



# **Portfolio of Work for the Professional Doctorate in Counselling Psychology**

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## **Introduction to portfolio**

This doctoral thesis portfolio consists of four different areas of counselling psychology research and practice. It begins with an empirical piece of research, which explores the therapeutic relationship with adult adoptees as experienced by adoption counsellors. It is followed by a reflective essay, which presents the development of my personal and professional identity as a counselling psychologist. A theoretical essay will then be presented, which compares and contrasts process and content interventions in working with couples and uses clinical examples to illustrate attachment interventions and Murray Bowen's systemic therapeutic approach (1978). Finally, a process report reviews my management of the therapeutic relationship with a client who presented with symptoms of chronic depression and a history of physical abuse.

Counselling psychology draws upon and develops models of research and practice that "marry the scientific demand for rigorous empirical enquiry with a firm value base grounded in the primacy of the counselling or psychotherapeutic relationship" (British Psychological Society, 2005, p. 1). The British Psychological Society also states that counselling psychologists seek "to engage with subjectivity and intersubjectivity, values and beliefs" (p. 1). Throughout each portfolio component, the notion and relevance of the therapeutic relationship is reflected and commented upon with an emphasis on the subjective and unique experience of the individual rather than attempting to fit an individual into psychotherapeutic theory.

However, my way of practising and thinking as a counselling psychologist is naturally guided by specific therapeutic models, in particular Cognitive Behavioural Therapy (CBT). Additionally, psychodynamic thinking, which includes the theory of attachment, seems relevant when formulating process issues in the therapeutic relationship. I am aware that my way of perceiving, believing and being in the world is one of many possibilities and that there is no single or ultimate truth or final conclusion. This also means that my development as a counselling psychologist is always a work in progress, and this portfolio is therefore a snapshot of my personal and professional development at the point of writing.

In the following, I will briefly outline the four components of this portfolio and highlight how the therapeutic relationship and the subjectivity of individual experiences link the different sections of my work in research and practice.

### **Component 1: Empirical research project**

There is a paucity of qualitative research exploring the experience of the therapeutic relationship with adult adopted clients from the therapists' point of view. Research suggests that human beings "relationality" begins in the mother's womb way before birth, but continues throughout life (Righetti, Dell'Avanzo, Grigio, & Nicolini, 2005). This is in accordance with one of the suppositions of my research, namely that early years might be particularly relevant for the individual's capacity to form fulfilling relationships in later life. Therapeutic relationships are influenced by past relationships that the client and the therapist have had (Hardy, Cahill, & Barkham, 2010). The adopted child has experienced multiple losses, in particular the loss of the birth mother or primary attachment figure, though the exact combination and the consequences depend on the individual child and the circumstances of adoption (Hindle & Shulman, 2008).

From an adopted individual's perspective, establishing a therapeutic relationship can revive and re-evoke intense feelings and anxieties in relation to their adoption. However, little is known about whether therapists might experience particular issues and challenges or whether they engage in modifications to their practice when working with adult adopted clients. To explore in depth how six adoption counsellors might experience the establishment, maintenance and ending of therapeutic relationships, semi-structured interviews were conducted and analysed using Interpretative Phenomenological Analysis (IPA) (Smith, 1996). IPA research is interested in the individual's sense-making process and tries to seek the meanings of experiences (Finlay, 2011). This research method strives for a reflective focus with idiographic sensibility in order to make sense of an individual's lived experiences and is therefore deemed suitable to use in order to answer the research questions.

## **Component 2: Reflective essay**

This section entails reflections on my experiences during the training programme and offers some evaluations that consider my own evolving professional identity, which I view as an ongoing process. This essay highlights the importance of being grounded in my therapeutic approach, which is CBT. This seems relevant in order to be attuned to my clients and gives me a set of conceptualisations, theoretical understandings and practical tools and techniques. Equally, I emphasise the need to be open to other approaches such as humanistic and psychodynamic therapy in order to facilitate attendance to the therapeutic relationship, depending on the individual client, in the knowledge that in our lived experience it is not one, but many things that can produce therapeutic change.

## **Component 3: Theoretical essay**

This component consists of a theoretical essay that explores couple therapy from a family systems and psychodynamic perspective. Both theories have the freeing from past family relationships positioned as a focus point in therapy, as these relationship patterns can be repetitive and restricting (Gerson, 2010). Primarily, couple therapy is considered the treatment for couple distress or for improving couple relationship satisfaction. It is a treatment that is established as being effective in this way (Lebow, 2013) as there have been indications, both in research and in clinical experience, that individual therapies for couples can often lead to relationship break-up (Gurman & Kniskern, 1986). The needs of some individuals might therefore be better met within couple therapy, again emphasising the importance of the subjective individual experience of the client.

In this essay, I compare and contrast the Murray Bowen family systems theory (1978) and attachment theory. I present the theoretical underpinnings and contextualise these within counselling psychology practice.

## **Component 4: Process report**

The final portfolio component comprises a process report, in which I critically reflect upon and evaluate my therapeutic relationship with "Paul" (pseudonym), who

suffered from symptoms of depression and experienced physical abuse as a child. This report shows the philosophy of utilising multiple theories, with an emphasis on viewing Paul's beliefs and strategies through his developmental history, using CBT, attachment theory and cognitive analytical therapy in an attempt to increase the understanding of Paul's difficulties. The therapy excerpt that I commented on followed a potential rupture in our therapeutic relationship, and the client described the session as a turning point. I felt that this piece of work showed the relevance of drawing on additional psychological theories to increase my understanding of the therapeutic relationship with this client, which might not have been possible by adopting a purely CBT approach. The report also highlights features of the profession of counselling psychology: The fact that no single model or theoretical approach is valued over another (Rizq, 2006) and that the practice of counselling psychology relies heavily on the self, interpersonal skills and the therapeutic process (Woolfe, Strawbridge, Douglas, & Dryden, 2010). Its philosophy emphasises that the client's work is done in relationships, which this report attempts to illustrate.

**Component 1 - Empirical research project**

**A qualitative analysis of how therapists  
experience the therapeutic relationship  
with adults who were adopted as infants**

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**A thesis submitted to London Metropolitan University in  
partial  
fulfilment of the requirements for the Professional  
Doctorate in  
Counselling Psychology**

by Birgit Vote

## 1. Abstract

Research suggests that adoptees are seen in therapeutic settings in a greater proportion than their prevalence in the general population (Kennedy Porch, 2007). Few studies concentrate on adult adoptees, and those that do mainly focus on adjustment and the search for / reunion with the birth family rather than on therapy research. In particular, there seems to be a lack of empirical and theoretical understanding of the complexities of the therapeutic relationship when working with adults who were adopted. Early experiences can affect an adult's ability to form trusting relationships with others, including with a therapist.<sup>1</sup> Counselling psychology, as a discipline, has a particular interest and skill base in understanding the therapeutic relationship and is therefore in the position to offer a valuable contribution to research on the therapeutic relationship with an individual who has been adopted as an infant. Through six semi-structured interviews, adoption counsellors currently working with adult adoptees were asked to share their experiences and understanding of the nature and the role of the therapeutic relationship. A qualitative methodology guided by Interpretative Phenomenological Analysis (IPA) enabled detailed exploration of the adoption counsellors' perspective. Three master themes were identified in the analysis: An awareness of the early rejection in all stages of the therapeutic process; a personal commitment to provide a corrective emotional experience; and the psychological consequences of working with adult adopted clients for therapists. The analysis highlighted the challenges that participants perceived in terms of establishing, maintaining and ending the therapeutic relationship with adoptees. The findings of this study extend the pre-existing research base by emphasising the interconnectedness of the personal and professional experiences of adoption counsellors and the need for flexibility in their practice in each phase of the therapeutic process, predominantly with regard to therapeutic boundaries and engaging in a different ending experience. The themes are discussed in relation to existing literature with an emphasis on attachment theory. The discussion also highlights practical implications, particularly the importance of familiarisation with aspects of adoption due to their likely influence on the therapeutic relationship and the need for reflective practice.

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<sup>1</sup> To aid readability, the terms *therapist* and *counsellor* are used throughout this study and also include other professionals working in psychotherapeutic practice.

## **2. Introduction**

### **2.1 Background**

Adoption has a long history in human civilisation; its existence can be traced back as far as biblical times (Javier, Baden, Biafora, & Camacho-Gingerich, 2007). A current definition in Western culture views adoption as a fundamental, permanent and legal change in the life of a child that intends to provide the child with new attachment figures and a safe base for childhood and throughout life (Courtney, 2000). It simultaneously fulfils the needs of children who need families and families who desire children (Jones, 1997). Adoption is a multigenerational and ongoing process that permanently affects the lives of the adoption triad: Adopted child, adoptive parents and birth parents. The adoption that has been finalised through an adoption order is viewed only as the midpoint (Henderson, Sass, & Carlson, 2007) as each adopted individual has different psychological needs that shift developmentally across the life cycle (de Peyer, 2013).

There is a variety of different types of adoption, for example within-country (domestic) or international adoption, interracial adoption, adoption by family members and adoption at various ages. Thus, adoption refers to a diverse set of family circumstances, and generalisations about adoption must be made cautiously (Grotevant, 2003). A distinction has to be made between special guardianship and step-parent adoption. Special guardianship was introduced in 2005 and while this promotes a permanent relationship between the child and the special guardian (Department for Education and Skills, 2005), it maintains the legal link between birth parents and children. While step-parent adoption is legally binding, it is likely to be experienced differently than other forms of adoption.

It is also important to understand the distinctions among closed, open and semi-open adoptions, as these differences can influence the adoptee in how they experience being an adopted individual at each stage of their life.

Closed adoption means that the adopted person and their family have no contact with the birth family unless a search is initiated, which usually happens in adulthood.

These adoptions are becoming less common, but many of today's adult adoptees are involved in closed adoptions (Corder, 2012).

Open adoptions have taken place when the adoptee and their family have contact with the birth family through letters, pictures or face-to-face visits. This form of adoption is more common nowadays (Siskind, 2006). Open adoptions vary considerably in terms of the amount of contact that takes place, but generally, adoptees know the names of their birth parents and have some form of contact with them or at least the potential to have contact.

In semi-open adoptions, birth families and adoptive parents do not exchange identifying information, such as their last name or where they live. All information is generally sent through an intermediary, such as an agency or a legal representative. Often, letters and pictures are sent on a routine basis, for example once a year (Corder, 2012).

The type of contact however does not necessarily entail an open communication with the adopted child about their adoptive status. Furthermore, within the research community, notions of 'openness of attitude' (Fratter, 1996) and 'communicative openness' (Brodzinsky, 2005) - the openness of adoptive parents in thinking and talking about adoption, have been identified as equally, if not more important than what kind of contact takes place. Some of the important responsibilities for adoptive parents are sharing adoption information with their children, helping them understand the meaning and implications of being adopted, and supporting them in their efforts to cope with feelings related to their family status, including those connected to loss (Brodzinsky, 2011).

Many adoptees never seek or require counselling, but empirical research has found a higher proportion of adopted persons in therapy (17.71%) than of non-adopted persons (8.67%; Miller et al., 2000). Also, studies have reported greater referral rates for adoptees to psychological services than for their non-adopted counterparts (for example, Borders, Penny, & Portnoy, 2000; Jones, 1997; Juffer & Van Ijzendoorn, 2005).

The support for adult adoptees varies across England. The first independent post-adoption service in England was the Post-Adoption Centre (PAC) in London in 1986. Since then, independent post-adoption services have been established in various parts of the country, although not all of England is covered by such provision (Harris, 2004). The PAC provides a range of post-adoption services to anyone involved in adoption. The PAC currently employs, for example, counsellors, a family therapist and a counselling psychologist. The work is supplemented by sessional workers, consultants and volunteers. Funded primarily by the subscription of local authority social services departments, the agency provides a core service to people with personal experience of adoption who live in a subscribing local authority area. The range of core services includes telephone advice, telephone and face-to-face counselling, training events for professionals, work with adoptive and birth parents and adopted children, and the provision of a venue for post-adoption contact and support groups.

Another post-adoption organisation is After Adoption, who merged in 2012 with another voluntary agency called Adoption Support. Since 1994, the organisation provides independent support for anyone affected by adoption including developing intermediary work and supporting birth parents and relatives in parts of England and Wales. Similar to the PAC, it provides free core services to people, who live in subscribing boroughs or whose adoption was arranged there. The organisation offers, for example, tracing, access to adoption records, individual and group work with birth parents, life story work, counselling to address issues raised by adoption and intermediary services for those making contact with their children.

Sass and Henderson (2002) reported that a common topic at adoption support group meetings is disappointment with therapists who were either not informed about adoption or downplayed the importance of adoption in a client's life. On a similar note, Brodzinsky, Smith, and Brodzinsky (1998) claimed that the therapist's modality is of minor importance when working with the adopted person. According to these authors, it is more important to have a clear understanding of the adoption-related issues that are likely to emerge in the course of treatment and that can affect the therapeutic relationship.

There is a variety of terms to conceptualise the therapeutic relationship, including working relationship, alliance, therapeutic alliance, therapeutic bond and working alliance (Hardy et al., 2010). For the purposes of this research, the term therapeutic relationship will be used for ease. The therapeutic relationship is seen as a central point in the philosophy of counselling psychology, which means that the clients' presenting issues are heard and aimed to be understood in the therapeutic relationship (James, 2009). A good relationship between client and therapist is considered to be the base from which all therapeutic work takes place (Hardy et al.). In recent years, much research in mainstream psychology has focused on the therapeutic relationship in therapy: "the quality and strength of the collaborative relationship between client and therapist in therapy" (Hovarth & Bedi, 2002, p. 41). A substantial body of evidence suggests that the quality of the therapeutic relationship is one of the key factors in determining outcomes in therapy (Cooper, 2005), accounting for approximately 30 per cent of the therapeutic outcomes across theoretical orientations (Assay & Lambert, 1999).

So far, counselling psychologists have not made extensive contributions to the field of adoption, even though, as this thesis suggests, they have much to offer that could extend adoption counselling literature. A series of articles in the American journal *The Counseling Psychologist* (one overview article and two detailed reviews) had the purpose of increasing awareness of the psychological and sociocultural issues involved in adoption and to provide frameworks for research in this domain. It also aimed to promote an understanding of empirical research in this area and to identify future theoretical, research and practice directions for the study of adoption, to which counselling psychologists can make a useful contribution (Zamostny, Wiley, O'Brien, Lee, & Baden, 2003). Baden and Miller (2007) concluded several years later that counselling psychology needs research that addresses questions related to the lifelong effects of relinquishment and adoption on adults. Clinical themes in adoption overlap with "traditional" counselling psychology themes, for example relationship and attachment processes, coping skills enhancement, coping with loss and transition and transcultural issues (Zamostny et al., 2003). These are all themes that are extensively discussed in the current edition of the *Handbook of Counselling Psychology* (Woolfe et al., 2010).

This study suggests that adoption is of interest to counselling psychologists and that the therapeutic relationship with adult adoptees as experienced by adoption counsellors is relevant for the profession generally and for individual counselling psychologists and other helping professions that work with adult adoptees in particular.

The thesis is structured as follows: The reflexive statement will outline my own personal and professional stance towards adoption and how I anticipated and managed my influence on the research process and data. This is followed by a literature review that aims to provide a specific context for my research and will lead on to define the research gap and concludes with the main research questions that underline this study. The next chapter describes and explores the rationale for the methodology used and gives a more detailed account of the research process and its participants. The main focus of this thesis is on the interview analysis, which describes the master themes and sub-themes that were found during this process and contains excerpts of participants' interviews. This is followed by a discussion, which attempts to draw together how the findings of this study may relate to and add to what is already known, and then there is a final reflexive statement, which concludes the study.

## **2.2 Reflexive statement I – At the beginning of the research process**

I was raised not knowing that I was adopted until I was in primary school. Still remembering the conversation about my adoption that I had with my adoptive mother back then, I felt that somehow my sense of being different was suddenly explained. However, I hardly thought about being adopted during my teenage years and felt loved and cared for by my adoptive family. When my birth mother tried to get in touch with me in my early twenties, I decided not to establish a relationship with her. I think that my move from another country to the UK after meeting my husband gave me the space I needed to make this decision and also to reflect upon my adoption in a way that I do not think would have been possible if I had stayed living near both families.

My personal history led quite naturally to my interest in this topic. Being adopted myself, the topic of adoption was discussed in my personal therapy, but I felt not with someone who really understood the adoption dynamics. It seemed to me that adoption was the "elephant in the room". I knew that it was important for me, that it shapes the way I relate to people and how I deal with life, but I only superficially touched upon it, which left me feeling dissatisfied and not understood. This first experience of therapy made me realise how difficult it was to find the "right" help that I needed in order to face myself and my difficulties in opening up about being adopted. I understood the importance (and the difficulty) of establishing a supportive alliance with my therapist and how this either encouraged or discouraged my discussion of adoption. I would look out for the therapist's responses towards my adoption and how it was acknowledged but sometimes not discussed any further. I suspected that facing my adoptive status could make me aware of my "primal wound" (Verrier, 1993, p. xxi), as Nancy Verrier calls the wound caused by the separation of the child from his or her biological mother. Gaining a deeper understanding of the influence of adoption would somehow mean, for me, "falling apart", "being different" and not being in charge of my life anymore, something I felt I had worked very hard for.

We enter into training as counselling psychologists as human beings with life experience that can be more or less valuable as a reference point in our work with others. Embarking on the journey to become a psychologist and subsequent counselling helped me to embrace differences in a constructive way, which also facilitated appreciating my own individuality. It aided my empathising with clients, but I have also become aware of the importance of "bracketing" those experiences from being actively worked out in my professional relationships. During my second year of training in counselling psychology, I had the opportunity to obtain a placement at post-adoption organisation X. This experience highlighted for me the absence of the adoptee's voice in other areas of psychology and in the therapeutic discussion as I have never encountered specific therapy-related issues when working with adoptees during my training in (counselling) psychology. Also, I have learnt how difficult this area of work is for me, which means "bracketing" was much harder, but it also brought up personal reflections relating to my own adoptive and

birth families. These experiences were something I worked on in personal counselling, but I again noticed that initially the adoption as such was not discussed, but rather the potential influence of adoption on the "here and now" with my family and my upcoming marriage.

I hope that by writing this statement I increase my own awareness of and critical attitude towards my impact as a researcher and my subjectivity in all aspects of the research. Part of reflexivity means contextualising myself so that the reader can recognise potential biases and realise how my previous knowledge of the phenomenon under exploration will inform my study, which also includes information about my epistemological stance in relation to this study. However, reflexivity is more than contextualisation and also includes the creation of a dynamic process of interaction within and between the researcher and his/her participants and the data that inform decisions, actions and interpretations at all stages of research (Etherington, 2004). Reflexivity recognises a "circulating energy between context of researcher and researched" (Etherington, p.32) and that both of them have agency.

If epistemological perspectives are understood to be on a continuum, a "critical realist" would occupy the middle ground, whereas positivist approaches would be at one end and social constructionist perspectives at the other. I am drawn towards the social constructivist perspective in my research. They argue that the inner self is an object constructed by the means of inquiry, that is, our interactions with others, and language is seen as a key ingredient for organising and interpreting experience. Identity is continually created and revised from relationships with others and actions in the public, outer world rather than being seen as existing a priori at the core of our being (Davy, 2010).

This sits well with the methodology in this study, Interpretative Phenomenology Analysis (IPA). I have chosen to analyse the interviews using IPA due to its suitability for my research questions. It involves a "double hermeneutic" (Smith & Osborn, 2003, p. 51): The researcher is making sense of the participant, who is making sense of a particular experience. These views are also in line with the British Psychological Society's Division of counselling psychology's "Professional Practice

Guidelines", which state that counselling psychologists should be able "to know empathetically and respect first person accounts as valid in their own terms. To elucidate, interpret and negotiate between perceptions and world views but not to assume the automatic superiority of any one way of experiencing, feelings, valuing, and knowing" (British Psychological Society, 2005, p. 1).

It is seen as inevitable that researchers bring their subjective selves into the research along with preconceptions which both blinker and enable insight (Finlay, 2011). Through reflexivity the illusory gap between researcher and researched and between the knower and what is known can be closed (Etherington, 2004).

Through informal discussions with colleagues, in supervision with other counsellors who work with adoptees and through my own experience in therapy, I formed certain beliefs about how our own adoption status influences the view of the therapeutic relationship with our adopted clients and the choices we make in the encounters with our clients, consciously and subconsciously. I observed the interface between the personal and the professional. For example, counsellors who experienced a problematic adoption might tend to view adoption as a difficult experience which needs to be "worked through" over many months and years and tend to hold the assumption that those difficulties crop up again during life-changing events, such as marriage or becoming a parent. In other words, I felt that issues of identification and over-identification might be at work here, and supervision is therefore extremely important in this area of work. It seemed to me at the time that I have understood some of the challenges that this type of work might involve. However, this is obviously my subjective experience, and I think it is crucial for me to reflect upon how my own, the researcher's, adoption status might have influenced this study, as not only therapeutic work (and why we are training in a particular therapeutic model) but also our research can be influenced by our presuppositions, expectations or beliefs constituting our personal agenda.

My choice to focus my research on adoption counsellors was driven by my own experiences in counselling, in the client and also the therapist role. Naturally, my personal experience has an influence on all aspects of the research process. To begin

with, these areas are the choice of research questions, the searching of the literature, the reading/critiquing of the literature and the construction of the interview schedule.

My idea and the research questions for this study developed through these above-mentioned experiences. It was important to discuss these questions in depth with my supervisor and also to seek support during the construction of the interview schedule. As I am interested in the experience and understanding of adoption counsellors, the questions need to be exploratory and open as opposed to explanatory and closed; achieving this can be a common difficulty for a novice qualitative researcher (Smith, Flowers, & Larkin, 2009). Through informal discussion with peers, supervision and my reflective journal, I realised that I had to broaden my initial research idea, *trust* in therapeutic relationships, as I came to the conclusion that I might impose too many a priori theoretical constructs upon the phenomenon under study. As I am interested in the ‘phenomenon’ of the therapeutic relationship with adult adoptees, I therefore needed a broader research question that would help to tap in to the ‘essence’ of that experience as it was merely my assumption that *trust* in the therapeutic relationship is a concept that participants might have difficulties with. Additionally, Hefferon and Gil-Rodriguez (2011) warn against questions communicating some of the researcher’s ideas about the research topic, which can therefore lead to the researcher inadvertently “structuring the analysis before the process of data collection begins” (Brocki and Wearden, 2006, p.91).

With regard to the literature review/search, I noticed that for me there is a certain emotionality attached to the position of adoptees in research and therapy, which I think could lead to relating too personally to the presented literature. Again, I took extra care whilst doing my literature research to have appropriate supervision in place and to continue the use of my reflective diary, which facilitated the research process throughout.

Concerning the interviews, it is important for me to acknowledge that each therapist's view in my study is unique. My participants share a particular experience – they all work with adult adoptees – and I am interested in exploring what the therapeutic relationship means for them in this context and how they make sense of

it. This might differ from my own view, and it is important in all parts of my thesis and particularly during the interviews to acknowledge my preconceptions.

I make a conscious effort to consider these biases and interests when going into the research process, as there is a part of me that wants to campaign on behalf of adult adoptees, who I feel have not yet received the attention from the field of counselling/psychotherapy that they deserve. Additionally, it is important to remember that this research forms part of my doctorate in counselling psychology. I feel that research from a counselling psychology perspective can contribute to therapists' better understanding of the therapeutic relationship with adopted clients, which will hopefully enhance the therapeutic experience for clients.

Please refer to reflexivity statement II in the discussion section for more information on my position after completing the research.

### **2.3 Context of adoption**

Since adoption obtained legal recognition in England and Wales through the 1926 Adoption Act, nearly a million people have been adopted (UK Office for National Statistics, 2010). The number of adoptions peaked in 1969 with nearly 24,000, but have dropped dramatically during the 1970's and thereafter (UK Office for National Statistics).

Adoption reflects the customs, beliefs and social "preoccupations" of the time and the focus continuously changes to who is recognised to be at the centre of the process - the child, the adopted parents or birth parents (Brodzinsky & Schechter, 1990).

Initially, adoption was a response to the need to find better care for orphans and "war babies" following the First World War (Keating, 2009). At the end of the Second World War, adoption was focused on addressing the "social problem" of unmarried mothers and their illegitimate baby, was viewed as a solution to the problem of infertility and became popular amongst the middle classes (Triseliotis, Shireman, & Hundleby, 1997).

By the 1970's, there had been a decade of rapid social change and as a consequence the nature of adoption practices in the United Kingdom has since changed significantly over the last 40 years. Castle, Beckett, and Groothues (2000) name four main reasons for these changes in adoption: The Abortion Act in 1968, legalising abortion and making it more accessible; more effective contraception in the form of the birth control pill; the improvement in welfare benefits for single parents; and increasing social acceptance of illegitimacy and single parenthood, which has encouraged more unmarried mothers to care for their children.

Fewer children are being adopted and they are often older at the time of placement (Ludvigsen & Parnham, 2004). Babies are now rarely relinquished by their mothers and adoption now is much more likely to follow a period of neglect or abuse and time in care (Department for Education, 2012b). In 2012, only 60 babies were adopted in England (Department of Education), compared to 8500 domestic infant adoptions in 1970 (Thorburn, 2003). In an endeavour to adopt a baby, some people are turning to overseas adoptions, though inter-country adoptions are on the decline and were never as common in the UK as in the US and other European countries (Selman, 2009). The last 40 years has witnessed the growth of adoption as a placement option for older children. Many of these have special needs and histories of abuse and neglect and the adoption of 'looked after' children is now a central feature of the child care system in the UK (Performance and Innovation Unit (PIU), 2000). The focus of adoption has changed from providing children for childless couples to one of providing 'reparative' families for children. The placement of older children and children with special needs resulted in a widening of the range of people considered suitable to adopt and included older adopters, including those with established families, and single and divorced adopters (Triseliotis, et al., 1997). The Adoption and Children Act 2002 has extended this further to include unmarried couples and couples of the same sex.

In March 2012, the government published "An Action plan for adoption: tackling delays" (Department for Education, 2012b). This action plan sets out proposals to change the adoption process for children, improve services for prospective adopters, and strengthen the accountability of local authorities (Department for Education,

2012b). Subsequently, the government launched new scorecards for local authorities that reveal how long it takes to find adoptive parents for children in care (UK Office for National Statistics, 2013).

The age of adoption and the rates of progress for children from care to adoptive placement and then on to adoption itself can therefore vary extremely: For example, for babies who are placed directly from hospital, adoptive family life can start a few days after birth (Monck, Reynolds, & Wigfall, 2003). Meanwhile, a six-year-old boy who is finally removed from his harmful parents, perhaps with his brother or sister, perhaps not, is likely to wait another two and a half years or more before he finally joins an adoptive family (Department for Education and Skills, 2003). Research has shown that age is a risk factor for difficulties and disruptions in adoption; learning and health problems are also exacerbated the longer children are left in neglectful and violent homes (Hart & Luckock, 2004). Children adopted from the public care system are more likely to have experienced poor parenting, neglect or maltreatment and may have experienced frequent moves (Triseliotis, et al. 1997). As a result of these experiences, adopted children may experience a range of psychological difficulties. In addition, some children may have acquired disabilities or health problems as a result of abuse, neglect or in-utero exposure to drugs or alcohol. Each of these difficulties, therefore, brings challenges to the parenting role when adopting such a child.

In an attempt to further speed up the adoption process (see above), the government in the UK set up a number of reforms that came into force in July 2013, including the introduction of a fast-track procedure for approved foster carers and previous adopters who wish to adopt a child (Department for Education, 2013).

There has been an increase in the number of adoptions in the past year: There were 5,206 adoptions entered in the Adopted Children Register following court orders made in 2012, the largest increase in 15 years. This represents an almost 10 per cent increase compared with 2011, when there were 4,740 adoptions (UK Office for National Statistics, 2013).

Occasions remain when birth parents are unable to provide a home for their children. Adoption can be seen as a "fresh start in life" (Department of Health, 2000, p. 3), and provides children and their new parents with an opportunity to re-organise childhood and family life (Hart & Luckock, 2004). Research clearly supports the benefits of adoption when compared with alternative childrearing in foster and institutional care and by birth parents who are ambivalent towards or do not want to parent their children (Bohman & Sigvardsson, 1985; Triseliotis & Hill, 1990; Bohman, 1970). On the other hand, adoption can never provide a clean break from previous experience, and the formation of fresh attachments is partly influenced by the legacy of previous relationships (Hart & Luckock, 2005). Adoptive has become increasingly complex and is being viewed as a lifelong process rather than a single event (Howe and Feast 2000).

## **2.4 Literature review**

The following literature review intends to outline theoretical and contextual issues concerning individuals who have been adopted as infants. After discussing current research findings about adult adoptees' mental health needs and their help-seeking behaviour with regard to therapy, the theory and practice of adoption counselling will be reviewed, with emphasis on the therapeutic relationship in the context of psychodynamic therapy. The role of counselling psychology within the adoption field will be discussed, followed by the presentation of the main research questions.

### ***2.4.1 Psychological impact of adoption***

Whilst some research suggests that adoption creates a psychological risk for the adopted person (Brodzinsky, 1990; Brodzinsky & Pinderhughes, 2002; Cubito & Obremski Brandon, 2000; Levy-Shiff, 2001; Miller et al., 2000; Smyer, Gatz, Simi, & Pedersen, 1998), other studies concluded that the majority of adoptees managed to live lives free of psychopathology (Juffer & van IJzendoorn, 2007; Penny et al., 2007; Saiz & Main, 2004) and have found evidence suggesting that most adult adoptees were stable, well-adjusted and satisfied with their adoptions (for example, Schaffer & Kral, 1988; Triseliotis, 1991).

Levy-Shiff (2001) studied a non-clinical community-based sample of 91 adult adoptees and a matched control group of 91 non-adoptees. Data for this longitudinal study were collected at the ages of 18 and 28 respectively via Likert-type questionnaires. The findings suggested that, on average, adult adoptees had a less coherent and positive self-concept and more pathological symptomatology than did non-adoptees. This study also showed that adoption after the age of six months increased separation distress and increased maladjustment, but that general family functioning was also an important factor. The author concluded that an atmosphere conducive to open, constructive and non-defensive communication, as well as honest exploration of the many issues confronting adoptive family members, permits the adoptees to explore who they really are and supports the resolution of adoption-related conflicts, which in turn enables the development of a stable and positive self view (Levy-Shiff). The study highlighted that adoptees' adjustment should probably be viewed as a process in which personal and familial variables, adoption-related issues and adaptational outcomes have an ongoing interactive influence on one another, because a one-directional causal explanation is not possible through this data. Additionally, using self-reports and selection effects (such as the potential that maladjusted adoptees might be more motivated to take part; the country where the study took place (Israel)) influenced the generalisability of the findings.

Typical areas of difficulty that adopted individuals may deal with throughout life are loss and grief, the lack of genetic information and identity development (Child Welfare Information Gateway, 2004). One universal feature of all adoptions is the early loss of a primary object, an experience referred to as the "primal wound" (Verrier, 1993, p. xxi). This is a contentious theory that many adult adoptees have found helpful despite the lack of empirical research evidence. The idea that the child experiences the separation as abandonment by their birth parents could be criticised by non-relinquishing, but also relinquishing birth parents, as many have left their babies where they could be found and where they were safe.

It has been suggested that feelings of loss are rarely completely resolved in adulthood (Silverstein & Kaplan, 1988) and may intensify at milestone events, such as graduations, marriages and childbirths. For example, Nydam (2007) described

how some adopted adults during the act of giving birth have experienced a surprising wave of grief over the loss of their birth mothers. The lack of information regarding adoptees' origins, including the identity of their birth parents, genetic information and the reasons for their relinquishment, could additionally complicate the formation of a complete and stable identity (Brodzinsky, 1987).

Another area of difficulty could be the building and maintaining of close relationships with others (Corder, 2012), which could include a sensitivity to rejection (Nydham, 2007). Verrier (1993) proposed that the child's experience of abandonment causes the adopted individual to mistrust the permanence of the present caretaker, and therefore defends against further loss by distancing themselves from their parents. Russel (1996) suggested that "If the infant is separated from the only mother it has known for nine months, it will be more difficult to establish trust" (p. 66). Verrier explained that early trust issues may have long-term consequences: "the lack of trust is demonstrated over and over again in the adoptees' relationships throughout their lives" (p. 60).

Weider (1977) too felt that early trust difficulties will have affected adoptees' future relationships: "Adoptees have difficulty trusting her [the adoptive mother] ... or others who come to represent her" (p. 17). The adopted adult might, according to Jones (1997), not trust the idea that anyone would want to form an intimate relationship with them or might not trust that such a relationship would last. The adoptee might then cope with the threat of betrayal and abandonment through distancing and detachment (Bertocci & Schechter, 1991; Partridge, 1991).

These clinical observations are supported in a US study by Borders et al. (2000), who measured the psychological well-being of 100 adult adoptees and a matched group of friends. One of the results was that fewer adult adopted individuals classified themselves as securely attached and more adoptees described themselves as anxious-resistant / avoidant, which suggests that more of the adoptees in their study felt uncomfortable about being close to others.

Another study by IJzendoorn & Juffer (2006) tested a catch-up model of adoption through a series of meta-analyses on more than 270 studies that included more than 230,000 adopted and non-adopted children and their parents. Catch-up was measured in different developmental domains and findings suggested that adopted children out-performed their peers in the domains of cognitive development, school achievement and (lack of) behaviour problems. However, particular in the area of physical growth and attachment security / disorganisation the catch-up with peers was less complete. For late adoptees (after 12 months of age) this also included school achievement. The authors concluded that adoption is a successful intervention that can lead to astonishing catch-up, but they also recommended the increase of support for adoptive parents in facing the challenge of developing an attachment bond with their adopted child.

With regard to specific psychological problems, adopted adults were found to experience symptoms of depression and anxiety (for example, Borders et al., 2000; Cubito & Obremsky Brandon, 2000; Saiz & Main, 2004; Siebold, 2006) and had more personality disorders and higher levels of substance abuse (Sullivan, Wells, & Bushnell, 1995) than their non-adopted counterparts.

However, a meta-analysis by Juffer & van IJzendoorn (2007) found that adoptees' self-esteem did not differ from the self-esteem of their peers. Juffer & van IJzendoorn included 88 studies, which in total compared 10,977 adoptees with 33,862 non-adoptees. They also researched whether there might be a difference in self-esteem of specific subgroups of adoptees when compared to non-adopted persons. The following subgroups were identified: International adoptees, domestic adoptees, transracial adoptees, male vs. female adoptees, adoptive placement before and after first birthday and developmental stages (4-12 years, 12-18 years, and 18+ years). They found no statistically significant difference in self-esteem between adopted and non-adopted persons. However, this analysis solely focussed on one risk factor of psychological difficulties - self-esteem. The researchers concluded that protective factors within the adoptive family may be buffering the ill effects of the risk factors and might result in a developmental catch-up and resilience of the adopted children.

Wierzbicki (1993) conducted a meta-analysis of 66 published studies, which included studies published in English. The researcher compared the psychological adjustment of adoptees with non-adoptees. Findings suggested that adoptees have a greater psychological maladjustment, are over-represented in clinical populations and have more externalising disorders than non-adoptees (this includes, for example, attention deficit hyperactivity disorder and conduct disorder). However, the effect size for adult comparisons was relatively small, suggesting that differences in adjustment may become less noticeable beyond the adolescent years. Wierzbicki's study did not determine the causes of the increased rate of psychological problems in adoptees, as genetic, biological, psychological and social factors may contribute to the increased risk. Also, the review was unable to determine whether adopted individuals are over-represented in therapy clinics due to maladjustment or because of a selection bias, as adoptive parents might be more used to seeking professional help as they have already had contact with social services and are used to resorting to professional help when problems arise (Kadushin, 1966). They tend to have a higher socio-economic status (Jeffrey, 1962), which has been linked to a higher likelihood of seeking psychological support (Scrole et al., 1962). Additionally, only a handful of studies included adult adoptees in this meta-analysis, which highlights the lack of research involving adult adopted individuals. This has been emphasised more recently by Pearson, Curti, and Chapman (2007); they noted that most research focusses on adopted children rather than adult adoptees.

Penny et al. (2007) attempted in their study to explain the variability in adult adoptees' experience of adoption. Recruitment included 100 adoptees aged 35 to 45, found mainly through a state-wide adoption and foster-care agency in North Carolina, United States, and participants were sent a survey pack with questionnaires and open-ended questions regarding adoption. Independent raters were able to classify most adoptees into one of five so-called reconstruction phases, ranging from no or little acknowledgement of adoption issues (Phase 1) to a focus on adoption losses with strong, negative feelings (Phase 3) to a sense of integration and peace (Phase 5). It was found that the participants in Phases 1, 2 and 5 reported positively about adoption and psychosocial functioning, whilst Phase 3 participants described

adoption at the point of the survey as negative and exhibited, for example lower global life satisfaction, higher depression levels and lower self-esteem. However, these phases cannot be treated as sequences as participants were not asked how they arrived at the different points because cross-sectional data were collected at a particular time of the participants' lives. Interestingly, the authors derived the question from their data whether all adoptees have to experience intense, difficult struggles regarding adoption. Their study suggested that participants in Phases 1 and 2 achieved psychosocial health without such a struggle. They hypothesised that this could mean that being adopted is less central and important for some adopted adults. This exploratory study is one of the first to research empirically the reconstruction of adoption issues across the life span. However, most study participants were women (78%) in the US, well-educated and of high socio-economic status, who were adopted during the 1940s and 1950s, and two-thirds indicated that they received counselling at multiple points in their lives. Caution is therefore needed when drawing conclusions from this quantitative study as it failed to obtain a widely representative sample. Furthermore, the high female ratio limits generalisability and may prevent drawing conclusions about how gender may affect the experience of adoption.

With regard to help-seeking behaviour, a recent qualitative study by Jordan and Dempsey (2013) set in the UK explored the experience of adoption, and 14 Caucasian adult adoptees were interviewed. Grounded theory was used to analyse the data. One of the themes that was identified dealt with the support that participants accessed to help with adoption-related issues. They found an absence of formal support seeking, which was due to a lack of recognition of the need for support and a lack of knowledge that there were support services available. Instead, some participants used alcohol and drugs throughout their twenties to cope with adoption-related issues. Four participants accessed counselling with regard to adoption issues and reported that it helped them to untangle the influence of adoption on identity formation and relational behaviour. Participants also reported that speaking to another adopted individual was more beneficial than speaking to non-adopted individuals. The authors concluded that adopted individuals have a more in-depth understanding of adoption-related issues and stressed the importance of further

research in order to understand the adoption process and related emotions better. The study attempted to provide an in-depth understanding of participants' experience of adoption. Due to the lack of research in this area, it is explorative in its nature and further (qualitative) studies are needed to research adopted individuals' experiences of adoption and formal support services.

Contrary to the above findings, quantitative studies have consistently reported greater referral rates for adopted individuals to psychological services than for their non-adopted counterparts (for example, Borders et al., 2000; Jones, 1997; Juffer & Van Ijzendoorn, 2005). As mentioned before, caution is needed in interpreting such studies, as it has been found that seeking help was related to family variables, such as pre-existing relationships of adoptive parents with mental health professionals, heightened vigilance for or reactivity to potential problems, the likelihood of attributing the problem to adoption and adoptive families' higher socio-economic status and/or education levels, as well as psychological problems that could explain the difference. Despite these underlying reasons for a referral, most research suggests that adoptees are seen in mental health services in greater proportion than their incidence in the general population (Kennedy Porch, 2007). It therefore seems likely that mental health professionals will be working with adult adopted individuals at some point in their career, and this emphasises the importance of therapists educating themselves about possible adoption issues.

Care is also necessary when applying US findings in a UK context as adoption samples differ, for example, due to the different types of adoption, the varied ages of children at adoption or the levels of developmental difficulties at placement. Also, European research involves inter-country adoption rather than domestic adoption, which can carry additional issues for adoptees.

To conclude, the experiences of adopted adults and the emotional consequences differ due to different adoptive and pre-adoptive experiences and individual variability in temperament, resilience, personality and perception. It is therefore important not to over-generalise adoptees' experiences and to acknowledge that most adult adopted individuals are happy and healthy (Penny et al., 2007): Each adoptee

has a unique experience of being adopted, which should be respected and worked with in therapy.

#### ***2.4.2 Psychological support for adult adopted individuals***

According to Kreisher (2002), the need for support after adoption can be a lifelong process, and adult adoptees are more likely to seek psychological support when they are starting a family or struggling with questions about their biological and cultural backgrounds. Over the past four decades, support services for adopted adults have therefore developed to include birth records counselling, counselling, intermediary services and various groups, including those for transracially adopted adults (Harris, 2004). In the UK, the Adoption and Children Act 2002 (Department of Health, 2003) contains a new entitlement for adoptive families, adopted adults and birth relatives to receive an assessment of need for adoption support, however this does not contain an entitlement to services. Guidance sets the minimum support services that a local authority must either provide or commission. These services should be offered alongside or delivered by mainstream child and family services (Hart & Luckock, 2004).

The right for an adopted person to have access to his or her birth records on reaching age 18 was consolidated in section 51 of the Adoption Act 1976 (Department of Health, 2003). For adults who were adopted before 30 December 2005 the Adoption and Children Act 2002 provides the option to receive birth records counselling prior applying for a copy of their original birth certificate. This is to support them during the process of sharing or receiving information. Individuals who were adopted prior to 12 November 1975 are required to attend birth records counselling in order to be given the information necessary to obtain this copy. An adoption social worker or counsellor meets with the adult adoptee to discuss, for example, the implications and the consequences that receiving the information on the original birth certificate and adoption record can have on their lives. Also, adopted adults now have the right to ask an intermediary agency to obtain information about their adoption and/or trace an adult adopted birth relative and establish contact if it is welcome (Department of Health, 2003).

Before the Act became law in December 2005, therapists could provide adoption support to clients through psychotherapy and counselling (Rogers, 2010). The passing of the Act changed the situation, and the provision of adoption support as the main focus of the work with a client now requires registration as an Adoption Support Agency (ASA) with the Office for Standards in Education, Children's Services and Skills (Ofsted). Since April 2010, therapists under contract with an adoption agency or a registered adoption support agency are no longer required to register with Ofsted as individuals. According to the Adoption and Children Act (Department of Health, 2003), adopted adults are considered to be "vulnerable", because many children who become available for adoption in the UK have suffered trauma, including abuse and neglect (Rogers). Hence the Act was also introduced to ensure the provision of services from therapists who are both qualified and experienced and are thus expected to be more able to meet the particular needs of this group.

In the UK the qualification to become an Adoption Support Agency (ASA) registered counsellor can be attained through attending an "adoption counselling expertise" course, which is generally a 20-day course, spread over six months. The course includes information and expert training on adoption, including historical, legal, social and psychological aspects (theoretical models as well as clinical interventions). At the end of this course, large organisations or small groups can be registered as ASAs – subject to payment of a registration fee and an annual fee, an interview and an inspection – with Ofsted. Rogers (2010) argued that the requirement for practitioners to register makes therapeutic services less available rather than more available to people affected by adoption; however, no empirical evidence is currently available to reflect her concerns.

Traditionally, therapists have erred on the side of minimising the influence of adoption on their clients (Lifton, 1990; Rosenberg, 1992), which has resulted in their colluding in avoidance and risking repetition of empathic failure which these clients may have experienced with their adoptive parents (Carizey, 2004). Adoption experts argue that it is important for practitioners to understand the complexities of its psychological consequences to better serve individuals that are affected by adoption

(Barth & Miller, 2000; Okun, 1996; Pavao, 1998). While many books have been written about the experience of adoption triad members, little has been written about specific training for therapists desiring to work with adoption triad members and the clinical practice of adoption counselling (Janus, 1997). Also, authors have expressed concern that too often adoptees and their families find themselves in the position of teaching therapists about the most basic issues of adoption (Casey Family Services, 2007; Sass & Henderson, 2002; Smith & Howard, 1999).

A study by Sass and Henderson (2007) tested the hypothesis that psychologists need more education about the effects of adoption on triad members. Data were gathered from 210 psychologists in the United States, who filled in a questionnaire that consisted of structured and open-ended questions. Ninety per cent believed psychologists need more education about issues in adoption and 65% reported having no courses that dealt with adoption while at graduate school. Fifty-one per cent of these psychologists reported that they were only "somewhat prepared" to deal with adoption issues and 21% reported they were "not very prepared" or had "no knowledge of adoption issues". An important discussion point of the study is that even if adoption is not the focal issue for therapy, adoption might be an associated component or area of concern. Support for this was provided by the high percentage of adoptees who reported interest in discussing adoption in therapy (Sass & Henderson, 2002). Also, therapists who addressed adoption as an important clinical issue were perceived as significantly more helpful compared to those therapists who did not address the adoption experience (Sass & Henderson, 2002). Even though the questionnaires in their latest study were very brief and did not include information about the psychologist's age and gender, the findings emphasised the importance of adoption-related training. By enhancing their knowledge, therapists tended to be better equipped to support clients who present with adoption-related issues in clinical practice.

#### ***2.4.3 Psychodynamic perspectives on adoption***

Due to the aforementioned complexity of issues that adopted adults might experience and seek psychological support for, establishing and ending the therapeutic relationship in a sensitive manner is important (Jordan & Dempsey, 2013).

Psychodynamic and psychoanalytic traditions were the earliest theories to explore and value the relationship between therapist and client. Westen (1998) suggested in his review of psychoanalysis that all contemporary psychodynamic theories agree with five postulates.

1. A large portion of mental life is unconscious.
2. Cognitive and affective processes operate in parallel so that people who have conflicting motives, thoughts and feelings toward the same situation or person often activate psychological defences to deal with these conflicts.
3. Childhood experiences play a crucial role in the formation of adult personality.
4. Mental representations of the self and others are major components of personality, and they often explain a person's behaviour in interpersonal and social settings.
5. Healthy personality development reflects a move from a socially dependent state to a mature autonomous one.

Psychodynamic theories believe that the therapeutic relationship is a container which serves to allow clients to act out dysfunctional relationships and patterns from their lives. This is central to the therapeutic work as the therapist observes the relationship and the transference and countertransference reactions in order to inform further interventions.

Transference involves the displacement of thoughts, feelings and fantasies that were originally about important figures in childhood onto the therapist. It provides vital information and clues about a client's past and about why a client is feeling what he or she is feeling about others outside the therapy (Eichler, 2010).

Countertransference involves a phenomenon similar to transference, which this time occurs on the part of the therapist towards the client (Eichler, 2010). Thoughts, feelings and fantasies from the therapist may be displaced onto the patient as part of the regression that can take place within the therapeutic encounter. Sometimes the

term countertransference is also used to define a "reaction" on the part of the therapist "to the patient's transference" (Moore & Fine, 1990, p. 47). Again, these reactions provide valuable insights about the therapeutic interaction and additionally reveal much to the therapist about her/himself, because those regressive tendencies occur in the client and in the therapist (Eichler, 2010).

Psychodynamic perspectives, but in particular attachment theory, which today is best conceptualised as integrationist and multidisciplinary (Levy, Meehan, Temes, & Yeomans, 2012), seem applicable to clinical work with adult adoptees whatever the therapist's primary psychotherapeutic model might be. Attachment theory is influenced by other lines of thinking in constructing an empirically based theory of personality and social development (for example, evolution, ethology, control systems, cognition and neurology) (Clulow, 2001). From an attachment perspective, the formation and maintenance of adoptive relationships involve many atypical events and circumstances for adoptees that can have an influence on interpersonal functioning (Shaver & Mikulincer, 2005), including the therapeutic relationship.

Bowlby's attachment theory (1969; 1973; 1980), which adheres to Westen's (1998) five postulates, is built on the object relations principles: the need for relationships and the relational structure of the self (Gomez, 1997). Attachment theory postulates that human beings are born with inbuilt patterns of behaviour that promote and maintain relationships; relatedness is therefore seen as a fundamental motivating force in human behaviour (Huprich, 2009). Bowlby regarded attachment as having "its own internal motivation distinct from feeding and sex, and of no less importance for survival" (Bowlby, 1988, p. 136).

Early experience can affect the ability of an adult to form trusting relationships. McGinn (2007) suggested that an appreciation of the impact of the child's pre-adoptive experiences and an understanding of the need for attachment building will improve the chances of achieving healthy attachment outcomes for children placed in adoptive homes. However, when attachment figures are not reliably available and supportive, a sense of security is not attained and serious doubts about one's self-efficacy and others' intentions are formed.

To assess the representations of the attachment relationship, Ainsworth and colleagues have created the "strange situation technique", which is explained elsewhere (for example, Huprich, 2009, p. 79). Through this technique, Ainsworth et al. have been able to identify three kinds of attachment: secure, anxious-resistant and avoidant patterns. Later on, an avoidant / ambivalent and a disorganised / disoriented pattern have been added.

Attachment theory suggests possible long-term implications of potential difficulties: Experiences with caregivers are gradually internalised in the form of working models or generalised as expectancies about the self in relation to others. As working models are relatively stable and play an active role in guiding later interactions (Shaver, Collins, & Clark, 1996), negative experiences early in life are likely to influence adult adoptees' relational attachment (Feeney, Passmore, & Peterson, 2007).

Feeney et al. (2007) examined in their Australian study the influence of adoptive status and family experiences on adult attachment security and how attachment predicts relationship outcomes. 144 adults, who were adopted as infants and 131 non-adoptees were included in the study and filled out questionnaires at recruitment about attachment security, parental bonding and reunion experiences. Six months later, participants completed the same measures of attachment security again. In addition, they also completed questionnaires that measured risk in intimacy, loneliness, relationship quality and relationship changes. Key findings in this study was that insecure attachment seemed more prevalent among adoptees than among non-adoptees. Adoptive status itself predicted perceived risk in intimacy and reports of family and social loneliness. However, the self-reported parental bond was a more powerful predictor of the attachment dimensions than was the adoptive status. Attachment seemed to mediate the association between adoptive status and relationship outcomes: Negative associations of adoptive status with intimacy, family and social loneliness were fully mediated by an avoidant or anxious attachment style. The findings suggested that adoption may present a risk factor for relational difficulties later in life, at least in terms of family relationships, general

perceptions of intimacy / belonging and reactivity to relationship stressors. However, the adoptive status only explained small (but statistically significant) amounts of variance in the relational measures, although the attachment dimensions provided relatively strong prediction. These outcomes highlight the role of adoptive parents in the bonding process and the utility of attachment theory in understanding adoptees' relationship concerns.

Edens and Cawell (1999) also proposed the utility of attachment principles in their review study of adoptive relationships. The authors noted that adoptees may be at greater risk of prenatal or birth complications and parental psychopathology; in turn, such factors might increase the likelihood of particular attachment behaviours (for example, the dislike of being held) that make the role of adoptive parents more difficult. Adoptive parents might also experience a lack of role autonomy and uncertainty about role obligations, which might interfere with the bonding process. Also, disclosure of adoptive status might lead adoptees to feel they do not "belong" in the adoptive family. However, due to the limited amount of empirical research available that directly addresses the proposed relation between adult attachment style and interpersonal adjustment of adoptees over time, any generalisations have to be made with caution.

Individuals who are not securely attached tend to be less likely to experience trust in the therapeutic relationship (Simpson, 2007). Therefore understanding particular attachment issues and processes could help and guide counselling psychologists and other therapeutic professions who work with adoptees to understand the process of therapy. Attachment interventions are based directly on attachment principles (for example, Davilla, 2003; Johnson, 2003), and the role of the therapist is to create a secure base from which the client could explore him- or herself and relationships with others (Bowlby, 1988). Neuroscience and attachment research over the last three decades have confirmed that the loss of, or damage to, the baby's primary attachments through abuse and neglect can have a long-lasting affect on the child's ability to develop normal neural connections in the brain which facilitate mood regulation and trust in the self and others, so helping them to achieve optimal emotional and social functioning can be one of the therapeutic aims (Raicar, 2010).

This recognises the traumatising nature of loss and rejection, the self-fulfilling nature of working models and the therapeutic effects of interventions that focus on the need for secure emotional connections.

If adoption can have consequences for the development of the adopted person's self, the attachment to others and object representations, it might therefore have consequences for the therapeutic encounter. It is thus important that therapists beginning work with adopted clients are aware of these potential consequences.

Some authors have discussed the relevance of transference, countertransference and their manifestation in the therapeutic relationship with clients that present with adoption-related issues (for example, Zuckerman & Buchsbaum, 2007; Deeg, 2007).

Deeg's (2007) book chapter presents a psychoanalytic approach to understanding and treating adoptees, developed from his clinical experience. He suggested that adoption brings important and uniquely relevant idiographic information that increases the likelihood of specific dynamics. His notion of binary transference means that the transference to the therapist typically consists of affects connected to both sets of parents, biological and adoptive. He hypothesised further that the unfolding of this transference confronts adoptees with real loss and is met with the "full spectrum of affect and affect-infused relational derivatives" (Deeg, 2007, p. 466) that impacts the therapeutic relationship. According to Deeg, therapists need to acknowledge adoption-related issues whilst not perceiving the adoptee's self as something "special" that needs a different approach to therapy. An implication for the therapeutic relationship from the concept of binary transference seems to be that therapists need to be alert and open to the emotions that come up within the therapeutic relationship. These emotions can be related to adoptive or biological parents, who are either devalued or idealised, and they could manifest themselves in various patterns in the relationship with the therapist.

The clinical literature describes how work with adopted persons can be hard (for example, Dresser, 1988; Jones, 1997; Muller, 1989), and Jones (1997) concluded that working with adoptees can challenge our links to our parents as well as those to our children. Rogers (2010) argued that adoption support therapists "need to be able

to bear the weight of all the losses and grief of the adopted clients and [...] survive its enactment in the therapeutic space" (p. 3).

To date there is little empirical evidence available regarding how the therapeutic relationship is experienced and understood by adoption counsellors. Evidence relies heavily on single case studies described by practitioners working with adoptees and on anecdotal evidence to inform clinical interventions (Baden & O'Leary Wiley, 2007).

## **2.5 Adoption and counselling psychology**

Adoption has captured the attention of researchers and practitioners in many fields, including social work, psychiatry, anthropology and law (Brodzinsky et al., 1998). However, psychology has been less active in the field of adoption, and so far, research in adoption has focused almost exclusively on adopted children rather than on adult adoptees (Freundlich, 2002) even though it has been acknowledged that adoption is a lifelong process (for example, Kreisher, 2002). The sparse research on adult adoptees has almost entirely been on psychological adjustment and search / reunion rather than on therapy research (Zamostny et al., 2003). Sass and Henderson (2002) concluded that data from clients and therapists would enhance adoption research related to therapy practices in adoption.

Most research on adoption issues has been conducted in the USA, and this literature review cites numerous US publications to support the rationale for this study. Part of the reason for the shortage of research in the UK from a counselling psychology perspective could be attributed to the fact that counselling psychology is a relatively new discipline in the UK (Orlans & Van Scoyoc, 2009). There are, however, obvious contrasts between the USA and the UK. For example, the UK has universal healthcare and the role of the state in the lives of children is more pervasive (Bullock, 2006). Therefore, definitions of, understandings about and research on adoption need to take into account the historical and cultural context in which it occurred.

Counselling psychologists are in a special position from which they can offer a valuable contribution to understanding the therapeutic relationship when working with adult adoptees, as counselling psychology is a discipline that traditionally sees the therapeutic relationship as its most powerful medium (du Plock, 2006). Relational perspectives can make an enormous contribution to understanding people and working towards greater well-being (Milton, 2010), for example the obvious focus in terms of relationships between therapists and clients.

Although informative, adoption research from related mental health professions such as clinical psychology, psychotherapy and counselling may have limited applicability to counselling psychology, considering the distinctive values and roles of counselling psychologists. Apart from the emphasis on the therapeutic relationship, a number of other key philosophical principles set the discipline apart from other applied psychologists such as clinical and health psychologists. Counselling psychology is underpinned by a humanistic-phenomenological paradigm, emphasising respect for the personal and subjective over and above assessment and diagnosis (Strawbridge & Woolfe, 2010), and in a sense bringing back the counselling aspect into psychology, that is, being interested in the holistic view of human experience (Milton, 2010). Another distinctive feature is the requirement for personal therapy during training (Orlans & Van Scoyoc, 2009), stressing the importance of becoming reflective practitioners. Counselling psychology seeks to combine reflective and scientific practice in a way that is not shared with other areas of psychology (Lane & Corrie, 2006). Counselling psychologists' training in research methodology and clinical interventions can be used to increase awareness of issues that might arise with adopted adults in therapy from the view of adoption counsellors, as this is a population rarely attended to in psychology.

It has been suggested that professionals who work with adult adoptees must acknowledge the diversity and complexity of each adopted person's story, avoid overgeneralising in relation to this heterogeneous population and respect adoptees' individuality (Baden & O'Leary Wiley, 2007). The values and traditions of counselling psychology, that is, the importance of the helping / therapeutic relationship, the focus on well-being and personal development and the reflective-

practitioner and scientist-practitioner roles (Strawbridge & Woolfe, 2010) are a good fit with the needed increase in the knowledge base on adoption. The emphasis of counselling psychology on its acceptance of diversity and competing ideas along with respect for and utmost values of the phenomenological world of the client it seeks to serve (Hall, 2010) can be seen as particularly relevant to qualitative research within the adoption field.

## **2.6 Summary and research rationale**

Studies suggested that adopted adults can experience a variety of psychological issues and are over-represented in therapy services. Psychodynamic perspectives on adoption emphasised the occurrence of attachment-related difficulties that can influence interpersonal relationships, including the therapeutic alliance. Additionally, adoption-specific transference and countertransference modes can be played out in the therapeutic relationship, which might involve internalised relations with biological and adoptive parents that are projected onto the therapist.

More empirical studies that contribute to an in-depth understanding of therapists' experience of the therapeutic relationship with adoptees are needed, as studies of this population are notably lacking. Given the aforementioned complexities regarding therapeutic relationships that have been proposed to exist with individuals who have been adopted as children and present in therapy, and counselling psychology's philosophical basis and emphasis on the therapeutic relationship, questions about the nature and role of the therapeutic relationship in psychological therapy with adult adoptees would seem to be of particular interest and relevance to counselling psychologists.

Additionally, the literature review has demonstrated that attempts to develop frameworks that guide clinical practice have emerged. However, empirical research elaborating and testing these theories that inform practice work with clients has lagged behind, which limits the understanding of the influence of adoption on the therapeutic process. Also, these studies lack an exploration of the more in-depth subjective experience of adoption and how therapists perceive their relationship with adult adopted clients. This study is therefore in line with counselling psychology's

endeavour to engage in ongoing research that may have a bearing on practice, as the subjective experience of the therapeutic relationship with adult adoptees is currently underexplored.

It is believed that obtaining the views of experienced, practising adoption counsellors through in-depth interviews is a means of gaining an enhanced appreciation of the complexity of understanding the therapeutic relationship when working with adult adoptees.

## **2.7 Research questions**

The main questions the study addresses are:

- How do therapists experience the therapeutic relationship with clients who were adopted as infants?
- Are there any particular characteristics, challenges or issues that therapists experience when working with adult adoptees (compared with working with clients who were not adopted)?
- Do therapists modify or adapt their practice when working with adult adoptees?

### **3. Methodology**

#### **3.1 Research design and rationale**

The study will take a qualitative approach to investigate therapeutic relationships with adult adoptees from the perspective of the adoption counsellor, using semi-structured interviews. Several reasons why Interpretative Phenomenological Analysis (IPA) was considered the most appropriate methodology for this investigation are explored in the following sections.

##### ***3.1.1 Quantitative and qualitative research***

The general characteristics of quantitative and qualitative methods clearly differ, and the distinctions between these research approaches are typically framed in terms of opposites: realist versus relativist; objective versus subjective; deductive versus inductive; and normative versus interpretive. Historically, research carried out in the disciplines of psychology and psychiatry adhered to a concept of science represented by practices such as experimentation and accurate measurements of variables (McLeod, 2003a). Traditionally, quantitative scientific methods of inquiry were considered transparent and value-free. Some psychologists suggest that quantitative research may operate more successfully at the "macro level" of constructing and testing psychological models and that such work can be enhanced by "micro level", qualitative research, therefore opposing the traditional distinction between these two research methods. By illuminating individuals' subjective experiences, qualitative methodology may reveal previously unrecognised processes that are at work within the macro-level models, and it is the chosen research method for this study.

Qualitative researchers can lay claim to a range of diverse research traditions, some of which were allied to particular disciplines in social science, such as phenomenology which derived from philosophy and ethnography from social anthropology (Miller & Crabtree, 1999). There are multiple approaches to analysing data generated by qualitative enquiry, including narrative psychology, grounded theory, IPA and discourse analysis. Given the multiplicity of perspectives within paradigms, research traditions, methods and approaches to data analysis, qualitative research cannot be considered a single, homogeneous entity. However, there are

general characteristics that are shared, for example inductive analysis (used to search for similarities in broad categories and then develop subcategories) underpins the design, fieldwork and analysis of most qualitative research (McLeod, 2003a). Furthermore, reflexivity and subjectivity underpin qualitative studies and imply that no research can be an objective endeavour (Rafalin, 2010).

Traditionally, the discipline of counselling psychology has recognised that positivist research methods may not place the participant at the centre of the enquiry; therefore qualitative methods may seem more congruent with its subjective interpretative base and the key defining and differentiating principle of counselling psychology, which is to engage with people in ways that attend to each individual's unique experience (Rafalin, 2010). Qualitative research in the counselling/therapy field enables hearing about practitioners' own views, theories, approaches to and intuitive hunches about practice that allows the reader of this research to draw upon their experience (Finlay, 2011) and also appreciates the differences in and individuality of the therapists' responses in this study.

Numerous quantitative measures to research the therapeutic relationship have been developed (Kivnick & Kavka, 1999) and the most widely used are the Working Alliance Inventory (WAI) (Horvath & Greenberg, 1989) and the California Psychotherapy Alliance Scale (CALPAS) (Gaston, 1991). With its focus on quantifiable variables and the production of statistical data, quantitative research however does not allow for the exploration of personal meaning and cannot provide an insight into the 'lived' experiences of participants. This study is interested in highlighting the *processes* that occur within the therapeutic relationship and how the therapists involved in this inter-subjective experience make sense of their experiences. With the phenomenological underpinnings to the approach in this research, an 'insiders' perspective will be contributed, allowing for 'thick descriptions' that may help illuminate human experience.

### ***3.1.2 Interpretative Phenomenological Analysis (IPA)***

Interpretative Phenomenological Analysis (Smith, 1996) is a qualitative approach that is deemed to be particularly valuable for understanding the "lived" experience of

the individual participant. Furthermore, this approach is useful where the topic under study is dynamic, contextual, subjective and relatively under-studied and where issues relating to identity, the self and sense making are important (Smith, 2004). IPA therefore seems compatible with the research questions and it is congruent with the overall theoretical framework of this study.

The roots of IPA lie in phenomenology, Husserlian hermeneutics and symbolic interactionism (Smith, Flowers, & Osborn, 1997). The philosopher and mathematician Edmund Husserl depicted phenomenology as a reflective study of the core of consciousness, experienced from the first-person viewpoint. This entails a “redirection of thought away from its unreflective and unexamined immersion in experience of the world to the way in which the world manifests itself to us” (Thompson & Zahavi, 2007, p. 69). Symbolic interactionism is related to phenomenology in that it is also concerned with first-person viewpoints. It is a sociological theory, developed in the 20th century in the USA, which attempts to explain human behaviour as the outcome of the subjective meanings attached by individuals to other human beings, social situations, events and physical objects. The theory posits that social interactions are conducted through symbols, including language, that are created by human beings to refer to subjective perceptions of matters rather than to the objects or events themselves. As a sociological approach, it developed along separate lines from phenomenological branches of philosophy and, typically, has been employed by sociologists to investigate behaviours in smaller communities. Hermeneutics pertains to interpreting and explaining language, traditionally written texts. Idiography is another theoretical underpinning of IPA and aims for an in-depth focus on the particular and commitment to a detailed finely textured analysis (Smith, 2004).

IPA is phenomenological because it explores people's perceptions of the world and their experiences in it (Giorgi & Giorgi, 2003), and it is interpretative, or hermeneutic, in that it gives the researcher a key interpretative role in making sense of people's subjective, spoken or written accounts (Finlay, 2011). According to Smith (2004), IPA involves a double hermeneutic in which the

*"participant is trying to make sense of their personal and social world; the researcher is trying to make sense of the participant trying to make sense of their personal and social world." (p. 40)*

Whereas a phenomenological analysis is essentially a descriptive account of the first-person viewpoint, the double hermeneutic in data analysis is distinctive to IPA. IPA aims to allow the researcher to develop an analytic representation of the participant's account, which should be prompted by, and clearly grounded in, but may also go beyond, the participant's own sense making and conceptualisations (Smith et al., 2009). A detailed IPA analysis can involve asking critical questions of participants' accounts. Thus, interpretation can be descriptive and empathic, aiming to produce "rich experiential descriptions", and also critical and questioning "in ways which participants might be unwilling or unable to do themselves" (Eatough & Smith, 2008, p. 189).

The aim of the research in this qualitative study was not only to present my interpretations of individuals' accounts of their own interpretations of the role of the therapeutic relationship when working with adult adoptees, but also for me, the researcher, to relate themes identified in those accounts to psychological concepts found in the existing literature. Hence the double hermeneutic methodology of IPA was selected for this study.

It is understood that the epistemological emphasis within IPA is relatively flexible, and occupies a position somewhere between critical realist and social constructivist. Critical realism holds that human beings are bound to a reality that is independent of our consciousness and thoughts (Eatough & Smith, 2008; Houston, 2001), but that "all meaning to be made of that reality is socially constructed" (Oliver, 2012, p.372). Oliver argues that critical realism goes some way to bridging the gap between positivist ideas of quantitative research, which insists that we can search for evidence of a concrete and testable reality, and social constructionist ideas, which insist that reality is merely constructed as a social phenomenon. A social constructionist perspective holds that the social world, and therefore human experience, is "socially manufactured through human interaction and language" (Houston, 2001, p.846) and

“reality, is an invention or artefact of a particular culture or society” (Kelly, 2008, p.21).

### ***3.1.3 Alternatives discounted***

Whilst the rationale for using a qualitative approach and the appropriateness of IPA in this study have been discussed, it is also important to consider why other qualitative methods were discounted during the development of this study.

One of the first formally identified qualitative methods is grounded theory (Glaser & Strauss, 1967), which emerged from sociology in the 1960's and was created to research and describe social processes in the social science that was closely linked to the data. It aims to work from qualitative data to develop new, bottom-up theory by achieving "saturation" of the emerging themes. That aim guides the ongoing recruitment of new participants and/or the employment of different methods of data collection (Wimpenny & Gass, 2000). However, many different forms of grounded theory exist today, for example, full vs. abbreviated version and empiricist vs. social constructionist. Whilst the empiricist grounded theory is more closely linked to a more positivist stance, which assumes that the data is there and the researcher needs to find it, social constructionist grounded theory see categories as constructed by the researcher rather than emerging.

Empiricist grounded theory uses larger sample sizes within a heterogeneous sample. Purposive sampling (selected because of their relevant personal experience) in IPA may be contrasted with grounded theory, which would typically use theoretical sampling. It claims an ability to generalise based on the theoretical saturation and large samples. This may involve developing explanations for participant's accounts (Smith et al., 2009), which is not an aim of this research, and does not emphasise the lived experience to a great enough degree as required.

Grounded theory is highly time-consuming and, due to the time constraints of this research, difficult to employ. Furthermore, triangulation, through using different participants or data collection methods, does not play an equivalently important role

in IPA, where the emphasis throughout remains on discussing idiographic findings in relation to the existing psychological literature.

IPA and grounded theory focus on meaning making, but IPA focusses on how people make sense of phenomena, uses smaller samples to understand how a certain homogenous group of people make sense of their experiences. As this study is more interested in the personal sense making and meaning of the participant's experience rather than the development of an explanatory level account, IPA was deemed more appropriate.

It is for these reasons that it was decided that the emphasis within IPA was more appropriate, and grounded theory was not employed.

Another common qualitative approach is discourse analysis, which embraces a range of perspectives and aims and is useful to question the socio-political values and assumptions that underlie mainstream psychology (Crossley, 2000). It arose in the 1960's and is based on textual data. Language is seen as a social performance and the discourse is seen as constructing reality and not reflecting it. Hence discourse analysis focusses on the conversational features and linguistic resources participants drawing upon to account for their experience - and therefore construct their experience (Finley, 2011). Discourse analysis looks at the function of overlapping, turn-taking and topic initiation and generally uses naturalistic conversation and not interviews. There are two different branches of discourse analysis: Discursive psychology and foucauldian discourse analysis. Whilst discursive psychology analyses how people use words and language to achieve certain things, which emphasises the performative aspect of words, foucauldian discourse analysis focusses on the power element of language - how words can be used to construct the social world.

Its focus of research is therefore not people's idiosyncratic mental processes, as in IPA and in what constitutes this research, but their interpretative repertoires or resources. It shares with IPA the commitment to language and speech, but IPA analyses what participants say in order to learn how they are making sense of their

experience and the connections with embodied emotional dimensions. This is consistent with this study, which assumes a relationship between what a person expresses and what they believe.

### **3.2. Ethical considerations**

#### ***3.2.1 Ethical approval***

References to ethical considerations, including privacy, sensitivity, safety and reciprocity, are made throughout the research. The planning and implementation of the research was conducted within the British Psychological Society Code of Ethics and Conduct (2006) and the British Psychological Society Code of Human Research Ethics (2010). Ethical approval from the Departmental Ethics Committee at the Department of Psychology and Human Development at London Metropolitan University for interview questions and procedure was secured prior to the commencement of this study. Appropriate consent and information forms were administered and participants were clearly informed about the rationale of the project.

#### ***3.2.2 Briefing, debriefing and informed consent***

After individuals initiated contact, they were supplied with a consent form assuring anonymity, ample opportunity to terminate the interview at any stage and the removal of their data from the study during the first two weeks after the interview (Appendix 3). They also received further information about the study, which was also sent out via that email (Appendix 1). A convenient time for each interview was arranged with suitable participants, who were also informed that they would have the chance to ask further questions they might have prior to the interview.

Interviews took place at a mutually convenient time for the participant and the researcher and most interviews were conducted in a consulting room at the post-adoption organisation X. For some participants, their private practice room or, in one case, a public space was more convenient and the interviews were conducted there. In all cases the interviews took place within an environment where interviewees felt comfortable. Participants who are given the power to choose the interview site may

feel more empowered in their interaction with the researcher (Elwood & Martin, 2000). However, the choice of interview sites also raised privacy and safety issues. Due to personal circumstances, one interview took place in a public space (coffee shop) where we were able to talk confidentially; however, the background noises made the transcription of the interview very difficult. In all other interviews, no one but the interviewer and interviewee were present at the venue. A charged mobile phone was taken along to all interviews and an appropriate person was told by the researcher about the location and duration of the interview.

After the interviews, participants were given the opportunity to talk about concerns and thoughts they might have had and to ask any questions that arose during the interview. Participants were thanked for their involvement and fully debriefed, and the rationale of the study and the research questions were explained in further detail (Appendix 5). The participants were given the opportunity to request a final copy of the research report. Verbatim transcriptions were produced and served as the raw data of this study.

### ***3.2.3 Confidentiality***

Participants were made aware of the steps taken to ensure confidentiality and to preserve anonymity. In the interview transcripts, care was taken to ensure that information was kept anonymous to ensure that personal identification could not be made and that only the researcher knew the true identity of the participant. During analysis, a pseudonym was used to ensure anonymity and to ease discussion and respect confidentiality. All written data are kept in a locked filing cabinet at the researcher's home and electronic data are stored in a password-protected home computer.

The consent form made participants aware that the research was conducted within the British Psychological Society Code of Ethics and Conduct (2006). On this basis, the limitations of confidentiality and the procedure for breaking confidentiality in accordance with these guidelines were explained.

### **3.3 Participants**

#### ***3.3.1 Sample size***

Given the complexity of most human phenomena, IPA studies usually benefit from a concentrated focus on a small number of cases (Smith et al., 2009). For student projects and also for many studies by experienced researchers, a sample size of between three and six participants is deemed reasonable. In order to offer an analysis that does not lose the "subtle inflections of meaning" (Brocki & Wearden, 2006), whilst still allowing a large enough range of individuals to talk about their experience in depth, six participants were recruited via self-selection. The number of participants has therefore been purposefully kept small and homogeneous in line with the ideographic method of IPA in order to reveal these meaningful structures in the data (Smith et al., 2009; Smith, 2004).

#### ***3.3.2 Inclusion criteria***

A closely defined group of participants was therefore sought for semi-structured interviews, which tend to facilitate rapport, allow greater flexibility of coverage, produce richer data and allow the discovery of new areas (Smith & Osborn, 2008). Interviewees were required to be registered by an Adoption Support Agency (ASA) under the Adoption and Children Act 2002 as a post-adoption counsellor or to be undertaking referral work from adoption agencies or registered adoption support agencies. No exclusion criteria were set in terms of gender, age, race, sexual identity or other demographic characteristics. However, participants needed to have been working with adult adoptees at the time of the interview for at least two years. This was considered necessary as a certain level of experience can create greater richness to their accounts and hence to the data. The six participants formed a reasonably homogeneous, purposive sample (Smith & Osborn, 2003).

Table 1: Participant information

<b>Pseudonym</b>	<b>Theoretical orientation</b>
"Karen"	Integrative (person-centred, psychodynamic, CBT)
"Maria"	Integrative (transpersonal, CBT, art therapy)
"Julia"	Person-centred
"Tim"	Integrative (mainly psychodynamic)
"Louisa"	Psychodynamic
"Ally"	Integrative (TA, person-centred)

### **3.4 Procedure**

#### ***3.4.1 Recruitment***

Participants were informed about the study via email by the manager of the post-adoption organisation X (Appendix 2). The criteria for participation were explained and potential participants were asked if they would consider taking part. They were also asked to initiate contact via email if they decided to participate. The response to the recruitment was positive, and within four months all six participants had been recruited and interviewed.

#### ***3.4.2 Interview***

Given the theoretical background and the idiographic, inductive and questioning nature of IPA (Smith et al., 2009), the most widely advocated and used method of data collection is the semi-structured interview. A semi-structured interview aims to ensure the researcher's agenda is addressed while retaining a sufficiently flexible structure to explore new areas of interest that may emerge during the interview. Smith & Osborn (2003) recommend that the interview schedule should include general and specific questions and that the interview should move seamlessly between the two, and the specific questions should act as a prompt if participants are hesitant. Please refer to Appendix 4 for the complete interview schedule; the more specific questions are indented below the general questions.

Many IPA researchers come to an IPA study with prior knowledge of the topic area and have formulated their own ideas and questions from which the rationale for carrying out the study has developed. In these situations, the IPA researcher uses "bracketing". Bracketing may be described as a self-aware act of suspending judgements about reality. For phenomenologists this might mean, for example, discarding subjective assumptions about what is held to be of importance by another human being and why. For IPA researchers, it refers particularly to the reflective process of bringing their own preconceptions about the research area to the fore and temporarily holding them to one side in order to conduct interviews and analyse with an open, questioning and non-judgemental mind. The iterative process of the IPA researcher moving between "dwelling" with the data and interrogating the data has been described as a dance (Finlay, 2008).

A pilot interview had been carried out to test the interview schedule, and it appeared that the questions facilitated rapport and effective exploration of the research questions. The length of the interview seemed appropriate, and the feedback provided by the participant indicated that questions were easily understood and free of ambiguity. It was therefore deemed appropriate to include the pilot interview in this study as no changes to the interview schedule were made.

Semi-structured interviews are typically conducted face to face, although some researchers have undertaken telephone and email interviewing (Brocki & Wearden, 2006). In this study, participants were invited for face-to-face interviews, which lasted for between 42 and 68 minutes. At the beginning of the interviews, participants were asked to read and sign the consent form and any questions regarding the information sheet were answered. The interview schedule was used as a prompt and interviews were recorded with prior consent using a Dictaphone, from which transcriptions were made. Along with the recording and transcription, additional notes were also produced after each interview, containing key phrases or sentences, descriptions of the situation, reflections and observations regarding body language and things that happened during the interview that may not be obvious on the recording or the transcript. These notes were used at a later stage to inform the analysis.

### ***3.4.3 Transcription***

The transcription of interviews was completed by the researcher. Time spent with the recording and the transcript is an important phase of heuristic research: noting feelings and responses can enhance the depth and quality of the research process (Etherington, 2004). As well as being transparent about the influence of the researcher and the researched on the process and outcomes of a study, reflexive research also requires transparency about the process of data collection and the potential difficulties that the researcher might have encountered.

Unfortunately, during one of the interviews, the batteries of the Dictaphone ran out. However, the participant kindly agreed that the interview could be repeated at a later date. This obviously influenced the way the interview questions were raised and the participant also had a chance to think more about those questions, which in turn might have had an influence on how the questions were answered. However, upon reflection and repeated listening to the tape, I have decided that the recording still offers enough richness and depth to be included in the analysis, and I have therefore transcribed the interview.

Additionally, the quality of one of the recordings was very poor due to the chosen location (coffee shop) and an inadequate microphone, which picked up the background noises, and the task of transcribing was laborious, time-consuming and contains text omissions. Again, the interview was deemed rich and in-depth enough to be included in the analysis. Learning from those two mistakes, I used a better microphone, a different setting and two Dictaphones for the remaining interviews and also ran a test before beginning the conversation.

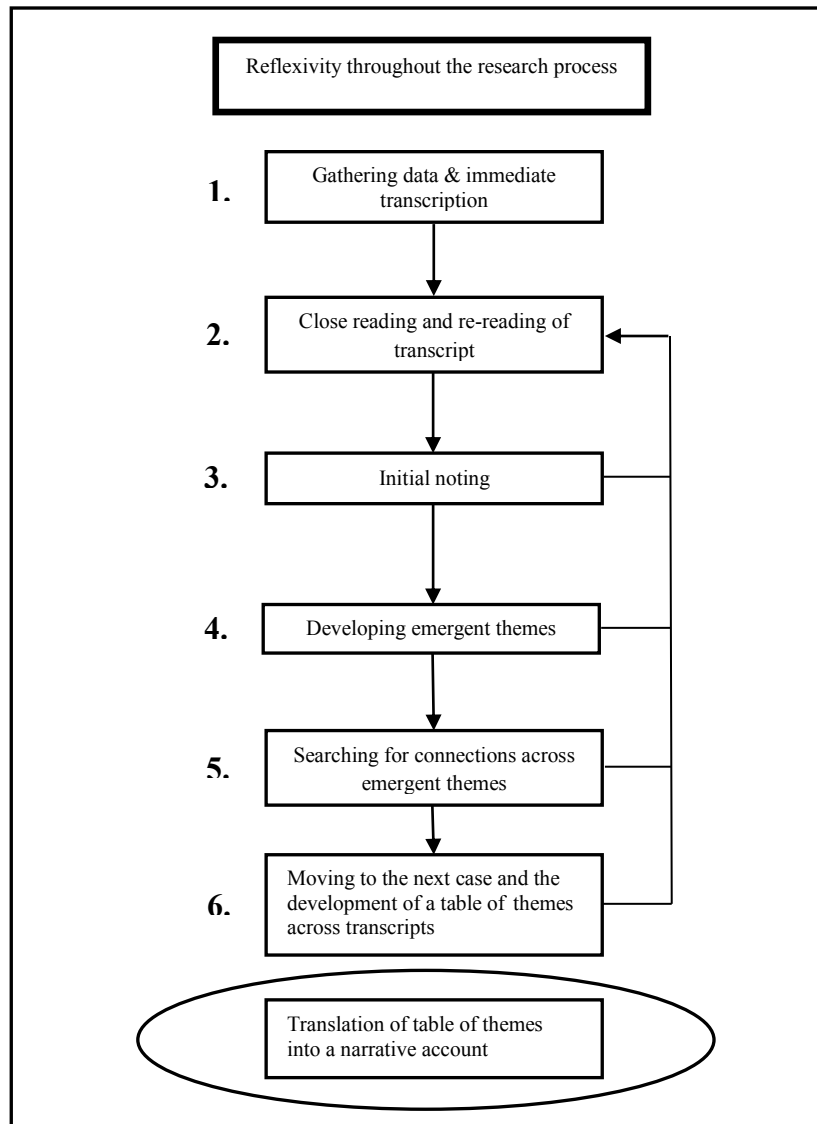
## **3.5 Data analysis**

The process of carrying out a rigorous and systematic IPA analysis, whilst not prescriptive, has been clearly described (Willig, 2001; Smith et al., 2009) and will guide the IPA analysis in this study.

Each interview was repeatedly read until I felt thoroughly familiar with all of the accounts. Going through the transcript again, I made brief notes in the right-hand

margin, capturing my impressions of what the participant was saying, associations and first attempts at very short summaries of the data. These notes then served to create a preliminary list of concepts that were present in the data (Appendix 7). These concepts were noted in the form of a list of key phrases (Appendix 8). Subsequently, each of the remaining five interviews were read and re-read and instances of the preliminary, identified themes were highlighted and noted in the left-hand margins, along with annotation of any data that suggested new concepts that had not previously been found. At the end of this process, the key words that had been extracted from all six interviews were written on separate sheets of paper and considered together. At this stage, I was trying to see any relationships and to organise the preliminary list of key phrases into clusters of connected ideas or themes. A continuous revisiting of the original transcripts and the reflective notes that I made after conducting each interview was deemed necessary.

Next, I created an electronic document in which these clusters were displayed as key themes, with references to the page numbers and paragraph of the transcript and examples of supporting quotations from participants (Appendix 9 for an example). At this point, I spent some time reflecting on this document and the story I could tell from it before embarking on the final stage of analysis, the narrative account, during which further insights, ideas and names of themes were developed through drafting and redrafting. Figure 1 illustrates the analytic process embarked on to analyse the transcripts.



*Figure 1: Analytic procedure*

### **3.6 Validity and reliability in qualitative research**

IPA is seen as a creative process and not a matter of following a rule book (Smith et al., 2009). Therefore, the application of reliability and validity criteria that are used in quantitative research is not deemed appropriate to assess quality in qualitative research. Willig (2001) has questioned the extent to which reliability should be of concern for qualitative researchers.

With regard to external validity, IPA does not aspire to use samples that are representative of the whole population of interest – indeed, the parameters of the population may not be known. This has clear implications for the generalisability of

the findings. IPA findings may be specific to the particular group of individuals sampled, who are representative only in as much they have personal experience of the topic being investigated. Salmon (2003) suggests that while claims to generalisability may be abandoned in qualitative research, it is not always clear what ought to replace them. Others (for instance, Duncan, Hart, Scoular, & Bigrigg, 2001; Touroni & Coyle, 2002) argue that knowledge can be advanced through detailed, qualitative analyses of small groups of individuals, which can produce useful insights into subjective experiences and processes. According to Smith & Osborn (2003), idiographic IPA findings may subsequently lead to claims being made for larger populations. Nonetheless, any claims of generalisation from IPA samples should be made with caution.

Common failures in quality of IPA studies are, for example, the lack of clarity in method section and paper trail, insufficient development of analysis, insufficient data extracts and lack of attention paid to convergence and divergence within themes (Smith, 2011). Following guidelines written by Smith et al. (2009), Yardley's criteria (2000; 2008) have been applied to this study to establish quality. These general guidelines are seen as sophisticated, flexible and pluralistic (Smith et al., 2009) and more suitable for assessing qualitative research. Four broad principles have been suggested and will be briefly described below:

1. Sensitivity to context

The researcher may show sensitivity to context through attending to, for example, the sociocultural milieu in which the study is situated, the existing literature on the topic and the material obtained from the participants. I have personal and professional experience of the topic under study. In the introduction / literature review section of this study I attempted to display my knowledge and understanding of the current literature concerning the topic. In the methodology section I have described the literature concerning IPA. I have used the participants' voices as much as possible during the write-up of the analysis to support the arguments I have made. I was also aware of reflexivity throughout this research journey, which is in line with Yardley's (2000; 2008) point about showing sensitivity to relationship with the participants.

## 2. Commitment and rigour

Having dedicated several years to studying counselling psychology and also having a clinical placement in the field of adoption, I feel that this shows my commitment to this IPA study. Yardley (2000; 2008) also suggests that the researcher may show rigour through the degree of attentiveness to the participant during data collection and analysis. The data collected for this study were deemed comprehensive and sufficient to address the research questions (see analysis section) and therefore demonstrates rigour.

## 3. Transparency and coherence

Transparency – to allow the readers to assess for themselves the researcher's interpretations and conclusions – is also an important component of rigour in qualitative research (Smith & Osborn, 2003). Throughout this study, I have been honest from data collection through to the final list of themes. I have evidenced this through the transparency trial (see Appendices) and through using participants' quotes in the final write-up. I have also written about reflexivity and my personal background to present my reflexive stance and maintained a reflective journal throughout this research process. Additionally, I have engaged in supervision and peer discussion and have attended the London regional IPA group and an IPA data analysis clinic to present my findings, therefore involving individuals who may be more objective than I am and potentially more able to identify and highlight possible biases I may have overlooked. The methodology section hopefully highlighted the coherence between research questions and the chosen methodology and the analysis section presents the themes in a coherent manner.

## 4. Impact and importance

The real validity, Yardley argues, lies in the research telling us something interesting, important or useful. This study is conducted to explore an under-researched area. Participants described how the interview prompted them to think about certain areas of their practice that they had not considered previously, and hopefully the resulting write-up of the analysis of this study reflects this and might influence future clinical practice for the reader.

### **3.7 Summary**

Based in the phenomenological epistemology of IPA, which is interested in the phenomena as it is experienced by the participant (Willig, 2008), relatively broad interview questions were designed to explore the experiences of adoption counsellors. With IPA, the researcher must step back from the literature when employing a semi-structured interview schedule, as participants often tend to naturally talk about what is important to them, and the researcher can visit areas of interest that have not been covered once the participant has “expressed their interpretation of their lived experience” (Hefferon and Gil-Rodriguez, 2011, p.756).

While providing a representation of a common experience in the themes, the idiographic nature of IPA also allows the researcher to highlight and acknowledge each person’s unique experience as an adoption counsellor (Hayes, 1997). This is seen as a significant advantage of employing this qualitative research method.

Smith (2004, p.43) argues that focusing on the particular and the detail of individual experience can bring us as researchers “closer to significant aspects of a shared humanity”. Given its idiographic nature therefore, the study’s strength lies in the depth of the analysis and the insight it provides in to the ‘essence’ of the phenomena being explored. It should be noted that it is not necessarily the intention that the results of this research be generalised to the population of adoption counsellors across the UK. Rather the research looks to gain a better understanding of how the therapeutic relationship is ‘lived’ by adoption counsellors, providing a context in which implications and ideas for further research can be developed.

## 4. Analysis

### Overview

The flexibility with regard to report length in a thesis permits greater transparency for the reader about the analytic procedures followed and the presentation of examples of what was actually said by my participants. Additionally, Appendix 9 contains an example of a master theme with identifiers (such as line numbers and quotes from the transcript) for each individual participant. Appendix 7 includes an extract of the interview transcript for Karen, one of the participants.

This analysis consists of two different levels of interpretation. The descriptive / empathic level involves analysing what participants say, whereas the abstract / interrogative level is described as the analysis of what the researcher feels about the participants' comments (Smith, 2004). The analysis of the six transcripts produced a great volume of data and resulted in three master themes and seven sub-themes, which will be described with an emphasis on the convergence and divergence between participants. The table below gives an overview of the themes that were found during the analysis.

Table 2: Overview of themes

<b>Master Theme 1</b>	<b>An awareness of the early rejection in all stages of the therapeutic process</b>
Sub-themes	a) Walking on eggshells – Therapist's response to the client's fear of rejection b) Not letting go of clients
<b>Master Theme 2</b>	<b>A personal commitment to provide a corrective emotional experience</b>
Sub-themes	a) Personal experience as a driver for working with adult adoptees b) The need to "re-parent" the vulnerable child c) Offering flexibility in order to keep connected
<b>Master Theme 3</b>	<b>The psychological consequences of working with adult adopted clients for therapists</b>
Sub-themes	a) "I can't give them that piece of sunshine" – Therapist's heightened emotional reaction b) "A heavy load to carry" – The necessity of looking after oneself

## **Master Theme 1: An awareness of the early rejection in all stages of the therapeutic process**

Participants discuss clients' early rejection and clients' earliest experience of separation as a traumatic one with enduring properties, which they believe can shape the relationship adopted clients have with their therapists. The awareness of the early rejection seems to have an influence on all stages within therapy. This has been one of the major themes that has emerged from the participants' interviews, and this theme has been clustered into two sub-themes, *Walking on eggshells - Therapist's response to the client's fear of rejection* and *Not letting go of clients*.

### **Sub-theme 1a): Walking on eggshells - Therapist's response to the client's fear of rejection**

Ally and Tim describe how the development of the therapeutic relationship is a prerequisite for therapeutic intervention and say that it is paramount to spend time on growing this relationship. They also emphasise why this might be a challenge for them when working with adoptees. Ally, for example, states:

*"The main issue is getting that relationship right, the therapeutic relationship, because that has to be built on trust, and very often the adopted adult is coming with issues that are about trust, being able to trust another person because of all the disruptions and disrupted relationships they've had in their lives." (Ally, line 71)*

This excerpt might convey Ally's personal experience when growing up, as she lost her mother and was fostered within the family, which indicates that she might have experienced disrupted relationships herself, and this might explain her personal interest in focusing on trust in therapeutic relationships and explicitly mentioning this in the interview.

Tim describes the initiation of the therapeutic relationship as *"extremely difficult, but when it's built, when it's there, it is a fundamental building block of our work, my work."* (line 258). Tim's choice of words when describing the beginning of the

therapeutic relationship conjures up an image of Tim being a house builder and the foundations of the house he is building collapsing if they are not done properly. It conveys the need to emphasise building a trusting therapeutic relationship in order for therapy not to "collapse". As he emphasises "*my work*", the question comes up as to whether Tim views the responsibility for a good enough therapeutic relationship as being solely in the hands of the therapist or whether he sees building as a collaborative endeavour.

Interestingly, the importance of the therapeutic relationship in the early stages of therapy is stressed explicitly by Ally and Tim, who have the least experience of counselling adoptees. Arguably, this could also be linked to Karen's response to a question about the interview experience: "*It's quite good to ask these things because you get to the point where you do things a bit automatically.*" (746). This might hint at different stages of personal and professional development and how consciously aware practitioners are about the formation processes of the therapeutic relationship.

All participants describe how the perception of the client's fear of rejection has shaped their therapeutic responses. Julia, for example, mentions that clients can face rejection during the search process for their birth parents, which she seems to believe heightens their vulnerability, as particular behaviours and emotions can come to the fore for clients during therapy at that time in their lives:

*"That they [the adopted clients] might get really dependent on them [the counsellors] and then experience any kind of failure as rejection. But certainly I think what the overriding feeling I've had, especially when I am providing counselling support for someone who's going through the reunion process, is an increasing awareness, it wasn't something I had before like when I was a social worker, of the anger underlying: the anger, rejection and the hurt and abandonment."* (Julia, line 326)

This excerpt shows how Julia feels that the anger clients have is linked to and originates from the initial rejection an adopted client has experienced as a child, which can lead to similar emotions later on in life, when clients feel rejected,

abandoned and hurt. Therefore, the initial rejection experienced by clients is seen to influence the development of the therapeutic relationship and the client's attachment to the therapist. But the excerpt perhaps shows as well how Julia's role as a social worker might have increased her awareness that adopted clients' experiences might be different from those of the general population. She seemed somewhat surprised about how the counselling training has sharpened and increased her awareness of these underlying, perhaps neglected, feelings that might come to the fore even more when she is practising in her role as a counsellor.

Julia further explains how her adopted clients react very sensitively to possible signs of rejection from her, the therapist, and how she deals with this:

*"I guess, really, the longer I work being more and more, I'm trying to think, alert to how I might be perceived, without being contrived. It's trying to be myself without ... while at the same time I guess being much more aware of how I might come across, possibly, as you say, rejecting or abandoning or whatever. And it places great responsibility, I think, especially on counsellors of adopted adults."* (Julia, line 319)

Julia seems to reflect on her placing an increased importance on watching herself closely in order to not come across as abandoning, whilst at the same time trying to be herself, a conclusion she seemed to have reached over time and with increased experience. The responsibility for this process in therapy seems to be perceived as being solely on the therapist. This could be interpreted as an ongoing self-evaluation that goes on during sessions with adoptees that seems to put a lot of pressure on Julia and might lead to her questioning her professional and personal identity, which in turn could explain her experience of finding this process *"quite difficult"* (Julia, 336).

Similarly, Karen describes having to monitor how she comes across in therapy sessions with adult adopted clients:

*"I find I have to tread carefully, because they might very easily feel rejected, and quite a small throwaway remark could be taken as rejection, basically."*  
(Karen, line 124)

This comment could indicate that Karen feels potentially constrained as she cannot be spontaneous when responding to clients. She also seems to distinguish quite clearly in this excerpt between "they" and "I", which perhaps conveys a distinction between how she would respond if she was at the receiving end of her remark and how adoptees, with their specific context, might react differently.

Tim's account reflects how he experiences a re-enactment of rejection in the therapeutic space:

*"That's the biggest challenge for my work. Is the client connecting enough to be able to come back? But they're constantly acting out the initial abandonment, so they want to abandon me, come back and re-abandon me, in the same way as they've managed to re-abandon themselves."* (Tim, line 53)

Here, Tim refers to rejection of the self as a consequence of the adopted client's past rejection experience. His emphasis on the influence of clients' past experience within the therapeutic relationship potentially alludes to his psychodynamic orientation. Formulating the clients' difficulties with the use of specific psychological concepts and theories might also be a safety net for the participant when asked about his work with adoptees, as the interview could make the challenges and issues of his work more current and potentially accessible for him. He explores how the rejection that clients have experienced can have a direct and tangible influence on the therapeutic work and relationship, potentially leaving the therapist wondering if his adopted clients will actually come back to the sessions. This quote also suggests that it might give the therapist a heightened sense of uncertainty and insecurity about their therapeutic work and their relationship with their client, which comes across in the majority of interviews. It could be interpreted that this might have an influence on the confidence that the clients have in their therapist's ability to be of help, as they might notice the insecurity and uncertainty the therapist potentially conveys.

However, another reading could be that this might also normalise this experience for clients.

Dynamics that might increase the complexity of the development of a therapeutic relationship are also mentioned by Julia:

*"There's a lot of ambivalence, much more than perhaps with other clients, the kind of wanting to do something and not wanting to do."* (Julia, line 453)

Her narrative suggests an ambivalence belonging to the adopted client as a consequence of the difficulty that they might experience in engaging in a meaningful relationship with another person in case of being rejected and abandoned yet again. It could be interpreted as an ambivalence that is also prevalent within the therapists, and not solely an ambivalence that is perceived to belong to the client, as the passive description might indicate. Therapists might feel drawn towards working with adoptees, while also realising the difficulties that this work entails.

### **Sub-theme 1b): Not letting go of clients**

Strongly prevalent within all narratives is the suggestion that the therapeutic work very often does not have a planned ending as such, because clients are likely to attend erratically (Julia, 124; Maria, 488; Karen, 167; Tim, 347), and the work often feels unfinished to participants as clients leave although they still have issues to work with (Louisa, 459). Louisa describes adoptees' experience as *"Their beginnings are always about loss"* (22) and, a little later, *"Loss, grief and melancholia, because of their very deep loss, but it's at the beginning"* (58), which seems to suggest that all of us eventually lose a loved one / attachment figure and that this will have certain emotional consequences, but it stresses the meaning the participant attaches to this loss experience when adoptees are babies or small children, which Julia terms a *"primal experience"* (280). Since they are at the beginning of their lives and utterly dependent on their primary caregivers, this loss is easily interpreted as rejection, being unwanted and, as Louisa mentions, can be connected to the thinking that the client has done something wrong that made the parents reject them (71). Therefore participants seem to believe, given the adopted clients' history of loss, abandonment

and rejection, that the loss of an intimate relationship, such as the therapeutic one, requires particular consideration.

Ally explains that, compared to working with other client groups, adopted clients require a different ending experience:

*"But it's not quite like that in this work. They need to know that I'm still available and that I'm helping them to make that transition across the ending: so we're finished but I'm always available here should you want me."* (Ally, line 45)

Ally suggests in this statement that endings are to be managed differently when working with adoptees; for example, former clients can come back for sessions at a later date (34), which is something she would discourage when working with general adult mental health clients. She also seems to reach for the impossible: *I'm always her should you want me*. Interestingly, Ally switches between "they" and "you" in this extract. There are multiple possible readings of this. Firstly, using the second person ensures that the reader gains a sense of her experience by being placed in the position of the client, as it increases the sense of being drawn into her narrative and comes across as an attempt to convince herself and the audience of her rationale about the need for the therapist's presence. Secondly, it might also reflect her wondering about the researcher's own adoption status, which was not disclosed in the interview.

The theme of being flexible is also reflected in Louisa's account when she describes how the relationship with adult adoptees continues after the sessions:

*"And I now remember, I said earlier, eventually it's like I carry them in my head ... and, um, I'm not sure that you ever stop having a relationship with them."* (Louisa, line 448)

Here, Louisa also stresses that she thinks about her clients, taking them with her wherever she goes, but it is unclear whether this is a conscious decision of hers.

Nonetheless, her statement seems to imply that the end of therapy sessions does not indicate the end of their relationship, and that this also forms part of the therapist's being.

Karen describes an example of her practice where the therapeutic relationship continues after sessions have finished:

*"As I say, she lost about everything. So what I allowed to happen there was the occasional email, but I'm just slowly weaning her off that as it were and I notice she's emailing me less often now."* (Karen, line 451)

Karen seems to give an explanation about why this adopted client needed additional support after their sessions finished, which indicates that this is an exception to her usual boundaries with her clients. Her client has *"lost...everything"*, and there seems to be a belief that her client would not cope with yet another loss. The control over this contact seems very much in the hands of the therapist, who might be compared with a nurturing mother who is gradually weaning their child – a potential indication of the role of the therapist as parent to the client.

Julia also describes in her account how she keeps in touch with clients after sessions via email or postcards (486) as she feels that it is vital to make them aware that they are still held in her mind as they are *"not held in their mother's mind, they're not held anywhere else"* (490). It seems that Julia stresses the need to remember and hold on to clients in order for those clients to feel acknowledged, understood and not forgotten.

Maria also mentions that adopted clients *"don't ever leave"* (381) the therapeutic space. However, in Maria's experience, it is the adult adoptees' choice to come back and work with the therapist on issues: *"They are still around me, because if you think about it it's an issue that doesn't go away"* (386). Here, Maria emphasises her belief that there might be the potential need for lifelong support for adult adoptees, perhaps from her, depending on what stage of their life clients are at.

Even though clients might come back for more sessions later on, Maria also talks about the difficulty of sustaining the therapeutic relationship until the final session and that the response of clients can be, *"I must go before you reject me"* (1203), which might indicate Maria's awareness of the initial rejection that clients have felt in the past with regard to their birth parents. Using the first person in this account seems to highlight for the reader, due to its immediacy, her belief in this statement, which comes across as powerful and important for the participant.

On a similar note, Louisa talks about the threatening properties of endings for adopted adult clients:

*"Because I think an ending is very threatening, it's another loss...And loss is such a big issue, they have to face it again. How do they respond...I think there is often like a threat left for my adopted client."* (Louisa, line 435 & 439 & 443)

Again, Louisa's account stresses the loss and rejection that adoptees might experience when the therapeutic relationship ends and how she perceives that adopted clients see endings as dangerous because they might be rejected again. It also acknowledges the therapist's uncertainty about how the adopted client might respond to this particular issue, but, as she uses the first person, it might equally be indicating the feelings that endings evoke in her: Louisa might also find it very hard to let go of her adopted clients.

Julia mentions that clients very often are in denial about the meaning of ending for them and the reality that the ending of therapy is imminent (482), which can lead to unplanned/premature endings and drop-outs. Again, this implies that it is necessary to discuss endings with clients and the meaning endings have for them. Tim expresses that endings are particularly difficult within short-term work, which can also very often lead to premature termination of sessions and chaotic presentation of clients (347), as clients *"act out a lot of past chaos"* (367). On the same note, Louisa states, with reference to her practice, that some clients do not stay long enough to establish trust (811).

In the following, Tim describes endings as a positive experience if they *"got to go on for a while"* (322) and are constantly talked about in order to give clients a different ending experience to what they are used to and to work through their initial *"abandonment"* (335):

*"Endings can be good, because it helps them to replay in a different way [inaudible 46:12], work through them and change something."* (Tim, line 332)

In accordance with Tim's narrative, Louisa explains that it is crucial for clients to *"let go of their unhappy story"* (573). She further elaborates that adopted clients often seem to go back to their place of unhappiness in therapy sessions, which might mean that they are potentially drawn towards their initial abandonment issues even though they would describe their lives at present as happy. Louisa describes happiness as not *"the only reason you stop therapy, but it is a good beginning"* (580). This account implies that ending therapy is a long process, which can start with contentment in the present moment.

Participants therefore seem to experience endings as difficult, and this seems to leave them with a plethora of emotions. The data also seem to capture the fact that the therapists themselves become attached and unable to let go. Julia, for example, states that she will never know how this particular person will be in the future (489). This is similar to Louisa's feeling of being left with a fantasy (548) when therapy finishes with a client. She gives an example of an unplanned ending with a client, which surprised her as he kept a book of hers, and this leaves her wondering whether he kept this as a potential *"transitional object"* (527). The therapeutic language was not further elaborated on as no further probing questions were asked, which might be an indication of the power difference between researcher and researched, but also of a shared background in psychotherapy. Her use of this term might allude to Louisa's longing for closure by interpreting her client's motives and potentially experiencing her missing book as a reminder of this particular client.

Only Maria mentions that she celebrates endings together with her clients (989 & 1076). This entails giving clients a small piece of jewellery that shows a tree, which

she uses to talk about clients' traits and the work that might still be outstanding (1011). Maria would also prepare a CD about the clients' individual therapy journeys (1048): a present from the therapist which might indicate the need to be remembered by her clients. There could also be a debate about how much this is also a celebration for Maria herself and a way of trying to let go of a client, which seems rather difficult for most participants, because, as Louisa describes, there is "*a ghost of clients who have not worked through a real ending*" (line 942), and which is carried and kept in the participants' minds.

### **Theme summary**

The theme "An indication of the early rejection in all stages of the therapeutic process" illustrates the ambivalent and ambiguous messages expressed by participants regarding the perceived presence of the early rejection in therapy. The common experience of self-monitoring in therapy seems to be an attempt to keep the therapeutic relationship going; this relationship seems to be constantly threatened. The narrative also suggests a different kind of ending experience when working with adult adopted clients and the perceived necessity to hold on to clients after sessions have finished.

### **Master Theme 2: A personal commitment to provide a corrective emotional experience**

All participants feel that therapy with adult adoptees incorporates a particular commitment from the therapist in order to engage clients and increase the likelihood of change. Participants reflect on their personal experience of adoption, which is explored further in the first sub-theme. The particularities of re-parenting will be considered in the second sub-theme, and being flexible in therapy, for example with regard to boundaries and therapeutic tools as a means to stay connected with clients, will be analysed in the third sub-theme.

### **Sub-theme 2a) Personal experience as a driver for working with adult adopted clients**

All participants describe having had some degree of experience or familiarity with adult adoptees prior to working as an adoption counsellor. This forms reasons for working with adoptees, but is also part of their toolkit when establishing the therapeutic relationship and working with adoptees. The data for this sub-theme emerged throughout all stages of the interview, not solely at the beginning when they were asked about their motivation for working in the field. This might suggest that participants' professional and personal experiences with adoption form an intrinsic part of their overall work and have an influence on the therapeutic relationship with their clients.

Participants in this study are therapists with considerable experience in the field and lengthy careers working with adopted adults. Ally and Tim, who had the shortest post-qualification experiences, undertook their training placements at the post-adoption organisation X and continued working there since qualification. The consistency amongst participants to stay within the adoption field or indeed retain their affiliation with the organisation seems to contrast with participants' acknowledgements of high drop-out rates and erratic attendance of clients.

Most interviewees talk about personal as well as professional experience with adoption. However, Louisa solely shared her professional experience as her reason for working in the adoption field. She has been working at the post-adoption organisation X for many years, but also saw adult adoptees in her private psychoanalytic practice before specialising.

Early experiences seem to have led to an interest in working in the field, as all other participants also share their experiences of personal familiarity with adoption. It is important here to remind the reader that this is also the researcher's path to working in the field. Julia used to work as a social worker in adoption and she then retrained as a psychotherapist. With regard to personal experience, she shares the following:

*"But on a personal level, having done all that, I realised that I had an unconscious interest in adoption because I had a sister who's always been on the outside of my family, but it took me a long time to realise that even my attachment therapy programme, which was trying to bring together mothers and babies, was actually for my own mother and this sister."* (Julia, line 23)

Julia appears to describe how her personal connection to adoption seems to be the primary motivator for working with adoptees, which she only became conscious of after having worked in adoption for many years. It seems that Julia sees the adoptive status of her sister as the main obstacle in the way of her mother and sister becoming closer. This could be construed as meaning that by helping other adoptees to connect through the therapy programme she described, she might intend to gain a sense of closure with regard to her own family circumstances. Another interpretation of the motive of bringing her own mother and sister closer by working as a therapist in adoption could be that it is an attempt to regain a sense of control and power over her own situation that she never had and potentially missed when growing up.

Ally was fostered within her family after her mother died (396), and she talks about this distinction between her experience and adoption:

*"Although I am always aware in my own case that I was not adopted, I was not given up by my mother. [...] So my experience is very different and I have to remind myself of that."* (Ally, line 395 & 397)

Ally makes her differentiation very explicit, and it could potentially be argued that her fostering experience had a less detrimental effect on her than adoption ("*given up by my mother*") might have had. This could also have an influence on how Ally might construe her clients' individual experiences and be reflected in her different therapeutic approach with adoptees compared to with non-adopted clients.

Tim was adopted, and he had therapy with adoption counsellors for some years. After working with an adopted adult within a National Health Service (NHS) setting, where he feels he had difficulties "*grounding*" (9) and "*containing*" (9) her, he made

a conscious decision *"to broaden my scope of working with clients"* (10), and joined the Organisation X as a trainee counsellor. His reasons seem to be related to an attempt to gain knowledge and expertise in working with adoptees, which in turn could be related to his experience of being adopted and working with an adopted client. Tim's professional and personal identity seems therefore deeply interlinked in his therapeutic work.

Maria mentions her personal experience as a reason for working in adoption. Several family members are adopted, and she recently discovered that her grandfather was adopted as well (14), which she describes as follows:

*"Yeah, so it's been an interesting discovery [...] But there are many adopted members of my family."* (Maria, line 19 & 23).

Maria laughs when she makes this statement, which could be interpreted as an attempt to distance herself from this recent finding and the influence this might have on her sense of self. The choice of the word *"interesting"* could be viewed from different perspectives. It might indicate a curiosity about this discovery and the need to find out more about it. However, the second excerpt seems to almost negate and minimise the impact that this new knowledge might have on her, as she views adoption as a common occurrence in her family.

For Karen, both professional and personal reasons play an important part in her interest in working with adoptees. Her first client was an adopted adult, which she wrote up as a case study and which had an influence on her decision to attend further training (14). She has a younger brother who was adopted, and her husband's brother and wife also adopted a child (19).

It was not only that personal experience created an interest in working with adoptees. Ally, Tim and Maria mentioned explicitly how this also facilitates their work with adult adoptees. Ally, for example, describes her views of personal experience when working with adoptees as follows:

*"I think it's really very helpful, extremely helpful I would have thought. To have had that experience yourself, no two situations will be the same but the fundamentals of that, of being adopted, have got, they're going to be same, aren't they?" (Ally, line 404)*

Whilst transcribing Ally's interview, it was realised that this question was asked in a leading way (400) as it was concerned with the *advantage* of personal experience and whether it helps/does not help with her work, which seemed at the time to flow with the context of her previous answer. However, this guidance might have cut off any discussion about potential drawbacks of personal experiences, and in hindsight it would have been more appropriate to have rephrased this question more openly.

There is a suggestion in Maria's account that, in addition to her training, personal experience laid the foundation of knowledge in the field:

*"Because, one, the experience helps as well in terms of coming from a family of adoption... [...] I think without the knowledge and the training it is very damaging for anyone to go and counsel adoptees without the level of, of, of expertise that is required." (Maria, line 172 & 178)*

Maria seems to suggest that specialist knowledge is required when working with adoptees, again highlighting the belief that adoptees differ from general adult mental health clients. Also, being an expert in adoption seems to be part of Maria's professional identity and might be a protector against the uncertainty and challenges that were described when discussing working with adoptees. Maria's experience could be linked to Karen's analogy of feeling *"like a rock on which waves are breaking"* (219) when working with adoptees, which potentially indicates that professional knowledge and grounding could facilitate this role. Karen mentions that her approach to therapy with adult adoptees can be subsumed into a different set of considerations that have to be taken into account (588), and she compares this to working with clients at different points in their lives, such as the "PhD student" or the "young mother". Therefore, she concludes that therapy depends on the context of the person's experience at that point in time (592). This stresses not only the

importance of an individualised approach and the adaptation of the therapist's work to each client, but also the adherence to the context that the person is situated in, for example adoption, which comes with certain considerations. It implies the need for flexibility on the side of practitioners in order to be able to work with individual differences within the context of adoption.

Tim's account reflects upon the important bond he experiences with adoptees; without having to disclose it verbally to them, he believes that his clients know his adoption status (200):

*"There's a knowing between me and adoptees; they know I am adopted and I have a knowing about their history and that strengthens our working relationship [...] But there's something that goes on between us, and that is so intense."* (Tim, line 130 & 136)

This extract seems to allude to a non-verbal understanding between Tim and his adoptive clients, which is perceived to facilitate their therapeutic relationship. His choice of the word *"something"* seems to indicate his difficulty in putting this feeling into words and brings to mind an almost magical interrelatedness that neither he nor his clients have any control over. Alternatively, his description could also be interpreted as being related to the experience of being in love, when potentially unknown factors could influence the attraction to another person. Tim describes his experience as *"intense"*, which might allude to having to be completely present in the therapeutic relationship and a potential hint that he prioritises his therapeutic work over other areas of his life.<sup>2</sup>

Tim also discusses in his interview his own therapy experiences and mentions that the therapists that he did not connect with were not adopted, and he concludes how important he feels his personal experience is for his work with adoptees (line 196). The interview took place in a busy café, but away from other people and music was playing in the background. It could be argued that the different, potentially more intimate setting of the interview might have had an influence on the way Tim

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<sup>2</sup> Please also see sub-theme 3b) for details.

answered the questions, as his answers came across as particularly in-depth and personal.

### **Sub-theme 2b) The need to "re-parent" the vulnerable child**

All participants discuss their belief that intimate relationships of adopted adults can be affected by their early experiences. Indeed, participants state that a common difficulty that adoptees present with in therapy are "*relationship issues in personal and work*" (Maria, 185) life and "*challenges around relationship*" (Louisa, 275). Therefore the tool that is mentioned by participants was the therapeutic relationship, and the focus here for some therapists seems to be on "re-parenting". Maria, for example, describes her awareness of what adopted clients might bring to the therapeutic encounter and its influence on the focus of therapy:

*"Their level of neediness. Yeah. Again, going back to the earlier childhood where they may not have gotten what they needed as babies [...] So when you are providing care as a parent to a child you are there 24/7, right? [...] That same level of neediness where, you know, you're treating the client, you know, in their rawness, their rawness being the trauma [...] that they're bringing to your space."* (Maria, line 1350)

In this excerpt, Maria's beliefs about the influence of unmet needs become explicit. For her, it seems that in the therapeutic relationship she is faced with this neediness, and it emphasises the necessity to provide a corrective relational experience for the vulnerable child within the adult adopted client. Her mentioning of the term "*rawness*" in relation to their trauma seems to show that Maria perceives the unmet needs of a child to still be present for the adult adoptee and to still be having an influence on relating to others in the present, including the therapist. This excerpt also seems to imply that Maria might take on the role of a parent to this "wounded child" in the adult adoptee, being there for them whenever they need her, which could be argued might somewhat explain the complexity and challenges that were mentioned when working with adult adopted clients. In the above extract, Maria uses the second person. This is striking, and could be interpreted perhaps as Maria using "you" to generalise from her account in order to potentially showcase her expertise

in adoption counselling, which might in some way be used to distract from the sense of uncertainty and ambivalence that the participant might experience.

Louisa discusses a similar notion to do with her belief about what therapy with adopted adults should consist of:

*"I am clear about therapy being an educated experience, providing a different kind of parenting."* (Louisa, line 780).

In her statement, utilising the first person, "I", could indicate a certainty and clear ownership of what has been said about her rationale for therapy. She seems to compare therapy to parenting, which might imply that she offers a kind of "re-parenting" to the adult adopted individual. However, Louisa does leave open how this different parenting might look, only mentioning that it would be unlike the experience the adoptees have had with their biological / adoptive family. A potential power dynamic between the participant and the interviewer might have prevented a further probing question, which could have clarified her statement further.

Some participants highlight the importance of knowing the relational background of their adopted adults in order to provide a different relational experience. Ally, for example, gives a vivid description of the process of finding out about a client's way of relating:

*"Now, in the first session, I thought, I don't know how I'm going to work this client because I was interrupting him, actually. So this is the way he operates: he says something and then he wants to kind of consider what he's said and leave a space and he wants me to wait and then we'll continue. But because I hadn't got a grip on it so I was actually interrupting and he didn't say, don't interrupt me, but he kind of ignored what I'd said. So that was telling me something. So once I'd got a hang of how he relates, how he interacts, the work started, I think, in session three."* (Ally, line 124)

In this excerpt, Ally describes how she experiences the individual and subjective relating of her adopted client within the therapeutic encounter. It seems that Ally views her preliminary work as adjusting to her client's way of relating, and this suggests that she takes sole responsibility when communication difficulties occur. This could leave the reader wondering whether Ally would, at a later date, address communication skills with this particular client and work with him on how his way of relating might contribute to some of the difficulties he might come across when he is with other people.

Ally's statement also seems to exemplify that *"always we have to take into account the way your client engages"* (Ally, 147) and Karen's notion of *"it's a matter of being attuned to the person who's sitting in the chair"* (Karen, 573). This being attuned to the client could remind the reader of the notion of parenting again and the importance participants place upon it. Tim, for example, reveals that he feels a bit like a *"fatherly figure"* (17) to his clients when they leave therapy and he has helped to restructure their outlook on life.

For Louisa, who is trained as a psychoanalytic psychotherapist, the therapeutic relationship is the working through of all other relationships the adoptee has had (876), but she also describes how she believes the therapist might be put in the role by the adoptive parents of "doing re-parenting" with adult adopted clients:

*"their adoptive parents don't know what to do to help the children sometimes, and then they cast them off on the therapist. And they kind of go, you do it now, I can't do it anymore."* (Louisa, line 773)

Louisa seems to convey her belief that for parents therapy seems to be the last resort to help their adoptive children with their psychological issues. However, these expectations that adoptive parents might have about therapy seem to stem from the adoption counsellor herself. There also seems to be a sense of hopelessness prevalent in her questioning of her ability to be able to meet these expectations that might be communicated through this excerpt. Arguably, what could be of interest is what the

awareness of this situation feels like for the therapist and whether this impacts on the therapeutic relationship even before therapy has started.

In Louisa's experience of working privately, some adoptive parents also pay for their adopted children to have therapy (705), which might indicate that the parents give Louisa permission to re-parent the vulnerable adoptee. She mentioned that through payment issues she learns about the relationship clients have with their parents (735). To describe the payment of sessions by (adoptive) parents, Tim used the metaphor of *"the sword of Damocles"* (375) to indicate a potential threat and the difficulty that can be caused by this form of payment. In Louisa's view, it devalues therapy (726) and brings the parents into the therapeutic space, potentially impacting on the therapeutic work with the adult adopted client.

Tim gives an example of a client whom he described as a *"kid"* instead of an adult due to the family dynamics that were brought into the therapy room (380). On a similar note, Julia describes the *"inner child"* of her adult clients and her work with it when facilitating a workshop for adopted adults:

*"Even when adopted adults are much older, they still feel that vulnerability and very much as a child. And I think, as I said before, that their inner child is out much more. [...] And I remember being really, really anxious, imagining everyone's inner child would be out, very hurt, very demanding, very angry, and in fact setting a very clear framework, trying to be very, very safe."* (Julia, line 460).

Here, Julia seems to state that the vulnerable child is still very much present in the adult adoptee, is out in the open and can potentially be experienced when in a relationship with them. Julia stresses her own, heightened, anxiety about what might happen when the *"inner child"* comes out. It brings an image of being attacked to mind, and the interviewee seems to shield herself (and the clients) from such an attack with her *"framework"*. The participant's anxiety might be related to the unpredictability and uncertainty of the emotional and behavioural response of adult adoptees. Her response to this perceived emotional and behavioural chaos seems to

be providing the opposite, namely safety. This seems comparable to Maria's response to challenges within the therapeutic relationship with adoptees: *"Not acting at a level that the clients is acting upon"* (1344), possibly indicating that Maria takes on the role of the adult who re-parents the vulnerable child within the adult adoptee.

Tim also explains working with the "inner child" in his interview in more detail:

*"So the inner child work is really to develop that innocent child before those defence mechanisms are built up, and to work with that and to help the adult adoptees to hold their inner child."* (Tim, line 413)

This excerpt shows again Tim's use of psychodynamic terminology, refers to Tim's view that part of his work seems to be about strengthening the "innocent child" and conjures up an image of a "clean child" which is not "blemished" by the trauma of adoption. This excerpt might allude to Tim's belief that clients have to build up a different relationship with hidden parts within themselves, which then in turn might influence relationships they have with others. However, the use of psychoanalytic terms in participants' interviews could also allude to an attempt to control how participants might be perceived by the researcher. It might express a need for safety and be something to guide them through exploring the work with adoptees, which has been described as complex, demanding and chaotic. Participants in this interview might use their therapeutic background not only in order to make sense of their clients' presentation, but also to potentially serve the function of coming across as competent and knowledgeable in their interviews with a trainee counselling psychologist.

### **Sub-theme 2c) Offering adopted clients flexibility in order to keep connected**

Participants describe their flexibility when working with adult adopted clients, in particular with regard to boundary modification. Initially, participants agree that adherence to therapeutic boundaries is beneficial and paramount for the therapeutic relationship and work with adult adoptees. This is best captured in the following statement by Maria:

*"If they've never had boundaries in their life then this is a good place to start."*  
(Maria, line 458)

Maria's statement seems to imply that her adult adopted clients might not have had boundaries set before for them and therefore she sees her work to be to adhere to them in order to contain her clients (454), and she also highlights that her own boundaries are *"not fuzzy"* (550), which could be read as an attempt to illustrate professionalism, expertise and safe practice during the interview.

The importance of boundaries is also reflected in Tim's account:

*"The boundaries are really high on my list of being able to work with the contract and them knowing where they stand [...] Structure – you know with adoptees they need structure, and that's a very important part of it."* (Tim, line 275 & 284)

Here, Tim stresses the importance in therapy with adoptees of having boundaries in place. His statement seems to be linked to a notion of chaos that the adoption experience might entail. It might also suggest that Tim takes on this responsibility for structure in sessions and implies that he knows what his adult adopted clients' needs are. It could be argued that this view might be influenced not only by his psychodynamic orientation, which emphasises the importance of boundaries, but also by his own adoption status and his own needs for structure and boundaries.

Flexibility with boundaries when working with adoptees has also been mentioned by most participants to the same degree as the emphasis on adherence to boundaries in therapy. This could mean that certain kinds of boundaries are potentially held more strictly by participants, whereas others might be more diffuse and can entail some flexibility with regard to adherence to them. Louisa sums up her therapeutic boundaries when working with adoptees compared to other client groups as follows:

*"All the things you don't do, I do...with adopted adults. It's only with that group"* (Louisa, line 208)

This seems to entail that certain psychotherapeutic rules that are usually important when working within general adult mental health do not apply as such when working with adult adoptees. Louisa also appears somewhat puzzled by her way of working with adoptees. This might remind the reader again of the uncertainty that this work seems to bring about for the participants and the perceived need for flexibility.

Ally gives an example of boundary modification and explained that she is less challenging and "*gentler*" (246) with adult adoptees, which was also mentioned by Louisa (853), and Ally justifies this with her realisation that this leads to better outcomes (247). This again alludes to a sense that the development and maintenance of the therapeutic relationship requires a modification of traditional therapeutic boundaries. Ally notices that she feels more attached to her clients (261) as what she is offering to clients is a "*positive attachment to another person*" (259), which could be interpreted as the perceived necessity to involve her self in therapy, more so than she would do with other clients.

Ally and Tim also mention the acceptance of gifts (273 and 339 respectively). For Ally this appears to be not just about appreciation of the service she offered, but also a sign of being kept in mind and not being forgotten, which she associates with working with adoptees (275). Tim describes it in this way:

*"I think a state of adoption as well is about being forgotten and how difficult it is not to [be], so adoptees leave their mark."* (Tim, line 122)

Here, it could be argued that Tim believes that the implications of not accepting gifts would be that his clients would feel rejected yet again and be unable to "*leave their mark*". This choice of words brings to mind the intrinsic need for demarcation of a personal territory and might stress the importance of accepting these gifts in order to keep connected.

Louisa describes several modifications of therapeutic boundaries, such as engagement in small talk (829), offering different price structures when clients cannot afford her fees (185), waiting longer for payment (181) and agreeing that

clients can speak to her in between sessions (744). Maria explains the need for flexibility when offering sessions, namely, she offers home visits (555) and tries to "squeeze in" session time for adopted clients (1339). Karen and Ally are explicit about their use of humour and their belief that this use has positive outcomes for the therapeutic relationship, as it facilitates a "real relationship" (Ally, 317):

*"It's treading carefully, I suppose, all along, and hopefully meeting their needs [...] Petruska Clarkson talks about the real relationship as well, and sometimes it might have a little joke at the end if that seems appropriate."*(Karen, lines 546 & 550)

Karen's rationale seems to be underpinned by the psychological literature,<sup>3</sup> and could be interpreted as a justification for using humour within the therapeutic relationship, as much for herself as for the researcher. This could be another indication of how psychotherapeutic knowledge might be utilised to enhance a feeling of safety and competence that some participants might have felt is needed during their interview and potentially for their work with adopted clients.

Karen and Maria are participants whose accounts explore the rationale behind the flexibility of boundaries. During her first interview, Louisa is unsure about the reasons for this (780 & 860), but mentions: *"I have to go an extra distance for them because they've already suffered such a terrible beginning."* (218), potentially meaning that she needs to work extra hard when clients have been adopted. During peer supervision before her second part of the interview, she noticed boundary modifications in her colleagues' work, too:

*"some of the people were all over the place with their boundaries [...] We kind of speculated, um, was it because we feel sorry for adopted adults and therefore we feel we have to give more?"* (Louisa, line 1242)

Louisa illustrates in this excerpt a feeling of pity and potentially of an anxiety, belonging to the therapists, about causing discomfort or confusion or upsetting the

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<sup>3</sup> Petruska Clarkson was a counselling psychologist.

adult adopted client. By mentioning a similar occurrence of boundary modification within the work of her colleagues, it seems that she takes solace in the fact that she is not the only therapist, but that similar responses of colleagues indicate a link to this particular client group. Additionally, within Karen's narrative, there exists the suggestion that the flexibility of boundaries might theoretically look unsafe, but it is of a "caring" nature and does not *feel* unsafe (480), and, she adds, *"that demonstrates that I am a really caring person, because I think that's what people need to know"* (489), which could be interpreted as indicating a belief Karen has that this increases the emotional connection the adopted client can make with the therapist. It might also point to the different view of the therapeutic encounter from within the relationship as opposed to an observer perspective. Talking about it might have potentially heightened Karen's awareness of how it could look for the "outsider looking in", potentially ensuring that she comes across as a safe and competent therapist.

Interestingly, Maria describes the flexibility of boundaries on both her part and the clients' part. To illustrate this, she uses the following analogy in which the therapist seems to take on the role of the "helpless victim":

*"Oh dear, they're like vampires. You know, they, they, it's like they suck and suck and suck because they are quite draining and there is just no limit...there is no sense of boundaries."* (Maria, line 1261)

This links in with the notion of work with adoptees being demanding that was made earlier and the high expectations of this client group that interviewees experience. For Maria, the modification of therapeutic boundaries is partly down to adoptees not being able to *"nurture themselves"* (365) and partly down to the fact that for the therapist *"that rescuing part comes into play"* (376), acknowledging how her own needs might be met by the boundary modification. Her quote (1261) might also show how the therapist could put herself quite deliberately into a position of having less power in order to offer clients a nurturing experience. It could allude to potentially having more control over her role as victim than she might realise. However, it is also important to acknowledge that this topic came up right at the end of her

interview after the participant's working day, and the reader might wonder whether this quote could also refer to the interview experience itself.

Maria also describes adult adopted clients as *"extended family members, only that you don't live with them and you don't see them every day."* (592). Later on, she states this happens only occasionally, but again, this shows the shift of therapeutic boundaries when thinking of and working with adopted clients and differs from the way participants described working with other client groups. As depicted earlier, Tim also views himself as a *"fatherly figure"* (17). The suggestion about seeing adopted clients as family members could also offer an explanation for the increased responsibility that therapists feel within the therapeutic encounter.

Another shift of boundaries is described by Julia and indicates that collusion with an adopted client can occur:

*"I am interested in spirituality and she was as well, and initially I saw it as a resource for her, but then I realised she was using it to fantasise as an escape. So I had to be very careful that I wasn't colluding with her, in her sort of like, basically, going off."* (Julia, line 192)

Here, Julia mentions how a potentially helpful coping strategy for one person – herself – can turn into an avoidance mechanism for another. This stresses the importance of an individualised approach, reflective practice and the necessity of the flexibility of therapeutic boundaries, depending on the experience of each adopted client, in order to be helpful to clients.

It seems likely that in an attempt to increase the connectedness with their adopted clients, participants use a range of different approaches and skills. Most participants in this study describe their therapeutic approach as integrative, which includes a variety of therapies and counselling approaches such as Psychoanalytic Therapy, Cognitive Behavioural Therapy, Art Therapy, Neuro-linguistic Programming or Person-Centred Therapy.

Regardless of the approach, most participants emphasise the importance of using self-help material when working with adoptees to increase a sense of connectedness. Karen explains further and offers a rationale for this therapeutic technique:

*"I think I do tend to bring a bit of theory, like sort of psycho-education a little bit more. [...] [W]hat they're not clued up about, because very few people in society are, the dynamics of adoption, and I think sometimes it helps to come in with that sort of thing, which I suppose is teaching, actually." (Karen, lines 410 & 414)*

Louisa and Tim both share their use of books about adoption with clients to enhance their understanding about the issues adoptees might experience. For Tim, books also manage to bridge the gap between sessions:

*"It's a bit like homework, so it's very easy for adoptees...because they're so good at shutting off, they leave the sessions and not think about it and come back." (Tim, line 427)*

Here, it could be interpreted that he uses homework as a way of staying connected with the session content and also with himself, the therapist, in between sessions. Louisa also emphasises the importance of creating a link between sessions and between herself and her clients *"somehow"* (188). It could be interpreted from this that she is emphasising the belief about the importance of feeling connected to the client and her potential reliance on her intuition, as she has not specified how this connection is made.

The use of different techniques depending on individual circumstances seems to be deemed appropriate by participants in order to deepen their connectedness with adopted clients. Another example of this is the use of positive role models that Julia describes, such as Barack Obama.<sup>4</sup> According to her, people will sometimes say *"okay, that gave him the motivation to keep going despite everything"* (line 219).

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<sup>4</sup> Not formally adopted, but partly brought up by his grandparents (Julia, line 217).

Additionally, when only a few therapy sessions are available, resource building seems to take priority over working on deeper-seated issues, as Julia's quote highlights:

*"And so basically I think what I will do is look for the resources and very much work on that basis to then help them to maybe also then look at their losses."*  
(Julia, line 85)

On a similar note, Louisa and Marie use art work with some clients in order to discuss highs and lows in their life and to hear their story (Louisa, 199). Louisa explains that this also helps to avoid sitting in silence with clients, which, she believes, clients might experience as *"persecuting"* (1122). Contrary to this, Maria sees silence as *"good"* and a process that the client chooses (734), and something she would feel comfortable with. Again this shows the perceived need for flexibility when working with adoptees, but also the different approaches of individual therapists, depending on their own personal and professional identity.

Offering flexibility in psychological therapy, particularly when doing short-term work with adoptees, therefore seems to entail role modelling and practical guidance, but also discussion about available support for some adopted clients when sessions have finished. Julia mentions the option of client referrals to different services after their sessions together (476). On this note, Ally discusses meditation with a client as something to aid him after therapy has finished (204). Once again, this might indicate to the reader that the need to look after their clients might not end once the sessions have finished, which seems to be particularly crucial when working with adoptees.<sup>5</sup>

Linked with the significance of loss for adopted adults and the consequences of this upon the development of the therapeutic relationship and their attachment to the therapist, explored by participants in the interviews, is Ally's description of being an attachment figure for the client. She perceives offering reassurance (777), continuity (324), dependability (307), consistency and predictability (Ally, 320) as paramount

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<sup>5</sup> Please also see sub-theme 1b).

for staying connected to a client. Additionally, Julia describes setting up a framework of weekly sessions that offers safety (135) and containment (343). She also emphasises the importance of listening to the clients and slowly making interventions (365).

All participants have worked within the field of adoption and have been Organisation X affiliates for a long time, which seems, here on a macro level, to express their dependability and the consistency of the service they provide. The tools mentioned above also seem to portray an attentiveness to and vigilance about the therapeutic process, which might be perceived by participants to make adult adoptees feel better, less nervous and not so intimidated. This, it could be interpreted, might potentially be an attempt by participants to encourage the client to trust the therapist and to reduce non-attendance and drop-outs, which are described to be two of the perceived challenges in their work. With regard to the impact these tools might have on the participants, therapists might feel more capable and better equipped to deal with the client's emotional state, for which some participants seem to take a high degree of responsibility.

### **Theme summary**

The theme "*A personal commitment to provide a corrective emotional experience*" appears to suggest that participants believe that personal experience of adoption facilitates their therapeutic work, including establishing and maintaining the therapeutic relationship. Additionally, particular attention to the vulnerable child within the adopted adults in therapy seems important, which also appears to imply a modification of therapeutic boundaries. The variety of techniques and tools used by participants seems to suggest a need for a great range of skills and to be creative and flexible during the delivery of psychological therapy that is imbedded in the therapeutic relationship.

### **Master Theme 3: The psychological consequences of working with adult adopted clients for therapists**

All participants reflect on the emotional impact the adoption work might have on the therapists themselves, which will be explored in this master theme. Additionally, supervision is cited, amongst other strategies, as useful in order to facilitate their work with this client group. I have grouped this theme into two sub-themes: *"I can't give them that piece of sunshine" – Therapist's heightened emotional reaction* and *"A heavy load to carry" - The necessity of looking after oneself*.

#### **Sub-theme 3a) "I can't give them that piece of sunshine" - Therapist's heightened emotional reaction**

Strongly prevalent in the narratives are the emotions that participants might feel on behalf of the client, which seems to be one of the reasons why the work with adoptees feels demanding for the therapist (Louisa, 1337). Both Louisa and Karen mention explicitly the *"weight"* (Karen, 105) of the work and having *"to hold"* (689) experiences of clients, whilst Julia emphasises clients' *"vulnerability"* (56). This terminology suggests that participants might experience a level of fragility and delicacy on behalf of the adoptee, and it also hints that they take on additional responsibility for what is experienced by clients in the therapeutic encounter.

Louisa (106) and Maria explain that the work *"has its challenges. It's, it's tiring"* (1308). Taking it further, Tim describes how the feelings he experiences with regard to clients change the way he views his work:

*"I always have difficulty in this field talking or saying that this is my vocation, it's a wonderful job, etc, etc, etc, because the emotional response that I have working with clients brings up so many issues for me, my own childhood."*  
(Tim, line 12)

Tim seems to express here that his reactions to what the client is telling him are about his *own* psychology, and this quote hints again at Tim's appreciation of intuitive processes within therapy. However, it also stresses the importance of

regarding feelings that come up in the therapeutic encounter as *jointly* created phenomena and the necessity of disentangling the interaction between therapist and client. Tim's extract describes the emotional consequences that this work has on him, and alludes again to the notion of the link between the personal and the professional identity.

Karen feels that the therapists' own emotional reactions heighten their level of empathy (681), and Ally gives an example of her reactions to her client's narrative and how she uses her empathic responses as a therapeutic tool with a client:

*"So I found myself crying, I've got tears running down and he's not. But I think it did him good to see me upset and listening to his material, because after that session, he did start looking at me a bit more."* (Ally, line 136)

Ally therefore seems to view her responses as a valid and informative source of knowledge and a vehicle for change, and she also values the use of one's self in the therapy setting. Additionally, it could be interpreted that *"I found myself crying"* might indicate a passivity and an inability to control her emotional responses in relation to this client. It could allude to an attempt to disown her response, which seems to be highlighted by the explanation of the benefits of her emotional response for the therapeutic relationship.

On a similar note, Louisa mentions how she feels left with feelings, perceived as belonging to the client, but that these feelings seem to support her to experience what it is like *"to be in the client's shoes but not be there"* (250). Karen specifies that it is paramount to stay with difficult feelings such as sorrow and grief in order to also feel joy intensely and to feel *"clients' joy"* (703). Emotions that come up in relation to clients can therefore help therapists to experience a heightened empathic response towards adoptees, but also seem to make the work and the therapeutic relationship with adult adopted clients *"demanding"* (Louisa, 631).

These perceived demands might also influence how the therapist acts in the therapeutic relationship with clients. Tim, for example, uses an analogy for his experience of the clients' needs, hopes and demands:

*"I can't give them that piece of sunshine that they need to hold onto, and it's really difficult."* (Tim, line 49)

Tim's description seems to indicate that he perceives that adoptees are in need of something very elusive and transient ("*sunshine*") with life-giving and enhancing properties, but regardless of how hard he works, adoptees will never be able to have it, due to its fluidity and uncontrollability. There is a suggestion in Tim's data that this is in part the difficulty when working with this client group – living with the disappointment of what is achievable within the therapeutic space and wanting to be more helpful. This quote indicates a perceived responsibility for the progress of the work that the therapist engages in with this particular client group and relates to the wish of the client who wants "*to be fixed instantly*" (Maria, 795).

On a similar note to Tim's account above, Louisa describes the consequences that the particularities of working with adoptees can have on the view of herself as a therapist:

*"some of the heaviness and all-over-the-placeness sometimes of the work can be a bit destabilising, really. And also you can feel quite deskilled, because, you know, you haven't given enough or you haven't got a clue of what's really going on and I know that's the same as your own ordinary everyday work as well, but it somehow feels, um, different."* (Louisa, line 1172)

Louisa seems very frank about feeling deskilled, seeing the reason for this in her client's presentation that is "*somehow*" different to general adult mental health clients, but she also seems influenced by the difficulty that she has in being able to see beyond the obvious. This resonates with a sense of vagueness and ambiguity here, and alludes to her being guided by her intuition, getting lost somewhere on her way to consciously understanding what is going on in the therapeutic relationship.

As a consequence, this seems noticeable in her finding the work *"destabilising"*, which might indicate a potential threat to seeing herself as an efficient professional. Louisa's statement might hint at a parallel process that occurs within the therapists themselves when they potentially question their own (professional) identity, an issue that was mentioned adopted clients do present with in therapy.

### **Sub-theme 3b) "A heavy load to carry" - the necessity of looking after oneself**

Most participants mention an awareness of the heightened expectations of therapy that adult adoptees might have compared to other client groups. Louisa describes this:

*"I think the clients feel more demanding...like they have a greater expectation of you, and I suspect that's because, um, you know, we're set up as adoption support counsellors and therapists."* (Louisa, line 1180)

She explains how the increased expectations of working as a specialist in adoption might make the work more demanding for her, and it might be argued whether this also entails an uncertainty on behalf of the therapist of being able to meet those demands. This might lead to a situation that was experienced by Tim, where he seems to prioritise attendance at client sessions over his own family commitments:

*"I've even missed my children's parents' evenings because [inaudible 37:08] they gave me nine days notice - not enough to cancel with my clients; that's what it feels like."* (Tim, line 272)

Tim appears to make a tremendous personal sacrifice for his clients. His statement alludes to maintaining strict therapeutic boundaries to the extent that it might be difficult to keep his sense of self and thus be left unprotected; this could be construed that Tim might struggle more with the challenges of the work.

An important aspect of dealing with the demands of working in a therapeutic relationship with adult adoptees is supervision; the space for reflection and the support that it offers seem to be particularly important in order to understand the

therapeutic processes that have taken place. The narratives account for the significance of supervision in terms of the difficult nature of the work, and this is captured by Ally's account below:

*"So supervision is necessary for that reason, so I'm able to debrief and I'm going to be given guidance so that I can contain that person and keep them safe."* (Ally, line 514)

Her statement seems to highlight the importance of using supervision to focus on her clients' safekeeping. It could be argued that her own sense of safety and containment is interlinked with her clients' and that supervision helps her to achieve this. Ally also highlights how difficult she experienced working with clients at a time when no supervision was in place, and she explains that supervision is different when working with adoptees, as adoption is *"the anchor, that's the baseline"* (519), suggesting a particular need for specialist supervision.

Louisa states that she is being supervised in three different places and that she has access to peer supervision as and when needed (1154). She feels that this support network and the supervision she receives are important for her work (1138) in order to let go of the heaviness and "all-over-the-placeness" after sessions (1172).

Tim feels that he is *"constantly left with things, even though I have wonderful supervision"* (118), which indicates that his experience of supervision differs from Louisa's. This might be explained through the importance he places upon remembering clients as *"they don't want to be forgotten"* (121). He also shares his use of personal therapy, which seems to have helped him in understanding some of his experiences within therapeutic relationships with individuals who have been adopted. Therapy has included exploration of his own adoption status, which in turn seems to have enabled a better understanding of his reactions to adult adoptees. This is an interesting point to consider, as not all therapists working with adult adoptees might have experienced personal therapy.

For Maria, supervision is particularly significant for reflecting on the *"boundary issue"* (359), which has repeatedly been discussed with her supervisor. It is also felt that for some participants the interview for this study itself provided an opportunity for them to consider elements of their work that they have previously not reflected upon in depth. The interview seems to be a catalyst for reflection for Maria:

*"It got me thinking, because very often one doesn't think about the process, so it got me thinking again."* (Maria, line 1440)

For Louisa, the peer supervision between the two parts of our interviews resulted in additional reflection upon the rationale for the shifts of therapeutic boundaries (1226). Karen mentions that the interview questions helped her to reflect on her unconsciously competent practice where *"you do things a bit automatically"* (746). Additionally, she describes that she constantly reads and discusses issues within her field of expertise and that she does not *"rest my laurels"* (748), which seems to imply that this might facilitate looking after her clients as well as her own wellbeing.

### **Theme summary**

In summary, therapists seem to express a sense of vagueness and of increased responsibility that is taken on in relation to their work with adoptees, which seem to have an influence on their professional and personal identities. Personal reflection on their work with adoptees through supervision, personal therapy and the interview process seems to facilitate a deeper understanding of their emotional responses to their adoptive clients and seems to lead some therapists to analyse their practice in more depth.

## **5. Discussion**

### **5.1. Overview**

Chapter four of this study presented the analysis of the interviews that were conducted. The aim of this chapter is to place the main findings of this analysis into a wider framework. Findings related to each research question will be discussed in turn within the context of existing literature, including practical implications. When relating these findings, psychodynamic contributions, specifically attachment theory, seem to be the most applicable and relevant theoretical approaches. This is partly a reflection of the participants' mode of practice, which was influenced by psychodynamic thinking, but is also due to the significance that psychodynamic theory places upon the therapeutic relationship and the importance of potential disruption in attachment and interpersonal relations for adopted clients. This chapter will also highlight research limitations and suggest future research directions before the discussion concludes with a reflexive statement.

### **5.2. Implications of findings**

The purpose of the study was to explore how therapists experience the therapeutic relationship when working with the adopted adult. The qualitative research design and analysis of the data using IPA (Smith, 1996) was well suited to an in-depth study into the therapeutic relationship with adult adoptees from the therapist's point of view, in what is a somewhat under-researched area. The results will also be helpful to gain knowledge of the adult adoptees' relative engagement as experienced by the participants of this study, which will be useful in informing various aspects of the work. A degree of generalisation is therefore important to highlight some implications for clinical practice.

#### ***5.2.1 How do therapists experience the therapeutic relationship?***

##### ***5.2.1.1 The significance of the therapeutic relationship***

Participants in this study described the role of the therapeutic relationship as central to their work and as influencing their ability to work with adoptees. The importance of the therapeutic relationship is widely known and, more specifically, the empirical

literature shows the association of a positive therapeutic relationship with a successful therapeutic outcome (Elvis & Green, 2008; Orlinsky, Grawe, & Parks, 1994), indicating that the therapeutic relationship is vital for therapeutic change. This is a perspective that is shared by the participants and the counselling psychology discipline in that the latter sees therapy as depending upon a capacity for being-in-relation (Strawbridge & Woolfe, 2010).

Bordin (1979) emphasised the importance of three features of the therapeutic relationship: therapeutic tasks, bonds and goals. What arose from participants' accounts was the importance of the therapeutic bond in their work. However, participants described how, very often, clients present with relationship difficulties, which can affect the development of the therapeutic bond.

#### ***5.2.1.2 Loss and rejection affecting the therapeutic relationship***

Studies have shown that secure attachment is associated with higher relationship quality (for example, Feeney, 1999). There is some evidence in the literature that insecure attachment is more prevalent amongst adoptees than non-adoptees (Yarrow & Goodwin, 1973; Yarrow, Goodwin, Manheimer, & Milowe, 1973; Feeney et al., 2007). For example, the results of the longitudinal study by Feeney et al. (2007) suggested that adoptees score significantly higher than non-adoptees on avoidance and anxiety, which have consistently been shown as the two main dimensions that underlie the measure of adult attachment (Brennan, Clark, & Shaver, 1998). They were also over-represented in the insecure attachment categories, particularly preoccupied attachment style, which is, according to attachment theory, the most problematic working model because it involves negative perceptions of self-worth and the availability and responsiveness of others (Bartholomew & Horowitz, 1991), potentially affecting interpersonal relationships, including those with therapists.

Participants suggested that the rejection and loss that adoptees experience have an important influence on the development of the therapeutic relationship. Ally, for example, emphasised how being able to trust the therapist is a prerequisite for the formation of a working relationship when counselling adopted adults, which is perceived as difficult due to the adoptees' past. This is in accordance with adoption

literature, in which the construct "trust" comes up and has been commented upon as being an important issue that can arise in psychotherapeutic practice with adoptees (McGinn, 2007). Trust is portrayed as vital for the development of healthy attachments and, equally, healthy attachments are also seen as essential for the development of a sense of trust (McGinn). Additionally, trust is seen as the positive component of the basic trust and mistrust stage of Erikson's (1968) model of development: The child whose basic needs are met can develop a basic sense of trust (Laughton-Brown, 2010). According to this model, the development of trust can be obstructed by the initial separation from the birth parents. This theory is therefore built on the premise that a lower level of trust in relationships early in life has a detrimental effect on the psychological foundation for happier and better functioning relationships (Simpson, 2007).

The description by participants of the effect of adoptees' loss on their relationship with the therapist adds to the knowledge base of existing studies that found that adoptees have significant experiences of loss, beginning with the loss of the birth mother (Deeg, 1989; Doka, 1989; Kennedy Porch, 2007; Saiz & Main, 2004). Loss can also include – depending on the adoptee's individual history and circumstances of adoption – the loss of foster carers or family carers, the loss relating to the discontinuity of the child's "personal story" or the loss associated with the realisation that adoptive parents may be less than the ideal parents the child might have hoped for or expected (Hindle & Shulman, 2008). These losses can lead to attachment-related difficulties (Yarrow & Goodwin, 1973; Yarrow et al., 1973). As mentioned above, difficulties in early primary caregiver–child attachments within the adoption triad may then have an impact on developing aspects of intrapsychic object relations and interpersonal relationships for the adopted adult (Brinich, 1995).

As described by participants, interpersonal difficulties might present in the light of the necessary mourning of early losses in life. This has also been mentioned by Nydam (2007), who described that relational difficulties should be understood as a reference to birth parents, that is, the adoptee is seeking the lost object. Participants in this study explained how this "*initial abandonment*" (Tim, line 54) might have an influence on an adoptee's attendance and engagement in therapy, but this perception also seemed to suggest that therapists monitor their own responses very closely,

indicated by Julia's quote: "...alert to how I might be perceived, without being contrived" (line 320), which potentially emphasised the importance of reflective practice.

The therapeutic relationship seems to contain features that can trigger the client's embedded expectations from past relationship experiences. It seems necessary for counselling psychologists and therapists working with adoptees to understand the nature of a client's attachment history, as for some clients with a dysfunctional attachment history, the activation of their attachment system within the therapeutic relationship can induce distress (Gillies, 2010).

In accordance with Holmes (1999), participants view the role of a therapist as similar to that of the primary caregiver: The therapist is emotionally available, offers a comforting presence, affect regulation and provides a sense of a secure base from which the client can explore inner experiences. Two quantitative studies by Mallinckrodt, Porter, and Kivlighan (2005) explored this influence in relation to the depth of session exploration and object relations. Consistent with Bowlby's (1988) concept of a secure base promoting greater exploration, secure attachment to the therapist was significantly associated with greater session depth and smoothness. Insecurity in attachment and avoidant attachment were reflected in the quality of the therapeutic relationship and were related to weaker working alliances, a sense of alienation and a lack of social skills (Mallinckrodt et al.). This seems to reflect Ally's account where she described relating to one of her clients during the initial sessions as challenging (line 124).<sup>6</sup>

As noted by participants, the fear of being rejected is ever-imminent for adoptees and well documented in the literature (Brodzinsky et al., 1998; Lifton, 1990; Silverstein & Kaplan, 1988). Frankel (1991) suggested that this overwhelming anxiety about not being worthy of being kept constitutes a key focus for psychotherapy with clients, and the re-enactment of this initial rejection in the therapeutic encounter has been explicitly described by Tim (line 53)<sup>7</sup> in this study.

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<sup>6</sup> Please see p. 72 for transcript excerpt

<sup>7</sup> Please see p. 59 for transcript excerpt.

Brinich (1980) has shown that the fear of abandonment is often displayed in the adopted client's repeated testing of the therapist's commitment. He described a case of a male client who acted in this way and suggested that this is a re-enactment of the testing of his adoptive parents. Additionally, participants in this study described methods of overcoming the fear of further rejection and loss and the defences that might occur during the development of the therapeutic relationship, such as the modification of therapeutic boundaries and the offering of different ending experiences when working with adoptees.

#### ***5.2.1.3 The need for expertise***

There are many books that have been written about the experience of adoption triad members, but little has been written about therapists' experiences of having specific training when working with adoption triad members. The importance of receiving specific professional training in order to work with adoptees has been made explicit by participants in this study and is something that adoption experts in the theoretical literature seem to indicate is essential. They argue that it is important for practitioners to understand the complexities of the psychological influence of adoption to better serve adoption triad members (Barth & Miller, 2000; Okun, 1996; Pavao, 1998).

Yet this research did not confirm the findings of Sass and Henderson's (2007) survey, which concluded that psychologists in their quantitative study feel undereducated on this issue and that they do not consider adoption to be a serious problem that triad members are facing. It is hypothesised that the therapists that were interviewed have chosen to work specifically within adoption and have therefore pursued additional expertise in their field of work, which seemed to increase their confidence in working with this client group and might facilitate the therapeutic process. In contrast, the study by Sass & Henderson surveyed licensed psychologists in the USA with little or no specific focus on adoption work.

Participants in this study discussed how they adapt their style and techniques to their adult adopted client, highlighting the importance of an inclusive psychological practice, which could mean being able to draw on a range of approaches and potential interventions. It therefore seems that counselling psychologists are well

equipped for working with adopted clients. Having training in at least two therapy models (Orlans & Van Scoyoc, 2009) means that rather than relying solely on one approach to guide their clinical work, counselling psychologists make sense of distress by drawing on competing therapeutic modalities, each potentially with something important to contribute, in order to tailor their approach to their clients' needs (Ashley, 2010).

The participants' personal familiarity with adoption seemed to be perceived as an important influence on their decision to work with adopted clients. Several participants also indicated that this personal experience facilitated the establishment and maintenance of the therapeutic relationship, and personal experience and professional experience were closely linked for most participants. To date, there is no research suggesting what impact, if any, personal experience of adoption counsellors has on therapists' relationship with their clients. However, it could be a factor that may indirectly contribute to the development of the therapeutic relationship, as Tim's account suggested: *"...they know I am adopted and I have a knowing about their history, and that strengthens our working relationship"* (line, 129).

A study by Wiseman and Shefler (2001) found that personal and professional development was closely interlinked and difficult to categorise, which is in accordance with the current study, where, as mentioned above, it seemed difficult for participants to disentangle the personal from the professional experience. Also, participants' views seemed to support the notion that therapists' personal characteristics were determining factors of the process and outcome of therapy, and the growing body of literature confirms that the therapist's professional and personal characteristics can influence the therapeutic alliance (for example, Daniel, 2006; Ligiero & Gelso, 2002; Rubino, Barker, Roth, & Fearon, 2000).

In addition to the importance of personal familiarity with adoption, it was evident from the interviews that, for the majority of participants, interest in working with adopted clients began during the earlier stages of their professional development in the area of psychotherapy. Consequently, this could be considered a significant

phase in which to engage therapists in psychotherapeutic work within the adoption field. An implication for counselling psychology training would be to increase the awareness of adoption issues that can be present when working with clients, as this can have a great influence on the development and maintenance of the therapeutic relationship. This might also enhance the interest in working in this specialist field.

Counselling psychology philosophy recognises the importance of engaging with subjectivity, respecting accounts as valid in their own terms, empowering the individual and acknowledging social contexts and discrimination (British Psychological Society, 2005). An awareness of adoption-related issues therefore adheres to these requirements and also places counselling psychologists in an ideal position to be able to work with adopted adults therapeutically, regardless of whether or not adoption is the main focus of their work.

### ***5.2.2 Are there any particular characteristics, challenges or issues?***

#### ***5.2.2.1 Therapeutic boundaries***

Participants in this study expressed the importance of therapeutic boundaries, particularly when working with adult adoptees. The main function of therapeutic boundaries is to provide a safe background against which both the therapist and the patient can focus on the task. In her work about the psychoanalyst Melanie Klein, Segal (2004) put Klein's words as follows, which is in accordance with participants in this study who used re-parenting as a therapeutic tool:

*"In therapy, firm boundaries may enable psychotic levels of the personality to be explored or held safely: without them the client or patient can be afraid of becoming too entangled with the therapist; of taking the therapist over or being taken over. Just as a small child is not helped by being allowed too many liberties, so a patient or a client is not helped by being allowed to take liberties."* (pp. 89–90)

It has been suggested that there are always implications when the boundaries change (Thomson, 2006). For example, when clients arrive late, cancel sessions or forget to pay fees, therapists might like to reflect on all the different reasons for this, which

was also a finding in this study. Exploring and understanding the meaning of boundary changes is, according to Thomson, an important part of the therapeutic process and provides a valuable insight into clients' inner worlds.

Shulman (2008) suggested that adopted clients' psychological boundaries of self and other are particularly susceptible to specific vulnerabilities which in turn are associated with specific psychological dynamics that can have a damaging effect on relationships. There seemed to be a consensus among participants that adopted clients evoke a modification of therapeutic boundaries. Most participants have revealed that their therapeutic boundaries with adopted clients differ compared to those that they have with non-adopted clients, and this is how Louisa put it: "*All the things I don't do, I do...with adopted adults...*" (line 208), potentially highlighting the increased responsibility taking to the adherence of boundaries by the therapist as opposed to seeing this as co-produced out of the interaction between both parties.

Some participants described how the modification of boundaries can also be helpful in facilitating the therapeutic relationship and enhancing the outcome of therapy, which is also advocated by Lazarus in relation to general adult mental health clients (1994). Nothing has been documented within the literature concerning the facilitating properties of the flexibility of boundaries when working with adult adoptees, so the observations of the participants are particularly novel and interesting.

Some participants hypothesised about their rationale for therapeutic boundary modification. The avoidance of perceived rejection by clients in the therapeutic encounter and that most participants see themselves as an attachment figure might result in an increased flexibility of therapeutic boundaries. Existing literature has described the adoptee's early loss experience as a potential factor for the tendency to experience the therapist as their lost birth parent or long-lost relative (Bertocci & Schechter, 1991; Kirschner, 1990). The result is that some clients potentially experience considerable ambivalence about the psychotherapeutic process due to a simultaneously occurring desire for attachment and fear of abandonment (Carizey, 2004). Also mentioned by participants in this study was a feeling of pity towards

adoptees and their early loss experience; this was suggested by one participant and might also manifest itself in modification of boundaries, cautiousness and hesitancy.

#### **5.2.2.2 Therapists' self-care**

The emotional consequences of the work and the importance of looking after oneself were discussed by most participants, and they highlighted the need for supervision and reflective practice. The need for supervision when working therapeutically with clients is supported by Bennett-Levy's (2006) declarative-procedural-reflective (DPR) model. An important part of supervision is aiding discussion of interpersonal processes in the supervisory relationship, exploring factors that may cause ruptures in the therapeutic relationship and providing strategies to improve interpersonal skills specifically to do with therapeutic relationships. Participants also spoke about the informal and formal support of peers within their everyday work, such as brief conversations with and supervision from colleagues. Some participants also referred to appreciating the process of participating in this research, since it promoted valuable self-reflection, which seemed to aid participants' understanding of their clients' difficulties, what action to take and also acted as a way of looking after oneself. Engaging in reflection seemed to be perceived as an aid to participants' efficacy as a therapist. This finding supports the DPR model (Bennett-Levy) and how it emphasises the development of reflection on self-care (Barnett, Elman, Baker, & Schooner, 2007). As in Tweed and Salter's (2000) study, participants in the current study appeared to engage in self-supervision, in particular when difficulties in the therapeutic relationship occurred or, as described in this study, when participants felt they were "*left with things*" (Tim, line 118), which might help them to decide what actions to take.

Additionally, the needs of the therapists must be addressed whilst working with trauma, which can be part of the issues that adult adoptees present with in therapy. The reliving of traumas can vicariously traumatise therapists if teams and workloads are not managed carefully. Supervision is again essential here, in terms of support and workload management, but also importantly in enabling therapists to maintain high standards of competency in treatment. It can also be a protective factor in relation to the well-being of the therapist (Duffy & Gillespie, 2009).

The findings indicate the importance of training and support for therapists working in this field and their potential need for additional support for their own psychological and emotional wellbeing to avoid becoming burnt out. Support given could involve commitments to regular supervision, monitoring how many adopted clients are on the therapist's caseload and continued training and professional development.

An aspect that sets counselling psychologists apart from the other specialities within the British Psychological Society is the requirement during training to undertake personal psychological therapy as part of becoming a reflective practitioner (British Psychological Society, 2005). Personal therapy might enable counselling psychologists to develop a conscious awareness of their own vulnerabilities as well as a high level of resilience (Orlans & Scoyoc, 2009), which seems essential when working with adult adoptees. Participants in this study emphasised the importance of reflexivity, which points to the development of skill in the active use of the self, and could raise the question of whether those who have not had the opportunity for personal development (such as personal therapy, supervision and reflective diaries) should be engaged with counselling adopted adults, due to the complexity of this work.

### ***5.2.3 Do therapists modify or adapt their practice?***

#### ***5.2.3.1 Re-parenting***

The notion of re-parenting the vulnerable child within the adult adoptee was mentioned earlier in relation to therapeutic boundaries when working with adopted adults, and emerged as one of the sub-themes in this study. Louisa, for example, alluded to providing a different kind of parenting, indicating that her role as therapist is akin to a role as parent. "Limited re-parenting" is an important feature of the therapeutic relationship in schema therapy (Young, 1990; 1999), which is an integrated approach for complex, long-standing psychological difficulties. Limited re-parenting involves providing, within appropriate boundaries of the therapeutic relationship, what clients needed but did not receive from their parents as children (Young, Klosko, & Weishaar, 2003). The therapist goes into this relationship as if he/she were a parent figure for the patient to provide a corrective emotional

experience, which seems to resemble the approach that some participants in this study suggested they followed.

#### ***5.2.3.2 Ending experiences***

Prevalent in the participants' narratives was that endings with adoptive clients are difficult. Participants revealed that some of their clients seem to be so fearful of the process that they try to avoid ending altogether, for example they drop out, attend erratically or leave with issues to work on at a later date. This is a direct reflection of the description in a case study by Samuel (2003), who experienced a premature ending with Mrs B in her psychotherapy work for the NHS.

Participants in this study seemed to suggest that given the adoptees' sense of abandonment and rejection, the process of ending an intimate relationship such as a therapeutic one requires particular understanding. Deeg (2002) explained that termination of therapy might lead to the reappearance of a specific manifestation of abandonment, and Siebold (1991) proposed the clients' tendency to experience the therapist as an abandoning object. It therefore seems important to create a new and different experience for clients in order to rework the clients' experience of separation and loss in a safe, empathic environment (Carizey, 2004).

An interesting finding in this study was that participants supported the idea of managing endings differently with adoptees, for example coming back for more sessions or staying in touch after therapy has ended, which was not explicitly mentioned in existing literature. The capacity for therapists to be flexible and to respond to clients individually might be facilitated by a current pilot project, where adoptive parents are given personal budgets to have a greater choice over the adoption support they receive (Department for Education, 2012a). If this is extended to adult adoptees, it might make it easier for adoptees in the future to act on their decision to come back to therapy at a later date once sessions have finished.

Potentially, these modifications, when working with adoptees, might lead to the difficulty participants themselves experienced with endings. Also, therapists who are adopted themselves need to process their own anxieties about abandonment enough

to be able to tolerate being left, otherwise they might unconsciously hold on to clients. Another possible consequence is the avoidance of evoking negative transference out of fear of being unlikable or unwanted and then perhaps abandoned and as a consequence, maybe, not allowing for a natural ending to occur. Another finding in this study was that one of the participants used endings to celebrate the work that she and the client have achieved together, which she perceived might facilitate a positive ending experience. These divergences emphasise again the importance of taking the individuality of each client, but also of each therapist with their individual working style, into account.

The findings are therefore consistent with the existing knowledge base regarding the heterogeneity of adopted adults. Wagner (2001) described the danger of over-emphasising and generalising the adoption experience, which she coined as the "Coat-Rack Defence", meaning adoption is the coat rack, or hook, that one can hang anything or everything on. She pointed out how adoption becomes equated with psychopathology and personality disorders. Similarly, Winnicott (1954) indicated that adoption is one context among many. On the other hand, however, there is a danger of dismissing the particular meaning for each individual, as adoption forms an integral part of a person's identity and their developmental struggles (Bonowitz, 2006). Kirk (1964) recommended that research about and practice with adoptees maintains a sensitive balance between "denial of differences" and "insistence on differences". This is congruent with counselling psychology's focus on the subjective experience, values and beliefs embedded in a social context, in this case adoption.

#### ***5.2.3.3 Perceived expectations***

Participants described the heightened expectations with regard to therapy with adoptees, and it seemed that this client group might have very definite expectations about what they need as they specifically chose an adoption counsellor. McLeod (2003b) reflected that most clients regard therapists as high-status "experts". He also explained that therapists are familiar with the settings of counselling and the rules of the counselling encounter, unlike clients. This could lead to a mismatch between clients' and therapists' expectations and could result in disruptions in the therapeutic relationship. In this study it also seems evident that these perceived heightened

expectations of clients further highlighted the challenges that sometimes occur when working with this client group.

Some participants tried to make sense of their inability to "leave their patient in the room", which might bring to light the particular emotional responses that seem to be evoked when working with adoptees. Clients were, for example, described as "*demanding*" (Louisa, line 631) and "*draining*" (Maria, line 1262), which might allude to the difficulties that the therapists had in understanding and working with these negative countertransference feelings and might potentially explain why the work with adoptees was described as challenging.

The literature in the area of adoption is filled with case studies of both adults and children. It is noteworthy that few studies go into great detail about therapist–client dynamics, particularly therapist countertransference. However, an awareness of these feelings might be effective in enhancing their understanding of their patients' difficulties (Kernberg, 1975). Lemma (2003) argued that during countertransference the therapist might have related, or the same, feelings towards clients as clients have experienced in past relationships; this seems to be in accordance with participants' descriptions in this study.

Caution, however, seems necessary with regard to interpreting the participants' emotional responses to clients, as therapy is a mutual process of exchange that involves both the client's and the therapist's experiences and unresolved conflicts (Meszaros, 2004). It is essential that counselling psychologists and therapists working with adopted adults are aware of their own pattern of relatedness in order to be able to identify and distinguish between areas of personal conflict and genuine countertransference responses to ensure their ethical practice. Again, personal development and supervision can play a significant role in supporting safe practice for therapists working with adopted adults.

In conclusion, the findings of this study may inform counselling psychologists and therapists working with clients who were adopted as infants about the specific types of difficulties and obstacles that therapists can face when working with adoptees within a therapeutic relationship. The findings also highlight those factors which can be unique to and significant in their work. Furthermore, this study offers some ways

of managing these challenges in psychotherapy and a relational view of conceptualising the experience of adoptees through the lens of adoption counsellors. It is hoped that the findings of this study might enhance therapists' theoretical and practical knowledge and help them develop more effective ways and better coping strategies for working with adult adoptees in psychotherapy. In turn, this could encourage those providing counselling psychology training courses to educate their trainees about working with adoption-related issues, as these can influence the therapeutic relationship regardless of the therapeutic work contexts.

### **5.3 Methodological considerations**

#### ***5.3.1 Limitations of the study***

This study has made several unique and valuable contributions to the existing knowledge base of an under-researched area, as discussed in the implications of findings section. Whilst this research possessed originality in terms of research questions and findings, it also has a number of limitations, which can subsequently indicate directions for future research.

The difficulties in recruiting counselling psychologists with experience of working with adult adoptees meant that a convenience sample consisting of adoption counsellors affiliated with the Organisation X was the best option. It is very likely that adopted adults who contact the organisation experience increased problems with adoption compared to those who do not contact post-adoption services, which might have influenced the participants' view of the psychological difficulties of adult adopted clients.

Homogeneity could also be an issue, as participants included counsellors and psychotherapists with different theoretical orientations and foci, whereas counselling psychologists usually work relationally with their clients and have a common philosophical underpinning that guides their practice. However, it seems vital that, as part of a still-developing discipline, counselling psychologists learn from colleagues who already work in the field. Even though psychodynamic thinking seems to have influenced participants' work with adoptees, the majority of adoption counsellors in this study described their way of working as integrative. The researcher attempted to

emphasise at relevant points throughout the analysis where themes may have arisen which reflect theoretical beliefs, but the incorporation of these variations proved challenging. Additionally, the post-qualification experience of participants varied from 5 to 25 years, which again might have had an influence on the homogeneity of participants.

A significant limitation that needs to be acknowledged is the fact that participants' own adoption status was not determined prior to the interview. This could have been achieved through including questions in a demographic questionnaire asking participants to disclose their adoption status. However, the first question in the interview schedule opened up this area in the interview, where all but Louisa described their personal familiarity with adoption, including Tim, who is adopted himself, and Ally, who was fostered by family members. Again, this could have impacted the homogeneity of the sample.

The researcher's inexperience in IPA and the recording difficulties during two interviews could have resulted in a limitation to the depth of the interviews and the richness of the analysis, although the hope was that there was a gradual improvement during the research process. Upon reflection, those two interviews were included as they provided a rich description of participants' experience.<sup>8</sup>

The sample size in this study could be perceived as a limitation; however, it was in accordance with the use of IPA (Smith et. al., 2009) as the sample was not intended to be representative. The findings cannot be generalised, as the therapists' experiences were idiographic, subjective and contextual, and there was no objective "truth" found about what it is like working with adopted adults. Therefore, the results in this study were based on six participants' accounts, and may or may not apply to other therapists' experiences. Also, due to the double hermeneutic within IPA, different interpretations of the experiences may have emerged for other participants with a different researcher. However, Smith and Osborn (2003) suggest that IPA can offer theoretical rather than empirical generalisability, so readers may create links between the findings, their own experience and the literature. It is hoped that these

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<sup>8</sup> Please see Methodology section for details.

findings do contribute to increasing the understanding of therapy processes with this particular client group.

In IPA, the participants made meaning of their lived experiences using language. In describing their experiences, the participants may have constructed a new reality in order to appear as they wished to the researcher. Furthermore, some participants' choice of words and inability to be articulate may not have been an accurate reflection of their feelings or experiences (Willig, 2001).

It may also be possible that the interactional process of the interviews influenced the responses offered by the therapists. Wooffitt and Widdicombe (2006) criticise qualitative research, specifically IPA, because there is a lack of appreciation of the manner in which the utterances of the interviewer affect particular replies from the participants. However, some of this has been reflected upon in the analysis section of this study, where I commented upon the questioning style.

Furthermore, the therapists' awareness of ethical guidelines may have affected their disclosure of some information about their patients. Some participants mentioned that giving examples of their clinical practice would involve a breach of confidentiality for them, which meant that their answers might have been more general than those of other interviewees.

Finally, despite the aims of this research being to explore the experience of the therapeutic relationship with adopted adults, some participants may have also had concerns that the research was in some way evaluating their therapeutic skills. This may have influenced their selection of material to reflect on. However, it should be noted that given the prevalence within the therapists' accounts of the challenges faced in therapy, it might be suggested that this was not the case.

### ***5.3.2 Suggestions for future research***

The findings of this study are felt to have made an important contribution to the existing knowledge base concerning the delivery of therapy and the therapeutic

relationship with adults who were adopted as infants. This study highlights several opportunities for future research projects.

Further research might take up an in-depth exploration of certain themes (for example, "not letting go of clients" or "offering flexibility in order to keep connected") highlighted in this study to gain a deeper understanding of the significance of these concepts, which could be important for therapeutic practice and the training of counselling psychologists and other therapists working with adoptees.

It would also be valuable to explore the specific experiences of therapists who have been adopted as infants themselves and how their adoption status might influence the relationship with their general adult mental health clients or adopted clients in therapy.

Reviews of the literature on adoption note that "the absence of the adoptee's voice in this debate is surprising" (Brodzinsky, 1993, p. 162), and it would be of value to have the adoptee's voice brought directly into the research. Therefore interviewing adopted adult clients about what it is like to be in psychotherapy would be of interest; there could be a focus on clients' experiences of the therapeutic relationship and the effects adoption might have on the development and maintenance of this relationship, again using a qualitative methodology.

#### **5.4 Reflexive statement II - At the end of the research process**

As noted previously, adoption is a theme that is close to my heart and continues to influence my life, both personally and professionally. Naturally, it also affected how I have approached the interviews, analysis and discussion, but I have aimed to maintain an empathic openness (Finlay, 2008) as much as possible. I recognise that my way of interpreting and analysing the data in this research study was just one approach to understanding the therapists' lived experiences (albeit one I have found to be helpful and enlightening), as there are many other possible ways of understanding and meaning making.

In terms of the interview process, I was mindful of the power differences between myself, the trainee counselling psychologist and the experienced adoption counsellors, which might have had an impact on my questioning style and the omission of some additional probing, particularly when therapeutic terminology was used. This could be partly due to my wanting to come across as professional, knowledgeable and trustworthy. Similarly, using terminology could have also served as a "security blanket" for the participants – as something to hold onto when talking about issues that can potentially threaten their identity as competent practitioners.

With regard to my own adoption status, participants might have assumed that I am adopted, and some participants asked me at the end of the interview; again, this might have influenced what participants shared with me and what was potentially omitted. However, Smith and Osborn (2008) concluded: "People struggle to express what they are thinking and feeling, there may be reasons why they do not wish to self-disclose, and the researcher has to interpret people's mental and emotional state from what they say" (p. 54).

At the time of the interviews, I was pregnant with my first child, which was a period in my life when thoughts about my adoptive status were highly present already and were potentially enhanced through the research process. This could have affected the interviews as I might have verbally and non-verbally responded more empathically to the answers that I felt were relevant for myself in that moment, despite my best efforts to uphold a balanced position towards all utterances in the interviews.

As most participants seemed to be passionate about research and promoting their work in the adoption field, I was concerned about representing their experience as accurately as possible and in a positive light, which led to a rather descriptive first draft of the analysis. The issue of representing participants authentically has been observed to be a source of frequent anxiety for qualitative researchers (Coyle, 2007).

Participants' exploration of the more negative aspects of the work was apparent, and I am very grateful to my participants for sharing those experiences, as they enriched the analytic process. I greatly enjoyed the creative part of the data analysis and

developing the sub-themes and the master themes of the study, which were also presented to and evaluated by the IPA group I attended. However, the process of writing up the final results was difficult at times, partly due to my personal experience of being an adoptee and other demands at the time of writing. I utilised supervision, peer support and my reflective diary to become aware of potential biases with regard to theme development to ensure they reflect participants' accounts.

During the discussion write-up I again realised the importance of having additional knowledge about adoption. I have seen several adopted adults in my work as a therapist in a primary care service during that time, and although their adoption was not the main presenting issue, struggles within relationships has been a common theme during the therapeutic process. This, I think, emphasises that knowledge about what it might be like to be in a relationship with an adult adoptee is fundamental to be able to offer client-centred care in non-specialist services for adoptees. Hopefully this study contributes towards enhancing this knowledge of counselling psychologists and other therapists working with adoptees, regardless of the services they work for.

## **5.5 Conclusions**

The context of the therapeutic relationship when working with adults who have been adopted as infants has not previously been the focus of empirical research, and this study therefore adds empiricism to the anecdotal and theoretical views that have previously been portrayed in the literature. The findings from interviews with six adoption counsellors support the notion that adoption dynamics and issues have a strong influence on the relationship in therapy. Participants described flexibility in their practice in each phase of the therapeutic process, for example with regard to therapeutic boundaries and engaging in a different ending experience. Additionally, participants valued personal and professional experiences for the initiation and maintenance of therapeutic work with adoptees. The study highlights the importance of support through reflection, for example in supervision and personal therapy, in order to provide a therapeutic environment in which a new, positive relationship experience for the client is possible.

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## **Appendices**

<b>Appendix 1</b>	<b>Participant information sheet</b>
<b>Appendix 2</b>	<b>Email accompanying information sheet</b>
<b>Appendix 3</b>	<b>Consent sheet</b>
<b>Appendix 4</b>	<b>Interview schedule (guide)</b>
<b>Appendix 5</b>	<b>Debriefing sheet</b>
<b>Appendix 6:</b>	<b>Collaborating organisation approval</b>
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## **Appendix 1: Participant information sheet**

**Study title: An investigation of counsellors' experience of working with adults who were adopted as infants.**

Thank you for your interest in taking part in my doctoral research project. I value the contribution that you can make to my study. Before you decide to take part, it is important that you understand why this research is being conducted and what it will involve. Please take your time to decide whether to take part or not.

### **Purpose:**

I am completing this research as part of my postgraduate course in counselling psychology at London Metropolitan University and the research has been given ethical clearance by my university. This research will explore counsellor's experience of working with adult adoptees. This is a relatively under-researched area of counselling practice and it is hoped that this research will increase awareness of important issues about working with this client group, and hopefully inform the professional training and practice within the area of adoption counselling.

### **Participant:**

As participant you need to fulfil the following criteria in order to be eligible to participate:

- You must be currently registered by an Adoption Support Agency (ASA) under the Adoption and Children Act 2002 as post-adoption counsellor or undertaking referral work from adoption agencies or registered adoption support agencies.
- You must have a minimum of two years counselling experience since completing an accredited training program and are currently working with adult adoptees.

### **Procedure:**

Your participation is entirely voluntary. If you decide to take part, I will send you a consent form for you to sign to participate in the study. You are free to refuse to answer questions and you can stop the interview at any point, without giving a reason. You are also free to withdraw entirely from the study until DATE, after which your data would be incorporated into the study. In addition, if you have any concerns or questions about how you have been approached or treated during the course of the study, you can contact my research supervisor at my university (London Metropolitan University, m.donati@londonmet.ac.uk).

The participation in this study will involve an interview, which will last for about an hour. This will take place at a location of your convenience. I am interested in having a conversation with you about your experience of working with adult individuals who have been adopted. Even though I have a set of questions as a guide, these are flexible to incorporate your experience as your individual experience is what is most important to me. Our conversation will be audiotaped for the data analysis using a dictaphone to enable me to analyse and transcribe the data. Segments of our conversation might be included in the final write-up to illustrate my analysis findings. The data you provide will also be reviewed by my research supervisor and the final thesis will be evaluated by my training programme.

All of the information you provide will be kept strictly anonymous. Data and signed forms will be stored in separate secure locations at the researcher's home. I may wish to publish the results of my study to inform practice. To allow for this, the anonymised transcripts of our interview will be kept for 5 years and then destroyed. Once I have written up my research, a copy of the doctoral thesis will also be placed in the London Metropolitan University library, which could be accessed by other interested researchers.

It is important to be aware that although all attempts will be made to maintain confidentiality, of course there might be instances when this might need to be mitigated if you disclose a danger of harm coming to yourself or others, or if you reveal details of practice that raises serious ethical concerns, according to the BPS Code of Ethics & Conduct (2006).

It is not anticipated that the interview will cause you any distress. After the interview, you will be provided with a debriefing sheet, which will contain additional information about the study and we will have time after the interview to discuss your experience of taking part in my research.

If you are happy to participate in the above study then please email the researcher, Birgit Vote, at [adoptionresearch@hotmail.co.uk](mailto:adoptionresearch@hotmail.co.uk). Thank you for taking the time to read this information.

## **Appendix 2: Email accompanying information sheet**

Dear counsellor,

I am a third year counselling psychology trainee at London Metropolitan University and a former placement counsellor at the post-adoption organisation X and I am looking for six counsellors who work with adult adoptees to take part in my research for my doctoral thesis.

The title of the research is:

**An investigation of counsellors' experience of working with adults who were adopted as infants.**

Taking part in the research would involve a conversation lasting about an hour with me to explore your own experience of working with clients, who were adopted. There will also be a debrief to discuss your experience of being interviewed and to raise any concerns and questions you may have.

Please find attached an information sheet about my study. Your participation would be greatly appreciated and will add to the body of research about this important issue in adoption counselling.

If you are interested in taking part in an interview, or if you would like more information about the study, please email me at [adoptionresearch@hotmail.co.uk](mailto:adoptionresearch@hotmail.co.uk) or call me on 07974 949290 (work mobile).

With kind regards,

Birgit Vote

### Appendix 3: Consent form

**Study title: An investigation of counsellors' experience of working with adults who were adopted as infants.**

Thank you again for considering taking part in this research. Before taking part, it is important that you understand and agree to each of the points below. Please ask the researcher if you need clarification.

- ☐ I confirm that I have read and understood the Participant Information Sheet for this research and have had the opportunity to ask questions.
- ☐ I understand that my participation is entirely voluntary and I am free to refuse to answer questions, without giving a reason. I am also free to withdraw my data entirely from the study until DATE.
- ☐ I understand that I will be asked a series of questions about my experience and that the interview will be audiotaped for the data analysis using a Dictaphone.
- ☐ I understand that the data will be anonymised by the removal of all identifying information and that the anonymised transcripts will be used in a doctoral thesis and potentially in future publications.
- ☐ I understand that the tapes and anonymised transcripts will be kept for up to 5 years and will then be destroyed. A copy of the doctoral thesis will be kept in the London Metropolitan University library.
- ☐ I understand that my confidentiality will be maintained wherever possible, but that it might need to be mitigated if I disclose a danger of harm coming to myself or others, or if I reveal details of practice which raises serious ethical concerns, according to the BPS Code of Conduct & Ethics (2006).
- ☐ I understand that I will be provided with a debriefing sheet, which contains additional information about the study and that I will have the opportunity to discuss my experience of taking part.
- ☐ **I agree to participate in the research.**

\_\_\_\_\_  
Name of Research Participant

\_\_\_\_\_  
Date/Signature

\_\_\_\_\_  
Name of Researcher

\_\_\_\_\_  
Date/Signature

Please send me a summary of the research findings: YES / NO (please circle)

Address to which details should be sent:.....

.....

E-mail address:.....

## Appendix 4: Interview schedule (guide)

1. To begin with, could you tell me a little about how you came to work in the adoption field?
2. What is it like providing counselling to adult adoptees in your experience?

Prompts:

- Do you think there is anything distinctive about providing counselling to this group?
- Are there any particular characteristics, issues or challenges in this kind of work?
- Are there any examples of that from your practice you could tell me about?

3. What is the therapeutic relationship and process like when providing counselling to adult adoptees?

Prompts:

- Are there any particular characteristics or issues you have noticed?
- What is it like establishing and maintaining a therapeutic alliance?
- What are endings like in this work? Are there any particular issues in managing these?
- Could you describe an example of that from your work with a client?

4. Are there any ways in which you modify or adapt your practice when working with adult adoptees?

Prompts:

- Could you describe an example of that from your work with a client?

5. Is there anything regarding this topic that you think is important that I have not asked you about?

6. How has the interview been for you?

## Appendix 5: Debriefing sheet

**Study title: An investigation of counsellors' experience of working with adults who were adopted as infants.**

Dear Research Participant,

Thank you for taking part in this research that is part of a doctoral project that the researcher is conducting. You can contact the research supervisor, Mark Donati, if you have any concerns or questions about how you have been approached or treated (M.Donati@londonmet.ac.uk).

You may be interested in this additional information about the rationale of the study:

*Adoption's long and rich history and practise have captured the attention of researcher and practitioners in many fields, including social work, psychiatry, anthropology and law (Brodzinsky et al., 1998). However, psychology has been less active in the field of adoption and Fensbo (2004) concludes that "well-documented research in the adoption field is necessary" (p. 62). Sass & Douglas (2002) suggested that data from clients and counsellors would enhance adoption research related to therapy practices in adoption. Early experiences can affect the ability for an adult to form trusting relationships with others (Laughton-Brown, 2010), including the counsellor. A clear understanding of adoption-related issues is important as they are likely to emerge in the course of therapy with adult adoptees. Thus, understanding of particular attachment issues and processes could help and guide counselling psychologists who choose to work with adoptees in understanding the process of therapy. Whilst adoption is generally viewed as a life-long process, few studies researched adult adoptees and those studies mainly focussed on adjustment and birth family search/reunion and not on therapy research. As the therapeutic relationship has consistently been associated with therapy outcome, this proposed study will therefore explore the question of how experienced adoption counsellors view the therapeutic relationship that can be crucial for process and outcome in counselling with adopted adults.*

I have greatly valued your participation in my research study. If you have any further questions, do not hesitate to contact me on my e-mail address: adoptionresearch@hotmail.co.uk. Emails will be checked regularly.

## Appendix 6: Collaborating organisation approval

**LONDON METROPOLITAN UNIVERSITY**  
**Department of Psychology – Counselling Psychology**  
**RESEARCH PROPOSAL**

### COLLABORATING ORGANISATION APPROVAL

(To be completed when the student's research involves the collaboration of another organisation)

**Student Name:** Birgit Prinz

**Student Number:** 07040676

**Student Contact Tel. No.** [REDACTED]

.....

#### Collaborating Organisation

[REDACTED]

**Contact/Liaison Person in Collaborating Organisation.**

[REDACTED]

**Tel. No.** [REDACTED]

I, the undersigned, have given permission to the above named student to carry out fieldwork for their research. I have been fully briefed as to the nature of the project and the requirements for obtaining a suitable sample, administration of questionnaires, conducting interviews, or other appropriate means of data collection, and agree this can be undertaken in this organisation during the period specified and approved.

All ethical implications that might affect the organisation's reputation and commercial integrity, the well-being of its employees, and significant third parties have been discussed and where necessary appropriate action taken. (Note, if this action includes the imposition of some form of restriction or limit on access to the final dissertation, please specify the extent of this restriction e.g. permanent or for a specified period.)

The student has been/will be briefed on company Health & Safety procedures as affects their planned data gathering activities.

**Signed:** [Signature] .....

**Position in Organisation:** CEO .....

**Date:** 25 Jan 10 .....



47

48 R: Yes, that's fine. What is your therapeutic approach to work?

49

*therapeutic approach*

50 P: Well, I started off as [redacted] Counsellor and I think that's my  
51 basis. But I definitely describe myself as integrative nowadays, and I've  
52 spent quite a lot of time immersing myself in everything really from  
53 psychodynamic to CBT, and we then had the opportunity to do that in  
54 various ways. And I do find that it's useful to be able to draw on the  
55 different approaches according to the person's needs. I use Petruska  
56 Clarkson's five relationships as the basis for that, I find that is a good  
57 unifying factor.

*integrative  
being flexible  
in working with  
adoptees*

58  
59 R: What is it like providing counselling to adults who were adopted?

60

*complexity*

61 P: Well, they almost all have moving stories. I think possibly there's often  
62 more complexity about their stories than there is the average, if there is  
63 such a thing as average of course. I actually find that out of all the  
64 adoption work I do, it's probably the most satisfying, because I do find  
65 that given a little help and understanding, which I think I can provide,  
66 they seem to flourish. So that is very satisfying, and fairly quickly  
67 actually. Mostly, obviously if there are some who don't, so one can't  
68 generalise.

*moving  
complexity*

*Satisfaction*

*no generalisation*

69 Now, after all, I do think that having done the training and having gained  
70 the experience, and also in the outreach quite often work as a pair, and  
71 sometimes the other person's a social worker, and I think this is one of  
72 the things that's different with a lot, but not particularly where the adult  
73 work is concerned of course. But it's really helpful to work with someone  
74 who's a social worker, because that brings in a different aspect really,  
75 and different considerations, and that's all been pretty new to me. And  
76 some of that is relevant with adopted adults, actually not a lot of it come  
77 to think, [??? 10:04] [R & P laugh] on the adopted adults.

*difficulties in being  
particular without  
generalisation*

*Could working with  
colleagues also enhance  
work with adoptees?*

78  
79 R: Is there anything distinctive about providing counselling for a group?

80

*labelling*

81 P: I'm not sure that there is. I think they're human beings and I think  
82 possibly it's almost a danger that you get caught up in thinking about  
83 them as an adopted adult constantly, you're constantly waving this flag  
84 almost, this label. And I do have to remind myself sometimes that this is  
85 one more human being. And so in a sense that's the danger I think, and I  
86 sometimes think it's quite hard for them to be walking around with this  
87 label.

*labelling' doesn't  
adopted being a  
danger -> again  
a sort of generalisation*

88  
89 R: And I'm wondering about that, because you have certain training in  
90 that area...

91

92 P: Yes.

93

94 R:... what do you make of that, having specific training for working with  
95 adult adoptees?  
96

97 P: Well, I'm of the view that context is important and I think it's the  
98 context of adoption really, I think it is important to have the knowledge.  
99 And so many people will say I've been to several counsellors, but  
100 they've never been to someone who understood adoption, it makes such  
101 a difference to have somebody who does. Because there are, it is a  
102 different experience, I'm quite sure, from the average experience, the  
103 sense of something being wrong, which probably originates from having  
104 been taken away from the birth mother, given to somebody else, the  
105 sense of loneliness, not belonging, all those sort of things are particularly  
106 acute where adopted adults are concerned.  
107

Context

Thoughts in adoption

context distinguished work with adoptees from non-adopted clients

loneliness, not belonging

108 R: We talked a bit about this, but are there any particular characteristics,  
109 issues or challenges in that type of work when working with adult  
110 adoptees?  
111

112 P: Yeah. Well, there is the whole issue of, as I say, the sense of  
113 something just being wrong and not belonging, a sense of loneliness, a  
114 sense of yearning. In fact a man I've seen off and on for some time  
115 who's in his [ ] who recently met his mother. But having been very  
116 shut in has found it really difficult to express his feelings to her. And he  
117 told me the other night he actually said to her, 'I've been missing you,  
118 I've been missing you all my life.' And that to me was very poignant, and  
119 there are a lot of those very poignant moments in adoption counselling.  
120

just being upset, sense of yearning

example

distinctive moments in adoption counselling

121 R: And did you notice any challenges when you're working in the  
122 therapeutic relationship?  
123

124 P: Well, I think trust is a big one, because it's a big one for them  
125 basically. I'm not happy about generalising on the whole, but I think I can  
126 generalise to some degree. I find I have to tread carefully, because they  
127 might very easily feel rejected and quite a small throwaway remark could  
128 be taken as rejection basically.  
129

Worries about trust

trust not happy about generalising

feel easily rejected -> importance of thoughtful approach

130 R: Can you tell me a bit more about what you mean by trust when  
131 you're...  
132

particular important aspects in adoption counselling

133 P: Yes. I think perhaps it's partly whether I will treat them with respect,  
134 whether I'll really respect and value what they're saying, not undermine  
135 them. Not in some way use their revelations in a manipulative way, that  
136 kind of thing.  
137

treating with respect value what they say not using revelations in a manipulative way

138 R: And how do you think that plays out in the therapeutic relationship?  
139 How do you notice that there is a trust issue?  
140

141 P: Yes, I think just you sense a sort of wariness about the person; it'd be  
 142 really hard to put my finger on it much of the time. And actually my mind  
 143 is strange... somebody for whom trust was a huge issue and not in fact  
 144 adopted, but she wanted to move the chair to a different position, she  
 145 kept saying, 'I think you don't believe what I'm saying.' And oddly  
 146 enough, the trust issue was greater with her than somebody I saw fairly  
 147 recently, and she comes first in my mind. But sometimes it's very subtle,  
 148 I think it's quite useful to have somebody who is so very obviously  
 149 untrusting and battling with it, that it kind of highlights it in a certain area.  
 150 In a sense I've learnt from her because I can see the less obvious signs  
 151 in the people I'm working with who are actually adopted.

example of  
trust issue of  
non-adopted patient  
→ again emphasises the  
importance of not  
generalising all  
adopter's experiences  
subtle wariness

152  
 153 R: Are there any other particular issues or challenges?

challenges

154  
 155 P: Yes, I think hopelessness, not necessarily depression, but the feeling,  
 156 you know, that this is never going to get better and they're going to go on  
 157 feeling like this. And I suppose in the years that I've been doing this fairly  
 158 intensively, which is about    years now, I've come across two people  
 159 who are alcoholic, and that was an exceptional challenge. And normally I  
 160 would actually refer people who are alcoholics to somebody else, but  
 161 they'd already been referred to me by alcohol counsellors because they  
 162 said, 'oh, you're adopted so I can't counsel.' And also I think in any case  
 163 the adoption issues need to be addressed.

hopeless

164 And sadly in both these cases both people, it's like because they  
 165 churned up so much stuff, alcohol was their coping mechanism. And  
 166 both of them ended up with drink driving charges and losing their  
 167 licences [laughs]. And one never came back after that [laughs], but the  
 168 other one kept coming and I think we've gone through that, and she's  
 169 pulled herself up by her bootstraps, as it were, and we had a very good  
 170 relationship. But the other one, I think sometimes, as with many clients,  
 171 it churns up so many painful feelings and they just can't stand it and they  
 172 use their destructive, self-destructive coping mechanisms. Go on...

again, a fault  
of being different  
how to cope  
in help coping respond  
drop out in therapy  
highest  
self-destructive

173  
 174 R: No, sorry, I don't want to interrupt

175  
 176 P: I was going to say that I think, especially where men are concerned,  
 177 they are often very shut down, and that again is a trust issue, that they  
 178 don't dare to express their feelings, they may not even know what their  
 179 feelings are I think, they act out what the feelings are. And this of course  
 180 has affected their relationships, and they come to me when they've  
 181 perhaps lost a relationship, and they're recognise, beginning to  
 182 recognise that it's their lack of expression of feelings is what's damaging  
 183 the relationship. And... But at the same time it's really difficult to get them  
 184 to feel that they can express their feelings therapeutically, openly. And  
 185 again, it's a matter of helping them to feel that it's okay to express  
 186 feelings and negative feelings and to sob in the room, but to get to that  
 187 point can take a very long time and just a matter of hanging in there.  
 188 Being there for them, sometimes they go off, come back again, another

adopted men as an  
undergroup of adopted  
into particular challenges

## Appendix 8: Example of initial table of emerging themes (Karen)

themes	sub-themes	line
<b>“I feel a bit like a rock on which waves are breaking”</b>		
<b>Therapist motivations</b>	Professional reasons	6
	Personal reasons	14
	Special training which opened up a different field of work	25
<b>Complexity</b>	Moving	61
	No qualitative difference	586
	Different set of considerations	588
<b>Hesitation about generalisation - labelling</b>	Difficulties in being particular without generalising about adoptees	68
	Labelling people as adopted being a danger	82
	Over-emphasis of adoption in the adoption field	598
	Wary about generalisation	763
<b>Satisfaction</b>	To see people flourish	66
	Being emotionally affected	652
	Own experience heightened therapist’s level of empathy	681
<b>Contextualisation of experiences</b>	Context distinguishes between adopted and non-adopted clients	102
	Adopted men as an under group of adoptees with particular challenges	177
<b>Theme of adoption</b>	Loneliness	104
	not belonging (not explained by conscious awareness when client was young)	112 (244)
	just being wrong	124
	sense of yearning	124
	Trust	124
	being different	141
	unhelpful coping responses,	141
	anger	196
	no knowledge about genetical relations – Who am I?	255
	Abuse by adoptive parents physical and psychological– shock for therapist	276
	Reasons for adoption	344
	Never being cared for	642
<b>Important aspects of counselling with adult adoptees</b>	Treatment with respect	133
	value what has been said	133
	not using revelations in manipulative ways	133
	difficulties with endings	133
	Adoptees are fundamentally quite stable, particularly those seen in private practice – easier working through adoption issues	303

	GSA Genetic sexual attraction	363
	Flexibility of Boundaries	402
	Psychoeducation	411
	Feeling understood	423
	Report of historic abuse – different confidentiality	507
	Remembering what people say	532
	“authentic chameleon”	542
	To have a variety of therapeutic tools	554
	Use of humour	549
	To be attuned	573
	“making people cry”	707
<b>Difficulties in therapeutic relationship</b>	subtle wariness	147
	hopelessness	155
	drop-out	167
	charging for service	228
	disappointment	234
	difficulty ending	441
	Establishing rapport	524
<b>Needs of therapist</b>	Talking about experience	696
	Questions helped therapist to reflect on “unconsciously competent practice”	746
	Staying with sorrow and grief can be enriching as joy can be felt more intensely	701

## Appendix 9: Example of master table with quotes

The psychological impact of working with adult adopted clients for therapists		
Participant	Line No	Two quotes
Karen	696	"Many things actually, but partly talking about it. You know the poet Khalil Gibran, he's a Lebanese poet, I think that's where he hails from, and he says if you, that sorrow makes a grove in the soul, but if you don't develop that grove then you don't feel joy either. And that's something that I kept in mind possibly more than anything else, that in fact in a kind of way to absolutely to stay with sorrow and grief and other powerful feelings is actually enriching in a strange way, and so that I can feel joy very intensively as well, and clients' joy. And maybe in some sort of way that facilitates the sorrow and the joy."
Julia	56	"Being aware of their vulnerability. I was thinking with birth mothers you have their vulnerability as well, but in a way I think with adult adopted people... for the birth parents, even if they've not felt that they had a choice about giving up their child for adoption, you still know that they should be adults in the present, but adopted adults you don't always get that. Sometimes on the advice line, I can remember very early on when I came here, I can't remember whether it was a letter I saw or someone on the advice line describing himself as an adopted child and that sometimes feels like... not with all adopted adults I see, but occasionally you get that, the child is very much out there."
	260	" But it's constant learning, and I think in any job we learn from our clients all the time, and it's particularly I think true in adoption that you're constantly learning from, whether the adopted adults or the birth mothers or adoptive parents, you can't even think oh, I know it, because you'll be surprised. And it's like any client, but I think particularly with adoption, because it is so complex, and the range of adopted adults I've seen here, some have been adopted informally, some have been adopted formally, some have been transracial, it's a very varied experience. So you can't start saying and being complacent and think you know it, and you absolutely have to go in and learn from the..."
Ally	191	"That was extremely difficult to work with because I felt extremely agitated as well and didn't know what to do with it. So I took it to supervision and the advice I got was excellent actually. You just sit with him. He just wants to be heard. You don't have to do anything with him; and that's actually all he needed. And right in the last session, because I was debating with myself whether I should bring this to his attention, because he was most concerned about making friends and he was quite a lonely person, and I thought this is one of the things that's going to get in the way, it's major. It got in the way of us. But actually I didn't need to because somehow or other he raised it himself. I don't know how, I wish I could remember how. He raised it himself and he gave me a peg and I took it, I grabbed it and I actually fed this back to him, how I experienced him and sort of suggested maybe you might want to do some medi-... And why I felt that this was happening. It was like a physical expression of an emotional state. And we talked about meditation and that can only be of help to him, and he was very interested to hear it. "

	508	"The importance of good supervision in this, that varies because we were without supervision for quite a while, a good few months, a long time. And it's essential because... it's essential anyway for any therapist but particularly in this work, because very often you're working with the most fragile clients; one of them was potentially suicidal. Because if you're going back to revisit this dark stuff, then you have to be very, very careful about how you're doing it. So supervision is necessary for that reason, so I'm going to be able to debrief and I'm going to be given guidance so that I can contain that person and keep them safe. And when it wasn't there it was really very difficult. But it's in place now and we've got a good supervisor so yes, I would say that the supervision is different too because it's about adoption. In the other world, it's about depression, OCD, whatever, but here that's the anchor, that's the baseline."
Maria	1308	" P:Yeah, so it has its challenges. It's, it's tiring...R:Yeah. P:Especially when some – you know, that is why after a while I take off my mobile voicemail... R: Yeah. P:Because sometimes I don't want to be coming back to messages, all kinds of message, you know, because you, you do want a break. R:Yeah, yeah. P:You do want a break... [Crosstalk 0:41:49] R:So something about self-care. P:I do need to take care of myself. R:Yeah. P:Because it's so easy, for me... R: Yeah. P:I don't know about anybody else, to say "Okay, I'll see you tomorrow." R:Yeah. P:So then I will try and squeeze them in in between, you know, rather than wait until next week. Of course, they're paying for it, it's not free... R:Yeah. P:But it is again about not acting at a level that the client is acting upon. Yeah."
	601	"P:Yeah. So, yeah, it's something that you live with. You know, it's like having, er, extended family members only that you don't live with them and you don't see them every day. R:Yeah. P:But just occasionally, yeah. R: Umm, interesting. P:Yeah, I don't know if anybody else has said this to you. It, it is heavy, it can be heavy. It, it just depends on what the person is presenting. R:Yeah. P:There are those that you don't really mind when they come back six months later because you know that there would be a genuine and a deep need... R:Yeah. P:To explore and a commitment, and a real commitment, that's the word, commitment to work through those six sessions or ten sessions. R:Yeah. P:You know, and whereas there are those that will come back and you think "Are we agreeing to six sessions knowing that you will only turn up for two?" And then the four would have been a waste of my time and, you know, a loss of income for me."
Louisa	637	"Uhm, you know it's so demanding this work. I can't tell you. You have to know what you're doing and what you're up against, even what the story is. I think you're do. I don't know, I think if you didn't have that you might not be alert enough to what was going on in the relationship. You might not deal with the adoption stuff. You might note it as a fact..."
	105	"I find it personally more demanding. I find it weightier in, erm, of what is required from me. I find it tiring and I find I am much more shattered after sessions with adopted adults than I am with other clients."

Tim	31	"And having worked in various different mental health settings, lots of mental health issues, medical stuff, PTSD, lots of different stuff going on, I can say without a doubt, this is the most difficult client group I've ever worked with. That could be my own stuff as well, so I have to say that."
	153	"Thinking of my personal history of therapists, and I have worked with half a dozen therapists, only two have disclosed to me and they both disclosed that they were adopted, and they are the two that I had the most profound experience with."

## **Component 2: Reflective essay**

**Cognitive Behaviour Therapy Level 3**  
**Module Code: PYP152C**  
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**“What we do with people is less important than how we think about what we do and how we are with them” (Woolfe, 2001, p. 347) – an essay about the process of developing my personal theoretical orientation**

This essay is an account of my professional development so far as a trainee counselling psychologist. Research suggests that clarifying the factors, which influence choice of counselling orientation, are important (Fear & Woolfe, 1999; Scragg, Bor & Watts, 1999), because psychological practitioners, who adhere to a theoretical orientation that does not share the metatheoretical assumption of their personal philosophy, will find themselves in a state of cognitive dissonance (Fear & Woolfe, 1999). This can lead to dissatisfaction, poor practice and leaving the profession (Fear & Woolfe, 1999).

Research suggests that personality traits of practitioners in part explain why they are drawn towards different theoretical orientations (Dryden, 2009). A study by Ogunfowora and Drapeau (2008) showed preference of cognitive-behavioural therapy (CBT) in samples of practitioners and student therapists who are “conscientious”. This also confirms previous research that demonstrated the tendency for CBT therapists to be conscientious, orderly and efficient (Arthur, 2000, 2001; Scragg, Bor & Watts, 1999). I can relate to these outcomes, as I would view myself in these terms and I have chosen CBT as my core theoretical approach. What also influenced my choice of CBT as my main training model is that the basic principle of CBT resonates with me, i.e. that people, to a greater or lesser degree, react differently to similar events and this emotional and behavioural reaction is determined by the idiosyncratic meaning an event has for a person. I also appreciate the structure of CBT, for example the setting of agendas, working towards clear goals and incorporating standard session elements (Mueller, Kennerley, McManus & Westbrook, 2010). I am also drawn to CBT because of its empirical approach, i.e. the general CBT preference for the gathering and careful consideration of evidence. This is also linked with the encouragement within CBT to focus on concrete examples (Dryden), for instance through homework assignments. I like that the role of the therapist is of a collaborative nature, i.e. that the therapist “walks alongside” the client as he/she explores new options of feeling and behaving (Westbrook,

Kennerley & Kirk, 2007). Ellis (1989, cited in Dryden) argued that CBT therapists are experts on CBT and the change process while the client is the expert on his/her experience, which is a view on collaboration that I share.

However, when I first heard about CBT in my undergraduate psychology course, I felt that there was something “dogmatic” about the way it was taught and it seemed rigid in its application, which sat uncomfortably with my view of pluralism – that there are many people and they are all unique (Boucher, 2010). I believe that there are many theoretical approaches of how to build an understanding of the human condition. Pluralism, along with contextualism, is one of the defining features of the post-modern attitude and counselling psychology – embedded in post-modern philosophy – as it endorses all traditional approaches to psychotherapy and each of these modalities are seen to make a useful contribution to our understanding of psychological difficulties (Rizq, 2006). I think this is the underlying view that drew me to counselling psychology and its inquisitive and open-minded attitude – to say it with van Deurzen’s words (2009): “For what is needed when we are anxious or depressed: to find someone who understands our troubles and puts them into a human context” (p. 144), a need that, in my view, excludes a universal theoretical principle and a set of established clinical “if... then” rules.

The beginning of my doctoral training also coincided with other significant personal life changes, for example, moving from Germany to the UK and getting married. In parallel with those changes, I felt that during the past 2½ years, I was and I still am changing myself and working towards achieving some personal resolution and solidity. Upon reflection it seems that, from the beginning of my training, personal and professional perspectives have become closely intertwined as I learned to value using oneself in the therapeutic encounter. I think these perspectives impact on why I have chosen, and the way I employ and think about, my core theoretical approach, i.e. CBT, and my client work in general. In the following paper, I will try to outline my learning on the training course in a linear fashion – beginning, middle and ending. Each stage will also include a clinical example of my work.

## **Beginning**

I longed to work with clients and I did not feel too nervous about it. I felt challenged and excited by the prospect, but also felt – as I started my placement very early on in the first academic year – that I had to rely on myself offering a therapeutic relationship rather than any CBT skills and techniques to bring in when things got difficult. Therefore, I used Rogerian core principles of empathy, unconditional positive regard and congruence (Rogers, 1951/1957) and it assured me at that stage that Rogers had asserted that the therapist's ability to be empathic and congruent and to accept the client unconditionally were not only essential, but sufficient conditions for therapeutic gains (Rogers, 1957). Since counselling psychology is rooted in humanistic philosophy, it recognises the importance of the therapeutic relationship as a significant component of therapy (Woolfe, 1996). People have a need to relate to, and suffer from, not just from their thoughts and feelings, but also from the limits of their relationships, and people are understood and restored in relationships (Ashley, 2010). Therefore, the first task is to establish a therapeutic relationship in which the client feels secure and where the counselling psychologist can inform his or herself of the client's idiosyncratic difficulties. It seems from client and supervisor feedback that, from the start, I have come across to clients as non-judgemental and non-threatening. I am aware that this can sometimes lead to a tentativeness in challenging, which was perhaps too restrained, and a reluctance at the beginning of my training to be directive, which was at times too extreme and might explain my hesitation when working from a "pure" CBT perspective. I also think that my reluctance to CBT, as I understood it at that time, related to my reading and the finding that the majority of CBT literature discussed the therapeutic relationship rather pragmatically and the definitions seemed more technical and one-dimensional (Beck, 1995, cited in Boucher, 2010). As such, I was aware of the lack of attention to process issues in the literature.

I remember with clarity one of the first clients I had, a 57-year-old counselling teacher presenting with relationship difficulties with his younger wife. Working with this particular client, I felt I was being thrown in at the deep end, though I did not question the appropriateness of the referral at this stage. I reflected upon our work in my first process report and I realised that I find this type of coursework quite

powerful as it has an effect on me feeling deeply connected to the clients I write about. The work with this particular client, and also the subsequent feedback for my coursework, raised an important issue for me both about assessment and allocation of clients to trainee therapists (which was somewhat haphazard in the volunteer agency I then worked for), but also the difficulty of untrained counsellors/trainee counselling psychologists gaining the experience they need. More safeguards for the client, such as careful assessment and intensive supervision, costly on time though they are, could mitigate against the client acting as guinea pig. It also assists me, the trainee, to build up my clinical confidence.

## **Middle**

As training progressed, I started to employ CBT interventions rather eclectically into my person-centred approach and, at times, I tried out something out specifically in order to be able to write about it for course assignments. It also seemed at times that I felt uncomfortable with the traditional CBT approach, which might have been influenced by my own pluralistic view and the group supervision I received (with a psychoanalyst and three other trainee counsellors who were on psychodynamic training courses). Therefore, early on in my training I therefore was exposed to, and was able to draw on, psychodynamic ideas and was trained to pay attention to the therapeutic process.

I think that I saw traditional CBT at this point as task-oriented and I placed it in the context of structured treatment manuals; for example, I used (and still do at times) Leahy & Holland's very useful book "Treatment plans and interventions for depression and anxiety disorders" (2000). However, at that point of my training I still found it difficult to see how CBT, as I understood it, could fit and employ counselling psychology's humanistic values.

Boucher (2010) made a useful distinction between two contrasting understandings of CBT, which I can relate to, as he sees the understanding of CBT on a continuum of application rather than as one definite modality. At one end of the continuum he described CBT as a technique oriented approach to treat disorders with specific pathological diagnostic criteria. The emphasis is on doing, as exemplified by out-of-

session homework tasks and guided discovery methods (Padesky & Greenberger, 1995) and defines it as a manualised application of method. At the other end of the CBT spectrum, and less prescriptive, the model is created around an individual's unique and valid experience, i.e. the attention is paid to "being with" an individual's experience rather than solely "doing to" it. This type of application offers an opportunity to disrupt and manipulate meanings, interpretations and beliefs according to the *client's* subtexts - not the therapist's - within a therapeutic relationship. This for me relates to the philosophy that underpins counselling psychologists, i.e. the ability to form relationships with other people is placed at the forefront of their practice (Division of Counselling Psychology, 2004, 2005). CBT techniques are therefore best offered within an empathic relationship and chosen because of their likely fit with the client at that moment, otherwise therapists might be received as cold or mechanistic (Cooper, 2008). I would therefore see myself drawn towards the ladder end of this continuum of CBT. Again it is important to be client-centred, i.e. taking into account what resonates most with clients during our explorative encounter and that this will determine where, on this continuum of CBT (application), our therapeutic work will be based. With some clients, a more prescriptive and manualised form of CBT seems to work effectively. To give an example: one of my clients who presented with panic attacks and moderate anxiety symptoms (PHQ-9 score 10) responded well to traditional CBT treatment, which is outlined in Leahy & Holland (2000) (i.e. symptom reduction (at the end of treatment PHQ-9 score 3)). However, counselling psychologists are concerned with their clients' wellbeing and their therapeutic work goes beyond symptom reduction to encompass exploration and clarification of subjective experiences and meanings (Boucher, 2010). Therefore, whilst working with this client, I also took into account her case formulation, in which the client and I thought about her early experiences, beliefs, rules for living, critical life events and coping strategies. Here, my psychoanalytic group supervision also proved valuable in the sense that it engaged me into thinking about transference and countertransference. I also experienced that our coursework in the second year highlighted the usefulness of psychodynamic ideas for case formulations for me, even when primarily working within a CBT modality. The supervision and the psychodynamic coursework enabled me to discuss different theoretical perspectives and reflect on my client work, which, according to

Rizq (2006), helps to review and rethink our stance and interventions. The appreciation of the process of therapy seemed important to me since counselling psychologists attend to people's relationships, both past and present, and especially to the relationship as it unfolds in the therapy room (Diamond, 2010). For Rizq, a maximally self-reflective stance in which the "person" of the counselling psychologist is constantly required, to provide an account of him or herself in relation to client, i.e. how own personalities, histories, backgrounds, belief systems, clinical judgement and choice of interventions contribute in helping or hindering therapeutic processes and progress. Many of these aspects are shared with conceptualisations of dynamic interaction within psychodynamic practice (Diamond, 2010) and, therefore, psychodynamic theory, and recently attachment theory in particular, has proved a valued framework for me when working with a client. My interest in attachment theory also in part influenced my choice of a thesis topic: trust in therapeutic relationships when working with adult adoptees from the perspective of experienced therapists. This is an example of integration of psychological theory and research with therapeutic practice, with which counselling psychologists are concerned (Orlans & van Scoyok, 2009). Attachment theory, which is a contemporary psychodynamic approach (Shaver & Mikulincer, 2005), enables me to think about a client's attachment history and their present relationships. Parallel to the idea that infants can only explore their environments freely when they feel they can return to a secure base, Holmes (2001) proposed that the therapeutic relationship should become a secure base from which clients can safely explore their inner worlds. In order to facilitate secure attachment, the therapeutic frame (Milner, 1952) needs to be adhered to, i.e. that I am on time for sessions, that I keep boundaries (as much as possible at my workplace, i.e. session length and sessions being held at the same time each week) and that sessions are held in the same room each time. Also, it is important for practitioners to understand the nature of a client's attachment history because, for some clients with a disorganised attachment history, activation of their attachment system can induce a frightening affect (Gillies, 2010). For example, being aware of a client's attachment system, and writing about his idiosyncratic presentation in a process report, helped me to reflect upon potential difficulties that might arise when ending therapy, i.e. his fear of abandonment that became heightened when the end of the therapeutic relationship came closer.

## Ending

As mentioned throughout, an important part of my personal and professional development throughout the course is a gradual increase in self-awareness, again an important feature in the philosophy of counselling psychology (Division of Counselling Psychology, 2004/2005). I do recognise that there is no end to this and of course, in this as in other areas as well, it is hard to know how much to attribute to the training and how much would have occurred regardless. Elements of the course by which I am thinking of facilitating my self-awareness involved receiving feedback from others, how to monitor and assess myself, the use of reflection through journal writing and relating to other trainees and staff at the university and at my placements.

The integrative nature of counselling psychology, and the different modalities we are taught, facilitates me, the “CBT practitioner”, to develop an understanding of the process in the therapeutic encounter, as psychodynamic concepts such as transference and countertransference are often missing in CBT manuals and theoretical outlines (Boucher, 2010) even though they were in Beck, Rush, Shaw & Emery’s (1979) initial conceptions and recently receive more attention in third wave CBT. I started becoming increasingly interested in those, particularly mindfulness-based cognitive therapy (MBCT) for recurrent depression (Segal, Williams & Teasdale, 2002). A growing body of literature has established the potentially positive effects of fostering mindfulness in clients presenting with a variety of issues such as depression and anxiety (O’Driscoll, 2009). MBCT takes a more holistic, formulation-based and client-centred approach than early CBT therapies did (Diamond, 2010), which resonates with my view of therapy. I did the eight-week programme myself, which was developed by Segal, Williams & Teasdale, as the importance of firsthand experience of mindfulness practices on the part of the psychologist in imparting such information has been stressed by several authors (Crane & Elias, 2006; Kabat-Zinn, 2003; Schure et al., 2008; cited in O’Driscoll). I started practicing mindfulness regularly and I am currently gaining my first client experience with this approach via facilitating a mindfulness-based cognitive therapy group at my work in a primary care service. What I particularly like about MBCT, which is quite different to traditional CBT that I practice with individual clients, is

that clients do not just learn skills or techniques to be used at the first signs of stress. They also learn a more general mode of mind that is especially helpful in relating to difficult experiences (Segal et al., 2002). Regular meditation hopefully facilitates clients to understand the nature of their thoughts, simply as thoughts, and to *observe* the relationship they have to them, thus enabling them to move toward acceptance of all experiences, including feelings and bodily sensations (Segal et al., 2002). I also appreciate the emphasis in MBCT on regular individual practice, as I view therapy as not ending when the sessions with the practitioner finish, but as a lifelong process in which the client becomes his/her own therapist and finds his/her own solutions. According to Nanda (2005), meditation has also a positive impact on the therapeutic relationship if therapists practice meditation, i.e. it seems to enhance the “being qualities” that are necessary in the therapeutic relationship. Existing literature on meditation seems to emphasise that being present to one’s breath and one’s thoughts and feelings, in a non-judgemental way, opens oneself up to love and compassion for oneself and others (Thich Nhat Hanh, 1990, 1998). The value of acceptance of one’s difficult emotions and staying with them in meditation (Sumedho, 1987; Trunpa, 1985, cited in Nanda) seems to have an impact on therapeutic practice, as has the ability of staying with one’s own difficult feelings in a non-judgemental manner and, hence, being able to stay with difficult feelings of others (O’Driscoll, 2009).

However, I think that additionally to my own philosophy of practice, the therapeutic context in which I am employed is a major factor in the reality of my therapeutic work. Counselling psychologists have to attend to the tensions that exist between knowledge and values and the contexts in which they are used (Milton, Craven & Coyle, 2010). The challenge for me seems to be the incorporation of these above mentioned “being” qualities, which are important to me, and organisation I primarily work for, where the emphasis is on skills, short-term interventions, directive change and symptom reduction. However, Cooper (2009) mentioned that even if we are working within such diagnostic-based treatment programmes such as IAPT, where my work is mainly based, we can still ensure that our clients feel understood and embraced in the totality of who they are and not just in the diagnosis around which their treatment is based.

## **Conclusion**

Although I structured this essay in a linear way, I think of the continuing developmental process of myself as a counselling psychologist in a cyclical, ongoing fashion. Reflecting upon and going back to earlier experiences in academia, my therapeutic practice and personal life seems to be important since, through that acquired knowledge, I am able to obtain information that influences my current way of working with clients and also conducting research.

In my view it is necessary to be grounded in my preferred approach (i.e. CBT) as this helps me to follow and be attuned to the client and gives me a useful set of conceptualisations, theoretical understandings and practical tools and techniques. However, at the same time, I find it important to be receptive to other theories as outlined above, such as humanistic and psychodynamic ideas, and potentially pursuing further training in, for example, MBCT. This is in line with Boucher's (2010) observation that we as practitioners are drawn to expanding our theoretical knowledge base, possibly in recognition of our lived experience that it is not one, but many, things that produce therapeutic change.

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### **Component 3: Theoretical essay**

**With reference to two theoretical models, compare and contrast process and content interventions in working with a couple. Use clinical examples to illustrate the theory.**

**Couples & Groups  
Module Code: PYP048C  
Student Number: 07040676  
Word count: 3299**

## **Couple Therapy from a Family Systems and Attachment Perspective**

A substantial amount of people seek counselling as a couple, because they noted that their problems are rooted in their relationship rather than being attributable to individual issues (McLeod, 2003). The aim of this essay is to demonstrate a working knowledge of how psychodynamic (and family systems) theory and concepts contribute to an understanding of couples in difficulty. I have chosen to discuss the orientation of Murray Bowen (1978) as an example of a systemic approach and I will explore working with adult attachment to illustrate psychodynamic practice in working with couples. I will conclude the essay by briefly mentioning the importance of the psychodynamic concepts of transference and countertransference. But I will begin the essay by outlining an example of a couple. This case example will be used to illustrate the process and content interventions. As I do not see couples in my clinical work, I have to refer to a female client I have seen for individual therapy sessions, and I have chosen this client as she presented with relational difficulties in a primary care setting. However, I therefore only know the client's side of the story and the examples given are merely suggestions of how their relationships might have been with each other and their attachment figures. For reasons concerning confidentiality pseudonyms are used and the couple will be referred to as "Mary" and "George".

### **Case example**

Mary and George were in their late thirties; they married eight years ago and lived together for ten years. They had two small children. Mary described having ups and downs in their marriage, and said that George did not talk about his feelings and kept them "bottled up". Arguments became more frequent since her mother-in-law moved in several months ago after her father-in-law died of cancer. She said that she was not asked whether she consented to her mother-in-law moving in, and discussions about it ended in arguments with George. Mary said that she is angry with him of always siding with his mother, who was very critical of her since she moved in. Mary described her relationship with her mother as emotionally close since she was an adult, and she talked to her most evenings on the phone as they lived some

distance apart. Mary worked part-time, partly “to get away from her mother-in-law”, which George did not support. Mary felt guilty about working, as she felt that she “should be there for the children”. George worked in a job that was not well-remunerated, so there were financial anxieties attached to her mother-in-law moving in for Mary. Mary came from a large family and she is the eldest daughter and had responsibilities looking after her younger sisters and she described having to grow up quickly. His father was working long hours and died when Mary was 10. Mary described George’s relationship to his father as cold, aggressive and distant and his mother as “loving, but passive”. His father was also a heavy drinker. George occasionally witnessed physical violence between his parents and was then sent to his room by his father, and his door was locked.

### **Systemic Couple Therapy Interventions: Murrey Bowen (Family Systems Theory)**

Systems concepts are useful in cases where the divisive issues centre around the involvement of one or more other family members, in the case example here in particular the mother-in-law(s), and can be understood as dealing with issues that are non-negotiable between the couple (Belsey, 1990). I have chosen to discuss Bowen’s orientation, because it is known to be the most inviting to psychoanalysts (Gerson, 2010) as it is congruent with the views of psychoanalytic writers such as Meissner (1978), Nadelson (1978) and Kohut (1977). Two major differences that impact on the practice in couple therapy can be found: the non-existence of the unconscious and the declaration of transference as artificial in Bowen’s theory (Gerson, 2010). The foundations of his theory are the constructs of triangles, anxiety contagion, differentiation of self, and multigenerational transmission processes (Bowen, 1978), which I will briefly outline in the following.

The apparent functional-dysfunctional balance in a couple can be seen as two sides of a triangle, with a third needed to provide stability (Belsey, 1990). Dyads are seen as inherently unstable as relationship units, because of the anxiety generated about both separateness and merging (Gerson, 2010). Anxiety is, according to Bowen’s theory (1978), an automatic response of the human organism to threat and it is passed from one person to the next in subtle and multiple ways. Disruptive anxiety

could be reduced by involving a third party (Gerson), in the case example mentioned above this might have been the mother-in-law, but also their two children. Less well-functioning units are more readily involving a third party, who becomes peripheral once the anxiety decreases.

Bowen seems to share the reluctance to differentiate pathological from normal processes and structures with psychoanalysts (Gerson, 2010), which is also compatible with counselling psychology's focus on facilitating well-being (Sinitsky, 2010). Bowen devised a "differentiation of self scale" from 0 to 100 to conceptualise human functioning on a continuum scale. People have the task of separating from their family of origin (Street, 1991) and it has been found that individuals tend to be attracted to others who have achieved the same degree of separation (Bowen, 1976). Differentiated people are seen to respond better to life's stresses, however in times of relative calm, even undifferentiated families may appear to function appropriately, but stress can cause them to break down (Bowen).

With regards to Mary and George, it seems that they followed their family pattern and both remained psychologically close to their mothers. George became physically close to his mother again to the dismay of Mary. Even though Mary had relatively little physical contact with her mother, she might have still complied with her family-of-origin psychological instructions and messages. In order to highlight family messages that might be relevant for their presenting problem and a transgenerational scanning of emotional themes, the construction of a genogram can be used (McGoldrick, Gerson & Shellenberger, 2008). The genogram allows a quick and graphic overview of family composition, life-cycle stage and history for all parties to see (Street, 1991). Generally though, a genogram is a spatial representation of three generations, organized around demographic data (i.e. births, deaths, work commitments) (Gerson, 2010) and is therefore also a useful assessment tool (Alilovic & Yassine, 2010). In the case example, the therapist could focus on the overcloseness at present between mother and son/daughter. It would therefore allow an investigation of the presence of this theme within each generation as well as those in between generations.

The therapist remains central during therapy sessions, and discourages “reactivity” or responsiveness between members of a couple and most importantly tries to resist being triangulated by the couple (Gerson, 2010). The therapist encourages “I” statements rather than accusations and he/she might invite George and Mary to listen attentively to each other’s “I” statements about responsibility and emotional closeness. For example, George could be encouraged to statements such as “I have learned to support my family financially by my father; this is the only way I am used to offer support”. On the other hand, Mary could be discouraged to form accusations and demands and instead invited to calmly state her preference for increased involvement and emotional intimacy and plans could be discussed in which way she could achieve her wishes. For both parties, it is important to go back to their family-of-origin and experience reinvestigation of those relationships (Gerson). Mary could be encouraged to find the source of her difficulties in living with her mother-in-law. George, however, could be facilitated in looking for the roots of his disengagement with his wife and his underlying reasons for inviting his mother to live with them. According to Gerson, the focus in therapy would be on the individual in the presence of the other. The increased differentiation of self is a described goal of therapy, which means that therapy is long-term as self-differentiation is seen as a developmental phenomenon that once set during rearing, is very difficult to increase later in life (Roberto-Forman, 2008). The final phase consists of “planned investigative sojourns” (p. 36, Gerson) at the family-of-origin sides (in Mary and George case they already live with his mother and would therefore go to her mother to stay). This family-of-origin work (Framo, 1976, 1996) can mark the beginning of opening up conversation and relationships that are deeply moving and healing in their effects (Jenkins, 2006). Unlike other systemic therapies, Bowen focuses on the past rather than the present tense, which is similar to psychodynamic theories, i.e. freeing oneself from family-of-origin relationship positions that are repetitive and compulsively restricting (Gerson). On a monthly basis, the couple can review with the therapist their progress in de-triangulation.

## **Psychodynamic Couple Therapy Interventions: Attachment theory for couples**

From a Bowlbian perspective, the search for establishment, maintenance and mourning of couple relationships are central themes of adult existence (Holmes, 2001). Bowlby's attachment theory is built on the object relations principles: the need for relationships and the relational structure of the self, and it looks for objective evidence for object relations concepts (Gomez, 1997). Bowlby and his major colleague, Mary Ainsworth, combine key insights from psychoanalysis, ethology, developmental psychology and cognitive psychology to create a theory of emotional bonding and emotional regulation that has been tested and elaborated in hundreds of studies over the past 25 years (Shaver & Mikulincer, 2005). Huprich (2009) proposes two basic concepts that are distinct in attachment theory. Firstly, responsible and accessible caregivers need to create a secure base for children, thus providing children with the sense that the caregivers are accessible and dependable. And secondly, the way the emotional bond develops becomes internalised, and internal working models are formed. Attachment theory postulates that human beings are born with inbuilt patterns of behaviour that promote and maintain relationships; relatedness is therefore seen as a fundamental motivating force in human behaviour (Huprich).

There is growing consensus that the quality of a person's primary attachments in childhood is intimately linked with patterns of interpersonal relatedness throughout the life-span (Fisher & Crandell, 2001). Attachment theory as a guide to clinical practice with couples is congruent with systems thinking in several fundamental ways as well as being monistic (Gerson, 2010). While systems theory states that the study of one system always involves the study of a sub-system of a wider system, attachment and object relations theories retains the complementary, and also valid perspective, that systems are created in the image of their sub-systems (Clulow, 2001). Whilst Bowen (1978) regarded the unconscious as artificial, attachment theory takes into account uncounscious and defensive processes, such as denial, projection or splitting. However, the formation and persistence of an internal world and the relationship of reciprocal influence between this and the individual environment seems to be inherent in both, Family Systems and Attachment theory.

Attachment theory might therefore be seen as a bridge, moving between interpersonal systemic to the internalised history, which is often not immediately available to the conscious (Jenkins, 2006).

It is proposed by attachment researcher that in adult couple relationships each partner functions as an attachment figure for the other, therefore attachment is bidirectional (Fisher & Crandell, 2001). It is further anticipated that the quality of attachment in the couple will be strongly influenced by each partner's representational models of attachment.

Secure couple attachment involves the ability to shift freely between the depended-on positions, i.e. each partner experiences both the position of the "infant", who is emotionally dependent upon the attachment figure, and that of the attachment figure who provides comfort and reassurance to the "infant" (Fisher & Crandell, 2001). There is therefore symmetry within the individual and within the system and ability present to engage emotionally, which Gottman & Notarius (2000) regard as crucial to marital resilience.

Different patterns of insecure attachment have been proposed, but they all share the lack of flexibility and mutuality and the lack of reversible bidirectional characteristic of secure couple attachment (Fisher & Crandell, 2001). Studies have shown that when couple members had insecure working models of attachments (based on descriptions of relationships with their parents) they fought more when alone as a couple (Cowan, Cohn, Cowan & Pearson, 1996).

Adult attachment within close relationships can be measured by the Current Relationship Interview (CRI, Crowell & Owens, 1996, in Clulow, 2001). This is a narrative assessment intend to examine the influence of the partner's attachment behaviour and ideas on the individual's representation of and his/her own attachment behaviour (Crowell & Treboux, 2001). It therefore investigates the attachment representation within the adult partnership. Additionally, couple therapists are also interested in the relationship between the parents that couple members internalise from their childhood experiences (Clulow, 2001).

Although in the above case example I was not able to formally assess Mary and George's attachment style, I presume that they might have a preoccupied/fearful couple attachment style (Fisher & Crandell, 2001). Adults with a preoccupied attachment style are unable to trust in the availability of attachment figures (Nelson, 2005). Mary might demonstrate a desperate desire for connection along with a strong fear of rejection and it is likely that she shows an anxious, even demanding need for caregiving and soothing coupled with great difficulty in being soothed. It seems that Mary had to take over the role as a caregiver early on for her younger siblings. However, when she tried to persuade George to talk about his feelings (i.e. Mary being in her usual role of a caregiver), this would lead him to withdraw even further. Also, compulsive caregiving to others might be a way of containing her anxiety and be an attempt to secure the presence and caregiving responses of the attachment object. Her husband George on the other hand might have developed a fearful attachment even though he might describe his mother as "loving" and it seems that she was quiet and appeasing to avoid conflict with her husband. George continued to be afraid of his father, who seemed highly dominant and critical, whose discipline bordered on abuse and George had to actually watch physical abuse between him and his mother. George was sent to his room by his father when he showed signs of distress, therefore he might have learned as an adult to hold his feelings in and to deal with problems on his own. He might have concluded that others are unlovable and unavailable and that he himself is unlovable and avoids intimacy due to a fear of being rejected. The couple's respective internal working models might therefore be reenacted in different ways in their married life.

Psychotherapy with couples is one approach to create conditions within which secure partnerships can be fostered, but attachment couple therapists have to be clear that their client is the partnership rather than either of the individual within it (Clulow, 2001). Bowlby (1969) hypothesised that change in attachment patterns could occur later in life through the influence of new emotional relationships and the development of formal operational thought. He saw the role of the therapist as analogous to that of a mother who encourages the child to explore the world from the secure base she creates (Bowlby, 1980). Bowlby (1988) described the position of the therapist as being "you know, you tell me" rather than "I know, I tell you" (p. 188),

which is congruent with the view of counselling psychologists as we rely heavily on the self, interpersonal skills and the therapeutic process (Woolfe, Dryden & Strawbridge, 2003) and our philosophy emphasises that the client's work is done in relationships.

Attachment couple therapists emphasise moment-to-moment interactions and the capturing of micro-intense interactions, which is similar to the emphasis in systemic practice (Gerson, 2010). However, whilst systemic therapy works directly with relationships, the emphasis in psychodynamic therapy is rather on the hypothesised internalised relationships as described above (Jenkins, 2006).

If George and Mary would be in therapy with an attachment couple therapist, the therapist would focus on establishing a secure therapeutic base, i.e. the predictability of setting and time and establishing a therapeutic alliance through working at becoming attuned and responding appropriately to the couple's signals. The therapist would encourage the exploration of the predominant and shared working models that hamper the development of the couple by discussing patterns in their relationship (Clulow, 2001). For example, the way the couple might replicate behaviour that they exhibit when they are at home. Their different ways of managing emotions and how these strategies act upon the other and influence their behaviour together might become apparent (Clulow, 2001). The more George held back, the more Mary might press him to talk during sessions. He might show a tendency to see the therapy as chats, wanting to gain information and advice whilst maybe reacting impatiently towards Mary's "wallowing in feelings" and he might explain his difficult upbringing in a matter-of-fact way. For Mary on the other hand, it might be difficult to find an autonomous perspective on her past and present family situations.

The moment-to-moment interactions are an important intervention as they encourage exploration within the session so that what is feared as unsafe becomes less frightening. For example, crying in psychotherapy, for Mary or for George, may represent a move towards a more secure caregiving connection with the therapist (Nelson, 2005). Also, moment-to-moment interactions are important in breaking a negative interactional cycle as described above through accessing and reprocessing feelings and fears (Clulow, 2001). Hardy, Aldridge, Davidson, Rowe, Reilly &

Shapiro (1999) observed therapists at different moments in therapy and were able to cluster therapist's responsiveness in long-term therapy. Early on in therapy, the primary need of the client is for the therapist to be present and available as attachment figure. In the course of therapy, therapists move between helping clients to feel understood and challenging them through interpretation. The deciding factor Hardy et al. noticed in making those choices is the level of anxiety operating in the therapeutic relationship. The therapist worked at what they described as the level of proximal development, where emotions were manageable, but arousal was sufficient to enable change and development.

It has been suggested that a combination of systemic and psychodynamic concepts allows therapists to choose which problems to approach, and which to leave untouched at any given moment in the therapeutic process (Belsey, 1990). Particularly attention should be given to transference and countertransference feelings and reactions in relation to each couple member, as this is absent in Bowen's theory, but can have an impact on the therapeutic relationship. This is coherent with our engagement as counselling psychologists in reflexive practice and asking questions about the role in the therapeutic work (Sinitsky, 2010).

Transference involves the displacement of thoughts, feelings and fantasies that were originally about important figures in childhood onto the therapist. It provides vital information and clues about a clients' past and about why a couple member is feeling what he or she is feeling about others outside the therapy (Eichler, 2010). The incorporation and exploration of transference reactions in sessions with a couple is challenging as it is complicated by the fact that though one member of the couple may raise an issue, everything is raised in the presence of the other couple member (Gerson, 2010).

Countertransference involves a phenomenon similar to transference, this time occurring on the part of the therapist toward the couple (Eichler, 2010). Research suggests that therapist's unresolved attachment issues may be confounding countertransference reactions (Mallinckrodt, 2000). Therefore it is critical for counselling psychologists to be aware –through supervision and personal therapy - of

our own pattern of relatedness in order to be able to identify and distinguish between areas of personal conflict and genuine countertransference responses to ensure ethical and competent practice (Skourтели & Lennie, 2011).

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## **Component 4: Process report**

**Applied Therapeutic Practice  
Module Code: PYP047N  
Word count: 4389  
Transcript word count: 1091  
Actual word count (excluding transcript):  
3298**

## **Introduction**

### **a) Overview**

This process report critically presents my work as a Trainee Counselling Psychologist with "Paul" (pseudonym), who has symptoms of chronic depression and a history of physical abuse. We have met for six sessions of Cognitive Behavioural Therapy (CBT) (Beck, 1976) in an Improving Access to Psychological Therapies (IAPT) service and therapy sessions are still ongoing at the time of writing. I receive weekly supervision by a Counselling Psychologist (CoP).

I have chosen to critically review my management of the therapeutic relationship with Paul after he missed our fourth session, drawing on additional psychological theories and therapeutic models. The transcript is part of the subsequent discussion about his commitment to therapy. I found this impacted upon the therapeutic relationship which is a vital part of my work and identity as a CoP and has the greatest influence on outcome for clients (Laughton-Brown, 2010). This report aims to facilitate an understanding of the complex subjective experiences of the client and myself, using a multi-theoretical formulation.

### **b) Referral information**

Paul's GP referred him for "counselling to try and find out triggers for his depression". I work in a community hospital and our multi-disciplinary team of Counsellors, Nurses, and Applied Psychologists assess clients for suitability. Paul's daughter completed his assessment form that contained Paul's PHQ-9 (27/27) and GAD-7 (16/21) scores, indicating severe depression and anxiety.

His GP also prescribed Paul the maximum dose of Venlafaxine (antidepressant) for many years. I wondered whether the referral carries the message that his problems are so severe, they cannot be solved. Clients who are chronically depressed can pose a challenge to therapists as they are likely to have been within the mental health system for years (Townend, 2008). This frequently evokes a heart sink reaction amongst clinicians (Scott, 1998), due to a cycle of helplessness and hopelessness for both clients and clinicians (Westbrook, Kennerley & Kirk, 2011). There is a high

risk of relapse even when recovered from depression (Segal, Williams & Teasdale, 2001), and only around half of people with severe or chronic depression respond to either pharmacotherapy or psychological therapy (NICE, 2009).

### **c) Client information**

Paul is a 57-year-old white British male. He is divorced and he has one daughter, who is 23-year-old and a 3-year-old grandson. Paul lives with his 89-year-old mother in a small house. Paul has limited social contact and is unemployed for twelve years.

## **Assessment and Formulation**

### **a) Initial interview**

Paul didn't attend our first session and service guidelines state that a client will then be discharged. In this instance, I phoned Paul to discuss re-scheduling. I am wondering about my motivation here: Partly, this seems to be influenced by a recent team meeting where the increase of cancellations was discussed. I question now whether this has led to me taking on raised personal responsibility for the team. However, there might also be a connection between my own "reaching out" to Paul and how other people respond to him - his mother, daughter and GP.

Paul attended his re-scheduled assessment on time. The client appeared to be casually dressed and was clean, but unkempt, which gave the impression of some personal neglect. He described his main problem as "being depressed" and mentioned sleeping difficulties, low mood, withdrawal, avoidance, and suicidal thoughts (no plan or intent to act on them).

Paul talked about his upbringing as an only child and described it as lonely, but "privileged"; defined as going on expensive holidays. He mentioned saving a child's life when he was a boy - did he mention this partly to illustrate his caring nature?

We spend the remainder of the session discussing what happened at the onset of his depression. Paul said that he went through a divorce, which was initiated by his wife. It left him subsequently without money, home and frequent access to his daughter. During their divorce proceedings, his father, whom he said he admired (but subsequently hardly mentioned), died. Paul started self-harming - cutting his wrists, which he last did as teenager. Additionally, Paul said that he got violent towards strangers.

During assessment we also discussed medication ("not helping"), his previous therapy experience (person-centred and CBT), which he said didn't help longer-term, but whilst attending. He explained that his daughter and mother encouraged him this time to seek professional help.

Countertransference is a psychodynamic construct, but relevant for informing any therapeutic encounter as it can give therapists a valuable insight about therapeutic interactions (Gilbert & Leahy, 2007). It involves displacement of thoughts, feelings and fantasies from the therapist onto the client (Miranda & Andersen, 2007) and can also be a "reaction to the patient's transference" (Moore & Fine, 1990, p.47). I thought about Paul's commitment to attend therapy as it seemed he received a great deal of help obtaining the appointment and experienced some apprehension: Would he see therapy as futile? Does he understand his depression as a medical problem? Would he stay? Already in my countertransference were themes of ambivalence, power attribution and meanings of care.

We both agreed on weekly to fortnightly sessions and contracted for eight sessions initially with the possibility to extend. Also we discussed and agreed on limits of confidentiality.

## **b) Formulating**

My decision to use CBT took account current research, service requirements and the client's previous experience of CBT, as he could identify with the general principles. There is a large body of evidence accumulated over the years which attests to the efficacy of CBT for depression (Grant, Townend, Mulhern & Short. 2010).

After exploring my initial responses to Paul and formulating his case after discussion in supervision (Appendix 1&2), we collaboratively discussed a simplified, preliminary CBT formulation in the third session providing a framework for understanding Paul's presenting issues.

He described his mother as over-involved, cold and demanding. He also alleged that she physically abused him. However hard he tried, it was difficult "to make her happy". The experiential derived paradigm of learned helplessness (Seligman, 1975) might facilitate understanding Paul's vulnerabilities for depression: Paul's childhood experience might have taught him that there is no effective voluntary control over important environmental events. This might explain somewhat the onset of his symptoms during critical incidents such as Paul's father's death and the divorce.

Paul's father was largely absent due to work, but Paul has fond memories of him. Paul may have resorted to defensive strategies of splitting and idealisation to protect his good object (father) (Klein, 1946). Splitting takes the form of oscillation between alternative positive and negative perspectives towards the self and others with a rigid distinction between them, to insure the perceived bad (highly critical, cold mother) cannot contaminate the good (kind, strong, hard-working father) (Cooper, 2000).

Understanding Paul's beliefs and strategies through the lens of his developmental history is crucial as these are seen to develop from childhood (Kuyken, Padesky & Dudley, 2009). We collaboratively hypothesised that Paul's early life experiences might have encouraged core beliefs such as "I have to please others", "I have to be in control" and "I am a failure". Early attachment experiences could influence the development of these and lay the foundation for the developing self (Shaw & Dallos, 2005). Insecure attachment could have contributed to Paul's vulnerability for emotional problems. Although I didn't formally assess Paul's attachment, through his narrative I sensed that he might have an anxious-resistant attachment style. A person with this attachment style has a strong desire for connection that is combined with a fear of rejection (Nelson, 2005). Paul's experience of having an emotionally distant mother and the absence of male figures, might have influenced his attachment behaviour, which could be important when relating to me, the female therapist.

Miranda and Anderson (2007) propose that individuals experience specific emotional reactions in transference that involve the particular attachment style they have with significant others. It might therefore be important to think about these reactions when understanding our relationship. I also realised that Paul evoked feelings to take care of him in me and reminded me of my reaction towards my own father, who currently is recovering from an operation. I have to monitor this countertransference carefully, as this might have already influenced the way I engaged with Paul, for example, through phoning him and being particularly accommodating about session times.

The high levels of expectations by his parents and gaining affection mainly when expectations have been met, might have also reinforced his dichotomous thinking (Leahy, Holland & McGinn, 2012), for example, "being a success/failure" or being "submissive/controlling", which in Cognitive Analytic Therapy (CAT) terms are linked to reciprocal role procedures (Ryle, 1997): Paul experienced himself as submissive to his mother but has also learnt the opposite role of being controlling which he enacted towards himself and others, for example through self-harming as teenager and being a leader in the Scouts.

His need for control and his urge to take care seem to be linked and appear to be recurrent themes in Paul's life. *Traps* in CAT are circular procedures in which the attempt to solve a problem perpetuates it (Llewelyn, 2003). Paul's hypervigilance with regards to potential threats to his safety might be a strategy to keep in control: He will constantly look out for threats by attempting to read others' intentions. His response usually seems pleasing others in order to gain control and through this, Paul neglects his own needs, which could lead to him feeling depressed and resentful. When he eventually cannot contain his resentment much longer, an angry outburst or withdrawal occurs, to which others might react to in reciprocated anger or in taking care of him. Paul then seems to receive proof that his sense of control is threatened and hence redoubles his attempt to please others, which increases his resentment and depression further.

Following the initial formulation, goals for therapy were agreed on, such as increasing his activity levels in order to break traps and "thinking more balanced". We also discussed the provisional treatment plan (Appendix 3).

## **Transcript and Commentary**

### **a) Overview of therapy**

Paul gave positive feedback about the content of the previous three sessions and his psychometric scores improved, which I assumed meant that he felt we were making progress towards symptom reduction. However, he didn't complete his homework and his mother cancelled our next session.

The purpose of the fourth session is to evaluate reasons for this cancellation and explore therapy ambivalence in order to clarify process issues. I agree with the notion that instead of seeing ruptures in therapy as standing in the way of work, it can be engaged with as therapeutic change opportunities, their resolution being the central therapeutic task in this instance (Shadbolt, 2012). The decision to focus on this is also informed by the initial formulation and discussed with Paul when re-arranging.

### **b) On-going evaluation of therapeutic session (start: 0:00 end:10:10)**

Therapist

T 1: We had this phone conversation didn't we, two weeks ago.

Client

C 1: Yeah, two weeks ago.

T 2: Tell me a little bit what happened.

*Even though my intention was to show empathy, I find my tone of voice sounds exasperated. Has this lead to his response in C2 about not taking it "the wrong way"? I wonder whether I have taken on some personal responsibility for his non-attendance, a tendency I noticed in other areas and taken to supervision. In*

*hindsight, I question how Paul would have initiated our session instead if I slowed down the pace. I feel that in previous sessions I might have rushed "into the therapist toolkit" (Schwartz & Flowers, 2007, p. 47) too quickly to resolve his difficulties and it still feels rushed here.*

C 2: I realised I was trying to please you and, don't take this the wrong way,[T: No] but jumped through all the hoops and found that I couldn't, I couldn't and the last couple of days, I've been worried about coming and seeing you. Well, I'm saying it's worry – all my jaw became very tense. I've been grinding my teeth. I've been very standoffish with people, my mum, my daughter, everyone really. I've sort of gone into myself more but I think that was as a result of realising what I was doing, you know?

T 3: Yeah. How did you realise that you were just doing this to please me? Was that something that you were quite aware of?

*It seems I mistook compliance and co-operation for recovery in earlier sessions and T3 is my attempt to find out how conscious the process of pleasing me was. I wondered whether the formulation made him more aware of process, which can be part of the use with clients (Butler, Fennel & Hackmann, 2008). On reflection, I feel that I should have acknowledged that he is now able to share this with me in order to foster our therapeutic relationship.*

C 3: I think because in the past, if you like, in a normal life, I've always... as I've said to you, everything's been very black and white to me, and it's about pleasing people or making sure things are done properly. And to find that you can't is just horrible.

T 4: The realisation that you can't please people (*client starts talking*)

*Paul does talk over me on some occasions throughout therapy. Occasionally, this has made it difficult for me to summarise or rephrase what he said. I find this a little confusing, as I am sometimes not sure whether I am actually disrupting his flow or whether he wants to keep control of the conversation.*

C 4: The realisation, yeah, and that sort of thing really brings me down again, you know, obviously. I couldn't say of one specific thing that actually triggers it. It's all of it, everything because it's all sort of written in into my head and all of a sudden, you sort of, you start to get the fear of failure a bit but going on – all of that.

T 5: You were saying in the last couple of days you were worried about telling me that, that you tried to please me.

*At the time I missed how general he speaks about his mood decline: "everything" triggered it. It might have been useful to unpack this further. I could have first summarised what he said, as Egan (1994) understands summarising as a "bridging response", which can be used to provide links between statements. Then, a potential question could have been "I wonder what you are actually saying to yourself?"*

C 5: Yeah.

T 6: What was this worry about? What were you thinking might happen if you tell me?

*I move us back to the starting point and my question here is an attempt to elicit automatic thoughts (Beck, 1995) about an earlier response. I think I left his frame of reference in this instance, taking over the session rather than expressing empathy through a summary.*

C 6: Well, I suppose I didn't want you to think bad of me.

T 7: What do you think that would mean? Let's take the example I would think bad of you.

C 7: Okay.

T 8: What would that mean to you if I do that?

C 8: I've failed again – that whole failure thing sort of crops up and no one wants to be disliked.

*I used guided discovery (Greenberger & Padesky, 1995) in order to explore the content of his beliefs and fears as this can change as sessions go on (Gilbert, 2007). I notice now that he starts speaking in general terms about not wanting to be disliked, which I use in T9 to prompt further exploration.*

T 9: So you'd think that I would only like you if you get better?

C 9: Yeah, I suppose if we're using 'like' – I don't know if that's the right word. But yeah, I suppose so.

T 10: Like or respect, not want to work with you.

C 10: Yeah, why would you want to trouble yourself, you've probably got loads of people on your caseload that need the time.

*This might relate to his attachment with his mother, where affection was conditional. Attachment-related representations are unconsciously activated by threats, and this activation affects the cognitive processing of attachment-related material (Shaver & Milulincer, 2005). It seems that Paul reacted with an associated increase in distressing thoughts about rejection and abandonment. These thoughts and feelings might play a part in his cancellation - threatening to leave before being left.*

T 11: So something about not being worth the time.

C 11: Yeah, sort of worthless I suppose.

T 12: And again that feeds into your depression.

C 12: Yeah. Probably.

*Paul often agrees with me and I am very conscious about it now as this is part of his way to please people. This might also be linked to my countertransferential reactions towards Paul: taking care of him by saying the "right" things and an increased responsibility to him for getting better. This contradicts one of the aims of CBT, which is becoming one's own therapist (Beck, 1995) and might be an indication of my own black and white thinking style in this instance. Rather than giving interpretation that he simply agrees to and not leading to further exploration, it might have been more useful to summarise his experience to acknowledge that I am listening.*

T 13: And do you think that made you cancel the session or ask your mum to?

C 13: No, I was really rough and I was in bed actually when she phoned you I think, and I was in a really sort of bad place. I just didn't want to know anyone, do anything at all. It's strange, isn't it, because the realisation was even when I was feeling like that was that I had to contact you and let you know and, therefore, I must have cared a little bit about, if you like, me, like I said, getting better, feeling better... to just get her to phone, otherwise I could have just shut up, done nothing, you'd have sent me a letter or phoned me.

*One of the few times he disagrees with my suggestions, which helped increasing my awareness of what he went through at the time of cancellation. His response might potentially hint at the importance of being in therapy for him in order to feel that he cares for himself. He argues how his withdrawal made it difficult to attend session and it might have been useful to link this to current maintenance processes to remind him of what keeps his problem going (Westbrook et al. 2011).*

T 14: You could have ignored that and then I'd discharged you and that's the end of the story.

C 14: That would have been it and I don't want that.

T 15: That's good. So there is a part there, something, as you said before...

C 15: Yeah, but it doesn't feel that good.

*Listening to the tape, it feels as if I want to instil hope, as hopelessness is a common element in depression and letting clients know that one doesn't find their problems hopeless is important for beneficial therapy (Schindler, Hiller & Witthoeft, 2013). In hindsight it would have been better to ask if that feels good rather than stating it almost as a fact.*

T 16: How does it feel?

C 16: Pretty crap really. I suppose because what goes through my head is the previous fact that, you know, all that thing about letting you down, letting yourself down, failing.

T 17: But also what I'm feeling is this taking responsibility of what other people think of you.

C 17: Yeah.

T 18 And the importance of making them feel good.

C 18: Probably, yeah.

T 19 : How long has that been going on?

*Hearing it now, I remember that I felt a bit stuck and in hindsight it seemed that I have to provide "something" in order to take care of him. My factual question reminds me of how I would respond to my father. Additionally, I seem to be guided by my interpretation in T17 & 18 rather than listening to his "probably" response. This makes me wonder if he still tried pleasing me and be a good client, which I could have shared with him. It might have also been appropriate to indicate that I am still listening through minimal encouragements to see what he makes of my interpretations rather than pushing him into a different direction with my question.*

C 19: Ask me another one [T smiled]. It goes on for years and years and years, even back to I suppose... I would have said when I used to work in A&E.

T 20: And how long ago is that? Roughly?

C 20: Blimey, it's 25-plus years and there is a buzz to saving people's lives. I used to be on a crash team, doing the job well and making sure that person isn't going to die in front of you is very rewarding, but obviously there's the times when that goes wrong and you sort of deal with it with a bit of gallows humour I suppose afterwards.

T 21: With colleagues.

C 21: Yeah, you arrange to go and have a cup of tea and sit there and pull it apart.

T 22: How do you think that experience relates to how you're feeling now?

*In hindsight, I noticed that I felt we went on a tangent and that it didn't seem relevant to me at the time. I tried to stir our discussion back to his current situation by linking it to the content of C20.*

C 22: I think possibly it's because that and the jobs I've done since for me. There's been a sense of caring in them, even sort of when I was doing court work and what have you. You're still sort of trying to uphold the law, making things right. If a court has said so and so and you're there to enforce that, then it's important you do that, you know, and there's sort of a little thread of care I suppose through that.

Even repossessing cars and boats and stuff, you're repossessing it because some Muppet hasn't kept up their payments, their hire purchase payments, therefore the vehicle or whatever it is doesn't belong to them. You're sort of doing what you can for the company, the hire purchase company.

T 23: And by the same token, you try to do the best you can maybe in therapy here to please the therapist or...?

*Here, I use the "here and now of the therapeutic relationship" (Safran & Segal, 1990, p. 154), which I hoped would facilitate a learning process grounded in concrete experience that could allow him to test unhelpful beliefs. I seem rather tentative in my suggestion and say "therapist" rather than "me", which seems to mirror how he didn't own some of his earlier comments.*

C 23: Yeah, yeah maybe [...]. Well, actually [...] yeah, I was going to say no but I think you're right. There must be a bit of that.

We used the remainder of the session to discuss his ambivalence to change and carried out a cost/benefit analysis and then moved on to explore his need for certainty and control. We ended the session with homework and session feedback.

## **Evaluation**

Counselling Psychology training engenders a non-threatening curiosity of orientations and theories that fit within the philosophy of Counselling Psychology and have a research base (James, 2009). I felt drawing on additional psychological theories such as attachment theory (Bowlby, 1969; 1973; 1980) and learned helplessness (Seligman, 1975) facilitated increased understanding of the therapeutic relationship. This is particularly important with more complex cases where CBT alone might be seen as theoretically weak and not sufficient to enable a client to cope with their issues (James).

I felt that we needed to establish trust and a working relationship after the cancelled session. Paul explored subsequently that the fourth session signified a "turning point" for him: It increased his awareness of his difficulties (for example, "change feels frightening"). To me, this is a more useful outcome than solely the short-term reduction of symptoms, in that Paul appears to have gained the ability to understand and perhaps prevent difficulties in the future.

We revisited his formulation and integrated our findings, as the formulation work may be even more important than the end product (Butler et al, 2008). At present, we

continue with his treatment plan and arranged to meet for another six sessions, which gives us a chance for more reflection and working at a slower pace.

I feel that this case demonstrated some of the tension when working in an diagnostic-based IAPT service as a CoP, namely the emphasis on "doing" CBT *to* a client, whereby I was at risk of losing sight of Paul by focussing on psychometric measures and compliance. Needs and desires of the clients, personality and current circumstances are just a few of the important aspects which a scientist-practitioner (and reflective-practitioner) must consider when deciding which intervention is appropriate (Blair, 2010). Working with relational depth - as CoPs promote - Paul might feel more engaged and involved in his development than when his behaviour is "externally" modified or his thinking directly challenged as it is the case in traditional CBT (DiCaccavo, 2008). For example, in therapy I could have given more consideration early on to his ambivalence to change, for example, through discussing his reluctance to thought records (Padesky, 1996) in more depth rather than using a solely psychoeducational approach.

This report highlighted for me my tendency to take on some responsibility that belongs to the client, which seems evident in my countertransferential feelings (my need to take care) towards him. I also wonder whether his non-attendance might have been an "attack" on me, a potential sign or wish not to need me, which lead to me trying even harder to convince him of the opposite. Writing this report and supervision has aided my identification of these blind spots, which emphasised for me the importance of making these feelings conscious in order to deal with them. CoPs should be receptive to the (unconscious) communication between therapist and client (James, 2009) and think about how our own issues impinge upon our relationships with clients (Simms, 2008) in order to assist them.

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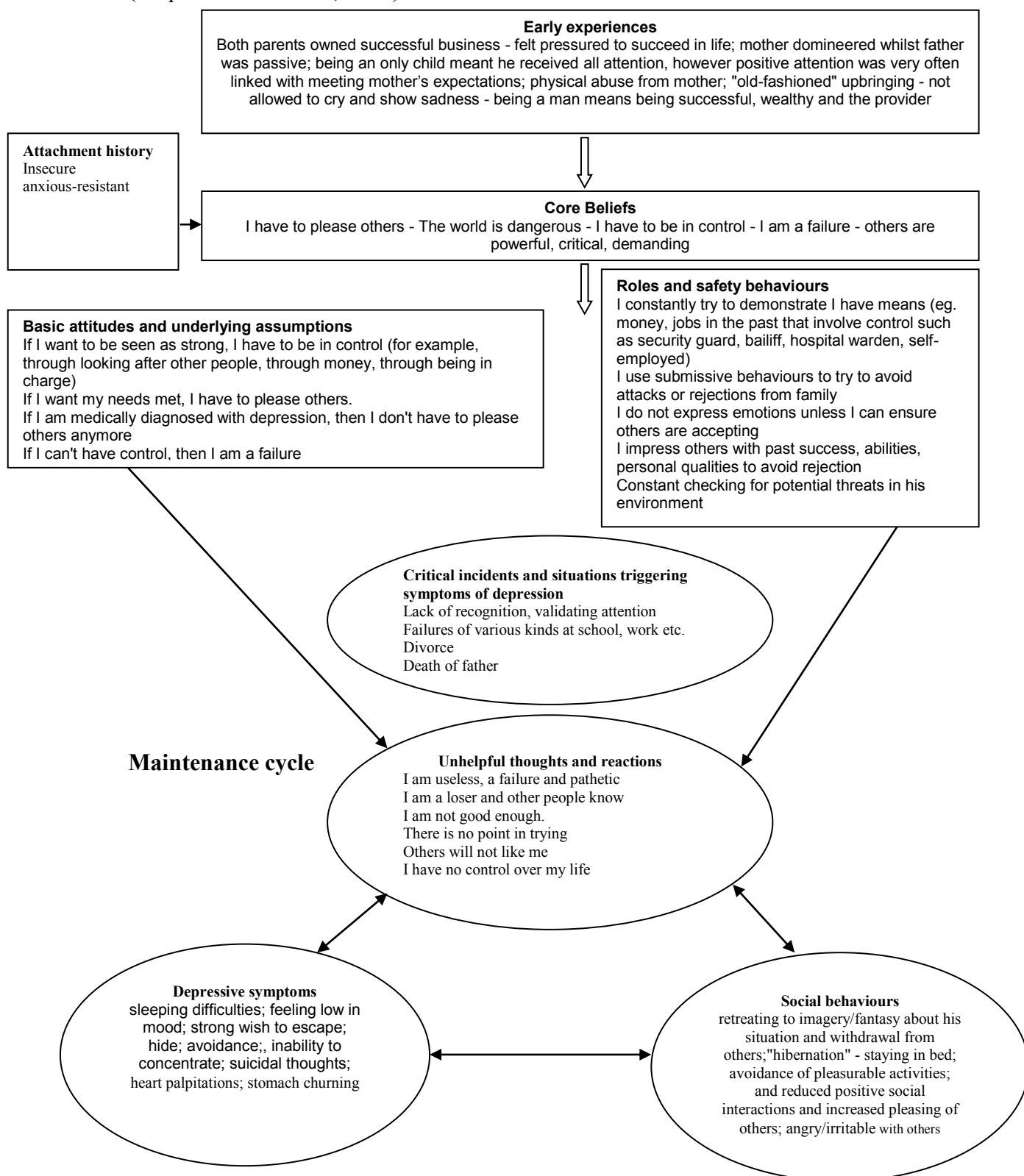
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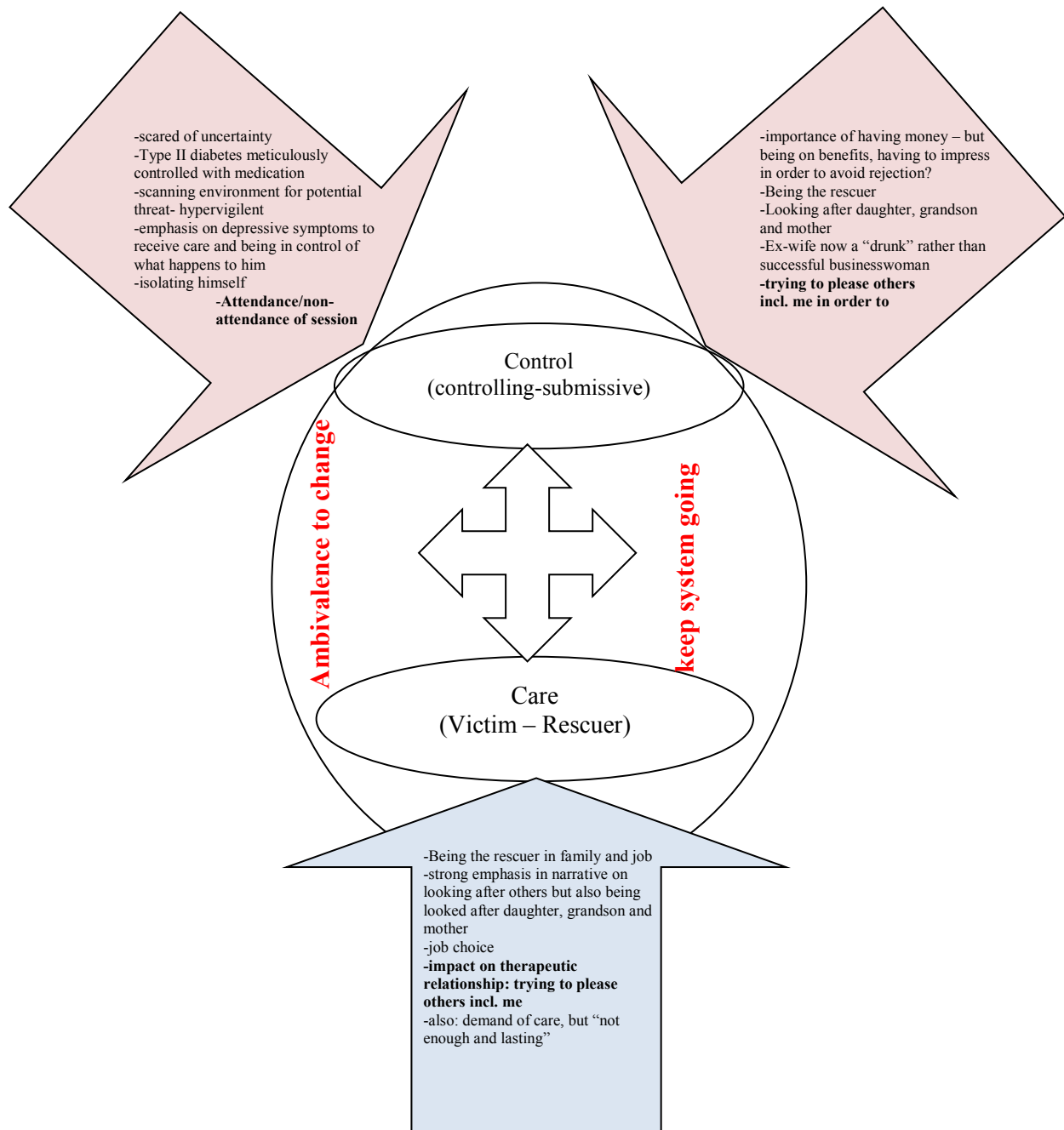
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## Appendix 1 A preliminary longitudinal cognitive focused formulation for Paul

(adapted from Gilbert, 2007)



## Appendix 2 Diagram of recurrent patterns



## **Appendix 3 Treatment Plan**

### **1. Assessment**

- Ascertain development and maintenance of presenting problem and suitability for CBT
- Explain CBT and give handout about depression and anxiety
- History
- Evaluate suicidal risk
- Medication
- Minimum Dataset administration

### **2. Improve sleeping (7-8 hours/ night)**

- Learning to implement sleep hygiene strategies
- Teaching and practicing deep muscle and breathing relaxation strategies

### **3. Increase activity level**

- Reward planning and graded activity scheduling
- Increase self-reward
- Decrease passive/socially isolating behaviour
- Behavioural experiments

### **4. Reduce unhelpful automatic thoughts - "thinking more balanced"**

- Evaluate reasons for and challenge therapy ambivalence
- Psycho-education: facilitating the verbal expression of feelings in session
- Psycho-education: relationship between thoughts & feelings
- Elicit and challenge unhelpful automatic thoughts with specific cognitive techniques (for example, cognitive restructuring and distraction)

### **5. Relapse Prevention**