifestations of children include not only the projection of early repressed relationships but also displacements of the crucial relationships with the living contemporary

> parents. We suggest that corollary to this, the counter transference potential in work with children embraces the parent-child unit as well, and includes the therapist's responses to the contemporary parents of the child, as well as to the child's transferences and displacements (p. 61).

Ekstein, Wallertsein and Mandelbaum (1959) are embracing the opportunity of including the parents in the child's therapeutic process and progress, and the parent's influence in the counter transference dynamic. However, it becomes more complicated when there either are no parents available to the psychotherapist, or a parent/primary caregiver has passed away. This will influence the child's displacement of roles which will likely be placed onto the psychotherapist. According to Rasic (2010), "even in the physical absence of a parent, counter transference feelings are commonly directed at the imagined parental figure" (p. 251).

Vulnerable children who have lost a primary caregiver often look to the therapist to fill that gap. Winnicott (1949) comments on this in his one article stating: "…the child of a broken home, or the child without parents. Such a child spends his time unconsciously looking for his parents" (p.71). It is often within the safe and nurturing therapeutic space that the bereaved child may unconsciously, or even consciously, desire the psychotherapist to play the role of the parent that has passed away.

2.4.4 Learned helplessness in a child

The bereaved child presents as a fragile client in the therapeutic space. The child is grieving, displacing the psychotherapist's role into that of filling their lost one's place, as well as being more likely to create a counter transference reaction in the psychotherapist than that of an adult client. This combination of factors occasionally causes the psychotherapist to overlook the child's resiliency and capabilities and the psychotherapist becomes overwhelmed with the child's vulnerability and the helplessness of their situation. If this is not registered as a counter transference response in the psychotherapist, then this may lead to a learned helplessness in the child. This is subsequently fostered in the therapeutic environment when the

psychotherapist mistakenly believes themselves to be protecting the child, when in actual fact they are causing detrimental effects on the child's locus of control.

Seligman (1975) described learned helplessness as a perceived absence of control over a situation or an outcome. Consequently, the client suffering from learned helplessness will face deficits in their level of motivation, their emotional capacity, a decline in their cognitive responses, feelings of apathy, anxiety, depression and passivity, and ultimately a failure to learn that events are controllable (Seligman, 1975). Thus, the individual will not develop an internal locus of control. This can be damaging for a child who internalises this learned helplessness and then continues through life feeling that they are a victim of circumstances and not feeling in control of their future. It is therefore important that the psychotherapist challenge the child therapeutically and not over-indulge and over-protect the child.

Ekstein, Wallerstein and Mandelbaum (1992) stated that the child and adolescent psychiatrist and psychologist is exposed to this risk by virtue of the client's age and the parental pressure it places on the professional. The child is still learning and does not have a fixed personality as would an adult client. This instils a sense of vulnerability that may result in the professional viewing the child as a defenceless product of their own environment (Ekstein, Wallerstein, & Mandelbaum, 1992). As a result, a common counter transference reaction is that of being over-protective toward the child, which in turn increases the likelihood of unintentionally encouraging a sense of learned helplessness in the child's internal working model should the psychotherapist not be aware of this counter transference.

2.5 Counter transference and the psychotherapist's position

The psychotherapist's position within the therapeutic space and alliance is dependent upon their training and the school of thought which they advocate. This will impact their role within psychotherapy, as well as how they will respond to their client's transference and their own counter transference. As is the case with counter transference; there is a classical stance on the psychotherapist's position in therapy as well as an opposing view to this stance.

2.5.1 The objective psychotherapist

Freud (1910) encouraged the perspective that the psychotherapist's position should remain objective and neutral in the therapeutic environment. Thus, the client should not impact the psychotherapist, nor should the psychotherapist affect the patient. This is in keeping with the classical stance as described previously. Freud supported the notion that the psychotherapist's role within psychotherapy was to remain a blank screen for the client; self-disclosure was not promoted as this was not remaining impartial. The client was not to gain a sense of who the psychotherapist was or any personal information as the psychotherapist's role was to remain detached. As the psychological field grew and developed, so did the scholars who began to question Freud's assumption.

2.5.2 The subjective psychotherapist

Criticism and opposition to Freud's ideology of an objective and neutral psychotherapist grew. This was in reaction to Freud's beliefs about counter transference, as well as remaining detached within the therapeutic alliance. The commitment to be a *tabula rasa* for the client was declining in popularity; and according to Goldner (1993), "therapists cannot help beaming their version of the "truth" to their clients, no matter how committed they are to a stance of neutrality" (p. 160).

Pick (1985) agrees with the philosophy of the 'myth of neutrality'. Thus, he agrees that it is impossible for the psychotherapist to remain completely objective within the therapeutic relationship. It is unavoidable that the client will influence the psychotherapist, and the psychotherapist in turn will affect the client. This is the nature of the dynamic and complex therapeutic relationship. It is inevitable that the client will observe some parts of the psychotherapist's personality and it is futile to try and obstruct this process. It is even argued that how the psychotherapist's office is arranged and decorated will offer some level of insight. Pick (1985) continues this debate by stating:

> To suggest that we are not affected by the destructiveness of the patient or by the patient's painful efforts to reach us would represent not neutrality, but falseness or imperviousness. It is the issue of how the analyst allows himself to have the experience, digest it, formulate it, and communicate it as an interpretation… the contention that the analyst is not affected by these experiences is both false and would convey to the patient that his plight, pain and behaviour are emotionally ignored by the analyst (pp. 164 & 165).

As demonstrated by Pick's (1985) quote, this perspective is completely in opposition to Freud's theory. This stance holds that to remain neutral is detrimental to the client and their emotional well-being. The belief is that the harm that can be caused is by not effectively handling the counter transference reaction, rather than the damage being that the psychotherapist's position is not neutral.

Jung promoted and supported the notion that the therapist should not be a blank slate. Sedgwick (1994) elucidates that Jung wrote extensively on the reciprocal influence that exists between client and psychotherapist and that the psychotherapist cannot remain unaffected by their client. This reciprocal influence is maintained by Goodheart (1984) who determines that "nothing happens in a therapeutic hour within the patient or therapist which is not an interactional product" (pp. 90 & 91).

2.5.3 The various positions of the psychotherapist's counter transference

A study was conducted in order to explore the different manifestations of the psychotherapist's counter transference (Betan, Heim, Zittel Conklin, & Westen, 2005). The results are in favour of the 'myth of neutrality' and demonstrate the psychotherapist's position within the therapeutic relationship is affected and influenced by the transference and counter transference dynamic. The study surveyed 181 adult psychologists and psychiatrists, and focused on the transference and counter transference reactions of these professionals (Betan et al., 2005). Eight domains were identified in the results, including overwhelmed/disorganised,

helpless/inadequate, positive, special/over-involved, sexualised, disengaged, parental/protective, criticised/mistreated. Furthermore, there was a direct correlation between the professionals' counter transference and the client's personality pathology. Proving that counter transference has an important impact on the diagnostic and clinical process (Betan et al., 2005).

The findings expected for the present study, while working with bereaved children, would be the counter transference reaction of parental/protective. To experience any of the above mentioned eight domains, it would require the psychotherapist to be taking a step away from being the *tabula rasa* and more toward admitting that the therapeutic alliance is a mutual process of identification and influence.

2.6 Counter transference and attachment

2.6.1 A summary of attachment theory

Bowlby (1988) was considered to be the forefather of attachment theory. Bowlby considered attachment to be an affectional bond between two people. An attachment relationship has a different quality to that of a close relationship. An attachment bond serves a purpose in that a need is fulfilled to remain within proximity during times of distress. The attachment figure in the relationship will then operate as a secure base The most common example is that of a mother and child. The child requires a secure base to return to when feeling uncertain and needing reassurance and looks to the mother to be able to provide this. The attachment is fixed on the ability of the caregiver to remain responsive and sensitive to any distress from an infant, this primary attachment figure will determine what type of attachment style the child will adopt in their future relationships. Bowlby (1988) referred to this as the individual's 'internal working model' of the self and others. According to attachment theory, sudden loss of an attachment figure may elicit anxiety and concerns of abandonment and rejection into the child's internal working model. This would be a primary concern of a psychotherapist who is working with a bereaved child.

2.6.2 Attachment and the therapeutic alliance

The therapeutic alliance, or relationship, is a relationship that exists between two parties, the psychotherapist and the client. As per Greenson's (1967) definition, the therapeutic relationship is an amalgamation of three factors including transference, the real relationship, and the working alliance.

Parallels can be drawn between the understanding of attachment and counter transference. Both give reference to an influential emotional bond to another individual and the ways of connecting are established in early childhood experiences (Parish & Eagle, 2003; Sack, 1996). The therapeutic relationship is essentially a form of an attachment relationship that develops between the client and the psychotherapist (Bowlby, 1988; Parish & Eagle, 2003). The nature of psychotherapy is that the client attends therapeutic sessions when facing a personal stress or trauma. The psychotherapist is then sought after to offer comfort, security and safety for the client. This is the primary function of an attachment role, the psychotherapist acting the role of a 'secure base' for the client (Bowlby, 1988). Thus, naturally the relationship for the client is a reminder of the psychotherapist as the safe and nurturing mother; for a child client who has lost a caregiver, there is a high likelihood that the child will try to replace the lost attachment figure with that of the psychotherapist who is a reminder of that lost relationship and attachment.

Reading (2002) comments that psychotherapy fosters an attachment relationship and that this relationship brings out the client's transference. This is in order for the psychotherapist and client to work through it in a safe environment. This encourages the acknowledgment that the very nature of the therapeutic relationship is an important variable in the process of psychotherapy and that this promotes therapeutic change. This in turn reflects the idea that the psychotherapist cannot remain objective and neutral, but rather that the dynamic of the therapeutic relationship is that of "two-person psychology". The psychotherapist is an active participant alongside the client and this relationship and attachment fosters therapeutic positive change (Mohr, Gelso, & Hayes, 2005).

2.6.3 The psychotherapist's attachment and the caregiver role

As mentioned previously, the psychotherapist plays an active role in the therapeutic relationship. Thus, the psychotherapist will have their own attachment style that will influence this relationship. Previous research studies have found a connection between the role of care-giving and attachment behaviour (Bowlby, 1988; Grossman & Grossman, 1991; Slade, 1999). Lessard (2002) notes that a psychotherapist's personal characteristics may play a role in their proficiency to establish and sustain a relationship. It is quite often the case that the psychotherapist's own childhood experiences will direct them toward a care-giving and helping profession. The research of Fussell and Bonney (1990) indicated that psychotherapists reported having increased instances of: emotional deprivation, childhood trauma and parent-child role reversal. Mar (2000) explored that such influences in the helping profession may aid in the therapeutic relationship, but may also hinder it if the psychotherapist is affected too much by their own emotions, and this may lead to an avoidance of discussing the client's pain, or an over-identifying with the client's narrative, or enmeshment with the client. Such factors may come into play when counter transference is not acknowledged by the psychotherapist, and it may also be emphasised by working with children who are able to cloud the psychotherapist's judgement more than an adult client as discussed previously.

2.7 Counter transference and ethical considerations

Psychology is a professional practice and thus is governed by a regulating body to ensure that psychotherapists remain ethical and moral, both toward their clients as well as to the overall reputation of the psychological field. In South Africa, the governing body is the Health Professions Council of South Africa (HPCSA). A psychotherapist must be aware of their ethical obligations that are fundamental to practising psychotherapy. Should a psychotherapist not uphold ethical behaviour within their practice, it is within the client's rights to lodge a formal complaint with the HPCSA. The HPCSA will then investigate the psychotherapist and they reserve the right to revoke the psychotherapist's license to practice psychology. Thus, ethical

awareness is of paramount significance to the psychotherapist. The importance of remaining conscious of ethical dilemmas has risen in recent research as it has become a popular topic of interest amongst professionals.

Glass (2003) characterised three main variants in ethical dilemmas that are encountered by the psychotherapist within their varying degrees. These include boundary crossing, exploitative boundary violations, and controversial gray areas. All three variants are factors which will disrupt the therapeutic frame. Glass (2003) comments that, should the psychotherapist be aware of this frame disruption, it can be used to their advantage to enhance and strengthen the therapeutic alliance. However, if it goes unnoticed that it can be harmful to the client and the psychotherapist. Plaut (1956) commented that "the dangers of boundary loss are important, for it is frequently only in retrospect that the analyst may be able to see clearly what has been happening" (p.157).

This portrays the notion that ethical dilemmas are not in fact clear-cut rules, but rather that they are open to interpretation and are subjective in nature. The psychotherapist needs to draw on their own initiative, morals and ethical understanding of the current governing rules as depicted by the HPCSA. It is inevitable that a psychotherapist will encounter ethical quandaries within the therapeutic environment and that the psychotherapist will need to engage in ethical decision-making. This is particularly imperative when the psychotherapist's unconscious is having an influence on their ethical behaviour, such as reacting in the therapeutic space to their own counter transference. At such times, supervision and process notes become helpful for recognising this unconscious process in order to remain ethical.

Ethical codes are deemed to be the moral framework from which a profession operates. This moralistic foundation is used to navigate and to provide guidance for professionals in the ethical decision making process. There are two main stances on the ethical decision making process. Cottone and Tarvydas (1998) consider professionals who follow and obey principle ethics as more objective and rational individuals who "tend to view the application of universal, impartial ethical principles,

rules, codes and [the] law as the core elements of ethics" (p. 145). However, others, including Kvale (1996) place emphasis on the role of interpretation within the psychotherapist's ethical decision-making process. This school of thought proposes that ethical codes are not always definite for each context and "are more like texts to be interpreted than rules to be followed; they provide guidelines that must be judged according to their relevance to specific situations" (p. 110).

Within the South African context, Ivey (1992) commented on the role of counter transference management in relation to ethical considerations. Ivey (1992) argues that South African psychotherapists are specifically susceptible to compromising the therapeutic process and space due to their enactment of their own counter transference. Ivey (1992) continued to link this enhanced counter transference enactment to the fact that many South African universities are humanistic and cognitive psychology orientated and these theories tend to not pay enough attention toward the role of counter transference in relation to the therapeutic alliance.

2.7.1 Ethical dilemmas arising from counter transference

Shopper (1998) warns that counter transference should neither be prized nor despised, but acknowledges that it is challenging and narcissistically frightening for the therapist to recognise that the client may mirror some of the therapist's own unresolved issues. Rao et al. (1997) conclude that counter transference can lead to a variety of difficulties, including "unconscious acting out [of the therapist] … treatment failure, liability suits, license revocation, and patient decompensation and suicide" (p. 3). If the potentially harmful effects of counter transference are not acknowledged, the boundaries and roles of the therapist may blur which will contaminate and unravel the therapeutic process and relationship.

Exploration into the effect of decision-making based on the role of emotions has become popular and this links with the impact of a psychotherapist's counter transference reaction and their ability to make decisions. Cognitive neuroscientists have found evidence that when confronted with uncertainty, emotions assist in the role of decision-making. A network of pathways including the amygdala, ventromedial

and dorsolateral prefrontal cortices provide a neuroanatomical origin for this process (Naqvi, Shiv, & Bechara, 2006). Rentmeester and George (2009) concur with this research and concluded in their study that counter transference feelings significantly influence decision-making. This is due to the setting whereby treatment decisions incite strong emotions in the psychotherapist and these in turn elicit intense counter transference reactions (Rentmeester & George, 2009).

Parsons (1990) investigated the positive and 'warm' counter transference feelings toward a client that may lead to an ethically harmful process. He understood this to be the psychotherapist trying to "hang-on" to a client whom they have positive emotions toward. The psychotherapist may even harbour fantasies about fulfilling a certain role or need for that client. Unconsciously the psychotherapist creates the possibility of fostering dependence with the client; thus being unaware of therapeutic progress and therefore keeping the client in therapy for longer than is required. Parsons (1990) argues that this is even more likely to occur when engaging with a child or adolescent client, that not allowing a client to move on can be a form of resistance on behalf of the psychotherapist, and that this originates from the psychotherapist's own counter transference. As a result, a co-dependent alliance may develop in the therapeutic relationship between the client and the psychotherapist. Ethically, it is the psychotherapist's responsibility to avoid creating this co-reliance.

These ethical predicaments are an accepted 'side-effect' of the psychology profession, an occupational hazard. Counter transference is a natural effect of the therapeutic relationship. However, continuous exposure to counter transference and intense client transference can take a toll on the psychotherapist emotionally, physically, spiritually and cognitively. Self-sacrifice in the helping profession often leads to burnout, which in turn unintentionally leads to ethical lines being crossed or neglected. For example, a psychotherapist suffering from burnout may experience a disruption in their empathetic abilities, may encounter difficulties in maintaining a therapeutic stance, a loss of energy, lowered commitment levels, boundary violations and in extreme cases, resignation (Pearlman & Saakvitne, 1995).

2.7.2 Self-sacrifice in the helping profession

The helping profession can be both rewarding and detrimental to those who provide services. The profession of helping and caring creates an emotional burden for the psychotherapist if they are continuously subjected to sitting and holding the distress of others, their clients. Winnicott (1949) determined that counter transference originates from the empathetic response from the helper who projects themselves into the experience of their client. Thus, the foundation of the constructs of 'burnout', 'compassion fatigue' and 'vicarious trauma/secondary traumatic stress' are born out of the counter transference reactions of the psychotherapist. The psychotherapist's tools of compassion and empathy mean that they tend to focus on their clients' well-being and as a result they often neglect their own self-care needs (Figley, 2002).

Within South Africa, the level of violent crime exposure is high and this can lead to primary or secondary Post Traumatic Stress Disorder (PTSD). The clients are thus often exposed to a trauma or stress and that is why they seek professional help. The trauma or stress of a child who has lost a primary caregiver is significant, as this is the loss of a primary attachment figure in their life. A child will also struggle to grasp the finality of death and the loss is then re-lived more frequently as the child struggles to adapt to their denial and loss.The psychotherapist is then exposed to this trauma or stress of each client. Bride's (2004) research indicated that work involving troubled or difficult populations can increase the risk of burnout and this is true for those working in the mental health field. There is confirmed proof that powerful and unresolved counter transference feelings can contribute to physician burnout (Meier, Back, & Morrison, 2001). Furthermore, significant symptoms are detrimental to both the professional, as well as their clientele. Thus, it is important that professionals both self-monitor, as well as attend supervision in order to detect any emerging symptoms of burnout.

The helping professional is one that is privy to the distress and trauma of others and this increases the risk of contracting symptoms related to burnout, compassion fatigue and vicarious trauma when working in the mental health field. Van Deusen and Way (2006) comment that greater still is the negative impact upon the

psychotherapist when working with children who have been victims of trauma. Stamm (1999) notes that mental health care workers often deny, or are hesitant to acknowledge their symptoms of severe work-related stress in apprehension of being regarded as inadequate or incompetent within the profession. However, the overwhelming stress will inevitably lead to the psychotherapist offering less effective treatment, perhaps becoming detached from their work and clients, and in severe cases, the psychotherapist may leave the profession all together, or continue to practice and cause unintentional harm toward their clients (Pearlman & Saakvitne, 1995).

Consequently, the essence of exposure to trauma and stress is rooted in the psychotherapist's counter transference reaction and the intensity of their reaction. The professions with the greatest desire to help and assist with change are the ones that will be exposed to and experience burnout, vicarious trauma and compassion fatigue (Gentry, 2002). The concepts of burnout, vicarious trauma, secondary trauma and compassion fatigue are often used interchangeably within the profession. However, each term offers some variety and is an indicator of the level of the severity along a continuum.

Burnout can be defined as: "a state of physical, emotional and mental exhaustion caused by long term involvement in emotionally demanding situations" (Figley, 1995, p.11). Central to this is the interconnectedness between the experience of the individual with the work environment (Collings & Murray, 1996).

Vicarious trauma places emphasis on the psychological effects of working with a client population that has experienced trauma (McCann & Pearlman, 1990); hence highlighting the inner experience of the psychotherapist as opposed to just the work environment and its stressors. Vicarious trauma can originate from the helper over-identifying with the client, or responding to the client with a sympathetic response (Figley, 1995).

Compassion fatigue is a result of the psychotherapist being willing to engage in an extremely empathetic relationship and this will inevitably expose the psychotherapist

to their client's trauma at a deep and intimate level. This empathetic relationship and readiness to listen is integral in the work of effective psychotherapists and cannot be eluded. (Figley, 1995).

2.7.3 Self-reward in the helping profession

As evidenced above, the helping profession does expose the professional to potential emotional harm in the form of burnout, vicarious trauma and compassion fatigue. With negative consequences toward helping others, professionals need to balance their career with some positivity and this is often the notion of utilisedself-reward or the sense of reward and positivity that comes from helping others. This more positive approach has resulted from an increase in positive psychology's influence, thus a salutogenic approach has emerged. McCann and Pearlman (1990) commented on this with the belief that trauma reactions can be "an area of growth for the helper" (p.146). This field has become a popular topic for research. Vicarious exposure to bereavement has been researched and the result was that post-traumatic growth was found with those that worked with bereaved clients (Arnold, Calhoun, Tedeschi, & Cann, 2005). The professionals under scrutiny for this salutogenic approach include research psychologists, funeral directors, disaster response workers and mental health practitioners, such as psychiatrists and psychologists (Arnold, 2005).

The term 'compassion satisfaction' helps to describe the positive effects. According to Stamm (2002), compassion satisfaction occurs when the psychotherapist gains personal satisfaction and a sense of achievement from working with individuals who have faced a trauma or stress, and engages with these clients in an empathetic relationship. Stamm (2002) defines compassion satisfaction to be: "the pleasure derived from being able to do your work well…feeling positively about your colleagues or your ability to contribute to the work setting or even the greater good of society" (p.5).

Psychotherapists have reported benefits including an increase in confidence, a positive sense of self-worth, a stronger sense of self, self-knowledge, a sense of

purpose and an increase in their faith in the human spirit and resiliency (Pearlman & Saakvitne, 1995). It is considered to be the antidote to burnout, compassion fatigue and vicarious trauma.

Similar thinking has been explored in the term 'vicarious post-traumatic growth', which is seen as the antidote for vicarious trauma. It is a positive psychology stance on working with traumatised clientele. In this case, psychologists report positive effects such as growth in personal relationships, an increase in spiritual well-being, value and appreciation of human life and relationships, and an increased ability to cope with adverse situations (Pearlman & Saakvitne, 1995).

2.7.4 Self-care

In order to avoid burnout, it is vital that professionals engage in self-care behaviours and allow themselves to rest emotionally, mentally, physically and spiritually. If counter transference and fatigue is not acknowledged and processed, it will affect the psychotherapist both inside of therapy, as well as outside of sessions into their personal life.

Frequently, the drained psychotherapist will not admit to their professional fatigue; Figley (2002) refers to this as "the conspiracy of silence among the profession" (p.1440). Thus, indicating that there is still a stigma for professionals to admit to their counter transference and that they too need empathy and support in order to thrive. Figley (2002) continues to explore this by stating "psychotherapists gradually view themselves as others view them: someone who is an expert at helping others cope with life's challenges. They seem to forget that they are human beings as well" (p.1439). Catherall (1995) emphasises the belief that psychotherapists need not feel ashamed of their counter transference reactions or symptoms of emotional burnout; and that these are in fact normal reactions which are a result of empathetic engagement with the client.

Figley (1995) notes the following preventative measures in the form of self-care: meditation, hypnosis, positive visualisation exercises, self-soothing and stress

management skills, and restful sleep. He continues to express the importance of the psychotherapist having a support system within their personal life in order to remain therapeutically 'fit'. Such activities and time for the self are critical for gaining mastery over distress that result from the psychotherapist's work with their troubled clients. Pearlman and Saakvitne (1995) insist that the psychotherapist must maintain a fulfilling personal life and seek self-care through the following mediums: being creative, regenerating and healing activities, art, exercise, music, writing, dancing, hobbies, meditation, healthy recreational activities and quality time spent with friends and family.

Thus, to engage in self-care behaviours and to remain aware of one's limits is to remain ethical as a professional in the mental health field.

2.7.4.1 Supervision

Counter transference is often in the psychotherapist's unconscious and it takes various avenues to bring the counter transference into the psychotherapist's awareness. One such avenue is in the form of supervision. Attending regular supervision sessions is a means by which the psychotherapist can engage in self-care behaviour as well as ethical conduct. Counter transference is a very strong and persistent emotional reaction to a client and this can occur within the psychotherapy session, as well as outside of the therapeutic environment. Waska (1999) observed:

> Certain aspects of the intrapsychic and interpersonal communications between therapist and patient can continue beyond the hour or even past termination. Therapists speak among themselves of being hounded by a session and having it follow them into their personal lives. They can unwittingly bring home clinical situations and even find the patient's material invading their dreams (p.156)

As stated above, counter transference can affect the psychotherapist's professional and private life. Thus, it is vital that the psychotherapist attend to it and be aware of it in order to practice ethical demeanour and to avoid burnout. In order to recognise

counter transference, one needs to obtain a clinical skill that can be taught in clinical training in the form of attending supervision sessions. Thus, the training psychotherapist can attend a supervision session following a session with a client and use the space to self-reflect in a non-judgemental environment. This self-reflection will encourage the training psychotherapist to recognise their emotional reactions in client interactions and thereby identify their counter transference reactions (Alonso & Rutan, 1988; Hughes & Kerr, 2000). Supervision should provide the psychotherapist with an on-going process where it is safe to explore emotional distress in order to increase stress management skills and an appropriate identification of emotions (Figley, 1995). Supervision can be done one-on-one or in a group, with a fellow professional psychotherapist or with a peer.

A major transformative model for training in counter transference has been the integration of intense and consistent supervision sessions (Rao et al., 1997). The current school of thought is that universities should include training programs and compulsory supervision (peer, group and one-on-one) sessions that will enable the training psychotherapist to become aware of managing their counter transference in a beneficial and constructive manner (Rao et al., 1997).

As mentioned previously, in order to be ethical, one must be aware of one's counter transference so that it can be used as a therapeutic and diagnostic tool. According to Rao et al. (1997), in order to achieve this awareness, one must engage in self-analysis and this is most successful when engaging in personal psychotherapy with another skilled psychotherapist. It is stated that:

> It provides a unique stage upon which the interaction of the self with another can be viewed, with the aid of the other as a participant observer. Furthermore, the cognitive and affective elements of the [training psychotherapist's] experience of the self-other interaction may be promoted to higher levels of awareness through facilitation by interpretive comments of the other and the development of finer self-observation skill by the [training psychotherapist] (p.9).

Working in a treatment team is also beneficial as it offers a supportive network and environment, as well as the sharing of reflections. It enables members to assist the psychotherapist with maintaining boundaries and realistic and manageable caseloads (Comaz-Diaz & Padilia, 1990). This is a form of group and peer supervision.

2.8 Chapter summary

This chapter provided an overview of the literature relevant to this study. The definition of the terms 'transference' and 'counter transference' were explored in order to contextualise this study. A brief historical review of counter transference was examined in order to portray the development of the term. As the present study focuses specifically on counter transference when working with a bereaved child, literature pertaining to this topic was discussed. The role of the psychotherapist was analysed in relation to the myth of neutrality. The function of attachment in the therapeutic relationship and its influence on counter transference was investigated. This naturally led to a detailed exploration of the ethical considerations when encountering counter transference in psychotherapy and the obstacles that the psychotherapist may face.

The focus of Chapter 3 will shift to the methods employed in conducting the research.

CHAPTER 3
RESEARCH DESIGN AND METHODOLOGY

3.1 Introduction

This chapter will serve as a discussion of the research design and methodology that was utilised for this dissertation. The chapter will commence with an explanation of the purpose of this research. The requirements with regards to the research framework will then be discussed. An Interpretative Phenomenological Analysis (IPA) paradigm met the requirements for this research and provided the overall framework. This will be discussed in detail focussing on the primary features of a qualitative design; the philosophical foundations of the IPA phenomenology; the ontological assumptions; and the epistemological implications of IPA. The design of this research will then be explained, including the methods of sampling; data collection; data transcription, and data analysis. Ethical considerations will be discussed, and finally the issues of reliability and validity in qualitative research will be outlined. All of the abovementioned terms will be clarified in the pages that follow.

3.2 The purpose of the research

The purpose of this study was to explore and gain an understanding of the lived experience of therapists in their work with bereaved children. Therefore, the goal was to obtain rich data that would enable one to gain insight into the therapists' lived experience of their thoughts and feelings which develop when confronted with counter transference as it transpires during the therapeutic relationship. Furthermore, the aim was to gain a deeper understanding of the impact of counter transference both within therapy and in the therapist's personal life. The question this study asked was: What will an exploration into the child therapist's thoughts and feelings around counter transference yield?

The following section will focus on the framework that was utilised in meeting the goals of the study. Specifically, the ideological orientation, the strategy employed, and the philosophical underpinnings will be detailed.

3.3 The research framework

3.3.1 Ideological orientation: Qualitative research

The aims of this research were best met by an IPA framework within a qualitative paradigm. Qualitative research is focused on meaning-making. It is rooted in the personal experiences of individuals who are involved with the phenomenon in question, and enables the individual to express their experiences and derive meaning from their encounters with the phenomenon (Mertens, 1998; Whitley, 2002).

Willig (2008) stated that "qualitative researchers tend, therefore, to be concerned with the quality and texture of experience, rather than with the identification of cause-effect relationships" (p.8). Hence, qualitative modes of enquiry seek to gain a rich and deeper understanding of the phenomena being explored; whereas quantitative methods of investigation tend toward observable characteristics of phenomena that demonstrate a cause and effect relationship. This study utilised a qualitative phenomenological approach, as the goal of the research was to gain an understanding of the lived experiences of therapists who have worked with bereaved children in order to reflect on the phenomenon of counter transference. Using a qualitative approach, the researcher was able to explore these experiences from the individual's perspective, to delve into contextual narratives of the participants and to become ontologically and epistemologically established with the therapists' experiences of counter transference when working in a therapeutic relationship with bereaved children.

The research participants had first-hand experience with the phenomena and this made them experts in their field. These experiences and meaning derived from these accounts were used in the development of themes that became the foundation for understanding the research topic. Such an approach allowed for the possibility that new information could surface and be added to the existing information that the psychological community has on counter transference.

A qualitative method enabled the researcher and reader more freedom as the topic of study was not confined to predetermined hypotheses and limits, but rather it was open to exploration. Furthermore, the focus was on the narratives of the participants' experiences and the meaning that was derived from their accounts. The researcher's interpretation of the participants' experiences played a role in the meaning-making process of the research. Babbie, Mouton, Vorster and Prozesky (2001) note that the major features of a qualitative design include an ideographic strategy; the generating of open-ended data; an inductive approach towards analysis; and the acknowledgement of the researcher's involvement in the research process. These major features were employed in the research conducted and will be expressed in the pages that follow.

3.3.2 Research strategy: Interpretive Phenomenological Analysis

IPA was the selected strategy for this research. IPA was suited to the research question as it allowed for understanding of the first-person perspective from a third-person stance through inter-subjective inquiry and analysis. Therefore, the focus was on the meaning that the participants ascribed to their experiences of the phenomenon of counter transference when working with bereaved children. This included the process, events and the therapeutic relationships. IPA was used to produce open-ended data from which participant meanings could be identified and inductively interpreted. This strategy draws on philosophies of phenomenology, hermeneutics, and interpretation (Smith & Osborn, 2003), which are explained in further detail below.

3.3.2.1 Philosophical underpinnings: Phenomenology

Edmund Husserl is considered to be the father of phenomenology. Husserl's work was based on Descartes' Meditation and he focused on the philosophy of the lived experience of the individual. Husserl argued that the human and lived experience is made up of layers of meaning and, in its entirety, can be explored and investigated as a fact and a real phenomenon from which to draw theoretical deductions (Edie, 1965).

Husserl's phenomenology explored the various meanings that can be ascribed to objects or phenomena in the world, such as, their structure, their texture and their aesthetics. Husserl believed that this representation of the object or phenomena is stored in the immediate consciousness in an intentional manner or as the consciousness is directed and focused upon them (Cooper, 1990). Thus, the objects or phenomena are always present to the individual's consciousness, but the individual's consciousness can only gain access to them by intending them. Thus, these ascribed meanings are governed by the consciousness and then processed and translated through the individual's experience and action of intentionality (Cooper, 1990; van der Mescht, 2004).

The phenomenologist's main objective is, therefore, to explore and uncover the essence of an object. This is achieved by entering into a person's lived experience, their *Lebenswelt,* their experience of that object, and then investigating and exploring the meanings of the phenomena as they are represented in the individual's consciousness (Giorgi & Giorgi, 2003). According to LeVasseur (2003), while exploring the individual's consciousness one may encounter difficulties surrounding assumptions that are produced regarding immediate experiences. Such assumptions may include the individual's own personal history and matters of time and space. Husserl referred to a method *epoche*, which is to suspend or bracket such assumptions.

Husserl's phenomenology is based on various foundations, such as: a universal structure of the self, which he termed 'a transcendental ego'; the fully shaped structure of phenomena in the world; and an individual's adequate ability to expressive themselves linguistically (Gendlin, 1965; Grabau, 1965). His foundations have been the focus of some debates within the field of phenomenology. For instance, Grabau (1965) commented that subjective symbolic constructions are mistaken for universal experiences. He further stated that historical structures play a role in determining one's current acts of experience and meaning-making. Cooper (1990) argues a similar point, that phenomenological studies are grounded in subjective knowledge, hence, the phenomena or object cannot be objectively

observed. As a result, phenomenologist took on a hermeneutic custom in an effort to rectify this criticism. They moved away from trying to access and explore the true experience of the individual and, instead, highlighted the inevitability of contextual consideration within the construction of experiencing a phenomenon or object.

3.3.2.2 Philosophical underpinnings: Hermeneutics and inter-subjectivity

The word 'hermeneutic' is derivative of the Greek name *Hermes. Hermes* is a Greek god that is responsible for clarifying and interpreting messages between other gods (Thompson, 1990). Thus, a hermeneutic stance is one that interprets the experiences and meanings of the individual, rather than simply describing their experiences (Lopez & Willis, 2004).

Gadamer (1976) understands hermeneutics to be the process of interpreting; the origin of which traces back to the field of theology, whereby hermeneutics was used in an effort to make sense of religious texts. Hermeneutics is bound to a discourse of inter-subjectivity and the core assumption is that the principle meaning is not always readily available, but rather requires explication (Gadamer, 1976). Such explication of meanings is required as the individual's experience is placed within situational, historical and dialogic contexts (Unger, 2005). Such contexts influence the meaning that individuals ascribe to their experiences and do not allow for a sense of neutrality (Unger, 2005).

Martin Heidegger (1962) was a figure in the development of hermeneutic phenomenology. His stance was that an individual's consciousness cannot be separated from prior conceptions and knowledge, or from considering future possibilities (LeVasseur, 2003). Therefore, there is a predisposition toward meaning-making and the pre-understandings and assumptions that shape the individual's experience and their process of understanding these experiences (Unger, 2005).

Hermeneutic phenomenology encourages the researcher to acknowledge their own subjectivity rather than attempting to suspend it. This involves taking a reflexive role in being transparent about how the researcher has been influenced by their own

experiences and meaning-making process. Thus, the researcher's personal background and historical understanding of the phenomena being studied need to be considered. In addition, the concept of inter-subjectivity, which is based within the qualitative research paradigm, suggests that the interaction between the researcher and the participants also affects the meaning-making experience. During the data collection phase, interviews are recorded between the researcher and the participant, and it is therefore important that the researcher be aware of the role of reflexivity during this phase. The analysis of the collected data can be referred to as a hermeneutic circle. This is the process of continually shifting back and forth between the participant's experience and meaning, and the researcher's own subjectivity.

3.3.2.3 The role of the researcher

A researcher's individual interests and style of learning will impact their pursuit of a particular topic within a field of study. This creates a pre-determined theory background and basis that will influence the researcher's study and their research framework. For example, in the case of the current study, the researcher was drawn to the subject of counter transference when working with children due to her own experiences. She had an interest in this field, and in particular the historical development of counter transference from a taboo topic to that of a therapeutic tool. Furthermore, she had her own experience of working with a bereaved child during her Masters practical training. She became aware of counter transference and discussed the issue in supervision. She saw the magnitude of her decision as, had she not acknowledged the counter transference, she could have damaged the therapeutic relationship and the cathartic experience for the child. Instead, she was able to then use her experience and personal feelings as a therapeutic tool to enhance and aid her child client in therapy. This personal experience would inevitably have influenced the study, and such reflexivity needed to be explored with trusted professionals in the field. Included in the analysis of this study are the researcher's interpretations that she has made transparent. The impact of these assumptions on this research will be commented on in the reflection on transparency section of the final chapter.

In the following section, the research design will be delineated, focusing on the methods of sampling, data collection, data transcription, and the data analysis.

3.4 Research design

3.4.1 Sampling

Purposive sampling was employed for this study. This means that participants who met the inclusion criteria were chosen for the purpose of the research, providing the researcher with a closely defined group for whom the research question was relevant (Smith & Osborn, 2003).

IPA is an idiographic method of inquiry and focuses on specific in-depth cases that are detailed and individually orientated (Porta & Keating, 2008). A great deal of time is required for the researcher to become immersed in the details of each case and to analyse transcripts. The result is that sample sizes need to be small. According to Smith and Osborn (2003), it is sufficient to have three participants in a study in order to obtain rich and descriptive data and for the comparison of themes, as well as a broad enough perspective to start discerning experiential patterns for future research. These small groups are selected specifically for their compatibility in terms of their experiences, and the sample should be as homogenous as possible (Smith & Osborne, 2003). Therefore, in the current study, a sample was drawn from a population of South African psychologists, and their experiences were analysed based on the research question. However, the findings cannot be generalised to a broader population, it rather provides a deepened understanding of the phenomenon of counter transference from the perspective of the psychotherapist when working therapeutically with a bereaved child client.

Via word-of-mouth, the researcher was provided with a list of psychologists who would meet the inclusion criteria. Thus, a convenience sample was created. These psychologists were contacted via an email which outlined the purpose of the research and requested their voluntary participation. Three psychologists replied to the email and agreed to participate in the interview.

3.4.1.1 Sampling inclusion criteria

IPA recommends that the sample be homogenous, and sample inclusion criteria helps to ensure this. The inclusion criteria for this study were as follows:

The participants could be male or female, belonging to any racial group or culture, and of any religion; they had to be able to converse fluently in English; they had to be registered with the Health Professions Council of South Africa (HPCSA) as a clinical, counselling or educational psychologist; they had to adhere to a broad-based psychodynamic paradigm; and they had to have experienced counter transference during therapy with a bereaved child. They were required to have at least five years' experience in the therapeutic field of working with bereaved children. It was considered that five years' experience would provide rich data as the therapist would inevitably have been subjected to the complex process of counter transference within their therapeutic practices. Finally, the bereaved child with whom they worked had to be under the age of 12 years, and must have lost at least one primary caregiver.

3.4.2 Data collection: Semi-structured interviewing

The semi-structured interview is a data collection tool that uses interviewing techniques for data collection as required by the IPA strategy (Smith & Osborne, 2003). Semi-structured interviewing was employed as it would allow for the use of open-ended questions, which in turn would allow for rich and spontaneous data from the participants. Some structure was provided by an interview schedule, however, this allowed the space for the participant to respond as they desired and for the researcher to probe areas of interest as deemed relevant (Smith & Osborn, 2003). Thus, the researcher had an idea of the area of interest that was to be focused on and the participant would respond closely to the direction that the interview followed, yet the participant could introduce new questions and detail into the flexible interview schedule. In this way the participant was viewed as the experiential expert on the phenomenon, and was allowed maximum opportunity to share their story as they desired (Smith & Osborn, 2003).

With semi-structured interviewing, the researcher and participant influence one another's meaning; the participant guides the researcher, and the researcher influences the participant. Kvale (1996) expanded on this view by commenting that the interview is an interchange of views, an 'inter' 'view'. The researcher and participant exist in a dialogical, reciprocal, non-polarised relationship whereby the generation of meaning is not considered neutral but co-constructed (Hollway, 1989). Thus, the researcher was aware of this and their impact during this process.

Kvale (1996) explains that the procedure of interviewing encourages individual perception and experience as the fund of knowledge. Flick (2006) describes interviewing as a method for attaining verbal accounts of participant experiences. These verbal accounts are gathered through face-to-face interactions between a researcher and the participants, where the participants are presented with a space in which to express their experiences in their own words.

Smith and Osborn (2008) summarise the advantages and disadvantages of utilising a semi-structured interview. Semi-structured interviews have the advantage of facilitating rapport and empathy; they allow for increased flexibility of coverage; they allow the interview to cover new areas; and they tend to produce richer data. However, these interviews have the disadvantage of reducing the control that the investigator has over the situation; they take longer to conduct; and they are more difficult to analyse. In this case it provided deep insight into the phenomenon of counter transference and was an effective method for eliciting abundant data.

3.4.3 Data transcription

In the current research, three interviews were conducted in total. Each participant was interviewed once in a face-to-face interview. These interviews were recorded by utilising a high quality digital voice recorder. A duplicate back-up recording was made on an alternative recording device. These recordings were then transferred to the researcher's personal computer for storage. The recording with the highest quality was kept and the other was deleted. All audio recordings were transcribed by the researcher. A trusted third party was used for reliability purposes to confirm that the

transcription matched the audio recording. A clause stating the possible use of a third party when transcribing was stipulated to the participant's before the interview, which they agreed to and signed. There were benefits to the researcher transcribing the data as it enabled the researcher to become familiar with the raw data and have repeated exposure to the content (Smith & Osborn 2003). This also allowed for simultaneous analysis and interpretation of the data whilst transcribing it. The recordings were not compromised by background noise and thus could be transcribed with accuracy.

3.4.4 Data analysis

Data analysis was controlled as prescribed by IPA. Smith and Osborn's (2003) five stage analysis process was followed. The first step involved the researcher familiarising herself with the raw data and her total immersion in the transcripts. This enabled new comprehension to occur with each reading and re-reading of the data.

The second step included the analysis of the transcribed data by creating two columns on either side of the transcription. This enabled free commenting on the data, and Smith and Osborn (2003) refer to this process as finding the units of meaning. The transcripts were dealt with individually during this phase so as to not contaminate the free commentary across the interviews.

Step three required the researcher to deduce the initial units of meaning that were gathered in the former step. This involved initiating a logical structure into the text through solid and precise themes, and forming clusters of concepts and meanings that shared this reference, and that rounded within a psychological frame of reference (Willig, 2001). These were noted in the right-hand column of the transcripts. The psychological themes are the result of an inductive interpretation based on the participants' lived experiences. Any themes that seemed irrelevant were excluded, such as themes that were minor in regard to the phenomenon being studied, or that were not well represented within the text (Willig, 2001). The analysis was a continuous interaction between the researcher and the text (Smith & Osborn, 2003).

Step four, as suggested by Smith and Osborn (2003), was to create a connection between the themes that emerged as a result of step three. This involved the categorisation of what had been coded in chronological order (Smith & Osborn, 2003). Thus, the themes were clustered into superordinate themes. This step required frequent clarification at previous steps as the themes would merge into one another at times. The researcher therefore needed to clarify the theme's original purpose, origin and the meaning for each particular participant in order to rectify this.

The fifth and final step was that of creating and establishing a final table of clustered themes (Smith & Osborn, 2003). This master table made use of the generated psychological themes and their relationship to the gathered data. This step also mirrored the hermeneutic process of comparing the researcher's own interpretation and the participants' interpretation and consulting the original transcripts. Thus, this master theme table reflected the experiences of the participants as a whole (Willig, 2001). The themes were grounded within the data and were based on all the cases (Willig, 2001).

Appendix IV includes a master table of themes and subthemes. Transcripts are available on request.

There are various ethical issues that need to be taken into consideration when doing research and when using interviews. The ethical considerations as they pertain to this particular study will be discussed in the following section.

3.5 Ethical considerations in interviewing

Ethical principles and guidelines were endorsed and utilised as per university requirements and recommended by authors, such as Kvale (2007). There are numerous ethical concerns with regard to interviewing. Kvale (2007) comments on the moral process, by which the participant's private life and thoughts become known to the public. Thus, the researcher needs to demonstrate sensitivity and respect for the well-being of the participant. The research process and, in particular, the data collection process was accomplished under a set of ethical guidelines.

An ethical protocol with general information regarding the nature and intention of this research study was provided to each participant (*see Appendix I*). This was administered prior to the interviews in anticipation of any ethical concerns with regard to the research. Participants were informed of the nature of the study; that it was a Masters research study; the topic of the research; the aims of the research; the sampling inclusion criteria; the features of the research design; the nature of the data collection; access to the data; the rights of the participants; the voluntary nature of the study; and that no foreseeable harm would come to the participants. These ethical considerations were compiled into a written document and emailed to the participants.

Accompanying the ethical document was a participant consent form that served as an agreement between the researcher and the research participant (*see Appendix II*) that was emailed before the interview. The consent form detailed the researcher's information and contact details, the researcher's supervisors' contact details; the nature of the study; the confidentiality that will be applied to the participants and their clients who they speak of; anonymity; and the right to withdraw from the study at any given time.

A third document was emailed prior to the interview process. This was a consent form to tape the interview sessions (*see Appendix III*). This served as a permission and release form to use tape recordings for research purposes. Thus, to obtain the participant's consent for the interviews to be tape recorded, provided that anonymity and confidentiality were maintained.

The signed copies of the above mentioned three documents remained in the secure possession of the researcher. Any identifying or sensitive information was omitted from the transcripts and analysis, albeit that the participant took primarily responsibility for his/her own client's confidentiality. The researcher also upheld this ethical obligation.

It was expected that, should this research be published, the findings could be valuable to the population of therapists who have experienced counter transference

with a bereaved child, in terms of knowledge production and theory generation. All three participants found their counter transference to be helpful within their therapeutic relationship, and these experiences are revealed in this research investigation. However, it was not the intention of the researcher to endorse the practice of counter transference for therapists, but rather to expose some of the influences and experiences that it has had for others. The research was qualitative and did not aim to make general claims on the phenomena in question nor the population being represented. It was focused on the importance of anecdotal information, and how different experiences and opinions could arise and make way for more research within this field.

In the section that follows, the validity and reliability of this research will be discussed.

3.6 Trustworthiness, transparency and dependability

Reliability and validity are rooted in a scientific and positivist perspective and are a way of testing and measuring quantitative values (Golafshani, 2003). However, qualitative data is not made up of observable and measurable facts, but rather subjective experiences (Golafshani, 2003). Reliability within the qualitative paradigm must be assumed through quality issues (Golafshani, 2003), including: triangulation, transferability, dependability, reflexivity and transparency. The researcher ensured reliability of data by having a third party check the generated transcriptions.

First, triangulation strengthens a study through combining methods (Golafshani, 2003). The methodology of triangulation was employed to authenticate the trustworthiness and validity of the study (Smith & Osborn, 2003). Thus, the data is triangulated from three different sources. The data is interpreted by the researcher, by an independent colleague, and by the participants themselves. This allows multiple perspectives on the interpretation of the collected data.

This can be accomplished through the use of a colleague to ensure that the data has multiple and diverse interpretations. Second, transferability or generalisability is important within the qualitative paradigm and refers to the degree to which findings

can be applied to different contexts or respondents (Babbie et al., 2001). This involves ensuring that participants meet the sampling inclusion criteria and fortifying the relevance of the data collected (Babbie et al., 2001). The researcher ensured that all avenues to ensure trustworthiness, transparency and dependability were taken during the course of the conducted research.

Third, research findings need to be dependable. Thus, if the study was to be repeated with the same target population, the second study should yield similar results (Babbie et al., 2001). This can be reinforced by ensuring that one has conceptualised the topic clearly, that the participants are aware of the research question, and that the data collection process is consistent across studies.

Fourth, reflexivity means that the study provides a clear boundary between the comments made by participants and the researcher's interpretation of these comments (Willig, 2001). The researcher must be aware of his or her own preconceptions regarding the phenomenon. The researcher must not favour a particular theory in interpreting the phenomenon. There must be no social or cultural assumptions made by the researcher. Therefore, the research findings must not be a result of the researcher's own bias. This can be monitored and avoided by maintaining a paper trail which can be reviewed by other professionals and this encourages transparency.

Thus, the final quality issue is that of transparency and being transparent about the process. Transparency enables the reader to follow the researcher's process and to examine the level of trustworthiness of the study (Golafshani, 2003). By keeping an accurate record of interviews and transcripts (a paper trail), and making them available to the reader, it is possible for others to follow the study in a logical step-by-step sequence. It should be possible for a study to be replicated by following the researcher's notes and explanations. The researcher's involvement can also be noted, as seen in the role of the researcher subheading.

3.7 Chapter summary

The aim of this chapter was to discuss all aspects relating to the methodology of this study. The purpose of the study was discussed in relation to the qualitative research framework and IPA strategy utilised in the investigation. Following this was a detailed explanation of the research design, including methods of sampling, data collection, data transcription and data analysis. Ethical considerations were outlined, as well as issues of trustworthiness in qualitative research.

The following chapter will focus on the results of the study.

CHAPTER 4
DATA ANALYSIS

4.1 Introduction

The following chapter will provide the results of the conducted research. A brief overview of the participants' narratives will be provided in order to offer the reader a contextualised understanding of the participants. This brief overview involves a look at the participants' experiences in the field and their qualifications; their therapeutic paradigm; their stance on counter transference as either advantageous or harmful in psychotherapy; and their understanding of the terms 'transference' and 'counter transference'.

Three superordinate themes emerged from the participants' accounts and they were identified using an interpretive approach, as was discussed in *Chapter 3: Methodology*. These themes stem from the related experiences of the participants. Not all of the themes were narrated by all of the participants, but were noteworthy in their own right and hence were mentioned. The three themes are: 1) the myth of neutrality: the dual role of the psychotherapist; 2) ethical dilemmas: the "pity lens" in bereaved child psychotherapy; and 3) containing the therapeutic frame: avoiding the blind spots. Following the participant narratives, an analysis of these three themes is explored and these themes are evidenced by detailed descriptions of the participants' accounts from their interviews.

4.2 Overview of participant narratives

4.2.1 Participant 1: Judy

Participant 1, Judy (pseudonym), is a female clinical psychologist. At the time of this study, she was working at a government hospital in a big city in South Africa. In terms of her qualifications, she has a Masters degree in Clinical Psychology and a doctorate in Psychology. She has six years of experience within the field working as a registered clinical psychologist. She is involved in custody settlements and the

assessment of children. She has experience in working at child units of psychiatric hospitals for approximately six years.

Judy practices within a psychodynamic therapeutic paradigm and commented “I like to work in quite a relational psychoanalytic way”. She also feels her work is influenced by attachment theory. Judy believes that counter transference is a therapeutic tool that can be “very useful in therapy if managed in the best interest of the client”.

Her understanding of the terms ‘transference’ and ‘counter transference’ were:

> Transference is obviously what is laid out in the therapy in terms of the dynamics around early relationships. I think maternalised figures. And then counter transference obviously there is a very subjective response to the client and obviously being influenced sometimes by my own dynamics around attachment and caregiving figures.

4.2.2 Participant 2: Kathy

Participant 2, Kathy (pseudonym), is a female clinical psychologist working in a private practice in a big city in South Africa. She is registered as a clinical psychologist and has been practising in this field for twenty years. She has extensive experience working with children over the past two decades, both in private practice and in governmental institutional settings.

Kathy is a psychoanalytic psychotherapist. She utilises counter transference from a Winnicott and Kleinian perspective and believes it to be a therapeutic tool.

Kathy described her understanding of ‘transference’ and ‘counter transference’ as:

> It is what is evoked, what is projected by the client into the psychotherapist and whether there is a meeting in some way, or whether those feelings are taken in and being able to give them back to the client… counter

> transference is often unconscious and it is often only in enactments that one becomes aware of it. So it is everything that is projected onto the psychotherapist I would see as transference. And counter transference, the transference to that transference... it is also about what gets evoked for oneself… I think counter transference is an unconscious process and it is about fantasy. You see it is the fantasy of something being projected and then the other person contains it.

4.2.3 Participant 3: Fatima

Participant 3, Fatima (pseudonym), is a female clinical psychologist. At the time of the study she was working at a government hospital in a big city in South Africa. She has six years of experience in working with children and is completing a doctorate in the field.

Fatima's therapeutic paradigm is primarily psychodynamic psychotherapy. She described counter transference to be an important therapeutic tool, and she makes use of "[her] own counter transference a lot to guide the process". She also used counter transference as a means to measure her therapeutic progress with a client.

Fatima understands 'transference' and 'counter transference' to be:

> Very simply I would say my counter transference feelings are my response to my client, my emotional response. And if I think about it more psychodynamically I think about it as the projections or me having projective identifications with my clients. And my client's transference responses, sort of how they envision me as the psychotherapist, as kind of someone in their unconscious or internal world.

4.3 Results

Below is a tabulated format of the three superordinate themes that were generated from the participants' narratives of their lived experience of counter transference

when working with bereaved children. These three themes were produced from the data via a procedure of induction as determined by the researcher.

Summary of master table of themes and subthemes (see appendix IV for full table):

1. The myth of neutrality: the dual role of the psychotherapist
1.1 Emotional enmeshment
1.2 Multiple roles
1.3 The impact of attachment and a concern of re-enacting abandonment
2. Ethical dilemmas: the "pity lens" in bereaved child psychotherapy
2.1 Being mindful of therapeutic boundaries
2.2 Enabling the child's helplessness and dependency on the psychotherapist
2.3 Creating special exceptions for the bereaved child
3. Containing the therapeutic frame: avoiding the blind spots
3.1 Ethical management
3.2 Self-awareness and self-reflection
3.3 Personal growth as a psychotherapist

4.4 Analysis findings

This process was an in-depth one. The researcher read and re-read the interview data. This immersion in the scripts enabled the researcher to extricate various units of meaning from the data and then connect these to a higher order structure of subordinate themes. It should be noted that this also entails a hermeneutic process whereby the researcher's familiarity of the topic does influence the units of meaning that are extracted. The rest of this chapter will present an analysis of the participants' meanings as precisely as possible. This will be presented as extracts from their interviews as per each corresponding superordinate theme. The researcher has also strived to reflect upon her process of interpretation in order to be transparent in the process.

4.4.1 The myth of neutrality: The dual role of the psychotherapist

In this study, the participants all felt that their role as the clear-cut psychotherapist was blurred when working with bereaved children. They were faced with strong counter transference pulls as a reaction to the bereaved child's transference. This led to emotional enmeshment with the child client and the taking on of multiple roles beyond just that of being the child's psychotherapist. This in turn led to an intense attachment in the client-psychotherapist therapeutic relationship. This attachment facilitated the psychotherapist to experience concern with regard to re-enacting the child's abandonment issues in the therapeutic relationship. All these factors played a role in the participants' ability to remain 'detached'.

Thus, the psychotherapists, when faced with a bereaved child in therapy, were unable to remain as the traditional model of a psychodynamic psychotherapist that is neutral and objective in therapy. Instead, they were faced with taking on dual roles and grappling with their own emotions and childhood experiences that were surfacing as a result of the counter transference that was being experienced in the sessions.

The researcher categorised these narratives as experiences that substantiate the myth of neutrality. It is a myth due to the dual role that the psychotherapist acquires when working with bereaved children and their transference, and how this is influenced by emotional enmeshment, multiple roles and the impact of attachment and re-enacting abandonment.

4.4.1.1 Emotional enmeshment

All three participants were unanimous in sharing experiences of emotional enmeshment. One participant raised the notion that bereaved children are emotionally deprived and this factor also influences the therapy. The psychotherapist may over-compensate due to this, or may more readily respond to the child's transference. The participants all experienced a common emotion of sadness in working with bereaved children. This was expressed in the following statements:

Judy: There are feelings of sadness really. Identifying with a loss… But because of his frailty you tend to be emotional.

Fatima: It is such heart-breaking work.

Kathy: The feelings with bereaved children are quite intense, all the sadness.

Fatima: Bereaved children do have a special… And yes you are making me think a lot more about it now, a special way of really pulling at those counter transference feelings, it feels so much stronger.

The propensity to emotionally enmesh with the child occurred when the psychotherapist would emotionally share the bereaved child's experience; or would engage in feelings about the child's experience after the session in their own private time. Fatima identified this experience of emotional enmeshment as occurring when the psychotherapist moves away from feeling empathy and towards feeling sympathy for the child and their situation. This is reflected in the statement:

Fatima: I think there is a tendency to feel a lot of empathy for them and sympathy even.

Thus, to feel sympathy rather than empathy is for the psychotherapist to allow their own emotions to obscure their therapy. The questions that the psychotherapist then face are: 1) are these my feelings or the child's feelings? and 2) is this my need or the child's need? This occurs when the child's transference is being felt by the psychotherapist, and their counter transference reactions take precedence. Kathy shared how her bereaved child client had unresolved anger regarding his mother's suicide, and Kathy began to share his anger towards the mother:

Kathy: They are terribly sad therapies you know. I would also feel with the boy whose mother committed suicide, furious with his mother for putting him through that. He was an ordinary little boy and then at 10 having to deal with the suicide of his mother. We finally got to his anger with his

mother. I mean he always was very protective of her so I think it was partly counter transference but I think it was also my own counter transference…. Like once this little boy was at school and he didn't have the right kit and you know… what a mother would do. And then I did think about that afterwards and was cross with the mother.

Fatima felt emotional enmeshment with a child client who had lost his mother. Hearing about this gap in his daily life made her feel emotionally responsible and she wanted to protect him from his emotional pain. She stated:

Fatima: And in the little boy I am talking about now I just remember him saying that, he was very articulate, saying – I just need a Mom to do what Mommy's can do. And I asked him, like what? And he said, like helping with homework and driving me around and coming to my games and all sorts of things. And I really felt like kind of scooping him up into my arms and like holding onto that kind of, holding onto him. So I do think there is a tendency to feel a lot more with these children, connect to them.

The emotional enmeshment with the child led to the psychotherapists reflecting on their own experiences of loss and their own childhood. This identification with the child and their emotions may cause the psychotherapist to have an increased period of self-contemplation, as they are reminded of their own personal history and experiences that are similar to that of the child's. This is reflected in statements such as:

Fatima: I think being a bereaved child, not for a parent but for a sibling, I think I always kind of feel connected to these children that have lost loved ones fairly early on in their lives. So I think it does evoke something for me personally.

Judy: And that I may be identifying with some of those feelings of vulnerability that are my own in terms of where I come from – my background and my style and approach. I might have had a blind spot in terms of that.

4.4.1.2 Multiple roles

The three participants all experienced the pressure to perform multiple roles for the bereaved child. The singular role of being the child's psychotherapist was exceeded as a result of the child's transference and the psychotherapists' counter transference reactions. The bereaved child's transference creates an extra sense of emotional responsibility for the psychotherapist. This is seen in the statement:

Judy: But I think you feel very much… it's more intense, you are the only person for this child and you can take on that transference role.

Judy in particular commented on the various multiple roles that she experienced when working with bereaved children in therapy, stating that:

Judy: When you are working with children you have to wear a lot of different hats. So you are primarily the psychotherapist in terms of managing the case, and it is also about… I suppose part of a parent role is also preparing the child for life. So I think there is that aspect to it too. Not just the nurturing but also sort of making sure that he negotiates all the milestones as he needs to for where he is at developmentally. Then there is working with children in general. They often try and put you in the teacher role because that is what they know in terms of relationships with adult figures. Especially if it is their first time in therapy…Or doctors. So I think a lot of it is a way of asking for nurturing, sometimes moved into sort of relating to me as his Doctor. So for example he would complain of headaches and things like that in therapy.

All three participants felt forced into one specific role, over and above that of being the child's psychotherapist. This role was a maternal one:

Judy: There is a huge sort of maternal transference. Sort of really wanting to take over the role of container and be a very holding environment. Definitely a sort of substitute Mom and a big sister in some ways too… Because for me it was taking on a very maternal, supportive and nurturing role.

Kathy: For example with this boy who had lost his mother. I do think I became like a mother figure to him. But I think the way I… but I was always his psychotherapist… But yes that sort of feeling that I wanted to be a mother to him.

Fatima: I think with these children when they yearn for this kind of maternal or paternal kind of caregiver to provide something and being a psychotherapist here is in some ways providing that kind of role.

The bereaved child may provide opportunities within the therapy session for the psychotherapist to play out the maternal role. Thus, the child's transference is that of wanting the psychotherapist to be their mother figure, and the psychotherapist's counter transference response is to act the part of the mother within the therapy session:

Judy: He went through a huge phase where he just wanted to read stories, which doesn't sound like therapy. But I think he might have been responding to some of my maternal role that I was taking. Sort of mom reading bedtime stories, that kind of playing.

Fatima: I would be drawing with a child and drawing whatever comes to mind and find myself going in a particular direction. And I think I also see that as kind of sharing a part of how I am feeling or what is going on between us in the relationship, or the position I have taken in play I

guess. Whether I am the mommy or the sister or the bad guy or whatever it might be.

The role of mother is assigned to the psychotherapist by the child's transference; likewise, the psychotherapist's counter transference response will affect the child. They are integral to one another. Fatima commented on this process of portraying a maternal figure and what impact it may have on the bereaved child who experiences this:

Fatima: It is also very difficult as well I think being alive and having an awareness that you might be evoking something that the child is so aware that they don't have. So here is a woman in front of me that could act as a mother, or in the therapy is looking after me in this kind of way, but I can't go home with this person. So I think that there are difficult feelings there as well.

Judy is not currently a mother, but would like to be. She explores the role that this plays in her maternal counter transference:

Judy: But for me maybe there is something about a need of my own which is not yet fulfilled but I think it is fertile ground for someone to take on. Especially because I do want children so it's not like I am… And I think it hooks into something, obviously a root need of mine at the moment. So I think I am quite vulnerable in that way to acting on the counter transference because of being in that position.

4.4.1.3 The impact of attachment and a concern of re-enacting abandonment

Thus far, it has been suggested that the experiences of these three participants has been that of emotional enmeshment and playing multiple roles when working with bereaved children in the therapeutic environment. Naturally, these factors will foster an intense level of attachment in the client-psychotherapist therapeutic alliance. This attachment will be the cause and effect of the child's transference and the

psychotherapist's counter transference in response to the child's transference. This in turn suggests that the attachment will also be reciprocal in nature. Two of the psychotherapist's related to this as an experience:

Judy: He gets quite upset when… he misses me when I am sick and I miss a session.

Fatima: There was quite a hectically strong feeling that emerged and I really started to feel very attached to this girl and I think she felt very attached to me.

Judy discussed her experience of attachment and how it impacts her decision-making and judgement skills in terms of when to terminate therapy sessions with the child client. Being attached to the child makes her want to continue therapy in order to have the therapeutic relationship with the child, yet she constantly needs to be mindful of this process and to access whether the child still being in therapy is her need or the child's need:

Judy: Like termination, a child like this maybe you could keep them in therapy for ever which actually is not… most really I think that is a challenge for me keeping in mind does he still need to be here or is it my need or fear that he… it never goes away. I think that is a tricky one. I really need to think about it for the last while. Because he has been in therapy for two years now and to really review it at points whether he does still need to come. But it is just my counter transference that is keeping him there.

Due to the attachment in the therapeutic alliance, the psychotherapist may begin to demonstrate a sense of tentativeness when working therapeutically with the bereaved child. The attachment and the role of playing a mother figure will encourage the psychotherapist to act in a protective manner and, as a result, the psychotherapist will not confront the child for fear of upsetting them. This was most evident with two of the participants who avoided challenging the child in therapy. This

was due to a concern of re-enacting the child's abandonment issues of losing a parent and losing their identified parent role in the psychotherapist too:

Judy: I was less sort of confrontational in the therapy. I would probably spend a lot more time making it a safe space for him because I really could identify in a way with his potential fear of trust, and his fears of abandonment and loss. So I was very aware of the fact that he has developed trust and I need to really make it safe for him and be very aware of potential ruptures to the therapy or termination issues.

Fatima: Sometimes children need more but we can't afford as such to give them more of what they need which again re-evokes all sorts of feelings of loss and being abandoned or whatever it might be that they do have.

Judy explored the concept of attachment and counter transference and offered her view-point whereby she is able to use her attachment and counter transference in the therapeutic relationship as a therapeutic tool that enriches the therapy and aids the child in treatment:

Judy: It is the capacity to attach but I think in terms of relating authentically with another person, I think that is very powerful. And that is where the counter transference is really useful. I think it is about an emotional connection, an emotional exchange which if used correctly and not acted on as an enactment by a psychotherapist it may, and this is where the challenge comes in, give a child a sense of what they may elicit from others. And how in them being authentic, and acknowledging strength, and not identifying with helplessness, it can be productive and useful for them as well.

4.4.2 Ethical dilemmas: The “pity lens” in bereaved child psychotherapy

The participants all describe various experiences in which they saw the bereaved child through what the researcher has termed a “pity lens”. The bereaved child is a client population that can be perceived as more vulnerable due to the circumstances of their having lost a loved one. Their transference may encourage this fragility in the therapeutic relationship and the psychotherapist may respond by being more lenient with the child than they might be with other clients. This counter transference of pity can cloud and complicate the therapeutic process. Such instances can lead to ethical dilemmas should the psychotherapist not be conscious and aware of their counter transference. Ethical dilemmas that were contained within the participants’ narratives included needing to be mindful of therapeutic boundaries; being aware that their pity can enable the child’s helplessness and encourage dependency on the psychotherapist; and creating special exceptions for the bereaved child.

4.4.2.1 Being mindful of therapeutic boundaries

Therapeutic boundaries are ethical guidelines for the psychotherapist to follow in order to avoid any ethical complications. There are numerous therapeutic boundaries including: not giving physical items to clients, such as food, clothing, goods; keeping to the agreed upon time frame; being ethically responsible; keeping only appropriate physical contact; ensuring that the client-psychotherapist relationship remains professional; and only interacting with the client in the therapeutic environment. However, the bereaved child may present as emotionally wounded and this may cause the psychotherapist to treat the child with extra care as they begin to play into the maternal role. A maternal role by its very nature will make the psychotherapist want to offer more nurturance, protection and affection for the child. The three participants were unanimous in wanting to cross therapeutic boundaries. They were aware that this was a result of their counter transference and maintained their professionalism due to their awareness; however, they did fantasise about breaking the therapeutic boundaries for the bereaved child:

Fatima: I may find myself enacting something, wanting to give the child something special or being a little bit more flexible with the frame, giving them a few extra minutes, or a few less minutes because it is too difficult to think about something.

The participants were all tempted due to certain deprivations that the bereaved child exhibited. In some cases, the child had not only lost a parent, but was also socio-economically deprived and did not have access to abundant goods, such as food or toys. The psychotherapist would observe this and wish that they could provide for the child:

Judy: The depravation it really comes through. So, like for example, I don't really believe in making food for kids etc, but for him when I sensed and he said he was hungry, and would ask for things, you know, there's a huge pull to act on that. There as huge pull around like even giving toys and things like that. But it speaks to… I think with deprived children that is often the case.

Fatima: Like fantasies of dropping stuff at her house maybe, talking to my husband about that. Maybe like, there is a client who is really suffering. He was like, oh just buy a food package and drop it off…I never did but really feeling pulled into doing something physically for her actually.

Similarly, the bereaved child may be emotionally deprived. They may have lost the love and nurturing of their parents. The psychotherapist may experience the child's longing for such emotional nurturance:

Kathy: Often my counter transference was I wished I could just take him home you know.

Judy: I think that's where the challenge really is to… it can be very easy to slip into carrying on session after session after session just caring for this child.

Kathy experienced a child client unknowingly requesting that she break the therapeutic boundary by requesting that she see the child outside of therapy and outside of the role of being his psychotherapist. It is likely that the child viewed Kathy as a caregiver figure and wanted her physical presence as well as her emotional support:

Kathy: Like in the first year he wanted me to come to his, he was 10 he turned 10, he wanted me to come to his birthday party.

4.4.2.2 Enabling the child's helplessness and dependency on the psychotherapist

Perceiving the child to be fragile will encourage the psychotherapist to treat the child through a "pity lens". Thus, the psychotherapist may unintentionally create concessions for the child. The consequence may be that it fosters the child's dependence on the psychotherapist, as well as encourages the child's level of helplessness. Similarly, this will not enable the child to individuate from the psychotherapist, and the psychotherapist may not make use of and build upon the child's pre-existing resilience. Two of the participants alluded to this, especially Judy who has had such experiences:

Judy: It was really around feeling quite tentative and careful and almost a hyper awareness of the vulnerability of the child, which is tricky because you might miss out on a lot of the resilience that can come with that… I might be losing out on opportunities to reinforce the resilience that is there and his own capabilities.

Judy continues to explore the impact that this may have on her bereaved child client:

Judy: I think the concern is that it might enable helplessness. Which is a concern. So if I indulge that vulnerability and that fragility too much as a psychotherapist it might really reinforce some of his own ideas around his own inadequacy in managing his feelings and being in the world on

his own. Which is problematic obviously, because it must really be about trying to find a balance around managing my own tentativeness and almost hypersensitivity toward his vulnerability with the idea that he needs to learn those skills for himself too.

Judy went on to explore her understanding of this enabling behaviour and how this had an impact outside of the therapy room. In this case Judy's making allowances for the child and enabling his behaviour was creating a problem for the staff at the shelter that the child was residing in. The child began to expect the same treatment from everyone that he received from his psychotherapist:

Judy: I reconsidered around how my attitude was reinforcing dependency which in certain ways makes, you know, leads to psychotherapists being needed in a way. Fulfilling that with your role. But I was also aware of the frustration that was happening outside in terms of staff that needed him to do things for himself and become more independent… So sometimes I wonder if some of his acting out did increase with me around. Me enabling him in the sessions so, maybe tolerating.

Judy and Fatima both experienced the effect of colluding with the child's perceived vulnerability and how it would affect the child's session. They would avoid painful topics that would upset the child. This enabled the child to avoid any challenges in therapy, as well as encourage the child to be helpless rather than resilient. Consequently, the psychotherapists would protect the child emotionally and this fostered a dependency on the psychotherapist to always be protective and safe:

Judy: In a way I realised I was delaying going there because I was afraid of the fall out and of the fact that he would be totally unable to cope with it. Or go to pieces, he could decompensate, his own fragility.

Fatima: …colluding with the child's defenses and not thinking or talking about the parent that has passed away.

4.4.2.3 Creating special exceptions for the bereaved child

By fantasising about breaking therapeutic boundaries, as well as cultivating a dependency on the psychotherapist and enabling the child's helplessness, the psychotherapist is in effect creating special exceptions for the bereaved child. The psychotherapist is over-compensating in their field of work and is providing more for the child than they are professionally required to. Thus, the bereaved child is given special treatment that perhaps is not reserved for other clients. This is another consequence of viewing the child through a "pity lens" and reacting to the child's transference with the psychotherapists' counter transference. The psychotherapist will feel responsible and demonstrate the need to go above and beyond their expected call of duty in order to help the bereaved child. This was commented on by two of the participants:

Judy: I think right from the beginning I was aware of sort of my overwhelming need to give and provide for him from the first session.

Fatima: You provide more support then perhaps than with other sorts of clients. I was very aware of her social circumstances living with her granny in a one bedroom, one room sort of place without a bathroom, all sorts of things. And I think those feelings I had for her came out in that I organised other members of the department to help push for a grant for her. So not in the session per se but in terms of the work I was doing outside of that. Even though she didn't qualify for a grant, she didn't have a medical disability or whatever, I really went to great lengths to help her and kind of provide in ways which I was very aware that I shouldn't really be doing. But I think there was such a sense that this loss carried not only an emotional sort of hole in her life, but also materially her circumstances had deteriorated so far that it felt like that was at least something I could do and that I wasn't totally powerless in what it felt like just in the therapy and talking about all this stuff emotionally.

Judy discussed how this creates certain expectations of the child for outside of therapy sessions, and how she takes on responsibility for the child and the child's behaviour due to viewing the child through a "pity lens":

Judy: Indeed and I also think the need to defend and protect. So when for example one of his nurses that work at the home might come and say he is acting out, he is being naughty, he is being cheeky, in a sense I am more inclined to try and tell her to try and tolerate it and go easy on him, when actually what he also needs to learn is a lot of consistency and discipline and structure too in spite of all his losses. So I need almost to make a special exception because I feel almost that I should compensate for all the things he has been deprived of in his life. I suppose to make excuses for it. He probably is naughty. I don't see it in my session which might be somewhat of a response to what we were talking about. A response to the counter transference. He really is… He won't bring. So he won't come and talk in therapy about getting into trouble or being naughty. So he doesn't bring that stuff. And I think it might be something around him, if he is in some sense colluding with the image I have of him.

4.4.3 Containing the therapeutic frame: Avoiding the blind spots

The previous superordinate themes have enabled the researcher and reader to explore how the psychotherapist is unable to remain neutral when conducting therapy with a bereaved child, and how this is impacted upon by their emotional enmeshment, their multiple roles over and above that of being the child's psychotherapist, as well as the impact of the attachment of the client-psychotherapist alliance. These factors incite the psychotherapist to view the child through a "pity lens" and this lens creates ethical minefields in terms of maintaining therapeutic boundaries with the child; enabling the child's dependency and helplessness, as well as initiating special exceptions for the child.

Thus, one needs to ask oneself, how does the psychotherapist contain the therapeutic frame? How do they avoid these blind spots that are created and possibly maintained by the psychotherapists' own counter transference in order to escape being professionally unethical and possibly unintentionally harmful toward the child's development in therapy? The participants' narratives reflected three examples whereby they are able to remain aware of their counter transference in order to be ethical and to acknowledge their blind spots. These included being responsible and making use of ethical management; taking the time to maintain self-awareness and self-reflection; and reflecting on their personal growth as a psychotherapist as a result of experiencing counter transference and being ethical and using their counter transference as a therapeutic tool to learn and grow for both themselves as professionals and for the benefit of the bereaved child.

4.4.3.1 Ethical management

All three participants maintain an ethical management regime of their therapeutic process with the bereaved child. This enables them to be aware of their blind spots in the therapeutic process, as well as encouraging them to remain mindful toward their counter transference within the session and with the bereaved child. This empowers the psychotherapist and they are able to maintain their professional integrity and ethical standards through such processes. All three participants noted the extreme importance of keeping process notes of each session in order to document their thoughts. Furthermore, they all attend their own personal therapy to be able to process any unresolved issues in their own life that they may be reminded of by the child's psychotherapy or situation. They all also attend supervision sessions, whereby they are able to process their blind spots and counter transference with another trained psychologist who will be able to offer a more objective and neutral viewpoint of the process:

Judy: I think really it was in supervision that I became aware of what I might be doing. I might be enabling because of my response to him… get supervision. Be aware of your own issues around parents, around death, and around loss. Be aware of dependency and vulnerability with

regards to the therapy preparation too, because you really should be conscious and aware of those all the time and burnout… obviously process notes help a lot in terms of working things through and I'm in my own therapy.

Kathy: I do think one always has to be very aware of ones counter transference. That's why I think the importance of therapy and supervision…That helped with writing up this session which is another opportunity to think about it, and with a supervisor, because they often can be quite difficult because difficult feelings are evoked… So I think it is always important you know to think about ones counter transference reactions and I think that is also the real importance of one's own therapy. To try and deal…Because you know a blind spot is a blind spot you are not going to see it. And one's own supervision, I think one needs to be in ongoing supervision because the supervisor will see that.

Fatima: I guess I am always aware of the feelings I have or what feelings are evoked for me in the session or after the session and a lot of that kind of processing happens in supervision and when I am writing up my process notes…I am in my own personal therapy and have lots of supervision and kind of take all that stuff there to try and sort it out.

Kathy and Fatima also suggested two other routines that they partake in which they find useful in maintaining a sense of ethical management when working with a bereaved child:

Kathy: Reading groups, I am in a lot of reading groups you know. Meeting with colleagues, supervision, my own therapy and I think reading as well also helps to… Whether its novels you know, where bereavements are dealt with there for example or all the books, Psychoanalytic. I really do think theory is our support and I think the

more we can understand theory I think we really, really helped in the work that we do.

Fatima: But the other thing that is very helpful is that I work in a team. Here in this environment we are a multidisciplinary team. We have ward rounds; we have a lot of contact with other psychotherapists who are seeing clients so professional support is a big one as well.

4.4.3.2 Self-awareness and self-reflection

In order to avoid blind spots, the psychotherapist needs to be mindful and conscious of their counter transference toward the client. This can be achieved by taking the time to become cognisant through self-awareness and self-reflection. Increased self-awareness and self-reflection inspires insight and it aids the psychotherapist in maintaining an ethical and responsible practice to the benefit of the client and themselves. This was an undisputed factor with all three participants.

Judy: With the child obviously the challenge is you have to as a psychotherapist acknowledge in yourself what is going on, and then choose what you would need to take into the room and what you have to be quite firm around in terms of limit settings and boundaries… And I can see as therapy has progressed that I become more of aware of my blind spots in working differently. He has become a lot more independent.

Kathy: And the working through of it is that you can own and understand your own feelings, but it is in the process of understanding it…reflecting on either my thoughts during the session or after the session… being aware of something that is going on…It is about really processing it and making sense of it …You know it is to recognise an unconscious process, to recognise feelings might be stirring up, to do the internal work.

Fatima: In a first session I would really want to observe and take that in and kind of sort through, is this evoking something for me about my own bereavement stuff or death stuff or whatever it might be, and just kind of sit with that…I think that if counter transference isn't processed or thought about we can really go in and kind of collude with all sorts of projections that are being identified with.

With self-awareness comes self-reflection. The psychotherapist will inevitably have counter transference feelings that will be a result of relating their experiences, thoughts and feelings that are a consequence of their own background and experiences. Thus, the psychotherapist will explore their own life and reflect on their thoughts and feelings as an outcome of their counter transference:

Judy: I do spend some time actually feeling sad. It makes me look at my own life in context and be grateful for the fact that I still have my parents around. It makes me grateful for my life but also quite sad. I feel guilty sometimes but you know… I have had privileges that he hasn't. In terms of having a care giver, a parent, a parental figure. It makes me reflect on my life. In terms of thinking would I do anything differently?

Fatima: Also thinking and wondering about my own parents when I see parents who have lost children.

The three participants all experienced self-awareness and self-reflection when engaging in activities that they enjoy and find relaxing. Examples they offered included thai chi, exercise and gardening.

4.4.3.3 Personal growth as a psychotherapist

Working with a bereaved child is emotionally and psychologically draining and challenging. However, it does have its benefits. Each psychotherapist felt that, despite their experiences, they would continue to work with the bereaved child client population. They were able to find numerous advantages in working with this group,

as well as how it has created growth for them as a psychotherapist. These participants were able to acknowledge their counter transference and use it as a therapeutic tool:

Judy: It has encouraged me because I think that it is a reality of the country that we live in. There are lots of children without parents. So it hasn't been a negative experience. It has been quite a growing point for me as a psychotherapist too and to see my own blind spots and to really recognise the strengths and vulnerabilities of working with children like this… As a psychotherapist you grow because it makes you confront your own ideas around loss. A loss of fantasies, idealized parental figures, and also ideas around vulnerability. Ideas around resilience so it really expands your capacity in terms of what children can deal with. Often more than what we give them credit for.

Kathy: But it is very rewarding work because you do the work, go through the process of mourning and they get better… I mean if you also think that one of the goals of therapy is to help the person regain split off parts of themself. It is also assisting in integration. Helping the person actually be able to deal with those feelings rather than getting rid of them…I suppose I did explore more what mourning was about, dealing with loss, those sorts of things.

Fatima: I certainly use my counter transference as a guide for my interpretations or even my reflections to the child. I think it allows me to be more sensitive into whatever they are bringing or what they are not bringing to the room as well… I think I have more of an ability to process those feelings and not try and act on them. Whereas before, I think that kind of mechanism of processing those feelings and learning to stay with them rather than thinking or wanting to act on them. So in some ways I think it has gotten easier to stay with those feelings…I guess when I started training I really held onto that. I think perhaps as

a defense to really get involved with my clients and feel for them, and being trained psychoanalytically, dynamically, like really feeling that I should be some kind of neutral person. But I think I have learned as time has gone on that I think the more that I can bring of myself and my personality and my feelings to the work, the deeper the work is, the more valuable I think it feels for me and for my clients. And I guess the more genuine I can be otherwise I think they don't take well to like a cold, distant kind of stance.

4.5 Chapter summary

The goal of this chapter was to discuss the three superordinate themes that were uncovered by the researcher. These themes were based on the interview data of the participants' narratives. The three superordinate themes were each divided into three sub-themes and each sub-theme was discussed and then illustrated with extracts from the participants' interviews. The first theme examined was the myth of neutrality: the dual role of the psychotherapist. The second theme reviewed was that of ethical dilemmas: the "pity lens" in bereaved child psychotherapy. The third theme was that of containing the therapeutic frame: avoiding the blind spots.

The following chapter will be a discussion of the findings in relation to the existing body of knowledge on the subject matter derived from each theme.

CHAPTER 5
DISCUSSION

5.1 Introduction

The goal of this chapter is to discursively explore the participants' experiences. These experiences were categorised into themes in the previous chapter. The meaning of these themes will now be explained within a theoretical framework that is entrenched in existing literature on the area under discussion.

The current study identified three superordinate themes within the participants' narratives. Each superordinate theme was broken up into three sub-themes. The first theme discussed was the myth of neutrality or the dual role of the psychotherapist. This involved aspects such as emotional enmeshment; multiple roles; and the impact of attachment and a concern of re-enacting abandonment. The second theme discussed was that of ethical dilemmas or the "pity lens" in bereaved child psychotherapy. This involved aspects of being mindful of therapeutic boundaries; enabling the child's helplessness and dependency on the psychotherapist; and creating special exceptions for the bereaved child. The third theme discussed was that of containing the therapeutic frame or avoiding the blind spots. This involved aspects of ethical management; self-awareness and self-reflection; and personal growth as a psychotherapist.

Each theme and sub-theme will now be discussed in relation to the existing literature and previous research studies.

5.2 The myth of neutrality: The dual role of the therapist

It was unanimous that all of the participants struggled to maintain a straightforward and uncomplicated relationship with the client that entailed merely the basic role of psychotherapist and the role of client. This was attributed to the unique therapeutic relationship of working with a bereaved child. This therapeutic alliance facilitates intense and reciprocal feelings of transference and counter transference. This is

further complicated by an emotional enmeshment that was described by the participants whereby their therapeutic and empathetic response began to be distorted by a maternal sympathetic reaction. This unique alliance cultivated and nurtured an attachment dynamic between the psychotherapist and the bereaved child client. The attachment encouraged a maternal responsibility for the psychotherapists who then began to act tentatively with the child in an attempt to protect the bereaved child.

All the above mentioned factors create the sub-themes of the first subordinate theme of “the myth of neutrality: the dual role of the therapist”. These sub-themes do have some overlap and they indicate that the psychotherapist cannot remain detached; which contradicts the traditional perceived role of the neutral and objective psychotherapist as advocated by Freud (1910). The participants’ narratives suggest a finding that correlates with the totalistic stance. The discovered themes substantiate the view of the myth of neutrality and the standpoint that counter transference can be utilised as a clinical tool (Bemporad & Gabel, 1992; Betan, Heim, Zittel, Conklin, & Westen, 2005; Brandell, 1992; Ens, 1998; Gabbard, 2004 & Heimann, 1960). Previous research of Mohr, Gelso and Hayes (2005) noted that the therapeutic relationship is a two-person psychology and that the client and professional interact together as active participants in a dynamic process in order to yield positive therapeutic change; consequently the psychotherapist cannot remain objective and neutral. This is indicative within this sample group that South African psychologists may be more inclined toward the totalistic and modern day perspective on counter transference as opposed to Freud’s opinion on the subject matter; as they advocate that within the therapeutic relationship with a bereaved child, one cannot remain objective and detached. Thus, the modern stance that was substantiated in this study is that the psychotherapist is no longer a *tabula rasa* due to the therapeutic relationship that is a mutual process of connection and influence.

5.2.1 Emotional enmeshment

Emotional enmeshment was a unanimous finding amongst the participants. Interestingly, the one participant shared the view that bereaved children are emotionally deprived due to their loss and this influences the emotional landscape in the session. The psychotherapist responds more easily to the child's transference, or over-compensates emotionally for the benefit of the child. The most common theme that was experienced was that of an intense sadness. This emotion may have significantly influenced the therapeutic relationship and interaction as this can lead to sympathy as opposed to empathy. This is in keeping with the work of Kroenengold who researched the role of counter transference in working with children in his case study (2010). His conclusion is consistent with the findings of the study at hand, as Kroenengold ascertained that the psychotherapist may over-identify with the child client and the client's need and this is a result of the transference and counter transference dynamic. This result is consistent, yet the researcher would argue that the emotional enmeshment may be even stronger when working therapeutically with a bereaved child client who has lost a primary caregiver as the child is even more emotionally raw and vulnerable.

The inclination to emotionally enmesh with the bereaved child was significantly increased when the psychotherapist could emotionally share and identify with the bereaved child's experience. Such self-introspection inevitably led to the psychotherapists reflecting on their own experiences of loss, experiences in their own childhood, and a reflection of their own personal histories. These experiences are in line with Moody's (1955) view that the creation of counter transference reactions from the child's transference has a huge emotional and personal impact on the psychotherapist and their own past. Moody concluded that therapeutic work with children is far more reciprocal than adult clients and this is a possible explanation for the deep introspection that the psychotherapist experiences when confronted with the child that begins to represent their own inner child.

The emotional enmeshment was further strengthened when the psychotherapist would take time in their personal life to reflect on the child's experiences and feelings from a session. Thus, the psychotherapists were unable to separate their private lives and their professional capacity from the bereaved child. Lang (2010) supports this stance and describes therapeutic work with children as a time when "their world and our world overlap" (p.33). Thus, Lang describes the overlap of boundaries being blurred, as well as the psychotherapist exploring and re-visiting their own childhood. The impact of the child's transference is so strong that it cannot be compartmentalised into only the psychotherapist's professional life, but overflows into the psychotherapist's private life too. This validates a description of one of Shopper's (1998) counter transference traps when working with child clients. This could indicate and suggest that the child's vulnerability in the session is then mirrored by the psychotherapist's vulnerability and inability to separate the child from their private time and thoughts.

The participants began to feel emotionally responsible for the child's well-being and this led to a maternal protective response in their counter transference (see next subheading for more detail). This reaction and role is more evident when working with a bereaved child as opposed to an adult client that is bereaved; Abbate (1964) and Showalter (1985) both confirmed this in their own research. Both authors concluded that a child's quality and intensity of transference is a different experience than that of an adult client's transference, and that children create a stronger emotional and counter transference reaction in the psychotherapist. This is in keeping with the findings from this study, as well as a consistent with Rasic (2010) who inferred in his work that child clients create complex and confusing emotions for the psychotherapist, and that working with a child client can substantially impact the psychotherapist's clinical judgement. This researcher would again argue the possibility that the child client being bereaved can further complicate the therapeutic relationship, the emotional landscape of the session, and the psychotherapist's judgment.

5.2.2 Multiple roles

A common theme among the three participants was the notion of having to perform multiple roles for the bereaved child client. The pressure to be more than the child's psychotherapist is a result of the increasing transference and counter transference dynamic between the child and the professional. The transference dynamic is widely acknowledged as being a factor in the psychotherapist's counter transference response. In support of this view was the study conducted by Betan et al. (2005) that indicated the psychotherapist's position within the therapeutic alliance is influenced by the type of transference. The vulnerable child unconsciously places emotional responsibility on the psychotherapist. A noteworthy counter transference reaction that this study established was that the main role that the participants felt forced into was that of a maternal role and to play a mother figure to the bereaved child during psychotherapy sessions. Betan et al (2005) conducted a study that identified eight counter transference reactions, one counter transference response is to take on a parental and protective role and this is in keeping with this research study.

This study highlighted that a bereaved child client's transference dynamic plays into the psychotherapist's counter transference reaction to be a parental and maternal figure for the child. Ekstein, Wallerstein, and Mandelbaum (1959) recognised in their own research that children and adolescent clients have an extreme impact with regard to their transference to the psychotherapist, particularly in projecting early repressed relationships and the displacement of crucial relationships. Thus, in the study at hand, the bereaved child's transference for a parental figure is the displacement of a "lost" caregiver figure onto the psychotherapist who then reacts to the transference with a parental and care giving role. Consistency between this theory of role displacement and the participants' experiences can also be depicted in the work of Rasic (2010) who noted that, in the absence of a parent, counter transference feelings are often directed at the imagined parental figure. In the study at hand this was the psychotherapist who played the role of the imagined parental figure. These like-minded views are further supported in Winnicott's (1949) commentaries whereby he identifies that a child without a parent will unconsciously look for such a figure, and in this case, the figure is found within the safe and

nurturing therapeutic relationship with the psychotherapist. This finding suggests that, whether consciously or unconsciously, the bereaved child's transference influences the psychotherapist's counter transference reaction to play the role of the parental figure that has passed away.

A noted gap in literature to consider for future research is the issue of how the psychotherapist is affected if they themselves are parents, and how this affects their counter transference response to the bereaved child client when compared to psychotherapists who are not parents. This could be considered to be an additional role that the psychotherapist plays that will influence their counter transference response. Research on this particular topic was not discovered by the present researcher when conducting a literature review.

5.2.3 The impact of attachment and a concern of re-enacting abandonment

The above mentioned themes, the therapeutic alliance, and transference dynamic will unsurprisingly cultivate an attachment in the child client-psychotherapist therapeutic relationship, as was evidenced in the participants' experiences and narratives in the study at hand. The intensity and emotional quality of the attachment is an outcome of the transference and counter transference phenomenon. Similarly, the attachment is also circular and reciprocal in nature and is experienced and influenced by both parties. This notion of mutuality in the relationship is recognised in the theory of Greenson (1976) in relation to the working and authentic alliance and the transference dynamic.

The intensity of the attachment was a significant factor in terms of impacting the participants' decision making and judgment skills, especially with regard to the termination of therapeutic sessions. This is due to the maternal role that goes hand-in-hand with wanting to protect the bereaved child client. However, this encourages the psychotherapist to act tentatively in therapy. The emotionally invested psychotherapist will try to avoid making the child feel abandoned for a second time, in terms of losing a second parental figure at the termination of psychotherapy. There is a consistency between what the participants describe as a fear of re-enacting

abandonment and the theory of Bowlby (1988). Bowlby's previous study of attachment found that the unexpected loss of an attachment figure may prompt the anxiety and trepidation of abandonment and rejection into the child's internal working model. Thus, the theory substantiates that the participants' concerns are valid and an awareness of such issues around the bereaved child's fears of abandonment are real and need to be treated accordingly.

The attachment research of Bowlby (1988) determined that an attachment bond serves a purpose within a relationship; a need for safety and closeness during periods of distress will warrant an attachment bond. A child who is bereaved and has lost a primary caregiver will justify as a child in distress and the psychotherapist will affirm as a secure attachment source. Bowlby (1988) continues on to state that the most familiar example of attachment is between a mother and her child. In the study at hand, the participants each took on the role of being maternal toward the bereaved child client. This could be indicative of the quality and intensity of the therapeutic alliance and attachment when confronting a professional female who is trained in empathy with a child client in emotional turmoil. The attachment style may naturally progress toward that of a maternal protectiveness toward the emotionally fragile child. Bearing this in mind, the very qualities that encompass a psychologist are those which Bowlby (1988) identified as creating a successful attachment - the caregiver must be responsive, sensitive to distress, and consistent. This supports the participants' experiences of nurturing an attachment with the bereaved child as the emotional climate of the child, the qualities of a psychotherapist, and the circumstances create the perfect climate for creating and maintaining a reciprocal attachment relationship. This finding suggests that there is an increased likelihood that a bereaved child will try to project and replace the lost primary caregiving relationship with that of the psychotherapist who reminds the child of that lost relationship; this is a result of the transference dynamic and the attachment bond in the therapeutic space. Confirmation of this finding exists in the literature (Bowlby, 1988; Parish & Eagle, 2003; Sack, 1996) which recognises this parallel between attachment and counter transference and the influential emotional connection that develops between client and psychotherapist as a result. This also links to the previous research studies that established a correlation between the role of care-

giving and attachment behaviour (Bowlby, 1988; Grossman & Grossman, 1991; Slade, 1999).

Of significance was the stance of one participant who felt that the attachment in the therapeutic relationship was beneficial as it could be used as a therapeutic tool to enrich the psychotherapy experience and treatment for the bereaved child. It can offer the chid an authentic connection and a means by which to explore their loss whilst still feeling safe and unthreatened due to the attachment in the therapeutic alliance. This opinion supports Reading's (2002) theory that an attachment relationship within the therapeutic space is necessary in order to enable the client's transference to emerge. Thus, Reading (2002) notes that it is the attachment relationship that fosters a safe environment for the transference phenomenon to develop, and that this phenomenon is an agent of transformation that can bring about therapeutic change. In this way a therapeutic relationship necessitates an attachment in order to promote therapeutic shifts and change during sessions, as was suggested by the participant in relation to their own experiences.

5.3 Ethical dilemmas: The "pity lens" in bereaved child psychotherapy

A collective experience shared by the participants was one whereby the bereaved child was perceived as emotionally vulnerable. The researcher coined this mutual experience as seeing the bereaved child through a "pity lens". The child is perceived to be emotionally frail due to their context of having lost their primary caregiver. Consequently, the participants experienced the child's fragility in the transference dynamic and the therapeutic relationship. The participants' collective counter transference reaction in the study at hand was to treat the child as vulnerable. This treatment resulted in the participants providing the bereaved child with a more lenient therapeutic space; this at times meant indulging the bereaved child. The researcher would venture a hypothesis that this lenient behaviour was the result of letting the participants' pity, sympathy, and own feelings obscure the psychotherapists' clinical judgment.

Taking the researcher's hypothesis and interpretation above into account, consider this in context of the Developmental Grieving Model as proposed by Pannells and Smith (1995). The framework of the model suggested that grieving children will contemplate death and face certain anxiety, fear, and distressing thoughts. This will present itself in the therapeutic space and transference dynamic. Furthermore, the framework is age-related and evidenced that bereaved children are developmentally incapable of self-care and are therefore substantially more vulnerable and emotionally exposed when facing the death of a caregiver. This model supports the participants' encounter in this study of experiencing the bereaved child as fragile (Pannells & Smith, 1995).

Such cases have an increased probability of encountering ethical quandaries. This is especially true if the psychotherapist is not aware of the influence of their counter transference reaction in such a situation when working with a bereaved child population. Ethical dilemmas that were documented as experiences by the participants in this research included the temptation to break therapeutic boundaries; enabling the child's helplessness and dependency on the psychotherapist; and as a result creating special concessions for the bereaved child. These results seem to confirm previous studies. For example, Mar (2000) noted that a psychotherapist's judgement is more obscured when working with a child client in comparison to an adult client. Mar (2000) goes on to present his findings that demonstrate that unacknowledged counter transference by a psychotherapist may result in their emotions controlling their clinical judgment which results in an avoidance of discussing the client's pain during therapeutic sessions; an over-identification with the client's narrative; and enmeshment with the client. This finding supports the research as unacknowledged counter transference toward a child client can lead to ethical predicaments. However, the study at hand indicates that this is perhaps more so with a child client who is bereaved and additionally emotionally vulnerable.

What is apparent in the participants' accounts is that unconscious positive counter transference reactions can be ethically challenging as well as damaging to the therapeutic space and the bereaved child client. In support of this is the body of literature by Parsons (1990) who explored the warm counter transference feelings of

psychotherapists toward their clients, and the ethical challenges faced as a result of this. Parsons (1990) determined that ethical impasses notably included fantasies of fulfilling certain roles for a client; unconsciously fostering dependence; stunting therapeutic progress; and delaying psychotherapy termination. These results are consistent with the conclusions drawn in the research study under discussion. Notably, Parsons's (1990) research also supports this study in the deduction that such ethical conundrums are increasingly expected to occur when participating therapeutically with a child or adolescent client in contrast to an adult client.

5.3.1 Being mindful of therapeutic boundaries

Therapeutic boundaries serve a purpose as ethical guidelines for professional conduct between the psychotherapist and client. The blurring of boundaries can occur emotionally, as well as physically. Such boundaries are in place for the integrity and safety of the client; psychotherapist; and the therapeutic relationship.

Thus far, this study has determined that attachment, emotional enmeshment, multiple roles, and unconscious counter transference reactions can lead to the loss of ethical boundaries. According to Glass (2003), three ethical issues present in the therapeutic session - boundary crossing; exploitative boundary violations; and controversial grey areas. Thus, consistent with the present study, Glass (2003) noted that all three factors, whether occurring independently or collectively, will result in a disruption of the therapeutic frame. Consider a psychotherapist that is operating from a maternal counter transference position, the psychotherapist may be tempted to operate from motives based on maternal protection and nurturance, as opposed to professional obligations. In this research, the participants unanimously agreed to being tempted to cross therapeutic boundaries; however, an awareness of their counter transference enabled them to understand this desire and to remain ethical in their behaviour. This temptation to break professionalism was a shared experience due to two factors presenting with the bereaved child - emotional deprivation due to the loss of the caregiver; and socio-economic deprivation for access to basic goods. The bereaved child's transference will encompass these deprivations. Consequently, the pressure for the psychotherapist to be emotionally and physically available inside and outside

of the therapeutic space will become apparent. Glass (2003) supports the notion that recognised and conscious counter transference can ease the temptation to break the therapeutic boundaries and rather be used as an ethical advantage in the therapeutic situation in order to strengthen the therapeutic relationship. However, in keeping with the participant experiences in this research, Glass (2003) and Plaut (1956) caution against unconscious boundary breaking as it can be harmful toward the client and the psychotherapist.

5.3.2 Enabling the child's helplessness and dependency on the psychotherapist

By treating the child as a fragile client and viewing them through a "pity lens", the participants in this study admitted to inadvertently enabling the possibility that the bereaved child client will develop a learned helplessness, as well as unintentionally cultivating the child's dependence on the psychotherapist. The participants' experience of the fragile child is predicted by the previous literature of Ekstein, Wallerstein and Mandelbaum (1992). Their literature explored the child and adolescent impact on the psychotherapist and psychiatric staff. In their findings, the child's age and unfixed personality make the professional view the child as a defenceless product of their environment, thereby placing parental pressure onto the professional (Ekstein, Wallerstein, & Mandelbaum, 1992). This is another trend that depicts similar findings to this study in terms of the different ways that psychotherapists approach a child client in comparison to that of an adult client.

The participants in this study voiced the concern that the "pity lens" blinds the psychotherapist to the child's ability to cope and to be resilient. The researcher noted that the psychotherapist may be overwhelmed by their counter transference response and accidentally cause the child to question their internal locus of control. Thus, the psychotherapist's unconscious counter transference with a bereaved child will have a detrimental effect on the child's internal resiliency. Seligman's (1975) literature on learned helplessness is in alignment with the findings of this research. He warned of the dangers that a client can face when engaging in learned helplessness including deficits in their level of motivation and emotional capacity, a decline in their cognitive responses, feelings of apathy, anxiety, depression and

passivity, and ultimately a failure to learn that events are controllable (Seligman, 1975). The researcher implores the reader to consider the extent of such damage in a bereaved child and the importance of the professional in upholding their ethical obligation to be aware of their counter transference reaction. Therefore, the findings suggest that the psychotherapist remain ethically aware and have faith in the bereaved child's ability to be challenged in psychotherapy, and that to over-indulge and over-protect the child out of maternal counter transference is in fact harmful to the child's development.

This study found that the participants colluded with the child's transference of being vulnerable, and this often resulted in a maternal counter transference. The participants would protect the child from challenging topics in psychotherapy and this encouraged a sense of helplessness in the child. The child came to depend on the participant to "rescue" them from unpleasant situations. Parsons (1990) could shed some insight into the reasons for this. Parsons (1990) researched the unconscious resistance of the psychotherapist to allow a client to grow and 'move on' in psychotherapy and that this resistance was the result of the psychotherapist's counter transference. Thus, Parsons's view was that a co-dependent alliance develops in the therapeutic relationship between the professional and the client. This highlights the relevance of researching the role of attachment as it also creates a co-reliance dynamic. The client's dependency on the psychotherapist will stem from this. Ethically, the psychotherapist must be aware of this dynamic and avoid creating a co-reliance (Parsons, 1990). These results are in line with the study at hand of the participants' experiences whereby they recurrently noted the importance of acknowledging one's counter transference as a psychotherapist in order to prevent ethical crises.

5.3.3 Creating special exceptions for the bereaved child

The participants admitted to fantasising about breaking therapeutic boundaries, and at times creating an environment that may cultivate the child's dependency on the psychotherapist and instil a sense of helplessness. Such a climate of a strong transference dynamic will ultimately result in special exceptions being made for the

bereaved child. The maternal counter transference will place pressure on the psychotherapist to provide for the child, to nurture the child and to protect the child. Such pressures and experiences were noted by the participants. Again, the findings suggest that creating special concessions for the bereaved child is a result of the psychotherapist engaging in a counter transference whereby the bereaved child is viewed though a “pity lens”. This finding indicates that this is a self-inflicted sense of responsibility that the psychotherapist undertakes as a result of the child’s transference.

Of significance, was one participant that experienced and shared her enabling behaviour with a bereaved child and this influenced the child’s conduct. Through her “pity lens” counter transference, the participant made special exceptions for the bereaved child and enabled certain behaviour in the therapeutic space and relationship. The child experienced special concessions in the therapeutic environment and then began to expect the same attitude from others outside of the therapeutic space. This caused behavioural concerns for the staff that were providing the bereaved child with shelter. Thus, inadvertently, the participant’s counter transference influenced the child’s behaviour inside and outside of the therapeutic room. Such a case signifies the impact that the psychotherapist’s counter transference can have on a child’s behaviour and their internal belief system which they apply to all relationships. This creates an ethical issue that will continue to grow should the psychotherapist not be aware of their counter transference and how it is affecting their clinical judgment. In effect, the psychotherapist is operating form an emotional attachment as opposed to a professional stance.

A possible explanation for this finding can be explored in the literature on the impact of emotions on decision making (Naqvi, Shiv, & Bechara, 2006; Rentmeester & George, 2009). This study has thus far demonstrated that emotions go hand-in-hand with a counter transference reaction, which in turn effect’s one’s ability to make ethical decisions. Naqvi, Shiv, and Bechara (2006) used evidence from cognitive neuroscientists to explain that when the brain is faced with uncertainty, emotions come into play when using the parts of the brain to assist in decision making. Similarly, Renmeester and George (2009) yielded results whereby they concluded

that counter transference feelings will significantly influence decision-making due to the intense emotional climate of the therapeutic relationship. Thus, the counter transference of the participants makes it more difficult to remain neutral toward the child, and as a result, the psychotherapist will unintentionally create special exceptions for the bereaved child client. However, this counter transference needs to be kept in the forefront of the psychotherapist's awareness in order to avoid ethical dilemmas.

5.4 Containing the therapeutic frame: Avoiding the blind spots

As evidenced above, there are many ethical considerations when working therapeutically with a bereaved child population. In order to maintain the therapeutic frame, the psychotherapist must avoid any blind spots. This research has demonstrated that blind spots develop and are maintained as a result of the counter transference phenomenon and from ethical pitfalls. Thus, the participants explored the very important ethical considerations and obligations that should be upheld by the professional in order to maintain the therapeutic frame, and hence, maintain ethical practice.

South African psychologists are governed by a body, the Health Professions Council of South Africa (HPCSA). The HPCSA upholds and enforces ethical behaviour through a set of ethical guidelines. The participants were unanimous in the importance of remaining ethically aware when working therapeutically with a bereaved child. The HPCSA provides guidelines, but in the very crux of ethics, there are grey areas, as was explored in this study. In this regard, professionals are encouraged to engage with their own moral compass. Like-minded literature was suggested by Cottone and Tarvydas (1988) and Kvale (1996).

Interestingly, according to Ivey (1992), South African psychotherapists are more susceptible to compromising the therapeutic frame due to their counter transference as a result of their humanistic training. This confirms the importance of conducting this research with South African psychotherapists who have engaged in counter transference when working with bereaved children. The participants have offered

their recommendations through their authentic experiences as to how to remain ethically aware. Such recommendations can be researched further and advocated into South African Masters training programs in order to counter-act the issues put forth by Ivey (1992).

The findings of this research with regards to the various harmful effects of unrecognised counter transference, and the impact it can have on ethical judgement, confirms the literature of Shopper (1998) and Rao et al. (1997). The participants in this study discussed their stances on remaining ethically cognisant of the effects of counter transference when working with bereaved children. Three suggestions were highlighted in the research findings and these centred around participating in ethical management techniques; maintaining self-awareness and self-reflections; and reflecting on personal growth as a psychotherapist.

5.4.1 Ethical management

It was undisputed with the participants that clinical cases need to be ethically managed. According to the participants' experiences, the goal is to combat two pertinent issues. First, to avoid unethical behaviour such as unconscious counter transference; and second, to avoid burnout which is a common symptom in the mental health profession.

Burnout is a side-effect of working in a field that is laden with expressive content and emotional burdens. Winnicott (1949) reviewed concepts such as 'burnout', 'compassion fatigue' and 'vicarious/secondary trauma' and concluded that these concepts originate from psychotherapists' counter transference responses. The research of Meier, Back and Morrison (2002) collaborated that unresolved counter transference will inevitably contribute to physician burnout. It is widely accepted in the literature that experiences that involve burnout, compassion fatigue and vicarious/secondary trauma are detrimental to the psychotherapist and those who they aim to help (Bride, 2004; Figley, 2002; Gentry, 2002; Peralman & Saakvitne 1995; Stamm, 1999). The study at hand supports the finding of Van Deusen and Way (2006) who determined that the negative impact of an emotional toll on the

psychotherapist is greater when working with children who have suffered trauma. Thus, to avoid burnout it is imperative to engage in reflective and ethical measures.

In order to remain ethically mindful, the participants from this study routinely participate in ethical management regimes. Documented process notes that reflect on each session are considered to be useful in identifying any counter transference dynamics. Working in a team was also considered valuable for obtaining more neutral feedback. The merit of teamwork has standing in previous literature. Comaz-Diaz and Padilia (1990) note that a treatment team is a form of group or peer supervision and it is beneficial for a number of reasons, including offering a support network, the sharing of reflections, and the maintaining of boundaries. Personal psychotherapy was considered to be of great worth in terms of addressing any unresolved issues that may contribute to the psychotherapist's own counter transference reaction. However, the technique given the most weighting was the importance of attending supervision with another trained professional with an objective stance. The importance and worth of supervision for engaging in self-care and ethical conduct has already been identified as beneficial by numerous sources of literature (Alonso & Rutan, 1988; Figley, 1995; Hughes & Kerr, 2000; Rao et al., 1997; Waska, 1999).

5.4.2 Self-awareness and self-reflection

A need for contemplation was deemed necessary by all participants in order to remain ethically aware and to exercise self-care. This research paper found two important factors that were considered necessary for such contemplation and cognisance - self-awareness and self-insight. These two factors go hand-in-hand with self-reflection. Counter transference arises from the psychotherapist's own feelings, cognitions, experiences and background. This finding supports the research of Lessard (2002) and of Fussell and Bonney (1990). Thus, to truly understand one's counter transference, one needs to reflect on the origins of such a reaction. The participants' authentic experiences of engaging in such cognisance was to participate in experiences that they find enjoyable and relaxing, such as, exercise and gardening. These participant experiences are echoed in the work of Figley (2005)

and Pearlman and Saakvitne (1995). Both studies collaborate with this study and determine that preventative measures of self-care are vital. Their studies offered suggestions for self-care to avoid work-related distress, and these suggestions included meditation, hypnosis, positive visualisation exercises, development of self-soothing and stress management skills, restful sleep, a support network, a fulfilling personal life, being creative, regenerating and healing activities, art, exercise, music, writing, dancing, hobbies, healthy recreational activities and quality time spent with friends and family.

Thus, the findings of this study highligh the importance of self-care for professionals working in the field of mental health. As evidenced by the work of Pearlman and Saakvitne (1995), self-care will encourage ethical and professional conduct in the personal and professional life of the psychotherapist; and too much self-sacrifice and unresolved issues will inevitably lead to ethical faux pas and burnout.

5.4.3 Personal growth as a psychotherapist

The participants in this study felt it important to acknowledge the positive outcomes that arise from counter transference. All three participants concluded that counter transference can be a valuable clinical tool, and one that has greatly benefitted them in their clinical experiences. Numerous studies support this opinion that counter transference can be a useful therapeutic tool (Gelos et al., 2002; Heimann, 1949; Waska, 1999). It has been presented as a diagnostic tool that aids treatment plans and enables psychotherapeutic change. Heimann (1949) presented his finding that counter transference is especially useful for enabling insight into the child client's unconscious. Consistent with the present study, Heimann (1949) concluded that counter transference is a dynamic and circular process between the psychotherapist and the client and that it is an essential process in the therapeutic relationship.

The participants also felt that, despite the numerous challenges of working with bereaved children, this is still the population that they will continue to work with as they find it to be personally rewarding. Furthermore, they felt that cases such as the ones they shared with the researcher were the cases in their career thus far that had

challenged them, and as a result had allowed for their growth as psychotherapists. Such reflections have enabled this research study to promote the notion that counter transference is a naturally occurring phenomenon and not one that needs to be feared or considered a negative stigma of the therapeutic relationship. Such views are supported by the likes of Figley (2002) and Catherall (1995). Previous research explores theories that connect to the participants' ability to take a positive experience from a challenging experience. Such a notion has been termed as 'self-reward' in the mental health field that comes from helping others that are in distress. This shift toward focusing on positive outcomes stems from the positive psychology movement (Arnold, 2005; McCann and Pearlman, 1990).

The research of Arnold, Calhhoun, Tedeschi and Cann (2005) was in line with the results of this study as those that had worked with bereaved children found a sense of 'post traumatic growth' from their experiences. Stamm's (2002) research confirms this stance, but he terms this positive attitude and self-reward as 'compassion satisfaction'. Thus, this is the stance that a psychotherapist will be rewarded with a sense of personal achievement and satisfaction from engaging in an empathetic relationship with a distressed client. This is reflective of the participants' experiences in this study when working with a bereaved child client. Pearlman and Saakvitne (1995) described the same situation and termed it 'vicarious post-traumatic growth'. In this research, psychologists reported positive effects that developed from their work, such as growth in personal relationships, an increase in spiritual well-being, value and appreciation of human life and relationships, and an increased ability to cope with adverse situations (Pearlman & Saakvitne, 1995). These positive psychology theories developed as a means by which mental health workers could counteract the effects of burnout, compassion fatigue and vicarious trauma. Therefore, the participants shared a similar sense of self-reward benefits as the participants in Pearlman and Saakvitne's (1995) literature: an increase in confidence, a positive sense of self-worth, a stronger sense of self, self-knowledge, a sense of purpose and an increase in their faith in the human spirit and resiliency.

5.5 Chapter summary

The first superordinate theme dealt with the notion that the psychotherapist cannot remain neutral in the therapeutic alliance and that this is the result of counter transference. Counter transference will develop when the therapeutic relationship becomes complicated by the transference dynamic. There will be emotional enmeshment between the client and the professional. The psychotherapist will take on multiple roles for the bereaved child; most significant was that of a maternal role. Furthermore, the role that attachment can play as a mutual process in the transference dynamic.

These three factors led to the second superordinate theme. This dealt with the notion of viewing a bereaved child through a "pity lens" due to a counter transference reaction to an emotionally vulnerable child client. The emotional climate had the ability to influence the participants' ability to make their clinical judgments, which in turn opened the door for ethical dilemmas. Three ethical dilemmas were noted by the participants, including the loss of therapeutic boundaries; enabling a child's dependency and sense of helplessness; and as a result, creating special exceptions for the bereaved child. All three can have detrimental effects on the child, the professional and the therapeutic relationship. There was unanimous agreement that the best solution is for psychotherapists to remain aware of their counter transference at all times in order to avoid such ethical predicaments.

This naturally progressed to the third superordinate theme. This theme dealt with the experiences of the participants in terms of their solutions to maintaining the therapeutic frame to avoid any blind spots that are created due to ethical conundrums and the emotional nature of counter transference reactions. The findings indicated that the participants engaged in ethical management of their cases. Most useful is the role of supervision for the professional. The participants acknowledged the importance of remaining self-aware and engaging in self-reflection in order to understand where one's counter transference is originating. Finally, to reflect on their personal growth as psychotherapists and how to use counter transference as a tool within psychotherapy.

The three superordinate themes and their subheading findings were all based in existing literature and could be explained using the previous literature of other researchers. This research elaborated and explained on existing findings. Additionally, the findings unearthed in this study can be used to explore new areas of study in the field of counter transference. The main findings of this study have indicated that counter transference is a naturally occurring phenomenon within the therapeutic environment and relationship. However, counter transference can be amplified when engaging therapeutically with a bereaved child, in comparison to that of an adult client. Furthermore, counter transference can be used as a clinical tool in the therapeutic space. Significantly, it is vital that the psychotherapist acknowledge their counter transference and remain aware of its impact. Should this not occur, it can be damaging and detrimental to the therapeutic process, including to the client, the professional and the therapeutic alliance. Ethical and professional conduct is an important factor when considering the role of counter transference when working with bereaved children as per the experiences of the participants in this study.

The following chapter will conclude this study with a synopsis of the research conducted, a reflection on transparency, a delineation of the limitations of the study, and recommendations for future research.

CHAPTER 6
CONCLUSION

6.1 Introduction

The concluding chapter of the study offers an overview of the research whereby the study aims and methodology are reiterated. Subsequently, a synopsis of the main findings will be represented. The researcher has suggested recommendations for future research, as well as offered insight into the limitations of the study.

6.2 Overview of the study

The evolution of the phenomenon of counter transference has changed over the course of psychology's history. Freud's school believed counter transference to be a weakness on behalf of the psychotherapist and it was something that was criticised and shrouded in shame. New schools of thought began to develop and with these came new viewpoints in relation to counter transference. There was a distinct shift in the stigma toward counter transference. Psychologists began to use it as a tool in psychotherapy for understanding their clients. Yet it is still considered a weakness for many inexperienced student psychologists. The researcher experienced intense counter transference when working with a bereaved child and it took courage to admit to this in supervision. It was through this experience that the researcher gained insight into the benefits of counter transference and began to question the relationship between the client and psychotherapist, particularly that of a psychotherapist and a bereaved child client. This study attempted to explore this within a South African context. South Africa is a country that has an elevated violent crime rate, as well as a high incidence of HIV. This places many South African children at a high risk of losing a primary caregiver. It is therefore plausible that the majority of South African psychotherapists will experience counter transference with a bereaved child at some point in their careers. This research can create a platform for further research into this phenomenon in order to equip South African psychologists for such cases, and to contribute and build upon pre-existing theory in relation to this topic.

This dissertation was best suited to the qualitative methodology of an IPA design. In order to obtain rich data, in-depth semi-structured interviews were held with three participants who fulfilled the inclusion criteria and who had experienced counter transference when working with bereaved children. The interview data was then analysed using a hermeneutic and an inductive approach as recommended by Smith and Osborn (2003).

6.3 Summary of findings

The three participants shared their experiences during the semi-structured interview. The interview data enabled the researcher to develop three primary themes, namely: (i) the myth of neutrality: the dual role of the psychotherapist; (ii) ethical dilemmas: the "pity lens" in bereaved child psychotherapy; and (iii) containing the therapeutic frame: avoiding the blind spots.

The myth of neutrality: the dual role of the psychotherapist enabled the researcher to explore the impact of counter transference when working with bereaved children. The psychotherapists were unable to remain neutral and objective in psychotherapy sessions. There were three components that indicated this: (i) emotional enmeshment; (ii) multiple roles; and (iii) the impact of attachment and a concern of re-enacting abandonment. Each psychotherapist was unable to remain emotionally neutral toward the bereaved child and their situation. The child's emotions and therefore, transference, affected the psychotherapist's counter transference and their own emotional responses toward the child. The psychotherapists played multiple roles for the child and were not identified as just the clear-cut psychologist. Of significance was the maternal role that the psychotherapists were placed into. Due to the emotional enmeshment and maternal role, there was a certain level of attachment between the child clients and the psychotherapists. At times the attachment would cloud the psychotherapists' judgement and they would place immense responsibility onto themselves to make sure that the child's abandonment fears were not re-enacted by themselves. These three factors reinforced the main

theme, that the psychotherapist cannot be neutral when confronting their counter transference in psychotherapy with a bereaved child client.

Ethical dilemmas: the “pity lens” in bereaved child psychotherapy was a substantial theme. This theme highlighted the ethical dilemmas that the psychotherapists encountered when they were re-acting to their own counter transference without being fully aware of it. The researcher termed this to be a “pity lens” that affected the psychotherapists’ reactions as they were operating from an emotional stance as opposed to a more neutral stance. Thus, they allowed the vulnerability of the child and the child’s transference of fragility to make them more lenient in psychotherapy. Three ethical dilemma factors were noted: (i) being mindful of therapeutic boundaries; (ii) enabling the child’s helplessness and dependency on the psychotherapist; and (iii) creating special exceptions for the bereaved child. The “pity lens” played on the psychotherapists’ sympathy as opposed to empathy for the bereaved child. Thus, the psychotherapists were more willing to bend the therapeutic boundaries for the child and fantasise about ‘rescuing’ the child. This leniency toward the child fostered the child’s feelings of helplessness and dependency on the psychotherapist. Had they not been aware of their counter transference, this could have been detrimental to the child and their therapeutic progress. It was noted that the psychotherapists would create special exceptions for the bereaved child both inside and outside of the therapeutic context. Therefore, the theme of ethical dilemmas due to a “pity lens” is an important one as it demonstrates what could go ethically wrong should the psychotherapist not be aware of the impact of their counter transference within the therapeutic environment.

The final main theme elicited from the participants’ narratives was containing the therapeutic frame: avoiding the blind spots. This theme emerged from the advice from the psychotherapists in terms of how to avoid breaking the therapeutic frame despite not being able to remain neutral and the blurring of ethical lines that takes place. The participants voiced their experiences on how to remain ethically aware and responsible and how to avoid burnout. The participants felt it important to be conscious of the therapeutic blind spots in order to contain the therapeutic frame for both the child client and the psychotherapist.

The themes which were identified through this research are all relatively well-known psychotherapeutic factors which have been explored within existing literature, yet not all of them have been researched in relation to the phenomenon of counter transference when working with a bereaved child from the unique perspectives of South African psychologists.

This study created a better and deeper understanding of the complexity of the experience of counter transference as a psychotherapist when working with a bereaved child population. The participants' experiences demonstrated connecting accounts of an emotional relationship that develops between the bereaved child client and the psychotherapist, and further demonstrated that an awareness of this emotional relationship should be considered good ethical practice.

6.4 Reflections on transparency, the limitations of the study and recommendations for future research

A potential limitation of working from the qualitative IPA approach is that of the subjectivity of the researcher. This in fact strengthened the study as the researcher could make sense of the experiences because of her lens. Still, the researcher strived to be transparent and reflective in order to be transparent about her subjectivity with the subject matter. However, the depicted themes are interpretations of the researcher, and therefore coloured by the researcher's perspective, as well as the participants, and this creates a co-construction of understanding. Within the analysis, the researcher made her interpretations transparent.

This study had a strict sample inclusion criterion. The researcher had three participants willing to spare some of their work time to participate in an interview for this study. All three were female clinical psychologists. Thus, a more diverse sample group may yield different results. Perhaps the inclusion of male psychotherapists and psychotherapists from different registration categories may have offered varied data and responses.

Future studies could look toward a complementary study, whereby the same method is applied, but the research focuses on the experience of transference from the client's perspective. An adolescent population may be willing to share their experiences, as it may prove difficult to obtain consent from a child sample group and they may lack the necessary insight.

Another consideration would be to conduct the same study, but have two separate participant groups. A sample group that comprises of psychotherapists who are also parents, versus a sample group of psychotherapists who are not parents. The two sample groups' experiences could then be explored in relation to one another to see what impact or bias being a parent has on the psychotherapists' counter transference when working with bereaved children.

A study could be conducted to ascertain the relationship between student psychologists and their shame to admit to counter transference. This may shed light on the perspective of the phenomenon of counter transference as a perceived stigma from a novice's point of view in the field of psychology.

6.5 Conclusion

The study used an IPA approach as it was best suited to the research question, especially as it enabled a new exploration of the counter transference phenomenon where a gap in the field was identified by the researcher. An IPA study allowed the researcher to explore the topic with great understanding. This research appears to be the first study that has used an IPA approach to explore psychotherapists' experiences of counter transference when working with a bereaved child within the South African context. The study enabled the researcher to gain an inside perspective on three psychotherapists' experiences and this generated rich data in which three up-to-date main themes were elicited. These three themes shed light on the emotional challenges of working therapeutically with a bereaved child, as well as the possible ethical implications should the psychotherapist not be consciously aware of these challenges. This study may aid in the reawakening of the theoretical exploration

of issues surrounding counter transference as a therapeutic experience and make the phenomenon of counter transference more tangible to the psychology profession.

This study could benefit from improvements by future researchers who are interested in replicating this study or researching a similar topic. However, it is useful as it could also provide South Africa with the opportunity to explore the vast benefits of counter-transference within therapy. Once the benefits of addressing this phenomenon and using it as a tool in therapy have been made more public, it may become more popular for further research. Furthermore, the experience of counter transference and its impact on psychotherapy may become more widely accepted. This study enables some of the shame stigma to be removed for inexperienced student psychologists who may be uncomfortable to admit to their counter transference feelings in supervision, or who may be too afraid to be aware of their counter transference. It is hoped that this study has helped to contribute to existing knowledge and could provide the rudimentary basis for future studies relating to the phenomenon of counter transference and working therapeutically with bereaved children.

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APPENDIX I

UNIVERSITY OF JOHANNESBURG

DEPARTMENT OF PSYCHOLOGY

GENERAL INFORMATION FOR THE PARTICIPANT REGARDING THE NATURE AND INTENT OF THIS RESEARCH STUDY

1 This research project is conducted by a Masters Psychology student, Ashton Hayley Robertson, who attends the University of Johannesburg. This Masters research paper is being supervised by Mrs. Larise du Plessis, who lectures at the Psychology department at the University of Johannesburg.

2 The title of this research study is: Reflections on Counter transference: An Interpretative Phenomenological Analysis of Therapists' Experiences of Their Work with Bereaved Children.

3 The research question is: What will an exploration into the child therapist's thoughts and feelings around counter transference yield?

4 The aims of this research are to explore the experiences of the therapist and their work with bereaved children. To explore the counter transference that develops during the therapeutic relationship. To explore and gain an understanding of this impact both within therapy sessions and in the therapist's personal life. Furthermore, to gain an understanding of how the therapist deals with this. Thus, to develop a deeper understanding of the therapist's feelings and thoughts around counter transference when working with bereaved child clients.

5 Participants need to have at least 5 years of experience in a therapeutic practice. The therapist must be registered with the Health Professions Council of South Africa (HPCSA) as either a clinical or counselling or educational psychologist. The therapist must have experienced a situation where counter transference was experienced when working with a child client (under the age of 12 years) who has lost at least one parent or primary caregiver figure.

6 This study is an interpretative phenomenological study and thus requires the participant to share their experiences regarding counter transference with child clients through the structure of an interview.

7 The interviews will be face-to-face with the researcher and with permission will be audio-recorded for transcribing purposes. The interview will be approximately one hour in length.

8 The interviews may be transcribed by either the researcher or the researcher's assistant, however, all personal details will be kept in confidence and anonymity will be ensured regardless of who the transcriber will be.

9 The raw material obtained from the interview will be password encrypted in electronic files and will be deleted at the participant's request.

10 The participant is required to partake voluntarily in this research study. The participant will need to read and sign a consent form, a form providing permission to audio-tape the interview and to sign this document.

11 The participant's identity will not be disclosed in the published paper and pseudonyms will be used. Furthermore, the recordings will be deleted after one year upon the completion of this research to ensure the original identity of the participants is not available. Thus, anonymity can be assured.

12 Should the researcher decide to publish their work, this permission will be granted by the participant provided that their identifying details are kept confidential and that their anonymity is guaranteed.

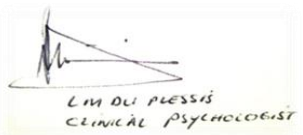
13 The participant is free to withdraw from the study at any time. However, the participant must commit them self to full participation unless some unusual circumstances occur or they have concerns about participating that the researcher did not originally anticipate

14 Everything possible will be taken into consideration so that no foreseeable harm will come to the participant.

I _____hereby understand all the above information and the nature of this research study. I am willing to participate in this study.

Signed date:_____

Participant's signature: _____
Researcher's signature: _____
Supervisor's signature:



APPENDIX II

UNIVERSITY OF JOHANNESBURG

DEPARTMENT OF PSYCHOLOGY

INFORMED CONSENT AGREEMENT BETWEEN RESEARCHER AND RESEARCH PARTICIPANT

I _____agree to participate in the research project of Ashton Hayley Robertson on the following topic: Reflections on counter transference: An interpretative phenomenological analysis of therapists' experiences of their work with bereaved children.

I understand that:

1 The researcher is a student conducting the research as part of the requirements for a psychology Master's degree at the University of Johannesburg.

2. The researcher may be contacted on 082 943 0179 or at ashtonhayley28@gmail.com. The research project has been approved by the Head of Department Committee, and is under the supervision of Mrs Larise du Plessis in the Psychology Department at the University of Johannesburg, who may be contacted at lmduplessis@uj.ac.za.
3. The researcher is interested in exploring the experiences of the therapist's counter transference with children in therapy who have lost a primary caregiver and its impact within the therapy room and in the therapist's personal life.
4. My participation will involve my partaking in an individual, face-to-face semi-structured interview that will be approximately an hour to two hours in length.
5. I will be asked to answer questions of a personal nature but I can choose not to answer any questions about aspects of my life or my therapy which I am not willing to disclose. I will protect the identity of the client I choose to talk about and will respond during the interview in an ethical manner.

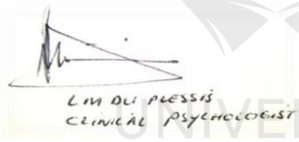
6. I am invited to voice to the researcher any concerns I have about my participation in the study, or consequences I may experience as a result of my participation, and to have these addressed to my satisfaction. Should I need any form of counselling I will ask the researcher to supply me with the names and addresses of trusted therapists.
7. I am free to withdraw from the study at any time - however I commit myself to full participation unless some unusual circumstances occur or I have concerns about my participation which I did not originally anticipate.
8. The report on the project will contain information about my personal experiences, attitudes and behaviours, but that the report will be designed in such a way that it will not be possible for my identity to be recognised by the general reader.
9. I am willing to sign a consent form to have my interviews audio-taped for transcribing purposes.

Signed date:_____

Participant's signature: _____

Researcher's signature: _____

Supervisor's signature:



APPENDIX III

UNIVERSITY OF JOHANNESBURG

PSYCHOLOGY DEPARTMENT

Permission and release form to use audio recordings for research purposes

Participant name & contacts (address, phone etc): _____

_____

_____

Name of researcher & level of research:

Ashton Hayley Robertson, Masters in Psychology at the University of Johannesburg

Brief title of research:

Reflections on Counter Transference: An Interpretative Phenomenological Analysis of Therapists' Experiences of Their Work with Bereaved Children

Supervisor: Mrs Larise du Plessis

DECLARATION:

1. The nature of the research and my participation has been explained to me both verbally and in writing.
2. I agree to be interviewed and to allow audio recordings to be made of the interview.
3. The audio recordings may be transcribed by a third party that the researcher trusts provided confidentiality and anonymity is ensured.
4. I give my permission for the audio recordings to be retained after the study and for them to be utilized for the following purposes and under the following conditions:_____

_____

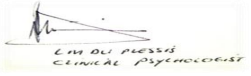
_____

SIGNATURES:

Signed date:_____

Participant's signature: _____

Researcher's signature: _____

Supervisor's signature: 

APPENDIX IV

MASTER TABLE OF THEMES AND SUBTHEMES

THEME	**PARTICIPANT 1: JUDY**	**PARTICIPANT 2: KATHY**	**PARTICIPANT 3: FATIMA**
THE MYTH OF NEUTRALITY: THE DUAL ROLE OF THE PSYCHOTHERAPIST **Emotional enmeshment**	"There are feelings of sadness really. Identifying with a loss… But because of his frailty you tend to be emotional." "And that I may be identifying with some of those feelings of vulnerability that are my own in terms of where I come from – my background and my style and approach. I might have had a blind spot in terms of that."	"The feelings with bereaved children are quite intense, all the sadness." "They are terribly sad therapies you know. I would also feel with the boy whose mother committed suicide, furious with his mother for putting him through that. He was an ordinary little boy and then at 10 having to deal with the suicide of his mother. We finally got to his anger with his mother. I mean he always was very protective of her so I think it was partly counter transference but I think it was also my own counter transference…. Like once this little boy was at school and he didn't have the right kit and you know… what a mother would do. And then I did think about that afterwards and was cross with the	"It is such heart-breaking work." **"**Bereaved children do have a special… And yes you are making me think a lot more about it now, a special way of really pulling at those counter transference feelings, it feels so much stronger." "I think there is a tendency to feel a lot of empathy for them and sympathy even." "And in the little boy I am talking about now I just remember him saying that, he was very articulate, saying – I just need a Mom to do what Mommy's can do. And I asked him, like what? And he said, like helping with homework and driving me

		mother."	around and coming to my games and all sorts of things. And I really felt like kind of scooping him up into my arms and like holding onto that kind of, holding onto him. So I do think there is a tendency to feel a lot more with these children, connect to them." "I think being a bereaved child, not for a parent but for a sibling, I think I always kind of feel connected to these children that have lost loved ones fairly early on in their lives. So I think it does evoke something for me personally."
THE MYTH OF NEUTRALITY: THE DUAL ROLE OF THE PSYCHOTHERAPIST **Multiple roles**	**"**But I think you feel very much… it's more intense, you are the only person for this child and you can take on that transference role." **"**When you are working with	**"**For example with this boy who had lost his mother. I do think I became like a mother figure to him. But I think the way I… but I was always his psychotherapist… But yes that sort of feeling that I wanted to be a	**"**I think with these children when they yearn for this kind of maternal or paternal kind of caregiver to provide something and being a psychotherapist here is in some ways providing

	children you have to wear a lot of different hats. So you are primarily the psychotherapist in terms of managing the case, and it is also about… I suppose part of a parent role is also preparing the child for life. So I think there is that aspect to it too. Not just the nurturing but also sort of making sure that he negotiates all the milestones as he needs to for where he is at developmentally. Then there is working with children in general. They often try and put you in the teacher role because that is what they know in terms of relationships with adult figures. Especially if it is their first time in therapy…Or doctors. So I think a lot of it is a way of asking for nurturing, sometimes moved into sort of relating to me as his Doctor. So for example he would complain of headaches and	mother to him." "But for me maybe there is something about a need of my own which is not yet fulfilled but I think it is fertile ground for someone to take on. Especially because I do want children so it's not like I am… And I think it hooks into something, obviously a root need of mine at the moment. So I think I am quite vulnerable in that way to acting on the counter transference because of being in that position."	that kind of role." "I would be drawing with a child and drawing whatever comes to mind and find myself going in a particular direction. And I think I also see that as kind of sharing a part of how I am feeling or what is going on between us in the relationship, or the position I have taken in play I guess. Whether I am the mommy or the sister or the bad guy or whatever it might be." "It is also very difficult as well I think being alive and having an awareness that you might be evoking something that the child is so aware that they don't have. So here is a woman in front of me that could act as a mother, or in the therapy is looking after me in this kind of way, but I can't go home with this person. So I think that there are difficult feelings there as well."

	things like that in therapy." "There is a huge sort of maternal transference. Sort of really wanting to take over the role of container and be a very holding environment. Definitely a sort of substitute Mom and a big sister in some ways too… Because for me it was taking on a very maternal, supportive and nurturing role." "He went through a huge phase where he just wanted to read stories, which doesn't sound like therapy. But I think he might have been responding to some of my maternal role that I was taking. Sort of mom reading bedtime stories, that kind of playing."		
THE MYTH OF NEUTRALITY: THE DUAL ROLE OF THE PSYCHOTHERAPIST	**"**He gets quite upset when… he misses me when I am sick and I miss a session." "Like termination, a child like this		**"**There was quite a hectically strong feeling that emerged and I really started to feel very attached to this girl and I

The impact of attachment and a concern of re-enacting abandonment	maybe you could keep them in therapy for ever which actually is not… most really I think that is a challenge for me keeping in mind does he still need to be here or is it my need or fear that he… it never goes away. I think that is a tricky one. I really need to think about it for the last while. Because he has been in therapy for two years now and to really review it at points whether he does still need to come. But it is just my counter transference that is keeping him there." "I was less sort of confrontational in the therapy. I would probably spend a lot more time making it a safe space for him because I really could identify in a way with his potential fear on trust, and his fears of abandonment and loss. So I was very aware of the fact that he has developed trust and I need to really make it safe for him and be very aware of		think she felt very attached to me." "Sometimes children need more but we can't afford as such to give them more of what they need which again re-evokes all sorts of feelings of loss and being abandoned or whatever it might be that they do have."

	potential ruptures to the therapy or termination issues." **"**It is the capacity to attach but I think in terms of relating authentically with another person, I think that is very powerful. And that is where the counter transference is really useful. I think it is about an emotional connection, an emotional exchange which if used correctly and not acted on as an enactment by a psychotherapist it may, and this is where the challenge comes in, give a child a sense of what they may elicit from others. And how in them being authentic, and acknowledging strength, and not identifying with helplessness, it can be productive and useful for them as well."		
ETHICAL DILEMMAS: THE "PITY LENS" IN BEREAVED CHILD	**"**The depravation it really comes through. So, like for example, I don't really believe in making food for kids etc, but for	**"**Often my counter transference was I wished I could just take him home you know." **"**Like in the first	**"**I may find myself enacting something, wanting to give the child something special or being a

PSYCHOTHERAPY **Being mindful of therapeutic boundaries**	him when I sensed and he said he was hungry, and would ask for things, you know, there's a huge pull to act on that. There as huge pull around like even giving toys and things like that. But it speaks to… I think with deprived children that is often the case." "I think that's where the challenge really is to… it can be very easy to slip into carrying on session after session after session just caring for this child."	year he wanted me to come to his, he was 10 he turned 10, he wanted me to come to his birthday party."	little bit more flexible with the frame, giving them a few extra minutes, or a few less minutes because it is too difficult to think about something." "Like fantasies of dropping stuff at her house maybe, talking to my husband about that. Maybe like, there is a client who is really suffering. He was like, oh just buy a food package and drop it off…I never did but really feeling pulled into doing something physically for her actually."
ETHICAL DILEMMAS: THE "PITY LENS" IN BEREAVED CHILD PSYCHOTHERAPY **Enabling the child's helplessness and dependency on the psychotherapist**	**"**It was really around feeling quite tentative and careful and almost a hyper awareness of the vulnerability of the child, which is tricky because you might miss out on a lot of the resilience that can come with that… I might be losing out on opportunities to reinforce the resilience that is there and his own capabilities."		**"**…colluding with the child's defenses and not thinking or talking about the parent that has passed away."

	"I think the concern is that it might enable helplessness. Which is a concern. So if I indulge that vulnerability and that fragility too much as a psychotherapist it might really reinforce some of his own ideas around his own inadequacy in managing his feelings and being in the world on his own. Which is problematic obviously, because it must really be about trying to find a balance around managing my own tentativeness and almost hypersensitivity toward his vulnerability with the idea that he needs to learn those skills for himself too." **"**I reconsidered around how my attitude was reinforcing dependency which in certain ways makes, you know, leads to psychotherapists being needed in a way. Fulfilling that with your role. But I was also aware		

	of the frustration that was happening outside in terms of staff that needed him to do things for himself and become more independent… So sometimes I wonder if some of his acting out did increase with me around. Me enabling him in the sessions so, maybe tolerating." "In a way I realised I was delaying going there because I was afraid of the fall out and of the fact that he would be totally unable to cope with it. Or go to pieces, he could decompensate, his own fragility.		

ETHICAL DILEMMAS: THE "PITY LENS" IN BEREAVED CHILD PSYCHOTHERAPY **Creating special exceptions for the bereaved child**	**"**I think right from the beginning I was aware of sort of my overwhelming need to give and provide for him from the first session." I also think the need to defend and protect. So when for example one of		**"**You provide more support then perhaps than with other sorts of clients. I was very aware of her social circumstances living with her granny in a one bedroom, one room sort of place without a bathroom, all sorts of things. And I

	his nurses that work at the home might come and say he is acting out, he is being naughty, he is being cheeky, in a sense I am more inclined to try and tell her to try and tolerate it and go easy on him, when actually what he also needs to learn is a lot of consistency and discipline and structure too in spite of all his losses. So I need almost to make a special exception because I feel almost that I should compensate for all the things he has been deprived of in his life. I suppose to make excuses for it. He probably is naughty. I don't see it in my session which might be somewhat of a response to what we were talking about. A response to the counter transference.He really is… He won't bring. So he won't come and talk in		think those feelings I had for her came out in that I organised other members of the department to help push for a grant for her. So not in the session per se but in terms of the work I was doing outside of that. Even though she didn't qualify for a grant, she didn't have a medical disability or whatever, I really went to great lengths to help her and kind of provide in ways which I was very aware that I shouldn't really be doing. But I think there was such a sense that this loss carried not only an emotional sort of hole in her life, but also materially her circumstances had deteriorated so far that it felt like that was at least something I could do and that I wasn't totally powerless in what it felt like just in the therapy and talking about all this stuff emotionally."

	therapy about getting into trouble or being naughty. So he doesn't bring that stuff. And I think it might be something around him, if he is in some sense colluding with the image I have of him."		
CONTAINING THE THERAPEUTIC FRAME: AVOIDING THE BLIND SPOTS **Ethical management**	"I think really it was in supervision that I became aware of what I might be doing. I might be enabling because of my response to him… get supervision. Be aware of your own issues around parents, around death, and around loss. Be aware of dependency and vulnerability with regards to the therapy preparation too, because you really should be conscious and aware of those all the time and burnout… obviously process notes help a lot in terms of working things through and I'm in my own therapy."	"I do think one always has to be very aware of ones counter transference. That's why I think the importance of therapy and supervision…That helped with writing up this session which is another opportunity to think about it, and with a supervisor, because they often can be quite difficult because difficult feelings are evoked… So I think it is always important you know to think about ones counter transference reactions and I think that is also the real importance of one's own therapy. To try and deal…Because you know a blind spot is a blind spot you are not going to see it. And one's own	"I guess I am always aware of the feelings I have or what feelings are evoked for me in the session or after the session and a lot of that kind of processing happens in supervision and when I am writing up my process notes…I am in my own personal therapy and have lots of supervision and kind of take all that stuff there to try and sort it out." "But the other thing that is very helpful is that I work in a team. Here in this environment we are a multidisciplinary team. We have ward rounds; we have a lot of contact with other psychotherapists who are seeing

		supervision, I think one needs to be in ongoing supervision because the supervisor will see that." "Reading groups, I am in a lot of reading groups you know. Meeting with colleagues, supervision, my own therapy and I think reading as well also helps to… Whether its novels you know, where bereavements are dealt with there for example or all the books, Psychoanalytic. I really do think theory is our support and I think the more we can understand theory I think we really, really helped in the work that we do."	clients so professional support is a big one as well."
CONTAINING THE THERAPEUTIC FRAME: AVOIDING THE BLIND SPOTS **Self-awareness and self-reflection**	**"**With the child obviously the challenge is you have to as a psychotherapist acknowledge in yourself what is going on, and then choose what you would need to take into the room and what you have to be quite firm around in terms of limit settings	**"**And the working through of it is that you can own and understand your own feelings, but it is in the process of understanding it…reflecting on either my thoughts during the session or after the session… being aware of something that is	**"**In a first session I would really want to observe and take that in and kind of sort through, is this evoking something for me about my own bereavement stuff or death stuff or whatever it might be, and just kind of sit with that…I think that if counter transference isn't

	and boundaries… And I can see as therapy has progressed that I become more of aware of my blind spots in working differently. He has become a lot more independent. " "I do spend some time actually feeling sad. It makes me look at my own life in context and be grateful for the fact that I still have my parents around. It makes me grateful for my life but also quite sad. I feel guilty sometimes but you know… I have had privileges that he hasn't. In terms of having a care giver, a parent, a parental figure. It makes me reflect on my life. In terms of thinking would I do anything differently?"	going on…It is about really processing it and making sense of it …You know it is to recognise an unconscious process, to recognise feelings might be stirring up, to do the internal work."	processed or thought about we can really go in and kind of collude with all sorts of projections that are being identified with." **"**Also thinking and wondering about my own parents when I see parents who have lost children."
CONTAINING THE THERAPEUTIC FRAME: AVOIDING THE BLIND SPOTS **Personal growth as a psychotherapist**	**"**It has encouraged me because I think that it is a reality of the country that we live in. There are lots of children without	**"**But it is very rewarding work because you do the work, go through the process of mourning and they get better… I	**"**I certainly use my counter transference as a guide for my interpretations or even my reflections to the child. I think it allows me to be

	parents. So it hasn't been a negative experience. It has been quite a growing point for me as a psychotherapist too and to see my own blind spots and to really recognise the strengths and vulnerabilities of working with children like this… As a psychotherapist you grow because it makes you confront your own ideas around loss. A loss of fantasies, idealized parental figures, and also ideas around vulnerability. Ideas around resilience so it really expands your capacity in terms of what children can deal with. Often more than what we give them credit for."	mean if you also think that one of the goals of therapy is to help the person regain split off parts of themself. It is also assisting in integration. Helping the person actually be able to deal with those feelings rather than getting rid of them…I suppose I did explore more what mourning was about, dealing with loss, those sorts of things."	more sensitive into whatever they are bringing or what they are not bringing to the room as well… I think I have more of an ability to process those feelings and not try and act on them. Whereas before, I think that kind of mechanism of processing those feelings and learning to stay with them rather than thinking or wanting to act on them. So in some ways I think it has gotten easier to stay with those feelings…I guess when I started training I really held onto that. I think perhaps as a defense to really get involved with my clients and feel for them, and being trained psychoanalytically, dynamically, like really feeling that I should be some kind of neutral person. But I think I have learned as time has gone on that I think the more that I can bring of myself and my personality and my feelings to the work, the deeper the work is, the more valuable I think it feels for me and for

			my clients. And I guess the more genuine I can be otherwise I think they don't take well to like a cold, distant kind of stance."