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An Interpretive Phenomenological Analysis of Psychotherapists' Experiences of Vulnerability

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AN INTERPRETIVE PHENOMENOLOGICAL ANALYSIS OF PSYCHOTHERAPISTS' EXPERIENCES OF VULNERABILITY

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ABSTRACT

AN INTERPRETIVE PHENOMENOLOGICAL ANALYSIS OF PSYCHOTHERAPISTS' EXPERIENCES OF VULNERABILITY

By

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May 2021

Dissertation supervised by Lori Koelsch, PhD

In the service of forging a deep authentic connection that has the power to heal and transform, psychotherapists create and hold space for their patients to show themselves in a deeply vulnerable manner so that they can be known and accepted as they are. At the same time, psychotherapists are also flawed and wounded mortal beings who cannot help but bring their own woundedness, personalities, and limitations into the space, and must negotiate the delicate balance between restraint and expressiveness of their vulnerability. This study is a phenomenological inquiry into how psychotherapists experience their vulnerability given the demands of their role. In the spirit of practicing vulnerability as a researcher, this text begins with my personal reflection on experiences that evoked curiosity in me about my vulnerability and expands into an extensive literature review that delineates the physical, emotional, and narcissistic vulnerabilities of psychotherapists. Following that, I explain my use of a phenomenological framework for this project, which anchored my focus on the lived experience of vulnerability, rather than on its technical definitions or theoretical

conceptualizations alone. To collect rich, detailed first person accounts about such lived experiences, I interviewed six psychologists at various stages of their training and career individually about their experiences of vulnerability in their role as psychotherapists. I analyzed the data using Interpretive Phenomenological Analysis (IPA), which yielded overarching themes such as the different ways in which psychotherapists may experience being vulnerable, the experience of exposure, and the experience of facing uncertainty, as well as the idiosyncratic theme of vicarious traumatization and vicarious transformation. In addition to conveying the raw, embodied experience of vulnerability, participants touched on the experience of coming to grips with their immense social power and their relational power in the therapeutic relationship. They described their simultaneous awareness of their own and their patients' vulnerability, as well as their active engagement in complex cognitive and emotional work to make sense of the unfolding therapeutic process and decide every step of the way how to proceed in the most beneficial manner. Participants also spoke about their experiences of confronting their mistakes or limitations and processing their clients' experiences of those mistakes and limitations, including when there were ruptures in the therapeutic relationship. In addition to discussing how the findings resonate with accounts of psychotherapist vulnerability in the literature, I identify the implications of this study for inviting thoughtful, experientially resonant conversations about vulnerability, particularly in a world where psychotherapists are increasingly expected to be machine-like technicians who deliver results with speed and efficiency.

DEDICATION

This dissertation is dedicated to all my psychotherapists, former and current – Meghann, Clare, Sarah, and Paul. My life changed and continues to change for the better because of your labor of love and your willingness to go deeply into our shared experiences of vulnerability.

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Introduction

On Choosing to Study Vulnerability

One of the most satisfying self-care activities I engaged in as a psychotherapist in training was binge-watching the first season of *In Treatment* at a time when my personal life was in shambles. Retrospectively, the most helpful aspect of my movie marathon was the exquisite pleasure of watching the life of the protagonist Paul Weston, a psychotherapist, fall to pieces as he found himself pulled into a messy erotic enactment with a client. It was such a relief to not be alone in having my own life fall apart even as I strove to keep up with my clients' developments. The mistakes I made in sessions, the missed opportunities, and unforgivable moments when I let my attention wander while pretending to listen, paled in comparison to Paul's boundary transgressions. This fictional colleague was just the downward comparison I needed. Nonetheless I was not able to hide my pain from a few of my more emotionally attuned clients, who began asking me if I was okay. I always dismissed their questions and quickly turned the focus back on them. As though sensing my insecurity about what I was offering them, these clients also spoke effusively about how helpful the sessions had been. Rather than accepting their gratitude with an open heart, I registered their words without letting them touch me and doled out pedantic lines to the effect of "Well, that is my job," with an emotional detachment rivalling that of the couple in Grant Wood's American Gothic.

I began to wonder why it was so difficult for me to simply acknowledge to my clients that I was indeed having a difficult time, which would have validated their perception as accurate, and demonstrated to them that I could be both suffering and there for them. Why was I so afraid of being seen in both my weak and wonderful moments, and how might the therapies have evolved differently had I allowed my patients to have even a glimpse of the soft spots and tenderness underneath the role of the helper and giver?

And then there were the countless clients whom I failed to help, or who would not let me matter to them, whose eyes told me that they were walled off and worlds away even as I sat right across from them, pleading with my face and voice for them to notice that I was deeply touched by the enormity of their suffering. They were my greatest teachers in the pain of being alone and disconnected together. Their refusal to be moved forced me to confront the falsity of the selflessly giving persona that I had been hiding behind and to recognize the selfish reason that I had come to this field, particularly to depth-oriented psychotherapy – my longing for the deep connection that comes with joining others in the shared existential condition of suffering, in our shared vulnerability.

On Choosing the Word "Vulnerability"

I chose the word "vulnerability" intentionally for its emotional resonance. For me, it is a descriptive and evocative word that speaks to a receptivity to being touched, moved, and shaped by the presence, the expressiveness, and the suffering of others. When I have shared my dissertation topic with my peers and elders in the field, their responses have spoken volumes about the reach of this simple but powerful word into the depths of their experiences as clinicians. Supportive reactions have ranged from immediate looks of recognition and something along the lines of "I know exactly what you're saying," followed by a disclosure of a relevant clinical moment, to spontaneous impassioned elevator speeches about the importance of vulnerability in clinical work. In addition, my colleagues who witnessed the Herculean struggle I went through to even write the dissertation proposal frequently offered good-natured teasing along the lines of "Of course it is hard to write – because writing about vulnerability makes you feel so vulnerable!" Many others, including me at times, wondered whether this topic had hit too close to home. To read and write about vulnerability demanded that I sit with parts of myself that were tender, aching, and sometimes unbearably painful.

In conversations with colleagues there were other words that came up as alternatives to "vulnerability," such as "openness" and "humanness." To explain my decision to stay with "vulnerability" it is necessary to be grounded in the definition. According to the Oxford English Dictionary (OED) Online (n.d.), the first use of the word "vulnerability" appeared in 1808, and its equivalent "vulnerableness" last appeared in 1894. The Merriam-Webster Dictionary (n.d.-b) records that its root word, the late Latin adjective *vulnerabilis,* goes back to noun *vulnus* which means "wound," and its associated verb *vulnerare* which means "to wound." *Vulnus* is related to both the Latin verb *vellere* which means "to pluck" and the Greek word *oul*ē which also means "wound." "Vulnerable" in today's usage of the word mainly means "capable of being physical and emotionally wounded," or "open to attack and damage." Interestingly, when it was first used as an English word in the early 1600s (1609 and 1616), "vulnerability" carried the double-edged definition of "capable of being physically wounded" and the now-defunct "having the power to wound" (Merriam-Webster; OED Online). The figurative sense of being vulnerable only appeared in the late 1600s when its definition was expanded to include being "defenseless against non-physical attacks" (Merriam-Webster), such as "raillery, criticism, calumny" and so on (OED Online).

The colleague who suggested the term "openness" clarified that it captures the non-defensive receptivity that psychotherapists ideally bring to their work, but without connoting weakness or woundedness in the way that "vulnerability" does. From her perspective, openness relies on the clinician's capacity to self-validate and exercise resilience from a place of being a differentiated individual – a capacity that is not evoked by the term "vulnerability." This alternative was a tempting prospect: it would be far less vulnerable to interview clinicians about their experiences of being open than about their experiences of being wounded and risking woundedness. I ultimately decided against going with "openness" because on a personal and professional level, I am much more invested in holding space for

psychotherapists to reflect on how they negotiate their relationship with the ever-present possibility of being wounded, than in admiring the finished product and therapeutic ideal of being accessible and minimally defensive. In other words, I did not want to restrict myself to studying one of the myriad ways of engaging with vulnerability; I wanted to also hear about times when psychotherapists were not open, felt defensive, or enacted counterproductive strategies to avoid woundedness. In relation to that, I was intrigued by the obsolete definition of "vulnerable" as "having the power to wound." It brought up questions as to whether being susceptible to wounding is intimately connected to having the power to wound, and in what ways power and vulnerability may be connected. Furthermore, I went with "vulnerability" because it carries the meaning of being "susceptible to injury or disease" (Merriam-Webster, n.d.-b). The psychotherapist is mortal. This definition is particularly relevant considering that it is one that is seldom discussed among psychotherapists, as though there is a lack of recognition of how the psychotherapist's deterioration from sickness or injury and inevitable death could be traumatizing for patients, and doubly so when there are no prearrangements made in the event of the psychotherapist's incapacitation or death.

In speaking about psychotherapists' vulnerability, I am also speaking about their humanness, i.e. the qualities that are "representative of or susceptible to the sympathies and frailties of human nature" (Merriam-Webster, n.d.-b). However, I decided not to use the term "humanness" because the frailties and capacities that I am studying, including the capacity to be wounded physically and emotionally, are most often characteristics of not only humans but of nonhuman animals. While humanness connotes the attributes of being human, vulnerability refers to a capacity shared by all sentient beings. Indeed, I chose the word "vulnerability" partly to acknowledge my intellectual debt to Cary Wolfe and Martha Segarra. Wolfe (2008) drew on animal studies and disability studies to speak to vulnerability as the shared experience of all sentient beings. He asserted that a preoccupation with agency

and ability have misled human and animal rights activists to determine "Who has rights?" based on the presence or absence of certain capabilities, such as "Can they speak?" and "Can they reason?" Such narrowly defined, anthropocentric criteria inevitably consign certain human and nonhuman subjectivities to the realm of not being worthy of rights, and consequently, perpetuate the ableism that they have been trying to abolish in the first place. Wolfe suggested that we focus instead on our shared vulnerability as the marker of sentience and the reason for our collective need for care. Segarra (2006) pointed out along similar Derridean-inspired lines that nonhuman animals can teach human animals about our forgotten capacity to endure, suffer, and offer compassion from a place of being-with, rather than from a place of domination and superiority. Reading Wolfe and Segarra at a time when my heroic rescue fantasies of my clients were shattered by my confrontation withing my limitations, follies, and shadow qualities, I found myself sobbing as I read this passage from Derrida's *The Animal I Therefore Am*:

> What of the vulnerability felt on the basis of this inability? What is this non-power at the heart of power? … Mortality resides there, as the most radical means of thinking the finitude that we share with animals, the mortality that belongs to the very finitude of life, to the experience of compassion, to the possibility of sharing the possibility of this non-power, the possibility of this impossibility, the anguish of this vulnerability, and the vulnerability of this anguish. (cited in Wolfe, 2008, pp. 120-121)

My rational mind could not comprehend my emotional reactions to this passage. There was something about this invocation of vulnerability that struck such a primal chord in me that I could not put into words what transformation had begun in my psyche. This experience ignited the fire in me to discover, what is this notion of "vulnerability," that awakened a feeling so deep and primordial inside me, that I can subject to intellectual scrutiny, and yet is also a reality that is much more all-encompassing than my intellect? What

does it mean for me to be a vulnerable psychotherapist, dedicated to the holding of vulnerability? All in all, using the word "vulnerability" is a tribute to the authors whose heartfelt scholarship transformed me both as a clinician and person, and a statement of my decision to join those before me who have grounded ethics in vulnerability.

Literature Review

Reflection on My Literature Review Process

Vulnerability by its nature cannot be tamed. It is an ineffable, abstract concept that cannot be easily concretized, so at first when I tried to torture this expansive term into conceptual boxes to begin my literature review, I ended up with a collection of "areas" of vulnerability that hung loosely and awkwardly together, with little overall theoretical coherence. Rereading my literature review from the proposal stage, I was reminded of this brilliantly evocative passage that circulated on social media a while ago of a teacher explaining to a student why they got such a low grade on a paper:

> Actually, you didn't turn in a paper. You turned in a random assemblage of sentences. In fact, the sentences you apparently kidnapped in the dead of night and forced into this violent and arbitrary plan of yours clearly seemed to be placed on the pages against their will. Reading your paper was like watching unfamiliar, uncomfortable people interacting at a cocktail party that no one wanted to attend in the first place. You didn't submit a paper. You submitted a hostage situation. (cited in Soonpaa et. al., 2015)

Adaptive self-deprecating humor aside, it speaks to one of the challenges of this process, which was that psychotherapists' experiences of vulnerability can be studied from various perspectives without ever mentioning the term "vulnerable." The formal definition of vulnerability per the Merriam-Webster dictionary gave me little in way of search terms for targeted literature reviews. At the same time, a search in PsycInfo with the key term

"vulnerable" (vulnerab*) together with various synonyms of "psychotherapist" returned very few results, most of which were from nursing and medical fields. For the sake of beginning somewhere, I relied on both my own intuition and the suggestions of colleagues to capture areas in the literature where scholars and researchers might have written about psychotherapists' experiences of vulnerability. I also pursued any related topics that came up during the literature review. For example, in examining the phenomenon of burnout, I came upon literature on impairment and misconduct in psychologists. In examining literature on mortality, I also happened upon writings on psychotherapists' countertransference hate, which provided me with a review of relevant transference-countertransference dynamics and complemented my readings on psychotherapists' narcissistic vulnerability.

Retrospectively, this scattershot of gloomy topics also revealed my state of mind at the beginning of this project: I was a burned out, insecure, and narcissistically wounded psychotherapist in training who had just terminated six long-term psychotherapies with clients at a four-year practicum, and a few months before that, underwent a health crisis that precipitated a period of morbid preoccupation with death and incapacitation. I was especially disturbed to discover that my speculative fear about having to abandon clients in the event that I fell gravely ill also hid a wish. Like a typical depressive personality with an obsessive streak, I was guiltily convinced that if I could not crack the code of psychotherapist vulnerability, I was going to contaminate and ruin every single therapy in my career with my ostensibly toxic, destructive countertransference feelings, especially my anger, hate, and resentment. Additionally, I knew about Brené Brown's extensive research on vulnerability, but perhaps because I was feeling too vulnerable at the time, I ironically avoided reading her work for the proposal stage, as though terrified that she would offer hopeful words that I was not ready to believe. Fortunately, at the earnest suggestion of my dissertation committee members, I finally dipped my toes into Brown's scholarship as well as existential-humanistic

psychology perspectives on authenticity in the therapeutic relationship, which provided much more coherence and structure to my review.

There were also modifications that I made in my literature review from the proposal stage as a result of the growth in my knowledge and perspective, as well as of chance discoveries. For example, I included a review of articles that discuss psychotherapists' exposure to physical threats and violence on the job not only because of my research participants' stories about being assaulted or threatened by clients, but also because at the time of the writing of this dissertation I began working for the first time in my career with violent clients. Furthermore, I added a section on the "Wounded Healer" archetype when I discovered, while doing some leisure reading on the Jungian concept of the "shadow," that the notion of the "Wounded Healer" has much more depth, substance, and relevance to the psychotherapist's vulnerability than I had known. My reading of literature on the shadow and the Wounded Healer archetype showed me that the areas of our psyche of which we are most deeply unconscious – the qualities, attributes, and potential we refuse to acknowledge in ourselves – harbor tremendous energy that can be immensely destructive, or, if used well, can also be profoundly constructive and important for providing balance and wholeness to our character. It rounded out my observation that power and vulnerability, particularly power and woundedness, seem to be intimately connected.

Next, I organized all the aforementioned topics on vulnerability into a semi-coherent whole. In the manner of a good Cartesian subject who cannot help but conceptualize reality in dualisms, I divided them into: the category of physical vulnerability, which included the topic of mortality, disability, and illness, as well as physical threats and violence; the category of emotional vulnerability, encompassing the real personhood of the psychotherapist, the history of disavowal of vulnerability in psychotherapy, and the notion of the Wounded Healer; the category of the psychotherapist's fallibilities, including issues of burnout and impairment,

sexual misconduct, and hate in the psychotherapeutic relationship; and finally, the category of narcissistic vulnerability, which spoke to the vulnerability of empathic immersion, and some common defenses against narcissistic vulnerability among psychotherapists.

Physical Vulnerability

The physical vulnerability of the psychotherapist pertains to their susceptibility to falling ill, becoming disabled, or dying from natural cause, and to being physically wounded or even killed on the line of duty. The literature suggested that there is a climate of denial and silence on the physical vulnerability of the psychotherapist, which comes at a great cost to both psychotherapists and patients. Considering that many patients come to psychotherapy scarred by losses or trauma in their efforts to attach to caregivers in their early lives, clinical practices that fail to acknowledge and factor in the psychotherapist's mortality and vulnerability to illness and incapacitation risk replicating the patients' attachment trauma. Additionally, considering that mental health professionals are likely to come across impulsive, narcissistic, intoxicated, delusional, or vindictive individuals at some point in their practice, the undertraining of psychotherapists in the prevention and management of violence risk in clinical practice puts them in a position of potentially being defenseless against patient threats and assaults.

Mortality, Illness, and Disability

The inevitability of death, the ever-present possibility of becoming physically sick, disabled, or even incapacitated is a fact that all sentient beings face. That we are mortal beings is the fundamental vulnerability underlying every sentient being's existence, and yet mortality has been an understudied aspect in most theoretical orientations, with the clear exception of the existential psychotherapeutic approach (Yalom, 1980). The existential orientation posits that psychopathologies are essentially unsatisfactory ways of coping with the "confrontation with the givens of existence," (Yalom, 1980, p. 1) primarily with death,

the isolation that comes with existing as individuals with private subjective worlds, the staggering freedom to make choices about how one lives, and the dearth of inherent meaning in human existence (Yalom, 1980, pp. 8-9). Yalom (1980) situated existential psychotherapy as a "dynamic" orientation, in that it attends to the conflict between psychic forces at "varying levels of awareness" including complete unconsciousness (pp. 6-8). Unlike traditional psychodynamic psychotherapies, however, which depending on the particular school of thought, may emphasize intrapersonal conflict between instinctual drives, or interpersonal conflict between the needs of children and the responsiveness of adult caregivers, existential psychotherapy emphasizes the centrality of conflicts related to the existential givens: the conflict between "the inevitability of death and the wish to continue to be"; "between our confrontation with groundlessness and our wish for ground and structure;" "between our awareness of our absolute isolation and our wish for contact, for protection, our wish to be part of a larger whole;" and between our need for meaning and the facticity of our being "thrown into a universe that has no meaning" (Yalom, pp. 8-9). He wrote evocatively about this existential wounding, describing our death awareness as the "costly price" of self-awareness, as "(o)ur existence is forever shadowed by the knowledge that we will grow, blossom, and inevitably, diminish and die" (2008, p. 1). Yalom postulated that defense mechanisms arise to push the anxiety evoked by these conflicts out of conscious awareness, and like all defenses, while they provide an illusion of safety and security, ultimately "restrict growth and experience" (pp. 9-10).

Psychological defenses against death anxiety operate not only at an individual level but may also be shared by collectives. In *The Denial of Death*, one of Yalom's inspirations, Ernest Becker (1973), described human beings as existing in an excruciatingly irreconcilable split between their lofty and almost limitless capacity for symbolic thought that can contemplate concepts as abstract and profound as infinity, and their inevitable fate of

"go(ing) back into the ground a few feet in order blindly and dumbly to rot and disappear forever." (pp. 26-27). Hence, Becker wrote, to keep themselves from being driven insane by their awareness of the impossibility of reconciling this terrible contradiction, they must delude themselves into forgetfulness, constructing and participating in "social games, psychological tricks, personal preoccupations," essentially substituting one form of madness for another – an "agreed madness, shared madness, disguised and dignified madness, but madness all the same" (pp. 26-27). Citing Ferenczi's statement that "character traits are secret psychoses," (cited in Becker, 1973, p. 27), Becker argued that all social, personal affectations – "the tight-lipped masks, the smiling masks, the earnest masks, the satisfied masks" (p. 27), are a "vital lie" (p. 47).

The field of psychotherapy, including the psychoanalytic traditions, have also participated in this vital lie and distraction from death anxiety. Yalom (2002) noted that many psychotherapists ignore the issue of death because they do not know what to do about it, think of it as irrelevant, or fear inducing more anxiety in the already distressed patient, and he added, tongue-in-cheek, because it makes the psychotherapist anxious too (pp. 124-125). He observed that many psychotherapists, despite having had "long years of personal analysis, have not explored and worked through their personal terror of death" (Yalom, 1980, p. 59), and hence collude with the patient in avoiding the topic. When the patient brings up death anxiety, it has usually been conceptualized as a "stand-in" for anxiety about something else, such as "abandonment" and "castration" (Yalom, 2003, pp. 18-19). In her address to Division 39 (Psychoanalysis) of the American Psychological Association during its 2016 Spring Meeting, Nancy McWilliams (2017) pointed out a historical reluctance in psychoanalysis to talk about mortality and its implications. This silence began with the founding father of psychoanalysis Freud himself, who, believing that the unconscious mind cannot experience its own death and therefore has no representation of death, failed to appreciate the significant

role that "the human terror of no longer existing" (McWilliams, p. 51) plays in the genesis of psychopathologies (Yalom, 1980, p. 65).

Yalom (1980) hypothesized that Freud in his pursuit of greatness was too single-mindedly focused on developing a theory of the psyche that held the most potential of propelling him to fame (pp. 70-74). A theory rooted in death anxiety was too much of an "old hat," (Yalom, p. 73) already talked to death – pun fully intended – by legions of thinkers before him; a theory rooted in speculations about infantile sexuality, shocking to Victorian sensibilities and original-sounding, held the most promise of being his great discovery (Yalom, pp. 70-74). With regards to theoretical reasons, serious consideration of death anxiety as a motivating force in psychic life was precluded by Freud's mechanistic view[1] of the "mental apparatus" as consisting of a pair of basic, opposing drives (Yalom, pp. 68-70). The capacity to envision one's own death, which "requires a complex mental activity – the planning and the projection of self into the future," (Yalom, p. 69) was far too sophisticated of a task to be accomplished by such a crude mental apparatus. Moreover, despite speculating extensively on the psyche of children, Freud had never analyzed children, and erroneously believed that very young children were unable to conceptualize death (Yalom, p. 80). Given his theoretical position that the human psyche is shaped in the earliest years of life, Freud concluded that death anxiety could not be a contributing factor to the neuroses of adults (Yalom, pp. 79-80), stating the following in the *Interpretation of Dreams:*

> Children know nothing of the horrors of decay, of freezing in the ice-cold grave, of the terrors of eternal nothingness – ideas which grown-up people find it so hard to tolerate, as is proved by all myths of the future life. (cited in Yalom, p. 79)

[1] Yalom (1980) attributed Freud's mechanistic view of the psyche to Freud's most significant influence, Ernst Brücke, who held the Helmholtzian thesis that there are two basic forces within the organism – "attraction and repulsion" (p. 68).

This quote not only showed Freud's perspective on children's psyche, but also suggested that he was indeed well-aware of death anxiety in adults. Indeed, when unencumbered by the need to address his formal theory of psychopathology, Freud mused "boldly and energetically about death" (Yalom, 1980, p. 66). In *Our Attitude Towards Death*, which was written in the wake of the staggering death and destruction witnessed in World War I, Freud (1918) made several observations of great relevance to death anxiety. For instance, he noted our tendency as a society to treat death as an "accident" rather than a "necessity" (para. 3) and remarked that religious teachings about afterlife that "depriv[e] death of its meaning as the termination of life" serve to bolster the denial of death (para. 18).

Ironically, within a few years Freud himself was to deprive death of its meaning, when he began positing that psychopathologies stem from human beings' innate drivenness to return to their earliest state – being dead. Specifically, in *Beyond the Pleasure Principle*, Freud (1922/1961) postulated that all living organisms have an instinctual drive to return to their original inanimate state, in the same way that the inorganic matter of which they are composed tends to return its original resting state, following the principle of conservation of energy. Furthermore, he claimed that it is the natural death, and not just any kind of death, that organisms are driven towards, and hence, all efforts at self-preservation ultimately serve the goal of letting the organism "die only in its own fashion" (p. 33). Freud believed that this drive to revert to an earlier state accounted for why soldiers suffering from traumatic neuroses related to their war experiences seemed compelled to relive their trauma endlessly in the form of dreams and flashbacks. In *Civilization and its Discontents*, Freud (1930) built on this theory of the death instinct even further, characterizing it as a drive towards destruction that exists in tension with Eros, the drive towards life. Per this theory, when we destroy something in the external world, we discharge some of the energy that could have been turned inwards at ourselves, and hence, Eros prevails, and vice versa. Although the

theory of the death instinct finally brought the issue of death to the table, it served as another distraction for the field of psychoanalysis: the notion that death is itself the aim of life deflects from discussions about how we feel and think about our personal death. It once again reflects the mechanistic, deterministic nature of Freudian psychology, whereby the psyche is conceptualized in terms of impersonal forces. Yalom (1980) noted that the theory of the death instinct neglects the way in which our relationship with death determines whether we experience life as meaningful or meaningless:

> To proclaim death a fundamental drive does not solve the problem: it fails to consider death as a future event, it overlooks the importance in life of death as a beacon, a destination, a final terminal that has the power either of stripping life of all meaning or of beckoning one into an authentic form of being. (p. 70)

In addition, the hint of cynicism in Freud's theory of the death instinct – that the organism is fundamentally driven towards death and destruction – was at least in part influenced by the tremendous grief and despair Freud must have experienced in the last two decades of his life, marked by tragic losses, harrowing trauma, and narrow brushes with death. In 1920 he was devastated by the unexpected death of his daughter, his "dear, blooming" Sophie, from the Spanish flu (Gay, 2006, p. 391). He confided in Ferenczi that he had braced himself for the loss of his three sons who were drafted during World War I (which they ultimately survived), but in no way did he anticipate losing his young daughter (Gay, 2006, p. 393). A mere three years after the death of Sophie, one of her sons – his favorite grandson, Heinz – died from miliary tuberculosis, plunging the man into a depression so severe that "he described himself as now a stranger to life and a candidate for death" (Gay, 2006, pp. 421-422). He wrote a friend about his difficulties coping with the loss, stating that Heinz "meant the future to me and thus has taken the future away with him" (Gay, 2006, p. 422). In between those losses, Freud was diagnosed with oral cancer, which tormented him

for sixteen years until his death (Gay, 2006, pp. 418-561). In the same decade, several of his followers died (Gay, 2006, p. 587). In 1938, the frail, elderly Freud, had to flee the Nazi-occupied Vienna, where Jewish inhabitants either were shipped off to die in concentration camps or killed themselves to put an end to the misery of awaiting that fate (Gay, 2006, pp. 621-622). Despite wrangling his connections to help his sisters escape Vienna, he did not succeed, and went to his grave afflicted with "survivor guilt" (Gay, 2006, pp. 630-632). Perhaps Freud coped with the too-muchness of death in his life by divesting it of emotional charge and putting it under an intellectual microscope.

Interestingly, notwithstanding the fatalistic tone of his theory, Freud's own actions in the face of his imminent death were anything but fatalistic. Rather, he was determined to put his house in order and having the ability to "die in freedom" [2] (Gay, 2006, p. 629). He continued reading and writing even as he suffered great pain and weakness from his illness (Gay, 2006, pp. 632-650), was frank with his friends that his days were numbered and asked them to visit him soon (Gay, 2006, p.636), and closed his analytic practice on August 1, 1939 (p. 649). Roughly two months later, he asked his physician and friend Max Schur to deliver the terminal sedation, "facing death with dignity and without self-pity" (Gay, 2006, pp. 650-651). Ironically, for someone who so staunchly believed in biological determinism, the stoicism that Freud exhibited in his last days were perhaps his way of coping with the fear of losing control over his physical and mental faculties on his deathbed:

> Nearly four decades earlier, Freud had written to Oskar Pfister wondering what one would do some day, "when thoughts fail or words will not come?" He could not

[2] Despite being fortunate enough to have the protection and assistance of friends (particularly Princess Marie Bonaparte) to secure his passage to England, Freud was so stubborn about staying in Vienna that it took a great deal of persuasion by Ernest Jones before he finally relented (pp. 624-627). Additionally, when their chances for leaving Austria grim, he shut down his daughter Anna's suggestion that they kill themselves, stating, "Why? Because they would like us to?" (Gay, 2006, p. 622).

> suppress a "tremor before this possibility. That is why, with all the resignation before destiny that suits an honest man, I have one wholly secret entreaty: only no invalidism, no paralysis of one's powers through bodily misery. Let us die in harness, as King Macbeth says." He had seen to it that his secret entreaty would be fulfilled. The old stoic had kept control of his life to the end. (Gay, 2006, p. 651)

Whether Freud's failure to theorize about how death anxiety contributes to psychological suffering was motivated by personal death anxiety, professional concerns, or both, Freud diverted decades of psychoanalysts away from this topic, even though there were notable exceptions such as Otto Rank, Alfred Adler, Carl Jung, Melanie Klein, and Ernest Becker (Yalom, 1980). More than three decades after Yalom's critique of psychoanalytic schools as ignoring death anxiety, the burgeoning psychoanalytic literature on the psychotherapist's physical mortality is only starting to discuss this issue. McWilliams (2017) called attention to how even the Psychodynamic Diagnostic Manual (PDM) task force responsible for putting together the first edition of the PDM in 2007 had conspicuously neglected to include the developmental challenges faced by the elderly, even though the committee consisted of almost exclusively elderly analysts anywhere from 70 to 90 years of age, including McWilliams herself (p. 51)! When death anxiety in psychotherapists gives rise to defensive neglect on their part to make contingency plans, it results in patients' being traumatically abandoned in the event of the psychotherapists' unexpected prolonged absence or death. In a Wall Street Journal article, Zaslow (2004) reported that many patients whose psychotherapists had died struggle with transitioning to care under another psychotherapist because unlike physicians who "leave behind thick files for inheriting physicians, … many therapists keep sketchy notes at best" (para. 6). Furthermore, some psychotherapists fail to keep a list of their clients to contact in the event of their deaths, leaving their colleagues scrambling to figure out how to find that information and contact patients without breaking

their confidentiality to family and friends (para. 8). This lack of foresight is corroborated by disclosures from analysts themselves. Dewald (1982), who had to take an extended absence due to an almost deadly parotitis, discovered in talking with his peers that none of them had made provisions for patient care should they die unexpectedly or be incapacitated by an illness (p. 348). The sudden death of renowned analyst Karl Abraham was preceded by months of silence and speculations about the severity of his decline, leaving confused and devastated patients in the wake of his demise (Pinsky, 2017, p. 20). A similar attitude of denial was found among elderly analysts who participated in van Raalte's (1984) dissertation research: when asked about concerns regarding their health, they spoke as though healthy lifestyles alone could protect them from ill health and death (cited in McWilliams, p. 51). McWilliams (2017) reflected on her own and her colleagues' procrastination in writing up a professional will despite repeated suggestions from the American Psychological Association (p. 51), which in 2004 had about two-fifths of members over the age of 55 (Zaslow para. 6). McWilliams humorously confessed, "'A very good idea,' I always find myself thinking, as I keep transferring that task from one to-do list to another" (p. 51). Despite the psychoanalytic credo to engage courageously with experiences we would rather repress, McWilliams stated, analysts do not cope with death anxiety more stoically than other kinds of professionals (p.51).

Ellen Pinsky (2017) voiced her concern about psychoanalysis' silence on mortality forcefully in her book *Death and Fallibility in the Psychoanalytic Encounter: Mortal Gifts*, which she dedicated to her analyst Joseph Nemetz who had died suddenly while she was still in psychotherapy with him. She disclosed that prior to his death Dr. Nemetz had declined her request to transition to analysis with him because he thought that it would be unethical to begin analysis knowing that he, at seventy-one, might die before seeing her through it (Pinsky, pp. 119-121). His foresight, borne out of a respect for the power of analysis as a

treatment method, spared her from even more painful feelings of abandonment that would have arisen, if she were to have lost him in the middle of an analysis that he had begun knowing that he might leave her hanging. Although an analyst's death might feel like an abandonment, there is still a part of us that can process it as a biological occurrence independent of the analyst's intention, and therefore not as painful as an abandonment that the analyst could see coming but did nothing to prevent.

Like Pinsky, McWilliams (2004, 2017) urged psychotherapists to take seriously the heavy responsibility that comes with the fostering of an intimate bond with the patient in the service of therapeutic change. She noted that the healing power of the therapeutic relationship consists in patients allowing the psychotherapist to matter enough to them, so that the psychotherapist can provide a relational experience that is counteractive to the negative impact of their developmental histories and capable of altering their deep-seated, habitual ways of being (McWilliams, 2004, p. 386). The psychotherapist encourages the patient to let their guard down enough, allowing powerful dependency needs to awaken, so that the dyad has a fighting chance of figuring out together what goes awry when the patient tries to get those needs met in relationships. In initiating a process that leaves patients in such a vulnerable space, it is the psychotherapist's ethical responsibillity to do their best to stay healthy and alive throughout the work. Indeed, she asserted, when psychotherapists take patients into their care, especially long-term psychotherapy, they are also implicitly agreeing to be available for the patient during that duration, as much as is humanly possible (McWilliams, 2004, p. 386). She noted that "the relational power necessary for healing has just as much potential to do harm" because "our death risks traumatizing those who have depended on us" (McWilliams, 2007, p. 51), particularly for patients who harbor deep-seated fears about their "toxicity," for whom the literal survival of the analyst over the course of the psychotherapy is an essential element in healing (McWilliams, 2004, p. 386).

With regards to the psychotherapist who is aware that their availability could be truncated due to being afflicted with severe or even life-threatening illnesses, she referred to the works of Pizer (1997) and van Raalte (1984) to highlight how important it is for the psychotherapist to communicate truthfully and transparently with patients. Pizer and van Raalte found that when there was a lack of honest conversation about the analyst's ill health, patients struggled when the analyst died, blaming themselves for failing to keep their analyst's interest, as though they had literally bored their analyst to death (cited in McWilliams, p. 51). These findings resonate with an increasing number of studies showing that when facing imminent death, patients and their families value candidness in discussions about the course of the illness and end-of-life preparations (Rodin & Zimmermann, 2008, p. 182). The capacity for the severely ill to discuss their deaths has been underestimated for such a long time in part because when death anxiety was examined in previous decades, they were conducted with healthy patients, obscuring evidence from studies of terminally ill cancer patients that death anxiety is not only tolerable and manageable, but also coexists with a "strong will to live" (Rodin & Zimmermann, 2008, pp. 185-186). Additionally, as Pinsky (2017) reminded us, the experience of loss through the biological death of the psychotherapist is far more benign than the experience of abandonment through retaliation, including neglect. The psychotherapist's willingness to be emotionally present with the patients as they work through their abandonment fears prevents the inevitable loss of the psychotherapist from constituting an experience of retaliation.

We might borrow some wisdom from the field of nursing, where the mortality of the helper has been much more extensively studied. One such study is that of Malone (2000), whose scholarship was inspired by a shocking awakening to her own existential vulnerability in her work as an emergency room nurse. The epiphany struck her when she incidentally glimpsed at her patient's clean white socks on his otherwise bloodied, mangled body, and

experienced a nauseating realization that this dead man's day had begun just like hers and everyone else's (p. 2). She noted that such realizations are often disturbing to nurses, but they are also easily pushed aside due to the relative anonymity and rapid turnover of patients, which allow nurses to focus on their tasks rather than on the personhood of the patients. Nonetheless, when the patient is a 'frequent flyer' (p. 3), that is, a chronic patient, the unique personhood of the patient makes its way into the nurses' experience, forcing them to confront their shared humanity. She found that in contact with emergency room 'frequent flyers', nurses often resorted to what she called "mythmaking" (p. 6) and "distancing" (p. 7) to cope with the disturbing awareness of their shared vulnerability with the patients. In "mythmaking," nurses focus on the apparent indestructability of the frequent flyer, elevating them to the status of a superhuman survivor and simultaneously excluding them from the rest of humanity, thus protecting nurses against the awareness of not just the frequent flyer's vulnerability but also their own. On the other hand, when "distancing," nurses may preoccupy themselves with the minutiae of their tasks, mentally put up walls between themselves and patients, or chalk the patient's death up to 'destiny' to avoid feeling the guilt and helplessness that may have come up in trying and 'failing' to save the patient (p. 7). Malone observed from the nurses' narratives that watching frequent flyers deteriorate and die is so profoundly painful that nurses become detached and lose touch with the patients' personhood (pp. 8-9). However, she also found that at times these nurses plucked up the courage to recognize their shared vulnerability with a patient, imagining the patient as 'someone's child' and feeling empathy and compassion rather than defensive contempt for the patient (p. 9).

Based on those observations, Malone (2000) proposed that there are two primary and contrasting definitions of vulnerability in nursing research: a "public health model" of vulnerability versus an "existential" model of vulnerability (p. 3). The former defines vulnerability as a "susceptibility to particular harmful agents, conditions, or events at

particular times," whereas the second definition regards vulnerability as "the common condition of all sentient beings" (p. 3). While the first definition views vulnerability as something to be overcome, the second definition calls for an acceptance of our shared vulnerability as the ground upon which to build "richer and more authentic relationships with patients" (p. 3). In other words, the existential view of vulnerability is that it is not a problem to be solved, but rather a condition shared by all sentient beings that ought to be embraced by the healer, because it is ultimately what connects the healer to the patient. This view of vulnerability is valuable because while the concept of woundedness as a bridge that connects healer and patient is not foreign to psychology or to medicine, such as in the archetype of the Wounded Healer, whose irrevocable woundedness allows the healer to connect with and understand others' wounds (Viado, 2015), the focus has frequently been on the developmental wounds of the psychotherapist, not on the existential wounding of being a mortal creature.

Psychotherapists, like all human beings, are not exempt from confronting and struggling with existential concerns and the tragedies that happen in every life. The therapeutic encounter is likewise haunted by the specter of its ending, which sometimes comes before either party has agreed to it. Just as the psychotherapist's experience of suffering can facilitate compassion and empathy for the patient's suffering, this shared existential woundedness can become the fertile common ground on which to cultivate authenticity between them. In other words, while existential vulnerability can be a source of dread and anxiety, it is also the shared existential bedrock that allows the healer and patient to meet and join with each other as two suffering, meaning-seeking, and vulnerable human beings (p. 10). Yalom (2002) proffered the therapeutic stance of the psychotherapist as one of a "fellow traveler" who walks alongside the patient on their journey, which breaks down the false us-versus-them dichotomy of "healers" versus "the afflicted" (p. 8).

Echoing Yalom's 'fellow traveler' model, Kaethe Weingarten is a psychotherapist living with cancer who works with patients with chronic illnesses or serious disabilities and writes about how psychotherapists can connect with their patients in the shared condition of living in pain-ridden, exhausted, or variously disabled bodies. Weingarten (2012) discussed the artificiality of a dualism that is often assumed in the construct of "care" in discourses about disability, namely that care is between a "strong," "altruistic" giver and a "weak," "needy" receiver. In her words,

> Positions of altruism and vulnerability exists only in moments in time; they are temporary, not stable. We all live in ratios of dependence, interdependence, and independence. However, we obscure this. Those in healthy body/minds act as if those in unhealthy body/minds live in a foreign territory that is utterly different. (p. 13)

Weingarten remarked her own increased dependence and obvious need for physical care has allowed her as a psychotherapist to exemplify being a giver and receiver at the same time, which challenges her patients' rigidity around allowing themselves to be dependent. She further observed the ideal stance towards working with individuals who suffer from chronically debilitating illnesses or disabilities is one of "compassionate witnessing," which is a stance of empathic immersion into the other person's experience and effecting therapeutic actions aimed at furthering the other person's interests rather than reducing one own's emotional pain as a witness to profound suffering (p. 10). Being able to anchor oneself in the memory of being incapacitated or disabled even if momentarily such as due to a bad flu can help able-bodied psychotherapists to join with those patients, without unhelpfully playing out the strong/weak, caretaker/cared-for dynamic (p. 452).

Physical Threats and Injuries

While the previous section touched on the inevitability of death and the haunting prospect of incapacitating illness and disability, this section discusses more specifically the

occupational hazard of being harassed, stalked, or physically wounded by patients, and in rare but harrowing instances, even killed on the job. In September 2006, 53-year-old psychiatrist and National Institute of Mental Health administrator Dr. Wayne Fenton, who was known for his research and clinical practice with clients who had the most severe presentations of schizophrenia, was beaten to death in his private practice by a 19-year-old man whom he had been treating for diagnoses of bipolar and schizophrenia (Oransky, 2006; Sherer, 2007). A former practitioner at Chestnut Lodge with a reputation for being a "therapist of last resort" who could get through to the most resistant patient "by sheer force of sympathy and good will" (Carey, 2006), he was most acutely aware of the violence risk factors in untreated psychosis (Sherer, 2007). His tragic end demonstrates that expertise, warmth and a nonthreatening personality cannot protect psychotherapists from patient assaults. Sometimes, mental health professionals may also be exposed to danger by virtue of being in a setting with others who work with potentially violent patients. In February 2008, 39-year-old David Tarloff brutally murdered 56-year-old psychologist Dr. Kathryn Faughey and seriously wounded her 70-year-old officemate psychiatrist Dr. Kent Shinbach (Munsey, 2008a, p. 39; Buettner, 2013). Dr. Faughey's practice, which served clients with anxiety and depression, would have never crossed anyone's mind as putting her at risk of coming in contact with violent patients. Tarloff later revealed to the police that he had intended to rob Dr. Shinbach, whom he claimed had diagnosed him with schizophrenia and arranged for his involuntary commitment in a psychiatric hospital 17 years earlier.

Accounts of patient assaults and murders of mental health professionals have detrimental consequences on both the field and the patients served. According to forensic psychiatrist Dr. Spencer Eth, the shock and horror of news about mental health professionals being murdered may discourage prospective recruits from even entering the field, particularly women who naturally feel more vulnerable to physical violence, and simultaneously increase

the risk of recurrence of such acts via the "contagion effect," i.e. "making such an act more conceivable" to other people (cited in Paul, 2008). While most patient assaults do not result in serious injury, they leave the mental health professional with emotional scars and trauma (Anderson & West, 2011; Purcell et al. 2005). According to a survey of Australian psychologists who had experienced stalking by their clients, 29% of them thought about terminating their psychology practice altogether (Purcell et al., 2005). Such incidents also tend to perpetuate fierce debates about legal, risk-management perspective of reducing the risk of violence in untreated psychosis versus the civil rights of the psychotic patient to refuse neuroleptic medications (Carey, 2006). It also fuels the age-old inaccurate and harmful stereotype of psychiatric patients as violent, contributing to further discrimination and stigma (Anderson & West, 2011; Rueve & Welton, 2008; Skeem & Mulvey, 2011).

Before I proceed to detail the prevalence of violence and aggression towards mental health professionals it is important to note that contrary to popular stereotypical media portrayal of the violent schizophrenic, the psychiatric diagnoses most highly associated with increased violence risk are personality disorders, substance use disorders, and neurocognitive impairment due to Alzheimer's dementia, traumatic brain injury, or medical conditions; individuals with other psychiatric illnesses are much more likely to become victims than perpetrators of violence (Rueve & Welton, 2008, pp. 40-41). Psychotic symptoms alone do not tend to contribute to violence, but violence risk increases when accompanied by factors such as paranoid ideation, persecutory delusions, and cognitive disorganization (Rueve & Welton, 2008, p. 42). The diagnosis of a psychiatric illness per se also does not robustly predict violence and only a small percentage of violence that occurs in society can be attributed to individuals diagnosed with a psychiatric illness (Anderson & West, 2011, p.35; Rueve & Welton, 2008; Skeem & Mulvey, 2019, pp. 12-13).

Mental health professionals regularly encounter individuals with a combination of various static and dynamic violence risk factors. These risk factors include alcohol and other substance use, psychopathy, impulsivity, anger-fear management difficulties, a history of criminal behaviors, a prior history of violence or aggression, neurological impairment from traumatic brain injuries, dementia, or delirium states, occupational or developmental histories that desensitizes individuals to pain and violence such as military service or a history of childhood trauma, acute suicidality, homicidality, hopelessness, paranoid ideation, and treatment nonadherence (Anderson & West, 2011; Drummond et al., 2012; Rueve & Welton, 2008; Skeem & Mulvey, 2019). Additionally, demographic characteristics that increase the risk of violence include being young and male (Anderson & West, 2011, p. 35; Rueve & Welton, 2008). Although physical aggression and violence in the general population tend to be perpetuated overwhelmingly by men, some evidence suggests that the diagnosis of a psychiatric disorder tends to flatten the gender difference (Anderson & West, 2011). Male psychiatric patients are much more likely to attack male clinicians than female clinicians, but clinicians who had been attacked by a male patient were also likely to have been attacked by a female patient as well (Guy et al., 1990, p. 494).

Short of physical assaults, mental health professionals are also at risk for stalking by clients. In the general adult population, 1 in 12 women and 1 in 50 men in the US will experience stalking in their lifetime (Tjaden & Thoennes, 1998). Purcell et al. (2005) surveyed Australian psychologists and reported that 1 in 5 psychologists will be stalked in their lifetime. Although the gender of the psychologist did not seem to affect the lifetime rate of stalking by a client, men tend to experience significantly more same-gendered stalking than women (Purcell et al., 2005; Tjaden & Thoennes, 1998), although it may be possible that male clinicians underreport stalking incidents by female clients due to their perception of female clients as less dangerous. The methods of stalking included phone calls, letters, faxes,

or emails, “unwanted approaches,” “loitering nearby,” and getting “offensive materials” or “unsolicited goods” (Purcell, 2005, p. 540).

The stark reality of physical violence towards mental health professionals is especially concerning in the United States, where there is ready access to firearms, which is a well-documented violence risk factor (Anderson & West, 2011; Drummond et al., 2012). There is evidence that individuals who work in the mental health field face a higher risk of being assaulted than individuals in many other professions. Anderson and West (2011) reviewed statistics from the U.S. Department of Justice National Crime Victimization Survey conducted from 1993 to 1999, which estimated that every year 6.82% of mental health professionals such as psychiatrists, psychologists, and social workers are assaulted on the job, which is 5.4 times higher than the percentage of workers in other occupations assaulted annually (pp. 34-35). Mental health custodial workers run the highest risk of being assaulted, at a rate of 69 per 1000 workers every year (Anderson & West p. 35). Numbers vary on the prevalence of physical assault on psychologists by patients. In an anonymous survey of 701 psychologists by Guy et al. (1990) who practice psychotherapy, about 40% of the sample reported having been physically assaulted at least once by a patient, while in another survey by Pope and Vasquez (as cited in Pope, n.d.), close to one in five psychologists reported having actually been attacked by at least one patient; more than 20% reported calling the police or other security officers; approximately 3% reported acquiring a weapon; about 80% endorsed having been afraid of being attacked by a client, and more than 50% reported fantasizing about an attack by a client. While not all threats culminate in actual assaults, psychologists who had gotten the most verbal threats also reported the greatest frequency of being physically attacked (Guy et al., p. 494). The statistics may even underestimate the actual prevalence due to underreporting (Anderson & West, p. 37; Guy et al.). Agency staff may underreport these incidents for fear of supervisory censure, a lack of perceived support

from management, the belief that violence is inevitable in their profession, and that they should be equipped to deal with it by themselves; indeed, many institutions do not require staff to report violence incidents and may even "subtly discourage reporting" in order to avoid lengthy documentation (Anderson & West, p. 37).

Physical assaults on psychologists are about twice as likely to happen in inpatient settings than in independent psychotherapy practice (Tryon, 1986, as cited in Romans et al., 1996). Emergency rooms and inpatient psychiatric units not only have patients at their most acutely disorganized, but also tend to be loud, crowded, unpleasant, and devoid of privacy or personal space, which Rueve and Welton (2008) marked as environmental factors exacerbating aggression. In the US alone, patient assaults happen by the thousands in these settings, particularly because violence risk is at its highest upon patient admission to the hospital (Rueve & Welton, p. 36). Staff working in public psychiatric hospitals are also much more vulnerable to patient violence than staff at private psychiatric hospitals (Guy et al., 1990), and maybe even more so nowadays due to a trend of "forensification" observed by Wik and colleagues (2019), that is, an increase in the number of forensic patients such as those deemed not guilty by reason of insanity, incompetent to stand trial, or civilly committed sexual offenders who have been assessed as sexually violent predators. As noted earlier, prior criminal history and violence predict future violent behaviors (Anderson & West, 2011, p. 42). Between 1994-2014 in the US there has been a 76% increase in the number of forensically involved adult patients in public psychiatric hospitals nationwide, with the majority of the increase accounted for by individuals court-mandated to receive treatment for competency restoration (Wik et al.). Forensic psychologist Reid Meloy (2002), an expert on psychopathy and violence risk, observed that what distinguishes patients who assault staff from those who do not when they feel mistreated is "pathological narcissism," which is most frequently associated with personality disorders and substance use disorders (p. 230). In

pathological narcissism, there is an extreme sensitivity to shame that predisposes them to rageful responses including physical assaults (p. 230). In addition to patient population characteristics that contribute to violence risk, inpatient staff, particularly nurses, are much more likely to spend substantial amount of time in close proximity with patients play the role of setting limits that may be highly frustrating to patients, and manage violence through forcible means such as physical and chemical restraints and seclusion, which exacerbates power-control dynamics (Anderson & West, 2008; Sheridan et al., 1990). Even post-discharge from the hospital, during which violence risk is once again at its highest for about ten weeks (Rueve & Welton, 2008, p. 36), patients have been known to stalk, threaten, and harass the inpatient staff they worked with, particularly male patients who carry diagnoses of a personality disorder, have a history of threatening behaviors, or exhibit paranoia of the erotomanic type, (Sandberg et al., 1998).

Although experience does not offer full protection (Guy et al., 1990), psychologists in their training years and early career are more likely to become victims of violence (Guy et al., 1990). Firstly, newer psychologists tend to work in the most dysregulated settings with the most impaired patients (Guy et al., 1990; Munsey, 2008b). Secondly, less experienced psychologists tend to be more permissive and less adept at recognizing warning signs of violence (Munsey, 2008b). Moreover, there is overall insufficient training for psychologists in violence risk assessments, strategies for deescalating potentially violent situations, and ways to manage client intrusiveness (Guy et al., 1990, p. 495; Purcell et al., p. 541), reflecting a climate of denial in psychology about violence risk (Kleespies, cited in Munsey, 2008b).

Unsurprisingly, professionals who practice in isolated settings are at increased risk, as are those who tend to work with patients with a criminal history, substance use disorders, and history of aggression. Forensic psychologists are most at risk, followed by clinical and counseling psychologists (Purcell et al., 2005, p. 539). Psychologists face increased risk of

violence because they are routinely called upon to assess, manage, and reduce risk of danger to self or others. By nature of their social power to make decisions that have major impact on people's lives, such as evaluations for involuntary commitments, fitness for duty, competence to stand trial, disability, and so on, they may tend to be viewed as persecutory authority figures when the outcome goes against the patient's wishes. In Purcell's and colleagues' (2005) survey, all the forensic psychologists who reported being stalked by clients attributed it to clients' resentment (p. 540). Even in settings generally considered safe such as university counseling centers and private practice with neurotically anxious or depressed clients, staff may face threats to their emotional and physical safety. A study by Romans and colleagues (1996) found a 5.6% incidence rate of stalking incidents by patients towards university counseling center staff, as well as stalking targeted at family members of staff in 7.9% of the sample. Most of the staff and their family members experienced more than one stalking incidents (p. 597). According to Purcell et al., 42% of the clinical psychologists who reported being stalked by "infatuated" clients (p. 540).

According to Rueve and Welton (2008), essential to reducing violence risk in patients is the psychotherapy itself: evidence suggests that patients who are regularly engaged in treatment are less likely to make physical threats or act violently against their families. Romans et al. (1996) discussed effective limit-setting, which consists of identifying the client's threatening or assaultive behavior as inappropriate, being clear with the client about the limits of the therapeutic relationship as well as emphasizing consequences for continued inappropriate behaviors (p. 598). Positive, peaceful behaviors should also be reinforced (Rueve & Welton, p. 44). Rueve and Welton highlighted the potency of "seemingly simple interventions" that "can have a tremendous impact on violent outcomes" when patients are agitated, such as offering food or drinks, making the immediate environment safe, "avoiding

intimidating direct eye contact," giving "quiet time," maintaining a relaxed posture with uncrossed arms and empty visible hands, and using calming statements (p. 43).

Moreover, in order for psychotherapy to be effective with violent patients, the management of countertransference reactions is of paramount importance, particularly because psychotherapists may find themselves trapped in unproductive countertransference patterns that lead them to mismanage violence risk (Rueve & Welton, 2008, p. 44). They may underestimate risk in an overzealous attempt to build trust and rapport with the patient, dangerously dismissing important emotions such as fear and disgust and putting themselves at heightened risk of assault; they may alternately overestimate risk and be unable to relate at all to the patient, resulting in a weak therapeutic alliance (Rueve & Welton, 2008, p. 44). Rueve and Welton (2008) also highlighted the importance of collegial support, citing a comprehensive review by Alpert and Spillman (1997), which showed that in addition to training for clinicians in violence risk management and the maintenance of a safe environment, psychotherapists must have ready access to consultation and supervision to help them self-monitor countertransference reactions

Additionally, in the aftermath of the murder of Dr. Faughey, the American Psychological Associations published guidelines to making one's practice more secure, such as keeping the entrance locked such that patients with appointments would need to be "buzzed in" in order to get to the waiting room, having patients put their belongings in a locker before coming into the office, installing heavy chairs that cannot be lifted and thrown, staying closer to the door than the patient, avoiding working alone at night, not keeping objects within reach of the patient that can be used as a weapon, learning self-defense techniques, and screening prospective clients (Munsey, 2008b). Meloy (2002) recommended that psychologists make use of psychological assessments to ascertain violence risk for every patient, such as the Minneosta Multiphasic Personality Inventory (MMPI)-2 and forensic

violence risk instruments (cited in Munsey, 2008b). He noted that a large number of psychologists assume erroneously that they can predict their patients' violence risk based on clinical interviewing alone. The guidelines also recommended installing a video monitoring system that covers all common areas and which can be accessed in the receptionist area, having a "panic room," that is a "secure space … where staff can retreat and telephone for help," and having an "officewide evacuation drill" (Munsey, 2008b). When meeting with patients with elevated violence risk, it is advisable to let colleagues know ahead of time that they may interrupt a session to check in, and if the psychotherapist is feeling uncomfortable, they should make up an excuse to leave (Munsey, 2008b).

Equally important to evaluating and disseminating effective ways of managing and preventing patient violence in clinical practice, is the need to understand the mechanisms that perpetuate denial in the field of psychotherapy about the real risk of physical assaults on the practitioners. Flannery et al. (2011) situated this problem of denial within the larger context of an "American culture [which] in general usually denies and minimizes violence and its impact on victims," (p. 20) and in fact, blames victims of violence. This victim-blaming operates in assaulted mental health professionals as well, who may rationalize their experience of violence as an inevitable part of the work. Furthermore, they argued that this denial may be motivated by the fact that "violence teaches us how tenuous our links to life may be" (p. 20). Thus, we circle back to the issue of the psychotherapist as a mortal, and therefore vulnerable being. Without acknowledging ourselves as mortal, we risk overlooking the precautions we can take to maximize our chances of staying safe and alive in our practice.

Summary on Physical Vulnerability

This section on physical vulnerability provided an overview of issues related to the mortality of the psychotherapist as their susceptibility to physical injuries on the job. Following Malone's (2000) classification of models of vulnerability into the public health

model and the existential model, I cluster the implications of this review into two broad categories: best practices to reduce physical risks on the job, and deeper lessons afforded to psychotherapists about the nature of psychotherapy and their role when they confront the inevitability of death, illness, and disability. From a public health perspective, considering the prevalence of patient assaults, stalking, and harassment, it is clear that psychotherapists cannot naively ignore the real dangers of serving individuals struggling to contain their aggressive, even violent potential. There are recommendations in the literature that can help us utilize a variety of physical protections, collegial supports, and assessments. From an existential perspective, even when those best practices have been put into place, there is no ultimate protection from physical risks, and like all sentient beings the psychotherapist must still fall sick, die, lose functions, and risk becoming incapacitated. While psychotherapists should try their best to take care of their physical health to stay alive when they have patients in their care, they must also prepare for the possibility that they may not succeed in that effort, by planning for how patient care should be handled in the event that they die or become incapacitated. Since his first book on existential psychotherapy Yalom (1980) has maintained that "though the physicality of death destroys us, the idea of death saves us" (p. 40). Contemplating the fact that our time on earth is limited can motivate us to reexamine our priorities, let go of meaningless pursuits and petty resentments, and engage in life more vividly. In that way, life does not simply pass us by. Similarly here, although the physicality of death destroys the psychotherapist, the idea of death saves the psychotherapist from irreversibly re-enacting the patient's worst emotional convictions about their toxicity and from perpetuating a one-down relationship based on an illusory dichotomy of the invulnerable savior and the vulnerable one in need of saving.

Emotional Vulnerability

This section concerns "vulnerability of the heart," as one of my participants put it. I begin with a review of Brené Brown's extensive research on vulnerability, and dive into existential-humanistic, contemporary psychoanalytic, and analytical psychological perspectives on authenticity, mutuality, and reciprocity in the therapeutic relationship. I also specifically address the issue of the real personhood of the psychotherapist and gather a brief history of disavowal of vulnerability in the discipline of psychotherapy.

Brené Brown's Research on Vulnerability

Social work educator and researcher Brené Brown is perhaps the most well-known scholar on the topic of vulnerability. Working from a grounded theory approach, Brown (2012) was led to the study of vulnerability from her original interest in understanding human connection, which she attributed to the fundamental assumption from her social work background that "love and belonging are irreducible needs" of all human beings, which when unmet, "always leads to suffering" (p. 15). When Brown began by interviewing individuals about their most significant relationships and "experiences of connection," she was surprised by her participants' focus on the "betrayals, heartbreak, and shame" in those relationships and their fear that they were not worthy of "real connection" (p. 14). These data prompted her to embark on a six-year-long study of shame and empathy (p. 14). In addition to understanding shame, Brown sought to understand the experiences of individuals whom she called "Wholehearted," (p. 13) that is. those who believed in their worth despite experiences of shame, and engaged unreservedly in relationships and meaningful work in spite of fears about future losses and disappointments. She found that these individuals did not necessarily have fewer experiences of adversity or lead easier lives, and were not immune to feeling shame, but had somehow developed practices of being resilient to shame (p. 15). They operated from a default assumption that they were unconditionally deserving of love, belongingness, and

joy, and that their mistakes or failures did not define them. In a sense, they had cultivated practices than ran counter to what Brown had identified as a widespread culture of "never enough" that breeds shame and chronic feelings of scarcity (p. 17). Rather than focusing on appearing perfect or "bulletproof" (p. 10) and letting themselves be held back by self-doubt and negative self-comparisons, "Wholehearted" individuals deliberately practiced self-compassion, courage, and authenticity. They were able to reality-test and take in feedback that mattered while reaching out for support when subjected to mean-spirited attacks (p. 106). Because their self-worth was not on the line each time that they take a risk, they were much more willing to be vulnerable – defined as embracing uncertainty, risk, and emotional exposure (p. 11) – in their relationships, work, leisure activities, and other important areas of their lives (p. 15). Indeed, Brown noted that "Wholehearted" individuals "attributed everything—from their professional success to their marriages to their proudest parenting moments" to their willingness to be vulnerable (p. 15). Brown further emphasized that the ability to embrace vulnerability did not just happen to a few fortunate souls by sheer stroke of luck; instead, her participants consistently described their use of defensive strategies to avoid exposure before "finally letting it go" (p. 75) and surrendering to the inevitability of vulnerability. In other words, it is a practice that people chose to come back to over and over again.

In addition to defining what vulnerability is, that is, uncertainty, risk, and emotional exposure, Brown (2012) also addressed what vulnerability is not (p. 29). First and foremost, she dispelled the myth that vulnerability is weakness, conjecturing that the confusion originates in an emotion-phobic culture that conflates feeling with weakness, and hence vulnerability with weakness (p. 29). She cited her interview data of participants about a moment when they felt vulnerable. Across the board, individuals named events in which they marshalled great courage to rise to the occasion and embraced the inevitable discomfort that

comes with taking risks, being present and engaged, and displaying effort and investment in a goal or relationship they care about. Participants named actions such as "exercising in public," "initiating sex" with one's partner, helping a dying loved one with making a will, voicing unpopular opinions, and "trying something new" (p. 30). Through these examples she argued that being vulnerable involves being courageous and truthful, which may be uncomfortable, but not weak (p. 30). Brown also clarified that as the "core of all emotions and feelings," vulnerability per se is neither "good" nor "bad" (p. 29). In particular, she noted, the view of vulnerability as weakness comes from the rejection of "dark emotions" such as "fear, shame, grief, sadness, and disappointment" (p. 29). Anger as a "secondary emotion" is often the one "socially acceptable" negative emotion (p. 29) that conceals other more vulnerable emotions. By turning away from vulnerability for fear of those dark emotions, individuals also turn their backs on opportunities for experiencing its positive aspects including "love, belonging, joy, courage, empathy, and creativity" (p. 29). She further illustrated the linkage between both the positive and negative feelings that come from the same "birthplace" of vulnerability – to allow ourselves, for example, to experience love for someone is to also risk the existential reality that this person may leave us, not love us back, get hurt, or die (p. 29).

Brown (2012) further asserted that vulnerability was not optional because life always consists of risks, uncertainty, and situations of emotional exposure, but people can choose how they engage with vulnerability. Drawing on Theodore Roosevelt's famous "Citizenship in a Republic" speech, also called "The Man in the Arena," Brown contrasted two modes of responding to vulnerability: one is akin to the critic "sitting on the sidelines and hurling judgment and advice" (p. 11) at the man in the arena, while the other is akin to the man who dares to show up in the arena and strives steadfastly towards a cause important to him, risking the inevitable failures that come with performing any feat. This latter mode of engagement is

about “being all in,” “dar[ing] to show up and let ourselves be seen” (p. 11), while the former is characterized by taking great lengths to avoid shame, exposure, and critique, staying safe but never fully in contact with life and therefore cut off from joy and connectedness. These avoidance strategies may include “foreboding joy,” that is, not allowing oneself to fully “sink into” joy (p. 29) and constantly planning ahead for disasters, perfectionism, emotional numbing using substances or socially acceptable, if not valorized ways of dampening feelings, going to great lengths to control or get out of the uncomfortable situation rather than facing it head-on, and putting on a cynical, critical front (pp. 82-105). Some individuals in her study adopted what she called a “Viking or victim” worldview that segregates people into a strong-weak, winner-loser binary (p. 94). It rationalized their use of power-control tactics to disavow their vulnerability and attack it in others, or on the flipside, to claim perpetual victimhood as the cause of their suffering (p. 94). Both worldviews leave the individual with little wriggle room for a more tenable and expansive worldview (p. 94). She further clarified that oversharing with people who are not ready for it or who have not yet earned trust and the privilege of hearing the information, or other ways of cutting through people’s boundaries and “grabbing” their attention, are both defenses that “misuse” vulnerability and pushes people away rather than build connectedness (pp. 97-101).

In addition to explaining ways in which individuals try to sidestep vulnerability, Brown (2012) elucidated ten “guideposts” for Wholehearted living that she had developed based on the narratives of individuals who embrace vulnerability: authenticity (letting go of what people think), self-compassion (letting go of perfectionism), resiliency (letting go of numbness and powerlessness), gratitude and joy (letting go of fear of the dark and scarcity), faith (letting go of the need for certainty), creativity (letting go of comparison), play and rest (letting go of exhaustion as status symbol and productivity as self-worth), calm and stillness

(letting go of anxiety as lifestyle), meaningful work (letting go of self-doubt and 'supposed to'), laughter, song and dance (letting go of being 'cool' and 'in control').

At the heart of the human struggle with true intimacy, Brown (2012) argued, is a double standard that we hold vis-à-vis our versus others' vulnerability: we try to be perfect in the eyes of others and avoid showing vulnerability, and yet when we seek to connect with others the first thing we seek out is their vulnerability. She noted that underlying this reluctance to show oneself is the fear that who one is and what one has to offer is not enough, and therefore if shown, would invite judgment that confirms this fear. Interestingly, she noted, when asked to describe how vulnerability feels, participants overwhelmingly responded that it was like being "naked" (p. 31). Building on this metaphor, she likened the ways in which we may try to defend against the experience of vulnerability to wearing "masks" and "armor," which although may provide an illusion of safety, also "become suffocating" and weigh us down (p. 73). It also prevents people from feeling connected to each other. She pointed out, the longer one dons a mask, much like a "persona," it starts to feel like a "second skin" that may feel indistinguishable from one's real self (p. 73).

The notion of armoring may remind us of Wilheim Reich's concept of "character armor," which is both a metaphor for resistance to the psychoanalytic process, that is, an "imperviousness to being touched by interpretation and education," and also a demonstrable bodily phenomenon that takes the form of muscular tension and rigidity, "spasms," "decreased motility," or "postural misalignments," enacted to guard against "unwanted or intolerable feelings, sensations, emotions, or experience" (Samsel, n.d., paras. 1-2). Over time, the adoption of the character armor results in "emotional rigidity, poor contact with others, and a feeling of 'deadness'" (par. 1). Importantly, Reich noted, unlike psychological defenses, which "can still slip or be overwhelmed at times," the character armor is "always on" because it tends to be deeply unconscious as it is affected by the autonomic nervous

system rather than the skeletal nervous system (Samsel, n.d., para. 4). In other words, the body is now in charge of defending against unwanted experiences, and as such, the conscious mind does not have to be involved.

In a courageous act of researcher reflexivity, Brown (2012) reflected how her data challenged her to examine her own reluctance to embrace vulnerability, particularly to discuss her research on vulnerability in a personally, emotionally connected way. She stated that it took her more than a decade to recognize that vulnerability as a construct did not simply emerge with other variables such as shame, belongingness, and worthiness by coincidence, despite the fact that she had begun writing about vulnerability from the beginning of her career (p. 16). Brown warned, based on her own example, that having an intellectual understanding of the importance of embracing vulnerability and ways to do so does not necessarily translate into Wholehearted living. Brown cited her fear of compromising her credibility as a researcher by being "too relatable," as she, like many researchers and academics, learned early on that keeping a "cool distance" and maintaining a lack of "emotional accessibility" is somehow key to being credible, and experience vulnerability as a shame trigger (p. 16).She summarized this common conundrum vis a vis vulnerability in the following statements: "I want to experience your vulnerability but I don't want to be vulnerable"; "Vulnerability is courage in you and inadequacy in me"; "I'm drawn to your vulnerability but repelled by mine" (p. 32). Those attitudes ultimately get in the way of the experience of connection and acceptance, and thus perpetuate the shame that is the driving force behind such attitudes in the first place.

The Psychotherapist as a Real Person

In modeling personal vulnerability in her work, Brown (2012) exemplified her belief that as parents, teachers, bosses, or other types of leaders, "[w]hat we know matters, but who we are matters more" (p. 17). Of note, by "leader" she refers to "anyone who holds her- or

himself accountable to finding potential in people and processes" (p. 117), which fits the definition of a psychotherapist too. Extrapolating from this stance, one could infer that Brown would appreciate a psychotherapist who dares to show up in the therapeutic relationship, take risks, tolerate uncertainty, and accept emotional exposure as the prerequisite for deep connection with clients. Yalom (1980) asserted:

> There is no way around the conclusion that the therapist who is to relate to the patient must disclose himself or herself as a person. The effective therapist cannot remain detached, passive, and hidden. Therapist self-disclosure is integral to the therapeutic process. (p. 411)

Yet, there are many barriers, both personal and collective, to psychotherapists' showing up vulnerably with their patients. In the same way that Brown could not sidestep her own baggage with vulnerability despite her scholarly understanding of the ways that engaging with vulnerability enhances life, psychotherapists are not immune to holding themselves to a double standard of inviting others' vulnerability while hiding their own. A fear of being emotionally vulnerable with clients can be defensively avoided by portraying oneself as so generously concerned with clients' wellbeing that the psychotherapist's self is completely effaced. The experience of receiving care from an other entails being seen and recognized in one's vulnerable state of needing care.

Certainly, a source of vulnerability for psychotherapists hence lies in their identification with the role of the healer, so much so that the analytic relationship has often been regarded as analogous to a parent-child relationship, with the analyst being the caregiver and the patient being the recipient (Shabad, 2017, p. 360). Shabad (2017), in his article about the "vulnerability of giving" and the "generosity of receiving," explored the openness and trust it takes for a therapist to receive care from a patient who has taken the risk to give it. He argued that psychotherapists do not often realize how much their patients care about how they

are doing, in the same way that children often "look out for and worry about" their parents (p. 360). As a result, psychotherapists tend to turn questions about their wellbeing back onto their patients, which although is "consistent with the norms of psychotherapy," perhaps also forecloses the possibility of letting the patient experience giving back to the psychotherapist and thus building a sense of self-trust (p. 360). The invitation by their patients to be on the receiving end of care might be experienced as threatening to the therapist's identification with being the healer. Receiving, after all, requires that one "suspend(s) one's own expressive passion to make way for the contributions of an Other" (p. 361). Brown (2012) argued furthermore that "[u]ntil we can receive with an open heart, we are never really giving with an open heart," because as long as we judge ourselves for needing and receiving help, we will "knowingly or unknowingly attach judgment to giving help" (p. 39). Practicing from a self psychological tradition, Richard Geist (2017) is fond of relating a story in which he had gone into analysis one day excitedly asking his ego psychological analyst if she had watched a certain movie lately, only to be asked, "Did you notice that you just asked me a question?" Annoyed by her patronizing query, he snapped back that of course he knew he had asked a question, and that he had expected an answer. Unfazed, she remarked that they needed to talk about his anger. While sometimes psychotherapists have good reasons not to self-disclose, in this case, her stern refusal to respond to a question with some human decency only provoked iatrogenic rage, which she then smugly repackaged as evidence of his problem with anger. In other words, when psychotherapists deny the relational component of the therapeutic alliance, they may fail to take responsibility for their contributions to the transference-countertransference field, creating an injurious situation whereby clients are blamed for reactions to the psychotherapists' empathic failures. Receiving also pertains to an openness to accepting influence from the client. In his compilation of advice to rising psychotherapists, Yalom (2002) beseeched them to let their patients matter to them, stating, "I urge you to let

your patients matter to you, to let them enter your mind, influence you, change you, and not to conceal this from them" (p. 27).

In contrast to allowing oneself to be seen and received, and to receive the other, some psychotherapists might opt to hide – a reaction formation against what one feels to be unacceptable exhibitionistic wishes. Hiding can be snuck into the therapeutic frame under the guise of upholding the three pillars of psychoanalysis: abstinence, neutrality, and anonymity. It masks the analyst's grandiose exhibitionistic wishes. We may recall that one of Sigmund Freud's main motives for asking his analysands to use the couch was so that he did not have to be stared at so much. Kuchuck (2014) corroborates the observation of hiding tendencies in psychotherapists, stating that even relational analysts and others who embrace a two-person psychology still struggle with classical Freudian superego pressures to resist "the longing to be known" and hence act out the "defensive temptation to hide" (p. xix). He quoted Lewis Aron (1996) in talking about how the profession of psychotherapy abounds with "narcissistic conflicts around voyeurism and exhibitionism" because "why else, he asks, would we choose a profession where we listen so intently to others while sitting silently and hidden?" (Kuchuck, p. xix). Aron was not alone in making this pronouncement. Greenson (1967) observed that a large subset of psychoanalysts "suffer from a marked degree of stage fright" and possibly chose the profession partly to assume the position of hiding behind the analytic couch, where they can "remain remote in order not to explode with anger or panic" and have a "haven from the fearful direct contact with people" (p. 400). McWilliams (personal communication, April 18, 2018), at a preconference workshop of the Division 39 Spring Meeting in New Orleans, shared that the second most common personality organization among therapists after depressive is schizoid, which is characterized by conflicts around intimacy and the fear of engulfment, which makes sense given that the therapeutic frame can offer such individuals a safe, bounded space within which to experience intimacy. Cameron

(1995), a writer who works with artists recovering from creative blocks, suggested a rather morose view that some psychotherapists are "shadow artists," (p. 43) that is, people who secretly harbor creative gifts and ambitions but are too afraid to pursue them, and thus shadow other real artists, hoping to live vicariously through them. In her words, rather than becoming the "gifted storyteller" they are and telling their own stories, they listen to other people and get their stories "secondhand" (p. 44).

Whether or not Cameron's pronouncement that psychotherapists secretly want to be artists is accurate, it certainly highlights the danger of being overidentified with the role of the psychotherapist as healer. Guggenbühl-Craig (1971) expounded on the dangers of split archetypes present in the professions of medicine, social work, teaching, and psychotherapy, that is, when the patient, welfare recipient, student, or analysand is seen as helpless, needy, ignorant, and childish, whereas the doctor, social worker, educator, or psychotherapist holds all the power, knowledge, and benevolence. One of the dangers he named was that the analyst, for instance, stops having symmetrical, intensive relationships with equals who can challenge them and stimulate their growth, but rather, only relates to patients and disciples, and treats even their loved ones as patients. Indeed, he made a pronouncement that is even more ominous and concerning than the statement from Cameron,

> the analyst gradually ceases to lead a vital life and contents himself with the lives of his patients … his own psychic development comes to a standstill. Even in his nonprofessional life, he can talk of nothing but his patients and their problems. He is no longer able to love and hate, to invest himself in life, to struggle, to win and lose. His own affective life becomes a surrogate. Acting thus as a quack who draws his sustenance from the lives of his patients, the analyst may seem momentarily to flourish psychically. But in reality he loses his own vitality and creative originality.

> The advantage of such vicarious living, of course, is that the analyst is also spared any genuine suffering. In a sense, this function, too, is exercised for him by others. (p. 56)

In a way, Guggenbühl-Craig (1971) was speaking of a psychotherapist who ceases to be the protagonist in the arena of their own lives, but rather, perpetually sits on the sidelines of their patient's lives. Such a psychotherapist, Guggenbühl-Craig argued, are harmful to their patients because the latter now bring their stories into the consulting room not because they want to live more fully but because they have been implicitly recruited to sustain the psychotherapist's vacuous life (p. 56). Seen through the lens of defensive strategies against vulnerability, the practice of psychotherapy can indeed become a seductive way to avoid the vulnerability of living. As individuals who are often called to the profession because they want to help people, psychotherapists run the risk of preoccupying themselves with the vulnerability in others as a way to deflect from their own vulnerability. Consistent with Brown's thesis that who one is matters more than what one knows, a psychotherapist who does not engage vulnerably in life cannot help but model a fearful disengagement from vulnerability.

Psychotherapy's History of Disavowal of Vulnerability

The therapeutic orientation that has most consistently and emphatically promoted the presence of the psychotherapist as a real person in the room is perhaps the humanistic tradition pioneered by Carl Rogers, who asserted that the therapeutic relationship needs to be "genuine and deeply personal" (cited in Yalom, 1980, p. 409). Similarly, Yalom (1980), who is one of the forerunners of the existential framework, asserted that psychotherapists need to "open [themselves] up to the other" and "fully experience the patient" in order to be effective (p. 411). He surmised that much like master chefs who furtively throw in undisclosed spices and condiments to transform their recipes from great to special "when no one is looking," (pp. 3-4) many psychotherapists, irrespective of their theoretical orientations, from time to

time “despite themselves and often unbeknownst to themselves” stray away from the confines of prescribed techniques and the constraints of their professional role and reach out to the patient in a human and deeply personal manner”(p. 414). These moments frequently become turning points in the therapy, but due to the fact that they “reside outside official ideological doctrine” which scorns them as “excesses” (p. 402), psychotherapists often feel obliged to downplay their importance in their practice or even hide them from public view, for fear of disapproval and shame.

How did the field of psychotherapy come to regard the psychotherapist’s lack of human responsiveness and inauthenticity as indicative of “good technique” (Yalom, 2002, p. 26)? The misguided notion that for optimal effectiveness the psychotherapist should adopt a detached attitude of simply “observ(ing) and listen(ing)” (Yalom, 1980, p. 411) and comport themselves as a “blank screen” (Yalom, 2002, p. 75) for projections from the client is an unfortunate historical legacy of classical psychoanalysis, which posited that the analyst’s enigmatic and inscrutable presentation allows the transference to take hold, providing a more accurate reconstruction of their early family dynamics (Yalom, 1980, pp. 411-412; Yalom, 2002, pp. 75-82). Analysts were taught to set aside personal needs to ‘self-negat(ing)’ extremes, not to show emotions, and to ensure that “office and personal dress were completely ‘neutral’” (Kuchuck, 2014, p. xxi). The authoritarianism in psychoanalytic training institutes kept candidates from daring to deviate from the standard lest they be expelled (Kuchuck, 2014, p. xxi).

This state of affairs was due in part to historical context. Sigmund Freud’s earliest patients were largely women whose boundaries had been violated in significant relationships, and hence it makes sense that they would have responded very well to a nonobtrusive presence (McWilliams, personal communication, February 2, 2020). Additionally, his personality dynamics tilted towards a more schizoid organization, such that he found personal

attention, particularly idealization, to be deeply uncomfortable (Strozier, 2004, p. 285; McWilliams, personal communication, February 2, 2020). Yet, he was far from being the archetypal blank screen analyst. He was capable of being effusive and demonstrative, warm and involved, or commanding and irreverent; he sometimes gave advice, rejoiced with his patients when they had particularly important insights, conducted home visits, talked to their family members to advocate for his patients, and attended his patients' social functions (Yalom, 2002, pp. 75-76). He was so invested in one of his client's care that he solicited an invitation to her private dance "so he could 'watch her whirl past in a lively dance'" after they had successfully worked through the psychogenic loss of her ability to walk (Yalom, 1998, p. 4). Despite being a bold participant in the extra-analytic lives of his patients, Freud proclaimed that the therapeutic ingredient in psychoanalysis was the analyst's interpretation, not the "authentic encounter" between him and his patients that was arguably much more central to his patients' recovery (Yalom, 1980, p.403; p. 412). The disciples of the master, overzealous effort to imitate their teacher, generated dogma that certainly did not help to dispel the blank screen myth. Even in the early 1990s, the notion of the "analyst's subjectivity" was rarely discussed except pejoratively (Kuchuck, 2014, p. xx).

In the 1950s when the "nontransference," (the real aspects of the therapeutic relationship) began showing up in the literature among analysts writing in the ego psychology tradition, attention to nontransference was rationalized as a technique to prevent the emergence of hostile transferences (Greenson & Wexler, 1969, as cited in Yalom, 1980, pp. 412-413). In other words, to attend to the real relationship was not so much for the sake of getting to know the other person deeply and as they are, but to prevent the patient from getting so frustrated that they cannot contain their hostility towards the analyst. So controversial was the idea of the psychotherapist's real personhood in the room that during a discussion in 1954, Anna Freud regarded her own remarks about the analytic relationship as

being a ‘real personal relationship’ between ‘two real people of equal adult status’ as ‘subversive thoughts’ that ‘ought to be handled with care’ (cited in Yalom, pp. 412-413). One wonders what sort of flimsy structure could be subverted by the mere thought of a real relationship between the analyst and patient! Both a devotee of her father until the end of her life, and yet a member of a community much disdained by her father’s theory (women), Anna Freud perhaps on some level intuited the fragile rigidity that underlay the disavowal of relationality in the analytic encounter, exemplified by the positioning of an analysand who assumes a maximally vulnerable posture while becoming emotionally naked by volunteering every thought and feeling in full view of an analyst who essentially hides behind the couch.

One may protest that the blank slate ideal has been left behind nowadays. Particularly with the relational turn in psychoanalysis (Mitchell & Aron, 1999), constructs such as authenticity, mutuality and reciprocal vulnerability have made their way into the vocabulary of self-respecting practitioners. In theory, the stodginess of old psychoanalytic styles should no longer be a problem. Nonetheless, we can still find traces of this “archaic analytic superego” (Kuchuck, 2014, p. xxi), most apparently in the gulf that has remained between psychoanalysis and psychotherapy. Aron (2016), who set forth a genealogy and Derridean deconstruction of the “psychotherapy/psychoanalysis binary” (p. 21) argued that this sharp dividing line is a split along the dichotomy of vulnerable/invulnerable. He noted, for instance, writings from Fenichel (1941) and Rangell (1954) that respectively compared psychotherapists and psychoanalysts to those who join the patient’s ’game’ versus those who steer clear of joining the transference pull, or those who play the game versus those who act like impartial referees at a tennis match (p .24). This comparison may remind us of Brené Brown’s descriptions of how acting cool and unaffected is a mask to ward off vulnerability. Calling out the defensiveness in these analogies, Aron wrote, “Well, if you are off the field,

not playing the game, then you cannot get scored on. You are not likely to get hurt, and if you call the ball out, then it is out; you are invulnerable" (p. 24).

Aron (2016) argued that the fantasy of invulnerability reflects a collective psychic splitting in a discipline that "repeatedly arose out of traumatic circumstances," founded by marginalized and vulnerable Jewish immigrants "repeatedly fleeing persecution, poverty, prejudice, and anti-Semitism" (p. 19). As is the case in intergenerational trauma, psychoanalysis inherited the imprints of the trauma alongside an amnesia for its trauma narrative, "its tendency toward splitting and fragmentation, and its structure of reversal and manic defense in which all vulnerability is projected, displaced, denied, and dissociated" (p. 19). Tracing this split back to the founding father Freud, a refugee fleeing the Holocaust, Aron noted that Freud's own personal childhood experience of neglect and traumatic losses throughout his life gave rise to his "aversion to helplessness, to childishness, and to human vulnerability" (p. 24). As we might recall in an earlier discussion on the denial of death in psychotherapy, Freud deeply feared losing control, especially during the dying process. Furthermore, despite being quite radical in his thinking and tolerant of ambiguities[3], he was not insusceptible to internalizing the prejudices of his time (p. 23). As a member of the male Jewish community scorned and denigrated by the anti-Semitic majority as "effeminate" (attributed to the practice of male circumcision), "immoral," "concrete," unenlightened, he internalized and projected these scorned qualities onto women (Aron, p. 22). He aligned psychoanalysis with the "masculine" traits of being "autonomous, scientific, and objective," in opposition to hypnotic suggestion, which carried the unwanted "feminine" traits" of being "relational, irrational, unscientific, and subjective" (Aron, p. 22). Amidst all the prejudices

[3] Aron (2016) attributed Freud's capacity for tolerating ambiguities to Freud's experience of occupying the status of being "both insider and outsider" – seen as "neither Austrian nor German nor Jewish," "neither white nor black," "a doctor, but not a real university doctor," "straight and even patriarchal, … [but] … not a phallic man from the point of view of his anti-Semitic surrounding" (p. 38).

about Jewish people as unscientific, and his being barred on the basis of being Jewish from earning the title of a medical doctor, Freud may have felt obliged to compare psychoanalytic techniques to the incisive interventions of the scalpel-wielding surgeon in order to establish psychoanalysis as a science and earn it some credibility and prestige. When psychoanalysis triumphed in the United States over hypnosis, the denigrated qualities were projected onto psychotherapy, and to this day, many psychoanalytic institutes would not touch psychotherapy with a ten-foot pole, as though to teach psychotherapy "might contaminate the purity of analytic training" (Aron, p. 22). A split that began with Freud was greatly reinforced by his followers, and decades of psychoanalytic theory and practice designated the "other" status to gay men (due to the perception of them as effeminate), children, black people, so-called primitives, and so on (Aron, pp. 28-20).

Drawing on the work of Celia Brickman (2003) who examined racism towards indigenous populations in psychoanalysis, and of Julia Kristeva (1982), Luce Irigaray (1985), and Martha Nussbaum (2010) on gender, identity formation, sexuality, and death, Aron (2016) discussed how the conglomerate of other-ed qualities of femininity, primitivity, and relationality, corresponds to vulnerability in the form of permeability, fluidity, and death, a projective process through which male "bodily, animal vulnerability" is disavowed (pp. 26-27). Specifically, the heterosexual cisgender male is valorized as "penetrating" like his "phallic, whole, and firm" sexual organ, viewed as impenetrable and thus invulnerable, whereas the heterosexual cisgender female is "penetrated," "castrated" (the clitoris being viewed through a misogynistic lens as a lesser penis) and yielding, with "openings that leak menstrual blood and vaginal fluids" (pp. 27- 28). Per Nussbaum, the homophobic person's "disgust" at the idea of homosexual male sex is due to the fact that the image of "semen and feces mixing together inside the body of a male" violates the fantasy of "a sacred boundary against stickiness, ooze, and death" (cited in Aron, p. 27). It is also interesting that

vulnerability and vulva share the root word of "vulnus," which means wound (Merriam-Webster, n.d.-b), further demonstrating this conflation of openings with woundedness, and the etymological, cultural associations of women with vulnerability. These observations echo those of Becker's (1973) who examined humans' disgust at the sight of menstrual blood and excrement through the lens of death anxiety. Refuting Freud's interpretation of the human horror and fascination with blood, feces, sex, and guilt in Oedipal terms as due to "urges to patricide and incest and fears of actual physical castration," (p. 35), Becker reasoned that those feelings reflect our horror at the strangeness of our bodies, which in spite of our soaring imagination and cognitive capacities," have "a definite ascendancy over [us] by its demands and needs," (p. 30) and humiliate us with its putrid excrement and bodily processes (p. 31).

To bring this thread back to the psychotherapeutic or psychoanalytic situation, the fantasy of impenetrability corresponds to the idealized image of the analyst who is so well-analyzed that they are immovable by the analysand's seductions into their interpersonal games. The ideal analyst from this perspective is an independent, autonomous, phallic hero with solid ego boundaries, who can brave the dark waters of the patient's unconscious without being contaminated, who does not attempt a crooked cure or suggestion because it encourages regression, dependence, and therefore vulnerability, but instead, persuades through rational argumentation, allowing the patient to be an independent thinker who accepts the influence after subjecting it to reason (Aron, 2016, pp. 28-29). Reason, independence, autonomy, and a bounded self are aligned with men, and the opposites projected onto women. In this dualistic view, [t]he dark, feminine, oozing unconscious is penetrated by the analyst's interpretations – 'the firm analytic instrument'" (Aron, 2016, p. 31). Indeed, Freud (1964/1937) explicitly stated that the foundation of psychoanalysis is "the repudiation of femininity" (cited in Aron, 2016, p. 28). If we consider for a moment Becker's (1973) argument that anality is a defense against "accidents of life and danger of death, trying

to use the symbols of culture as a sure means of triumph over natural mystery, trying to pass himself off as anything but an animal" (p. 32), we could say that psychoanalysis inherited the obsessional neurosis of its ancestors, with the end result of a still-faced, stiff upper-lipped analyst that is ironically more dead than alive. The only person who cannot be hurt, after all, is a dead one.

Lest one thinks that this disavowal of vulnerability resides only in psychoanalysis, it is worth examining other major schools of psychotherapy and the field of psychology as a whole. Rather surprisingly for instance, Carl Rogers unintentionally reinforced this "blank screen" position by recommending a nondirective style of reflective listening, which has often been parodied as consisting of dispassionately parroting the client's last sentence, despite the fact that Rogers himself became much more directive and involved in his later years (Yalom, 2002, pp. 74-82). Even more unfortunately for the humanistic tradition, the qualities of "empathy," "genuineness," and unconditional positive regard which have long been endorsed by its practitioners as the critical ingredients of successful therapies are frequently misrepresented as techniques that can be implemented by reading a manual, rather than descriptions of a way of being with another person (Yalom, 2002, p. 409). The over-emphasis on techniques results in the loss of spontaneity and openness, stifling the possibility of a genuine relationship. In (2002) Yalom's words, "The very essence of the authentic relationship is that one does not manipulate but turns toward another with one's whole being" (p. 410).

Yalom (2002) further argued that this excessive focus on technique stems from individual psychotherapists' intolerance of uncertainty (p. 410). Speaking of techniques and uncertainty, it is also worth looking at cognitive-behavioral therapy (CBT), which has become a relentless expanding empire marginalizing other psychotherapies and the dominant form of therapy taught in clinical training programs affiliated with academic institutions. First

known as cognitive therapy, CBT was originally created by a frustrated Aaron Beck (1979) who recognized that the psychoanalysts of his time were not joining their patients in exploration and discovery, but imposing far-fetched, experientially dissonant interpretations on the patient about their supposed unconscious processes. Within two decades, the collaborative and exploratory spirit of Beck's CBT has been side-lined, replaced with manuals, worksheets, and session limits, and brief CBT has become almost synonymous with talk therapy. As Yalom (2003) noted, strict adherence to manualized CBT precludes the formation of a genuine, "intimate" and "unscripted" therapeutic relationship (p. 223). Instead of encountering and getting to know a stranger deeply, its practitioner has already prepared diagnostic categories for the patient's symptoms to fit into and to dictate the kind of treatment to plug-and-play. In addition to greed and convenience, why else would the field take a complex psychotherapy and water it down, except to escape uncertainty and create the illusion of order, linear progress, and perfect containment, and to flee from the messiness of spontaneous relationality?

Where to go from here? Aron (2016) stated that very perspectives afforded by the relational movement can help us as a field overcome the split that disavows vulnerability and projects it onto patients and other-ed communities. Recently, there has also been a return in popularity of the scholarship of Ferenczi, often called the "mother" of psychoanalysis in reference to Ferenczi's consistent emphasis on relationality in the analytic process (cited in Meyer, 2005). Long before there was a well-defined relational psychoanalytic movement, it was Ferenczi who "anticipated future theorists who would move psychoanalytic treatment from a one-person psychology to a 'two-person' psychology" (Aron, p. 21), who had suggested that the repetition of the patient's early trauma is not only an inevitable outcome, but also the opportunity for the pair to experience the repair of a ruptured relationship. The repair happens through the analyst's non-defensive and non-masochistic willingness to accept

responsibility for their contributions to the rupture, giving the patient a corrective experience of being "recognized" (Aron, p.32) and met by the analyst. Over time the patient learns that there is a "lawfulness" (Aron, p.32) to relationships, constituted by the cycle of rupture and repair, and through that, learns to have faith and love. Without the analyst's willingness to join the patient and be pulled into the re-enactment of the original crime scene, and the messy, emotionally challenging attempts at repair, healing through the patient's "surrender" (Ghent, 1990) to that lawfulness in relationships cannot happen.

The Wounded Healer: Integrating the Shadow

In not disavowing vulnerability, the psychotherapist must come to terms with their own woundedness. The archetype of the Wounded Healer is no stranger to conversations about the vocation of psychotherapy, but more often than not it is discussed as an "intellectual construct" and not an "emotional reality" (Page, 1999, p. 109), or cursorily understood as a psychotherapist who was "once wounded – now recovered," rather than "one who is currently vulnerable as well" (Sedgwick, 1994, p. 112). Given that no sentient being is immune from suffering, the healer is by definition wounded, but what differentiates a psychotherapist who is wounded like everyone else and does the work of healing from a psychotherapist who lets their wounds inform their healing, is that the latter allows themselves to be wounded by the patient and uses the experience of wounding to feel their way into the lived world of the patient. For Sedgwick (1994) this experience is more profound and deeper than "empathy" via "vicarious introspection" (p. 28).

To have a deep understanding of the Wounded Healer archetype it is necessary to familiarize ourselves with two other constructs from Jungian psychology, namely the "persona" and the "shadow" (Page, 1999, pp. 18-19). As briefly mentioned in Brown's comments about the persona as a stage mask, the Jungian idea of the persona refers to the socially acceptable front that individuals inhabit when they face the world. It would be

erroneous to equate the persona with a Winnicottian false self[4] or a useless façade, however, as the persona is not only a real aspect of the personality but also necessary for helping individuals align with constructive ideals and contain unhelpful or even destructive urges. The shadow on the other hand, contains the attributes and potential that are typically disavowed by both the individual and collective. The shadow is a necessary flipside of ideals – when something is promoted as good and beneficial, by definition its opposite is denigrated as bad and destructive. Indeed, the more magnificent the ideals, the longer the shadow. Some authors have also put forth the construct of the "bright shadow" (Taylor, 2009, pp. 236-237) to account for the disavowal of positive, creative qualities and gifts that are unique to the individual. Page (1999) argued that psychotherapists begin their training by putting on the professional persona and practicing the "way of being and relating" (p. 114) prescribed by this "counselor persona" (p. 19) such as being empathetic, caring, responsive, and ethical. The counselor persona helps the psychotherapist to function within the parameters of their roles and responsibilities, thus serving a protective function for the client. There are various archetypes that psychotherapists may find themselves being drawn to as a result of their "particular psychological predisposition" and sociocultural identities and background, such as the "healer," "parent," "savior," "shaman, priestess, priest, mage, witch, sage, guru" and "trickster" (p. 47). This cast of characters each contain different sets of potentialities that can greatly energize the psychotherapist's work and push them to grow in a particular direction.

Nonetheless, if the psychotherapist stays stuck behind a particular professional persona, which may remind us of Brown's (2012) evocative description of the mask or second skin, it encourages rigid overidentification with the persona and a loss of the

[4] In contrast to the "true self," which has "the capacity to be creative and spontaneous," that is, "play," the "false self" (Page, 1999, p. 150) pertains to an inflexible, rigidly defensive use of personality characteristics that were once developed to adapt to an environment in which the child took on the role of caregiver towards their parents.

psychotherapist's extra-professional identity. Ideally, the psychotherapist sloughs off aspects of the persona that are incongruent with their personality and draws on disavowed, lesser-known, or even feared attributes in the shadow that can ultimately promote the psychotherapist's growing into a more individuated self. For example, he discussed the importance for psychotherapists to not only practice and cultivate their compassion, but also their "dispassion" (p. 24). He relayed an anecdote of how a group of mental health professionals whose enthusiasm had been worn down by a challenging clinical situation were visibly reenergized when they began complaining and venting to one another in the lunchroom about how insufferable their clients were. Although such expressions would certainly be inappropriate in a therapeutic setting, their being able to gripe to each other in the lunchroom helped them acknowledge the "harder, dispassionate, more aggressive feelings" (p. 25) that they had to contain when they were working directly with their clients, and thus released the energy that they needed to recover from their exhaustion. He described the function of dispassion as a counterbalance to compassion:

> If this enthusiasm is based upon denial of our dispassionate side then this must no longer be sustainable at some point. The dispassionate aspect will demand expression in one forum or another. It may be displaced so that we find ourselves very compassionate and committed to our clients but cut off and disinterested in our personal relationships. It may start to leak back into our counseling work: being sharp with one client, losing interest in where the work is going with another … In reality dispassion does have a significant and appropriate place in our counselling, when balanced by compassion. It is the source of the uncompromising presumption we draw on when we confront … or when we refuse to offer inappropriate sympathy or reassurance. (p. 24)

In other words, the shadow attributes of the psychotherapist are destructive insofar as

we remain unconscious of them and thus unwittingly allow them free reign. When we acknowledge and recognize the kernel of gold contained in them, we can use them to enhance our therapeutic effectiveness. Page (1999) suggested that the Wounded Healer undergoes an evolution by which they discover shadow attributes and integrate the "opposites within our psyche" so that they can "move towards a greater wholeness" (p. 114). He emphasized that this "wholeness" is not a state that can be reached once and for all, but a "dynamic possibility that occurs from time to time before we move on to confront other hidden aspects of ourselves" (p. 114).

The Wounding Healer: The Psychotherapist's Fallibilities

When our own woundedness is activated, it can either inform our work productively or take the focus away from the client, resulting in abandonment or destructive reenactments. Page (1999) noted that psychotherapists have to understand and accept their woundedness, including their shadow qualities, such that they become less of a threat and more of an opening into greater "humility, the ingredient that separates true compassion from mere pity" (p. 108) – a statement that once again, resonates with the existential psychotherapeutic viewpoint that shared woundedness forms a bridge between the healer and patient and unveils their equality. If on the other hand the psychotherapists' shadow qualities are banished from consciousness, the unconscious acting out of those qualities can be of real harm to patients. The section of this review on burnout, impairment, and misconduct addresses the issue of how psychotherapists come to be so wounded by the demands and vicissitudes of the profession that, in the absence of ways to overcome the splitting in their psyche, they become ineffective or even harmful in their rendering of services. The failure to integrate the shadow also takes place on a collective level: when psychotherapists who are impaired or who have transgressed professional boundaries are demonized and regarded as radically different from

the rest of the professional community, it discourages psychotherapists from recognizing red flags signaling impairment and potential misconduct in themselves or their colleagues.

Burnout.

Burnout speaks to the vulnerability of the psychotherapist to emotional exhaustion. In addition to posing a danger to psychotherapists, it also prevents them from investing themselves emotionally in a way that benefits their clients. Since Freudenberger (1974) invented the term "burnout" to capture the experience of "emotional and physical exhaustion" among providers working in healthcare institutions (cited in Farber & Heifetz, 1982, p. 293), researchers have been studying and documenting it among professionals in various fields. Two years after the term was coined, Christina Maslach (1976) authored the Maslach Burnout Inventory, coalescing the features of burnout into three main dimensions: "emotional exhaustion," "depersonalization" (also known as "cynicism"), and "reduced sense of personal accomplishment" (cited in Morse, et al., 2012). This well-validated instrument was the predominant tool used across studies that assessed burnout in mental health professionals. Maslach found that burned out mental health workers experienced more psychosomatic symptoms and familial discord, demonstrated diminished care and concern for clients, and frequently spoke about clients in derogatory, blaming-the-victim language that served to deflect their helplessness, or otherwise, used "technical jargons" and "diagnostic terms" to distance themselves from clients (cited in Farber & Heifetz, 1982, p. 293). Already here we can see how clinicians who exhaust their compassion are now in danger of acting under the influence of the shadow of dispassion, which, when not given proper acknowledgement and the space to be felt and integrated, manifests in the form of detachment and apathy.

Prior to burnout research, clinicians were already well aware of the psychological hazards of working in the mental health profession. Farber and Heifetz (1982) saw that Freud himself wrote about the "dangers of analysis" (p. 293), and in the two decades prior to the

explosion of burnout research in the 1980s, various clinicians offered anecdotal accounts of the challenges inherent to the psychotherapeutic profession. For example, Greenson (1966) self-deprecatingly remarked in his lecture-turned-paper *That Impossible Profession*, named after Freud's original quote, that his work was inspired by a day when everything went wrong in his clinical practice: he thought of the "right interpretation only after the patient had left"; found out that what he had thought of as a "profound insight" was just "a complicated confusion"; offered his "kindly passivity" only to have it experienced by patients as "inattentiveness" (p. 9). He asserted that this profession is inherently stressful due to its demands on the analyst to walk a tightrope between being empathic and detached, being warmly present and yet maintaining a certain measure of silence and distance, and being relatively anonymous while being a collaborator with the patient.

Farber and Heifetz (1982) noticed that despite the availability of such rich narrative accounts from clinicians, there was a paucity of systematic research on burnout among mental health professionals to corroborate those anecdotal impressions, especially ones that documented the prevalence of burnout, contributing factors, and implications among psychotherapists of various training backgrounds and settings (pp. 293-294). In response to this gap in the literature, they conducted a study in which Farber interviewed 60 clinicians, including social workers, psychiatrists, and psychologists, for two hours about how they experienced work and its impact on them. They learned that more than 50% of the participants attributed their experience of burnout to the "nonreciprocated attentiveness, giving, and responsibility demanded by the therapeutic relationship" (p. 295). Other contributing factors to burnout included being disheartened by the "slow and erratic pace" of therapy, having one's own "personal issues" reactivated, and "isolation," each of which was mentioned by about 10-20% of participants (p. 296). In addition, Farber and Heifetz concluded although organizational factors such as heavy workload and "organizational

politics" were stressful for participants, over 70% reported the "single most stressful aspect" of their work was a "lack of therapeutic success" (pp. 7-9). In other words, it was believed that there were aspects of therapeutic work that were emotionally taxing apart from the contextual challenges of being in unsupportive work environments.

Fast forward three decades, more researchers began to recognize the gap in the burnout literature in the mental health sector (Morse, et al., 2012; Johnson, et al, 2018). In the UK, a review by Walsh and Walsh (2001) of studies examining the mental health of social workers, psychiatrists, clinical psychologists, and psychiatric nurses in a variety of settings suggested that the dangers posed by mental health work is far greater than previously estimated and cannot be solely accounted for by pre-existing psychological vulnerability among people who choose to be in such professions. The psychological wellbeing of mental health workers whose caseloads were heavy or overrepresented by severely ill patients, particularly psychotic patients, was particularly compromised.

In 2008, Saakvitne and colleagues of the Advisory Committee on Colleague Assistance described an "interactive model" of occupational hazards faced by psychologists, which proposed that clinicians' vulnerability to occupational stress, distress, and impairment depends on the confluence of a) personal factors, including the "deeply personal" historical and temperamental reasons that called them into the profession in the first place, as well as positive and negative events in the clinicians' current lives (paras. 4-8), and b) factors pertaining to clinical work, including being stigmatized by association with the mentally ill, facing diminishing financial returns and bureaucratic constraints when working within managed care systems, being isolated, being emotionally exhausted from listening day in and day out to clients' painful experiences which occasionally elicit unsettling and puzzling emotional reactions in the clinician, and the constant need "manage both the relational and transference demands and the business and legal demands of the work" (paras. 9-12).

Moreover, they pointed out that although there has been convincing evidence demonstrating these occupational hazards, the vulnerability of mental health professionals has been scarcely discussed in the literature, in part due to the "misguided belief" that mental health professionals should be immune to the impact of their work, which contributes to the isolation experienced by clinicians with regards to work-related stress and distress (para. 2).

A review by Morse and colleagues (2012) indicated that 21% – 67% of mental health professionals endorsed high levels of burnout (p. 342). The huge variability in that range (21% – 67%) reflects a tricky methodological problem that has long plagued burnout research, which is that there is little consensus as to what constitutes a "high" level of burnout (Morse et al., pp. 342-343). In addition, the degree of burnout varies depending on the settings in which the psychotherapists practice, and a high score on one of the three dimensions of burnout is not always correlated with a high score on any of the other two. A 2007 study by Rupert and Kent showed that psychologists working in agencies and hospitals tend to experience less personal accomplishment than those working in private or group practice (cited in Morse et al.). There is also evidence that community-based social workers experience more burnout than nurses and psychiatrists, according to study by Priebe and colleagues (2005, cited in Morse et al), and that job satisfaction tend to be lower among social workers than among psychiatrists (Prosser, Kuipers, Szmukler, Bebbington, & Thornicroft [1997] as cited in Morse et al.). There was only one study, a comprehensive review by Onyett and colleagues (1994), that showed high emotional exhaustion among staff across all mental health disciplines (cited in Morse et al.). Such results raise the questions of whether it is fair to conclude that the level of burnout among clinicians is truly high or an artefact of arbitrary operational definitions of "high" level of burnout, and whether it is more useful to study clinicians as a heterogeneous group, or to conclude that different kinds of mental health professionals vary in their vulnerability to the three dimensions of burnout. The

lack of systematicity in this research as highlighted by Farber and Heifetz (1982) has persisted to this day.

Despite these methodological problems, authors have generally agreed on the costs to patients who are cared for by burned out clinicians. Burned out mental health professionals are more likely to experience flu-like symptoms, gastroenteritis, and substance use problems (Morse, et al, 2012, p. 344), struggle with providing quality patient care, miss work or take sick leaves, and contemplate quitting their jobs (Dreison, et al., 2018, p. 18). Needless to say, an increased turnover of clinicians compromises patient care (Morse et al., 2012, p. 344). In addition, a study by Holmqvist and Jeanneau (2006) of 510 psychiatric workers in 28 different units replicated the findings of Maslach (1967), showing that higher levels of emotional exhaustion and depersonalization among the psychiatric workers are associated with more "distant" and "rejecting" attitudes towards clients (cited in Morse et al., 2012, p. 344) – attitudes that have been associated with worse client outcomes and satisfaction. Furthermore, left unresolved, burnout tends to remain chronic and stable over time, according to a 1993 review by Burke and Richardson (cited in Morse et al., 2012) showing that whereas 30% of workers became less burned out in the year following the assessment, 40% remained just as burned out.

With regards to the etiology of burnout, the difference between earlier studies of burnout, such as that of Farber's and Heifetz's (1982), and more recent studies such as that of Morse et al. (2012), is their respective emphasis on factors inherent to psychotherapy versus systemic organizational factors that contribute to burnout. Farber and Heifetz saw psychotherapy as something that is fundamentally stressful to conduct, whereas Morse et al. tended to situate the increase of burnout within the context of decreasing governmental support for these professions. In fact, Morse and colleagues predicted that burnout rates will continue to rise, especially with decreases in funding for social services and rising costs of

providing healthcare to employees – financial burdens on mental health institutions that will ultimately be shouldered by employees, who are increasingly pushed to squeeze as many "billable services" as possible into their schedules (p. 343). Similarly, Dreison and colleagues (2018) noted that "job instability and understaffing" (p. 18) which are the direct consequences of underfunding, can contribute to staff burnout. Other authors have expressed similar conjectures as well. The latest study by Johnson and colleagues (2018) reported, based on statistics from the National Health Service, that employees working in mental healthcare "take more sick days" than their counterparts in acute trust and primary care and reported being unwell more than their colleagues in acute trust (p. 22). They chalked up the extra stress faced by mental health staff to the amount of emotional labor that they undertake while facing risks to their personal safety and wellbeing when patients are violent or suicidal, and the psychological and physical costs to them of participating in coercive actions including involuntarily detaining, restraining, secluding, or sedating patients. Although not mentioned here by Johnson and colleagues, one can imagine the numbing and dissociation that might be required to perform such "treatments" on vulnerable individuals who have come under one's care, especially if going into mental healthcare was a career choice borne out of a desire to provide compassionate care. They also noted that studies have shown a trend of underfunding for mental healthcare in the UK and the US, which they believed to be important contributing factors to burnout (p. 23).

Extant studies on burnout may even miss the more insidious manifestations of burnout. Freudenberger and Robbins' 1979 paper challenged our usual conception of what burnout looks like. When we think of burnout in mental health professionals, we may picture exhausted and irritable staff in a psychiatric hospital with severely overtaxed resources, but we may not think of the rich, workaholic analysts who charge exorbitant fees of their celebrity analysands. The originator of the term itself, Freudenberger, initially conceptualized

burnout as a phenomenon that happened in healthcare institutions, but soon recognized that analysts were at risk as well; in fact, he and Robbins went as far as to name burnout as the biggest hazard in psychoanalysis to analysts themselves, their patients, and their families (Freudenberger & Robbins, 1979, p. 275). Whereas psychiatric workers in institutions might show obvious signs of burnout, well-to-do analysts who are so burned out that they are merely going through the motions still have the privilege of masking their ennui and depersonalization with material goods and the appearance of a thriving, hectic practice. To support such a lifestyle, the analyst might see fewer and fewer patients who cannot afford their increasing fees, and present fewer and fewer difficult cases to their colleagues for fear of presenting a less-than-perfect image. They may rationalize their hefty fees by pointing to the "economic reality" (p. 284) of the patient's day-to-day world, rather than questioning whether psychotherapists should necessarily "mirror the value system of society" (Freudenberger & Robbins, 1979, p. 284). In other words, what looks like a pursuit of upward social mobility and an enthusiastic dedication to the work might be the analyst's increasing reliance on material possessions and a relatively non-threatening or challenging caseload to provide narcissistic supplies that they are sorely lacking. They wrote that analysts might find themselves locked into "a way of life that requires higher and higher levels of income, more and more patients, longer hours, bigger and better homes and richer furnishings" (p. 276) to hide their painful sense of their disconnection from themselves, their clients, and their lives outside of the analytic office.

In addition, while Farber and Heifetz's 1982 study provided systematically collected data that provided clarity regarding the relative contributions of various factors that lead to burnout, there was less attention paid to how historical, contextual factors shape the expectations and attitudes of the psychotherapist in ways that exacerbate the problem of burnout. The impressionistic accounts that they were so critical of for lacking empirical basis

often provided a more holistic view of how burnout is bred in the psychoanalytic community. For example, Freudenberger and Robbins (1979) argued that analytic training itself can be a predisposing factor to burnout because of its infantilizing and punitive atmosphere that discourages analytic candidates from risking the presentation and discussion of therapeutic failures, and the way in which they are implicitly or explicitly discouraged from being open about their feelings for fear of seeming unprofessional (p. 279). Again, what we are seeing here is the consequence of casting experiences into the dark shadow rather than letting candidates learn from the painful lessons of the shadow.

In summary, the craft of psychotherapy can be neither learned overnight nor practiced without the continual replenishment of emotional stamina, and through the phenomenon of burnout, we see psychotherapists who have been emotionally injured and taxed to the point of depletion. In this state, they are likely to be neglectful or even do harm. From the perspective of analytical psychology, such acting out can be understood as a manifestation of the psychotherapist shadow. While it may be easier to sweep it under the rug and simply label it as unethical practice, as suggested in my discussion of the Wounded Healer archetype, the work of shadow integration itself could provide energetic replenishment and balance to the psychotherapist's persona.

However, when therapists do not have the resources within themselves and in their environment to contain and detoxify the emotional suffering that comes with being immersed in the suffering of others for extended periods of time, their clients are the ones who take the toll of abandonment and abuse. In addition, a societal lack of willingness to acknowledge and protect the vulnerability of the psychotherapist – maybe particularly, managed care companies' callous and deliberate indifference to it – ultimately hurts patients who are most in need of help: those who cannot afford the steep fees of long-term therapies that are not reimbursed by insurance, those who might be rejected from analytic treatment because they

are deemed too damaged, or those who will continue to be abused by overburdened mental health staff in institutions.

Impairment in Psychologists.

Impairment is defined by the Advisory Committee on Colleague Assistance of the APA Practice Organization (2008) as the end state of prolonged stress. They described the stress experienced by psychologists as lying on a stress-distress-impairment continuum: unresolved stress can lead to a state of distress that is "distracting and difficult to manage," and ultimately to impairment (para. 9). Like burnout, impairment is an extreme example of therapist vulnerability. Impaired psychologists are not only less effective and more mistake-prone, but also more likely to engage in unethical behaviors that endanger clients.

Given the dangers of clinician impairment for psychotherapy clients, it should alarm us that, according to a study by Pope et al. (1987) more than 59% of psychologists endorsed having continued working when they knew that they were "too distressed to be effective" (cited in Saakvitne et al., 2008., para. 9). This troubling statistic not only demonstrates a lack of acknowledgement among psychologists about their vulnerability, but also points to what the O' Connor and colleagues (2003) have noticed as a general reluctance among psychologists to intervene with impaired colleagues. They chalked this collusion up to the difficulty psychologists have in acknowledging their collective fallibility: if our colleagues are not immune to making mistakes that jeopardize the wellbeing of clients, then neither are we. This reality constitutes a threat to psychologists' need to see themselves as ethical and selfless, which may motivate an attitude of denial. Such denial "foster(s) the myth that people who are impaired are a different breed of psychologists," preventing psychologists from recognizing their own vulnerability to the risk of impairment (para. 3).

Sexual Misconduct in Psychologists.

Like many institutions where there is a power differential between those who serve and those who are served, psychotherapy is haunted by the prevalence and high-profile status of sexual boundary violations. Nonetheless, Andrea Celenza and Glen Gabbard (2003), who have each conducted rehabilitation with analysts who had committed sexual transgressions with their clients, noted that the field tends to respond to such occurrences with denial and scapegoating of the offenders, rather than treatment and understanding. Celenza and Gabbard argued, based on their clinical experience and research on this population, that while a small but sizable portion of offending analysts are unsuitable for remediation due to psychopathic personalities or sustained attitudes of denial and rationalization towards the transgression, the majority of analysts are not a "lost cause" (p. 617), but demonstrate genuine remorse characterized by a shocked realization of the "rationalizations" and "compartmentalization" they had utilized to justify their misconduct, "the way (their) own values have been betrayed," and a real desire to understand what drove their behaviors and take full responsibility for the misconduct (p. 629). As such cases tend to be quietly resolved whereas the cases of predatory or unremorseful offending therapists tend to be loudly publicized, we do not hear about the former as much as we hear about the latter (Celenza & Gabbard, pp. 619-621). As a result, it perpetuates a tendency in the field to split practitioners into those who have offended and those who are immune from it – a splitting that is dangerous because it discourages practitioners from recognizing ethical red flags in one's own practice and prevents the timely consultations or other precautionary measures to avoid offending. In their words, "(t)he temptation to deny this universal vulnerability is viewed as effectively replicating the kind of vertical splitting or compartmentalization that makes one vulnerable to sexual misconduct in the first place" (Celenza, 1995, p. 617). In fact, psychologists tend not to seek consultation when they are most at risk of sexual acting out with their patients

because they risk being scorned for harboring "inappropriate feelings" and struggling with the maintenance of boundaries (p. 306).

We might also take a lesson from Celenza's (1995) observation that when trainees disclose erotic countertransference towards their clients to their supervisors, they are often asked to read relevant literature or bring this issue to their own personal therapy, rather than welcomed to explore the erotic countertransference so that they can learn something from it that can be used in service of the patient (p. 306). She recommended that supervisors share more openly their own experiences of confusion and struggle with transference-countertransference phenomena so that supervisees may experience a "less punitive and shaming professional atmosphere" within which they can safely acknowledge and work through erotic countertransference, rather than stay silent for fear of being judged (p. 306). Similarly, perhaps, rather than referring suffering therapists to literature on self-care or recommending personal therapy and then calling it a day, we need to place more emphasis on cultivating a culture of support, openness, and acceptance among clinicians towards each other's vulnerabilities, starting with those in graduate and professional training.

Hate in the Psychotherapeutic Relationship.

In this section I address the theme of the psychotherapist's vulnerability to hateful, aggressive feelings or urges towards the patients, which may go unnoticed especially when one is married to the image of an all-loving and all-competent healer. Hate – such a strong and unpleasant affective state – might be a difficult feeling to experience, what more to express with regards to our experience of clients. It might be tempting to cast it into the shadow and never let it see the light of day. Pinsky (2017) argued that if they are honest with themselves, psychotherapists will recognize how hate plays into their failures to arrange for their clients' care in the event of their deaths. From her perspective, the silence on the death of the analyst may not be a simple matter motivated by an ordinary, human fear of death, but

one that is complex and connected to our other fallibilities and foibles. She speculated, might we not sometimes resent the intensity and heatedness of the transference, for their "craving and insistent demands," for "mewling and puking in our arms" (pp. 17-18)? Moreover, they might continue to need us even after we are dead! (p. 17). Is there a possibility that our neglect to take measures to soften the blow of our deaths to our patients hides a sadistic intent for patients to experience the fullness of the shock and pain that follow such an event? We might even harbor "revenge fantasies" of letting clients suffer the "chaos," perhaps with the masochistic hope that clients will finally realize how much they need us, and how much they failed to value us while we were alive; that is, "Now you'll appreciate me!" (p. 17). Perhaps by letting them fall hard without a safety net they will be so distraught by our absence that they cannot be angry with us for the many ways in which we have failed them. Perhaps it is a way of warding off the hate of the patient and exploiting the common grief response of idealizing the dead person. In addition, Pinsky added, we might even feel some anticipatory jealousy that whereas we do not get to live to see another day, our clients get to keep a piece of us and carry on with their lives bettered by it (p. 17). Pinsky's argument showcases the connection between our vulnerability to injury and capacity to injure – our impotence and helplessness as a healer can together with our own proclivities for hate and revenge motivate our unfortunate human tendency to then turn the tables on the client, changing a situation of vulnerability into one of punishment and dominance. The intellectual understanding that being overwhelmed by the needs of clients necessarily comes with the territory of being a psychotherapist in depth-oriented treatment does not prevent psychotherapists from experiencing resentment towards their "needy" clients.

In talking about hate for the patient, Pinsky (2017) follows the lead of Winnicott, who among many other things wrote his famous "Hate in the Countertransference" in 1949, comparing the hate that analysts may have for patients to the hate of a mother for her new-

born infant. The mother, in Winnicott's (1949/1994) opinion, has many good reasons to hate her baby even if her baby is lovable and exciting, because the baby is also frustrating, demanding, at times aggressive, and even hurtful and spiteful, acting without any sympathy for the mother. The mother "has to be able to tolerate hating her baby without doing anything about it" (Winnicott, pp. 355-356). Similarly, the analyst of a "deeply regressed" patient must be able to tolerate the long period of time when the patient is unable to take the analyst's perspective at all, and the analyst must be able to recognize and tolerate their hate for their patient without acting it out, or expressing it before the patient is capable of tolerating such knowledge (pp. 355-357). Winnicott thought that hateful feelings arise in the analysts of all kinds of patients although they are especially apt to come up when treating "psychotics," a term which Gabbard clarified in the preface to the 1994 reprint of the article as meaning those who have "borderline or other severe personality disorders" (Winnicott, 1949/1994, p. 348). Because we are mortal, it is impossible to provide an endless supply of love. Winnicott warned us against sugar-coating hate, contending that, "Sentimentality is useless … as it contains a denial of hate" (p. 356). For both the mother of a new-born and the analyst, the practice of tolerating hate without acting out ("benign passivity") is crucial, as it is what then allows the child or the patient to tolerate their own hate for the mother or the analyst for their various limitations (cited in Pinsky, p. 17). Winnicott further pointed out, partly tongue-in-cheek, that there are built-in features of the therapeutic frame that allow analysts to contain their hate: the end of the analytic hour and the collection of payment. The setting of these limits renders the intensity of the process more tolerable for both the patient and the analyst, comparable to the subtly hateful lullaby "Rock-a-bye-baby" that mothers sing to their "demanding and hateful baby" (p. 18) to verbalize death wishes to the preverbal baby without enacting them. Without these limits, it would be difficult for psychotherapists to tolerate being used, needed, and at times rendered impotent.

Acknowledging the extraordinary challenges of working with severely ill psychiatric patients, Winnicott (1949/1994) ventured that psychiatry's easy reach for invasive, damaging interventions such as electroshocks and leucotomies perhaps reflects the profession's unspoken hate for the psychotic patient, acted out under the guise of delivering scientifically sound treatments (p. 350). In short, he said, "However much he loves his patients he cannot avoid hating them, and fearing them, and the better he knows this the less will hate and fear be the motive determining what he does to his patients" (p. 350). This viewpoint was also expressed a few years prior to Winnicott by Fliess, who described the therapeutic potential of the analyst's "metaboliz(ing)" the hate that had been defensively projected by the patient, which allows the patient to re-introject a less toxic form of the hate (cited in Mehlman & Glickauf-Hughes, 1994, p. 437). In doing so, clients learn to tolerate everyday hate in their own relationships and become less inclined to dichotomize love and hate. For such results to be achieved, the analyst must first be willing to be vulnerable to their own hate – a difficult task for people who come into the field expecting to be benevolent saviors.

Other authors have also written on the dangers of ignoring the analyst's countertransference hate, including Celenza (1995) and cooperatively with Gabbard (2003), who learned from their work with analysts who transgressed sexual boundaries that the dynamic underlying the misconduct often involved an intolerance of countertransference hate and a "defensive transformation" of the disavowed hate into idealized love (Celenza, p. 302; Celenza & Gabbard, p. 626). Unable to distinguish defensive countertransference love from a kind of therapeutic love that can admit the full range of the patient's experience, analysts who transgressed sexual boundaries often fell prey to the dangerously erroneous belief that their love alone can bring their patient back to health, and regarded their sexual enactment as a loving act of self-sacrifice for the patient (Celenza, p. 303, Celenza & Gabbard, pp. 624-626). In line with Winnicott's (1949/1994) observation that hateful feelings tend to arise when

treating deeply regressed, borderline, or psychotic patients, Celenza and Gabbard found that the majority of the sexual boundary violation cases they worked on involved patients who were "actively suicidal at the time of the misconduct" and who had diagnosable "Cluster B personality disorders or dissociative disorders" (p. 625) – symptoms and pathologies that can understandably evoke in any analyst much despair, helplessness, and hate towards the patient for "being cast in the role of the bad object" (p. 656). In such a situation, a risk factor that particularly heightens the risk for sexual misconduct is a habitual tendency in the analyst to rely on reaction formation: rigidly dis-identifying with the projected bad object (such as the hated internalized parental figure of the patient), the analyst gives "a defensive form of love" (p.626), which becomes sexualized and rationalized as true love (p. 623).

Celenza and Gabbard (2003) further observed that analysts who undergo rehabilitative therapy for their misconduct will often eventually "recognize [their] escalating sexualization as an attempt to avoid the countertransference hate generated by the patient's undermining efforts, depressive despair, and frank suicidal threats" (p. 626). The sexual misconduct often ends up being traumatizing for both parties – the patient as it is a re-enactment of childhood sexual trauma, and the therapist as it is a concrete manifestation of a "self-depriving and self-destructive rescue fantasy" (p. 624). Nonetheless, as there is an inherent power imbalance in the therapeutic relationship that necessitates the therapist's taking full responsibility for any sexual enactment in the treatment, and because there is such a widespread tendency to demonize therapists who have violated sexual boundaries as beyond redemption (Celenza & Gabbard, 2003), the vulnerabilities of the therapist that led up to and resulted from the misconduct are often ignored, preventing other analysts from learning from their colleagues' mistakes and paying attention to their own risk factors for sexual misconduct.

An unfortunate implication of these boundary violations is a "whenever there is smoke there is fire" attitude towards any sort of boundary crossings, or what Yalom (2002)

called the "snapshot mentality," that is, an avoidance of anything that taken out of context, potentially looks like a boundary violation (p. 192). For example, there is a commonly held belief among psychotherapists that self-disclosure is "the inevitable beginning of a slide into that most unethical and egregious boundary violation, having sex with a client" (Bloomgarden & Mennuti, 2009, pp. 5-6). As Zur (2007) pointed out, this "slippery slope" argument mistakes correlation for causation – the fact that psychotherapists who crossed sexual boundaries with their clients also tended to be self-disclosive to them, does not mean that all psychotherapists who self-disclose will have sex with their clients (p. 6). Bloomgarden and Mennuti (2009) noted that some lawyers go as far as to counsel their psychotherapist clients to "never cross a boundary," including self-disclosing (p. 6). They noted evidence that this excessively conservative, defensive "risk management" stance increases the likelihood of unethical practice by hindering "good clinical judgment" (p. 6) and discouraging honest conversations about self-disclosure and other forms of boundary crossings. In other words, if as a field we cannot help practitioners to begin even unpacking what lies in the psychotherapist shadow, then they are going to be so phobic of anything that remotely resembles the destructive manifestation of the shadow, that some of the most powerful therapeutic acts – touch, self-disclosure, being human – become scapegoated as bad practices. When this happens, psychotherapists are discouraged from being real with their clients, which ultimately, prevents the forging of a transformative relationship with the client.

Narcissistic Vulnerability: Vulnerability Related to Threats to Self-Esteem and Ego-Image

This section of the literature review includes two sections that focus on the vulnerabilities related to threats to one's ego-image as a psychotherapist. The first part discusses the narcissistic vulnerabilities common to all psychotherapists, especially those new to the craft, whose grandiose ideals have not yet been tempered by inevitable disappointments

in treatment. The second part talks about the vulnerability that is inherent in the work of empathic listening as it requires a temporary loosening of one's grip on cherished world views and assumptions so as to understand the client's perspective.

Narcissistic Vulnerabilities in the Profession

> Man is a fool and he also dies – we can contrast with Donald Winnicott's well-known aphorism, "The analyst survives." Pinsky (2017, p. 7)

As mentioned earlier, "that we can die" is not the only meaning of mortality; the psychotherapist is mortal also in the figurative sense, that is, that the psychotherapist is fallible (Pinsky, 2017, p. 2). Being finite means that we will invariably be wounded in our attempt to help because our inevitable failures to help and soothe force us to face the reality of our finitude. Leigh and Silbert (2016) posited that this human desire to help alleviate suffering and gratify unmet needs puts the therapist in the vulnerable position of not only privately experiencing their own limitations, but also having the client witness them struggle with those limitations, even be angry with them about it, the pain of which can be so great that they may opt to hide behind theories and interpretations that scapegoat the client's so-called regressive tendencies (pp. 324-328). The pain of failure comes not just from one's own historical fears about what failure means but also from the implications of "failing in the eyes of our profession" (p. 329). Reflecting on her experience of being angrily confronted by a long-term client on the usefulness of their therapy, Leigh observed how "quickly … (she) … move(d) to an internal defensive position, wanting to pathologize him for asking this pertinent question" (p. 322) by framing his angry accusations as characteristic of his tendency to blame others rather than take responsibility. Pinsky would perhaps interject here and say that it was Leigh's demonstration of "hate" for her patient! Furthermore, Leigh recalled similar moments in other treatments when she was faced with clients' dissatisfaction with treatment and how she had held back from giving them potentially useful guidance or

collaborating with clients in thinking of solutions, justifying that doing so would constitute an "unhealthy symbiosis" (p. 328) – a defensive intellectualization of the fear of contact with an angry client who confronts us with our failures. Leigh and Silbert argued that to avoid doing harm to clients out of the thwarted need to be an effective helper, we must accept the inevitability of mistakes and failures, and be willing to face the painful feelings that arise together with our clients (p. 328).

This conclusion mirrors that of Pinsky (2017), who as we have read earlier, argued for an honest confrontation with our own propensity towards very hateful and painful feelings for our clients – feelings we would rather not acknowledge. In fact, Pinsky proposes that psychoanalysis works precisely because the psychotherapist is mortal – one who can both make mistakes, and who can die: "Only an imperfect being can energize this extraordinary offering, as no god or robot could do" (p. 1). In other words, it is exactly because the psychotherapist is mortal that the work is valuable to the client. If we were able to love and give perfectly, then the love and care, including our capacity for benign tolerance of hate and fear towards the patients, and the capacity to correct our mistakes will not be such a precious, lifegiving gift. It is only through working with a limited, mortal being that the patient comes to terms with limitations and grieves the losses they have and will experience in their lives. Moreover, a being that can love and give perfectly lacks the emotional depth and breadth to be able to respond to the patient's hate and fear. Sedgwick (1994) reminds us, citing Searles (1966), that the goal of maturation or progress in psychotherapy is not to become free from neurotic feelings, but to become "increasingly free to experience feelings of all sorts" (p. 106).

At the same time, we must not underestimate how much a therapeutic mistake or failure may constitute a blow to one's self-esteem above and beyond an ordinary disappointment at being unable to help, because in clinical practice the personal and the

professional are less separable. Brightman (1984) argued that the profession of psychotherapy tends to attract people whose self-esteem depends on the degree to which they can personify the "heroic" cultural archetypes of the "hero, the sage, and the healer," all of which are powerfully embodied in the idealized image of the omnipotent, omniscient, and omnibenevolent therapist, "setting forth to battle the dark forces of the human soul" (p. 295). He noted that being trained in psychotherapy carries its inherent risks of narcissistic wounding, as the grandiose vision of the self as that savior meets the harsh reality of the entrenchment and puzzling complexity of patients' suffering, carefully cultivated to defeat any hope for change.

Alice Miller (1979), famous for *The Drama of the Gifted Child,* observed that analysts tended to have been children who grew up exploited by their caregivers for their emotional gifts of "sensibility, … empathy, … intense and differentiated emotional responsiveness, … unusually powerful 'antennae'" which "predispose him as a child to be used – if not misused – by people with intense narcissistic needs" (p. 54). She even went as far as to argue that if it were not for the fact of being used to gratify their parents' narcissistic needs, the emotionally gifted child will not become an analyst, because no one else "… would muster sufficient interest to spend the whole day trying to discover what is happening in the other person's unconscious" (p. 49). Brightman (1984) similarly argued that for a subset of analysts their choice of profession is a "re-enactment" of their parentification in childhood, having been used to gratify the needs of their caregivers (p. 295).

Hyde (2009), in her unpublished doctoral dissertation, argued that Miller's account described depressive rather than narcissistic dynamics (cited in Hyde, 2012; McWilliams, 2011). Specifically, she found some evidence that compared to geologists and academic psychologists, clinical psychologists tended to be much more characterologically depressive. She suggested that "(f)or many of us, … the practice of psychotherapy provides a salve,

enabling the practitioner to have his/her needs for intimacy unconsciously met and their feelings sanctioned without their conscious awareness" (Hyde, 2012, p. 36). Both Hyde (2012, p. 36) and McWilliams (2011) argue that the work may be largely motivated by a reaction-formation against one's sense of inner badness, in that a kind of selfless giving compensates for the pervasive sense of guilt that is common in depressive personalities, and perhaps gives the illusion of keeping much-feared aggression and anger under control (p.286). Echoing Hyde (2009), McWilliams observed that being "characterologically depressive" psychotherapists tend to credit their patients with therapeutic successes but take the blame for therapeutic failures (p. 276). Greenson (1967) shared that in his experience, "the best empathizers seem to be those analysts who have overcome a tendency to depression" (p. 383), although he did not elaborate on the useful qualities and lessons that one may draw from a depressive episode.

Similarly, the Advisory Committee on Colleague Assistance (2008) when describing the risk factors for impairment in psychologists wrote that the factors that render the psychologists vulnerable to stress are often the same gifts they bring to the work, namely a sensitivity to loss and pain that originates from their own losses. Such sensitivities can lead to "over-identification" with clients, making it difficult for psychologists to maintain a workable distance from their clients' problems. In addition, they often have the "need to be seen in a positive light," a desire that is often disappointed as clients make use of them in less than flattering ways (para. 5). In addition to these observations by experienced supervisors, there is evidence from a study by Firth-Cozens (1999) of such self-selection too: she found a significantly higher level of depression in medical students who became psychiatrists compared to medical students who later became surgeons (cited in Walsh & Walsh, 2001, p. 125).

Suffice to say, whether one conceptualizes psychotherapists' motivation as driven by narcissistic or depressive dynamics, what all these authors bring attention to is how much psychotherapists depend on therapeutic success to bolster a sense of self that was injured in early childhood. Relative to other kinds of professionals, they may have a harder time separating one's professional self from one's personal self because in psychotherapy the "instrument of practice" is the self of the therapist, and hence the analyst's "own character development and functioning" are seen as intimately tied with their capacity to be a successful therapist (Brightman 1984, p. 295). Persistent difficulties in a patient's treatment could raise anxieties about one is "well-analyzed" enough. Such anxieties are especially incapacitating if one is taught the perspective that one should regard countertransference as solely one's own baggage. For example, McWilliams (2011) observed that

> some psychoanalytic supervisors put so much stress on their students' understanding of their own dynamics that they foster a distracting degree of self-consciousness. No emotional energy is left over for reflecting on what can be learned about the patient from one's responses. A kind of navel gazing comes to substitute for real relatedness, and people of talent and compassion become reluctant to trust what are often excellent natural instincts because they fear they are acting something out. (p. 121)

Furthermore, learning psychotherapy itself is a vulnerable process that requires an openness to critical scrutiny and feedback (McWilliams, 2011, pp. 286-287). McWilliams (2011) quipped that "(m)edical school and psychotherapy training programs are famous for taking successful, autonomous adults and making them feel like incompetent children" (p. 227), because they are simultaneously tasked with being "responsible" adults and expected to be dependent on their "elders" in their field, but without the "protection and comfort" that usually comes with dependent relationships (p. 287). Not only that, many graduate students were the superstars of their college classes, only to come into a field where progress is often

slow and unpredictable – much slower than is enough to support the therapist's self-esteem. To add to the struggle, Farber and Heifetz (1982) observed, while student clinicians are often "assigned appropriate reading material," they are not trained to work through the disillusionments that are inherent to clinical work, and hence their susceptibility to "high rates of burnout" (p. 299).

Reflecting on the dangers of uncontained narcissistic needs on the part of the analyst, Miller (1979) noted that the analyst could harm the patient by using them to prop up their own self-esteem (p. 54). Patients who are perceptive about the analyst's narcissistic needs to be right may easily detect an analyst's wish for the patient to confirm their theoretical presuppositions and present with "all the affects and insights required" to prop up the cherished interpretations and theoretical perspectives (Miller, p. 54). In a similar vein, Boston-based self psychologist Richard Geist (2017) explained how insisting on theory-centered rather than patient-centered interpretations even when they do not fit with the patient's experience could be an expression of the therapist's need to be validated as a good enough therapist, at the expense of clearing the space for understanding the patient's subjective truth. This is a problem that is not exclusive to the therapeutic situation but comes with any kind of hierarchical relationships where one is dependent on the other. As we may recall, parent-child relationships are a fertile field for the exploitation of the child for the parent's narcissistic needs, especially if the parent themselves had been used for their caregivers' benefits. From Miller's viewpoint the manipulation of children by parents are really "unintentional and unconscious," stemming from unresolved narcissistic injuries from their own childhood (p. 56). She wrote that,

> It seems to me that if we can do anything at all, it is to work through our narcissistic problems and re-integrate our split-off aspects to such an extent, that we no longer

have any need to manipulate our patients according to our theories but can allow them to become what they really are. (p. 56)

To allow patients to become what they are – a tall order indeed!

The Vulnerability of Empathic Immersion.

Being a psychotherapist can be a narcissistic challenge in and of itself because empathically immersing oneself in another person's world "requires a willingness to temporarily and partially give up one's own identity," which can be especially difficult for therapists who are inflexible and intolerant of changes in their self-image (Greenson, 1967, p. 16). At the same time, Greenson (1967) noted, the therapist must be able to maintain their sense of self and their role as the analyst (p. 16). It is not easy to live up to the dual challenge of maintaining one's self while giving up cherished aspects of one's identity to identify with the patient. Greenson even went as far as to say that rigidly obsessional people are unsuitable analytic candidates because their self-image is so fixed that they cannot allow themselves to empathize. In short, empathy requires a strong sense of self that continues to be differentiated even with long periods of immersion in another person's world.

Just as workers can be injured by their tools, therapists can be injured from empathic immersion. Freudenberger and Robbins (1979) warned that a profession that relies so much on a temporary giving up of the self-image harbors the risks of losing oneself. They contended that this loss of the personal self is one of the reasons for professional burnout among clinicians and explained that analysts can become so good at listening to others that they forget to listen to themselves, and gradually lose the distinction between their personal and professional selves (pp. 281-285). As a result, they "may be listening too intensely to be able to hear or follow (their) own personal drumbeat" (p. 285).

Defenses Against Narcissistic Vulnerability.

This part of the literature review briefly addresses the common defensive barriers that psychotherapists may enact to avoid painful experiences of vulnerability. Intellectualization is perhaps one of the most common defenses against closeness and the lack of control that one has over the course of therapy. Brightman (1984) described a form of "obsessional adaptation" (p. 301) that is common among trainees, characterized by a defensive shift from caring about the work on an emotional level to attending to their "thoughts and hypotheses" (p. 301) about the work under the guise of being a cautious, scholarly practitioner who is more invested in theory-testing and "scientific rigor" (p. 301) than being a clinician who is understandably moved by the currents of confusion, uncertainty, and frustration inherent to the work. Despite, or perhaps because of the inevitability of therapeutic puzzles and failures, the field of psychotherapy is chock full of heroic discourses which keep at bay those discomfiting realities. One does not need to search too long and deep to find anecdotal accounts by psychoanalytic practitioners about how proponents of manualized treatments based on randomized clinical trials are misguided by Enlightenment progressivist fantasies of improving science collectively to a pinnacle of omniscience where decisions in the face of uncertain outcomes can be voided. However, the practitioners of depth-oriented therapies are just as guilty of this fantasy. Leigh and Silbert (2016) noted for instance that despite the availability of evidence supporting the curative potential of the relational turn in psychoanalysis, it remains to be acknowledged that this advancement will not protect clinicians from failure, and that we need to avoid "being seduced by a contemporary promise of cure and that this time, we the profession, could get it right and avoid our human capacity to fail and injure" (p. 324).

The schizoid defense – putting the client at arm's length to preserve the illusion of an untouchable "I," and the hysterical defense – recklessly flinging and dissolving oneself into

the “we” to sidestep the terrors of real intimacy of which “I” am a prerequisite, are another pair of defenses that psychotherapists may use to cope with fears about the rawness of the human-to-human contact. At best, the schizoid defense deprives the therapeutic dyad of a powerful potential to enliven the therapy, but at worst, it may be injurious to the patient. Brightman (1984) noted that trainees who react to the struggles of analytic or psychotherapy training with “psychological flight and withdrawal” (p. 303) may create a damaging therapeutic environment for patients with early losses or relational traumas, in which patients attempt in vain to evoke emotional responsivity from therapists only to be stonewalled (p. 304). Alternatively, the therapist might adopt the hysterical adaptation, emphasizing emotional catharsis and spontaneity are above and beyond any serious consideration of theory and techniques, resulting in “a high degree of enmeshment and affectivity” in the psychotherapist’s treatments (p. 302). Psychotherapists may also vacillate between these two polarities. In her book *A Shining Affliction*, Annie Rogers (1996) gave a compelling account of how she was harmed by an analysis that shifted from being full of warmth and seductive promises of love to being cold, impersonal, and distant. She wrote,

> We can … create a greater distance to protect ourselves and even appear to be unmoved by our patients’ responses to that distance. But the effect on our patients is deadening whenever we show them that they do not affect us. Or alternatively, we can create an illusion of intimacy by making false promises, unwittingly seducing patients to reveal their deepest and oldest wishes, as if we could somehow mete out the right responses and withhold what would be harmful, as if we really knew the difference. (p. 320)

The last part of this quote, “as if we could somehow mete out the right responses and withhold what would be harmful, as if we really knew the difference,” warrants some extra attention as it echoes the observations described in an earlier section on the archetype of the

Wounded Healer that the difference between help and harm can be on such a razor edge that the difference appears to be blurred.

Summary on Emotional and Narcissistic Vulnerability

This section began with an overview of Brené Brown's grounded theory research on vulnerability, including her work on Wholehearted individuals who practice resilience to shame and embrace vulnerability by engaging deeply in their work and relationships. I followed that review with an examination of how the field of psychotherapy has historically taken up the notion of the real personhood of the psychotherapist. I described the existential-humanistic perspective that the psychotherapist's ability to be vulnerable in the therapeutic relationship is a precondition for the formation of a deep bond with the client that has the power to heal and transform. Additionally, I explored the historical disavowal of vulnerability in psychoanalysis, which, albeit ameliorated somewhat by the relational movement, has continued to haunt the field in the form of the artificial division between psychanalysis and psychoanalytic psychotherapy. I described the response from the relational movement on this psychoanalysis-psychotherapy schism, which posits that the psychotherapists' acknowledgement of their own vulnerability prevents the disavowal and projection of that vulnerability onto their patients and colleagues. Furthermore, I discussed the Wounded Healer archetype and the notion of the shadow and explored how the disavowal of the shadow might be conceptually relevant for the phenomena of burnout, impairment, and misconduct.

There are both anecdotal and empirical explanations regarding the personality characteristics and occupational factors that render therapists vulnerable to burnout and impairment. The demands of the psychotherapeutic profession on therapists to use their emotional receptivity to receive and understand clients' suffering, while at the same time have some measure of restrain on their emotional reactivity and to maintain a balance

between closeness with and distance from the client's world, are taxing and difficult to sustain, especially for beginner therapists. Pressures in this era of managed care to prioritize cranking out billable hours over providing careful patient care further exacerbate work-related distress among therapists, which can lead to burnout and impairment that in turn compromises the quality of care. Moreover, several researchers and clinicians have talked about how psychotherapists, who are disproportionately depressive in terms of personality organization, often place demands on themselves to be loving, competent, and effective at all times in an unconscious attempt to compensate for what they feel to be their inner badness and to ward off feared emotions such as anger and hostility. Unfortunately, it is the splitting off of anger and hostility that sometimes places therapists at risk for boundary violations and misconduct with patients. Furthermore, I briefly reviewed some defensive adaptations common among therapists when faced with their vulnerability, and how they may inadvertently harm the patient. I spoke about how therapists tend to be predisposed to conflicts around intimacy and receiving care, which can get in the way of providing a corrective experience for clients who need to build trust in their capacity to evoke affective responsivity in and have a positive influence on the therapist.

Implications of Literature Review

Pinsky (2017) clarified that the goal of her discussion of the psychotherapist's mortality is not to recommend better ways of handling it. A one-side focus on finding solutions can become a compulsive defense whereby we busy ourselves with the practical side of the problem, creating protocols to handle unexpected absences and death, and considering the pros and cons of interventions, and overlook the importance of spending time reflecting on our vulnerability as humans who might die an untimely death and leave loved ones in shocked grief. Similarly, I do not intend this project to be an extension of the literature on burnout and impairment among clinicians that proposes solutions or protocols,

because adopting an agentic and heroic approach in the face of vulnerability ultimately sidesteps the need to sit with the experience of vulnerability.

One of my hopes for this project was that through speaking with psychotherapists about their experience of their vulnerability, I could help to bring more personal, more vulnerable voices to the wider conversation about psychotherapists' vulnerability that are less heroic and more revealing of the weakness, helplessness, fear, and worry that they feel when confronted with their own existential finitude and limitations in their capacity to help. Another hope I had was to find out what creative and constructive underbelly there might be to psychotherapists' vulnerabilities. If we revisit the dictionary definition of vulnerable, we are reminded that it means being "capable of being physical and emotionally wounded" (Merriam-Webster, n.d.-b). The definition is somewhat of an oxymoron: rarely do we say that we are *capable* of a state of being that happens to us or is inherent to our being. At the same time, perhaps there is a truth to that oxymoron, that is, that vulnerability is a form of capacity, albeit one that appears passive rather than agentic. In exploring this capacity, I hopefully joined an already increasingly loud chorus in psychoanalytic circles about how working through the pain and disappointment of limitations often energizes and inspires the flowering of creative potential (McWilliams, 2017).

Method

Research Question

The research question I posed was: *How do psychotherapists experience vulnerability?* Since the focus of this question was on experience, I used a phenomenological methodology. In the following sections I describe how the phenomenological orientation guided my inquiry, my use of Interpretive Phenomenological Analysis to execute the project, and the process of data collection and analysis.

Phenomenology: Recapturing Lived Experience

The linear presentation of the introduction and literature review followed by this method section should not mislead readers into thinking that my phenomenological inquiry proceeded in this linear fashion. Phenomenology is not a collection of procedures that I followed after I had come up with my research question, but an orientation towards the world that seeks to grasp "life as we live it" (Van Manen, 2014, p. 39), which has also been called "lived experience" (Dilthey, 1987, cited in Van Manen, 2014, p. 39). This stance of openness and receptivity often allows phenomenological questions to arise in the first place. Van Manen (2014) stated, "Doing phenomenology is becoming infected with a certain pathos that creates an openness to the world and a wondering attentiveness that is the trigger for phenomenological inquiry" (p. 36).

This "basic disposition of wonder … dislocates and displaces us" (Van Manen, 2014, p. 37) from our ordinary mode of moving through life with a "taken-for-grantedness" (Van Manen, 2014, p. 31). This everyday taken-for-grantedness is part of what the pioneering phenomenologist Edmund Husserl called the "natural attitude" (cited in Smith et al., 2009, p. 13). In the natural attitude, we are immersed in the seamless moment-to-moment flow of experience (van Manen, 2014, p. 28), "caught up, unself-consciously" (Smith et al., 2016, p. 2) with the engagement at hand. Unless we are deliberately recalling what happened, our experience simply fades into the past without much notice. As soon as we pause to reflect, that seamless flow of experience is punctuated, and "we have the beginnings of what can be described as 'an experience' as opposed to just experience" (Smith et al., 2009, p. 2). What was originally lived prereflectively now has the opportunity to be reexamined. At the beginning of this dissertation, I described how this process of stopping and examining experiences in retrospect planted the seeds of this phenomenological inquiry. In particular, there were several instances in my clinical training when I caught myself hiding behind my

helper persona rather than being more authentically myself with my clients. At that realization my supposedly therapeutic words suddenly rang hollow to my own ears and my stoic presentation struck me as somewhat stilted. The stirrings of wonder about that shift in my experience of myself in relation to my clinical work prompted me to pause and understand the significance of that experience and led me to wonder about that sort of experience among other clinicians.

It is important to emphasize that phenomenology goes beyond everyday introspection; it is an attempt to recapture what was like to live through that experience. In phenomenological terms, it is interested in experience as it presents itself or appears in our consciousness – also called "phenomenon" (van Manen, 2014, p. 39), hence the term phenomenology. Due to its focus on getting closer contact with experiences as they are lived, phenomenology "is obsessed by the concrete" (van den Berg, cited in van Manen, 2014, p. 65) and "existential meanings" (van Manen, 2014, p. 66) as opposed to abstract, intellectualized ways of understanding the world. Thus, in contrast to many other research methodologies, phenomenology does not offer fodder for generating theories that help with predicting and controlling events (van Manen, 2014, p. 37). In the words of Van Manen (2014), "the ultimate aim of a phenomenology of practice is modest: to nurture a measure of thoughtfulness and tact in the practice of our professions and in everyday life" (p. 31). Furthermore, the understandings gathered from phenomenological projects can help to fill in where theory falls short of doing justice to how phenomena are actually experienced by people (p. 67).

Since researchers cannot help but bring their personal biases, conceptual frameworks, and common-sense assumptions to the table, an essential practice in phenomenology is to become aware of how those prejudices shape our experience of phenomena. Phenomenologists handle this challenge through the practice of "bracketing," (van Manen,

2014, p. 222). The early phenomenologists viewed that as a process of temporarily setting aside prejudices but remaining aware of their impact on their attempt to apprehend the phenomenon of interest. Other schools of phenomenology view the project of brushing aside presuppositions as not only futile but also unnecessary. For instance, from the perspective of hermeneutic phenomenology, researchers often find out how their "fore-conception (prior experiences, assumptions, preconceptions)" (Smith et al., 2009, p. 25) affects their engagement with the text only after they have engaged with it. Hence, bracketing is a "cyclical" (Smith et al., 2009, p. 25) rather than linear process; with each reading, the researcher gleans a clearer sense of their fore-conception and reengages with the text with a renewed perspective each time. Due to the centrality of the practice of bracketing to phenomenology, van Manen (2014) called phenomenology a practice of "abstemious reflection," in that phenomenologists strive to "abstain from theoretical, polemical, suppositional, and emotional intoxications" (p. 222). A sustained disposition of wonder helps us behold the phenomenon of interest "as if for the first time" (van Manen, p .43). From a phenomenological perspective, even experiences that may have seemed ordinary and mundane become extraordinary when observed with wonder (van Manen, p. 223).

Yet, as much as phenomenologists try to "grasp attentively the living sense of the experience" (van Manen, 2014, p. 39) they have to do so in the medium of language. When I stopped to reflect on my experiences, I had to find the language to articulate them. I explained in the introduction that I chose the word "vulnerability" for its emotional resonance; it came closest to evoking the mood of those significant experiences. Van Manen (2014) pointed out that we can use different words to describe the same experience "as long as we remain aware that the focus is not on the word but the experience" (p. 38). My focus is ultimately on the experience of vulnerability – emphasis on the word experience – rather than of vulnerability per se.

Another way in which language serves phenomenology is by its capacity to help us express more fully the "nature, meaning, significance, uniqueness, or singularity" (van Manen, 2014, p. 39) of experience. The creation of a phenomenological text is not merely the dutiful reporting of findings, but an integral part of the research process. Language can either be wielded as a "cognitive apparatus" that "intellectualize[s] our awareness," or also as an "expressive medium" to "evoke understandings" (Van Manen, 2014, p. 242). The words we use to recollect, describe, and explore the significance of experiences can either breathe life into the text or dull and deaden our senses. Phenomenologists may use "pathic mediations of language such as fictivity, example, anecdote, and poetic image" to express meanings that cannot be conveyed through more straightforward prose.

In summary, I illustrated how my phenomenological inquiry began with wonder at the experience of vulnerability. I described the phenomenological attitude as one of sustained wonder and an openness to how phenomenon presents itself, in addition to a concerted effort to avoid the seduction of theoretical and common-sense explanations that objectify experience. I also discussed the importance of evocative, sensuous language in creating a phenomenological text that are rich, enlivened, and nuanced, such that its readers can come as close as possible to the experience as lived. In the following section, I described my use of a specific phenomenological method called Interpretive Phenomenological Analysis.

Interpretive Phenomenological Analysis

Interpretative Phenomenological Analysis (IPA) is a qualitative research method with roots in phenomenology, hermeneutics, and idiography (Smith et al., 2009, pp. 11-32). The history of IPA began with the publication of Jonathan Smith's landmark paper *Psychology and Health* in 1996, in which he posited that psychology research can be "experiential and qualitative, and … still dialogue with mainstream psychology" (Smith et al., 2009, p. 4). Since 1996, IPA studies have proliferated in clinical, counseling, educational, and social

psychology (Smith et al., 2009, p. 4). The phenomenological foundation of IPA is apparent in the description of IPA researchers by Smith and colleagues (2009) as "especially interested in what happens when the everyday flow of lived experience takes on a particular significance for people" (p. 1). In contrast to phenomenology as a philosophy, however, which has much more ambitious aims such as identifying the essential structures of experience, IPA is idiographic. It emphasizes the particularity and context-dependent nature of lived experience, and therefore aims to understand how a phenomenon is experienced by particular individuals (Smith et al., p. 29). IPA samples tend to be small and homogeneous. Additionally, rather than expecting results that can be generalized to a larger population and making connections between results from different studies, IPA emphasizes the value of understanding individual cases and "exploring connections *within* a participant's account" (Smith et al., p. 51, emphasis in original). The experiences of those small handful of individuals, most typically collected through interviews, diaries, and other first-person accounts (Smith et al., pp. 56-57), are analyzed in great depth and detail, and extrapolations from those particular cases to a broader population are considered with caution (Smith et al., p. 29). Because I was interested in both the different ways in which psychotherapists experience vulnerability in their role, and potentially any common threads running through their accounts, IPA stood out as a method of choice. Furthermore, I wanted a method for studying lived experience, and its origins in psychology research makes it especially suitable for studying human experiences that are of interest to psychologists.

The hermeneutic underpinning of IPA differentiates it from traditional Husserlian phenomenology. Firstly, IPA is characterized by a "double hermeneutic" (Smith & Osborn, 2003, cited in Smith et al., 2009, p. 35): "the researcher is making sense of the participant, who is making sense of [the experience]" (Smith et al., 2009, p. 35). In any research study, when the researcher makes sense of the participant's experience, they can do so by taking the

participant's narrative at face value, or, bring in an external, typically theoretical perspective that questions the participant's perspective (Smith et al., 2009, p. 36). IPA researchers typically take a "center-ground position" (Smith et al., 2009, p. 36) that accepts both interpretive routes as tenable as long as they help to reveal the phenomenon with greater clarity. Secondly, as briefly mentioned in the previous section, hermeneutic phenomenology views bracketing as a cyclical rather than linear process. In the same spirit, data analysis in IPA is understood not as a linear process but an "iterative" process (Smith et al., 2009, p. 28), whereby the researcher "moves back and forth through a range of different ways of thinking about the data" (Smith et al., 2009, p. 28). In hermeneutics theory this process is called the "hermeneutic circle" (Smith et al., 2009, p. 28).

This back-and-forth, iterative process took place on various levels. For instance, it unfolded when I relied on my own intuitive sense of what vulnerability means for psychotherapists in order to start my literature search. By brainstorming ideas and associations I personally had on the topic, I was also identifying my assumptions and preconceptions about the topic. As mentioned at the end of my literature review section, it took retrospection for me to recognize that those perspectives were heavily influenced by my state of mind and developmental challenges as a psychotherapist in training at the time. This realization allowed me to refine my literature review to include other viewpoints on vulnerability. Then, when I was analyzing my data, I moved between various ways of reading the data. In making sense of one part of the data, I developed an idea of the data as a whole. Likewise, engaging with the data as a whole changed my relationship to parts of the data. Furthermore, outside of this project, I continually changed as a person, and many of those personal transformations affected not only the way I read my data, but also my writing and rewriting of this text. Because "in writing we may deepen and change ourselves in ways we cannot predict" (van Manen, 2014, p. 20), writing this text changed my reading of the data,

and even as I rewrote parts of the text to reflect that shift, I continued to change. As stated by Smith and colleagues (2009), "here the 'whole' is the researcher's ongoing biography, and the 'part' is the encounter with a new participant, as part of a new research project" (p. 35). Consequently, this dissertation text is a snapshot of where my thoughts landed at the time of finalizing this draft. It does not exhibit the ongoing evolution of my relationship to this topic and my interpretation of the data.

Recruitment of Participants

To collect first-person accounts of psychotherapists' experiences of vulnerability, I utilized individual interviews with a purposively selected sample of six psychotherapists in various stages of their career. As the amount of experience may change how psychotherapists experience vulnerability, I aimed to recruit at least two participants who were still in clinical training (MA or MS in clinical or counseling psychology, PhD in clinical or counseling psychology, or PsyD), two early career professionals (fewer than five years post-graduation, whether licensed or unlicensed), and experienced (more than five years post-graduation, and licensed). Because deep immersion in the work of psychotherapy is crucial for a rich recall of experiences with clients, I included only licensed therapists who were practicing psychotherapy for at least an average of two full days of psychotherapy per week (roughly 7 hours/week), and psychotherapists-in-trainings who were practicing for an average of at least 4 hours of psychotherapy per week.

I advertised my study by word-of-mouth by posting recruitment flyers (see Appendix A) on professional listservs and social media pages and by emailing training directors of clinical programs. Prospective participants were asked to contact me via email, phone call, or text. A total of seven psychotherapists emailed me with interest in my study. I responded to them with an email that consists of a list of screening questions (see Appendix B) as well as an informed consent document (see Appendix C) to ensure that they met criteria for the study

and to be transparent about what participation in the study entailed. I also reminded them in the email that participation is voluntary and that they can withdraw from the study at any point. Six participants ultimately confirmed their participation and completed the interviews. One prospective participant did not respond to my first follow-up email, and since I had already gathered a big enough sample, I did not send a second follow-up email. Consistent with my target sample, the final sample consisted of two psychotherapists in training, two early career professionals and two seasoned professionals in private practice.

I recruited psychotherapists from around the Pittsburgh area and conducted the interviews in-person, as I reasoned that many subtle and nonverbal cues may be missed when conducting video interviews. Of note, I completed recruitment and interviews between February-April 2019, a little less than a year before the novel coronavirus (COVID-19) global pandemic necessitated social distancing measures and the movement of many research activities to virtual platforms. Each interview ranged from 60 to 90 minutes. Some were conducted at the Duquesne University Psychology Clinic while others were held in the interviewees' psychotherapy offices. Prior to each interview, I perused the consent form (see Appendix C) carefully with the participant, reiterating the study goals, procedures, and potential risks and benefits. I also informed them that I would perform a "member check" (Koelsch, 2013). Specifically, I let them know that after completing the data analysis and interpretation, I would send them a draft of my findings so that they could give me feedback regarding the accuracy and representativeness of my interpretation of their accounts. It would also give them a chance to withdraw any direct quotes or details that they did not want to be printed in the final version. After answering any questions the participant had, obtaining their signatures on the consent forms, and giving them a copy of the consent form for their own reference, I began the interview.

Interviewing Participants

Handling Participant Confidentiality and Privacy.

I recorded each interview with two audio recorders in the event that one recorder malfunctioned. I positioned both recorders in plain sight and announced to the participant that I was going to begin recording. At the end of the interview, I informed the participant that I was going to stop recording. I then collected demographic information and details about their clinical practice (see Appendix D) before ending the meeting.

To reduce the risk of data breaches, after each interview I transferred the audio files from the audio recorders to a password-protected external hard drive and deleted the original recordings from the recorders. After transcribing the interviews with the aid of the transcription software Temi, I saved the transcripts to the password-secured external hard drive. After transcription was completed, I destroyed the original audio recordings. Any identifying information was redacted from the final transcripts, which were kept in a secure folder on a password-protected laptop computer.

The Process of Interviewing

Although I had a semi-structured interview guide (see Appendix D), I did not adhere to it strictly or ask all the questions on it, using it instead as a tool to open up a participant-led conversation. I started each interview by asking the participant to tell me about a time when they felt vulnerable as a psychotherapist. In order to collect "'rich' data," (Smith et al., 2009, p. 56), I encouraged participants to go deeper into their experience of particular moments, using exploratory questions along the lines of "What was that like for you?" or "Can you say more about that?" In order to steer away from overly intellectualized discussions, I took care to avoid questions along the lines of "What do you think about …?" When a line of inquiry dried up and further questioning about it felt forced, I took it as a cue to ask a new question. In general, I spoke very little, allowing participants to take the reins and expand on whatever

felt most interesting or significant to them. I used reflective listening to ensure that I was hearing participants accurately and also to help participants hear themselves so that they could check whether their words resonated with their experience. Additionally, I maintained an awareness of my internal reactions to what participants were saying. In particular, I had to keep in check my habitual tendency to respond as a psychotherapist rather than as a researcher. Whenever I found myself thinking, "Is that defensive?" I mentally noted to myself to set aside my questions and remain open to the participant's perspective.

After taking leave of each participant I immediately jotted down my initial impressions of the interview, including a very rough character sketch of the participant, my experience of myself vis a vis the participant, any confusion, doubts, and questions I had, as well as any extra-linguistic and paralinguistic cues during the interview that I found interesting. The process of the interview generated data that were as important to me as the content. For instance, I noticed that it was particularly challenging for participants to answer the question "What does vulnerability mean to you?" Some participants asked me this question spontaneously at the beginning of their interview, explaining that they were not sure which "kind" of vulnerability I wanted to hear about. Their confusion was an intriguing juxtaposition to the feeling of immediate recognition and resonance that many colleagues who spoke with me about my dissertation (not as participants) expressed.

Additionally, I was aware that I was reading my participants at the same time that they were reading me. Retrospectively, in relation to the more seasoned professionals, I felt like a student who was not so surreptitiously hoping for words of wisdom from those who had gone before me. It was an easy role to be pulled into not only because I felt a certain amount of deference to my elders in this field, but also because I was fascinated with their interesting clinical vignettes and their narrative of how they matured over the year as clinicians. In relation to the participants who were also in training or were earlier in their

career, I felt more like a peer and sensed their comfort around me. As a case in point, participant who had uttered a string of profanities during an impassioned philippic against disturbing trends in mental health, suddenly stopped and laughingly stated, “Sorry I said ‘fuck’ so much – but I know you are down [for it]!” These observations, alongside the explicit (pun not intended) statements made by participants, shaped the character sketches I wrote of my participants.

Following a strategy recommended by Smith and colleagues (2009, p. 66), after conducting my first interview I transcribed it first and reviewed the transcript before conducting my second interview so that I could check my interviewing strategies and find out how the questions on the interview schedule worked. I obtained feedback from my dissertation director about the interview by looking at the transcript together with her and revised my interviewing strategies accordingly. This procedure reflects the hermeneutic circle in IPA – my reading of the text produced from my first interview changed my relationship to the other interviews.

Additional Practice of Reflexivity: Becoming an Interviewee

I performed a slight modification to the practice of hermeneutic reflexivity in IPA by arranging for a consenting colleague, Celeste Pietrusza, PhD, to interview me on the topic using my semi-structured interview guide (see Appendix D), after I had finished interviewing all my participants, and before I began data analysis. There were several reasons for this step. Firstly, I knew going into this project that I had strong feelings, opinions, and thoughts about vulnerability, that trying to cognitively set aside these preconceptions and personal biases prior to data analysis and interpretation would be to set myself up for growing a long shadow of obliviousness to how I used my self as the instrument of research. Having my own preunderstandings articulated clearly and deeply allowed me to recognize more clearly how my voice and subjectivity shaped my reading and writing of the participants’ experiences.

Secondly, I wanted to have a taste of how my semi-structured interview guide worked, and in relation to that, how a different interviewer would make use of that guide, which would provide me with insight into how I operated as an interviewer, and how I might have worked differently to deepen my participants' exploration. Thirdly, I was curious as to how my participants' thoughts and feelings about vulnerability might have shown up in my own narratives about vulnerability, particularly because this step took place after I had completed the interviews of all six participants. I listened to the recording of this interview only after I had completed data analysis and interpretation, in part because I wanted to internalize my participants' voices while deeply immersed in the process of making sense of their experiences, and truthfully, in part due to the sheer cringe factor of listening to myself. I noted my experiences of being interviewed and the themes that came up for me that overlapped with those of my participants, as well as themes that were specific to me.

Data Analysis

Smith and colleagues (2009) noted that while there are many different strategies for analyzing data in IPA, there are some overarching principles and processes. Firstly, there is "a psychological focus on personal meaning-making" (Smith et al., 2009, p. 79). As such, there is a "development of a 'dialogue' between researchers, their coded data, and their psychological knowledge" (p. 79). Secondly, the data analysis proceeds from "the particular to the shared" and "from the descriptive to the interpretive" (Smith et al., 2009, p. 79). For instance, when identifying themes, that is the patterns of meaning, I generated individual themes for individual transcripts before looking for connections and commonalities across transcripts. Working methodically in this way also allowed for the development of an audit trail such that I could check my work and obtain feedback. My work with each subsequent transcript also reshaped my impressions of the earlier transcripts, so I would go back to revise the themes I had come up with initially.

IPA cannot be reduced to a collection of techniques. Nonetheless, having an outline of steps provided this novice IPA researcher with some structure so that my analysis could have sufficient rigor, thoroughness, and consistency. I adapted the following procedures from Smith and colleagues (2009) in *Interpretive Phenomenological Analysis: Theory, Method, and Research* (pp. 82-107):

1. *Reading and rereading*

Consistent with the principle of moving from the individual to the shared, I worked with one transcript at a time, starting from a "close, line-by-line analysis" (Smith et al., p. 79), before stepping back to read a whole segment at a time. After transcribing the first interview with a transcription software, I listened to the recording repeatedly while proofreading my transcript. Doing so helped me to recall my experience of the participant during the interview. I then read and re-read the transcript while imagining speaking from the participant's perspective. During my early close readings I noticed that I would often copy some lines by hand that stood out to me verbatim, as though I was trying to internalize the participant' voice. The primary activity at this stage of the analysis was close reading, with the goal of immersing myself in the participant's lived experience. To prevent myself from getting too distracted by my immediate thoughts, impressions, and reactions to the text, I jotted them down in the margins of the transcript (Smith et al., 2009, p. 82).

2. *Initial noting*

I reread the first transcript line by line and took notes on the margins of the transcript, with the goal of making "a comprehensive and detailed set of notes and comments on the data" (Smith et al., 2009, p. 83). The kinds of comments made included descriptive comments, linguistic comments, and conceptual comments. According to Smith et al. (2009), descriptive comments are notes on the content of the participant's talk, such as "key objects of concern such as relationships, processes, places, events, values, and principles," as well as

what those objects of concern mean to the participants (pp. 83-84). Linguistic comments on the other hand focus on how the participants used language to present content, such as the use of metaphors, tone, pitch, pauses and hesitation, word choices, and so on (Smith et al. p. 88). Lastly, conceptual noting involves an "interrogative" form of engagement with the data, whereby I posed further questions to aspects of the content that struck me as interesting (Smith et al., p. 88), including what may have been implied or unsaid. This level of engagement with the data was more interpretive than the first step, as I drew on my personal and professional experiences with the goal of exploring and "opening up a range of provisional meanings" (Smith et al. p. 89). I imported these notes onto a separate word document for each transcript so that I had a set of comprehensive notes for each interview such that at the next stage of data analysis I did not need to work directly with the transcripts (Smith et al., p. 91).

3. Developing emergent themes

Smith et al. (2009) described this stage of analysis as "mapping the interrelationships, connections, and patterns between the exploratory notes" (p. 91) and generating statements that are both faithful to the data and yet abstract enough to "speak to the psychological essence" of the data (p. 92). This process involved the use of psychological constructs and hence drew on my knowledge of psychology. It was important at this stage to check the emerging themes against my presuppositions to examine if I merely "found" themes I expected to see.

For the sake of presenting my findings in a linear fashion, it was inevitable that I had to find some ways of artificially parsing out the interview data into themes that appeared sufficiently unique and differentiated from each other. Nonetheless, the emergent themes are ultimately not separate, non-overlapping categories, but constituent themes that interrelate and make up the broader structure of the experience of vulnerability. This stage was the most

challenging part of the process because I realized that I could thematize the data in myriad different ways, and it often felt as though the themes bled into one another. To find a way out of this rut, I attended carefully to the language of the participants and looked for recurring words and phrases that suggested how the emergent themes hung together in their narratives.

4. Searching for connections and divergences across emergent themes

Smith and colleagues (2009) recommended that newcomers to IPA work manually with the emergent themes, such as by writing the emergent themes down onto separate pieces of paper and then physically manipulating them on a large surface to get a feel for how the themes may relate to one another (p. 96). I adapted the recommendation to my own preferences; I kept an electronic word document that listed the emergent themes according to the order in which the themes appeared. Additionally, I wrote the emergent themes down in different configurations of a conceptual tree, allowing myself to explore how the themes related to each other. My experience was consonant with their description that some themes acted like "magnets, pulling other themes towards them," allowing the analyst to "form clusters of related themes." Additionally, consonant with their description, some emergent themes struck me as super-ordinate themes that subsumed other emergent themes ("abstraction" p. 96), or on the other hand, some new super-ordinate theme subsumed other existing themes ("subsumption" p. 97). Some themes appeared to have "oppositional relationships" ("polarization" p. 97). I also counted the number of times each theme appeared ("numeration" p. 98) as a rough indicator of how important they are to the participant, while also not discounting themes that only appeared once or twice as less important, particularly, if they touched on topics that had been understated in the literature.

5. Moving on to the next case

After analyzing the first transcript, I repeated steps 1-4 with the other transcripts. For each transcript I kept a table of emergent themes for subsequent overall analysis.

6. Looking for patterns across cases

I printed a hard copy of each table of emergent themes and laid them out on a table so that I could explore the connections across cases (Smith et al., 2009, p. 101). I explored how the themes in each case had resonances for other cases, and reconstructed or renamed the earlier themes to better capture those resonances and connections (Smith et al., 2009, p. 101). In a way, it was like Step 4 except that I was working with all cases rather than with one individual case. Consistent with the idiographic emphasis of IPA, my goal was to have results that were "faithful" to the experiences of each individual and at the same time, showed how their experiences have "shared higher order qualities" (Smith et al., 2009, p. 101). I documented the findings in a table of super-ordinate and subordinate themes. This graphical representation helped me organize the data so I could write a narrative account of my findings. Of note, I continued revising the themes during the writeup of my results section, as the process of trying to present my findings in a narrative form helped me to recognize inconsistencies and incongruities in the coding and organization of my initial themes.

Member Check

Member checks (Koelsch, 2013) performed in qualitative research involve soliciting and incorporating study participants' feedback about the research findings. At its most basic level, it gives participants a chance to validate the factual accuracy of the information they have shared with the researcher and allows them to have a say in how their experiences are interpreted and depicted in the research text by the researcher. After all, the researcher's understanding of experiences shared by participants involves a "double hermeneutic" (Smith & Osborn, 2003, cited in Smith et al., 2009, p. 36) – the researcher interprets, through their own subjectivity, the participant's interpretation of their experiences of the phenomenon that is being studied. Obtaining feedback is thus a part of the researcher's reflexivity practice.

After the first draft of this dissertation was completed, I emailed every participant a Word document containing the participants' character sketches and the results section. I thanked them once again for their participation, explained that I was reaching out for a member check, and clarified my expectations and request. For each participant, I informed them of their pseudonym, offered them the chance to change the pseudonym if they wanted to, and had the sections that were relevant for them highlighted in yellow so that they could skip over other sections if they so wished. I requested that each participant peruse the sections that were relevant to them and to let me know by email if there was anything that they wanted me to revise for the sake of factual accuracy or for further protection of their privacy. I also offered to send the final draft of the dissertation if they wanted a copy. I requested that they send me their feedback within a little more than two weeks (12 business days) if possible. Four participants responded to the member check request within 4-10 business days. Two participants requested no changes; one participant requested a correction regarding the length of time she had been in independent practice; one participant requested a slight modification of a quote that had been shared, for privacy reasons. Two other participants did not respond. Due in part to time constraints, and in part out of my concern about being too intrusive, I opted not to send a follow-up emails to the participants who did not respond. I revised my text based upon the four participants' feedback and sent a copy of the final dissertation draft to participants who requested one.

Koelsch (2013) noted the importance of recognizing that participants' subjectivities do not remain fixed, and so participants may feel a sense of foreignness and distance with regards to what they shared during the study (p. 172). The member check presents an opportunity for participants to reflect on how their personal growth and evolution might have changed their how they view the experiences that they shared during the study, and on the other hand, how their participation in their study might have changed them. When the

research findings feel truthful to the participants, they not only resonate with their subjective experience, but also has the power to be "transformative" (Cho & Trent, 2006, cited in Koelsch, p. 169) in the sense of motivating individuals or communities to take actions towards social change, in addition to being "therapeutic" (pp. 175-176). Koelsch wrote:

> It is important to think about the effects of the research interview on participants in creative and constructive ways, even if we are not explicitly conducting research aimed at direct social change. If our projects are important and worthwhile, then we should expect that our participants might be changed by their participation. (p. 176)

The aforementioned observations were very much applicable to my experience of the member check. Even though my goals for the member check were to verify factual accuracy and reduce as much as possible the information that could be used to identify individual participants, all four participants who responded to the member check also spontaneously shared their experiences of reading what they had shared during the interview, which at that point, had taken place about close to two years prior. All participants congratulated me on getting to this stage in the dissertation process, shared positive comments about the text, with one participant remarking enthusiastically that I "brought it to life." Another participant commented on the experiential immediacy of the text, and further shared that reading the results allowed him to re-experience the "healing force" of the interview. In holding space for the articulation of experiences that do not always have get airtime, I was accidentally therapeutic. In the spirit of being authentic and vulnerable with my participants, I thanked participants for responding to my member check, verifying their corrections, and also expressing gratitude for their warm responses which gave me another much-needed dose of morale boost.

Summary of Method Section

In summary, I used Interpretive Phenomenological Analysis (IPA) to explore how psychotherapists experience vulnerability. IPA is rooted in not only phenomenology but also hermeneutics and idiography. I detailed the phenomenological foundation of IPA, which emphasizes understanding how experiences are lived through prereflectively, as opposed to conceptualizing and theorizing about experience. To collect data, I recruited six psychotherapists at different stages of their career and interviewed them about their experiences of vulnerability. I outlined the procedures I followed to analyze the data. I described the process of bracketing in IPA as iterative, in that my process of engaging with the data helped to reveal the presuppositions and prior understandings that I brought into the reading of the data. In addition, I described my member check with participants, and also my additional practice of reflexivity, which involved my being interviewed by a colleague.

Participants

Naomi [5], a White European-American woman in her early 30s, had been a licensed psychologist for a year and a half and in private practice for less than a year at the time of the interview. She identified her theoretical orientation as interpersonal and feminist. She was the first to contact me about participating, and my first interviewee. I sat in the waiting room nervously as I prepared to conduct my first "real world" interview with a "real professional." When she appeared at the bottom of the stairs, greeting me with a smile, my tangled nerves relaxed. She asked if I was able to walk up a flight of stairs to her office. "Welcoming" and "accessible" were the two words that came to mind when I called up my memory of being approached by Naomi and sitting on her couch. In her calm and quiet demeanor, Naomi described herself as self-selecting for this study because she had been contemplating practicing more self-disclosure, considering that her clients' reactions so far have been

[5] All the names of participants provided are pseudonyms.

largely positive or neutral. She identified being vulnerable as an important value in her clinical practice, explaining that if she expects her clients to "show up" with her and be vulnerable with her session after session, she needs to show up and join her clients too to some extent in that space. Her enthusiasm for my research gave me the much-needed morale boost for my subsequent interviews, and also gave me the feeling of having met a kindred spirit. My conversation with Naomi plumbed the depths of what it means to show up for and be with a client, particularly through self-disclosure.

Bill, a White European-American man in his early 60s and a licensed psychologist, had been in private practice for approximately thirty years at the time of the interview, He identified his theoretical orientation as existential, cognitive, and mindfulness-based. He eagerly shared his insights and lessons, while openly sharing his own challenges in navigating the uncertainties and existential questions that characterized the near-retirement phase of his career. Somehow managing to blend his dry humor and captivating storytelling with a straight-to-the-point, no-nonsense attitude, he both described his strategies for protecting himself from the verbal onslaughts and physical threats from clients and attorneys, and regaled me with these "rare" but "good stories" of credible threats he had received throughout the course of his career. He spoke with the succinct and deliberate manner of an expert witness with decades of experience in sloughing off superfluous verbiage and controlling the natural human urge to think out loud. At the end of the study he recounted the brusque rejections he encountered more than thirty years ago when he was recruiting participants for his dissertation research, and how particularly appreciative he felt towards therapists who were willing to speak with him. He saw his participation in this study as a way

to come full circle and pay it forward to another graduate student. Thirty years from now, he noted, I would be doing this for another graduate student[6].

Rachel, a White European-American woman in her early 60s and a licensed psychologist, has been in private practice also for over thirty years, in addition to decades of experience providing supervision and teaching psychotherapists in training. Her demeanor was gentle yet straightforward, and her speech dryly humorous. She was very fond of mocking her catastrophizing or self-critical thoughts in a high-pitched, cartoonish manner that brought much delight to my interview with her, and in many ways, felt soothing to me, as someone who also struggles with self-criticism when doing clinical work. I felt comforted to hear her share the insecurities she continues to feel from time to time and found consolation in her statement that as she grew more experienced, uncertainty became less frightening to her. In terms of her theoretical orientation, she stated the following in a way that reminded me very much of Albert Ellis, the founder of rational-emotive therapy:

> I'm primarily a cognitive-behavioral therapist so that … how you talk to yourself about it is … you know, if I tell myself it's going to be a disaster, then I have to run away. But if I tell myself it's going to be okay, then I can stick with it a little bit longer and see how it turns out. And surprise, surprise, it usually turns out okay.

Morgan, also White European-American, was in their early 30s at the time of the interview, identified as gender nonbinary, and was a doctoral level trainee. A graduate student with a hectic work schedule, they came to the interview on their lunch break, asking permission to "chomp on food" while speaking. They identified their theoretical orientation as psychodynamic. Their language was full of evocative imagery and narratives that held me in suspense. Morgan described themselves as drawn to my study because they see themselves

[6] My dissertation committee chair thinks that I should set an alarm on my phone for 30 years from now to remind myself to pay it forward. Alas, my phone calendar maxes out at 2037.

as “an artist in vulnerability,” who loves to throw themselves into situations of deep vulnerability to reap the rewards of deep connection, thrill, and experiences of the full palette of emotions. They also shared that due to their personal history of complex trauma, they have a paradoxical relationship with vulnerability, whereby they had to learn early on how to shut off their access to their emotional vulnerability in an instant and sometimes cannot choose to turn it back on, whereas other times, they may plunge into deep vulnerability before others are ready, which, in their personal life, simply rubs others the wrong way, but in clinical work, can be quite damaging. As such, unlike many trainees who struggle to let their guard down and be more exposed, they had had to learn over the years to time their self-disclosures more carefully and do them artfully rather than impulsively.

Nathan, a White European-American man in his early 30s at the time of the interview, identified as psychodynamic in orientation, and was a doctoral level trainee. He practiced as a masters level clinician for several years in various settings, including prisons and a poorly resourced state residential facility for adolescents, the latter of which provided the bulk of the context for the stories of vulnerability that he shared at the interview. At the time of the interview he was also early in his doctoral level training and seeing clients in an outpatient clinic. Like Morgan, he was on his lunch break, and during some moments while talking about experiences of deep vulnerability in his prior clinical work, he would humorously comment that he was eating to “chill out” from recounting those stories. Nathan reached deep into his experience to pull out the words that could have any hope of doing justice to it, and often times, deep sighs and pauses, took place of the words that failed. I found myself feeling immersed in his world and saw the pain in his eyes as he described the depth of his commitment and responsibility to the clients whom he ultimately could not prevent from getting worse. A few months after my interview with Nathan, I began a predoctoral internship at a state hospital where I worked with clients manifesting severe

emotional and behavioral disturbances. I felt deeply grateful to Nathan for having shared his stories with me as they helped me feel less alone when I found myself struggling with the entanglement of traumatic re-enactment with clients.

Hanna, a White European-American woman in her late 30s and a licensed psychologist, had been in private practice for about five years at the time of the interview and identified as psychodynamic in theoretical orientation. She had previously worked at a prison-based setting, where she experienced the vulnerability specific to working with individuals with psychopathic tendencies. Her experiences of vulnerability with those clients, who used her vulnerability as a weapon, provide a stark contrast to her experiences of vulnerability with many of her current clients, for whom her self-disclosures are powerfully shame-busting. Hanna conveyed an acute awareness of the ways that gender role expectations place female psychotherapists in a double bind of being expected to be accessible, emotional, and nurturing, or else risk being seen as cold-hearted, but also cool, professional, and stoic at the same time, or else risk being seen as not competent or not stable enough. With regards to her relationship with vulnerability, she noted that she struggles with the tension between recognizing on one hand that she could utilize and enjoy feeling more connected and less defended, but on the other hand, it still feels very scary to show up in that way. A particularly memorable moment in our interview was when I asked her when she felt vulnerable as a psychotherapist, she jokingly said, “All the time.” Me too, Hanna.

Results

Table 1

Themes and subordinate themes

No.	Theme	Subordinate theme
1	Defining Vulnerability	Vulnerability as Felt Sense
		Vulnerability is Not One Thing
		Vulnerability as Exposure to the Possibility of Injury

2	Exposure	Nakedness "Impostor Syndrome" Shame: Hiding in Plain Sight Out-of-Role Exposures
3	Space and Proximity	Self-Disclosures as Invitation Versus Imposition Containment Failure of Containment as Grist for the Mill The Space of Supervision and Consultation
4	Power	"Power With": Striving Towards Mutuality Identifying With Their Shame Using Self-Disclosures "A Terrible Responsibility": The Psychotherapist's Power Guilt Emotions in Female Psychotherapists The Title of "Doctor"
5	Being on the Precipice: Facing Uncertainty	
6	Physical Vulnerability	Situations of Heightened Physical Risk Coping With Physical Vulnerability Men's Physical Vulnerability Animality Mortality
7	Hell and Initiation: Vicarious Traumatization and Vicarious Transformation	"Ninth Level of Hell": Vicarious Traumatization "Initiation Into the Darkness of Psychology": Vicarious Transformation

Theme 1: Defining Vulnerability

Vulnerability as Felt Sense.

"Vulnerability," according to the Merriam-Webster dictionary (n.d.-b), is "the capacity to be physically or emotionally wounded." This technical and objective definition – objective in the sense of being impersonal and detached – was not what my participants came up with, however, when asked to define vulnerability. Rather, they used words that reflected their lived experience of being vulnerable as psychotherapists, such as feeling emotionally exposed or undefended, encountering threats to their physical safety, facing uncertainty, and not having answers. Morgan stated, for example,

> I think vulnerability for me is a word that I often think of in synonyms. When I feel weak, I'm feeling vulnerable. When I'm feeling incompetent, I'm feeling vulnerable….

The "feeling" of vulnerability that Morgan and other participants sought to define is not an emotion, but something much more holistic, closer to what Gendlin (1978) termed "felt sense," (p. 53) which he offered as an alternative to the usual translations of the Heideggerian concept *befindlichkeit* as "feeling" or "mood." *Befindlichkeit*, which in German roughly translates as "how-are-you-ness" (Gendlin, 1978, p. 44), refers to how we as humans find ourselves in our situation. Although "feeling" or mood" in colloquial and scientific discourses is often conceptualized as a subjective, emotional, internal state, separate from the "external," "objective" reality, *befindlichkeit* has a "basic unity" that precedes any artificial splitting of internal from external, emotion from cognition, speaking from acting, and self from other (p. 54). Far from being a disembodied reflection that is separate from our living in the world, *befindlichkeit* is the sense that we already have at an intuitive level, of where we are, how things are going for us, and how we are feeling, even before we formulate it in language. It is always already about our being in the world and living with others (Gendlin, pp. 44–51). Similarly, while many of my participants struggled to define vulnerability, they were not trying to think up a definition on the fly but reaching for words that resonated with their embodied experience of vulnerability as psychotherapists. Indeed, several participants shared that they were drawn to the study because the construct of vulnerability spoke to them, showing that they already knew implicitly what vulnerability meant to them. Gendlin noted that there is always already an "understanding" that is embedded in the felt sense, which can be made explicit through the process of "articulation" (p. 62). He wrote,

> This understanding is implicit rather than cognitive. It is sensed or felt, rather than thought – and it may not even be sensed or felt directly with attention. It is not made of separable cognitive units or any definable units. (Gendlin, 1978, p. 45)

Put differently, this pre-existing "understanding" can be thought of as an unarticulated nucleus of meaning that is already implicit in our living in this world, and through thinking

out loud, for example, the layers of meaning can be "lift[ed] out" (p. 52) and differentiated. Articulation is a move towards authenticity, allowing us to discover for ourselves what was once pre-reflectively lived. Articulation is a creative process whereby the speaker is guided by the felt sense, which "knows how to speak and demands just the right words" (p. 52). The felt sense shifts as it is being articulated, allowing a "back and forth movement between statement and feeling" (p. 65). Another quote from Morgan both illustrates the meaning of *befindlichkeit* and demonstrates the process of articulation:

> It's almost like a verb, more than a noun, right? Like I can't, when I reached for the affect, like what is vulnerability? I can't actually find a place, when I think about it in my body. It is almost like a verb, like a thing that's happening … it's something about … choosing to put myself or being thrust into a type of proximity with an other. It is much closer than I would normally allow. … and if I am doing that because I consent to do it, it feels fabulous. And if I'm doing it and I didn't consent to it, or I did accidentally, even if I did it to myself, it feels, terrible. Yeah. I think that's where I'm going to land.

In line with my speculation that participants were pointing to a felt sense of vulnerability, Morgan noted that vulnerability is not an affect. How then shall we situate the relationship between vulnerability and emotion? The renowned "shame and vulnerability" researcher Brené Brown (2012) stated that vulnerability is "the core" and "birthplace" of all emotions and feelings," and hence, "[t]o feel is to be vulnerable" (p. 29), demonstrating that the concept of vulnerability is both deeply connected to and much more foundational than emotions.

Another participant who alluded to this foundational quality of vulnerability, Nathan, described vulnerability as the "deep existential condition of our being," citing the poet David Whyte (2016) who wrote that "vulnerability is the underlying, ever present and abiding

undercurrent of our natural state" (para. 1). This line echoes Brown's (2012) declaration that being alive means inevitably experiencing "uncertainty, risk, and emotional exposure" (pp. 29-34) every day, and the only choice we have is how we engage with our vulnerability. Indeed, the quote from Morgan suggests that vulnerability implies the throwing of ourselves or being thrown into a situation of vulnerability, thus giving the word "vulnerability" a verb-like meaning. If we take this insight and refer back to the Merriam-Webster definition (n.d.-b) of "vulnerable" as "capable of being physically or emotionally wounded," we can think of the capacity to be wounded as not only a passive, receptive state of being subjected to the possibility of woundedness, but also an active living out of that capacity. In dualistic terms, when it comes to vulnerability the person is both the doer and the done-to, and the choice is not between being vulnerable and invulnerable, but between the choices we make about how to comport ourselves towards our inherent vulnerability.

Vulnerability is "Not One Thing."

"Vulnerability is not one thing," Nathan said, echoing other participants' statements that the word covers a wide range of experiences of which the valence ranges from positive, neutral, to negative. It includes situations as relatively innocuous as a safe, calculated self-disclosure with a client that strengthens the therapeutic relationship, and ones as extreme as facing physical danger when intervening with self-harming adolescents. There was a general consensus that the experience of vulnerability is so dependent on the context that it is difficult to have any singular definition of vulnerability. Their experiences corroborate the difficulty I had during my literature review in coming up with a definition of vulnerability that was neither too inclusive nor too restrictive. Unlike my participants, I had at my disposal a formal, tangible definition of vulnerability from Merriam-Webster as the capacity to be physically or emotionally wounded. Even then, in generating search terms for my literature review I found myself needing to go beyond only thinking of words connoting woundedness or the potential

to be wounded, but also brainstorming specific contexts in which a psychotherapist might experience the prospect of woundedness. Indeed, the phenomenon of psychotherapist vulnerability can be alluded to using a wide variety of clinical concepts without ever utilizing the term "vulnerable."

For some participants, the language of "types" of vulnerability best captured the diversity of their experiences of vulnerability as psychotherapists. "Emotional vulnerability," which was discussed in the most depth, pertains to emotionally wounding experiences when doing clinical work. It includes diverse experiences such as the vulnerability of unintentionally or sometimes inevitably inflicting pain on the client, and vulnerability due to uncertainty around how others would react to the revelation of something about the psychotherapist's emotional lives that is not typically presented to others. "Physical vulnerability" comes from the exposure of psychotherapists to physical danger on the job, such as threats, harassment, and assaults. Three participants also touched on vulnerability related to the limits of their expertise, doubts about their competence as psychotherapists, and the dread of being exposed and evaluated by others as truly incompetent. Two participants coined the terms "competence vulnerability" and "incompetency vulnerability." For the purpose of this dissertation I named it "competence-related vulnerability." One participant, Bill, mentioned two unique categories of vulnerability, the first of which is "legal vulnerability" which includes the possibility of being threatened with litigation or official complaints, as well as the challenge of facing antagonism from the opposing counsel when serving as an expert witness. The other category was mentioned but unnamed, and pertained to the inherent vulnerability of being a finite, mortal being who has built a life and career around being a helping professional, and who thus risks experiencing a crisis of identity at retirement and the emotional vulnerability of terminating with clients who still need care.

Vulnerability as Exposure to the Possibility of Injury.

> Vulnerability to me means, um … sort of being undefended, uh, feeling maybe a little bit exposed, um, sort of emotions at the surface … like there's … taking an emotional risk, or being placed in a place that feels emotionally risky perhaps.
>
> – Hanna

> It's not that the threat is always there but the threat could always possibly be there.
>
> – Bill

There were two elements that seemed to underlie all my participants' definitions and classifications of vulnerability. Firstly, vulnerability involves exposure to the possibility of injury to one's body, feelings, or pride. To be exposed, such as through self-disclosure, is to face possible shame, ridicule, and rejection. To practice in an unsecured building with potentially violent patients is to open oneself up to the danger of being physically attacked. To even take up the position of psychotherapist is to risk exposure as a finite being who does not always know what is going on or what to do, particularly in the face of frightened and impressionable patients who want an authority figure who has answers, or in the face of an attorney who wants to discredit the psychotherapist's formulation. Secondly, there is always an element of risk or uncertainty in vulnerability. Every act of throwing oneself or being thrown into a situation of heightened vulnerability involves some measure of risk. While it is possible to estimate the risk and anticipate the outcome, participants noted that the estimate itself may not always be accurate. For example, in letting down one's guard and inviting the client to connect, the psychotherapist cannot be certain that the client will always respond positively, even though they can make their best educated guesses based on their history with their client. With regards to physical vulnerability, Bill, who is quoted above, shared his realization that if he wanted to continue being a psychologist, he had to "be open to the possibility" of physical threats and that there is no way to ensure complete protection.

Summary of Theme 1.

Overall, the definitions that my participants gave of vulnerability were consonant with Brené Brown's (2012) characterization of vulnerability as involving "uncertainty, risk, and emotional exposure" (p. 29), and additionally, also captured the uncertainty, risk, and exposure involved in physical, legal, and competence-related vulnerability. Their definitions converged with Brown's statement that vulnerability is not an emotion but forms the basis of emotions. Based on their process of articulation, I observed that vulnerability is a "felt sense," that is always already lived out in their practice as psychotherapists even before they have stopped to reflect on what it means for them. Moreover, participants described the expansiveness of vulnerability as a construct, emphasizing that it is "not one thing" and that the experience of it changes based on the context. In the process of defining vulnerability their struggles demonstrated the difficulty of pinning it down into an exact definition that does justice to the experiential resonance and deeply intuitive nature of the construct.

Theme 2: Exposure

Exposure featured prominently in participants' description of their experiences of emotional vulnerability and competence-related vulnerability, both of which involve putting themselves or being put "out there," being seen, and risking evaluative responses. The language that my participants used, however, suggested some subtle differences in the experience of exposure in emotional versus competence-related vulnerability. Specifically, the exposure in emotional vulnerability is experienced at a much more embodied level as a feeling of being "naked" or varying levels of "undressed," such that what is "inside" or "underneath" their everyday presentation is rendered visible. While exposure in competence-related vulnerability also consisted of a sense of being revealed, that is, as "incompetent," it does not involve a sense of being undressed. Additionally, there was an overlapping subordinate theme in both types of exposure – shame – which was related to the anticipation

of responses from others who have witnessed the psychotherapist in a state of exposure. Lastly, there was a subordinate theme concerning the revelation of details about the person of psychotherapist that is separate from the role.

Nakedness.

Nakedness presented as a powerful metaphor with regards to emotional vulnerability, as it has much emotional resonance and implications for the therapeutic situation. Participants' use of phrases such as "emotional nakedness," "peeling it back," "undressed," "stripped," points to the fact that in emotional exposure, there is a change from a default state of being metaphorically dressed up and hidden to being unclothed and visible. On the flipside, participants also revealed their experiences of dressing up their emotional experiences to ward off vulnerability. Hanna, who shared her personal propensity towards "masking" her emotions for fear of being perceived as unstable or unprofessional, recalled a moment when her colleague was stunned to hear her talk about how anxious she felt about the outcome of a project she was heading, and asked her quite innocently, "You get anxious?" She remembered feeling quite disturbed and concerned that she came across as "stone cold," and learned from that experience to counteract that tendency towards masking her emotions by making an effort to verbally and openly share her emotions with others, rather than assuming that they are able to read her.

Hanna's example shows that experiences of emotional exposure may result both from verbal self-disclosure and also nonverbal demonstration of emotional reactions, some of which may be unintentional and feel particularly risky to share. Of the latter, participants mentioned exposures ranging from the subtle, such as "a shift in nonverbals" that betray the psychotherapist's internal experience of personal memories, thoughts, or feelings, to the more obvious, such as a look of irritation, or the more extreme, such as visibly dissociating. Additionally, during verbal self-disclosures, the exposure may be more about the nonverbal

component than the actual information. Because there is no guarantee as to how the other person would respond to exposure, even a simple self-disclosure can be fraught with fear of the risk. Describing a moment when she inadvertently revealed her age while sharing with a client that she had been "in a process of healing for over a decade," Naomi stated that it was not the content of the disclosure that felt risky to reveal necessarily, but the experience of being witnessed in her fear. She narrated:

> I would share but then not kinda meet the eyes with the other people … due to the fear of what's the response going to be like, or even to minimize how seen I felt in that moment. … It wasn't about the content because of course I was sharing that verbally with them … maybe it was more about emotions. So like if they saw my eyes in that moment and maybe they would see like … the fear that I was feeling in that moment of like taking my… taking a risk.

She clarified that even though the client may have been able to deduce some of the information given through the self-disclosure, such as her age, or be able to imagine that she has had difficult life experiences from which she is healing, it feels different from the act of "speak[ing] [her] own words around that experience" "out loud" and "naming" herself as someone in the process of healing.

Exposure also involves different degrees of emotional vulnerability depending on the material disclosed, the amount of safety and trust in the relationship, and the reactions of the clients. Apropos to the metaphor of emotional exposure as nakedness, while "peeling it back" is voluntary, being "stripped of [one's] defenses" depicts violation of consent and agency. Morgan remarked that there is a parallel between the vulnerability of an unwanted, involuntary revelation of information with the vulnerability of a sexual assault, in that both are deeply damaging as the result being forcibly stripped of self-protection and being compelled to be vulnerable in a way that was not consented to. For instance, Hanna had a

male client who sent her a series of angry emails, including put-downs along the lines of "it was embarrassing to see how nervous you were in the room," zeroing on her emotional display and "weaponizing" it to make her feel seen in a painfully exposed way.

On the other hand, when the exposure is voluntary and desired, the experience of that exposure is positive. Discussing their personal relationship with vulnerability, Morgan shared that outside of the professional world, they enjoy "whipping" their vulnerability "out all over the place" for the thrill of anticipating the other person's response, "like, what's it going to be?" Once again, the metaphor of undressing is quite apt and paints the image of Morgan experimenting with playful, bold, and adventurous exposure, bordering on a metaphorical form of flashing. Morgan further opined that sometimes therapists and clients almost enjoy the back-and-forth, push-and-pull in trying to have the therapist unmasked, as it is a "fun power play for [them] sometimes to not reveal and be this hidden figure."

The language of undressing and nakedness dovetailed with Brown's (2012) finding in one of her studies that when she asked her participants to complete the sentence stem "Vulnerability is …," the most frequently occurring response was about being "naked" – being naked "when everyone else is fully clothed" and dreams of being naked in public places (p. 31). Brown (2012) further expounded on how the fear of nakedness leads people to metaphorically don "masks and armor" (p. 73), that is, self-protective strategies to ward off uncomfortable feelings related to the emotional vulnerability of showing others the unedited, unembellished version of ourselves, or what she called the "kitchen table self" (p. 32). Putting on armor, metaphorically, may help us feel safer, but we will get tired of hauling around its weight, feel stifled, and hungry to be known by others (p. 73). When we have worn masks and armor long enough, they begin to "mold to our shape" and become "ultimately undetectable, … like a second skin" (Brown, p. 73). Wearing these masks get in the way of

connection, because ultimately what we crave is to be accepted and loved even when we show those parts of ourselves that we regard as defective, bad, or shameful.

In speaking of masks, Brown (2012) alluded to the Greek word "persona" which means "stage mask," which has been used in Jungian psychology to refer to the socially appropriate presentation of ourselves. The persona is the most superficial and consciously constructed layer of our personality, developed through a process whereby "desired attributes [are] emphasized and undesirable ones [are] discarded" (Page, 1999, pp. 19-20). In the context of learning the craft of psychotherapy, the creation of this psychotherapist persona takes place most apparently early in training, as individuals learn to contain personal characteristics and self-expressiveness that may get in the way of creating a safe space for clients to bring in and process what is important to them. When the persona is artfully breached, it can be clinically beneficial. For example, a few participants brought up the act of self-disclosure, which, in Naomi's words, presents "more humanness" of herself, rather than "this therapist who is sort of separate and apart" from her. Additionally, in order to be effective, the self-disclosure has to involve some depthful information about the psychotherapist; given that psychotherapists often ask patients to be deeply vulnerable, "superficial only" self-disclosure is insufficient to help foster feelings of safety.

Hanna's reflection on her self-consciousness and inner dialogue when clients stumble across her public music performances also exemplifies the way in which the psychotherapist role functions in part as a persona. In those moments she finds herself worrying about how she comes across and even whether her "funny outfit" makes her look "unprofessional" and not serious enough. Indeed, a source of emotional vulnerability for psychotherapists concerns their identification with the role of the healer (Shabad, 2017, p. 360), which makes it feel risky to shed that professional second skin to allow themselves to be seen in another capacity. Like all human beings, psychotherapists have narcissistic needs and vulnerabilities. They are

not exempt from desiring affirmation and acceptance and not immune from the terror that they will be exposed as not good enough and judged as unlovable. Some psychoanalytic authors have hypothesized that psychotherapists try to resolve the struggle between their longing to be seen and known by others and the fear of exposure and closeness by choosing a profession where they can experience interpersonal intimacy while remaining mostly hidden, anonymous, and protected by the frame and boundaries of psychotherapy (Greenson, 1967, p. 400; Kuchuck, 2014, p. xix; McWilliams, 2011, pp. 285-286). Moments of unexpected exposure like Hanna's shine light on this.

In a sense, the role of the psychotherapist itself serves as an attire that both conceals and amplifies self-expression. Page (1999) compared taking on the role of being a counselor[7] to "donning the suit of clothes" (p. 6): there is a wide variety of styles from which to choose, and that choice will be dictated by conscious and unconscious predilections. Moreover, while the person's appearance is changed by the clothes they wear, "the attire will appear differently on each individual" (p. 6). Similarly, the subjectivity of the counselor in terms of their "unique emotional, physical, psychological, social and spiritual" makeup, affects how they take on the role of counselor, and in turn, the "purposes, qualities and attributes" that make up the role of counseling also shape who the counselor is as a person, particularly when they are acting in that role (p. 6). Even though the persona on its own is not ultimately sufficient for deep therapeutic action, Page (1999) cautioned us against devaluing the falsity of the persona, reminding us that it protects the client from harm and exploitation by the psychotherapist, and also "protects the vulnerability of the therapist from undue exposure" (pp. 19-20). Here, the metaphor of nakedness appears to be an especially apt one because it also indicates that while being emotionally exposed is desirable for authentic connection, it is contraindicated to be exposed all the time, in the same way that public nudity is prohibited

[7] Page (1999) used the terms counselor, therapist, and psychotherapist interchangeably.

except in rare circumstances. One participant, Naomi, emphasized the importance of prudence and discernment in making sure that a move towards greater exposure is "clinically indicated."

Beyond dressing up and masking, armoring up suggest a much more guarded presentation. There are important distinctions between masking up, armoring, and simply wearing clothes. While wearing clothes is socially appropriate, and it might make sense to don a stage mask when performing, it is typically not necessary to put on armor. In the therapeutic situation, while it is judicious to practice some degree of emotional restraint in the role of being a psychotherapist, it is neither necessary nor beneficial to be excessively opaque and inscrutable. Indeed, as we will see in greater detail in the themes to follow, a desire to foster safety by rendering oneself more visible and accessible is a primary motivation for my participants' decisions to self-disclose to their clients when they sense that their clients might be feeling exposed and shameful. As several authors have observed, a person who is rigidly obsessional, self-contained, and compulsively defended is not suited to the profession as they cannot allow themselves to be vulnerable enough to be accessible in a way that is crucial for forming connections with clients (Gilbert et al., 1989, cited in Page, 1999, p. 10; Greenson, 1967, p. 16).

In my literature review I noted that Brown's (2012) language about armor is reminiscent of Wilheim Reich's concept of the character armor (cited in Samsel, n.d.), which can be understood nowadays as a phenomenon whereby the autonomic nervous system takes on the work of emotional defending through tensile and alignment changes in musculature and posture. In contrast, more conscious defenses involve the skeletal nervous system and hence are available for voluntary control. Considering Page's (1999) reminder that the persona of the psychotherapist serves useful functions for keeping undesirable self-expressiveness in check, while it may not ideal for the psychotherapist to be armored, there

are moments when the psychotherapist might mask their reactions. One participant Hanna, found herself fumbling for words to describe this masking process because it happens to her so automatically. While sitting with a client who frequently went on extended misogynistic diatribes and ruthlessly attacked communities in his language, Hanna felt her discomfort "rising up to the surface a lot," and was concerned about revealing her feelings of hurt and anger at the client before he had the resilience to process it therapeutically. Hence, she chose to follow her body's lead in choosing to "go a little bit father into [her]self" and reducing emotional availability through feeling the "insides and outsides" of her body with "different types of hardness," as though her body had gone through "an alchemy of sorts." Said differently, she put up "an invisible barrier where [she was] still feeling things very intensely, but not necessarily just demonstrating or displaying them." She reasoned that while emotional withdrawal did not facilitate the therapeutic relationship, it protected it in the long run by preventing the untimely intrusion of her own emotional experience into the relationship before the client was ready to hear about it.

"Impostor Syndrome."

Several participants spoke to their dread of looking incompetent or blissfully ignorant in front of clients, peers, or supervisors. Even in settings where the expectation is to air one's ignorance and open oneself up to receiving other people's perspectives and expertise, the fear of being judged as incompetent can be a great barrier to honest communication about clinical difficulties. A seasoned practitioner who has many years of not only clinical work but also teaching and supervision under her belt, Rachel shared that she still finds it incredibly difficult at times to reveal things about which she feels unsure. Her own experience has helped her empathize with the vulnerability of her colleagues who bring up their own clinical conundrums during case consultations, particularly when they hook into personal, historical vulnerabilities. She explained that even though the whole point of consultations is to share

"things that you don't think you're a hundred percent great at," one may still fear losing the respect of other colleagues. She further explained that doubts about one's competence can be intensified in peer consultation groups by negative self-comparison.

Additionally, moments when participants recognized the seriousness of their work also precipitated thoughts and feelings of being fraudulent. Hanna recalled a moment in graduate school when she was in a meeting and a professor had mentioned that in a few weeks, the students were all going to get their first clients, the feeling of "Wait, I am not ready for this," came up for her. She reflected that even nowadays when she feels a demand for something that is outside of her skillset or range of competencies, the old feeling back in the day of not being ready can get pulled up. For example, when she was transitioning from being in a postdoctoral program to private practice, for the first time in her career she saw "cold hard cash" from self-pay clients and hence felt the pressure to produce results faster than was possible. She also often questioned the value of her work. Her encounter with visible money had brought up self-doubts about the value of what she was offering and rekindled historical challenges with money. McWilliams (2004) noted that many psychotherapists struggle to demand reasonable compensation for their work because they feel like they are "just sitting there trying to understand" (p. 175). Early career psychotherapists in particular tend to underestimate the value of their work and fear that asking for payment will create a "misleading impression that they know what they are doing" (p. 174). McWilliams remarked that it reflects the propensity of "contemporary Western cultures … to undervalue activities that are receptive rather than based on doing, producing, manufacturing, achieving, and so on" (p. 175).

The dread of exposure that these participants described was very similar to the impostor phenomenon or impostor syndrome that Clance and Imes (1978) defined. In the original definition of the impostor phenomenon, a highly intelligent, capable individual is

unable to internalize their achievements and other objective markers of success, attributes their accomplishments to luck or other external factors, and dreads being found out as fraudulent or, in other words, as an impostor who "pretends to be bright but who really [is] not" (p. 3). This dread seems to be further amplified during instances when they have shown visible effort and investment in the work or appeared confident about a positive outcome. Morgan, who was the participant who referred to the impostor syndrome, shared that their response to the impostor syndrome was to "low-ball": they would procrastinate and set themselves up to complete a task against giant odds, in order to protect the ability to attribute failures to the circumstances and success to their competence. Specifically, if they did not do as well as they wanted, they could chalk it up to not having had enough time and not putting in enough effort, but if they did well, they would feel exhilarated about having succeeded despite putting in so little effort and time. Hence, when Morgan found themselves overwhelmed and retraumatized by their work with a severely disturbed client with psychosis they had advocated to keep in outpatient care, they found it too difficult to be honest about that with their supervisors. They relayed:

> Like, hey this thing I advocated for really hard, and put all this work into, I can't do it. And you know that there's the incompetency vulnerability, right? Having to admit that it actually is way too much for me. I cannot handle it and it's kind of fucking me up.

Morgan's candid reflection highlighted a crucial component of vulnerability that is well-captured by Brown's (2012) observation that truly showing up for the challenge, letting ourselves be witnessed in our struggle, hardships, and mistakes, and risking the criticisms of harsh, cynical spectators, is an immensely vulnerable act. Indeed, the pretense of playing it "cool" and indifferent is a classic mask that individuals may don to hide how much they care about the outcome of something they are invested in. From Clance and Imes' (1978) perspective, Morgan was using "cover-up strategies," which are ways to appear not invested

or effortful, which may also be used in conjunction with actual hard work to put up an appearance of "perfection with ease" (pp. 3-4). Furthermore, as mentioned earlier, this vulnerability is intensified when one presents as confident. Hanna noted, for example, that while she is fearful of coming across as incompetent, she has historically also been "way more scared of looking overconfident or narcissistic."

Of note, the participants who talked most extensively about their fear of appearing incompetent were either female or nonbinary identified, while the male participants were comparatively less focused on the fear of exposure as incompetent, and much more focused on grappling with the boundaries of their expertise and their human limitations. This result may have been a function of a small sample that had only two men out of six participants, and I do not doubt that there are male-identified clinicians who struggle with impostor syndrome. Nonetheless, this pattern in my data seems to be consistent with Clance and Imes' (1978) observation that impostor syndrome might affect women much more frequently and intensely than men. Clance and Imes believed that this phenomenon is due to differences in attribution styles among men and women in general – women tend to attribute their successes to chance and failures to their own inadequacies, while men generally have the opposite attribution style (p. 2). Additionally, they posited, a poor self-concept is syntonic with the "societal view that women are not defined as being competent," which, if they dared to challenge, would necessitate a daunting challenge of "go[ing] against the views perpetuated by a whole society" (p. 4). Successful women who dare to demonstrate self-confidence risk societal rejection in a culture where they are perceived, in Mead's (1949) words, as "a hostile and destructive force within society" (cited in Clance & Imes, p. 5).

Shame: Hiding in Plain Sight.

> Shame is the intensely painful feeling or experience of believing that we are flawed and therefore unworthy of love and belonging. (Brown, 2012, p. 47)

The notion of emotional exposure as nakedness indicates a vulnerability to shame: "bodily nakedness" has been linked for millennia to shame (Jacoby, 2002, pp. 9-15). More interestingly, even though shame was alluded to many times in the interviews, such as when participants talked about their fear of being exposed as incompetent, their gaze aversion when feeling exposed, or their feeling "awful" when stripped of their defenses, only one participant named the emotions of shame and embarrassment during certain moments of exposure. Elsewhere, shame was almost missing from the discussion, except in the context of using self-disclosure as an intervention to reduce clients' shame – and even then, it was focused on the client's, not the psychotherapist's shame! Here, ironically perhaps, my own anxiety about singling out the one participant who spoke about her shame prevents me from even naming her, despite the fact that it is a pseudonym. The way in which shame hid in plain sight, between the lines of my participants' narratives, and yet escaped being named, reminds me of a joke I once heard, that researchers took a really long time to discover the emotion of shame, because it has been hiding behind other emotions.

To be clear, not all instances of exposure were occasions for shame. In my participants' words, the emotional nakedness of "peeling it back" or voluntarily having one's "guard down and exposed" is vastly different from the shame of being "stripped." One participant in Brown's (2012) vulnerability research stated that being vulnerable "is like being naked onstage and hoping for applause rather than laughter" (p. 31). When one's nakedness invites applause, that is, acceptance and affirmation, the experience of exposure is positive, whereas when it is followed by ridicule, criticism, or rejection, it entails shame. Furthermore, Morgan's and Hanna's remarks about the vulnerability of being exposed as incompetent, particularly when they had appeared visibly effortful or confident in their work, point to the fact that the experience of being witnessed in taking visible action inevitably comes along with the possibility of shame. As McWilliams (2011) wrote, "a vulnerability to

shame comes with the territory of taking deliberate action that can be seen by others" (p. 412). Further substantiating this link, Jacoby (2002) remarked that while failures in events such as examinations may give rise to shame, it is failing during public performances or other events where we "seek them out … to expose ourselves" that evoke the most shame. He wrote:

> Discussion group leaders, givers of toasts, actors, musicians, lecturers all subject themselves to the expectation that they have something to offer that is worth the public's hearing or seeing. When they fail, their disgrace is compounded by the embarrassment of having their high opinion of themselves revealed for all to see. (p. 5)

He further wrote that the inhibited, shame-avoidant person is "afraid of laying oneself open, standing out in the crowd, taking initiative, since these actions risk revealing one's ignorance and incurring a loss of self-respect and the esteem of others" (p.6).

"Out-of-Role" Exposures

This subordinate theme concerns the exposures of information about the person of the psychotherapist separate from the therapeutic role. Such information may include private details such as where they live, their marital status, whether they have children, what they do when they are not seeing clients, and so on. "Out-of-role" exposures are not just about the content of the exposure, but also the absence of intent and choice. For example, while a piece of biographical information that has nothing to do with the psychotherapist's role may be disclosed with the intent of being therapeutic, in "out-of-role" exposures, the psychotherapist often does not even have a choice as to whether that information is revealed.

Regardless of the outcome of the exposure, there is an element of vulnerability that comes with the recognition that the psychotherapist never has complete control over what private information gets revealed to clients. No matter how carefully psychotherapists guard

their personal information, details about them can be obtained intentionally or inadvertently by clients through the grapevine, social media, public records, or simply through unplanned encounters outside of the therapy office (McWilliams, 2004, pp. 240-243, pp. 259-261). When Hanna was an intern at a forensic hospital, despite her own best attempts at preserving her anonymity, a group co-facilitator casually told their mutual client that Hanna and the client were from the same hometown. In this case, the impact of the exposure was negative because the client ultimately used the information to intimidate Hanna. However, even in the absence of adverse outcomes for the psychotherapist or negative impact on the psychotherapy, there is still a sense of vulnerability in not being able to control clients' access to information. For example, Hanna shared even though she was "never doing anything outrageous" when her clients stumbled across her performing music, the experience of "being seen without having the opportunity to step into the role that [she] was understood to be with that person" remained surprisingly startling for her. McWilliams (2004) described running into clients outside of work as "a source of significant unacknowledged stress for psychotherapists" (p. 240) because it violates the psychotherapist's expectation of having that personal space where they can set aside their psychotherapist persona and not exercise as much self-restraint. She noted that to the client, the psychotherapist is "never really 'out of role'." Thus, they find themselves having to be thoughtful about how they carry themselves around the client during those unplanned encounters and how they process those encounters with their clients.

Summary of Theme 2.

Exposure appeared to be a huge component of experiences of vulnerability among psychotherapists. Their language conveyed that emotional exposure feels a lot like nakedness; when it is voluntary, it is like undressing and revealing one's true self, whereas when it is involuntary, it is like being stripped. With regards to the dread exposure of oneself

as incompetent, participants shared that it is much worse when they have shown visible effort or confidence. While it is not associated with feeling naked, it has a quality of being revealed as an "impostor." Additionally, just as nakedness can be experienced with shame, exposure can bring feelings of shame, even though it was not directly named by most participants. Finally, I described the experience of out-of-role exposures and the unique stress it brings.

Theme 3: Space and Proximity

> It's a lot of what we do in therapy, creating the holding space for clients.
>
> – Naomi

> Vulnerability … it is about choosing to put myself or being thrust into a type of proximity with an other. It is much closer than I would normally allow.
>
> – Morgan

In the previous theme, the exposure of the psychotherapist was described as revelatory of the self of the psychotherapist. Following that revelation is the theme of proximity and space in the therapeutic relationship, because the more exposed the psychotherapist, the more available they are for a deeper human-to-human connection with the client. At the same time, the risk of centering the psychotherapist's subjectivity becomes more salient. Participants were acutely aware of the potential for harm to the client or themselves when in the effort to create intimacy they fail to consider giving the client or themselves space. At the same time, participants discussed the importance of having a strong enough of a presence in the room as a vulnerable fellow human being to foster safety in the relationship. The process of deciding whether or not to make a verbal self-disclosure, which Nathan characterized as a "classic, textbook" example of a "clinical use of the therapist's vulnerability," provided a striking example of this dialectic of being inviting without being imposing. Some participants also brought up the topic of nonverbal self-disclosures, which can also unwittingly have the effect of being disinviting, intrusive, or even wounding. In

relation to that, participants discussed the act of containment – not only of their clients' strong emotions, but also their own evoked by things that the clients say or do. All in all, this theme addresses the dialectic of space and intimacy – the intimacy necessary to create space, and the space necessary to create intimacy in the therapeutic relationship.

Self-Disclosures as Invitation Versus Imposition.

Several participants considered verbal self-disclosure a powerful intervention that can increase client's sense of safety, but only when well-timed, well-planned, and well-calibrated. Morgan shared that if they self-disclose when the client is verging on being vulnerable, it opens the "floodgates" of the client's vulnerability and deepens the connection between the client and psychotherapist. Nathan described it in a light-hearted tone as "more of like what I feel like I signed up for when I became a therapist … you know, like, 'I'll cry, you'll cry, you know, we'll have a good cry, it'll be all right.'" On the other hand, when clients were not ready for a psychotherapist's self-disclosure, particularly of the psychotherapist's deep personal vulnerability, it could become an imposition that makes it more difficult for clients to feel free to take up space.

To avoid overwhelming clients, participants make the decision to self-disclose based on some level of case conceptualization, using information they already know about the client to predict how the client would respond. Naomi stated that while it can be helpful to process a rupture when a self-disclosure backfires, the intent is not to create a rupture, but to "show up" in a vulnerable way that encourages the client to be more vulnerable. Morgan shared an example of a self-disclosure that backfired, which taught them the importance of knowing a client well enough to gauge their ability to tolerate the psychotherapist's vulnerability. Specifically, Morgan disclosed early on in their work with a chronically suicidal client, that when they were much younger, they too struggled with suicidality. Their aim was to normalize the client's experience, but much to their dismay, the client started bawling

uncontrollably, convinced that she was going to end up making Morgan kill themselves. She was someone with a "very dispersed, very little sense of self" and harbored a deep emotional conviction that she was "bad" and "too much," and would in fact act so cruelly and sadistically towards her previous therapists that she had been fired many times, confirming her view of herself as toxic. Rather than processing Morgan's self-disclosure as a hopeful message that she too could heal from her own suicidality, the client viewed Morgan's past struggle as indicating a fatal weakness that meant they would not be able to survive her too-muchness. The experience of this self-disclosure as an imposition rather than an invitation was conveyed in Morgan's narrative that they felt like their "vulnerability had hurt someone."

In addition to verbal self-disclosures, nonverbal self-disclosures can also have the same effect of being either inviting or imposing. Bill shared that he avoids displaying anything in his office that is highly personal, such as pictures of his wife and children, because it "invites boundary incursions" for many patients who may "feel compelled to ask questions." Similarly, he does not share his political affiliation or leanings, allowing patients to project their own desires, wishes, and preferences onto him. From his perspective, letting patients have such personal information may have the effect of inducing them to become cautious about what they say for fear of hurting the psychotherapist's feelings. He stated:

> People, you know, … they don't want to get into an argument. They don't want to feel rejected, cause I'm gonna say like you know, I don't like your crypto-fascist ramblings, or like, your leftist Pinko ramblings. You know, you want to create the maximal space for them to be comfortable with whatever they're bringing in.

What the participants have highlighted here is the importance of giving space for the unfolding of the client's internal world. As intersubjective theorists have noted, while some clients may at least occasionally welcome the mutuality of vulnerability in the therapeutic relationship, there are also others who are not ready to witness the therapist's

separate subjectivity and experience it as an impingement (Benjamin, 1998, cited in Kuchuck, 2014). The need for space harkens back to Winnicott (1958), who stated that the development of the capacity to rest in one's solitude hinges on having internalized the experience of being alone while in the non-intrusive presence of the parent, or later, the analyst. Without having been held in the caring presence of another, and hence, lacking in internalized good objects, so to speak, individuals experience not a benign intersubjective space, but a dreadful void in which they do not exist and from which they must escape. Benjamin (1998, cited in Kuchuck, 2014) added it is the capacity to be with others and still know who one is without becoming submerged and overwhelmed by others' subjectivities.

Put differently, it is an intersubjective space that allows for self-other, subject-object differentiation, or in other words, the "third" that mediates between the dyad (Benjamin, 1990, pp. 196-197). If we recall Morgan's client's panicked reactions to their self-disclosure about past suicidality, the client experienced the self-disclosure as an impingement, because there was no sense for her of an intersubjective space that could help her differentiate the real Morgan from the Morgan of her fantasy who could be driven to suicide by her omnipotent badness. Notably, this same self-disclosure could have gone over very well for another client, as it did many times for Morgan's other clients. It substantiates the participants' observation that it is important to have some level of case conceptualization in order to self-disclose effectively and judiciously. The importance of case conceptualization and self-awareness when determining whether or not to self-disclose is backed up by findings from a qualitative study by Pinto-Coelho and colleagues (2018) which examined successful versus unsuccessful self-disclosures in 13 seasoned practitioners. Participants generally opined that successful disclosures involved sharing of experiences that were similar to those of the client's and felt relevant to the client at the time. On the other hand, unsuccessful self-

disclosures involved disclosures motivated by unexamined countertransference reactions and disclosures made when the psychotherapist was feeling overly vulnerable.

The psychotherapist's awareness of the potential for self-disclosures to be either inviting or imposing was further demonstrated in the different decisions that Rachel and Nathan made with regards to self-disclosure shortly after the 2018 shooting at the Tree of Life synagogue in Pittsburgh. Known to some of her clients as an active member of the Pittsburgh Jewish community, Rachel found herself navigating clients' questions about her wellbeing. After determining that more in-depth self-disclosure would not likely be for the benefit of the client, she made an intentional effort to share only in generality that she was "struggling, like everyone else" and promptly returned the focus back to the client. She explained that in her experience the underlying concern in these questions is the fear that their therapist will be too impaired to help them - an observation that lines up with Morgan's experience with their client who feared that they would become too impaired to help her. On the other hand, Nathan, whose clients for the most part were not aware of his Jewish identity, decided to disclose his Jewish identity with a client who had been spent the whole session raging about the massacre. Nathan recalled telling the client that he had debated on whether or not to disclose to the client that it had meant a tremendous amount to Nathan personally as a Jewish person to hear how enraged the client was. As he was sharing his feelings he began to tear up, at which point the client too began started to tear up, which was out of character for him. This self-disclosure invited the client to further open up about how much Nathan meant to him. Whereas in Rachel's example, she held back from disclosure of personal feelings to prevent her already empathically attuned clients from making their therapy sessions about Rachel, Nathan found the occasion to reach out in a deeply human way to the client, which facilitated a moment of mutual appreciation and recognition.

Containment.

At times what the client brings to the psychotherapist may be so personally triggering or emotionally upsetting that the psychotherapist may feel pulled to say or do something that is not therapeutic, or to show emotional reactions that might be disturbing to the client. Containment, defined as "the act, process, or means of keeping something within limits," (Merriam-Webster, n.d.-a) is a skill that, as Naomi noted, psychotherapists practice over and over again so that they can continue to "hold space" for their clients in those moments.

As mentioned in the theme of exposure, Hanna found herself trying to mask her emotional reactions with a misogynistic client. She explained the conceptualization that went into this purposeful withdrawal of emotional availability, stating that this client is extremely attuned to "little tiny micro movements" that she might not even have time to process, and at this stage in their therapy, it would not be therapeutically beneficial to show that she is offended or hurt as it would more likely risk centering her in the therapy. At the same time, she reported wondering whether she had the ethical responsibility to expand a client's narrow worldview or address a problematic value system. In terms of the act of containment, she relayed that when she feels emotionally reactive to his words she finds herself "very purposefully almost freezing [her] face and the body" to prevent the client from being able to pick up on changes in her nonverbal presence, maintaining a highly considered, neutral appearance.

Additionally, Hanna's language about feeling the "insides and outsides" of her body with different hardness suggests that containment involves muscular tension and the use of the body as the container. Indeed, we may recall that implicit in the metaphor of undressing is a spatial duality: what is "inside," "underneath," or "depth" is hidden and therefore safe from scrutiny, whereas what is "outside" and on the surface is visible and thus available for judgment. Participants spoke about emotions arising from the depths to the surface, or of

"opening up," which suggests that being vulnerable is to allow something that is usually hidden in the depths to surface and become exposed to others, or to invite someone to witness what is inside or underneath. For Naomi, her core is the locus of the "self" where her emotions and other depthful personal experiences are felt. She explained that her body is the "container" for these depths of herself, for her vulnerability, in contrast to the limbs that are the further removed "extremities." When the material that the client brings in "triggers [her] to come into contact with and reflect on something that is painful" for her personally, she would then have to both manage the pain that has come up internally and work to be present with the client in that space. She further shared that when she experiences heightened vulnerability in a session, the sensations of anxiety take place in her core in the form of shallow breathing, warmth, increased heart rate, and trembling. This is particularly true, she noted, of personal material about which she harbors intense feelings due to self-judgments.

Because containment takes energy, it could be challenging to do so when fatigued. Naomi stated that when depleted, she experiences doubts about what she can "take in." Bill remarked that when his supply of energy or willpower is low, there are limits to relying on one's cognitive powers and will:

> There are times where on an intellectual basis I can appreciate what's happening and I can create a plan, but that's where it is like, especially if your willpower supply's low or if you're vulnerable, or if the hits just keep on coming, you can wind up experiencing vulnerability that you weren't even aware of.

Furthermore, containment requires an ability to consciously recognize one's own and the client's boundaries. Morgan shared for instance that as someone who had experienced a lot of childhood trauma they had developed "an intuitive sense of boundaries" that allows them to instantaneously numb any feeling and stop experiencing any vulnerability. In their words, "the walls just slam up," and the feelings are "dry, evaporated." As such they have

found it challenging to learn to help their sobbing, intensely distressed clients to "dam it back up" at the end of sessions.

When physical containment at the core is not sufficient to reign in the reactions, participants resorted to using their mental resources to dampen their emotional reactivity. Naomi noted that she gives herself an acknowledgment of what she is feeling in that moment and tries to put limits around how much access she has to the material in that moment, by "creating some kind of internal distance" from it, "moving away," or "moving [her] thoughts elsewhere." The most extreme of this attempt at containment is perhaps dissociation, a reaction that Morgan reported experiencing at times when client behaviors trigger a trauma response due to their personal history of complex trauma. Morgan recalled during one of those instances that they were "glass-eyed, like glazed over staring at the floor for five minutes solid," "probably a little bit up here" (pointing to the ceiling), "or definitely was somewhere, not here." They added that dissociating is an act over which they sometimes lack control or choice, indicating the limits of containment in the case of extreme emotional vulnerability. On a less extreme end, the psychotherapist may intentionally limit their awareness of the affect conveyed by the client's words in order to prevent themselves from becoming saturated with the negative affect. For instance, Hanna shifted her attention to the client's language rather than the emotional undertones in order to contain the feelings that come up for her when the client put down women verbally. She explained that she became "very mindful of listening very carefully to the words" and "hearing it as language" rather than also taking in the "emotional register" along with the words.

In addition to establishing some internal distance from the upsetting material, psychotherapists also use self-talk to contain their emotional reactions and keep their attention focused on being effective and present with the client. Situations that were particularly challenging for participants included having to maintain a therapeutic stance in

the face of circumstances that are dangerous for the client and/or other people in the client's lives. They may experience an overpowering wish to "save" the client from the situation and hence intervene in ways that were less likely to be effective. For example, Rachel reminds herself to maintain a professional stance when hearing horrific stories of domestic violence. She shared that over the years she has learned to "stay in the room" and let the client "be in the driver's seat," while managing the anxious monologue going on in her head, which she narrated in a whimsically high-pitched tone,

> When the back half of my brain is going, 'oh my god, oh my god, oh my god, oh my god, he's going to really hurt her,' um, and figure out how to take that conversation in the back of my head and translate that out of my mouth and do something that would you know, will be helpful.

She explained that the client typically has conflicting priorities and desires that prevent them from leaving the abusive relationship, not to mention that leaving such a relationship without a well-thought-out plan increases the risk of their being murdered by the abusive partner. Inhibiting the urge to "jump in" and rescue the client creates the space for the client to explore their thoughts and feelings without judgment, and paradoxically, helps them gather the resolve and think through a viable plan to leave the relationship safely. In this way, the desire to leave is coming from the client, rather than from the psychotherapist.

Other participants also echoed the importance of slowing down and inhibiting reflexive responses to avoid making a costly mistake whether in psychotherapy or in deposition. Bill shared that he has formulated a "three-second rule" for himself such that even when he is answering yes-no questions, he gives himself time, even if not exactly three seconds, to consider the response and speak reflectively. He explained that in addition to making sure that he is not saying something that cannot be taken back, the degree of forethought and control "helps to minimize the sense that things are spinning out of control."

Having served as an expert witness many times, he has learned the ways that attorneys on the opposing council may exploit a psychotherapist's emotional vulnerability to bullying, threatening, or even "seducing" them:

> like, 'Oh, you're so smart! That's such a brilliant insight!' And they hope that you then have, you know, diarrhea of the mouth if you go on and on because it's when you say things in that unchecked way that sometimes you'll slip something in that you go like, no, I shouldn't have said that. And then, then you're stuck. It's like, well, how do I walk that back without sounding like a complete idiot, without sounding like everything that I said should now be put into question.

The notion of slowing down and thinking critically also points to intellectualization through theoretical conceptualization as another form of containment. It takes place not only on an individual level – it is also done collectively as a discipline for practitioners to organize a lot of information into a coherent narrative and allow them to maintain a therapeutic stance. Hanna, who joked self-deprecatingly that Nancy McWilliams needed to get half of her co-pays for how much she continues to reference McWilliams' work[8], attested to the usefulness of going back to the literature and books to help her "draw back in" and "get [her] bearings." Nathan shared that at the residential facility he worked at, he and his colleagues conceptualized their practice as "attachment-based, as deeply relational" work with children who had attachment trauma. He explained that it was necessary to "slap some clinical jargon onto it" to justify and document their practices to state stakeholders, but in addition it, helped to create order and some kind of emotional distance from the intensity of the work. The cynicism with which Nathan described the clinical language during the interview also demonstrated the detachment he felt towards it:

[8] Me too, Hanna.

> I was like, yeah, well we're, we're doing, uh, you know, we're doing relational therapy for reactive attachment disorder, uh … super imposed, comorbid with, you know, um, psychotic, this and that like those, you know, like just like list, diagnostic bullshit.

It was deeply unsatisfying because even if it provided some semblance of logic and order, it barely did justice to the wild, uncontained, and traumatizing impact of the work. Nathan particularly detested the language of "treatment," which he described as "cold," "clinical," and "detached," invoking the sense of being an observer. He lamented, "It didn't fucking feel like treatment – it felt like I am afraid right now!" His commentary on the staff's need for the use of conceptual language to keep themselves from falling into feelings of chaos and helplessness also support earlier findings that burned out mental health workers were much more likely to resort to the use of jargons and diagnostic language to distance themselves from clients (Maslach, 1976, cited in Farber & Heifetz, 1982).

In addition, participants also touched on times when they had to provide containment in the therapeutic relationship by setting limits with the client. For instance, Bill has had to turn down many requests to submit documentation for a disability-related claim, set boundaries with clients who propositioned him, or respond honestly to loaded questions like "Do you love me?" or "Will you support me no matter what?" In describing his acceptance of the emotional discomfort of inevitably letting clients down, he stated that he "learn[ed] to deal with not being the relentless wish fulfilment device." Bill's acknowledgement of the limits of what he can give patients speaks to the clinical observation that the client heals through the relationship not only because they rediscover their capacity to love, but also because they learn what relationships cannot give (Yalom, 1980). Yalom (1980) wrote:

> Psychotherapy is a cyclical process from isolation into relationship…The patient, in terror of existential isolation, relates deeply and meaningfully to the therapist, and

then, strengthened by this encounter, is led back again to a confrontation with existential isolation. (Yalom, 1980, p. 406)

Failure of Containment as Grist for the Mill.

Therapists may receive angry E-mail or calls from patients, they may not be able to offer the comfort desired by the patient, they may be deemed omniscient, they are never questioned, or always challenged, they may be late, make an error in billing, even schedule two patients for the same hour. Though I feel uncomfortable going through some of these experiences, I also feel confident that, if I address them properly, I can turn them into something useful in the therapeutic work. (Yalom, 2002, p. 71)

The title of this subordinate theme comes from Yalom (2002), who suggested that anything that takes place in the immediacy of the therapy hour can be used as "grist for the therapy mill" (p. 70), whether the event is addressed immediately or returned to at a later time. As alluded to in the subordinate theme of containment, containment is not always possible. It is inevitable that containment fails, sometimes due to the idiosyncratic or simply human limitations of the psychotherapist.

In fact, the failure of containment can also be transcended, even when it is "the coarsest of the coarse" grist for the mill (Kuchuck, 2008, p. xxiii). Rachel shared a time when her acknowledging being too distraught to work became a turning point in her work with a very narcissistic young man. A few minutes before the session she had just gotten off the phone with an extremely distraught family member and realized twenty minutes into the session that she could not focus at all on what the client was saying. At that point she interrupted the session, explained what was going on, and asked to reschedule. To her surprise, the client was not only empathic, understanding, and appreciative of her honesty, but even followed up with her the next week as to how she was doing and how things had

turned out with her family member. This interaction showed her a glimpse of the vulnerable and empathic part of him that he did not often show. Although they did not process it further and went right back to the issues he was bringing in, Rachel still found it helpful to be able to "tell that there's something, there's some of that in there somewhere" and think about how she could help him express that more often. It also helped her see him more holistically, not just as someone who was obnoxious and exploitative of women, but as someone who was in great pain. Here, Rachel's admission of vulnerability to the client became an occasion for the client to show a softer side of himself that she might not have otherwise been able to access, given his tough, hypermasculine presentation.

These were also times when psychotherapists used their clients' reactions to visible negative countertransference feelings as information for case conceptualization, and invited the client to examine their reactions to increase self-awareness. Hanna shared a vignette that exemplified the way in which the psychotherapist's negative emotional reactions can be used fruitfully even when the expression of what she was feeling was accidental and unwanted. She once unintentionally revealed a look of irritation towards a client for making a lot of demands, and he seized upon it as evidence that he was going to be dismissed from psychotherapy. She was able to use that opportunity therapeutically to help him reflect on his tendency to extrapolate from an accurate piece of information to an overly generalized conclusion that is not accurate. She reported that "it was a moment that brought [them] closer." Reflecting on the difference between this situation versus when she emotionally withdrew while he went on diatribes about women, she noted that while irritation feels less threatening to her, the hurt feelings of being attacked by virtue of being a member of a group that the client was denigrating were much more difficult to contain.

The Space of Supervision and Consultation.

Clients are not the only ones who need a holding space; in order to continue facilitating that holding space for clients, psychotherapists also need to be held, through supervision and consultation. Three participants spoke to the helpfulness of feedback from supervisors or consultants that normalizes the experience of competence-related vulnerability as well as emotional vulnerability related to the activation of personal wounds. Two participants discussed the effectiveness of realistic feedback that validates their de-skilled reactions to challenging therapeutic situations without contributing to their already heightened performance anxiety. Such feedback typically recognizes the demand characteristics of the therapeutic situation, the personal vulnerabilities that get understandably triggered, and helps them calibrate their expectations of themselves accordingly. In one example, Morgan recalled a particularly soothing and balanced response that a supervisor gave them after they had shown, with much trepidation and self-judgment, a video recording segment of a session in which they visibly dissociated for five minutes while their client was "laying into" them and "reading a memoir of all [their] faults." Morgan relayed that their supervisor validated that it was not "the ideal reaction," but also emphasized that it would be very difficult to have an ideal reaction in the face of such an interpersonally callous and sadistic treatment from a client. This feedback helped Morgan recognize their unrealistically expectation of themselves to respond flawlessly under such difficult circumstances and challenged their fearful conviction that their trauma-based susceptibility to dissociation meant that they were "a terrible therapist" or "couldn't be a therapist."

Similarly, Hanna asserted that one of the most helpful aspects of consultation is reflecting to her that she is "doing enough" rather than feeding into her performance anxiety of doing a "good job" or "bad job." She gave an example from a time when she was receiving consistent feedback from the client's family that she was not doing enough for them. Her

consultants gave her feedback and validation that both normalized her reactions of wanting and trying to do more, while also helping her notice that she had taken on too much responsibility while erasing all the effort she had already put in. On the flipside, hearing from clinicians who present themselves as always having the perfect things to say exacerbates her feelings of inadequacy. She also recalled sitting in graduate classes where professors claimed something to the effect of "And then I made this interpretation and they never had the symptom again."

A few participants also spoke about the importance of the supervisor's modeling willingness to take risks and join with the supervisee's experience of vulnerability, whether in terms of emotional vulnerability or competence-related vulnerability. This stance towards vulnerability can be shown through the supervisor's willingness to address dynamics in the supervision dyad or group that seems to be getting in the way of connectedness, as well as through self-disclosure of their experiences of vulnerability in their own clinical work. Naomi recounted an experience she had in group supervision when she was a graduate student. The group members had felt guarded and disconnected from each other for more than a year due to an unexpected upheaval in the graduate program that had been devastating and destabilizing for everyone. When the supervisor paused the group supervision to check in with them about the group dynamics, Naomi felt emboldened by the supervisor's willingness to hold space for that conversation, and began to share her own experience of the group dynamics, despite her fears about professional ramifications. She explained that the consistency of the supervisor in the way that she "showed up in relationships," the clarity with which she voiced her expectations of the trainees, and the willingness to be vulnerable that she modeled by stopping the supervision to share her observations, all helped to foster a sense of safety. In her words, she could "use the safety of that supervisor to help increase the safety."

One participant discussed the importance of normalizing the supervisee's experience of personal feelings that get in the way of the work. Rachel explained that almost every beginning therapist believes that the emergence of personal feelings in the work means that there is something wrong with them, and as such it is important to disabuse them of that notion. In her role as a supervisor in the past, she helped trainees explore and articulate the personal material that had gotten activated while being mindful of not turning supervision into therapy, and helped them think about the appropriate skills to use to manage those feelings as well as what would get in the way of using those skills. She added that to become a good therapist, it is crucial to identify "what's going on inside of you that might interfere with or enhance your ability to use a particular skill at a particular time."

Also with regards to normalizing trainee experiences, Hanna talked about her conscious effort as a supervisor not to reinforce the fantasy of always having that perfect thing to say or being "the arbiter of knowledge about something," but to share her own experiences of struggling and not knowing what to do in certain situations in order to normalize those experiences in supervisees. She recalled how reassuring it was to read clinicians whose books include experiences of challenges or failures. She explained that this sort of sharing is "part of storytelling" and "connecting with people on a more human level," even though she is in a position of evaluating someone. She stated that sometimes sharing her own struggles and getting feedback from her supervisee allows for "a closer relational experience" and "more of an equal position in the room," giving the supervisee an experience of consultation.

The sharing of emotional burden is also a benefit of consultation. Rachel recalled that after some time of working with female victims of domestic violence and fearing for her own safety from the husbands or ex-husbands of these clients, she came up with the idea of telling her peer consultant the name of the husband or ex-husband, letting the consultant know that if

she is “dead someday,” the police should go and talk to that particular man. Since her consultant is only going to use the information in the event that she was found dead, it does not protect her physically, but it gives her a sense of control over a situation over which there is little control, and a feeling that “somebody is looking out for [her].” Additionally, it allows her to convey the gravity of the situation to someone who can empathically relate to that risk and talk to her about it in a collegial but also human-to-human manner. She added that after she started using this strategy, her consultant has made a similar request of Rachel when the consultant was facing risks to her physical safety in her clinical work.

Summary of Theme 3.

This theme was firstly about negotiating proximity and space: how much space to give clients, and how to do so in a maximally inviting way without being intrusive or imposing. Participants shared that it takes energy and forethought to contain these emotionally challenging situations with clients, to ensure that what they reveal, whether in the form of verbalizations or emotional expressions, can be used therapeutically and does not get in the way of clients feeling safe and free enough to discuss what is important to them. While the participants emphasized the importance of giving space and not being intrusive with their self-disclosures, they also underscored the importance of being sufficiently present. Secondly, this theme was about containment; participants discussed using their body as a “container” and using self-talk and other intellectual resources to establish some emotional distance. Taken together with the theme of exposure, this theme conveys that while remaining inscrutable and detached may ward off feelings related to the vulnerability of being exposed and accessible, it seals off the possibility of connection and its potent therapeutic action. On the other hand, without space, there is the danger of doing harm to the client, and to the self of the psychotherapist. Thirdly, even when containment fails, processing the failure with clients often yields therapeutic benefits. Finally, while

psychotherapists work to hold the space for clients, they must also have their own holding space through supervision and consultation.

Theme 4: Power

Power is the ability to have influence, impact, or control. This theme addresses the power of the psychotherapist as well as of the client, who must both learn to relate to their own power, chiefly by exercising power in the therapeutic relationship. The issue of power was implicit in the previous two themes: to be exposed and to let others come closer to us than we usually allow means to let them inspect us more closely, notice our flaws and imperfections, become important to us in some way, and perhaps bring us joy but also potentially hurt us in that relationship. Participants grappled with the immensity of their power as psychotherapists not just interpersonally with the client but also socially as mental health professionals. This theme caught my attention because across the board, participants spent a great deal of time also discussing the vulnerability of their patients when asked to narrate a moment when they were vulnerable as psychotherapists, indicating their acute awareness that their client's wellbeing is the priority even as they contemplated their own vulnerability. It appeared that their awareness about their vulnerability went hand-in-hand with their awareness of their capacity to have a significant impact on their client for better or worse, and the existential guilt that comes along with that heavy responsibility. Additionally, they spoke to the process of moving towards power sharing and mutuality in the therapeutic relationship as a necessary component of healing for many clients and less reliance on power-control, win-or-lose dynamics.

"Power With": Striving Towards Mutuality.

In having a handle on someone's vulnerability, the client may also, in Hanna's words, "weaponize" it, whether consciously or otherwise. For example, a client may use knowledge about their personal vulnerabilities or normative human vulnerabilities to bully or intimidate

the psychotherapist into giving them what they want. It may include making threats to kill or hurt the psychotherapist, but most often they took the form of emotional manipulation or callousness. Participants mentioned times when they were hurt by their clients who were interpersonally callous or sadistic, or in Hanna's words, clients with "soul wounds" who "need to hurt others to feel better." For example, after learning from Hanna's colleague that she was from the same state as he was, an incarcerated, psychopathic client fixated on that information and began aggressively mining other personal information about her, playing the power game of "I'm locked in here and you're out there, but I can still make things happen." While she was typically comfortable disclosing general information about herself with other clients, or in the case of private practice, with having art on the wall that implied places where she has lived, she remembered being very mindful of sharing anything with this client that could then be further mined for other sources of information. In her words, "it means something very different when someone is like, I can have people find you."

Among the participants who discussed working with such clients, they found it helpful first and foremost to bear in mind, in Bill's words, that clients are not being difficult because they enjoy it, but because there is an underbelly of suffering. The next task is then to work towards mutuality with the client, including being clear about boundaries and expectations with the client, treating them as an adult of equal status. Bill stated that when clients are unclear about or flirt with the boundaries of the therapeutic relationship, he has a discussion with them that is "not insulting to them, not pandering to them, and that's also a hundred percent crystal clear." At times that involves accepting that the client was going to be so unhappy with the answer he gives that they leave.

As we might recall, Morgan had a client with whom they had prematurely self-disclosed a personal history of suicidality as an adolescent, which precipitated a rupture in the therapeutic relationship. This client had such an intuitive sense of people's personal

emotional vulnerabilities that she knew exactly what to say to be hurtful. Morgan recalled that "it was very powerful, and it worked." In particular, she often attacked Morgan's vulnerabilities around their sense of competence, parading any small mistake in front of them for months, and claiming that those mistakes were the reasons that she would not be able to make any progress in therapy. Morgan believed that it was their letting the client have this impact on her that facilitated her healing. They stated:

> When her therapist who referred her here then took her back, she was just like, 'I'm shocked by how much this person has progressed … like, she's such a different human than when she went into your care.' She's so much better and I just felt so awesome about that and I couldn't help but think that letting that client have that power over me is part of what did it. Or had that power with me really, because it couldn't be over, I could have cut it, I could've stopped it whenever I wanted, but I let it be. So, letting her have that power with me, I just feel like was so much of it.

What seems especially illuminating of the use of the psychotherapist's vulnerability is Morgan's comment that they allowed the client to have "power with" them, even though they "could have cut it, could have stopped it whenever [they] wanted, but [they] let it be." In other words, they allowed themselves to be receptive and accept influence, rather than walled off or shut down. Indeed, so great was the client's impact that Morgan marveled at how their work "absolutely changed [their] sense of self" for the time that they saw her, "in fundamental ways" that they did not fully understand until later.

What also stands out to me in Morgan's case vignette is the client's view of herself as simultaneously so powerfully bad that she could not imagine bringing what she needed to bring to therapy without killing her therapist, and yet, also as so tremendously powerless and dependent that any mistake Morgan was devastating. She vacillated between experiences of omnipotence and complete victimhood, unable to find a middle ground. Witnessing her

significant emotional impact on Morgan chipped away at her sense of powerlessness. At the same time, as Morgan repeatedly demonstrated resilience to the client's vicious attacks, without abandoning her or retaliating, ultimately surviving her fantasized destructiveness, it disconfirmed her emotional conviction of "toxicity" (McWilliams, 2004, p. 386), allowing her to arrive at a more balanced, reality-based experience of her interpersonal power.

In the language of Winnicott (1969), the client moved from object relating to object use; by destroying the object of her fantasy, created through her own projections – the "Morgan" that could be killed by her badness – the real personhood of Morgan emerged to the client as existing outside of her own subjectivity. It is a movement from a solipsistic experience of the world consisting of projections and distortions, towards the recognition of others as distinct selves, and a greater capacity to perceive oneself and the world through the perspectives of other people. Benjamin (1990) described this Winnicottian thesis in the following quote:

> When the destructiveness damages neither the parent nor the self, external reality comes into view as a sharp, distinct contrast to the inner fantasy world. The outcome of this process is not simply reparation or restoration of the good object, but love, the sense of discovering the other. (p. 192)

In contemporary relational psychoanalytic terms, Morgan and their client went through cycles of what Safran and Muran (2000), following Kohut (1984), termed the "rupture-and-repair" process. The premature disclosure by Morgan which had resulted in a huge rupture, was nevertheless salvaged and transformed into an opportunity for the client to experience the possibility of repair in a relationship. This is significant considering that clients come in with wounds from past relationships in which the other person was not available or willing to repair the rupture; in other words, the object did not survive, leaving the client with a disproportionately powerful sense of badness or victimhood that gets played

out in a perpetual dynamic of what Jessica Benjamin (2004) famously termed “doer-done-to” (cited in Aron, 2016, p. 19) with others, including their therapists. Writing about the importance of supporting the “reparative impulse” in children who bully, Neil Altman (2020, April) stated, “When people feel that there is no way to repair the damage they have done, they develop an image of self as fundamentally destructive, eventually embracing this self-concept and reinforcing it with their behavior” (para. 8).

When psychotherapists get inevitably pulled into the perpetrator-victim, doer-done-to dynamic (Ferenczi & Dupont, 1988/1932, cited in Aron, 2016, p. 31), psychotherapists must then find a way of helping the client transcend this binary opposition (p. 19). Importantly, Aron (2016) noted, repairing a rupture does not consist of indiscriminately prostrating in guilt as though the client were a helpless victim, which would constitute a masochistic submission (p. 31), but is an acknowledgement of the psychotherapist’s contribution to that re-enactment of a familiar relational injury, the pain it resulted in for the client, and an invitation to restore that shattered feeling of connection. In doing so, the pair goes beyond the doer-and-done-to dynamic, becoming co-participants and co-creators of a relationship that is strengthened by the survival of inevitable breakdowns. Rupture-repair cycles create a corrective experience of a “lawfulness” to relationships that consists in “the co-creation and breakdown of patterns of mutual regulation and mutual recognition” (p. 31). The importance of rupture-repair experiences extends of course beyond the therapeutic realm; for instance, Brown (2012) touched on the notion of a “stretch-mark friend” (p. 107) – a person with whom our relationship have withstood the test of time, including discord, strains, and fallings-out. In Brown’s words, “our connection has been stretched and pulled so much that it’s become part of who we are, a second skin, and there are a few scars to prove it. We’re totally uncool with each other” (p. 107).

It is of course not only the client who must strive towards greater capacity for mutuality: so must the psychotherapist. In a parallel fashion to the abovementioned client, Morgan had felt "so powerless historically that [they] … did not believe that [they] could impact clients very much" and as such, did not think too much about people's boundaries. They recalled that at the beginning of training, they tended to "throw [them]selves recklessly" into vulnerability with their clients, self-disclosing too much too soon, and "learned very fast how damaging that is" both to the client and to themselves. Through learning from their mistakes, they learned to "re-structure the way that [they were] with other humans," take their impact on clients seriously, and seek intentional supervision on ways to help clients regroup after processing powerful affective material.

Psychotherapists are also not immune from the fear of being wounded in relationships. On one hand, connection seems to generate, in Naomi's words, "this really positive charge" that energizes her, and encourages her to be even more vulnerable. Morgan similarly described this experience of an energetic quality or charge to the experience of connection, specifically, when making eye contact. They stated:

> Um … I hate and love eye contact. I'm not great at making a ton of it, but when I do, I get like this (mimes to indicate spine shivers). Like I think one reason it's so hard for me, I'm so sensitive to it and I get this fffoo!!!-like feeling. Yeah so I just really love it.

At this point, I asked Morgan, "What is this Fffoo!! feeling?"

> Ffffoo…like uh … all your nerve endings fire off at once. Like your hair stand on end, or like the like, um, have you ever heard of ASMR? Like that. Like tingles up the back of your neck. I get ASMR pretty intensely. So something about my nervous system is overactive. And the way that it manifests is that vulnerability just feels like a, like a drug sometimes, like a drug that I could just like … take whenever I want. Like all I have to do is do a thing that makes me feel vulnerable and it's like I'm like a little high.

On the other hand, being connected with a client also means potentially being hurt and resonating painfully with the client's suffering. When Nathan was working with adolescents at a residential facility, he felt far more vulnerable when trying to stop a child from hurting themselves, such as by wrestling a razorblade out of their hands, than when defending himself from a potential attack. He explained that the former came with a heavy sense of responsibility to these deeply disturbed clients who often did not have other caring adults in their lives. His deep empathy with the experiences of these clients who had experienced pervasive attachment trauma made it difficult to decide to leave the facility.

"Identifying With Their Shame" Using Self-Disclosures.

> Everyone has a shadow side of which he is more or less ashamed. But when I see someone who resembles me, who shares the same symptoms, the same shame, and the same inner battles, then I say to myself, so I am not alone in this, I am no monster. (Simenon, cited in Jacoby, 2002)

This subordinate theme is an extension of the previous because self-disclosure is a way in which the psychotherapist emerges as a real person rather than remain an object of the client's fantasy. A few participants who routinely self-disclose shared that self-disclosures provide an opportunity to connect on a more human-to-human level beyond the duality of therapist-client, healer-healed. In Morgan's words, self-disclosure blurs the boundaries between therapy conversations and everyday human conversations. It might remind us of the discussion in the previous section on the importance of transcending the doer-done-to binary. Aron (2016) opined that when self-disclosures are used effectively, they are

> not technical maneuvers or confessions, but are rather undertaken as part of a disciplined relational process of exchanging relevant, mutually generated clinical data in the service of opening up space for both greater "relational freedom" (Stern, 2013)

> and intersubjective reflection, which together reestablish thirdness – that is, they move us beyond binary dualities. (p. 32)

As Naomi and Hanna both noted, occupying the role of the psychotherapist means that clients will idealize and look up to them as somehow having had their issues figured out. For many clients then, the psychotherapist's stepping off the pedestal and revelation of themselves as only human provides a powerful normalization of the clients' thoughts and feelings, especially ones that are shame-laden and interpreted by clients as indicative of their unique sinfulness. For example, Hanna related that when she has disclosed her own historical struggles with money, clients who were ashamed about their own issues with money felt profoundly validated and thanked her for her disclosures. She stated:

> I'm sort of identifying with their shame, and I think that that's done something in terms of whatever fantasy they have about, well, if I'm in this position, I must have financial stuff unlocked, or this is embarrassing to talk about, or those sorts of things. And that's been profoundly helpful, I think.

Given that shame is about the painful feeling of unworthiness of connection with others (Brown, 2012, p. 47), it makes sense that clients' shame can be alleviated by a self-disclosure along the lines of "Me, too," which conveys that the shame-ridden person is not in fact unworthy for having a particular flaw and not alone in their experience of shame itself. Yalom (2002) who is a strong proponent of therapist transparency, particularly through verbal self-disclosures, has noted an analogous mechanism of "universality" in group psychotherapy, whereby self-disclosures of shared struggles among therapy group members challenge clients' belief that they are unworthy of belonging to humanity because "they alone have thoughts and fantasies that are awful, forbidden, tabooed, sadistic, selfish, and sexually perverse," "provid[ing] a 'welcome to the human race' experience" (p. 97). Brown (2012) argued that while we cannot protect ourselves from experiencing shame, the practice of

resilience to shame, especially in the form of resisting the urge to hide and reaching out to trusted others who can empathetically hear our sharing of that shame story, can help us preserve our experience of connectedness to ourselves and others (p. 51). The practice of self-disclosure of a personal struggle fits this bill; the psychotherapist has to be willing to not only be present with their own shame, but also muster the courage to share it with their client. In other words, it takes the psychotherapist's willingness to show up and be "seen" by the client in their shame – a thread that ties back to the theme of exposure.

While the idealization of the psychotherapist reinforces the healer-healed, doctor-patient hierarchy, the de-idealization of the psychotherapist challenges the dichotomy and shifts the power dynamic, in Naomi's words, "towards greater alignment." She offered that although her client could have guessed that she was also a person who is in the process of healing from her own emotional wounds, the process of letting the client hear her "speak [her] own words around it" increased the client's access to her in that moment. It opened up the possibility for the client to ask follow-up questions if she wanted to. Her verbal self-disclosure both models and reciprocates vulnerability. Without showing her own willingness to "show up and be vulnerable," with the client, it could be more difficult for the client to feel safe enough to choose to come back and be vulnerable session after session with her. Her remark is supported by Yalom's (2002) assertions that "therapist disclosure begets client disclosure," (p. 77) an observation that has indeed been corroborated by the results of a meta-analysis (Henretty & Levitt, 2010, p. 69).

Despite the potency of self-disclosures, as Morgan observed, there is still a lack of transparent conversations about self-disclosure among psychotherapists, noting that "everyone admits that they do it" but only "in quiet conversations." They lamented that formal coursework and didactics typically give self-disclosure a short shrift and fail to address its use in a meaningful, experiential way, leaving much ambiguity and guesswork for

clinicians to figure out by themselves how to use this powerful intervention that has great potential for either help or harm. Morgan's experience is consonant with Yalom's (2002) observation that like expert chefs who "throw in" some special spices and add-ons to a dish that are typically not disclosed in the recipe, many psychotherapies are effective because of the "throw-ins" that are added when no one is looking. It is also consistent with Bloomgarden and Mennuti's (2009) observation that psychotherapists are eager to learn more about using self-disclosures effectively, and yet, the topic has remained somewhat taboo (p. 3).

With regards to the kinds of conversations that would be most useful for helping psychotherapists learn to use self-disclosure well, Morgan suggested that one would be around the issue of how much of the psychotherapist's own personal vulnerability is necessary to be revealed in order to build rapport, facilitate deep connection, and foster the client's feeling of safety. They expressed desire for there to be more methodical clinical training in "best practices" on "how to be vulnerable" with clients, such as using physical touch, eye contact, and having "the everyday conversations of therapy" in which the psychotherapist speaks to the client on a human-to-human level. They further differentiated between self-disclosure that is done in a "protracted, robotic" way from one done in a genuine, vulnerable way, such as sharing how they feel and think about the client, including qualities they appreciate about the person. They shared some ideas on ways to train psychotherapists to be vulnerable:

> Can you imagine, can you imagine sitting in like regular psychotherapy training courses and the professor would be like, okay, I want you to play with self-disclosure this week. You know, try to use this tool. Try it on a low level, one of these types of things. Self-disclose one of these types of things. Play with it and come back and see what the effect was. What did – where did it take you in the therapy? Did it feel good, did it feel bad? Did it make the therapy with faster or slower? Was it too much? Was

it not? You know, all these questions I've asked myself as I'm training myself to do self-disclosure.

"A Terrible Responsibility": The Psychotherapist's Power.

> Mutual vulnerability does not mean equality, nor does it imply symmetry. Patient and analyst are mutually vulnerable, but the analyst has a different role and distinct responsibilities, and in some respects the therapist holds power over the patient, often leaving the patient with greater exposure and less protection. (Aron, 2016, p. 37)

Participants spoke about their recognition of how much power and responsibility they have in the role of psychotherapist, especially with regards to the impact of what they say or do on the client's emotional wellbeing. The empathy that psychotherapists have for their clients' hurt feelings adds to the vulnerability of saying or doing things that end up being disappointing or hurtful to the client. Two participants also reported making a globally negative moral evaluation of the self, describing feeling "wrong" and seeing oneself as "not a good person" when a clinical mistake appeared to be wounding to the client.

Furthermore, even the psychotherapist's own vulnerability can become a weapon, whether intentionally or not. Morgan described vulnerability as a "double-edged sword" that "can make the work … so much faster," "or it can fuck it up." The participants' observation of vulnerability as double-edged corroborate Brown's (2012) reflection that vulnerability only enhances relationships when we share it judiciously with people who have earned the privilege to know us in that way (pp. 98-100). When vulnerability is shared with others who are not ready to receive it, or in a gratuitous, indiscriminate manner that Brown termed "floodlighting" (p. 98), people turn away, cover their faces, and disconnect. She compared vulnerability in relationships to string lights that bring a warm cheer to a dark night, in contrast to floodlights which are harsh and overwhelming.

Honest mistakes aside, there is also the risk of abuse of power. Bill described psychotherapists as carrying a "terrible responsibility," because of the tremendous potential for exploitation. The possession of psychological knowledge, credibility, and authority means that if they wanted to, they could easily "run people's lives" or get away with financially manipulating impressionable clients, such as by claiming that they have a serious psychiatric condition and need to be seen more frequently and longer than necessary. He also highlighted the impact that psychotherapists have on their clients' broader community, including their potential for peddling statements that have destructive effects on their relationships with significant people. Indeed, some participants even voiced their distress at not feeling complete certainty that they themselves can always act according to their own ethical and moral compass. Bill recalled, for example, that when he was much younger, he became anxious when a client propositioned him sexually because he had not yet developed a trust in himself that he would adhere to his values and professionalism.

This specter of exploitation and harm to the client reflects the ever presence of our human potential for good and bad, creation and destruction, that can be deeply unconscious. In the parlance of analytical psychology, we all have a "shadow." As Page (1999) noted, the image of the shadow reminds us that the unconscious is always there even when we are not aware of its presence, in the same way that our shadow follows us wherever we go even when we do not notice it (p. 18). It also indicates that the unconscious and conscious entail one another, like shadow and illumination (p. 18). In addition to a personal shadow that forms mostly during childhood, as psychotherapists grow into their role, they also develop a psychotherapist persona and shadow. They create the persona by deemphasizing the undesirable qualities and cultivating desirable qualities, such as being helpful, caring, compassionate, and in tandem the shadow grows; the more that some qualities are emphasized, the more the opposing qualities tend to be pushed out of consciousness (Page,

1999, pp. 18-20). The suppression of these shadow qualities causes a built-up of pressure for expression, and as such, these qualities usually emerge with a great deal of energy and take on an exaggerated and unbalanced version that tends to be counter-therapeutic (Page, 1999, p. 23). Page (1999) argued that the fearfulness of beginning psychotherapists reflects their awareness of the potentially destructive nature of shadow qualities, but over time, they will ideally learn to integrate the role with their personality and develop awareness of the shadow qualities and use them to balance the qualities associated with the ego ideal. In other words, what was split off can now be integrated rather than remained exiled in unconsciousness.

Guilt.

The terrible-ness of the terrible responsibility discussed in the previous subordinate theme perhaps consists of the terrible-ness of guilt. The emotion of guilt was not mentioned explicitly by participants, but it was indirectly named. The real or perceived act of wounding a client, whether intentional or unintentional, can be wounding to the psychotherapist particularly due to moral judgments towards oneself. When relaying an account of the aforementioned premature self-disclosure with a client, Morgan uttered the following:

> It hurt me cause it's like we were both sitting there just in a lot of pain. In that moment, you realize that when she started sobbing that it wasn't a, um … helpful therapeutic sob, you had made a mistake and that she was hurting and you started to hurt too. … Realizing that I had inflicted pain on her, not in a healthy healing way, but that it had actually been harmful.

The "initiative versus guilt" crisis that Erik Erikson (1951/1993, p. 229) identified primarily in preschool children speaks to the relationship between power and guilt, which is also encapsulated in McWilliam's (2011) pithy statement that "Non-neurotic guilt is a natural reaction to exerting power" (p. 412). Functionally, guilt seemed to slow my participants down and facilitate prudence when they were facing a decision point or coming up with a response

in a dicey clinical situation. In Naomi's words, the knowledge that a self-disclosure could potentially go poorly "puts [in] stop gaps about, is this for me, or for them, to think about whether to let down the guard a little bit more, or to show up in a more present way." Furthermore, the guilt that some of my participants conveyed had a depressive tone. Speaking about their feelings when they made mistakes, they talked about "feeling wrong" or "feeling like not a good person," and they related the vignettes with self-deprecating humor. Given that psychotherapists tend to be characterologically depressive (Hyde, 2012; McWilliams, 2011), that is, tending towards self-attack and self-blame when faced with a setback, it might not be surprising that most of the participants came across that way during the interviews.

Emotions in Female Psychotherapists.

> Don't get emotional, but don't be too detached either. Too emotional and you're hysterical. Too detached and you're a cold-hearted bitch.
>
> – Hanna

Gender role stereotypes in a heteronormative society consign women to the role of being receptive and men to being powerful. Aron (2016) stated that the dichotomy of male-female has historically in psychoanalytic thought corresponded to the binary oppositions of penetrating-penetrated, bounded-permeable, invulnerable-vulnerable, resulting in a disavowal and projection of vulnerability onto women. Here, I flesh out how my female-identified participants experienced the conflict between expectations of them as psychotherapists and as women, particularly as it relates to their emotional life.

Hanna, quoted at the beginning of this section, shared that her fear of appearing "not stable enough" and confirming other "highly gendered assumptions" about women, and therefore not be taken seriously as a professional, led her to attempting to appear much more stoic. She recounted how she felt pressured to "masculinize" how she thought about emotion in the room and presented herself as attending to her emotional states through artistic

expressions such as through writing and music as opposed to ways that are rawer and more unmediated. She recalled having male supervisors or faculty who would give advice about being "present and available in the room" and thinking about how it was easy for them to say that because to be present and available as a man is "pushing against a stereotype." She explained that when a male clinician softens and violates the expectation of being an "alpha male" it "can be seen as deviation that's meaningful in therapy." Additionally, she remembered passing judgments on her female colleagues who allowed themselves to be more emotionally vulnerable with their clients early on in training. Over time, however, she came to recognize how "the difference between connecting emotionally and being overcome by emotion" often gets lost when it comes to the perception of women.

In addition to expectations around emotionality in general, there are also social expectations around the expression of anger. Rachel noted that for many female therapists, clients' expression of anger "can sometimes make the most skilled clinician unskilled," and yet on the flipside, their "empathy skills are great," which speaks to power of gender socialization in the development of psychotherapists. She shared that earlier on in her career she felt daunted by angry patients – those who were "always unhappy," for whom "nothing [she] ever said or did was right," and "did not mind expressing that [anger]." She recalled with some self-deprecating humor that there were times when these clients would "leave a therapy session in a huff and not come back" and she did not really make attempts to reengage them, as she was secretly relieved that "that one is gone." She related it to female socialization to "be a nice girl" and not demonstrate or express anger. As such, earlier in her life she found herself always daunted by people who were more assertive, aggressive, pushy, or strongly opinionated. Working through this issue with anger made her very interested in recognizing and supporting her female colleagues who also struggle with being angry and receiving anger.

The Title of "Doctor."

Two participants touched on the impact of the title of "Doctor" on psychologists' relationship to vulnerability in contrast to that of psychotherapists in other disciplines. Morgan shared feeling "gross" that when she graduates, people will automatically assume by the letters after their names that they are more competent than their masters-level colleagues in other mental health disciplines. Similarly, Hanna noted that the title carries a "certain political and social seriousness" that generates a perception of power differential between doctoral-level and masters-level clinicians. She recalled a fishbowl discussion between two marriage and family therapists who had come to train psychologists on a topic, in which they disclosed fears of being seen by psychologists as less competent and being challenged by them. She further elaborated on her observation that her colleagues working in social work or marriage and family therapy are a lot more comfortable than psychologists with "a certain level of personal and vulnerable and authentic engagement with clients in different ways." She reasoned that by virtue of their work in systems they are often more exposed and attuned to systemic power dynamics, and as such, tend to focus more on social justice in clinical work. In contrast, she sensed the presence of a "push against vulnerability" and a push towards isolation in the profession of psychology. Furthermore, she noted that examining the structures of psychology and the practice of psychotherapy through an intersectional or feminist lens reveals the patriarchal assumptions and values built into the practice:

> Even in terms of the frame, what it means, this isn't only patriarchy but to hold a particular time and make this as transactional as possible and to have this sort of power-down relationship where I have special trainings so therefore I can give you feedback about yourself that you don't have available to you.

Hanna's and Morgan's observations about the loadedness of the title Doctor resonate with the findings of Turgeon-Dharmoo (2018) in his survey of Directors of Clinical Training

(DCTs) and directors of training clinics, where he asked them to imagine "a hypothetical and unlikely debate" conducted by the American Psychological Association, in which they had to provide arguments for or against the continued use of the title of Doctor for clinical psychologists. He reported that his participants generated a discernibly abundance of arguments for continuing the use of the title of Doctor than not (p. 180). Some of the main arguments included that the title of Doctor confers an elite status that allows them to "be on par with medical providers and be respected by them" (p. 185) and consolidates the identity of psychologists by differentiating them from "lower-level" masters level mental health service providers. While he noted that the unusually low response rate (18 out of 174 DCTs and 9 out of 161 directors of training clinic) precludes generalization of the data, it, in combination with a few undisclosed email correspondences he received from individuals who declined to participate in the survey, suggested that perhaps the topic itself was "off-putting" or "offensive" to prospective participants (p. 51). Reflecting on how psychologists are often encouraged to be thoughtful about the use of terms like "patients" versus "clients," and their power dynamic with patients, he noted how strange it is that the field has not called into question the hefty power contained in the title Doctor.

As we might recall Aron's (2016) reminder that questioning binaries and hierarchies does not mean denying differences and assuming symmetry and complete equality, the challenge posed to the title of Doctor is not to deny that differences exist in the training of psychologists versus other mental health professionals, or that there is no difference in the experience of going through a four-to-six year versus two-year training program, and certainly not to gloss over the great asymmetries in social power that is granted to psychologists versus masters-level clinicians. The deconstruction of binaries is a way to overcome the splitting that often happens when binaries are held onto too strongly. Similarly, writing about the "collective shadow," which refers to a group's repository of unwanted

qualities, i.e. the flipside of the "collective ideal" or collective ego (Guggenbühl-Craig, 1971, p. 112) which refers to the qualities most prized by members of the group, Page (1999) reminds us that it is when the unwanted characteristics are driven into unconsciousness that the danger of denial, projection, and acting out of those qualities is most salient (p. 146). The more tightly individuals cling to an identity that is defined by their membership to a particular group, the more they are not able to acknowledge their commonalities with others outside of the group. With regards to the title of Doctor, which as Turgeon-Dharmoo (2018) argued, is experienced by many as bestowing clinical psychologists with a prestige on par with medical doctors and differentiating them from clinicians with so-called lesser degrees, the collective shadow of the profession of clinical psychology is marked by an arrogance, elitism, and failure to learn from other neighboring professions. The rift here between clinical psychology and other disciplines is reminiscent of what Aron observed about the split between psychoanalysis and psychotherapy that I had discussed earlier in the literature review. By projecting incompetence and illegitimacy onto masters-level psychotherapists, clinical psychology risk overlooking its own potential for charlatanism, poor client care, and even abuses of human rights, such as has been exposed with regards to several high-profile APA members' involvement in torture. To quote Turgeon-Dharmoo (2018),

> The question is, are clients/patients best served by each field seeking to secure a solid identity via over-and-against hierarchical claims and titles (recovery-based identity) *or* by different fields seeking to foster moments of identification with one another based on what they can learn from each other (discovery-based identification)? In other words, might we not better aspire to *become* by learning from one another rather than *be* in opposition to one another? What would it look like if clinical psychologists as 'Doctors' focused more on teaching and learning from these kindred disciplines

rather than seeking to use their title to protect or recover an identity? (p. 206, emphases in original)

Summary of Theme 4.

The dynamic of power and responsibility reminded me of an oft-quoted story by Schopenhauer of two porcupines huddling on a chilly night to keep themselves warm: if they got too close, they pricked each other with their quills, but if they came too far apart, they shivered in the cold and were desperate to get closer again. Participants were well aware of what their quills were – their personal vulnerabilities, shadow qualities, old wounds, the part of them that could potentially exploit clients, the part of them that they do not want to identify with. They had to be aware of their quills and repair the rupture when they inevitably hurt the client. By engaging in power sharing with the client and striving towards greater mutuality in the therapeutic relationship, psychotherapists help clients achieve a realistic sense of their own interpersonal power so that they no longer have to re-enact their troubled relational past. By being aware of their vulnerability, psychotherapists can avoid misusing their power, and also model ethical responsibility to their clients. Through self-disclosure, they come off the pedestal and show that they too have those qualities that clients find so unacceptable in themselves. The therapist becomes real to the client. The more real they become the less mythical and the more human they are, and the more the client can accept and expose those human parts of themselves. Furthermore, participants talked about how gender role socialization gets in the way of female therapists owning their anger and displaying emotions, and discussed the power that comes with the title of Doctor for psychologists, and how it could be uncritically adopted as an instrument of splitting and projecting negative qualities onto clinicians with other degrees.

Theme 5: Being on the Precipice: Facing Uncertainty

> In psychoanalysis, when approaching the unconscious— that is, what we do not know— we, patient and analyst alike, are certain to be disturbed. In every consulting-room, there ought to be two rather frightened people: the patient and the psychoanalyst. If they are not both frightened, one wonders why they are bothering to find out what everyone knows. (Bion, 2005, p. 104)
>
> A certain degree of calculated risk has always been the hallmark of therapeutic practice that aspires, and at times reaches, beyond the mediocre. (Page, 1999, p. 102)

Rachel shared a clinical account that exemplified working under uncertainty. Within the first five years of her independent practice, an incest survivor she had been working with for a while disclosed to her that she had been involved as a child twenty years earlier in a Satanic cult that routinely sacrificed babies as part of their initiation ritual and that anyone who knew about it could be killed by the cult members. She recalled feeling haunted with incredulity and fear, wondering if the cult existed, and if it did, whether it still existed and was still sacrificing babies. Over the next few weeks, the thought that she could be at risk popped into her head from time to time and she would have to talk herself through it. She wondered about her responsibility with regards to reporting it as well.

Uncertainty is constitutive of vulnerability; as briefly discussed in the theme of Defining Vulnerability, vulnerability involves the possibility of injury. We do not know for certain what the outcome is going to be when we expose ourselves or take a risk. Furthermore, even when we may think we know what we are doing, we can be caught off guard by an unexpected turn of events. Brown (2012), who defined vulnerability in terms of exposure, risk, and uncertainty, stated that we are vulnerable as long as we are alive (p. 34). Psychotherapy seems to be a particularly fertile field for the experience of not knowing. Participants reported feeling emotionally vulnerable in being unsure about how to best

respond to what a client is saying or doing, being unsure what would happen if they say or do something, feeling surprised, confused, or caught off guard. They shared their struggles with fears of the unknown, their unsatisfactory solutions to bypass the gap between the known and the unknown, and their progress towards greater capacity to let themselves rest in not knowing. Bion, quoted at the beginning of this section, is known for applying the poet John Keats' term "negative capability" (Bion, 1984, p. 125) which conveys a stance of openness to the unknown, or in Keats' original words, "capable of being in uncertainties, Mysteries, doubts, without any irritable reaching after fact & reason" (1959, p. 261). Bion argued that negative capability is necessary for the analyst because the unconscious is the unknown, and thus, exploring it requires a tolerance of the confusion of not knowing.

Further complicating the situation, psychotherapists are in a paradoxical position of occupying the role of being an "expert" and yet at the same time, having to open themselves up to uncertainty and surprise (Voller, 2010). Although experience, skills, and expertise provide some level of assurance and confidence, they do not protect psychotherapists from uncertainty or fluctuations in their narcissistic equilibrium. Bill shared, for example, that there were times when his caseload was not absolutely full, which brought up fears that he was "losing it" and had "suddenly become a mediocre therapist." If we may recall, Rachel also reported experiencing insecurity from time to time about her competence. At the same time, the more seasoned psychotherapists expressed being less fazed by uncertainty than they used to be and being much more willing to tell clients that they do not know something or cannot provide something they want. They verbalized a certain level of trust in themselves that if they will figure out how to deal with a new or challenging situation. For Bill, there is no need to know ahead of time all the ways in which he may be vulnerable because "[he] will find out, in retrospect" as new experiences of vulnerabilities occur to him. When he is stuck or confused about what is going on, answers often pop into his head when he is running or

meditating, but rarely when he is trying to force an answer. Rachel explained that as she gained more experience with facing uncertainty, her ability to "sit with" and not be "scared off" by uncomfortable feelings has increased over the years, and along with that, more willing to "put [her]self in an uncomfortable place comfortably" with her clients. She stated: "What has expanded over the years is this kind of, 'Well I have no idea what I'm doing here, but let me find out more,' you know, that we're moving toward it."

In contrast, the less experienced participants struggled much more with acknowledging the limits of their knowledge. Hanna, an early career professional, recalled that particularly when she first went into private practice and began seeing visible money as part of the transaction, she felt so unsure of the value of what she was offering that she pressured herself to meet clients' needs and found it difficult to say, "I don't have" something, or "I can't do that for you." She also readily internalized their complaints about not getting enough results. During these situations she would find herself feeling pulled to provide more "concrete" interventions, even if the way that she usually worked achieved more or less the same effect. The less experienced clinicians were also generally in the midst of trying to navigate their relationships with the unknown and actively developing or utilizing supports to help them both grow in competence and confidence. For instance, Morgan and Naomi both spoke about getting intentional supervision and deliberate practice to work on their growth edges, which has improved their ability to respond decisively and therapeutically during situations that used to be overwhelming. For instance, Naomi described how over the years she has learned to operate effectively during risk assessment even when she feels fearful. She explained that her ability to sit with and manage the fear improved over time, and as she became more competent and confident, the fear also decreased.

In feeling my way into my participants' experience of not knowing, I attended to both their language and nonverbal cues, as the words on the transcripts alone did not adequately

convey the experience of hearing them talk about it. They described "being on the precipice," wanting to offer something "concrete" instead of something less tangible, "this all happen[ing] really fast" when they are trying to make a decision, and "anticipating" the outcome. Not knowing seemed to be like brushing up against the very edge of what is known and what is concrete and tangible, and beyond that it is a free fall into the unknown. In fact, the anxiety could feel so dreadful that one may try to concretize the ineffable or hope to bypass it rather than letting oneself feel the painful experience of the unknown. For instance, Morgan, a trainee, described holding onto working with a client despite being overwhelmed and retraumatized because they could not bring themselves to "admit to [themselves] that [they were] actually a clinician in training and maybe there [were] things [they] could not yet handle." It was as though that the period of training was this holding pattern that they were trying to circumvent by acting as though they were already in independent practice. It brought to my mind Gottlieb's (2016) research on the experience of not knowing among psychotherapists in training, in which she noted that there are "necessary leaps of faith" that must be taken when the psychotherapist does not know what to do. She wrote, "this space of not knowing" is rife with existential and personal vulnerability:

> In this space, participants feel most vulnerable to the existential realities of death and grief, for instance, or to attacks on their personal or professional worth as influenced by a racist context, or to insults hurled by clients, or to the uncomfortable feelings clients might be experiencing. (p. 152)

Psychotherapists can feel much "angst, anxiety, and occasional despair," as well as doubts about their competence or suitability to becoming a therapist (Gottlieb, 2016, p. 141). In the language of ego defenses, we might see the latter as a depressive solution of immediately concluding whenever there is a setback that the fault must lie within oneself –

which many psychotherapists are particularly prone to, given their depressive dynamics (Hyde, 2012; McWilliams, 2011).

Because psychotherapy sessions do not unfold like a prewritten book (I would argue, even during manualized therapy there is not hundred percent predictability), every decision that the psychotherapist makes involves a tolerance of uncertainty and a willingness to make a move that may turn out for better or worse. Naomi conveyed the breathless anticipation in that brief few seconds that she made a decision to self-disclose to a client, explaining that part of the vulnerability she felt had to do with her recognition of a choice point in whether or not to share her own experience, and being in a position of "trying to think fast and try and make the best decision." Furthermore, just as there could be the obsessive fantasy of postponing making a decision in hopes that one will have all the information necessary to make the right, guilt-free, shame-free decision (McWilliams, 2011, p. 411), there can also be the compulsive solution of obliterating the salience of having to make a decision by thoughtlessly plunging into action "without considering alternatives" (p. 411), or in Gottlieb's (2016) words, "jumping in or running ahead too quickly," without "spend[ing] time in the unknown." Counter to those obsessive and compulsive solutions would be to maintain a physical comportment of openness, and "sitting back and waiting or listening" (Gottlieb, p. 152).

Yalom (1980) noted that "the major task of the maturing therapist is to learn to tolerate uncertainty," that the therapist needs to learn relate as a real person with their patients rather than focusing on organizing information about the patient into "an intellectually coherent framework" (p. 411). Rigid intellectualization gets in the way of relating to patients as people rather than as "interesting cases" (Page, 1999, p. 23). Indeed, one of the dangers of psychotherapy training is that the possession of knowledge that have great explanatory powers about people can be used not only to manipulate and objectify patients, but as a "defense against the anxieties of everyday life" (Page, 1994, p. 23). Bill echoed this healthy

skepticism towards explanations, stating, “One of the great things about being a psychologist is after a while you can explain anything. Just because you can explain it doesn’t mean it’s the right explanation.”

Summary of Theme 5.

This theme was about the experience of uncertainty in psychotherapy and the importance of allowing ourselves as psychotherapists to not know the answer, to not know what is going on, or what will happen. The vocabulary that participants used suggested that the experience of uncertainty is like coming up against the very edge of what is concretely known. Some participants described experiencing a pull to reach for “concrete,” tangible interventions when they felt unsure about the value of what they were offering. The capacity to tolerate not-knowing, which has been called “negative capability” in the psychoanalytic literature, seems to grow over time, evidenced by the late career professionals’ narrative that they grew much more comfortable with acknowledging the limits of their expertise and accepting experiences of confusion, surprise, and puzzlement as they became more seasoned. They emphasized the importance of “sitting with” not-knowing, in service of allowing truths to emerge at their own time rather than forcing their own explanations.

Theme 6: Physical Vulnerability

Allowing someone to come close – including letting them into our space, such as an office, naturally brings up the issue of safety. As mentioned in the literature review, mental health professionals are at risk of physical assaults because they regularly meet with individuals who struggle with impulse control; who are managing intense emotions of anger, fear, and shame; who abuse substances, and so on. The five participants who touched on issues of physical safety in the capacity of being psychotherapists described being vulnerable not only because they work directly with emotionally and behaviorally dysregulated clients who are impulsive, narcissistic, or psychotic, but also by virtue of how their work is

perceived by members of the clients' community, particularly intimate partners. Short of being assaulted or directly threatened, some participants also reported being intimidated by clients or disgruntled spouses of clients in various ways. The quality of these experiences was described by two participants as having an "animal" quality, specifically in terms of how it activates visceral reactions of fear for one's bodily safety. Some participants talked about the steps they have taken to protect themselves or to feel safer and more in control, as well as how they have come to accept the inevitability of some degree of physical vulnerability in their work. Additionally, one participant talked about how gender role expectations shape others' perception of the therapist's physical vulnerability, and another participant brought up the issue of mortality.

Situations of Heightened Physical Risk.

Of the five participants, Nathan risked being injured directly when he physically intervened with severely dysregulated children and adolescents to stop them from hurting themselves with sharp objects. He explained that the risk of getting injured was even higher when interrupting their self-harming attempts than when defending himself from outright physical assault because it took greater skill and calmness to, for example, "very carefully wrestle a razorblade out of somebody's hand" than to resort to the use of restraints, in which he was well-trained. The chaotic, "ratty" environment of the residential facility certainly did not help with the level of physical violence, as Rueve and Welton (2008) have observed, that aggression is exacerbated by being in an unpleasant environment.

One participant, Bill, was directly threatened numerous times by disgruntled clients or their family members. For instance, there were clients who were unhappy with the documentation he provided for the purpose of disability services and threatened to have him shot. There were also times when people would call his house phone directly and he was left

wondering if they were actually going to show up on his doorstep. He described the typical threat he would get from family members,

> I can remember times where I would work with patients and it would usually be the husband of a patient. The way it would normally transpire, it would be like this: you would talk with your patient, the patient would go home, and they would say, well, Dr. Bill says that you're a moron and I should leave you. And then the husband would call up and say, my wife tells me that you told her that I'm a moron and she should leave me. Um, if you'd like, we can meet out in the parking lot and like we can handle this man to man.

Similarly, Rachel reported that by virtue of her specialty in working with women experiencing domestic violence, she is at risk of being hurt or killed by abusive husbands of her clients as revenge for "taking their wives away from them," even if she has not heretofore received direct threats. The motive of revenge corroborates the observations of Purcell and colleagues (2005) as well as Meloy (2002) that resentment and vindictiveness contribute to patient assaults on psychologists.

In addition to direct physical threats and possible revenge by family members, safety also became an issue for two other participants who had clients who were interpersonally intimidating. Hanna recalled that when she worked at a correctional facility, a colleague unthinkingly revealed to a psychopathic client that Hanna was from the same state as the client. The client "perseverated" on this piece of information and tried to manipulate her into revealing more personal details, conveying implicitly that he could enlist people outside of the facility to find her or her family. She recounted that what started out as appearing like benign curiosity about her as a person became increasingly "tinged with aggression." Morgan recalled a client who would jump on the couches, throw things at them, and talk about their visual hallucinations and fantasies of killing Morgan. At times, this client also lingered linger

around in the area for hours after sessions so that Morgan would walk by her and be frightened.

With regards to the experience of physical threats, participants reported that their response was a deeply embodied fear, even terror. Bill recalled feeling a "visceral thrill, in the old sense where your heart just palpitates," as well as a "gut-wrenching sense of oh my god, someone is threatening to fight me, or kill me, or destroy my property." Likewise, Nathan said of his experience: "I'm using air quotes, 'treatment' cause it didn't fucking feel like treatment. It felt like I'm afraid, right now …"

Coping with Physical Vulnerability.

Two participants talked specifically about the management of physical vulnerability, such as screening prospective clients to avoid taking on clients who might become unmanageable in private practice, securing the building, learning self-defense and restraints, not putting the patient between oneself and the door, installing video surveillance equipment in the waiting room, and finding out who on the police force can be contacted. These strategies are in line with the recommendations of the American Psychological Association (Munsey, 2008b).

In addition to management strategies, three participants talked about making peace with some level or physical risk. Firstly, there is an element of desensitization, or in Nathan's words, feeling "equipped" as a result of having "stared in the face of violence." Rachel expressed that very few experiences of physical vulnerability "grab" her or "rile [her] up" these days in the way they would have earlier in her career. The psychotherapist's personal history also factors into this: for example, Bill began his career already somewhat desensitized to violence due to his upbringing in a town with ubiquitous violence, even if most of it was not directed at him. In addition, Bill, Nathan, and Rachel spoke about the achievement of some perspective and acceptance on physical vulnerability. The first aspect of

this acceptance is the recognition that clinical work includes dealing with some people who have characterological predispositions towards violence. The second aspect consists in the willingness to accept the risk in order to continue serving a particular patient population or to work generally as a psychotherapist. For example, Rachel described herself as being much more willing to do what she thinks is best for the client even if it involves risks to her physical safety.

Men's Physical Vulnerability.

When asked about a moment when they felt vulnerable as psychotherapists, right out the gate, both male participants spoke about experiences of physical vulnerability. They were also the only participants who reported either receiving direct, credible physical threats, or having intervened legally or physically with aggressive or violent clients. On the other hand, the participants who identified as female or nonbinary led the interviews with moments when they felt vulnerable due to emotional exposure or uncertainty, even if they have also had experiences of physical vulnerability. They spoke much more about experiences of intimidation and harassment instead of direct threats, assaults, or physical interventions with clients. Again, while it is not possible to extrapolate from such a small sample, it appears these therapists tended to face intimidation tactics more than physical assaults. Tjaden and Thoennes (1998) reported that 1 in 12 women and 1 in 50 men in the US will experience stalking in their lifetime. Men tend to be more physically aggressive, as evidenced by the fact that men account for "90 percent of individuals convicted of murder and 82 percent convicted of other violent crimes" (Anderson & West, 2011, p. 35). They also tend to be the victims of violent crimes. It is small wonder then that physical danger was on the forefront of the male participants' minds.

Nonetheless, male therapists' physical vulnerability may be downplayed by female colleagues. For instance, Nathan shared that where he works, whenever there are clients,

especially male clients that no one else wants to work with, they end up being "dumped" onto him. On another occasion, during a conversation with colleagues about physical safety in clinical practice, he found himself abruptly "slapped down" by a female colleague with a dismissive retort along the lines of "Well, you're a dude." Based on his visible identity as a white man, many of his colleagues have assumed that he is "not vulnerable" and has never feared for his safety. Nathan's experience of "double standard of unhealthy masculinity" to be "tough and vulnerable, both, simultaneously," echoed Brown's (2012) findings that sexism is reinforced not only by men but by women who project toughness and invulnerability onto men. To Nathan this was not simply an inconvenience but a dangerous assumption that violates his sense of self and complicates his healing from the aftermath of the trauma he experienced with violent clients. He expressed impassionedly, "Without an acknowledgement of my own vulnerability, without space to be vulnerable and be acknowledged as vulnerable, I can't, we can't do this work!"

Animality.

> It shines light on my own animal-ness, and my own like, … I don't know, social contract to, not to not get up and attack my client or something or eat them.

Nathan said the above laughingly when talking about his work with adolescents who often sought out sharp objects to, in his words, "either tear open their own skin or tear open the skin of the people that are trying to take care of that." He described this experience as having a "real, raw, animal," "wild West" quality, an image that was echoed in a different way in Bill's narrative who, after recounting stories of being physically threatened by clients or their family members, reminded me that those occurrences were few and far in between and that he was "not … dealing with wild animals." Their use of the image of "wild animals" evokes the intensely raw and unmediated quality of their contact with potentially or actually violent individuals while on the job. It appears to be physical analogue of emotional exposure

and involves a breach of the implicit social contract that mediates the interactions between individuals. Nathan expressed:

> I guess it also, it's funny, I … like it, it shines light on my own animal-ness, and my own like … I don't know, social contract to, not to not get up and attack my client or something or eat them. … but that, that's like, that's both funny but also like there's a, there's a realness to that, particularly when clients are coming in with extreme distress, you know, and death and aggression and these things are really at their fingertips, you know. And they're less way less likely to act them out in an outpatient setting, but it doesn't mean they're not, they're not there.

Through this experience, Nathan came to appreciate that "there are monsters" that come out in the therapeutic space because they are part of human nature. He explained that when he does therapy, he is essentially "sitting in a room with another animal" that could hurt or kill him or themselves, and that this raw animal presence is not only applicable to "special cases of really disturbed kids" but to everyone. It helped him understand that for some clients, even in outpatient settings, "death and aggression" may be "at their fingertips" even if they may not show it in the same way that his adolescent clients at the residential facility did. While the animalistic aggression was the most salient part of such interactions, Nathan also expressed recognizing that those clients are also "trying desperately … to be human and contained."

The metaphor of animality also raised the subject of the false dichotomy between human animal and nonhuman animal, a duality that is so entrenched in everyday language and taken for granted that I had to be reminded by one of my dissertation committee members that humans are animals too, and have a capacity for violence and destruction that is great, if not greater than nonhuman animals. Reexamining this subordinate theme through the lens of that realization, I noted a similar struggle in my participants to grapple with human destructiveness. For instance, Nathan went back and forth between his use of the word

"animal" to capture the experience of confronting raw violent tendencies in his adolescent clients and a description of progress as humanization and containment, and on the other hand, his recognition that those "monsters" are endemic to being human.

Mortality.

Bill was the only participant who talked about the salience of his mortality and what it means for his clinical practice – not unexpected for someone who at 60 years of age has outlived a number of his relatives is and approaching retirement at age 65 – but perhaps also corroborative of the striking rarity with which psychotherapists talk about mortality. Considering how life after retirement is much more limited when one looks at the average lifespan of American men and the fact that the last few years are usually marked by infirmities and reduced functioning, Bill stated dryly,

> Not that I'm planning on dropping dead at 65, but when you look at the average age of death for American men, 76, but the last five years really aren't good anyway. So let's cap it down, 71. So if I retire at 65, I can more or less count on six good years unless I get some like incredible bad diagnosis, then all bets are off.

In addition to grappling with identity issues, he is contemplating the challenge of helping patients deal with their fears about termination as well as his own concerns about how it would feel like to terminate with clients he has worked with longer-term, including ones he had seen for a decade or more. Interestingly, even prior to coming upon this threshold in his life, Bill has reportedly always been acutely aware of the perspective that "time is precious" and worked fast, especially when the client's presenting problem is circumscribed and straightforward. As such, he has always adopted a "[t]each them what they need to know, respect their time, respect their money, you know, get them in, get them out" attitude. Interesting, he noted that most of his clients would wrap up their work in ten or fewer sessions, but at the same time, there was "a small group of people that [he was] going to see

forever." I was intrigued by the use of the term "forever," particularly alongside his grappling with the mortality. It would have been easy to simply chalk it up to the use of denial or humor to soften the grief that comes with facing the reality of retirement and death. Upon further contemplation, however, I found myself getting in touch with the wisdom and faith in the word "forever." Although as psychotherapists our work with clients end when we retire or die, the fruits of our labor and the unfinished work we leave behind are carried forward into the future by our clients and those in their community. Thus in that way, our work has a life of its own that extends beyond ours.

Summary of Theme 6.

This theme pertained to the ever-present prospect of being injured on the job in addition to the inherent vulnerability of being mortal. Five participants reported having encountered physical danger of some kind in clinical work or having experienced intimidation tactics that manipulate their vulnerability. With regards to the former, self-protection strategies mentioned included securing buildings, installing video surveillance equipment, positioning oneself closest to the door, screening clients, familiarizing oneself with using police assistance, training in restraints and self-defense tactics, and having security personnel. In addition to managing physical vulnerability, participants talked about a level of acceptance of the inevitability of some physical risk when dealing with emotionally disturbed clients, as well as issues of gender differences in the perception and experience of physical vulnerability. One participant also discussed vulnerability related to the existential concerns that came up towards the end of his career and as he contemplated his mortality.

Theme 7: Hell and Initiation: Vicarious Traumatization and Vicarious Transformation

At a poorly resourced state residential facility for children with severe emotional and behavioral disturbances where he worked for a few years, Nathan was not only was a relatively new and young clinician who was not receiving any clinical supervision, he was

also working with some of the most traumatized and dysregulated children in the state, exposed daily directly and indirectly to violent traumatic re-enactments, without any opportunity to disconnect and recharge. The bulk of Nathan's interview saw him articulating that experience. Consistent with the idiographic focus of Interpretive Phenomenological Analysis, which emphasizes the particularity of experiences in particular individuals, I devoted this theme specifically to examining what Nathan's experiences can tell us about psychotherapists' experiences of vulnerability. Furthermore, unlike my approach to the previous themes, whereby I led with the participants' language about their experiences before connecting them to theories and constructs from the literature, here I lead with an overview of the constructs of vicarious traumatization and vicarious transformation. Following that, I explore how Nathan's account of his experiences can enrich our understanding of vicarious trauma in psychotherapists.

Pearlman and Saakvitne (1995) coined the term vicarious traumatization to describe "the transformation that occurs within the therapist (or other trauma worker) as a result of empathic engagement with clients' trauma experiences and their sequelae," including changes in how they experience themselves, others, and the world (cited in Pearlman & MacIan, 1995, p. 558). Some of the symptoms of vicarious traumatization include autonomic hyperarousal, avoidance or numbing in relation to the trauma material, exaggerated startle response, anger and irritability, intrusive thoughts or dreams of the client's trauma, "feeling trapped" by the work (American Counseling Association, 2011, p. 1). Pearlman and Saakvitne emphasized that vicarious traumatization is not a sign that there is something wrong with the therapist, but is an "occupational hazard" for anyone who works with survivors of trauma, "listening to graphic descriptions of horrific events, bearing witness to people's cruelty to one another, and witnessing and participating in traumatic re-enactments" (cited in Pearlman & McIan, 1995, p. 558). Put differently, it is the "cost of caring," of

"opening our minds and hearts" to individuals who have gone through horrific experiences and making a commitment to helping (Pearlman, 2012, 0:13, 0:25). Pearlman and McIan (1995) also found that younger, newer clinicians were the most vulnerable to vicarious trauma, especially when they were not receiving supervision (p. 563). This finding is consistent with the observation that younger and less experienced clinicians were also most vulnerable to burnout (Pearlman & McIan, 1995). While lack of experience may account for the higher rates of burnout, it is also the case that the least experienced therapists tend to work with the most difficult populations with little support. In fact, in their study, most of the newer therapists worked at hospitals where a mere 17% of them received clinical supervision (Pearlman & McIan, 1995, p. 563).

"Ninth Level of Hell": Vicarious Traumatization.

Nathan explained that the clients he worked with at the state residential facility were violent towards themselves and others, almost all day and every day. In his office space they rummaged for weapons or objects with which to hurt themselves, essentially forcing his hand to wrestle the weapon out of their hands. He was also often up in middle of the night for hours coordinating hospitalizations or supervising clinicians who had called him about a crisis. When he did sleep, he would often have nightmares or be woken up thinking about work. The next day, sleep-deprived and exhausted, Nathan would have to meet with staff and account for what had happened barely a few hours ago. He described being stuck in a "miserable cycle" in which every day was a "really, really, really hard, horrible day, as hard as the day before." At the same time he was also "deeply, deeply invested" in the clients, unable to extricate himself without suffering pangs of guilt for leaving clients who had already been left many times by people who had shown up to take care of them. The repetition of the words "really" and "deeply" in Nathan's description conveys not only the nightmarish relentlessness of this cycle of extreme overwork and exhaustion, but also the

depth of the attachment that Nathan continued to have to his clients and to his work despite the sheer exhaustion. Like many individuals who reported experiences of vicarious traumatization, Nathan felt "trapped" by the work (American Counseling Association, 2011, p. 1) because he cared and felt keenly the suffering of his clients. Elaborating on the experience of fear for his own safety when intervening with a self-harming client, Nathan stated:

> I was vulnerable cause I like could've gotten attacked by … it in, in my own space with my own sharp object, while simultaneously being … feeling single-handedly responsible for the, the care and about being over this kid …

Furthermore, the lack of support and supervision only increased the magnitude of this sense of responsibility to the clients. He explained that the program director who was supposed to be available for him was never available, so other clinicians turned to him for supervision and instruction. While the state nominally had custody of the children, it "was just a diffuse set of bureaucrats" who "come once a month" to "check in to check all the boxes and make sure that everything's going as intended with where the funding is going." He deeply resented being "responsible by default," with no one to turn to, no one else showing up to share the burden. The recognition that the only way he could stop being responsible for them was to leave, felt even more "horrible" to accept because he saw how it was perpetuating the "revolving door of people who don't want to be there taking care of them but they have to." He was not alone in this experience of being trapped by the work: he recalled how the psychotherapists and the staff at the facility including himself "felt like a fucking hero all the time" and harbored the fantasy that they were the only ones who could "save" those clients. One of his closest colleagues, also in her 20s, even had serious intentions to adopt some of the children. Retrospectively, he saw that they needed to have this "bizarre" but "adaptive delusion of grandeur" to survive what felt like an unbearable reality

that they felt “total powerlessness and helplessness” and were working with children who were most likely to kill themselves or another person in the whole state. The “delusion” that kept him having some vestige of hope about the work also kept him trapped and unable to imagine leaving.

In fact, the thought of leaving angered him for a long time. Nathan expressed that he has found it helpful to think of his experiences as traumatic rather than “hard” or “annoying” because the “kind of resentment and anger” that he felt was often directed at his loved ones. He explained that he felt “especially bitter” towards his girlfriend, family, and friends who did not work there and conveyed their desperate wish for him to “dial that down” so that they could “have a nice time” together,

> Fuck you for thinking that the world is … is one way, when I'm aware of a world through my work that is … dark and … um, so painful for everybody involved and everyone's just trying to survive it. And fuck you for thinking that I can just turn that off, or that I can step away from it. I can't, I'm in it.

He was aware of how hurtful such expressions could be and attempted to manage them. He felt even angrier when someone would offer support because the gulf between his lived world of this “ninth layer of hell” and the lived world of others was so great that he would feel even more invalidated. He noted that as is the case with traumatic experiences, he got his support from the people who were “in it just as much” as he was, that is, the other psychotherapists at the residential treatment facility. He recalled that when he was working at the residential facility, he would sit on his colleague’s back porch and drink “bottle after bottle of white wine” while talking about work together. Although it felt neither good nor helpful, it reduced his sense of isolation as they were at least peers who were “speaking the same language” and talking about the same experiences. Yet, these days when Nathan attempted to give language to some of his experiences there, words often failed him. One of

the most striking aspects of his interview was how much he struggled to convey the feeling and image that he still carried with him from that time. Here were some particularly illuminating quotes:

> I can't even find the word … a clear sense of like a dissociation from like…yeah, I have the images, and I have the feelings over here, but they don't really talk to each other …
>
> Like I'm there and to watch somebody, um … uh … a kid … I realized that any, any attempt to articulate it, I'm just gonna like, I don't know … I don't have the words exactly. Cause it's a … I just have the, the, the images, I mean …

In short, similar to the clients he worked with, Nathan found himself in an isolated world of profound suffering that sometimes could not be put into words, particularly to people who did not share his experiences. The expression "ninth level of hell" not only conveys the depth of the pain and torment, but also the experience of being radically cut off from the rest of humanity. Although he could make the choice to leave that hell, the depth of his care and desperate desire to make a difference kept him there. At the same time, Nathan recognized in retrospect that he could not have been able to make the difference that he wanted to see, as this hell was created by the failure of society to nurture a culture of togetherness. He shared that he would feel extra angry and resentful whenever he heard conversations about how "we need more mental health services" for "these school shooters." He exclaimed with frustration that he was one of those providing just such a service, and yet "no one was helping." He further pointed out how the was state paying all this money for clinicians to try to do for the clients what "our culture should be doing for everybody" in terms of "community or togetherness or cooperation." As a result, the children and other individuals in the culture who are the most vulnerable to the "culture's sickness" end up being "thrown" into residential treatment facilities or jails.

Nathan's experience points to the need to examine the context within which vicarious traumatization of mental health professionals happen. The "dumping" of these clients on the facility, on the shoulders of clinicians who had virtually no oversight and support, appeared to be a re-enactment of the clients' abandonment trauma. Nathan described the facility as "sort of the black sheep of the state residential programs" where the apparently hopeless cases of the state were sent.

> We didn't do things the way that, you know, we didn't use as many evidence-based treatments, and the, the physical setting was like really ratty and kind of like just gross. So we ended up getting dumped on … with the, some of the most difficult like puzzling cases that the … whole, in the entire state, um … as like a last-ditch effort to, you know, do, do, do something of help. So we saw a lot of cases like just get worse.

Nathan's description is reminiscent of Altman's (1995) account of the demoralizing "squalor and neglect" surrounding inner-city public clinics (p. 153), which reflects the inner city's status of a "psychic dumping ground" for the rest of society, to which it is "supposed to be invisible" (p. 128). The staff who worked in the public clinics looked out of their windows at views of "abandoned buildings and stolen and stripped cars" (p. 153). In this physical setting, Altman noted, staff felt corresponding feelings of "frustration, deprivation, despair, and low self-esteem" (p. 153). Similarly, the "ratty" and "gross" physical environment of the facility that Nathan worked at is a physical manifestation of the dynamic of being "dumped on," is a physical enactment of the wider society's consignation of these abandoned children to the category of waste.

Nathan's concern that the responsibility of providing nurturance has fallen excessively on psychotherapists reflects the unfortunate dark side, that is. the collective shadow, of the psychotherapy's collective ideal of healing those who have been wounded. In Page's (1999) words, psychotherapists could be inadvertently pulled into the expectation to

"to fulfil the role of great mother archetype for society," tending to the casualties of societal, systemic dysfunctions, rather than putting the responsibility back on other institutions and systems to address the inequities and flawed policies and practices that wounded those individuals in the first place (p. 142). Clarifying that there is a place for psychotherapists to provide support as long as it is not seen as supplanting societal-level changes, Page wrote, "the social danger is that there is a general sigh of relief when 'mother' appears so that the energy and commitment to solving the more fundamental social and political problems may be dissipated" (p. 142).

Psychotherapists who are trained to take "quite restricted, psychologically based view of the nature of human suffering and difficulties" (Page, 1999, p. 143) are especially vulnerable to this pull, in contrast with psychotherapists whose education take a more systems-oriented approach. As we may recall from the discussion of the title of Doctor for psychologists, Hanna observed that her colleagues in social work or family and marriage therapy, whose training is more systems-oriented, tend to be way ahead of psychologists in their thinking of power in the profession. Page (1999) also suggested that the increase in formal training of psychotherapists on multiculturalism, diversity, and inequities can help rising psychotherapists develop more of a capacity to "rise above the immediate and view the overall landscape" (p. 143). Indeed, partly as a result of those experiences of extreme vulnerability and responsibility, Nathan developed a skepticism of the classic 50-minute individual psychotherapy session and a passion for thinking about models that go "beyond the therapy room, beyond treatment," such as peer movements that do not take on the medical model or idea of illness and treatment.

"Initiated Into the Darkness": Vicarious Transformation.

Trauma profoundly shifted Nathan's sense of self, but by not warding off the painful lessons in those experiences, he matured as a practitioner. He shared that the "monsters" he

witnessed in humanity through the severely disturbed children he worked with have been "integrated … into [his] body and [his] psyche," which has attuned him to their existence even in clients with benign presentations and deepened his capacity to "not so naively pretend like just listening and taking somebody at face value is all there is to it" in psychotherapy. Speaking with some humor and self-deprecation of the therapist he was prior to these traumatic experiences, he noted that as horrible as those experiences were, he does not desire to go back to who he was:

> Eight years ago or something, like when I was new in my master's program … I felt so good. I was such a … and everyone gave me such good feedback, 'Oh my, Nathan, you're such a good therapist.' And I was like, ah, I know, I'm like so attentive and attuned, you know? I was like Carl Rogers, right? (laughs) And I look back at that now and I'm like, that was fucking naive. And uh, I don't necessarily want that back because it was childlike or something, you know. I feel like … I mean, not to be too gross, but the word like castrated, like in a psychoanalytic sense comes up. It's like, yeah, I feel like I've been initiated into the darkness of psychology and psychotherapy. … There would be monsters … you know?

What Nathan named here appears to be what Pearlman (2014) termed "vicarious transformation," which she defined as the intentional transformation of experiences of vicarious traumatization in deeply positive ways that revitalizes us and "deepen[s] our own humanity" (1:00). She suggested the following strategies: "engaging deeply," "expanding resources," and "examining beliefs" (1:15). Specifically, she recommended that individuals engage deeply with all aspects of their experiences, across the "whole continuum," not picking and choosing which to attend to, and allowing all emotions to course through us and being aware of how they feel in our bodies (1:26). Deep engagement also includes deepening our relationships with trusted others through the sharing of our shame, worries, longings, and

dreams. This strategy echoes Brown's (2012) argument that individuals who experience themselves as living whole-heartedly are people who choose to engage with their vulnerability, across the full spectrum of emotions, rather than trying to circumvent difficult experiences. It also resonates with her assertion that reaching out to others in moments of shame helps to protect our connection with ourselves and others (p. 51). The strategy of expanding resources refers both to learning from survivors of trauma who have retained their zest for life, and also to connecting to our spirituality (Pearlman, 2014, 2:43) which is particularly important, as disrupted spirituality is one of the most hallmark symptoms of vicarious traumatization (Pearlman, 2012, 0:37). Thirdly, the examination of beliefs pertains to the use of cognitive-behavioral strategies to weaken the grip of negative beliefs about ourselves and the world, including by objectively examining evidence for and against those beliefs. What Nathan pointed to seems to be in line with Pearlman's first strategy, of engaging deeply with all experiences, or in Nathan's case, with the "monsters" that appeared in his work and becoming aware of the presence of monstrosity in humanity.

Summary of Theme 7.

This theme was on the phenomenon of vicarious traumatization and transformation, examined based on the experiences of one participant Nathan. While empathic immersion in the experiential world of survivors of trauma means being infected by their pain and horror, it also opens the doorway to vicariously transforming our sense of ourselves and the world to integrate all aspects of life, of our vulnerability. Additionally, I spoke to the importance of attending to the social context of vicarious traumatization: psychotherapists can be inadvertently pulled into the role of healing the causalities of society, instead of recognizing the limits of what they can do as individuals and in psychotherapy, and engaging the wider community to address the sickness of society.

Insights From My Own Interview

As mentioned at the end of the method section, I had a colleague interview me after I had finished interviewing all participants, and prior to beginning data analysis. This step allowed me learn from my colleague that what was most effective in her and my interviews was the focus on action words and verbs related to affective experiences, which allowed participants and me to stay close to embodied lived experience rather than the intellectualization of experiences. Although I only listened to the recording of this interview after completing data interpretation, I became aware that the interview helped me to articulate my personal reasons for embarking on this project as well as the implications of my research for the field of psychotherapy. It was through this interview that I realized how the pain of my experiences of not being able to reach some of my patients was the primary motivation for me to examine my reasons for becoming a psychotherapist. Specifically, I recognized a tendency in myself to disavow my own vulnerability by taking care of vulnerable others – certainly not rare among psychotherapists! When the healer persona began to strike me as a hollow, empty shell, it became possible for me to recognize my disavowed needs and woundedness that lay in the shadow. I realized then that this project was an attempt to go beyond the solipsistic world of my own subjectivity and learn from other psychotherapists about what they had to say about their experiences of vulnerability. Furthermore, unlike the participants, I only spoke about emotional vulnerability, and only Themes 3 and 4, which were "space and proximity" and "power," respectively, showed up in my own interview data. I spoke somewhat to the experience of being defenseless, not in terms of exposure, but in terms of feeling like my patients' expressiveness managed to "sneak past my defenses" and affect me in an unexpectedly deep way. Hearing myself speak also gave me a glimpse of how I had grown and changed as a clinician; during this interview I had just begun my predoctoral internship at a state psychiatric facility, and by the end of my data interpretation, I had

worked for several months as a full-time staff therapist at a college counseling center. Hearing myself speak about vulnerability in such an anguished way certainly gave me a sense of being somewhat astonished by the depth of my fear and despair about my vulnerability as a psychotherapist. It also showed me how I had matured as a psychotherapist and person over the course of my internship in terms of my confidence, comfort, and resolve in the face of obstacles to connecting with my patients. As a result, I was able to notice more of the hope and optimism in my participants' narratives and felt moved to explore the relationship between vulnerability with the repair-rupture processes in psychotherapy, which became an underlying thread in Themes 3 and 4.

Conclusion

To conclude, I return to the research question I posed at the beginning, which is:

How do psychotherapists experience vulnerability?

The first takeaway from my participants is that there are many different ways to experience vulnerability in the role of psychotherapist. For instance, the experience of feeling emotionally naked, which was the most commonly reported example of vulnerability, is very different from what it is like to feel afraid of being physically attacked by a client, which was reported by a smaller handful of participants. In the abstract sense, all types of vulnerability share the common elements of risk, uncertainty, and exposure that Brown (2012) had named, but how vulnerability is lived through and related to depended on the context. Attending to the language that participants used allowed me to grasp those differences. When participants were emotionally exposed, they felt undressed or unmasked, which can precipitate shame or the dread of being shamed. In contrast, when participants felt vulnerable in terms of feeling unsure about what to do or how to think about a clinical situation, they described feeling like they were coming up against the edge of their knowledge, experience and expertise – hence one participant's description that it was like being "on the precipice." Some participants further described feeling pulled to offer interventions that are more "concrete" so that they had something to hold onto. When participants described what it was like to be in danger of being attacked, they used words like "raw" and "wild animals" to communicate the feeling of being engaged in a brute struggle for basic physical safety. Additionally, participants brought to my attention that their experiences of various vulnerability were also shaped by aspects of their identity, especially gender. While the male participants found physical vulnerability to be an especially salient issue for them, the female participants were particularly concerned with their emotional displays, due to internalized gender stereotypes and prohibitions against expression of anger, for instance.

The second takeaway from this project was that vulnerability is not something that simply happens to psychotherapists. In addition to the more passive aspects of their experiences of vulnerability, they were also always actively engaging in complex intellectual and emotional work to understand what is happening in the therapeutic dyad, assess where the client is at emotionally, and decide how to proceed in a clinically indicated manner. They were also making sense of their own emotional reactions and deciding what to reveal, what to contain, what to use, and what to discard. Their description of this simultaneous awareness was most evident in their discussions of creating a holding space for the client. In order to create a safe, facilitative space where clients can be vulnerable session after session, psychotherapists must also model the willingness to show up vulnerably with their client by relating in an open, authentic manner. At the same time, having an adequate case formulation in mind is necessary to avoid as much as possible the mistake of being vulnerable too much, too soon, before the client is able to tolerate the knowledge that their psychotherapist is, too, a flawed and vulnerable person.

In relation to that, participants also discussed the challenges of being fallible individuals who are nonetheless imbued with immense social and interpersonal power. In fact, some of the vulnerability associated with being a psychotherapist came from their recognition of how much authority they have not just in the consulting room but also in society. One participant's characterization of the psychotherapist's social power as a "terrible responsibility" speaks to the awareness of the choice that psychotherapists have to use their power for good or for their own gains at the expense of their clients and the broader community. Moreover, even when they do not intend to be hurtful towards clients, psychotherapists sometimes say or do things that are upsetting or disappointing to clients. At the same time, participants also recognize the power that clients have as well. Indeed, participants spoke about the importance of allowing clients to matter to them, in order to use

the therapeutic relationship as a vehicle of healing. Psychotherapists work to manage not only the inevitable slights and slings of being in a relationship, but also the guilt that comes with making mistakes or having to let clients down in some way. In addition to tolerating guilt, psychotherapists also tolerate the uncertainty that comes with making their best guesses about what is going on with a client and determining how to intervene. While most participants reported some degree of anxiety or doubt about their competence, the more seasoned psychotherapists expressed that over the years they grew increasingly comfortable with accepting that they do not know something and waiting for truths to emerge at their own time rather than forcing answers and faking certainty.

Moreover, participants emphasized that while being vulnerable can potentially be a source of dread, it can also be a source of joy, connection, insight, and wisdom. As Nathan's experience demonstrated, even tremendously painful experiences of vulnerability, such as in the case of vicarious traumatization, hold the potential to transform psychotherapists into more mature and sophisticated practitioners who are better able to acknowledge and integrate the shadow aspects of themselves and of humanity. Their insights corroborated Brown's (2012) observation that while vulnerability may be associated with a variety of "dark emotions," it is also the "birthplace" of "love, belonging, joy, courage, empathy, and creativity" (p. 29).

That last point brings me to one of the most important takeaways, which is that much of the experiences of vulnerability as psychotherapists have to do with confronting and accepting limitations – the limitations of their knowledge, expertise, and competence, the limitations of their time and energy, the limitations of their care and compassion, the limitations of their capacity to hold and receive what the patients bring to them, the limits of life, and the limitations of what psychotherapy can do. As Bill put it, one learns to "deal with not being the relentless wish fulfilment device." Acknowledging the limitations of therapy

prevents therapists from being drawn into doing for the community what therapists cannot do in their role. Accepting one's personal limitations allowed participants to set appropriate boundaries with clients, protect themselves physically and emotionally, and know when to reach out for support from their colleagues. Additionally, effective self-disclosures of one's own limitations model self-acceptance to clients, who may struggle with those limitations in themselves.

Reflections on Process and Limitations

The phenomenon of vulnerability in psychotherapists was not simply "uncovered" in this study like a relic in an archaeological dig. Rather, I was learning about the phenomenon from a group of self-selected psychotherapists who were not only highly introspective and reflective, but also courageous in their willingness to share their experiences with me of vulnerability. Furthermore, my engagement with them in phenomenologically investigating their experiences deepened their reflection, producing both insights and further questions about the phenomenon. This latter point was especially apparent in Theme 1 "Defining vulnerability," in which I described the ways participants grappled with the many meanings of being vulnerable as a psychotherapist. It is important to note these characteristics of the sample as well as the research process because while all psychotherapists are vulnerable, by nature of being human, not all psychotherapists are as aware of and reflective about that vulnerability. In other words, the phenomenon of vulnerability in psychotherapists appeared in this study as complex and nuanced because of the complex, nuanced ways in which participants were able to think and speak about their experiences.

In terms of demographics, while there was a range in age and gender identities, all my participants were able-bodied White European-Americans. Although it was a function of who responded to my recruitment emails, it also perhaps reflects that overrepresentation of that demographic in academic institutions and the field of professional psychology. The lack of

demographic diversity contributed to the ways in which the participants described their experiences of vulnerability. For example, in speaking of exposure – being "seen" – they were drawing on specular language, which may not capture the experiences of psychotherapists with visual impairments. Likewise, the language of making sure that clients feel "heard" privileges the hearing community's experiences of communicating primarily by voice and listening, rather than psychotherapists who communicate by signing and lip reading. How would psychotherapists with different experiences of their embodiment have described their experiences of containment and their communication with their clients? Similarly, whereas participants spoke to the oppressive impact of gender role expectations and stereotype threats, specifically when it comes to the expression of emotions and concerns about physical safety, vulnerability related to the racial identity of the therapist and the experience of cross-racial therapeutic dyads did not come up, which may have limited the range of experiences of vulnerability that was captured in this study.

This was in part due to my not having asked questions exploring how this aspect of their identity shapes their experience of their and their client's vulnerability. I could have easily attributed this omission to the limitations of time, my desire to follow the participant's train of thought and what is important to them, the need to wrap up an already interminable dissertation by not including a treatise on race and vulnerability, and so on, but an honest soul-searching tells me that my avoidance was partly intentional. I was experiencing a great deal of "reflection fatigue" (Trumbo, 2017, para. 2) due to my having undergone an intensely introspective period during my predoctoral internship applications and interviews a few months before I began interviewing participants for my study. Already predisposed to spending too much time in my inner world, I was exhausted from being deeply immersed in introspection and speaking to others about my identity as an Asian woman, which while empowering and pride-giving in many ways, was also often painful and lonely. I was burned

out on, for lack of a better word, doing my race, and walked right into the colorblind trap I set up for myself when I spoke with my White participants. In some ways, my avoidance also speaks to my own temperamental tendency towards hiding and disappearing, not taking up space in the relational exchange – a desire that several authors (Greenson, 1967, p. 400; Kuchuck, 2014, p. xix, McWilliams, 2011, pp. 285-286) have noted, is common among psychotherapists, and additionally for me, a welcome reprieve from having to be the person who always stands out in stark contrast due to my skin color and conspicuous accent. More broadly, in a manner parallel to my participants' negotiating the strength of their personhood in the room, I tussled with dialing up and down different aspects of presence in the room as an interviewer and can only notice in retrospect how my questions guided their process.

My participants worked primarily, if not exclusively, with individuals, and four out of six participants were also in private practice at the time of the interview. As Hanna brought to our attention, there can be the danger of solipsism when only taking the perspective of the individual, as opposed to taking a more systems-oriented approach. Prolonged immersion in individual psychotherapy hones our ability to think in terms of dyads and the intersubjective space between the two individuals, but it does not necessarily flex our muscles for conceptualizing beyond the dyad, in terms of groups and wider systems. Added to that, as Altman (1995) has pointed out in his critique of the privatization of psychoanalysis and psychoanalytic psychotherapy, regular individual psychotherapy even in the public sector is not within reach some people for want of time, money, transportation, childcare, and other practical factors. Besides, whereas in private practice the psychotherapist can screen out participants, it is not feasible in settings like the one Nathan described, where psychotherapists end up being "dumped on" with clients whether or not it is a good fit. Hence, the perspectives that emerge from the participants are inevitably shaped by their experience of working with a population overrepresented by individuals who have some

measure of financial security and practical supports in their lives, and who have sufficient psychological stability to make the cut, so to speak, for outpatient individual psychotherapy.

This bias was balanced somewhat by the fact that at least two out of the four participants in private practice had clinical experiences working with severely disturbed patients in the public sector, whether at a hospital or a forensic treatment facility, and one other participant had spent years in the public sector before practicing at an outpatient training clinic. There was also quite a diversity of client population, ranging from patients with chronic pain to victims of domestic violence. Furthermore, Nathan's substantial reflection on the limitations of individual psychotherapy, particularly when psychotherapists are expected to make up for failures of society, brought to my attention a systems view of psychotherapists' vulnerability. More specifically, his reflection helped me understand vicarious traumatization in psychotherapists who work with clients who suffer the most from society's disavowal and projection of vulnerability – the proverbial canaries in the coal mine. The tragedy of course is these psychotherapists are set up to fail at least a large percentage of this population, as individuals alone cannot undo the sickness of an entire society. It may wound their sense of mission and morality as healers. On the other hand, there was a way in which this split was reflected and reified in my dissertation, with Nathan's trauma narrative essentially taking up a silo by itself, disconnected from the other themes. When I tried to work it into other themes or consider an umbrella theme that includes vicarious traumatization, I always wound up noticing the rift between the experiences of vulnerability that is right on or over the edge of what is bearable by the human spirit – those that involved terror, horror, a fundamental change in the sense of self – versus experiences that were stressful, challenging, or frightening.

Another limitation of this study was my inclusion of only psychologists. I started out with the intention of recruiting psychotherapists from a wide variety of disciplines and

education backgrounds, such as social work and marriage and family therapy. However, after some deliberation with my committee about the concern that doing so could add further noise to a study that already felt too expansive and ambitious, I decided to limit my study to psychologists. Retrospectively, while this concern makes sense, I also did not have the vantage point that I have now from practicing at a university counseling center with an interdisciplinary team of psychotherapists with a wide variety of backgrounds, degrees, and licenses, which has taught me that on the ground, the ways we work is almost indistinguishable from each other especially when it comes to individual psychotherapy. Yet, I am also left wondering if it would have made a meaningful difference had I recruited more broadly from other disciplines – certainly a plausible direction for future research studies.

Lastly, my choice of the word "vulnerability" proved to be another limitation of this project. As I mentioned at the beginning of this dissertation, I chose the word intentionally as a scholarly salute to authors on ethics and vulnerability who had inspired me, and also because it has such an evocative resonance. I also did not want to restrict it to the realm of civil human interactions through words like "humanness," or to a specific way of being such as "openness." As demonstrated in my participants' struggle to come up with a definition, "vulnerability" could mean anything under the sun (and moon), so I ended up casting a wide net for all manifestations of the psychotherapist's feelings, thoughts, attitude, beliefs, memories related to the ever-present possibility of being wounded in various ways. While it was interesting and illuminating to learn about the different and even surprising ways in which psychotherapists can be vulnerable, it also limited the depth of my phenomenological investigation. In casting such a wide net, I ended up trawling such an enormous amount of data that it was difficult to be clear at times what phenomenon I was studying. Since there is no singular phenomenon of vulnerability among psychotherapists, it became challenging to stay focused on studying experiences as they are lived and not get pulled into cataloguing

different kinds of vulnerability instead. The word "vulnerability" also proved to be quite an unwieldy word to use in phenomenological interviews, where the aim is a detailed exploration of how experiences are lived. I noticed that when participants and I focused on one aspect of the experience of vulnerability, such as emotional exposure, the narratives and descriptions became richer, more sensuous, and much less intellectual or abstract.

Implications

To understand the implications of this project, it is important to appreciate the wider social context in which psychotherapists are practicing today. In an era where there is mounting pressure from busy customers and managed care organizations to achieve results faster, psychotherapy is increasingly technologized using sophisticated data monitoring tools (Bowles, 2009; Shedler & Gnaulati, 2020). Bowles (2009) reported in a *New York Times* article that Kip, a therapy start-up, advertised its service with the following statement:

> The best therapists get you better 10x faster than average ones…We took world-class providers, supercharged them (and you) with our smart software tools, and designed a seamless experience for both clients and providers. (para. 7)

In response to such statements, a long-time defender of long-term psychotherapy, Shedler (2019), posted an image of his letter to the editors of *New York Times*, in which he expressed that psychotherapy should not be about supercharging the process ten times faster, but about "slowing things down" so that we can observe ingrained processes that otherwise happen "without reflection or awareness." He further stated: "The quest to quantify, accelerate, and optimize every facet of existence is not the cure for anxiety and alienation, it is the disease" (para. 3).

The manic quest for efficiency in psychotherapy overlooks the interpersonal process at the heart of healing in psychotherapy, which, as my participants described, is deeply intimate, messy, and full of surprises and uncertainty. My dissertation constitutes a response

to such a quest; by shifting attention away from heroism and productivity, to limitations, to vulnerability, it offers a more realistic and humane perspective on both the psychotherapist and the psychotherapy process. In fact, regardless of the theoretical approach from which they practiced, each and every single participant in my study endorsed the importance of tolerating uncertainty, accepting and working with one's limitations, and monitoring what is going on inside of them that may get in the way of their remaining present and responsive to the client. These are qualities that have to do with humility and self-awareness, rather than the possession of superhuman powers. It challenges the notion that progress lies in doing more, better, and faster; as my participants have illustrated, modeling a vulnerable, non-defensive acceptance of one's mistakes and moments of frailty can be profoundly powerful and healing. It is the relationship with a vulnerable being that heals.

Here, it is worth revisiting van Manen's (2014) statement about the value of phenomenology: "the ultimate aim of a phenomenology of practice is modest: to nurture a measure of thoughtfulness and tact in the practice of our professions and in everyday life" (p. 31). More concretely, by providing glimpse into how vulnerability is lived among the psychotherapists who participated in this study, I hope to offer readers a chance to slow down and reflect on their own experiences of vulnerability and perhaps inspire them to talk with others about these experiences. Clinical jargons have the tendency to be stale, cold, and detached, and as a result, fail to resonate emotionally with the psychotherapist and to open up conversations that can help them reach more deeply into their experiences. The majority of the themes and subordinate themes that I explored in this dissertation were created using phrases and quips from my participants. My hope is that it will provide fodder for conversations about vulnerability that does justice to its different aspects, whether it is about the animal, embodied fear for one's physical safety, or the struggle to negotiate one's presence and power in the space of the consulting room.

My findings also have implications for the training and ongoing care of psychotherapists. First and foremost, they reinforce prior literature that consultation and supervision are indispensable tools for helping the psychotherapist remain centered while navigating the push and pull in the therapeutic relationship with the patient. At the same time, because getting supervision and consultation involves exposing one's ways of working to supervisors or consultants, it is a deeply vulnerable process that requires resilience to shame. Even the most experienced participants in this study had moments of doubt about their competence; one shared that she still felt the vulnerability of exposure when she attended peer consultations. Moreover, Morgan's admission that they at times withheld information from their supervisors for fear of being regarded as incompetent is in fact not an anomaly in psychotherapy training. Some studies have suggested that about 40% of trainees admitted to "omitt[ing] or distort[ing] information they were uncomfortable sharing" during supervision (Coughlin, 2017, p. 12). Moreover, these conscious admissions do not even take into account unconscious distortions of information that many, if not all supervisees have engaged in without ever realizing it. My findings indicated some potential ways to encourage supervisees and consultants to be more forthcoming and candid: increasing supervisors' and consultants' awareness about the vulnerability to shame that comes with such exposure; training supervisors and consultants to assist in the growth of supervisees and consultees, particularly in the development of resilience to shame; recommending that supervisors and consultants give realistic feedback that does not reinforce the supervisees' or consultees' preoccupation with avoiding looking incompetent; and appropriate use of self-disclosures by the supervisor, consultant, or teacher of psychotherapy about their own experiences of failures and missteps in clinical work.

Additionally, a few participants talked about various barriers to vulnerable relating in the field of psychology, such as the lack of training in the use of self-disclosures and more

generally, other ways to reach the patients in deeply human ways, and the way that the use of the title of Doctor tends to reinforce a power hierarchy. They also indicated the lack of attention in the training of psychotherapists to how gender socialization, stereotypes, and dynamics may lead to the disavowal of physical vulnerability among male clinicians and anger among female clinicians. Indeed, while psychotherapy training programs teach psychotherapists to use various skills and techniques, they tend to overlook the cultivation of personal qualities that are vital for the work, such as the aforementioned capacity to tolerate exposure in service of growth and learning, as well as the "capacity to tolerate intimacy and closeness" (Coughlin, 2017, p. 209) in therapeutic relationships.

Interestingly, prior to its revision in 2017, the American Psychological Association's profession-wide benchmarks (2011) for determining competency for the professional practice of psychology used to include competencies such as:

- Accurately self-assesses competence in all competency domains; integrates self-assessment in practice;
- Recognizes limits of knowledge/skills and acts to address them; has extended plan to enhance knowledge/skills;
- Demonstrates reflectivity both during and after professional activity; acts upon reflection; uses self as a therapeutic tool;
- Self-monitors issues related to self-care and promptly intervenes when disruptions occur.

Suffice to say, these competencies involve a reckoning with one's true thoughts and feelings, and with one's limitations, which is a deeply vulnerable process. It goes beyond the scope of this project to speculate why those competencies were eventually removed. Perhaps activities such as self-reflection and the use of the self cannot be quantified and measured, much less taught in the classroom. Yet, as Morgan pointed out, it is possible to teach psychotherapists to

learn to use their experiences of vulnerability effectively, such as by encouraging students to learn by trial-and-error, including by trying different types of self-disclosures and monitoring its impact on the client and what that it was like for them personally.

Future Directions

There are various directions for future research that can be derived from the types of vulnerability identified by participants. One of the more glaring gaps in the literature is the lack of accounts on how psychotherapists experience their vulnerability to physical danger. One participant, Nathan, noted that while the experience of emotional vulnerability is well-documented in clinical literature and is perhaps the reason that psychotherapists "sign up" to be psychotherapists in the first place, there is no such equivalent for physical vulnerability. On the other hand, there is plenty of literature on effective ways to manage violence risk in practice as well as quantitative studies that examine the impact of patient assaults on mental health professionals. It may be a valuable research direction for qualitative researchers to inquire into the experiences of psychotherapists who had experienced physical assaults on the job. Additionally, Bill's brief mention of the existential issues that come up towards the end of one's career piqued my curiosity about what it is like to retire from clinical practice, or even short of retirement, to leave a clinical job that one had held for some time. In Bill's words, what is it like to turn off those lights and never turn them back on again?

My Personal Growth Through This Project

In my second year of graduate school I had a dream that I was taking a final exam, and the first question was "What is phenomenology?" In the dream I kept writing and erasing my answers because I was never satisfied with what I wrote. I never finished the exam. This dream portended my relationship with writing this text. In trying to breathe life into the text so that the living essence of experiences can be evoked in the minds of my readers, I had to find ways to make language communicate more evocatively than it seemed capable of, which

entailed a great deal of trial and error, and acceptance of the limits of language. I also learned that writing was not simply a dutiful reporting of the data. Rather, writing itself was a method of discovery. Often times I would begin writing with a rough outline of themes in mind but quickly find myself in a rut because I was trying to force the data to work for my preconceived notions, at which point I would have to revise my themes and organize my data differently. Because of the intense personal engagement with the text, the process of writing and rewriting felt like a cycle of self-creation and self-destruction, which added a layer of emotional vulnerability. Moreover, I had to stop somewhere eventually, which required an acceptance of the imperfections in this draft. This quote from van Manen (2014) particularly resonated with me as I was trying to make sense of my sadness at not being able to bring all that I wrote to life:

> In the act of naming and gaining knowledge, we cannot help but rob the things that we name of their existential richness. And so, while trying to become sensitive to the subtleties, nuances, and complexities of our lived life, writers of human science texts may turn themselves unwittingly into annihilators – killers of life: a sobering realization and an unusual beginning perhaps for thinking about phenomenology, reflection, research, and writing. (van Manen, 2014, p. 21)

Additionally, while there was pain, stagnation, despair, grief, and rage as I worked through the vulnerability of thinking about, feeling, breathing, and dreaming vulnerability for this project, there was also profound relief in being held by the stories that other clinicians offered about their vulnerability. Their stories also held me when I was going through my predoctoral internship. During times when I made mistakes that felt unforgiveable, the simple expression from Morgan that they "were just sitting there in a lot of pain" with their client after a huge rupture in their relationship, felt comforting and validating. Similarly, my participants' sharing about moments when they feared for their physical safety helped me to

process my own experiences of visceral dread when I was threatened and physically assaulted by a patient. Furthermore, the seasoned professionals in the study gave me much hope as a trainee when they shared that they became more comfortable with being vulnerable over time. In a way, I am living proof of the value of phenomenological research. To borrow an analogy from Yalom (2013, p. 203) – my participants' stories were like the lights from boats bobbing on the sea at night; I knew that there were other boats out there, also looking out over the dark sea to catch the glimmers of other boats. We have never been more alone as when we are vulnerable, and yet we have never been more together when we are vulnerable. I end with a quote from one of my personal heroes, Lewis Aron (2013), in memoriam:

> In acknowledging one's own permeability and vulnerability, however – one's embodiment, mortality, and humanity – one does not need to project all of the conflict, splitting, shame, disgust, animalistic embodiment, penetrability, and vulnerability onto the patient. By owning one's own vulnerability, the analyst reduces the patient's shame and thus allows the patient to face vulnerability with less pain and dread. (p. 38)

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Appendix A

Recruitment Flyer

Dear Clinicians,

My name is Kay Chai, and I am a clinical psychology doctoral student at Duquesne University. I am currently recruiting participants for my dissertation study on psychotherapists' experiences of vulnerability. Participation involves a 60- to 90-minute in-person interview with me. You will have the choice of being interviewed either in your own office or at the Duquesne University Psychology Clinic.

I am hoping to specifically work with psychotherapists who practice psychotherapy as their primary profession (i.e. at least 7 direct contact hours per week), whether as a clinician in private practice or working with an agency, or as a student therapist who is currently working with clients under supervision (at least 4 direct contact hours per week). Psychotherapists of both masters level and doctoral level qualifications (or level of study) are welcome – for example, those in the process of obtaining a MA or MS in clinical or counseling psychology, PhD in clinical or counselling psychology, PsyD, etc.

In you are interested in participating or have questions about participation, please email me at chaik@duq.edu. Please also consider forwarding this email to other therapists you may know. Thank you in advance for your help.

Sincerely,
Kay Chai
PhD candidate
Duquesne University Clinical Psychology program

Appendix B

Email with Screening Questions for Prospective Participants

RE: Dissertation Study on Psychotherapists' Experiences of Vulnerability (DATE)

Dear (NAME),

Thank you for expressing interest in becoming a participant in my dissertation study on psychotherapists' experiences of vulnerability! Participation involves a 60- to 90-minute in-person interview with me either at the Duquesne University Psychology Clinic or at your office (your choice) and will be scheduled at your convenience.

I have attached the consent form for your perusal so that you can make a more informed decision about whether you'd like to participate. Please bear in mind that you may withdraw your participation at any prior to the defense of this dissertation.

I have also listed some preliminary screening questions below to determine whether you meet criteria for participating in this study. Please respond to the screening questions relevant to you (student therapists OR professionals) and email them back to me, along with any questions, concerns, and curiosities you may have.

Screening questions for student therapists:
1. How many hours do you work **directly** with clients per week currently, i.e. **excluding** time spent on paperwork, supervision, and didactic training?
2. What kind of program are you enrolled in? (e.g. MA or MS in clinical or counselling psychology, PsyD, etc.)

Screening questions for professionals:
1. How many hours do you work **directly** with clients per week currently, i.e. **excluding** time spent on paperwork, supervision, and consultation?
2. When did you obtain your degree, and what kind? (e.g. MA, MS, PhD, PsyD, etc.)
3. Are you currently licensed? If so, what kind? (e.g. LMFT, LPC, etc.)

Thank you again for considering participating in my study, and I look forward to hearing from you! Please remember that you are always welcome to ask me about this study either through email or by calling me at # (or leave your name and call back number if you get to my voicemail box).

Sincerely,
Kay Chai
PhD candidate
Duquesne University Clinical Psychology program

Appendix C

Consent form

DUQUESNE UNIVERSITY
600 FORBES AVENUE ♦ PITTSBURGH, PA 15282

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

TITLE:
PSYCHOTHERAPISTS' EXPERIENCES OF VULNERABILITY

INVESTIGATOR:
Kay Yu Yuan Chai, M.A.
Department of Psychology, McAnulty College and Graduate School of Liberal Arts
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.
ADVISOR:
Lori Koelsch, Ph.D.
Department of Psychology, McAnulty College and Graduate School of Liberal Arts
Email: koelschl@duq.edu Phone no.: 412-396-1614 Office: 205 Rockwell Hall

SOURCE OF SUPPORT:
This study is being performed as partial fulfillment of the requirements for the doctoral degree in Clinical Psychology at Duquesne University.

PURPOSE:
You are being asked to participate in a research project that seeks to investigate how psychotherapists experience their vulnerability in the capacity of being psychotherapists.

In order to qualify for participation, you must be currently practicing psychotherapy for at least an average of 7 direct contact hours per week if you are a licensed practitioner, or at least an average of 4 direct contact hours per week if you are a therapist in training. If you are a therapist in training, you must be currently enrolled in a M.A., M.S., or Ph.D. program in clinical psychology, counseling psychology, or counselor education, or any other comparable masters or doctoral program that has psychotherapy training as an integral part of its curriculum.

PARTICIPANT PROCEDURES:
You will participate in an interview with me at either the Duquesne University Psychology Clinic (DUPC) or at your office, depending on your preference. For your comfort, it will be up to you to decide between one of the two venues. Please be aware that DUPC is an active clinic for Duquesne students and community members, and it is utilized by many student therapists. In addition, for transcription purposes your interview at DUPC will video-recorded. If you choose to be interviewed at your office, your interview will be audio-recorded and transcribed.

The approximate duration of the interview, including the informed consent and debriefing, will last 60-90 minutes. You will be asked to speak about what vulnerability means to you, to share specific examples of times when you have felt vulnerable as a psychotherapist, and your sense of how psychotherapists can work with their experiences of vulnerability in service of the therapy. After the interview, I will speak with you about how the interview was like for you, and discuss any question, concern, or strong feeling that may have come up during the interview.

After the interview you will be asked about some basic demographic information and information related to your practice of psychotherapy including your therapeutic orientation or modality, the average number of hours you practice each week, your practice setting and population, training or licensure status, and years of experience.

As the results of this study may be presented in written articles or conference presentations, you will receive a draft of the initial findings a few months from now so that you will have to chance to give me feedback or withdraw direct quotes or details that you do not want to be printed in the final draft. Additionally, I will remind you two weeks prior to the defense of this dissertation that I will be presenting my findings to a public audience so that if you change your mind about participating or wish to retract any information, you will have the chance to do so.

These are the only requests that will be made of you.

RISKS AND BENEFITS:
There are minimal risks associated with participating in this study, but no greater than those encountered in everyday life. Speaking about experiences of being vulnerable may bring up strong feelings, some of which may be painful. On the other hand, it may bring up positive feelings or even lead you to a better understanding of past experiences in your work. In addition, talking about past experiences may lead you to reinterpret an experience, whether positively or negatively. If you become too uncomfortable during the interview and would like to pause or stop the interview, you may let me know.

In participating in this study, you also help to contribute to the scientific knowledge about the role of the experience of vulnerability in the work of psychotherapists. Increased knowledge about how psychotherapists experience themselves in the work can lead to a clearer understanding of how the psychotherapist contributes to the therapeutic relationship and the outcomes of therapy, thereby indirectly benefiting psychotherapy clients.

COMPENSATION:
There will be no compensation for participating in this study. Participation in this project will require no monetary cost to you.

CONFIDENTIALITY:
Your participation in this study and any personal information that you provide will be kept confidential at all times and to every extent possible.
Your name will never appear on any survey or research instruments. All written and electronic forms and study materials will be kept secure in a password-secured computer. The audio or video recording made of your interview will be copied from the recording software or device to a secured USB drive and the original will be destroyed upon successful downloading. The copy will be destroyed upon the completion of transcription.

Any personal identifying information available through the interviews such as your name, the name and location of your training program or psychotherapy office, clients' names and their potentially identifying information will not appear in the dissertation text. Any study materials with such information will be maintained for up to three years in a password-secured file after the completion of the research and then promptly destroyed. Your response(s) will appear in the dissertation text or other presentations only in the form of direct quotes and thematic summaries.

RIGHT TO WITHDRAW:
You are under no obligation to participate in this study. You are free to withdraw your consent to participate at any time by calling, texting, or emailing me. If you withdraw your consent to participate I will destroy all recordings, notes, and findings related to your interview, and any information you have supplied will not appear in the dissertation text or during the public defense.

SUMMARY OF RESULTS:
A summary of the results of this research will be supplied to you, at no cost, upon request.

VOLUNTARY CONSENT:

I have read the above statements and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reason. On these terms, I certify that I am willing to participate in this research project.

I understand that should I have any further questions about my participation in this study, I may call Lori Koelsch, Ph.D. at 412.396.1614. Should I have any questions regarding protection of human subject issues, I may contact Dr. David Delmonico, Chair of the Duquesne University Institutional Review Board, at 412.396.1886.

_____ _____

Participant's Signature Date

_____ _____

Researcher's Signature Date

Appendix D

Semi-Structured Interview Guide with Demographic Questions

Preamble: "During the interview I will say very little to allow you space to speak. Occasionally I may interrupt or slow you down to find out more. Some of the questions I ask you may sound self-evident, but I am interested in learning how you understand and make sense of things."

1. "Can you tell me what vulnerability means to you?"
    Follow-up: "What does it feel like for you to be vulnerable?"
2. "Tell me about a time when you felt vulnerable as a therapist."
    If interviewee tells me about a specific moment in therapy, ask about periods of time: "From the beginning of your career until now, have there been times when you felt more vulnerable in your role of being a therapist?"
    If interviewee talks about general periods of time in their career when they felt vulnerable, ask about specific moment: "How about a moment when you felt vulnerable with a client?"
3. "When did you first become aware of your vulnerability as a therapist?"
4. "Has there been a time when you consciously made use of an experience of vulnerability to facilitate the psychotherapy?"
5. "Has there been a time when experiencing vulnerability got in the way of moving the psychotherapy forward?"
6. "How do you think your patients experience your vulnerability?"
7. If interviewee has not talked about supervision or consultation experiences:
    If trainee: "How have your supervisors been towards your vulnerability?"
    If not trainee: "How have your (previous) supervisors been towards your vulnerability?"
8. "Imagine that you experienced yourself as invulnerable with your patients. How would that change the way you experience and approach psychotherapy?"
9. If interviewee is currently supervising or has supervised other clinicians: "How are you /have you (been) responding to your supervisees' experience of vulnerability?"
If interviewee is not supervising and has not supervised other clinicians: "If you were a supervisor, how would you respond to your supervisee's disclosure of vulnerability?
10. "Is there something that I have not asked about vulnerability that you would like to tell me?"

"Finally, I am going to collect some basic demographic information. Please remember that you are not required to answer any question that you do not wish to."

1. "How old are you?"
2. "What is your racial or ethnic identity? "
3. "What gender do you identify as?"
4. "How many hours do you practice psychotherapy per week, on average? "
5. "What do you identify as your therapeutic orientation or modality?"
6. "How many years have you been practicing psychotherapy?"