The Emotional Psychologist

A Critical Discursive Analysis of Psychologists' Talk about Their Emotions within the Therapeutic Relationship

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Abstract

While psychologists' own emotional management is an integral part of psychological therapy, it is often assumed rather than discussed; the affective expectations for the profession are unarticulated. In this research I explore how psychologists talk about their patterns of emoting within the therapeutic relationship in order create an account of the profession's expectations for emotional expression and to open up a space for a critical examination of these expectations.

I understand emotion as affective practices which are both being constituted actively as people carry out the practice and shaped over time as past practice carves out grooves of emoting that become familiar and habitual (Wetherell, 2012). This understanding of emotions attends to both patterns, and points of tension or contestation. I asked practising psychologists about their emotional practices within the therapeutic relationship in four small focus groups and 11 follow up individual interviews.

I use the variety of discourse analysis developed within critical social psychology (Billig, 1987; Edley, 2001; Wetherell, 1998) to examine how participants made meaning around their emotions within the therapeutic relationship by drawing on different affective-discursive repertoires. The analysis includes an account of how psychologists have come to construct their emotions in dilemmatic ways in the context of clinical psychology as a profession (which has gone through many iterations in the years since its inception in the first part of the 20th century), and well as a consideration of how participants spoke about trying to resolve these points of tension and dilemma. I also consider participants' talk about when professional feelings go awry, how they work on themselves in order manage 'unprofessional' emotions, and the implications of these affective-discursive identity negotiations for their constructions of self. I suggest that that the exchange of certain emotions for remuneration within this profession becomes hidden within the individuals' subjectivity.

I consider some of the wider social power relations that both hold these practices in place and are reproduced as psychologists emote in prescribed ways. Finally I reflect on whether an affective practices understanding of emotions could be used as a rhetorical tool to help psychologists look more critically at the functions of their emotions within the therapeutic relationship.

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Introduction

I am studying to become a clinical psychologist in a time when some see it as a profession under threat. In a neoliberal era when "health decisions are being increasingly driven by economic agendas", and there is more demand on health resources in New Zealand due to an increasing and aging population, psychologists are under increased pressure to demonstrate that their services are efficient and effective (Bellamy, Feather, Gibson, Howard, & Lambrecht, 2014, p. 14). These perceived threats come from medically trained doctors and the assumption that psychotropic medications are more cost effective than psychological therapies, and in the other direction from professionals such as nurses, social workers and occupational therapists, who are now providing psychological therapies at lower pay rates. Mental health care in New Zealand is on the cusp of taking on a stepped care programme similar to that in the United Kingdom, which saw job losses for psychologists as other professions took on therapist roles (Bellamy et al., 2014).

This questioning of the worth of clinical psychology is not necessarily new. Clinical psychology has been a contested profession since its inception, with tensions evident between psychology and psychiatry since psychology moved into the territory of treatment (in addition to assessment) (Cheshire & Pilgrim, 2004). The institution of clinical psychology also has a history of attempting to differentiate itself from other groups providing therapy (e.g. self-help gurus or counsellors) on the basis of claims to more scientific legitimacy. There is also tension within this profession because of its highly contested knowledge base resulting from differing theoretical orientations (Cheshire & Pilgrim, 2004). Further to this, there is on-going debate and uncertainty around the effectiveness of psychological therapy in reducing psychological distress (Cromby, Harper, & Reavey, 2013). These pressures and tensions, both external and internal, require on-going boundary work in order to define and redefine the profession and its unique modes of discipline and control.

How might such pressures influence the way psychological therapy is understood, taught in training programmes, and practised? I am particularly interested in how psychologists negotiate their emotional practices in this context. What are the functions of the psychologist's emotions within this profession as it tries to maintain its status and power? Maroda (2009) argues that the current psychotherapy training programmes ignore the emotional impact of the work. She suggests that the increasing emphasis on homework,

relaxation, and minimising negative thoughts, inadequately prepares new therapists for the realities of the "black hole" of endless despair that many clients express. Morstyn (2002) suggests that currently psychological therapy exists in a post-modern society where deception and insincerity are widespread and that manualised psychotherapies instruct therapists on how to simulate sincerity and play the role of the warm and seemingly genuine therapist.

What does all this mean for how psychologists come to understand and practise emotions in the therapeutic relationship? If psychologists' emotions in these contemporary times are ignored or assumed to be simulated what does this mean for their professional identity and their work with clients? How do psychologists learn how to emote in accordance with the professional identity? My own experiences within the clinical psychology training programme and through past work experience have been at times bewildering. There have been occasions when I have been told that I am too flat and need to be more expressive and animated, and other times when I have been told that I am too expressive, too congruent and that caring about clients so much is not good for my own well-being. I have had supervision relationships where emotional expression is encouraged and others where it has been seen as an indicator of incompetence. I knew that there were certain expectations for how I was to be emotionally as I worked towards being admitted to this profession, however, it was not always clear what was expected, or at least expectations seemed to vary based on the context and who was talking. Through my own limited experience it seemed that the emotional work involved in being (and becoming) a psychologist is complex and nuanced. There are points of tension and contestation, and I became curious about how practising psychologists work to resolve these dilemmas, particularly in this time where the profession is seen as under threat. I wondered what the function of the psychologist's emotions might be for clients (and for the circulation of power), and how psychologists' emotional expectations might translate into the lives of clients who spend most of their time (when in not therapy) in diverse social contexts, with potentially different sets of assumptions and expectations around emotional expression. Through these wonderings I came up with the following research questions:

1. What psychologist emotions are deemed acceptable or unacceptable within the therapeutic relationship; what kinds of emotional identities and subject positions do psychologists endorse and try to assume, and what contradictions and dilemmas arise as psychologists draw on authorised ways of making meaning around emotion to understand their own practice?

2. What are the implications of profession's emotional expectations for psychologists themselves and what kinds of work on the self are they required to do?

3. How do psychologists' standpoints on emotion relate to wider social and emotional regimes?

I explore these puzzles through critical qualitative research, adopting an affective practice understanding of emotion (Wetherell, 2012) to consider both patterns and contestations in the way psychologists talk about their emotions within the frames set by the occupational identity. This involved intensive work with a small sample using focus groups and individual interviews. I used discourse analysis developed within critical social psychology (Billig, 1987; Edley, 2001; Wetherell, 1998) to examine participants' meaning making accounts of their emotions within the therapeutic relationship; how they articulate, and make sense of the practices in which they engage. Through this I have produced an account which captures some of the complexity and multiplicity of the emotional work psychologists do within the therapeutic relationship, which had previously largely been ignored due to the ubiquity of the scientific framing within psychology which privileges a single objective 'truth'.

In the analysis I discuss how different (and at times opposing) types of emotional expression are constructed as risky, and I suggest that this construction of risk is part of what holds certain affective practices in place. Here, in this Introduction, one brief example from the data will indicate how psychologists' formulations of their emotions are regulated and at times become complex and conflicted. In three of the four focus groups I conducted feelings of anger towards clients were articulated and then immediately contested. Anger towards a client became this sort of hot potato that no one could hold until it had cooled down to the more manageable frustration, as illustrated in the extract below.

> **Helen**: (breath in) So anger at kind of other people in their lives, anger at injustice [Pete: mmm], ever anger at the client?
> **Hayley**: Yip.
> **Pete**: Yip (quiet brief laugh).
> **Isabelle**: I would say probably more frustration [Pete: frustration] than anger.
> **Pete**: Frustration. (laughter)
> **Hayley**: Frustration is the word (laughter) [Pete: yeah].
> **Helen**: Frustration is somehow more like accurate or acceptable?
> **Hayley**: Accurate I think.

Pete: Accurate.

This denial and immediate reframing of certain emotions contradicts another dominant discourse that psychologists should be open to and experience all emotions within the therapeutic relationship. Ideological dilemmas such as this one cannot be neatly resolved with a clear set or rules or protocols and the analytic chapters of this thesis will demonstrate how participants work to resolve them.

Through this research I suggest that rather than there being one clear way to emote as a psychologist, there are different patterns of practice which, although contradictory, are all constructed as legitimate for the psychologist at different times. The emotional life of a psychologist as they practise consists of more than merely experiencing biological impulses and acting on them. It is tied into complex patterns of meaning making which are both constrained through prescriptions and expectations based on past practice and fluid because the points of difference and contestation (both within the discourses of participants and between them) creates space for change and movement. I also suggest that, as well as working with the client's emotions, psychologists are involved in working on their own emotion-laden subjectivities with some profound consequences for self and identity. I consider how this work on self both feeds back into wider social power relations and is part of the reproduction of social divisions.

It may not be news to many psychologists that their work involves working on their own emotions and includes complex negotiations of ambiguous situations. What this research adds is a way to understand these practices through a critical social perspective which can promote the discussion of puzzles and tensions that are currently obscured or disregarded, increasing reflexivity and the critical tools of the profession. There is a lack of research that reflects critically on the function of psychologist's emotions within the therapeutic relationship. This is partly due to the inadequacy in ways of theorising affect and emotion to date. Therefore one aim is to apply and extend new theoretically innovative approaches to emotion (e.g. Burkitt, 2014; Wetherell, 2012) which understand emotions as both constituted actively as people carry out the practice of emotions and shaped over time through histories of past practice. Adopting a broader approach of formulating emotions which attempts to capture "the constructive power of affective-discursive material, and its flexibility, mobility and action orientation" (Wetherell, McCreanor, McConville, Barnes, & le Grice, 2015, p. 57).

Widening the scope for how emotions are understood is practically important because understanding, formulating and practising emotions is a central part of psychologists' work. It is important from a critical political perspective because the current narrow understandings of emotions eclipses the broader social, cultural and historical conditions which privilege certain affective practices and marginalise others.

Summary of Chapters

Chapter 1 provides an epistemological base for the research. It starts with an overview of some theories of emotions that have prevailed within psychology and goes on to focus on theories that attempt to capture the social element of emotion. I locate the research in a broadly social constructionist framework that draws predominantly on Wetherell's (2012) construct of affective practices. I also review some theories around emotions and the circulation of power. Chapter 2 considers how emotions are constructed in different psychological therapies and how this relates to the way psychologists are expected to emote within these varying therapeutic modalities. Following this I review some of the more overarching understandings about the functions of the psychologist's emotions, and some of the dilemmas arising from the literature about how psychologist 'should' emote within the therapeutic relationship. Chapter 3, gives an overview of my critical constructionist approach, and an outline of the sort of discourse analysis and analytic constructs (affective-discursive repertoires, subject positions and ideological dilemmas) I am using. It also describes how I collected and worked with the data.

Chapter 4 is the first analytic chapter where I capture some of the complexity involved in psychologists' emotional work. This chapter develops an account of two broad affective-discursive repertoires (ADRs) that were pervasive in the data and the associated subject positions. I also draw some lines between the ADRs, and the types of therapy they most align with and briefly reflect on the social and political frames for the development of these types of therapy. I continue in this vein of analysis with the constitution of a third ARD in the first half of Chapter 5. Following this I briefly consider how participants constructed some of the functions of their emotions within the therapeutic relationship and elaborate on some of the key ideological dilemmas. Chapter 6 is a third analytic chapter which considers participants' talk about when professional feeling go awry; how this is managed; and what this means for psychologists' construction of self. Chapter 7 is a final discussion chapter, which looks

further at the relationship between how participants spoke about their professional emotions and social power relations. I also reflect on my decision to choose an affective practice theory of emotion and what might be gained from psychologists using this way of understanding emotions as a rhetorical tool. I conclude with a reflection on possible further implications for this research.

Chapter One – Constructing Emotion

To a large extent, therapy involves the management of emotion. Both the client's and therapist's affect is at stake. The research reported in this thesis investigates how a sample of psychologists working in Aotearoa/New Zealand formulate this key aspect of their practice. Clinical psychology is a branch of psychology concerned with the application of psychological principles to the assessment and treatment of psychological, emotional and behavioural problems. Clinical psychologists are the largest group working under the title of psychologist in New Zealand (Tripp, 2007). There are currently six clinical psychology training programmes in New Zealand, each admitting up to ten students per year. Becoming a clinical psychologist in New Zealand takes six to seven years of tertiary training and, once qualified, clinical psychologists are bound to a programme of on-going learning and development through the New Zealand Psychological Board's Continuing Competence Programme (New Zealand Psychological Board, 2011). This training and on-going professional development requires a degree of emotional restructuring in which the psychologist learns which emotions are to be negotiated within the therapeutic relationship and how. While the psychologist's emotional management is an integral part of any sort of psychological therapy, it is often assumed rather than discussed. This is particularly the case in New Zealand and Australia, as most Australasian universities do not teach psychodynamic therapy (Kazantzis & Deane, 1998), which uses the constructs of transference and countertransference (discussed in Chapter 2). The 'feeling rules' for the emotional psychologist are often implicit rather than explicitly communicated. By surfacing these issues, this research will create space to look critically at the function of the clinical psychologist's emotion.

To investigate these issues I will draw on a theory of emotion that allows for the understanding of emotions as both embodied and discursive in their constitution. I want to explore how emotions come to be patterned in on-going social relationships within the frames set by the occupational identity of the clinical psychologist, and consider how this relates to wider social relations (including power relations). My main focus, therefore, will be on theories of emotion that attempt to capture these social dimensions.

In order to situate my theoretical perspective, I give a brief review of some of the theories that have been used to construct emotion within the discipline of psychology. I start with

brief discussion about basic emotions. Basic emotion theory is not going to be useful for this research because it constructs the cause of emotion as biological and innate, therefore as an essentially asocial process. Appraisal theories and the psychological constructionist theory of emotion are more useful in that they consider how an individual's emotional response is mediated by the way they interpret the environment or situation. Although this widens the frame of reference, there is little elaboration on the social and relational aspects of emotion. I give an overview of social constructionism as an alternative epistemological approach to specifically consider the social construction of emotions. Following on from this I outline constructs of feeling rules and emotional labour and consider what elements of this theory might be useful to the research. I then come to the theory of affective practices which considers how emotions are patterned across relationships. Finally, I review some theories on how emotion relates to regimes of power[1].

Basic Emotions

Until recently theories of emotions could be broadly split into two general categories; 'emotions as inherent' and 'emotions as socially constructed' (with some theories overlapping the two) (Lupton, 1998). The 'emotions as inherent' camp is centred on the construct of basic emotions. It is important to consider this approach, because, to a greater or lesser degree, it permeates many psychological theories of emotions, and is implicit in most Western lay understandings. While most research into basic emotions acknowledges that emotional expression can be modified through social and cultural processes, it contends that there are underlying functional emotional processes that evolved over time and therefore are passed down primarily genetically (rather than learnt) so that we are all born with a universal set of basic emotions. There is some disagreement around how often basic emotions are present in their 'pure' form and about which emotions can be classified as basic. However, there is a general consensus on the emotions of happiness, sadness, fear and anger (Tracy & Randles, 2011). The original proponents of this work reported that there was evidence of

[1] Conventionally affect has been understood as a generic term covering all sorts of ways of being affected; emotions have been understood as the culturally established recognisable scripted kinds of affect; and feelings have been understood as the phenomenological experience. However, as soon as we move away from a basic emotions understanding those distinctions start to dissolve into each other. We are always in the cultural realm because feeling is unknowable until it become a communicable act in which case people are drawing on cultural resources.

universal facial expressions denoting these basic emotions. This was used to suggest that cross-cultural patterns of autonomic nervous system activity for different emotions exist and are relevant for survival (Ekman, 1992).

Tracy and Randles (2011) reviewed four more recent models of basic emotions in order to reach a consensus about the key prerequisite features for basic emotions. For an emotion to be categorised as basic there needs to be some evidence of cross-species generalisation and identified specific brain regions that are activated in response to specific emotions. In addition to this emotions need to be discrete in that they should have a fixed set of neural and bodily components along with a fixed feeling or motivational component. Finally, they should be able to be seen as psychologically 'primitive', meaning either that they originate from subcortical brain structures, or are most evident in their 'purest' form (e.g. in young children or in times of crisis). Basic emotions are said to interact with each other and with cognitive processes to produce emotions and behaviours that are more complex than 'pure' basic emotions (Tracy & Randles, 2011).

Theories of basic emotions are grounded in evolutionary theory which states that humans evolved under selection pressures, including those related to social relations and social organisation (Turner, 2009). Research has linked basic emotions to subcortical areas of the brain which developed earlier than the cerebral cortex and therefore it is suggested that basic emotions existed before so-called secondary or complex emotions. As the human brain evolved to become larger this allowed for the development of culture and a wider range of emotions, which made the species fitter because this strengthened social bonds and adherence to moral codes (Turner, 2009).

In recent years, there have been a number of critiques of the basic emotions framework. From a psychobiological perspective, there have been numerous meta-reviews of research into the links between basic emotions and discrete brain mechanisms which show that the findings are inconsistent (Wetherell, 2012). Barrett and Wager (2006), for instance, conducted a meta-analysis of studies that used neuroimaging techniques to try to find physiological evidence to support a basic emotions approach. To a degree this did show some agreement in the localisation of fear (the left and right amygdalae), sadness (the rostral portions of the anterior cingulate cortex) and disgust (the basal ganglia). However, the level of agreement was not particularly high; even for fear, which was the most consistent, only 60% of the studies in one

meta-analysis and 40% in the other showed that fear led to increased activation of the amygdala (Barrett & Wager, 2006). Questions have been raised about the methodologies of the individual studies, for example the fear-amygdala correspondence increases by 20% when only studies that used facial caricatures of fear were considered. Despite potential methodological flaws, the fact that on average half the studies did not show a correlation between fear and the amygdala does raise serious doubts about the so-called scientific validity of basic emotions (which, by definition, need to be associated with a specific part of the brain). Not only is there limited consistency there is also limited specificity. For example there are studies showing that the amygdala is also engaged by rewards or novelty. Therefore, it may be more involved with discerning the affective significance of a stimulus rather than a discrete emotional category such as fear (Barrett & Wager, 2006).

In another study, Barrett (2006) reviewed the range of research on emotions, and concluded that "even after 100 years of research, the scientific status of emotions as natural kinds remains surprisingly unclear" (p. 45). It is difficult to demarcate clear and consistent emotion categories and there is no strong evidence for distinct causal systems (Barrett, 2006). A later review of the neurobiological basis of emotions also reached the conclusion that it had not been fully determined as to whether distinct neural systems were linked to certain emotions (Daum, Markowitsch, & Vandekerckhove, 2009). For example research shows that when electrical stimulation is used on the exact same brain site it does not consistently produce the same emotion (Barrett, 2009).

From a cultural studies perspective, research shows that there are big variations in the ways emotions are described across languages and cultures, which suggests that there cannot be universal emotion concepts (Wetherell, 2012). Both across cultures and within cultures there appears to be more variability within emotion categories than between them (Barrett, 2009). Lutz (1998) suggests that the basic emotion research that claimed to have identified pan-cultural facial expressions for the basic emotions, ignored the fact that by applying the basic emotion categories that have been constructed in a Western culture onto the experiences of the other culture, they were superimposing these emotional categories onto other cultures without consideration of possible differences in understanding of the nature of self and emotion. These researchers reconstructed the emotional lives of members of other cultures as a reflection of their own.

From an evolutionary perspective, it has now been disputed that basic emotions solely involve the sub-cortical regions of the brain, as neuroimaging shows that when people are exposed to affective stimuli a broad network of brain regions are activated, including both cortical and subcortical regions. In addition to this, new research into the brain's flexibility and plasticity disputes the notion that we inherit fixed action patterns for the basic emotions (Wetherell, 2012). The old binary between biology and social context has been broken down by research on the brain's plasticity and the way the actual structure and function of the brain can be modified by contextual influences (Cromby, 2007). Cromby (2007) suggests that while some neuroscience is "conceptually confused, reductionist, and naively empiricist" (p. 97), there is mounting evidence from functional magnetic resonance imaging (fMRI) studies that show that the brain's structure and function is malleable with experience, indicating that the brain itself is socialised. This means we can move beyond the reductionism of dualistic, binary pairs such as mind-body or individual-society. Wetherell (2012) cites the work of Stephen Rose who describes the brain's architecture as dynamic and constantly changing. While this is most dramatic in the developing brain of infants and young children, it is also seen in the brains of adults. An example of this is research that suggests that psychological therapy has observable effects on brain function as seen in electroencephalography (EEG) and neuroimaging studies (Beauregard, 2009; Riess, 2012). While advocates of basic emotions suggest that these processes are just augmenting the evolutionarily-laid-down basic emotion responses, others, such as Rose, argue that culture actually transforms and re-models the possible emotional responses (Wetherell, 2012).

Appraisal Theories and Psychological Constructionism

Running alongside basic emotions research in psychology in the late 20th century was an alternative tradition of work that emphasised the role of cognition in emotion. Appraisal theories of emotions suggest that an emotion only becomes an emotion when a cognitive judgement or appraisal is made of the physiological reactions and what they might mean within the environmental conditions. Lazarus (1991) stated that "emotion cannot be divorced from cognition, motivation, adaptation and physiological activity" (p. 6). From this perspective the physiological reaction tells one that an important goal has been engaged (either being placed at risk or being advanced) and then this is appraised, resulting in the experienced emotion (Lazarus, 1991). Some researchers have critiqued this perspective in that there is evidence that people are often not aware of the emotions they are expressing

through their behaviour (Turner, 2009). However, recent research has suggested that commonly "the process of split-second appraisal and evaluation preceding bodily reactions will be interacting and finely tuned with on-going thoughts about situations, about representations of oneself in those situations, about what might count as an appropriate response and so on" (Wetherell, 2012, p. 45). While the environment is acknowledged in appraisal theories, the sociocultural context in which the appraisals are made is not considered in any detail (Lupton, 1998). So rather than focussing on the variability of emotional experience many appraisal theories appear to focus on trying to identify patterns of appraisal for each, presumed basic, emotion (Barrett, 2009).

Psychological constructionist theories of emotion focus on the sequence of events that make up an emotional episode, and in this way see them as being constructed each time to fit the circumstance, and cultural prototypes and scripts. They build on some of the insights of appraisal theories and also seek to incorporate the bodily dimensions of affect. They reject the basic emotions understanding of emotions as biologically determined (Russell, 2003). Russell (2003) goes as far as to say that the concept of emotion has no scientific use and that it can only be understood as a folk concept. Having rejected the utility of the construct of emotion, they go on to invent two new constructs of their own; 'emotion episodes' and 'core affect'. Prototypical emotional episodes are said to include a number of different processes: core affect; overt behaviour in response to the object; attention towards the object and appraisal of that object; the experience of oneself as having a specific emotion; and the neural chemical and other bodily reactions which underlie these psychological processes (Russell, Barrett, & Diener, 1999). This flips around the typical basic emotions understanding of emotion where all these components are seen being caused by the emotion, and instead sees them as coming together to construct the emotion. Core affect is constructed as "the most elementary consciously accessible affective feelings (and their neuro physiological counterparts) that need not be directed at anything" (Russell et al., 1999, p. 806). So a person is said to be always in some varying state of core affect. Therefore our emotional life does not consist of long periods of being non-emotional or 'normal', which are interrupted by the occasional emotional episode. Instead our emotional life is understood as being in varying fluctuations in core affect, and in some cases these fluctuations interact with perceptual, cognitive and behavioural processes, and become attributed to an object, in such a way that we draw on constructed 'common sense' categories and name them as a certain type of emotion (Russell, 2003).

Part of the psychological constructionist approach to emotion is the conceptual act model, which suggests that emotion words are 'common sense categories' that have come to correspond with mental events through past learning. These mental events are said to come from the interaction of more basic physiological ingredients; sensations from the world outside, sensations from within the body, and memory (past experience made available by the activation and inhibition of sensory neurons in the brain) (Barrett, 2009). Categorisation is said to be a natural consequence of how the brain works as a way of storing past representations and making them meaningful in the present. Therefore mental activity is ordered (e.g. into categories of emotion, perception or cognition) for a reason, that has to do with collective intentionality, communication and even self-regulation, but not because these categories are biologically reified (Barrett, 2009).

Psychological constructionism is useful for the purpose of this research in that it emphasises the diversity and inconsistency in emotional experience. It provides an alternative to the basic emotions framework and opens up a space to consider how emotional episodes could be constructed by different components. Emotions in this approach, however, still remain embedded in the emoting individual. Although the importance of culture is mentioned, it is not elaborated on, nor is the way emotion emerges in discourse, social interaction and on-going practice. While the psychological constructionists provide a convincing critique of basic emotions, they still ascribe to the fundamentals of positivist psychological science, most notably in their emphasis on the autonomous psychological individual as the centre of action.

Emotions and Social Relations One: Social Constructionism

An account of emotion that is underpinned by basic emotions and positivist epistemology leaves opaque central aspects I want to examine in my research. Social constructionism is an epistemology that rejects the positivist claim that through scientific research one can discover the true nature of emotion, as if emotion is some sort of objective reality that is waiting to be discovered. Social constructionism suggests that the way we describe the world does not directly relate to any single objective reality and that instead our explanations of the world are derived from our interactions within it (Gergen, 1999). In this sense it replaces the quest for discovering a single, objective truth with the idea of multiple 'truths' that are always local, interpretive and relational (Gemignani & Peña, 2007). Knowledge, from a social constructionism viewpoint, is the product of interactions which are socially and historically

located and preeminent cultural traditions are maintained over time in a continual process of meaning-making through social interactions (Gergen, 1999). What is deemed to be 'true' is what has been qualified as such by dominant forces within society and the constructions that we take for granted as unchangeable have been perpetuated as such by social interactions and political institutions (Gergen, 1985; Hosking & Morley, 2004).

From this perspective, psychology can be understood as bringing objects into existence through the process of knowing them. This knowledge can be understood as technological in that it entails the linking of thoughts, affects, forces, artefacts and techniques in order to create certain modes of existence which have to be addressed in certain ways (Rose, 1996). Therefore, from a social constructionist perspective emotions are "always experienced, understood and named via social and cultural processes" (Lupton, 1998, p. 15). Emotions are intersubjective, constructed through social and cultural processes. They are contextual rather than inherent and cannot be reified as separate entities (Lupton, 1998). Therefore our emotions, along with our intentions, memories perceptions and the like, are seen as being in the process of construction, both partially constructed and open to further construction, or reconstruction. Emotions along with other parts of the psyche only exist within embodied discursive practices (Shotter, 1997).

Harré (1986) in his book *The Social Construction of Emotion* writes that the idea of an emotion that exists independently and can be researched objectively is an ontological illusion. He suggests what is commonly assumed to be emotion is actually a felt perturbation, and it has been shown that such perturbations can be related to different emotions, even when the agitation is qualitatively the same. So the reason why a particular emotion word is attached to the bodily perturbation can be found in the common sense assumptions of the local culture (Harré, 1986). In this framework the field of emotional research is zoomed out from the individual to consider how a culture or subculture uses emotional vocabulary to define episodes in their emotional life. Harré (1986) suggests that "instead of asking 'What is anger?' we would do well to begin by asking, 'How is the word "anger", and other expressions that cluster around it, actually used in this or that cultural milieu and type of episode?'" (p. 5). So from this perspective the notion that 'pure' emotions are a biological response experienced by a passive individual who has little control over them is itself a construction and a social strategy which allows certain emotions to be manifested in certain interactions. Harré (1986) emphasises the importance of attending to the local moral order when looking at the social construction of emotions. An example of the force of the local

moral order is a study of loneliness where the subjective experience of loneliness was more related to the individuals believing they were more isolated than they would like to be, than their actual isolation as measured in the number of human encounters per day (L. Wood, 1986).

Social constructionist approaches to emotion create accounts that show how our taken-for – granted assumptions about emotional behaviour are in fact contingent on broader social and economic factors and as these change so will our constructions of emotion (Lupton, 1998). Traditionally, from within this framework, the role of language and other 'cultural artefacts' in the construction of emotional experience have been privileged. That is to say, our experience of emotion is constituted through 'emotion talk'. Shotter (1997) suggests that research should focus on the relational encounters between people and the dialogue they exchange. Therefore, the bodily sensations associated with the emotional experiences are seen as incidental, because the focus is on how we interpret them and represent them to ourselves and others (Lupton, 1998). What we come to know as our "self" or our "psyche" only comes into existence through the semiotic mediation of signs within our inner conversational processes (Shotter, 1997). However, the relationship between subjects, discourse and emotions is not seen as simple. Discourse is understood to be dynamic and people can choose from the discourses available to them and, within constraints, try to resist dominant discourses.

Social constructionist perspectives on emotion in some ways are similar to the psychological constructionist perspective in that they both dispute that the categories of emotions exist independently and objectively. However, the way that they set out to show this differs. The psychological constructionists are still essentially working from a positivist framework, where they attempt to dispute the science in order to disprove basic emotions, and open up space for their own constructions of emotional episodes and core affect. Whereas social constructionists explore the way people's experiences of and understandings of emotions differ across different cultures and over time. The cultural relativity of emotions can be seen in the different emotion words in different cultures, in the way some emotions are encouraged in one culture and supressed in another, in the way an emotion can exist in a stronger form in one culture and a weaker form in another culture, and in the way emotional repertoires have changed over time within the same culture (Harré, 1986).

A formative piece of research in this area was conducted by Lutz (1988) who spent time on a remote Micronesian atoll called Ifaluk, and documented emotional experiences which were qualitatively different to the emotional categories we have in English. An example is the emotion of fago, which is a combination of compassion, love and sadness. From a Western perspective fago entails some innate contradictions in that love is positive and activating and sadness is negative and deactivating. Lutz (1988) states that everyday life on Ifaluk shows the importance emotions have in negotiating social relationships and establishing social order. Expressions of fago are a way for the people of Ifaluk to express positive emotions towards one another, fago is used to let others know about the strength of a relationship, to talk about the pain of ending such relationships, and to show a readiness to care for the other (Lutz, 1988). Fago is also dependent on social maturity and requires mature language skills. It is also associated with power as those who are put in positions of power need to be fago, in their ability to care for others; they need to be gentle and nurturing. This also relates to the relatively powerful position women have on Ifaluk (Lutz, 1988).

Lutz (1998) suggests that there is evidence that "emotion experience, both in the West and in Ifaluk, is more aptly viewed as an outcome of social relations and their corollary worldviews than as universal psychobiological entities" (p. 209). While the biological basis of emotions is not denied she considers how social and cultural forces construct the way we understand and act on them. The way emotion is constructed within a culture includes a sense of compulsion to act, defining how individuals should behave in certain situations and therefore structuring social behaviour. Although she also acknowledges that there are occasions where the individual's interpretations or their individual desires are 'at odds' with the culturally constructed social morality.

Another interesting part of her research is that she suggests that the "material conditions of life on a coral atoll both order and are ordered by local theories of emotions" (Lutz, 1988, p. 213). These conditions contribute to the situations people encounter and need to interpret, often with the aid of emotion concepts. These conditions include limited land with high density of population, vulnerability to typhoons and high infant-mortality rates. The emotion of fago described above supports key social principles such as resource egalitarianism and cooperativeness, which are essential for social cohesion within this physical environment.

Importantly Lutz (1998) acknowledges the limitations in her own ability to understand the emotions of the people of Ifaluk because emotions are constructed and understood through social relationships and clearly the type of relationship she had with the people of Ifaluk as a foreigner was more limited that the locals had with each other.

This is just one example of a body of research that shows the social, cultural and historical contingency of emotions and how they are understood and experienced. In many ways Lutz's research sets out a useful framework for my research. Firstly emotions are constructed within social relations and are culturally specific. Her linking of emotion to social morality alludes to the role emotions play in social power relations. And her suggestion that the types of emotion experienced by the people of Ifaluk relates to the island's geography, encourages us to consider how emotion could relate to the physical space.

Social constructionism as a broad epistemology is useful and will be adopted as the epistemological foundation of this research. However, the social constructionist perspectives on emotions have been critiqued for privileging language at the expense of attending to the bodily aspects of emotion. Discourse analysis, a methodology used by many researchers who adopt a social constructionist epistemology, has traditionally stripped away much of the affective texture and reduces the understanding of discourse to "a system of meaningful statements which construct an object" (Parker, 2002, p.145). In response to this many social and cultural researchers in recent years have turned away from discourse analysis on the basis that focussing on meaning making does not adequately capture what has been formulated as the pre-discursive hit of events on bodies and the excess of affect (for example Anderson, 2006; Massumi, 2002; Thrift, 2004). The 'turn to affect' has seen affect constructed as something that is below or beyond discourse and seeks out research methods that attempt to work at the limits of what can be verbalised (Wetherell, 2013a).

Wetherell (2013a) argues that the separation of affect from discourse is unsustainable, because the registering of embodied states is always already bound up in meaning making and we cannot separate out a realm of pure affect from discourse. She calls for methods in social research that address the interrelation between embodied emotion and discourse. Rather than separating affect from discourse as much social research on affect does, Wetherell et al. (2015) see them as entangled and calls for the exploration of how the "domains of semiosis and affect become worked together in regular, ordered practices" (p.

57). Cromby (2007) suggests that signs and meaning-making systems other than language need to be considered, such as sign systems that are sensual, kinaesthetic and corporeal. That is to say, our experience of emotion comes from both our lived embodied experience, as well as from language and social relations. While understanding the social and linguistic practices is crucial to research on emotions, it should not be reduced to this alone (Cromby, 2007). This does not mean that there is some sort of inherent emotion lurking beneath the socially constructed one; our embodied experience is always constructed through and mediated by sociocultural processes because bodies are malleable (Lupton, 1998).

Emotions and Social Relations Two: Emotional Labour and Feeling Rules

A theory of emotion that comes under the broad umbrella of social constructionism (at least at first glance), is Hochschild's construct of emotional labour. Emotional labour involves trying to induce or suppress emotion in order to display the outward countenance that produces the required state of mind in others. It can be aided by an emotional work system and can be done by oneself, by others or to others (Hochschild, 1979, 1983). It is about trying to eliminate the discrepancy between what you feel and what you 'should' feel. Emotional labour is distinct from everyday emotional work in that it refers specifically to the type of emotional work that is done in exchange for a wage (rather than for something like mutual support). Hochschild (1983) distinguishes between what she calls 'surface acting', trying to change how we outwardly appear, and 'deep acting', trying to induce the actual feelings within ourselves and expressing them. This theory of emotion came out of her empirical research with flight attendants working for Delta Airlines in the 1970s. These flight attendants were expected to put on the right demeanour when at work – always smiling and being pleasant and using a friendly and reassuring voice – so that the passengers would feel safe and at home, increasing the chances of them flying with the airline again (i.e. increasing profits). This means being calm and accommodating even in when passengers were being difficult (Hochschild, 1983).

Feeling rules are a set of social guidelines that direct what we believe we should feel. Feeling rules can be seen in the notions of rights and duties that people attach to feeling and are implicit in any ideological stance (Hochschild, 1979). Hochschild (1979) states "as some ideologies gain acceptance and others dwindle, contending sets of feeling rules rise and fall"

(p. 576). There are varying costs to breaking feeling rules and taking on a different set of feeling rules can defy the dominant ideology and be a point of resistance (Hochschild, 1979). Feeling rules get commercialised and emotions become commoditised when they are bought and sold as an aspect of labour power. Hochschild does not see emotional labour as necessarily a bad thing. In fact, she suggests that it is a necessary part of our social fabric, but when the work gets sped up or undue demands are made on workers, then emotional labour can result in exploitation and alienation (Hochschild, 1983). Hochschild (1979) suggests that the commodification of feeling is more salient for the middle class than for the working class and that this is maintained through the way children are socialised differently in relation to emotion management. She suggests that many middle class jobs require one to follow certain feeling rules and have the capacity for 'deep acting', whereas working class jobs more often put demands on the individual's physical labour and the products of it. I am unconvinced of this aspect of her theory; I think there is still emotional labour and feeling rules in more working class jobs (although they may differ), especially as manufacturing industries have given way to the service economy in many Western liberal democracies.

Indeed recent work on emotional labour in call centres, for example, documents this (Korczynski, 2003). Interestingly, Hochschild (1979) suggests that the less financially rewarded one is for this emotion work, the less they are likely to see these professional feelings as part of themselves. This would suggest that relatively well paid clinical psychologists may see their 'deep acting' more as part of themselves. Rose (1990) talks about the subjectification of work, and "the saturation of the working body with feelings, emotions and wishes" (p. 224). This changes the purpose of work from being something you do for financial reward to something you do for personal fulfilment and the identity it offers. In this sense work becomes talked about in therapeutic terms and problems with work become concerns of therapy (Rose, 1990).

Hochschild and other authors since have researched the emotion work associated with various professions. Some of this research has focussed on the emotion work implicit in the clinical empathy required to work successfully as a medical doctor or nurse (Larson & Yao, 2005; P. Smith & Gray, 2001). The focus of this research has been on acknowledging the importance of the emotion work involved in these professions and a call to make it the focus of specific training. One study has looked at the development of professional feelings as a form of emotional labour for psychology students working as counsellors in a mental health clinic

(Yanay & Shahar, 1998). Most of the students interviewed saw mastery of the 'right' feelings as indicative of a professional identity. There was, however, an interesting split among those interviewed as to what the 'right' sort of emotional expression involved. Yanay and Shahar (1998) classified the two groups as the 'therapists' who believed in neutrality and objectivity, and the 'guides' who believed in being personal and emotionally responsive whilst maintaining their role as mediators. The authors suggested that each group had a different understanding of the emotional labour required in the same role. There does not appear to be any published research that looks specifically at the feeling rules for clinical psychologists or the emotional labour involved in the therapeutic relationship formed between the psychologist and the client.

Hochschild's constructs of emotional labour and feeling rules could be useful for my research, especially in the way these attend to the macro-social aspect of the context in which emotions are expressed (Lupton, 1998). However, as a complete theory of emotion, emotional labour is somewhat flawed. Hochschild (1979) writes that emotion work is traded, bought and sold by modern capitalist enterprise. The consequence being that the 'emotional proletariat' becomes estranged from authentic feeling. This is problematic in the sense that it splits emotional experiences into those that are authentic and those that are inauthentic. Another example of this is the notion that when a person does deep acting they come to see their inauthentic emotions as authentic ones. So underneath the managed emotion there is always a spontaneous and potentially unruly one that is being brought under control (Wetherell, 2013b). Although Hochschild critiques the organismic, basic emotions type view of emotions and focusses her research on the active management of emotional expression she later states that emotion is a "biologically given sense, and perhaps our most important one" (Hochschild, 1983, p. 229). Wetherell (2013b) suggested that these "contradictions between socially constructed signals and predefined biologically determined action plans reflected the theoretical impasses of the 1980s" (p. 5).

Burkitt (2014) acknowledges the importance of Hochschild's contribution, but calls it conceptually confused in its separation of the 'public' sphere of emotion and the 'private' sphere of emotion, and how it implies that emotion work was confined to the 'private' sphere (families and friendships) prior to the rise in commercialisation in the 20th century. He suggests that the so-called 'private emotions' (e.g. love) are also formed socially and often in practices which are constructed in the public realm (Burkitt, 2014). Through this split

Hochschild is suggesting that for emotion to be a deep and involuntary reaction to a relationship or situation it can only be experienced by the private self and that the public self is always involved in a self-induced performance based on feeling rules.

Burkitt (2014) suggests that that emotional labour might not be the result of external socially constructed feeling rules clashing with 'authentic' feelings, but rather a "social clash of different cultural expectations and the way they intersect personal relationships that create the situation in which such complex and ambivalent feelings arise" (pp. 136–137). That is, emotion work can ensue when there are contradictory cultural demands. He demonstrates this by citing his research with nurses where empathy and a degree of 'emotional attunement' are essential for them to be able to perform their jobs, yet this must be done with 'professionalism' so that they are not 'too close', and can operate with calm and poise. His research found that the nurses reported that they were more conscious of 'performing' the required emotions when they were under stress, such as when resources were scare and they did not have the time to adequately form caring relationships with their patients (Burkitt, 2014). I am interested in how these sorts of dilemmas are resolved (or not) within clinical psychology.

The construct of 'communities of practice' may be useful in my research with the professional community of clinical psychologists. The concept of a community of practice was developed by sociolinguists and refers to a group of people who engage in an on-going basis, working towards some sort of common endeavour (Eckert, 2006). It must involve shared activity and also working towards mutual sense-making (that can be consensual or conflictual). Through doing things together, communities of practice form shared ways of doing, ways of talking, power relations, and shared views and values. The study of communities of practice was developed in order to capture the interaction between social change and linguistic change (Eckert, 2006). It focusses on the fluidity of social space and the diversity of experience. Korczynski (2003) incorporates emotional labour into research on the communities of practice of call centre representatives and looked at the use of collegial support to deal with abusive customers (Korczynski, 2003). Many of these workers had favourable attitudes towards customers and gained enjoyment from their interactions, but also had to deal with irate customers. While management preferred them to do this individually, they tended to do the coping as a community of workers.

Hochschild's theory provides a way to think about how emotion can operate as a function of a professional identity and makes connections between emotion and economic systems. Despite their limitations the constructs of emotional labour and feeling rules represent some concrete concepts for developing a social analysis of emotion from a broadly social constructionist standpoint.

Emotions and Social Relations Three: Patterns, Complexes and Practices

The notion of feeling rules, while useful in reorientating emotion theory to power and social relations, is perhaps an overly simplistic way to understand emotion, as our behaviour would rarely take the ideal form outlined in such rules. In practice, feeling rules would operate as a loose accountability that forms as we recognise requirements and norms, yet leaving room for flexibility and change (Wetherell, 2013a). Therefore, Wetherell (2012, 2013a) suggests that emotions could be better understood through a practice-based approach and suggests a theory that understands emotions as affective practices. A practice is a 'loosely bound' nexus of saying and doing (Savigny, Knorr-Cetina, & Schatzki, 2001). From a practice-based approach emotions are both constituted actively as people carry out the practice of emotions and shaped over time as past practice carves out embodied grooves of emoting that become familiar and habitual. In this sense activity is "both constrained by past practice and the immediate situation and context, and open-ended in the sense that 'things can always be otherwise'" (Wetherell, 2013a, p. 360). So while the boundaries between different practices are often hard to define, participants can usually sense when they are moving from one to the next. Practices are also always shifting and moving as current practices form new pathways for future practices. In this way shared or expected emotions can be understood through shared past practice and through the societal expectations about the practices of certain groups. However, there is also space to consider how individuals with their particular histories can work to maintain, alter or resist these expectations (Wetherell, 2013b). Wetherell (2012) suggests that affect is always present, but that it comes in and out of focus. Some affective practices are relatively brief, particularly those involving intense body sensations (e.g. a panic attack), while others are more long lasting and involve semi-conscious background feelings. Affective practices can become entangled in technologies (e.g. in accordance with film genres) and shift with large scale social change (Wetherell, 2012).

While affective practices are dynamic and can move in divergent directions, the study of affect needs to involve the study of patterns. Affective practices become embedded patterns through things such as developmental processes, routines of emotional regulation, and relational patterns. Bodily responses, feelings, thoughts, interactions, narratives, social relations, personal histories, and ways of life get patterned together to form affective practices (Wetherell, 2012). From this perspective we are often involved in a process of "emotional quotation", continually plagiarising our own and others' past practice. Emotions are not objects but patterns. They are relational phenomena in the context of the moment patterned by social and historical relationships. These patterns can lead to the formation of affective ruts and one can consider the affective practices of entire social categories or historical periods (Wetherell, 2012). When taken to this level, issues of power, affective value and its distribution (which are always important) become even more relevant.

An important part of affective practices are accounts and narratives about affect. Wetherell (2012) writes "in learning how to talk about affect in socially recognisable and conventional ways, people also learn how to talk about and evaluate affect" (p. 93). Psychological therapy is one of the places where this talking about affect becomes a normative part of a recognised affective practice. The learning how to talk about affect through psychological therapy extends past the consulting room as seen in the dissemination of psychological theory through popular culture, so that psychological constructs become part of our everyday understanding of ourselves (e.g. Rose, 1985). Therefore this research will consider both how the psychologists talk about the way they emote within the therapeutic relationship and how this way of being could become understood as *the* way to be. Affect is not random and affective practices involve complex acts of subject positioning.

Wetherell's construct of affective practices is essentially the theoretical framework I will be using in this research, although I will draw on elements of Hochschild's work (outlined above) and that of other researchers who I will discuss below, in particular Burkitt. Burkitt (2014) suggests that emotions cannot be isolated and studied in themselves because they come to exist within patterns of relationships, including our relationship with the world. He suggests that we form emotional dispositions through the patterning of activity in these relationships. Emotional dispositions are formed throughout our lives as past patterns of relationships and action sediment into habitual emotional responses, which, in turn, continue to morph and adapt though our on-going interactions. The notion of dispositions is not one of

full determinism, but conceptualised as tendencies to act in certain ways which are context sensitive. Burkitt (2014) proposes a continuum with "being helplessly affected at one end to being very much in control and affecting the required responses at the other end" (p. 17). This sliding scale of agency does not sit quite right with me. It misses the qualification that the experience of being either helplessly affected or very much in control are socially constructed subject positions available to some individuals in certain situations and not others.
Burkitt (2014) does not suggest that we do not experience feelings in our body, rather he proposes that the study of emotions becomes problematic if they stop at the body. He uses an example of a young man getting aggressive on a train and the psychological explanation of him as having developed a paranoid cognitive style through the process of being taught by his father how to act aggressively. While considering this sort of explanation is useful, as it shows part of the patterning of his relational style, to consider it a full explanation is limited. By focussing too narrowly on the individual and his life experiences and cognitive styles it is easy to lose sight of the wider social context (e.g. class relations) where the patterns of relating are set. Burkitt (2014) points out that the use of violence for this young man could relate to violence being an "easily accessible way of restoring pride and controlling your world in a society that denies this group other resources of power and advancement, such as economic, educational and other cultural resources" (pp. 5–6). Furthermore, the fact that violent acts are more frequently enacted by men relates to the hegemonic forms of masculinity.

Burkitt (2014) also suggests that the mainstream psychological research into anger or aggression is problematic because they are not objects, but moral evaluations. For example, an old lady fighting off attackers would not be considered aggressive. So what is understood as aggression is not the action or the feeling per se, but how it is morally evaluated according to the local moral conventions. Therefore it is our relation to the situations and people that governs how we feel. It is possible that there can be a "clash of relational loyalties or of situational demands, which place contradictory expectations upon us and cause emotional confusion or dilemmas" (Burkitt, 2014, p. 135). Perhaps it is when we encounter these points of conflict or confusion that we become more aware of the complexity of our emotional dispositions, or affective practices. Like Wetherell, Burkitt suggests that it becomes problematic to reduce our understanding of emotion to any one of its many aspects (psychological, physiological, neurological, or social). His solution is to understand emotions

as complexes, both because they consist of many different aspects, and because they are a complex and intricate phenomena (Burkitt, 2014).

The way Wetherell and Burkitt understand emotions as patterns, practices and complexes gives me a way of understanding emotion that is consistent with the purpose of this research which looks for patterns in psychologists' accounts of their emotional practices and for points of tension or contestation. Registering an affective response to an event as a specific kind of emotional experience is a "multi-layered process in which body/brain processes intertwine with personal histories, discourses and culturally available ways of making sense, and intertwine also with larger-scale social histories and the material organisation of spaces and contexts" (McConville, Wetherell, McCreanor, & Barnes, 2014, p.136). From this perspective, psychological therapy could be seen as "orchestrated moments of embodied interaction" that are recognisable, although possibly hard to articulate, and tied into relative values and local moral orders (Wetherell, 2013a, p. 360).

This research analyses psychologists' talk about their own emotional practices when working with clients. While this adds a layer of abstraction to analysing the practices themselves, considering the way psychologists' make meaning around their emotions within the therapeutic relationship is both worthwhile and enlightening because discourse and practice are always intertwined. Embodied action interacts with talk at some point, either through talk in the moment of activity, or in subsequent accounts of the activity, where participants make sense of the action (Wetherell, 2013a). Discourse is also always already present in action when participants orient their current actions in relation to past actions in order to make them recognisable and meaningful. I am interested in how practising psychologists have developed distinctive ways of talking about their affective practices and how this is part of what demarcates them as a social group (Wetherell et al., 2015).

The affective practices of particular groups can become so familiar and routinised over time that people "mistake history for nature" (Edley, 2001, p. 195). This research will consider how the construction of emotions through discourse relates to certain sorts of epistemic regimes and how it constructs legitimate and illegitimate social actors (Wetherell et al., 2015). Ideology functions through affective-discursive social practice and this research considers how the construction of emotion is linked to the play of power.

Emotions and Social Relations Four: Power and Habitus

Emotions are involved in normative regimes of power and authority and some argue that the study of emotion must include the exploration of how it relates to social power relations (Cromby, 2007; Harding & Pribram, 2004). Power and knowledge always imply each other; power relations are seen to correlate and constitute a field of knowledge and knowledge always presupposes and constitutes power relations (Foucault, 1975). In this sense the emergence of psychology as a scientific discipline necessarily coincides with the development of disciplinary power with the function of objectifying people into certain categories (Hook, 2003), including emotion categories and emotion pathologies. As psychology has come into existence as a discipline of science it has "altered the ways in which it is possible to think about people, the laws and values that govern the actions and conduct of others and indeed ourselves" (Rose, 1996, p. 65). The individual's body and soul become the target for interventions which work on the structure of actions. Emotions as phenomena that are both embodied and representative of moral judgements emerge as a key apparatus in the dissemination of power. Disciplinary power not only refers to the discipline imposed by institutions and disciplinary agents, but as subjects of discipline ourselves we have become involved in self-discipline (Hook, 2003). I am interested in the dual role of psychologists not only as disciplinary agents in relation to others, but also in their own self-discipline in their management of their own emotions within the therapeutic relationship.

An example of how emotions have been used to maintain dominant power relations is the way that, since the Enlightenment and the hegemony of the scientific method, emotional expression has been equated with irrationality and positioned in opposition to rationality and reason. Consequently, the assignment of reason to bolster the authority of dominant groups and emotionality to discredit subordinate groups constitutes a practice of emotional hegemony (Harding & Pribram, 2004). Gendered constructions of emotion demonstrate this. In contemporary Western cultures women are constructed as being more emotionally expressive than men, and while this may mean that they are considered to be more emotionally skilled, it has also been equated with being less in control and this has been used to subjugate women and limit their access to positions of power. In order for these gendered emotional identities to be maintained they need to be constantly re-enacted, relived and re-felt (Harding & Pribram, 2004).

Burkitt (2014) writes that Foucault's ideas on technologies of government and techniques of the self are impersonal, saying that they miss the relational processes involved in "making and unmaking the different power regimes in which feelings and emotions appear" (p. 159). He suggests that there are varying degrees of power within social relations. Therefore some relations may have more influence than others which means relationships are never completely harmonious. While Foucault's notion of power is more nebulous, Burkitt (2014) suggests that emotion is always involved in power relations because those in power (governments, businesses etc.) will attempt to use emotions to direct a field of social action. He suggests that these attempts do not always work because people do not always respond as the regimes of power would intend, because we are all positioned differently in our relation to dominant discourses due to our unique experiences, and the intersecting of our multiple social relations in new situations or events (Burkitt, 2014). This affords different positions and potentialities for both government and resistance.

Sara Ahmed (2004) suggests that emotions shape the 'surfaces' of individual and collective bodies. Ahmed suggests that certain emotions stick to some objects and slide off others, so that some 'sticky' objects (e.g. asylum seekers) become saturated with affect and are sites of personal or social tension (Ahmed, 2004). Ahmed's account provides an interesting commentary on the mediation of collective affect. However, when it moves from text to talk-in-interaction, her construct of emotion as a sort of mysterious, disembodied force becomes problematic (Wetherell, 2012).

Bourdieu suggests that social action has both a sense of agency or strategy, and a sense of repetition and routine (Wetherell, 2012). Through this dual logic, power relations can be seen as both being reproduced and gradually transformed. He uses the construct of habitus to explain this relationship. Habitus can be understood as "generative principles of distinct and distinctive practice" (Bourdieu (1998), p. 8, referenced in Wetherell, 2012) that have come to be embodied through past practice either through direct conditioning (observation and modelling) or through intelligent and reflexive adaptation to new circumstances. Habitus includes particulars such as what and how someone eats, their political views and how they are expressed. These relational patterns are also power relations because we cannot separate people's emotional responses and judgements of value from the power relations in which they are located (Burkitt, 2014). Different social classes/groups of people have different habitus which dictates what is seen as good or bad (tasteful or vulgar) within that habitus.

Bourdieu would say that in most circumstances people are potentially free to act differently, but our familiar social practices that have been sedimented through habitus are what comes most easily to us and therefore we are likely to reproduce them. Burkitt (1997) suggests that culture provides an emotional habitus which trains people to develop emotional dispositions that can be expressed in certain contexts. In this sense emotions are not altogether voluntary as we are trained in them from an early age so their technique and associated feelings become spontaneous. For Bourdieu, emotion represented the non-conscious responses that make it difficult for a person to react in a way that is contrary to their habitus (Wetherell, 2012). Therefore, he is reproducing the bio-cultural model of emotion, where emotions are seen as a set of universal biological responses, though their expression is tempered by cultural experience, so that middle class anger appears different to working class anger.

Central to the construct of habitus is the concept of cultural capital which is a privileged set of appreciations, understandings, tastes and preferences associated with certain forms of habitus and less so with others (Wetherell, 2012). Cultural capital exists in relation to other forms of capital such as economic capital and social capital which together form relative advantage and disadvantage in society (Reay, 2000). Bourdieu made links between some forms of cultural capital and social class. Affect is associated with social class and as the landscape of social class is changing, affective patterning may become more important in maintaining difference than other traditional forms of division, such as political affiliations (Wetherell, 2012). Skeggs (2004) suggests that the modern middle class is "marked out by a deep-seated commitment to self-improvement, deferred gratification and the accruing of more and more 'property in the self'" (Skeggs, 2004, cited in Wetherell, 2012, p. 111). She states that research that identifies a 'late modern self' which is open, reflexive and 'worked over', is actually just the middle class self and this construction is rewriting the working class as deficient.

Extending on from cultural capital, the concept of emotional capital has been proposed to be a "stock of emotional resources built up over time within families and which children could draw upon" (Reay, 2000, p.572). Reay suggests that emotional capital is more than just the affect itself and how it is expressed, because it is dependent on who is expressing the emotion and on the norms and expectations of the specific context as to whether the affective practice accumulates other forms of capital (economic, cultural, social) (Wetherell, 2012). Class can relate to emotional capital in that those who have more cultural and economic capital may be

more able to manage strong emotions for the purpose of a long-term benefit than those who are already disadvantaged in other areas. However, the relationship is not that simple, for example in some cases the expression of anger can be beneficial if it gets one's needs met. Burkitt (1997) suggests that when the 'wrong' emotion is expressed it is seen as a sign of a lack of social skill, and at times as a psychological disorder; "the person has failed to learn the expected level of self-regulation and self-control, and because of this it is judged inadequate by those who are more powerful, or whose class upbringing has instilled in them a different set of controls and techniques which, because of their power, are seen as 'superior'" (p. 49). The emotional habitus of different groups (e.g. class, gender, race) involves the domination and subordination of certain groups. Reay (2005) suggests the "emotions and psychic responses to class and class inequalities contribute powerfully to the making of class", and that there has been a lack of research in to the emotional experience of being classed (p. 912).

The construct of emotional intelligence (EQ) is one example of how emotional capital can be understood as operating. It has been suggested that success in our modern times might have more to do with EQ than regular intelligence because the requirement for ever-expanding profits in neoliberal capitalist societies demands new markets and new innovations, not just in terms of products, but also working practices (Goleman, 1998 cited in Burkitt, 2014). Having high EQ requires more than just following feeling rules. It involves appearing more open and honest, while always holding other people in mind. Thus emotion is a resource to be harnessed for personal and professional success (Burkitt, 2014).

It can be argued that class relations in New Zealand are not as clearly demarcated as they are in Britain, however, they still exist and various ways of understanding class and social inequality in New Zealand have been proposed (Crothers, 2013). Given the relationship between emotional capital and other forms of capital, an analysis that includes a consideration of class may be important given that the tertiary education required to become a clinical psychologist means that psychologists are likely to have high levels of economic, social and cultural capital. Skeggs (2004) cites Bourdieu as saying "nothing classifies somebody more than the way he or she classifies" (p. 18). If this is true then the classifying powers attributed to psychologists locates them firmly in the middle class. Whereas a large proportion of clients being seen by clinical psychologists in public mental health settings are likely to possess less emotional capital, as research has shown that there is a strong negative

correlation between socioeconomic status and mental illness (Hudson, 2005). I am interested in how the concept of emotional capital is related to the therapeutic relationship. What emotional capital does the psychologist have to possess? Do they give emotional capital to the client? Does the client come to therapy to increase their emotional capital? If so, how successful is this? Is the emotional capital generated in psychological therapy useful and applicable to clients who operate in a different habitus to that of the socially privileged psychologist?

The construct of habitus is helpful in that it draws our attention to the way affective practices settle and can come to define the flavour of relations and habitus for a particular social group, class, gender, generation etc. (Wetherell, 2012). However, it is important to acknowledge the limitations of the constructs of habitus and capital, especially when they are limited to analysis of social class. While class relations are important to consider, they are just one of a vast number of regularities in positioning as we live in "a nexus of exceedingly complicated intersection between resources, histories, futures, investments and identifications" (Wetherell, 2012, p. 117).

The study of affective practices allows for the consideration of emotion as social activity which, among other things, can increase or diminish power and social value and work to encourage people to conform through emotions such as fear. But it also creates space for the study of plurality and diversity of shifting social relations. What is the habitus of the therapeutic relationship? When does the psychologist's emotion become emotion work? In a typical therapeutic relationship, who gets to feel what? My research (for practical and ethical reasons) focusses on clinical psychologists' accounts of emotion in the therapeutic relationship as opposed to, for instance, observation of actual therapy sessions or research with clients. Nonetheless, as I have argued above, meaning making is a central part of the assemblage of affective practice, a set of resources guiding and justifying actions in the moment and afterwards, and also, of course, central in the regulation of the profession and its members as well as in training programmes as new generations of clinical psychologists are recruited and learn how to be therapy professionals. This research will focus on the on the patterns in talk about psychologists' emotions in the therapeutic relationship, but will also attend to the dilemmas, contradictions and plurality in these accounts.

I will need to be open to points of agreement and contestation, both within and between individuals; so that I am not privileging pattern at the expense of contradiction and dynamism. My analysis will need to consider how both the patterns and contestations in the talk about the affective practices of clinical psychologists relate to the wider social relations and the circulation of power. This analysis can happen both on the level of interaction within the therapeutic relationship by exploring the construct of emotional capital, and at the societal level with the consideration of psychology as a disciplinary power.

Chapter Two – Affect and the Therapeutic Relationship

Wetherell (2012) is interested in the ways affective practices "sediment in social formations" (p. 103). This includes how institutions and historical periods acquire distinctive affective flavours. She quotes Ian Craib as saying "there are fashions in emotions and people come to talk about the fashionable ones" (Wetherell, 2012, p.103). One system that produces and reproduces the construction of different emotions is psychological therapy and its theoretical underpinnings. It could be said that the emergence of the psy-complex has changed way emotions are understood in Western culture, and as psychology and related institutions evolve they continue to change the way emotions are talked about and experienced in embodied practice. The psy-complex refers to the expansion of popular psychology and the way it has come to define how people are categorised, organised, and regulated (Parker, 2002). Psychological concepts (including constructions of emotions and their causes) have saturated contemporary cultural life so that they have become integrated into what we consider to be 'common sense' (Hook & Parker, 2002). An example of this is the psychodynamic concept of trauma and the idea that events from the past lie somewhere within us and if we are able to access them, then we will be able to find the solution to our current problems. This sort of understanding has become so ubiquitous that it is even required to understand children's movies, such as in *The Lion King*, where the protagonist Simba is only able to take action against his uncle when he uncovers the memory of his uncle killing his father (Parker, 1998). I am not suggesting that a linear, one-directional relationship exists between psychological theory and common understandings of emotions. Rather I want to consider the possibility of complex and reciprocal relationships between taken-for-granted understandings of emotion and its causes and broader regimes of power, including the disciplinary power of psychology.

With the advent of the professional psychological observer we are now monitored much more closely and watched for bodily signs which are indicative of our inner character, thoughts and feelings (Burkitt, 1997). Parker (1998) writes "psychology, then, is part of an apparatus of knowledge about the self which not only permits the elaboration of a range of theories about what is going on inside the mind and requires that those who have minds will work with those theories implicitly or explicitly, but also specifies how professionals and clients will be located in relation to one another for the theories to work" (Parker, 1998, p.3).

I will explore the contribution of psychological therapy to contemporary affective practices and the broad emotional milieu by looking at the differing ways emotions have been constructed within some of the different psychological paradigms that have been used to guide therapy in Western society in the 20th and into the 21st century. In effect, this will be a review of some of the predominant therapeutic models that have been available to psychologists as they consider therapy and the role of emotion in therapy. This review demonstrates the instability and social contingency of the construct of emotion and introduces some of the contradictions psychologists manage when doing therapy.

Psychology in New Zealand is most influenced by British and North American psychology and followed a similar, yet delayed, trajectory. In Britain psychology as an academic discipline had its roots in the 18th-century Enlightenment philosophies and became distinct from philosophy in the beginning of the 20th century. This separation from philosophy happened slightly earlier in the United States and did not happen in New Zealand universities until the 1960s (Kazantzis & Deane, 1998). Psychology as an academic discipline sought to separate itself from philosophy by defining itself as an 'applied science', aligning with positivist science in order to be legitimised as 'truth' producing. Therefore psychology can be seen as both produced in the context of and reproducing the wider socio-cultural norms of modernity, with its privileging of rationality and the belief in continual scientific and technological progress.

The modern era marked the movement away from feudalism and towards capitalism and the market economy. It saw an increase in programmes of governance of areas of social and economic life, with the aim of increased security of wealth, efficiency, profitable production, public tranquillity, personal responsibility and moral virtue (Rose, 1996). Rose (1996) argued that these social and economic programmes depended on the creation and measurability of individual subjectivity. Because the human capacities and mental processes on which these goals depended were not physically visible, psychology played a role in turning them into information that was measureable and calculable, creating procedures for the rational regulation of individuality (Rose, 1996). The modern era both produced the requisite for individualisation and categorisation, and the means of production, in that the creation of institutions such as schools and clinics meant that large groups of people could be assessed and compared leading to the creation of psychological 'norms'. The consolidation of psychology as a scientific discipline was based on the production of "techniques for the

disciplining of human difference"; individualising people by classifying what they do and what they are able to do, and managing and utilising their individuality (Rose, 1996 p. 105). These techniques turned human properties, capacities and energies into material forms (e.g. measurements, charts, diagrams), allowing for comparison and categorisation.

Clinical psychology as a profession came into being in the first half of the 20th century in Britain and the United States of America, but the first clinical psychology training programme was not established in New Zealand until 1961 (Kazantzis & Deane, 1998). Clinical psychology initially focussed on psychological testing of aptitude, intelligence, and other 'measurable' traits in response to an increasing demand for this testing as a result of World War I and World War II (Cheshire & Pilgrim, 2004). Rose (1996) writes that "the technical device of the test, by means of which almost any psychological schema for differentiating individuals may be realised, in a stable and predictable form, in a brief period of time, in a manageable space, and at the will of the expert, is a central procedure in the practices of objectification and subjectification that are so characteristic of our modernity" (Rose, 1996, p. 112).

While psychological therapy had been part of clinical psychology in the United States since its inception, it was not part of clinical psychology in Britain until the mid-20th century when Behavioural Therapy became popular. Clinical psychology's original mandate to be an applied behavioural science was formally married with the therapeutic role at the historic American Psychological Association conference in Boulder Colorado in 1949 where the guidelines for the 'scientist-practitioner model' were first outlined. Science continues to serve the function of maintaining the status of psychology (Usher, 1992).

The way emotions are constructed in different psychological frameworks translates into the associated affective practices for both the client and, importantly for the research reported in this thesis, psychologists. The types of psychological therapy I review are; psychodynamic psychotherapy, Behavioural Therapy, client-centred therapy, cognitive therapies, and Acceptance and Commitment Therapy. I spend more time looking at Cognitive Behavioural Therapy (CBT) because this is the type of psychological therapy most used by clinical psychologists in New Zealand currently, and the majority of clinical psychology training programmes in New Zealand and Australia are oriented towards teaching CBT (Kazantzis & Munro, 2011). However, the third wave behavioural therapies are also practised by many

contemporary psychologists in New Zealand. This will not be a comprehensive review of these forms of psychological therapy, rather I aim to provide a sketch of some of the main claims they make about emotion and the role of emotion in therapy. Nor does this chapter review all the types of therapy currently used by psychologists. I would have liked to include a review of the various forms of Family Therapy, Dialectical Behavioural Therapy, Narrative Therapy, Mindfulness-Based CBT, and Compassion Focussed therapy. However, given the constraints on the length of this thesis I chose to review just some of the major forms of therapy used by psychologists across the 20th and 21st centuries. I am also going to attempt to broadly contextualise the shifts in therapy in light of general social and economic trends as this helps illuminate the context in which different ways of understanding emotion have been produced and their implications. However, this is not an attempt to provide a detailed social history of clinical psychology, which would require a much more complex investigation of competing pressures and counter-pressures.

Parker (1998) suggests that patterns of therapeutic discourse, which are formalised in theoretical systems, make certain practices possible (e.g. a client sitting and speaking and finding solutions). The research reported in this thesis will create an account of the 'conditions of possibility' for psychologists' expression of emotion within the therapeutic relationship. While there are many similarities between the affective practices related to different psychological paradigms, there are also discernible differences which could create dilemmas for psychologists working eclectically.

Psychodynamic Psychotherapy

Psychodynamic psychotherapy has its origins in psychanalytic therapy developed through the work of Josef Breuer and Sigmund Freud at the end of the 19th and the beginning of the 20th century and was a dominant form of therapy for the first half of the 20th century in North America and Europe. During this period clinical psychology as a profession had yet to emerge and psychotherapy was practised by analysts who were trained in medicine. Phares (1998) writes that "despite Freud's protestations (Freud, 1959) the medical profession 'captured' psychoanalytic therapy, and in doing so made the subsequent entry of psychologists into the therapy game quite difficult" (p. 43). In fact, early clinical psychologists in Britain rejected the psychoanalytic therapy used by psychiatrists because they deemed it unscientific. Psychoanalytic therapy was adopted by some British clinical

psychologists later in the 20th century (Cheshire & Pilgrim, 2004). In the United States psychoanalytic therapy was taken up earlier by clinical psychologists and was more widely accepted, as many of the European analysts relocated to America after World War II, allowing for more crosspollination of therapeutic approaches (Phares, 1998). Probably due to their later establishment, psychoanalytic therapy and psychodynamic therapy have never been a part of clinical psychology training programmes in New Zealand. Independent psychodynamic psychotherapy training programmes exist, and graduates of these programmes are qualified as psychotherapists rather than psychologists. While some New Zealand based clinical psychologists do psychodynamic therapy, either because they trained overseas or have sought out additional training opportunities (outside of their core clinical psychology training), on the whole it exists on the margins within formal psychological practice in New Zealand. However, it is very much at the forefront of the public perceptions of psychology, and psychodynamic constructs feed into the psy-complex. Perhaps this the case because psychodynamic therapy is the oldest form of therapy, and we have been steeped in it for a longer time than the subsequent forms of therapy. Our globalised society and the amount of media we consume from countries where psychodynamic therapy is more common place is also likely to have had an effect.

Emotions from a psychodynamic perspective are expressed as a result of conflict between our unconscious instincts or drives and societal rules aimed at controlling them. Defence mechanisms are used to keep us from becoming aware of our unconscious sexual and aggressive impulses (Prochaska & Norcross, 2007). The avoidance of painful emotions is implicated in the aetiology and maintenance of psychological problems and therefore the expression of these negative emotions from the client is a fundamental part of the therapy (Mackay, Barkham, Stiles, & Goldfried, 2002).

In early psychoanalytic therapy analysts were not meant to show any emotion because they were supposed to act as a ‘blank screen’ in order to be able to reflect the client’s conflicts and defences (Phares, 1998). The focus of therapy was supposed to be purely on the client’s emotions and reactions. As time has progressed later iterations of psychodynamic therapy have seen an increased focus on the interdependent nature of the therapeutic relationship, including discussion around transference and countertransference (Waterhouse & Strupp, 1984). Transference is when the client transfers feelings experienced in an earlier similar experience onto the current interpersonal experience. The most common manifestation of this

in the therapeutic relationship is when the client begins to experience the psychologist as if she/he were mother or father (Bateman, Brown, & Pedder, 2000). When transference was initially named by Freud it was seen as interfering with therapy, however, later it came to be seen as a tool which can be used to access what is understood as the repressed past which becomes re-enacted through current transference. In this sense emotional expression is something that is encouraged and is essential for therapeutic change in psychodynamic therapy. With the proviso that the client has sufficient 'ego strength' to recognise that the strong feelings she/he is having towards the therapist are because she/he is relating to her/him 'as if' she/he was the parent and is able to accept this paradox (Bateman et al., 2000). The client needs to feel enough anxiety to be able to explore, but not too much, otherwise she/he will not be able to cope with the negative emotions triggered between therapy sessions (Mackay et al., 2002).

Countertransference on the other hand is a construct used to explain and examine the emotional responses of therapists towards clients. Maroda (2009) suggests that psychologists need to be aware of the intense countertransference feelings that are often stimulated in therapy and that this awareness can help them work with both the clients' affect as well as their own. Broadly, countertransference is used to describe two phenomena. The first is when the psychologist's emotional reaction to the client is seen to represent his or her own unresolved conflicts (past or present), this is referred to as subjective countertransference (Bateman et al., 2000). Maroda (2009) suggests that it is highly likely that both the therapist and the client will repeat past patterns of behaviour and emotion. The affective patterns of a person's early life are thought to remain pretty much constant, but layers or new affective patterns can be added though repetitive thoughts, feelings or behaviours. Subjective countertransference is seen as undesirable and is one of the reasons why people training in psychodynamic psychotherapy are required to also attend therapy themselves.

The second type of countertransference is referred to as objective countertransference, which assumes that the psychologist is not being influenced by his or her own unresolved conflicts, rather they are triggered by the client alone. The psychologist who attends to her/his own 'objective' feelings towards the client is able to gain insight into the client's attitudes and emotions that were previously incomprehensible (Bateman et al., 2000). Like transference, countertransference was originally seen as a hindrance to therapy, but later objective countertransference came to be conceptualised as a way of understanding the client's

unconscious and became a key part of the process. In this sense the psychologist uses her emotional response to the patient as a way of understanding the hidden meaning of the material brought up by the client (Sandler, Holder, & Dare, 1970)

While there is space in psychodynamic therapy for the therapist to feel a variety of emotions towards the client and discuss these emotions with both their supervisor and with the client, what they do with these emotions is still heavily circumscribed by professional rules and expectations. If the feelings are constructed as being related to the psychologist's personal issues, they need to recognise them and mitigate them so that they do not impact on the relationship with the client. If the origin of the emotion is attributed to the client's issues, the therapist is not allowed to act on them, but rather needs to detach from the feelings and articulate them to the client so that the client can gain an understanding of the feelings they evoke in others (Bateman et al., 2000). This assumes that the psychologist will be able to differentiate their objective countertransference from their subjective countertransference and therefore implies that it is possible for these two constructs to exist independently.

Behavioural Therapy

Compared to psychodynamic psychotherapy, emotions are constructed quite differently in Behavioural Therapy which came into practice in the 1950s. Rather than being reduced to instinctual or biological drives and understood through the unconscious, emotions from a behavioural theory perspective are understood as being determined by external circumstances and driven by past learning (Bennett, 2003; Prilleltensky, 1994). As discussed above, early clinical psychologists in Britain focussed primarily on psychological testing and assessment. They rejected therapy because the psychodynamic therapy of the day was deemed unscientific. The emergence of behavioural therapy allowed psychologists to take up the therapeutic role without compromising their stance as 'applied scientists'. Behavioural Therapy has been part of clinical psychology training programmes in New Zealand since their inception, although the teaching of Behavioural Therapy has reduced since the advent of Cognitive Therapy in the 1980s.

The appeal of a behavioural theory can be understood in the post-war context. The assumption that those mentally unwell people who ended up in asylums and workhouses came from a 'tainted gene pool' was no longer palatable, when some of 'England's finest

blood' were breaking down in the trenches (Cheshire & Pilgrim, 2004). The argument that one's environment impacts on one's mental wellbeing was also reflected in the broader social and political attitudes of the time. The political and economic power relations of the first half of the 20th century were complex and fluid, however, some themes can be discerned (Freeden, 2003). One such theme was the evolution of the 'welfare state' and the associated ideology, which became dominant in Europe and to a lesser extent the United States.

The 'welfare state' can be broadly defined as one in which the functioning of economic and political forces is deliberately regulated and modified in order to redistribute wealth (Freeden, 2003). Within this context human nature is no longer seen as "a static attribute of the individual, but a malleable feature of individuals in society" (Freeden, 2003, p. 14). If individual behaviour is the function of environmental factors, then increased political and economic intervention to improve wellbeing becomes justified. This was also a period of relative economic growth and prosperity in these countries, from the 1950s to the early 1970s. If state intervention was assumed to be the cause if this greater prosperity, then it made sense to conclude that human behaviour is governed by external factors such as social class. However, it is important to note that while behavioural theory acknowledges the influence of the environment on behaviour, the target for intervention and behavioural change is still the individual, who is measured and categorised based on her/his behaviour, and the goal of therapy is to meet behavioural norms.

Behaviourism privileges observable behaviour and hence emotions are understood through the behaviours they result in. In Behavioural Therapy behaviour is understood to be determined by external events (either rewarding or punishing) and driven by past learning (Gambrill, 1977). Therefore emotions are the result of either associating certain stimuli with certain emotions or through learning to express certain emotions through being rewarded or punished. An example of how emotion operates in Behavioural Therapy is in desensitisation strategies where fear needs to be activated through exposure to the feared stimuli and reduced by replacing it with an incompatible emotional state (e.g. relaxation) (Whelton, 2004).

The context in which behaviour occurs becomes of primary importance. Thus in this framework the emotional expression of the therapist is seen as important because it contributes to the 'environment' of therapy. While the recommended affective practices for psychologists who use behavioural techniques are less explicitly talked about (compared to

psychodynamic therapy), they still exist. For example Gambrill (1977) in her book *Behaviour Modification* quotes Egan (1975) as a good example of how behavioural therapists should conduct themselves "…a good helper is concrete in his expressions, dealing with actual feelings and actual behaviour rather the vague formulations, obscure psychodynamics, or generalities. His (sic) speech, while caring and human, is also lean and to the point" (p. 81). The psychologist using Behavioural Therapy is required to be warm and empathetic because the more valuable they are to the client, the more they become a 'social reinforcer'. However, on the whole, she/he will be more concerned with providing accurate treatment than accurate empathy (Prochaska & Norcross, 2007). Of particular importance in behavioural therapy, is the construct of the psychologist as the 'knowledgeable expert' who is in control, in order to build a base of social influence (Gambrill, 1977). The emotional expression of the psychologist has to be manipulated so as to create an environment within the therapeutic relationship that will optimise new learning and promote the acceptance of the expert psychologist's behavioural formulation of the client's problem. So whereas psychodynamic psychotherapy uses psychologist emotion as a revelatory tool, in Behavioural Therapy, psychologist emotion is more performative, action oriented and repressive of strong therapist emotion. To use Hochschild's terminology, it is more like 'surface acting' than the 'deep acting' required in other types of therapy.

Humanism and Client-Centred Therapy

Also emerging in the 1950s and rising in popularity in the 1960s was humanism and its offshoot Client-Centred Therapy. Through the second half of the 20th century there was a push back against the focus on psychometrics and Behavioural Therapy. This reflected a shift in the zeitgeist away from positivism and empiricism (Cheshire & Pilgrim, 2004). This was also around the time when there was a wholesale deinstitutionalisation of mental health services. This can be understood in the wider social context of the 1960s and 1970s where there was a shift away from traditional values and a new emphasis on individual rights through movements such as the civil rights and women's liberation (Kliewer, Melissa, & Trippany, 2009). The institutionalisation of people with mental health issues was challenged in this context and when it came to psychological therapy, new discourses emerged about the importance of the therapeutic relationship and building a strong therapeutic alliance.

Humanistic therapy was developed partly in response to the perceived limitations of psychoanalytic therapy and behavioural therapy where the psychologist was exclusively constructed as cool and detached, as an analyst or a scientist. Humanistic approaches traditionally took the stance that the complexities of human meaning-making could not be measured by scientific research methods. This created a point of tension within clinical psychology which had carved out its professional niche as by claiming science-based skills (Cheshire & Pilgrim, 2004).

In a New Zealand context, anecdotal evidence suggests that, up until the advent of CBT in the 1990s, the clinical psychology training programmes were made up of a seemingly antithetical combination of courses in behaviourism and humanistic-based encounter groups. Psychology training programmes in Britain at the time were described as "uncommitted, confused or agnostic regarding psychological theory" (Cheshire & Pilgrim, 2004, p.37). While there is no explicit training in humanistic therapeutic methods at a post-graduate level now in New Zealand universities, their historical influence still persists.

Client-Centred Therapy constructed problematic emotions as being a result of incongruence between an individual's actual total experience and what is symbolised as part of her/his self-concept. So for example a person may have a self-concept that she/he never gets angry, and when she/he experiences anger she/he defends against it in some way. By denying part of their experience they become estranged from themselves. This self-concept is formed as a result of conditional love growing up, so that the individual starts to only be aware of the behaviours that are consistent with conditions of worth (Prochaska & Norcross, 2007). In client-centred therapy the validated affective practices are framed in terms of genuineness and congruence (but not too much). This means that psychologists should be genuine in their expression of emotion, however, they are also required to only express unconditional positive regard and to demonstrate accurate empathy. The psychologist is required to be so deeply connected with the client's experience that any need to express negative feelings towards the client is nullified (Prochaska & Norcross, 2007).

Rogers (1951) suggested that the psychologist's own emotional biases and maladjustment do not come into this sort of therapy because the psychologist's focus is not on their own evaluation but on perceiving how the client sees things. This is reminiscent of Hochschild's idea of 'deep acting', so the psychologist is expected to induce the actual feelings of warmth

and empathy towards the client. Rogers (1958) stated "certainly it is not for the therapist to express or talk about his own feelings, but primarily that he should not be deceiving the client as to himself. At times he may need to talk about some of his own feelings (either to the client, or to a colleague or superior) if they are standing in the way" (pp. 133–134). The psychologist's respect for the client has to be a part of her/his "personality make-up, consequently the person whose operational philosophy has already moved in the directions of feeling a deep respect for the significance and worth of each person is more readily able to assimilate client-centred techniques which help him to express this feeling" (Rogers, 1951). Rogers (1951) makes the distinction between 'emotional identification' and 'empathetic identification'. Within the humanistic theoretical framework empathetic identification is what the psychologist needs to achieve with their client, this means that the psychologist is required to be connected enough to the client to perceive their feelings without actually experiencing them.

The core features of genuineness, unconditional positive regard and accurate empathy set therapy grounded in a humanistic paradigm apart from behavioural therapy where the psychologist is supposed to come across as the knowledgeable expert. Behavioural therapy, and its offspring Cognitive Behavioural Therapy (CBT), both traditionally de-emphasised these intangible therapist qualities and put more emphasis on the aspects of therapy understood to be 'measurable'. More recently the principal aspects of humanistic approaches have been integrated into discourses about the therapeutic relationship which span across the therapeutic approaches. At their core the expectations for psychologists' emotional expression that come out of the humanistic framework represent a fundamental dilemma for the psychologist's emotional expression; the need to be genuine, but not express any negative emotion. This is discussed further below.

Cognitive Therapy and Cognitive Behavioural Therapy

Cognitive Therapy and Cognitive Behavioural Therapy (CBT) (or the 'second wave' of behavioural therapy) shifted the focus away from the environment and the context (where it had been in Behavioural Therapy) and onto the thought processes that mediate the environmental trigger and the emotional reaction and resulting behaviour. Cognitivism emphasises individual thought and de-emphasises context, culture and history (Prilleltensky, 1994). Emotions and behaviours came to be understood as a function of individual thought

processes with less emphasis on the sociohistorical context. This shift away from the environment and towards the individual reflected another broad shift in power structures on the political and economic front. The oil crisis of 1974 and the following economic downturn lead to the questioning of the welfare state ideology and the formation of the ideology of the New Right and neoliberal economic reform. The New Right opposed government intervention, inferring that redistribution was morally wrong and that taxation amounted to forced labour (Goodin, 2003). The neoliberal economics that swept over many countries in the 1980s (including the United Kingdom, the United States, and New Zealand), promoted the open market, privatisation, and deregulation. The New Right emerged out of several criticisms of the welfare state relating to affordability and accountability. Linked to accountability was the idea of personal responsibility and the argument that the welfare state lead to the "demoralization of society, both discouraging and devaluing personal effort" (Goodin, 2003, p.210). Again parallels can be drawn with the rise of individual agency in psychology through movements such as cognitivism and the emphasis on the individual economic rights of neoliberalism, and the responsibility for poverty being placed back on the individual by the New Right ideology.

Cognitive Therapy and CBT came in to use in the 1980s and 1990s and became the most used form of therapy by psychologists in New Zealand (Kazantzis & Deane, 1998). Cognitive approaches were (and still are) taught as part of all the clinical psychology training programmes in New Zealand. With the addition of cognitive approaches to the training programmes, client-centred encounter groups were dropped from the curriculums. This may have been because they were not congruent with the rising tide of neoliberalism. It is also likely that clinical psychology training programmes were keen to shed this component for other reasons, as encounter groups had been associated with complaints around sexual harassment within the New Zealand clinical psychology training programmes, and there were media reports about the use of encounter groups in the Auckland-based commune Centrepoint, which was shut down after its some members were convicted of sexually abusing children (Gibson, Morgan, Woolley, & Powis, 2010).

CBT prescribed a stance for the psychologist that took elements from both behaviourism and humanism. The therapist is expected to use evidence-based practice and be rigorous in her/his implementation of psychological therapies that have been 'scientifically proven', while at the same time actively working to promote a strong therapeutic alliance. In Cognitive Therapy

emotional reactions are understood by accessing the meaning the individual attributes to the event which triggered the emotion. Emotions are constructed as occurring in response to the client's thinking (coming out of his/her beliefs) and ways of behaving and therefore the focus of the therapy is around changing beliefs and behaviours (Mackay et al., 2002).

Early Cognitive Therapy tended to view emotional expression as something problematic that needed to be brought under control. Wiser and Goldfried (1993) found that therapists using CBT thought that improvement in therapy came from experiencing less emotion, whereas therapists working from a psychodynamic perspective believed that the clients' emotions needed to be intensified (Wiser & Goldfried, 1993). With the exception of exposure techniques CBT focusses on overcoming negative emotions rather than experiencing them (Mackay et al., 2002). Accordingly early publications on Cognitive Therapy gave little explicit direction around what therapists should do with their own emotions (A. T. Beck, 1976).

Latter iterations of Cognitive Therapy and CBT started to put more emphasis on emotional processes and suggested that emotions can be the source of meanings (thoughts) as well as something that results from them. It is recommended that psychologists apply the techniques of Cognitive Therapy to themselves before using them with patients in order to get a better understanding of them and what barriers there can be to their application. This includes identifying moods, and their associated automatic thoughts, keeping a dysfunctional thought diary and ultimately forming a conceptualisation around what underlying beliefs are causing these thoughts and emotions (J. S. Beck, 1995). Beck et al. (2004) suggested that this application of CBT skills should be used when the therapist is experiencing strong emotions within the therapeutic relationship. "The way the therapist views or deals with therapy-related thoughts and emotions may need some cognitive restructuring to reduce the intensity of negative affect or to maintain adequate focus on therapy goals and objectives" (A. T. Beck, Freeman, & Davis, 2004, p.109). Over time the feeling rules and required affective practices for the psychologist using CBT have become quite finessed, for example the psychologist must put herself/himself in the client's shoes, but not so such so that she/he becomes too involved and loses 'objectivity'. There are also now recommendations for 'self-care' and stress management for the psychologist (e.g. using self-statements of encouragement and acceptance, or engaging in exercise and social contact) which extend beyond the consulting room to how the therapist should conduct her/his wider life (A. T. Beck et al., 2004).

While the focus of the psychologist's emotional management from a cognitive behavioural perspective has been more on managing the symptom (changing automatic thoughts, engaging in self-care), rather than on the cause, some authors have applied the cognitive behavioural framework to conceptualising the cause of the psychologist's emotional responses in the therapeutic relationship. Leahy (2007) suggests that "the patient's own conceptualisation of emotions and the therapist's parallel conceptions will either hinder or facilitate emotion processing" (p. 235). He suggests that people have different 'emotional philosophies' and 'interpersonal schemas', which constitute a set of rules that are often rigidly followed, regardless of the immediate outcome. The psychologist's emotional philosophies are constructed as having an impact both on their emotional expression and how they approach the client's emotional expression within the therapeutic relationship. For example one psychologist might see emotional expression as a way of deepening the relationship, while another might think that emotions should be eliminated or avoided. Leahy (2007) suggests that problems in the therapeutic relationship can arise when there is a 'mismatch' between the psychologist's and the client's emotional philosophies and interpersonal schemas. He encourages psychologists to become aware of their emotional philosophies and personal schema and recognise when they are operating in the therapeutic relationship, with the hope of gaining insight into how their reactions might resemble the reactions the client provokes in other relationships. Ultimately Leahy suggests that the psychologist can change the way she/he interacts with the clients to give them a different experience, for example one of emotional validation (Leahy, 2007).

While psychologists working from a cognitive behavioural framework do not typically consider the constructs of transference and countertransference, Cartwright (2011) suggests that these notions can be conceptualised from a cognitive behavioural framework where transference can be understood to come out of the core beliefs of 'self' and 'other'. These provide templates for relationships which the client brings to therapy and uses as a basis to respond to the psychologist (Cartwright, 2011). Cartwright and Read (2011) suggest that when psychologists working from a cognitive perspective do acknowledge countertransference it is usually of the subjective variety and is usually seen as something negative and to be avoided. Failing to attend to the objective countertransference may result in a lack of understanding about how the client is impacting the therapeutic relationship. They suggested that integrating an understanding of transference and countertransference into cognitive therapies could support reflective practice and supervision and they designed a

training for New Zealand psychologists to help "facilitate therapeutic understanding and management of countertransference" (p. 46). This training focusses on identifying the countertransference (and what sort it is) and then how to avoid enacting it (e.g. by using a calming technique). Once calm the psychologist in encouraged to step out of the countertransference response and back into the 'adult' or 'therapist' response which "is more compatible with maintaining the therapeutic alliance" (Cartwright & Read, 2011, p. 50).

On the whole the expectations around the emotional expression of psychologists using Cognitive Therapy or CBT, are akin to those of their predecessor, Behavioural Therapy, in that the emotional processes of psychologists are not usually explicitly addressed and if they cannot be ignored then they need to be dealt with so that they do not impact on the therapy. How realistic is it for the psychologist to operate in therapy so that none of their own emotional processes have an impact? A few recent authors incorporated constructs that come from psychodynamic therapy to suggest that psychologists can use their emotional responses in therapy to deepen their understanding of the client. This could be challenging as sometimes the psychologist's negative thoughts and emotions towards a client are below the threshold of awareness, in particular because psychologists may avoid addressing the negative feelings they have about their clients because they want to maintain a view of themselves as non-judgemental and empathetic (Wright & Davis, 1994).

Acceptance and Commitment Therapy

The rules and expectations around affective practices have shifted again with the advent of the 'third wave' of behavioural therapies which incorporate the constructs of mindfulness and acceptance with the behavioural strategies. The two most widely used third wave therapies are Acceptance and Commitment Therapy (ACT) and Dialectical Behavioural Therapy. ACT does not seek to directly change or reduce the client's negative emotions, rather it aims to help people live more rewarding lives in the presence of them (Flaxman, Blackledge, & Bond, 2011). ACT draws on the behavioural construct of functional contextualism which suggests that every behaviour can be explained in terms of contextual variables (Ruiz, 2012). The core doctrine of the third wave behavioural theoretical and therapeutic perspectives is that of synthesis of opposites – the 'both/and', 'finding the kernel of truth in the opposing potion', and integrating the acceptance and change. The way the third wave behavioural therapies construct the coexistence and integration of opposing and contradictory forces can

be seen within the broader social shift towards postmodernism, which questions enlightenment rationality and absolute truths, and favours instead relativism, pluralism, irreverence, and self-referentiality. This can be understood in the context of the changing social and political environment. The relentless need for growth and productivity of neoliberalism has resulted in globalisation and the new labour market where everything is moveable (Walkerdine, 2003, p. 137). This requires the production of the post-modern self, who is adaptable, flexible and responsible for her/his own success and can cope with constant change (Walkerdine, 2003, p. 137). The third wave behavioural therapies 'make sense' within this post-modern context.

In an ACT framework psychological distress or negative emotions are understood to be largely the result of human language processes which give us the ability to reflect on our existence and evaluate it negatively. This leads to experiential avoidance (trying to avoid negative emotions and thoughts). From this perspective the avoidance is seen to worsen the distress in the long run and get in the way of living a meaningful and purposeful life (Flaxman et al., 2011).

Proponents of ACT suggest that through this understanding of human suffering the psychologist will naturally be able to be warm and genuine within the therapeutic relationship (Hayes & Strosahl, 2004). The emotions of the psychologist are explicitly spoken about in ACT (in a way that is absent from the previous 'waves' of behavioural therapy), for example Flaxman et al. write"ACT is a powerful, expressive, painful, empowering, emotional, intensive and intimate form of therapy not only for the client but also for the therapist" (p. 151). Psychologists using ACT are encouraged to identify and express their feelings and thoughts in the moment within the therapeutic relationship (Hayes & Strosahl, 2004). However, while the therapist is constructed as having these intense feelings they are still heavily circumscribed in terms of what emotions they can feel (e.g. compassion) and how they are to act on their emotions (e.g. not avoiding them, but accepting them and 'sitting with' them). For example, the therapist is required to have flexible acceptance skills in order to be able to sit with the client's pain as well as to be able to make space to acknowledge their own difficult thoughts and feelings (Flaxman et al., 2011). Therapy is constructed as an opportunity for both the client and the therapist to 'grow', by approaching the client's 'painful material' with openness and acceptance (Hayes, Strosahl, & Wilson, 2011). Proponents of ACT suggest that psychologist's experiential avoidance (including the

avoidance of emotions) is invalidating and can mean that the client feels that he/she is unacceptable, tries to protect the therapist and/or adopts the same approach, sharing less of her/his problems (Pierson & Hayes, 2007). As with client-centred therapy, ACT venerates emotions and impels the psychologist to be open with the client but only to the extent that it can be done compassionately (Flaxman et al., 2011).

The specifics of the rules and expectations for the affective practices of psychologists differ depending on the type of therapy being employed. However, there are also discernible similarities between therapies that have originated from different theoretical paradigms. In every type of therapy there are restrictions on what kinds of affect psychologists are allowed to display and there is the assumption that this emotion work will impact the outcome of the therapy.

The Emotional Psychologist

The discussion above illustrates how the affective practices of the clinical psychologist may vary as a function of the theoretical framework of the therapy they are using. However, many psychologists in New Zealand use an eclectic mix of therapeutic models (Kazantzis & Deane, 1998). So what overarching conventions are there for the emotional expression of the modern clinical psychologist? Kaplowitz et al. (2011) conducted a pilot study where they attempted to assess the impact of the psychologist's 'emotional intelligence' on the therapy process and outcome. Emotional intelligence was understood as the ability to perceive emotions and integrate them into thoughts, and then to understand the emotions and manage them. This includes the ability to articulate, differentiate and manage difficult emotions and to be able to regulate one's own as well as other's emotions (Kaplowitz, Safran, & Muran, 2011). Of note are their findings suggesting that the emotion-management abilities component of emotional intelligence was associated with greater improvements in patient-rated symptomology and lower drop-out rates, but that these outcomes were not associated with higher rates of emotional intelligence as a whole. This suggests that emotional management in particular is a core competency for psychologists.

Much of the discourse around the psychologist's emotional management currently revolves around the importance of the therapeutic relationship and how to build a good therapeutic alliance between the psychologist and the client. The nature of this discourse varies

somewhat according to the type of therapy used. For example the therapeutic relationship and matters of transference and countertransference are fundamental to the therapy process in psychodynamic psychotherapy, whereas in cognitive therapy, although there is an acknowledgement of the importance of a strong therapeutic alliance, it is seen as a prerequisite to the effective implementation of cognitive and behavioural strategies rather than the focus of therapy (Cartwright, 2011). However, a strong therapeutic alliance is generally seen as important regardless of the theoretical orientation of the therapy and various meta-analyses have reported the importance of a strong working alliance to therapeutic outcomes across differing models of therapy (Horvath, Del Re, Flückiger, & Symonds, 2011; Martin, Garske, & Davis, 2000).

Whelton (2004) suggests that emotional responsiveness is at the heart of building a good therapeutic relationship. While several factors have been associated with building a strong therapeutic alliance what the therapist does with her/his own emotions is seen as critical. An example of this is that the psychologist is required to respond in a non-defensive way when the clients are hostile (Horvath et al., 2011). Change is seen to happen in therapy when the psychologist is perceived to be empathetic, affirming and collaborative, and the quality of the interactions early on in the therapy predicts outcome (Wright & Davis, 1994). The attributes associated with building a strong therapeutic bond are being empathetic and warm, while maintaining a moderate level of control. Whereas being hostile and over controlling are associated with not forming a good working alliance (Wright & Davis, 1994). One study found that when psychologists reported having "emotional difficulties" this was associated with problems in the therapeutic relationship such as the psychologists finding it hard to empathise with the client and feeling that the client did not accept them and the client perceiving the psychologist as being impatient and authoritarian and withholding the truth (Mcguire-Snieckus, McCabe, Catty, Hansson, & Priebe, 2007).

Clearly being a psychologist requires some considerable emotional labour. Psychologists need to be emotionally receptive, open to feedback and non-defensive. That is, they need to experience the emotions of others (including hostile ones) without expressing their own except in very prescribed ways. How does this happen if it is, as Maroda (2009) suggests, inevitable that psychologists will behave in ways that were established in their early experiences of attachment? She also states that "the client's emotional impact on the therapist is arguably the most neglected area in therapist training" (p. 6). 'Good' psychologists must do

their own emotional work on themselves; getting feedback from clients, attending psychological therapy themselves, as well as peer consultation and supervision. Psychologists are told to recognise that their own emotional well-being (or lack of it) impacts the therapeutic relationship and to acknowledge the need to attend to this through self-care practices (Jennings & Skovholt, 1999). The requirement for self-surveillance and self-knowledge is a hallmark of disciplinary power which makes individuals subject both to disciplinary agents and to themselves (Hook, 2003).

Almost any publication about the therapeutic relationship in psychological therapy will cite the importance of empathy. Empathy is the ability to understand and share the feelings of another and to a greater of lesser degree it is a core component of any sort of psychological therapy. How it is understood relates to how emotions are constructed within that particular therapeutic framework. In psychodynamic psychotherapy empathy means the therapist needs to be both tuned into the client's emotions and their own emotions and then be able to reflect on, but not act on their emotions. From this perspective empathy means being tuned in to both the client's conscious emotions as well as their unconscious emotions, which means thinking both with the client and about the client (Book, 1988).

While empathy is something that is widely discussed as a core aspect of the therapy in CBT, the actual nature and function of empathy in this context is not often conceptualised (Thwaites & Bennett-Levy, 2007). Thwaites and Bennett-Levy (2007) propose a model for understanding empathy from a cognitive behavioural perspective that includes four key components; empathic attitude/stance, empathic attunement, empathic communication skills, and empathy knowledge. The empathetic stance is benevolent, curious and interested. Attunement refers to being attentive to the client's emotions and listening as if they were the client. Empathetic communication refers to when empathy is communicated to the client. And empathy knowledge is what therapists learn from teachers or from reading during training and professional development (Thwaites & Bennett-Levy, 2007). The implementation of this specialist knowledge is what differentiates therapeutic empathy from "natural empathy". With this set of skills and knowledge an experienced psychologist is said to draw on the natural empathy they possess and then use their knowledge and skills to address what the client is feeling in the context of a psychological formulation. This construction of therapeutic empathy does not attend to the psychologist's own emotions other than to say that if the psychologist "has not learned to use his/her own emotions to internally

represent and reflect on the client's experience, then the empathic processing of more complex emotions may be deficient" (Thwaites & Bennett-Levy, 2007, p.604). The implicit assumption is that 'good' psychologists will only feel warm empathetic emotions in response to their clients. This is consistent with client-centred therapy and ACT which stipulate that the psychologist will feel empathy towards the client if they are connected deeply enough.

So what of Roger's emphasis on being congruent and genuine? Genuine empathy is something that is routinely cited as being a fundamental part of the therapeutic relationship (Thwaites & Bennett-Levy, 2007), but presumably to be fully congruent a psychologist would need to reflect the range of emotions they experience within the therapeutic relationship. A meta-analysis found that the contribution of the therapists' congruence to client outcome was mixed, but leaning toward the positive (Norcross, 2011). Congruence was more associated with positive client outcome if it was combined with empathy and positive regard (Duncan, Hubble, & Miller, 2010). Again it seems that there are constraints on just how genuine one can be, and if this is the case, does this really entail being genuine at all?

Ryan (2011) interviewed counselling psychologists around constructs of authenticity. There was a common discourse around authentic emotion which attributed importance to emotions and relates to being honest with oneself and others. While authenticity (including emotional authenticity) was constructed as something to aspire to by most of the participants, it was also problematised in respect to professional boundaries. This presented an ideological dilemma which the participants resolved in a variety of ways. Authenticity is only permitted within the limits of professional ethics. Therefore, inauthenticity may at times be considered more ethical than authenticity (Ryan, 2011).

Morstyn (2002) writes about the dilemma of whether therapists should be sincere or 'fake it'. He suggests that current psychological therapy exists in a post-modern society where deception and insincerity are widespread and there has been the rise of the pseudo-relationship where sincerity is manufactured by following manuals and using sophisticated technologies. Manualised psychotherapies instruct therapists on how to simulate sincerity and play the role of the warm and seemingly genuine therapist (Morstyn, 2002). Therapeutic empathy in CBT is defined as "the sophisticated set of skills that advanced therapists might use in the therapy" that are distinct from naturally occurring empathic experiences that lay people might use (Thwaites & Bennett-Levy, 2007p. 592). Fake sincerity means that the

therapist's behaviour can be scripted and standardised which allows for the development of time-limited interventions that fit well with the requirement for 'evidence-based practice' (Morstyn, 2002). Therapists who resist the pressure to work within the confines of organisational structures that promote time-limited manualised treatment can feel stressed and marginalised (Kirschner & Lachicotte, 2001). In addition to fears that being truly genuine and sincere may lead to boundary crossing and not fit within the current trend for manualised packages of care, there may also be the fear that being sincere will encourage the client to be sincere which may enable them to be more openly critical of the therapist (Morstyn, 2002). The potential costs of faking sincerity, Morstyn (2002) suggests, include; that if the client can see the therapist is faking sincerity they may feel alone, disillusioned, or fake it back; that it could reduce job satisfaction, and that it could make 'true' mutual sincerity difficult.

It seems that being genuine is important as long as it is genuine empathy the psychologist is expressing. So what of the emotions that are less desirable like anxiety, anger and hatred? Do psychologists experience them within the therapeutic relationship and if so what do they do with them? In a study by Williams et al. (2003) the 'distracting' feelings psychologists reported included feeling anxious, bored, attracted to their clients, confused, frustrated and angry. The focus of this study was on how psychologists managed these 'distracting' emotions in therapy and their findings suggest that the psychologists interviewed used refocussing on the client and self-coaching, and that the novice psychologists were also inclined to use disclosure of their emotions (Williams, Polster, Grizzard, Rockenbaugh, & Judge, 2003).

The construction of any emotions other than empathy and warmth as distracting and something to be minimised is emerging as one of the central themes in the literature on psychologists' affect in the therapeutic relationship. It is most discernible in Behavioural Therapy, and CBT, but is also implicit in the way client-centred therapy and ACT dismiss the likelihood of negative feelings towards the client if the relationship is strong enough (despite their theoretical assertion that all emotions should be accepted and validated). The other, contradictory discourse which comes out of the psychodynamic framework is that negative emotions towards the client always exist and need to be understood and incorporated into the conceptualisation of that client's presentation.

Prodgers (1991) from his psychodynamic perspective suggests that "hate is always there from the beginning of therapy, whatever the nature of the patient" (Prodgers, 1991, p. 4). He suggests that the nature of the psychologist's attraction to the profession unconsciously involves the repression of aggressive drives and psychologists who are heavily invested in working for the needs of the patient deny their own needs. Psychologists aspire to be compassionate, caring and non-judgemental, so when they experience hatred and aggression towards their clients, they defend against the conscious recognition of them as they are not conducive with their conscious motivations and self-image (Prodgers, 1991).

Maroda (2009) suggests that clients can also often pick up on facial expressions of anger and that denying this can be invalidating of their reality. From a psychodynamic perspective even if the therapist has supressed these feelings, these unconscious feelings could be perceived unconsciously by the client (Maroda, 2009). Madora (2009) suggests that clients value honest feedback, but that the if psychologists do choose to express their anger that it must be done in a self-aware and controlled way, rather than suppressing it until they 'blow up' which leads to shame and guilt.

Prodgers (1991) suggests that some of the negative outcomes of denying anger can be minimised if the hate is identified and processed in supervision early on in the therapeutic relationship. How likely is it that this will happen, that psychologists will allow themselves to acknowledge these feelings that run contrary to the image they have of themselves and take this to supervision? This may be especially hard for trainee psychologists whose supervision is related to their success in their training programme and it has been shown that trainee therapists often lie or refrain from discussing certain critical incidents in supervision (Hantoot, 2000; Howard, Inman, & Altman, 2006). Even though the construct of countertransference provides a framework for discussing emotions like anger for psychologists working psychodynamically "in practice conversations about anger towards clients rarely go beyond the mention of occasional frustration and irritation" (Maroda, 2009, p.197). Again it is suggested that psychologists process these strong emotions towards clients in their personal therapy.

The possibilities for what psychologists can do with feelings of love in the therapeutic relationship follow the same pattern as hate; in that in most types of therapy they are either ignored or promptly dealt to, and in psychodynamic psychotherapy love is conceptualised as

an important part of any therapeutic relationship and reflecting on it adds to the therapeutic process. Natterson (2003) suggests that the "therapeutic relationship becomes a loving relationship, and the therapeutic dialogue is basically about love and the expansion of its role in a person's life" (p. 514). Love is also conceptualised as a therapeutic agent in client-centred therapy, where the process of therapy is supposed to take the client from feeling unworthy, unacceptable and unlovable, to feeling accepted, respected and loved (Rogers, 1951). Love does not feature in discourses around the therapeutic relationship in the behavioural therapies. Even ACT which emphasises the human need for love and acceptance, goes on to focus on acceptance from the psychologist, steering clear of discussing this in terms of the psychologist's love of the client (Pierson & Hayes, 2007).

It is possible that this conspicuous avoidance of addressing psychologists' feelings of love comes from the relationship between love and sexual attraction, which all therapeutic frameworks agree is a clear boundary that must not be crossed. Despite this, it is a boundary that is sometimes crossed with 8.3% of male psychologists and 1.3% of female psychologists reporting having had sexual contact with a client (this is considered to be an underrepresentation due to reluctance in reporting) (Pope, 1988).

Two central dilemmas around the rules and expectations for psychologists' affect within the therapeutic relationship have emerged. The first is the construction of psychologists' emotions (other than empathy and warmth) as distracting and something that should be dealt with, repressed and minimised, so as not to have a detrimental impact on client outcome. This comes up against the construction of psychologists' emotions as ever-present and needing to be understood and utilised in order for effective therapy to occur. While these contradictory constructions originated from different theoretical frameworks, over time psychologists have started using multiple therapeutic approaches (rather being wedded to one school of psychological therapy), and in addition to this there has been seepage between constructs originating from different types of psychological therapy. Therefore, it is possible that psychologists are being asked to both deny their emotions and to understand and learn from them.

The second dilemma is whether psychologists should to be 'truly genuine' and 'authentic' with their emotional expression regardless of what that emotion is, or whether 'genuine' emotional expression needs to be reserved for the expression of 'genuine empathy'. That is

not to say that one ‘true’ or ‘pure’ type of affect exists, rather this dilemma highlights how complex and conflicting affective practices may arise within the therapeutic relationship.

Regardless of the therapeutic approach being employed psychologists are expected to manage their affect in a way that is unique to the profession. Through its history of evolving theoretical frameworks and therapeutic techniques various patterns of affect within the therapeutic relationship have emerged and become layered and intertwined. This research hopes to peel back and explore some of these practices, in order create an account of this profession’s rules and expectations for emotional expression.

Chapter Three – Methodology and Methods

This research produces an account of how psychologists make sense of the emotional work involved in delivering psychological therapy in the social context of the public health system, and how this might relate to broader social power relations and emotional regimes. I am considering the role certain discourses about affect and its management play in the maintenance of this professional identity. Researching discourse is important because it sets professional standards, defines institutions, disciplines and shapes conduct, guides practice, and constitutes identities, subjectivities and experiences. Discourse includes the formulation of affect, emotion categories and narratives, and the meanings assigned to embodied responses.

This research takes a critical social constructionist approach that sees discourse and people's accounts as social actions with effects embedded in power relations. People's accounts need to be interrogated for the work they do and the kind of worlds and minds they construct, rather than treated as neutral descriptions to be assessed for their truth value. A social constructionism epistemology (outlined in Chapter 1, pp. 13–18) is appropriate because it allows me to consider how psychologists construct meanings around their emotions when reflecting on the social interaction of therapy (and other social interactions such as training and supervision) and how this relates to the broader context in which psychological therapy is situated (Gergen, 1999). I am interested in how the participants make sense of their emotions and how the process of meaning making affects the emotional experience. A social constructionism epistemology also allows me to consider how the process of the interviews themselves contributes to this construction of emotion (Fossey, Harvey, McDermott, & Davidson, 2002). The active work of meaning making means that psychologists' emotions are being produced and reproduced both in the moment of their practice and in the moment of recounting their practice. Through this retelling participants are selecting and editing certain meanings and representations so that the data consists of a certain construction of the affective practices.

In this chapter I elaborate on the kind of critical qualitative research I am using and give an overview of how I collected and worked with the data.

Discourse Analysis and the Key Analytic Concepts

This project draws on discourse analytic approaches developed in social psychology and in particular on the more eclectic critical approach formulated by Wetherell (1998, see also Edley 2001), as opposed to the more fine grain types of analysis associated with discursive psychology (Edwards & Potter, 1992) and conversation analysis, and in contrast also with the more global forms of post-structuralist discourse analysis traditionally more focussed on large-scale epistemic regimes than on individual accounts. More generally, discourse analysis is "the study of how talk and texts are used to perform actions" and these actions are often embedded within broader practices (Potter, 2003, p. 73). A key tenet of discourse analysis is that it sees language as constituting our social realities. The social phenomena of interest to us in psychological research are produced and reproduced through discourse (L. A. Wood & Kroger, 2000). Thus discourse analysis is concerned with studying how social realities and identities are constructed through discourse rather than taking people's accounts as neutral descriptions of what 'really happened' (Wetherell, 2001). In any situation there are a number of available discourses, and it is the discourse analyst's task to ask why a particular discourse is being drawn on in any moment and how this relates to the wider politics of representation (Wetherell, 2001).

Critical discursive research in social psychology has been concerned with the rhetorical organisation of discourse including its ideological functions (Billig et al., 1988; Potter & Wetherell, 1995a, p. 90). Some discourses will be more 'available' or more 'to hand' than others because they have become so culturally dominant that they are seen as facts or taken for granted truths (Edley, 2001). Such analysis can consider what forms of discourse have become hegemonic and how these are maintained, resisted or transformed (Edley, 2001). The way discourse is produced and reproduced in any moment reflects complex social and historical processes forming a shared context for members of the same social group. The process of meaning making is a joint production as people relate to each other and the wider culture to come up with a shared sense of what the world is like and how it works (Wetherell, 2001).

This research will consider the participants' meaning making accounts of their emotions within the therapeutic relationship; how they articulate this and make sense of the practices in which they were engage. Again it is important to emphasise the circularity of this process,

talk does not objectively describe affect, rather the meaning making process affects the way one feels and the way one relates from various moral and identity positions. It is also important to note that meaning making does not always mean talking about things that are rational or immediately knowable; often they are things that seem automatic or uncontrollable. Meaning making involves selection and the editing out of other possible meanings, so that the account is a particular construction of what happened and what was felt. When people communicate an emotion it is not usually just describing how they felt, but it is a declaration about who they are in relation to others (Burkitt, 2014).

One way to start studying affective discursive threads is to consider how they develop in interpretative repertoires and associated subject positions (Wetherell et al., 2015). I will now outline the three key analytic concepts which sum up the kinds of patterns I am looking for and am interested in elucidating; affective-discursive repertoires, ideological dilemmas and subject positions.

Affective-Discursive Repertoires

Interpretive repertoires are the "available resources for making evaluations, constructing factual versions and performing particular actions" (Potter & Wetherell, 1995a, p. 89). They are coherent ways of speaking about objects and events that form over time and which we draw on to make sense of things, so that much of our discourse comes from what has been said before (Edley, 2001, p. 198). In other words they are a collectively shared 'package' of easily recognisable arguments, assumptions, metaphors, figures of speech and images (Wetherell & Potter, 1988; Wetherell & Potter, 1992).

While interpretative repertoires are formed through long histories of discourse and social relations that have come to form our 'common sense' ideas about what is, they emerge locally in everyday social practices (e.g. conversations, storytelling, arguments, lectures). In this sense interpretive repertoires provide a set of interpretative moves or potentials for actions, from which one can select the one or ones that fit most effectively in the context (Potter & Wetherell, 1995b). However, this does not preclude novelty as interpretative repertoires are flexible and conversations can be made up of a patchwork of parts of various interpretative repertoires (Edley, 2001). Analysis of interpretative repertoires is a 'midlevel' type of analysis in that it considers how individuals and small groups make meaning with the

available discursive resources. I am interested in researching the pattern of discourse at this level, however, because I am particularly interested in the patterning of affect, I understand these more specifically as affective-discursive repertoires (ADRs) and will refer to them as such. ADRs are the regularities in sense making, accounting and formulating *emotional* states, experiences, prescriptions and evaluations of conduct. I use ADRs to focus on how psychologists narrate their affective practices within their professional identity and how this is both part of wider structures of feelings or emotional regimes, and feeds back into and perpetuates dominant ways of 'doing' emotion.

While affective practices represent the assemblage of a whole lot of things (bodily responses, feelings, thoughts, interactions, narratives, social relations, personal histories), I am focussing on psychologists' accounts and narratives of past practice, and how these socially recognisable patterns of talking about emotion within this specific professional identity and context relate to broader patterns of relating. I am examining the regular ways of narrating the process of being affected and which certain feeling norms and emoting actors are privileged (McConville et al., 2014). While there will always be multiple responses and practices on any particular occasion, there are still repeated practices and affective discursive positions (McConville et al., 2014). The study of affective-discursive repertoires shows us what it is possible to say or to feel within a certain context or identity, and considers what is not possible to say or feel.

Ideological Dilemmas

There are often differing interpretative repertoires used to describe the same social object resulting in a tension or dilemma. Billig et al. (1998, cited in Edley, 2001) suggested that lived ideologies or 'common sense' (the beliefs, values and practices of a society or culture) are always dilemmatic in nature; they are inconsistent, fragmented and contradictory. In this way 'common sense' understandings often contain the seeds of their own negation (Edley, 2001). In a similar vein Rose (1996) sees truth, "not only as a construction but a contestation" (p. 55). There are battles over what can be accepted as true at any particular time and certain ideas are subjugated to the margins and are not permitted to enter the realm of the 'true'. There is often a struggle over how things are to be understood and we can consider how some accounts come to be dominant and whose interests this serves (Wetherell, 2001). Through these struggles or dilemmas, new identities and modes of representations can emerge. These

ideological dilemmas are constructed rhetorically, in that opposing ways of talking about an object develop together in a process of back and forth dialogue across time (Edley, 2001).

Analysis should include the consideration of how affective-discursive repertoires are organised around ideological dilemmas and how they are negotiated. These can be seen when the speaker oscillates back and forth between two or more contradictory 'common sense' understandings. It is important to consider both how these dilemmas are used for rhetorical purposes and their wider cultural significance (Edley, 2001).

Subject Positions

Discourse produces subject positions, because speaking at all is speaking from a position and affective-discursive repertoires involve complex acts of subject positioning (Wetherell, 2001). Davis and Harré (1990) formulated the construct of 'positions' as a way of considering the "dynamic aspects of the encounter", and as a point of contrast to construct of 'roles' which are more static, formal and ritualistic (Davies & Harré, 1990, p. 1). With subject positions the "focus is on the way in which the discursive practices constitute the speakers and hearers in certain ways and yet at the same time is a resource through which speakers and hearers can negotiate new positions" (Davies & Harré, 1990, p. 28). Therefore, discourses are more than just 'meaning systems' in that they contain technical and practical associations and devices that create 'places' for individuals to occupy in order to have the status as subjects (Rose, 1996). Being positioned as a certain subject carries with it particular relations to other subjects and to the world. "An interpretative repertoire very frequently formulates, for instance, not just a way of understanding the world but also a position from which to speak which affords the speaker a particular kind of character" (McConville et al., 2014). Speaking from a subject position means seeing the world in terms of particular metaphors, concepts, images and narratives (Davies & Harré, 1990). This research is interested in the emotional identities and forms of affect available to practising psychologists. Subject positions are identities constructed through specific ways of talking or affective-discursive repertoires, and because these can change, so can the identities of the speakers. Just as there are a variety of affective-discursive repertoires available at any time there are also a number of related subject positions offered for us to take up, respond from and move between. However, subject positions are not always easy to move between, often they need to be negotiated or won because they are bound up in power (Edley, 2001). Speaking from

different subject positions means drawing on the social, cultural and historical resources, and also piecing together language and voices in novel diverging ways (Wetherell, 2001).

This research articulates some of the affective discursive positions which are produced and reproduced in the data. The analysis of subject positions should consider what they do in the context of their production, as well and what they tell us about the broader ideological context (Edley, 2001). Analysis of subject positions means thinking about who is implied in an affective-discursive repertoire and what does a statement say about the person who said it.

The Type of Qualitative Research Used

Ideally, I would have liked to analyse footage of psychologists 'doing' psychological therapy with clients as a way to consider their affective practices in this context. However, I did not have access to this analytic resource and there were obvious ethical complications. Therefore, I conducted focus groups and follow-up individual interviews with practising psychologists about their affective practices within the therapeutic relationship.

I decided to conduct small focus groups and then individual follow up interviews as I anticipated benefits from both formats. Firstly, I wanted to talk to participants twice so that I could get an overview of the constructs at play in the initial discussion and then to use the second discussion to get more detail and to test provisional hypotheses and hunches. Secondly, I hoped that the focus groups and individual interviews would stimulate different types of information (discussed below). Using both focus groups and individual interviews provided more depth and richness and allowed for the building of rapport between me and the participants. This is particularly important because sufficient trust needs to be built in order for participants to be able to tell the 'truth' as they know it (Morrow, 2005).

The benefit of using focus groups was that I could generate more discussion, conjecture and debate, by having the participants discuss the topic with a few of their peers. Finding points of contestation is integral to this sort of methodology so that participants rehearse their typical patterns of sense-making dialogically through claims and counter-claims. When focus groups can provide a supportive environment, participants often talk in depth about sensitive topics and give a lot of information (Wilkinson, 1998). Because focus groups can facilitate participants talking to each other rather than just to the researcher, they can encourage

participants to use their 'real' vocabularies and ways of talking (Braun & Clarke, 2013). Crucially for this research focus, groups provide an opportunity to observe and be part of collective sense making (Wilkinson, 1998). Focus groups can also be empowering if participants share private views and experiences and realise that they are not alone.

Semi-structured interviews are the most common form of data collection in qualitative research. In semi-structured interviews the researcher has an interview schedule, but does not rigidly adhere to it either in the way the questions are asked or the order they are asked (Braun & Clarke, 2013). This flexibility allows space for the participants to bring up what is important to them and for the researcher to follow leads and lines of thought that come up in the moment. Semi-structured interviews are appropriate when the participants have some sort of personal stake in the topic, as the participants in this research did (Braun & Clarke, 2013). The interviews are not seen as objective accounts of the participants' experiences, rather they are they are seen as "complex cultural products, constructed in ways which make things happen and which bring social worlds into being" (Wetherell, 2001, p. 16).

Reflexivity

Reflexivity in this research means that as the interviewer and researcher I am part of the research; I am actively co-constructing the data with the participants during the interviews and focus groups (Burman & Parker, 1993). Thus the interviews and focus groups are treated as an interaction between two (or more parties) to be analysed (Potter & Wetherell, 1995b). The focus groups and interviews were a collaborative puzzling and pulling apart of the psychologist's emotional experiences, however, my questioning still guided the process. I was also an active participant in the process of analysis and interpretation (in a way the participants were not). Therefore there was a power imbalance, as my line of questioning in the interviews and my interpretations in the analysis were ultimately privileged. As such it is important for me to consider how different aspects of my social positioning could have affected the process. It is important to be aware of the possible impact of the power dynamic between the interviewer and the participants, in that the accounts from participants could be constrained by the power of the interviewer.

Feminist research has stressed the importance of "achieving symmetry in the social identities of the interview pair" (Hollway & Jefferson, 2000, p.29). As a Pakeha (New Zealander of

European decent) woman in my 30s I was also roughly matched in gender, age and ethnicity to most of the participants. Being a student in a clinical psychology training programme meant that I shared enough social identity to be able to relate to the participants' experiences. I was on the same path, but in the not-quite-there-yet position. A benefit of this positioning is that it reduced the implicit power imbalance because in a professional sense I had less power and authority, the participants were the experts in a field I was just learning about. Another benefit was that my experience in this role facilitated understanding and discussion. However, this positioning also required careful consideration and came with some limitations. In particular, while I was able to look at the institution of psychology critically to an extent, I was not able to fully step out of my own subjectivity and take the same sort of critical stance that someone who was not invested in it might be able to do. Being 'almost an insider' also was limiting because I may have professional relationships with the participants in the future and my research is part of the same small university programme which some of the participants went through.

My task was to negotiate the territory of producing research that was true to my critical positioning whilst being respectful of the participants. I also needed to be open to participants critiquing the university programmes, without jeopardising my own position within one of them. It was important for me to be aware of the impact I had on the how the data was collected and analysed and to make this transparent so that the reader can consider how these research findings were constructed.

Participants and Recruitment

Sampling in qualitative research is concerned primarily with the richness of the information collected. In contrast to quantitative research that focusses on getting a big enough sample to be able to say that it is representative of a population, the focus on sampling in qualitative research is on it being purposeful (selected to provide information-rich data), and criterion based (using specific criteria based on the research question) (Morrow, 2005; Taylor, 2001). The criterion I used for my sampling was that the participants needed to be practising psychologists who had graduated from their training programmes in the last five years. I originally intended for the sample to be limited to clinical psychologists, however, when a health psychologist expressed interest in participating I decided to expand the criteria so as not to be exclusive as I felt this would have been against the 'spirit' of my research and in

particular my critical stance. I also thought that she fitted the purpose of the criteria in that she was doing psychological therapy with clients. I focussed on clinicians who had graduated relatively recently to ensure that all the participants were trained within reasonably similar paradigms which reflected modes of psychological practice currently in use. In addition to this I was interested in the emotional restructuring involved in becoming a clinical psychologist and the function the training had in this, therefore it was preferable for the participants to have been through the training process relatively recently.

There was not a strict minimum number of participants required, rather the focus was on gaining sufficient depth so as to produce a thorough account of the phenomenon of interest (Fossey et al., 2002). My criteria meant that I had a relatively small pool to draw from, as there are only a small number of clinical psychologists graduating from the six training programmes in New Zealand each year. One way to justify selection in qualitative research is through choosing a relatively homogeneous group, so that the data reflects that group's shared cultural knowledge or skills (Taylor, 2001). While I had a relatively small sample, all being practising psychologists who had graduated in the last five years the data could be said to represent the shared knowledge and practices around emotional expression within this professional group.

I initially tried recruiting by placing an advertisement in the New Zealand Psychological Society newsletter. When this did not result in enough participants I used the professional networks of my secondary supervisor and other staff in the clinical psychology programme to distribute the advertisement. I also asked participants to forward my advert to other potential participants in their professional networks, if they felt comfortable doing so.

I recruited ten clinical psychologists and one health psychologist. Ten of the participants were female and one was male. They all fitted the criteria of currently practising and having graduated in the last five years. All participants worked in the public health sector, and one also did some private practice. There was an even spread over adult, and child and adolescent services. They all trained to be psychologists in New Zealand across four universities. The majority of participants were Pakeha and in their 20s and 30s.

I asked participants what the main types of therapy they used were. All participants reported that they used more than one type of therapy and some reported using three or four different

types of therapy. Ten participants reported using Cognitive Behavioural Therapy (some reported using Mindfulness-based CBT), six reported using Acceptance and Commitment Therapy, six reported using Dialectical Behavioural Therapy (or at least DBT skills), and three reported using some variety of Family Therapy. For each of the following types of therapy there was one participant who reported using them; Cognitive Analytic Therapy, Motivational Interviewing, Solutions-Focussed Therapy, and Compassion Focussed Therapy.

Procedure

As with much qualitative research, this study started with relatively broad questions rather than specific hypotheses. Qualitative research is considered emergent because it is flexible and responsive to the context (Fossey et al., 2002). My broad research questions needed to be refined as the study progressed in order to get a depth of understanding. The first step was constructing a provisional interview schedule based on my research questions and the key dilemmas identified in my literature review. In order to refine these questions and to practise my interviewing skills I conducted two informal pilot focus groups with classmates and an individual interview with a friend who was a practising psychologist. I asked those who participated in these pilot interviews to give me feedback on the process and I used this as well as my general impressions of the interviews to alter the form and content of my focus group interview schedule, for example removing the lengthy quotes from literature and making the style more colloquial. As I developed the interview schedules I was aware that from a social constructionist perspective research cannot be neutral because "all research in a sense produces its answers by the very frame through which the questions are set" (Hollway & Jefferson, 2000, p. 38). It was inevitable that my questioning came from my own subjective positioning.

I conducted three focus groups with three participants in each and one focus group with two participants (the third participant was unable to make it). They ranged between 70 and 90 minutes in duration and were held in private rooms at the University of Auckland. I used the same interview schedule as a guide for all four focus groups, see Appendix I. The groups focussed broadly on eliciting the participants' thoughts on psychology as a profession rather than probing for their individual experiences of emotion when working with clients. Despite this almost all participants spoke about their personal experiences in the focus groups.

Braun and Clark (2013) suggest that focus groups work best when they are either made up of friends or strangers, as opposed to acquaintances, as acquaintances tend to elicit a sense of uncertainly which can inhibit free speech. In this research, one focus group consisted of friends, one of strangers and the remaining two included acquaintances. It was true that the focus groups that contained the friends and strangers seemed to have more personal sharing and flow, and less pauses/hesitations (which could be interpreted as more self-censoring). However, it was hard to say definitively that this was a result of how well participants knew each other, and all four focus groups did produce rich and complex data.

I conducted 11 individual interviews that ranged between 40 and 60 minutes in duration. They were conducted wherever was most convenient for the participants, in private rooms either at the University of Auckland or the participants' place of work. The interview questions varied as they picked up on themes raised in the focus groups. They all had questions clustered around three broad sections; the personal versus the professional, the psychologist's emotional practices, and emotional labour. The questions were focussed on eliciting the individual's own practices and experiences. The interviews were conducted as 'conversational encounters' where myself as the interviewer and the participant were constructing meaning together (L. A. Wood & Kroger, 2000). Because I was not assuming that there was a single coherent answer it was important that my interviews encouraged participants to speak fully and display variability. This meant coming back to the same topic at different times.

Ethics

This study was formulated to adhere with The University of Auckland Human Participants Ethics Committee (UAHPEC) guidelines and was approved by the UAHPEC on the 29th of August 2014 for 3 years, Reference Number 012425.

My recruiting methods (using professional networks and snowballing) could risk potential coercion. While I recognise this possibility it was very unlikely with this group for several reasons (a) all were qualified professionals used to acting assertively (b) I was in a junior position in relation to them (c) my supervisors were not in any direct power relation with the participants (d) requests to participate via snowballing are commonplace in the profession and so refusal is also routine, (e) participants did not receive any payment or compensation

for their participation. Finally, many participants spontaneously commented that they chose to participate because they believed it was an important and interesting topic.

I considered the possibility that participants were likely to talk about having experienced negative emotions during the interview. While it was anticipated that as psychologists they would be familiar with talking about these issues and have the personal and professional resources to manage this, in the unlikely event that participants felt strong negative emotions as a result of their participation and did not have the resources to manage this, I planned to consult with my secondary supervisor, Dr Kerry Gibson, who is a registered Clinical Psychologist, regarding appropriate sources of support. This situation did not occur.

The process of discourse analysis and the interrogation of participants' talk can appear as though it is critical of participants. That is not the aim or intention of the research. Any critique is directed instead at the resources available to psychologists to work through these issues and the dilemmas these create.

Confidentiality was maintained in the write up and in storage of the data. As with most qualitative research quotes are used verbatim, however, participants were give fictitious names to protect their privacy. Participants came from a relatively small pool of people meeting the criteria for participation, therefore, any contextual information that provided clues to identity was removed. Confidentiality within the focus group could not be guaranteed as participants who took part in the same focus group might be able to recall other participants' contributions. In order to try to mitigate this risk as much as possible participants were asked in the Participant Information Sheet and Consent Form not to disclose anything discussed in the focus groups.

Participants talked about experiences they had had with clients. All the participants were registered psychologists and therefore were bound by their professional Code of Ethics to protect the privacy of the clients they work with. They were asked in the Participant Information Sheet to employ their usual practices to ensure client confidentiality was maintained. Likewise participants were asked to maintain the confidentiality of any colleagues they discussed during the focus groups and interviews.

Participants were able to withdraw from both the focus group and the individual interview at any stage and withdraw their contribution in relation to the interview up to one month after the interview. However, given the group nature of the focus group, participants did not have the option to withdraw focus group data. Participants were informed of this in the Participant Information Sheet and agreed to this in the Consent Form. Had there been concerns I would have done my utmost to remove any sensitive comments that could be traced to individual participants.

Participants did not have the opportunity to edit transcripts or audio recordings because this was not appropriate for this methodology which was not designed to gather expert knowledge so much as experienced realities retold in the moment. Having participants edit their transcripts is not considered standard practice in qualitative research. It is appropriate for research when experts are being asked to supply information that they may wish to edit for factual accuracy. In many qualitative epistemological frameworks, however, the aim is to capture meaning in its context. Editing interviews would have seriously risked compromising the integrity of the data.

Working with the Data

Transcription is important because it makes analysis possible by slowing down the discourse in order to identify details and to make a record of the data available to others. However, regardless of how rigorous the process of transcription is, it is impossible to make it a literal rendering of the interviews (L. A. Wood & Kroger, 2000). It is important to acknowledge that transcription represents the audio recordings I made during the interviews and that audio recordings represent the interviews themselves (i.e. two layers of abstraction). Understanding the data (transcripts) as representational requires that I consider the transcription process as an interpretive act rather than an exact replica of the interviews themselves (Lapadat & Lindsay, 1999). As such it is important that I am explicit about how the transcripts were constructed.

Even though the transcription process is not neutral it can still be thorough and consistent (Braun & Clarke, 2013). I used orthographic transcription that included all verbal utterances from all speakers, including words and non-semantic sounds, and highlighted the features of speech that have been shown to be interactionally important, for example overlap, trailing off and pauses. Nothing was corrected or changed (other than to protect participants'

confidentiality). Orthographic approaches to transcribing have been criticised because they do not produce the sound of the discourse very well (as opposed to a phonological approach) (L. A. Wood & Kroger, 2000). A phonological approach, while it may have provided more detail and completeness, would have been too time consuming both in transcription and analysis (it takes longer to read and comprehend). Interpretative repertoires are mainly focussed on understanding the content of discourse and how it is organised, rather than focussing in on the fine detail (Potter & Wetherell, 1995a, p. 90). My analysis was theoretically orientated to look for patterns of meaning making and therefore I wanted my transcription to provide as thorough a representation of the interviews and focus groups as possible, but also provide clarity of reading.

Due to time constraints I paid a professional transcriber to transcribe all the audio recordings of the interviews and focus groups. This transcription was rather crude as it did not include pauses and non-semantic sounds, and there were some mistakes. I then went through transcripts, slowly listening to the recording and making corrections, adding in non-semantic sounds, pauses, and parts of overlapping speech. It was important for me to do this as it added a lot of both tone and content. For instance the inclusion of laughter when something difficult was being spoken about changed the tone dramatically. I outline the conventions I used in my transcribing in more detail in Appendix II.

There is no clear set of rules or principles when it comes to forming an account of the affective-discursive repertoires in a text. Rather the process of analysis is a ‘craft’ that comes with practice and familiarity with the text; it “involves followings hunches and the development of tentative interpretative schemes which may need to be abandoned or revised” (Edley, 2001, p. 198). When similar explanations and arguments come up again and again (resulting in a sense of ‘having heard it all before’) and you start to recognise patterns in particular ways of talking across different people’s talk; you start to get a sense of the ‘discursive terrain’ of that topic (Edley, 2001).

Conducting four focus groups and follow up interviews with elven participants was considered adequate because similar patterns were emerging across the focus groups and interviews, indicating that I had reached ‘saturation’ (Fossey et al., 2002). Saturation is the point at which an adequate amount of data has been collected as no new data is being obtained (Morse, 1995).

The analysis started with going through all the transcripts and categorising all relevant text into patterns. This was not part of the analysis itself, merely a first parsing through to start seeing it as a whole; constructing patterns across interviews and highlighting exceptions and variability. This preliminary process was inclusive, erring on including possibly irrelevant sections of talk, rather than excluding them. It was also cyclical in that when a new pattern emerged I would go back over previously parsed over material to find any evidence of it. Some of the categories that initially seemed separate came to be merged together and other phenomena that at first appeared coherent were later broken into different categories.

After this initial parsing over I categorised all text into 112 loose themes, ranging in size from half a page to 30 pages (some of the narratives were much thicker and more elaborated than others). Once I had completed this exercise in grouping of ideas and ways of talking, I started looking further for patterns that could be categorised in broad affective-discursive repertoires. Then I considered the different 'speaking positions' or 'speaking personalities' associated with these affective-discursive repertoires. I also pulled out the different ways emotion was understood or constructed. I made notes about ideological dilemmas as I went along and elaborated on these later in the analysis. I became familiar with the material over a long period of time and asked myself "what was the talk being used to do?", "how might this statement work ideologically?", "what was absent from this version of the world?", and "how can this difference be justified?" (Potter & Wetherell, 1995a, p. 90).

The resulting analysis is an account of three broad affective-discursive repertoires and the associated subject positions, and ideological dilemmas in Chapters 4 and 5. Chapter 5 also includes a reflection of how participants constructed the function of their emotion work and elaborates on the key ideological dilemmas identified. Following this in Chapter 6 I consider the participants' talk about when they had trouble practising emotions in the required way, and what strategies they formulated for managing this trouble.

Chapter Four – To Contain or not to Contain;
An Account of Two Conflicting Affective-Discursive Repertoires

How do psychologists make sense of the emotional dimensions of the social interaction that is psychological therapy? What affective-discursive repertoires do they draw upon, what subject positions do these afford and what dilemmas do they create? Are some emotions revered and others feared? Where are the points of agreement and contestation about how the psychologist 'should' be emotionally? What tacit rules or unspoken expectations hold these practices in place?

> **(FG2) Helen**: … So what emotions do you think psychologists do commonly experience when working with clients? It's not what they should be experiencing but just what you think they do commonly experience when working with clients?
> **Amy**: Sadness.
> **Kate:** A little at the beginning anxiety [Helen: mhmm]. A little bit of worry.
> **Amy:** Frustration at times. (overlap)
> **Kate:** Hopelessness yeah, frustration.
> **Kate:** Proud. I get really proud [Amy and Tammy: mmm]. I think that's what tears me up the most [Helen: mmm] is when they do something really well.
> **Helen**: I can relate to that.
> **Amy**: Little moments of joy [Helen: yeah], like I guess that's related to that feeling of pride when you sense that a client is making progress [Kate: mmm] or making some changes [Kate: yeah].
> **Tammy**: I guess sometimes irritation when you can just see that there's no change [others: mmm] happening and so many benefits for the change but just doesn't seem to be working [Kate: yeah, yeah] in what you're doing.
> **Kate**: And they are getting wilful, we call it in DBT [others: (laugh)], they are getting wilful [Helen: yeah], that's difficult. That's quite a few [Helen: yeah]. That's probably the whole range [Helen: it is the whole range]. I can't think of any feeling...
> **Amy**: Yeah that you wouldn't have really-
> **Kate**: Even shame sometimes, I don't know.
> **Tammy**: And sometimes anger I think as well.
> **Amy**: Yeah that can certainly be provoked by particularly difficult clients.
> **Helen**: That does sound like the whole range. I am trying to think if there is anything .. umm things like...
> **Tammy**: Maybe scared.
> ……
> **Tammy:** ... Boredom sometimes
> **Amy**: Yeah certainly.
> **Kate**: Maybe disgust…

The extract above is indicative of a discourse running through the data about it being possible for psychologists (in the abstract) to feel the whole 'raft of human emotions', as one participant said "I don't think there's anything that psychologists wouldn't feel" (Haley,

FG4). Psychologists are constructed as coming to the profession as emotionally well-rounded humans, pre-equipped with the emotional wherewithal required to perform this professional identity. While there was talk about the possibility of experiencing any emotion, this does not mean that all emotions were considered acceptable to express.

In this analysis I have ordered the text into three broad affective-discursive repertoires (ADRs) and associated subject positions. This chapter is an account of two conflicting ADRs; that psychologist's emotions should be contained and not expressed, and that the psychologist's emotions should be natural and not faked or controlled.

Affective-Discursive Repertoire 1: The psychologist's emotions should be contained and not expressed – The Container/ The Scientist

> **(FG3) Frances**: And I think that comes back down to the kind of your expression is showing that you can cope [Helen: mmm] with really awful things, so whatever you are expressing you are tolerating. You are not losing the plot and should that happen you should be probably going and getting some support [Helen: mhmm]. I actually think that could be really damaging for people [Helen: mmm].
>
> **(FG4) Hayley**: But it is important [Pete: yeah], like if someone says something that disgusts you or horrifies [Pete and Helen: yeah] you or disappoints you [Isabelle: mmm], you can't have that all over your face-
> **Pete**: Yeah, that's it. Because you can totally invalidate- [Helen: mmm]
> **Hayley**: You can totally fuck things up...

This ADR supports the practice of psychologists holding their strong emotions inside and not engaging in emotional expression. The psychologist should contain both their own emotions and those of the client. Indeed, the psychologist operates rather like a one-way mirror, encouraging clients to express their emotions, while being opaque and not showing their own emotions. This affective-discursive repertoire with its central trope of 'containment' was used repeatedly by every participant. While there were different accounts about the 'how' and 'when' of containment, and its degree, there was consensus that it is a necessary part of providing psychological therapy. When this repertoire was brought up by one participant in the focus groups, others elaborated and strengthened accounts with their own contributions.

The Risks

Within this ADR various emotions experienced by the psychologist are constructed as 'risky', and potentially harmful to the client and to the therapy process if they were expressed. Emotions constructed as risky were; anger, shame/embarrassment, sexual attraction, fondness, disgust, anxiety/fear, boredom, sadness and hopelessness. This construction of emotions as potentially dangerous is used to justify the practice of holding in emotions, putting them in a box and closing the lid, presenting as calm, neutral and in control.

It is an interesting practice because rather than being a call to action, it is a call to inaction. Social power is enacted through the practice of restraint, suppression and control. I am not suggesting that some true innate emotion has been muted. Rather I suggest that the act of emotional suppression in order to meet professional requirements represents a clash in the social expectations and demands around emotional expression. The psychologist's histories of practice around emotions such as anger, and what social interactions might justify it, come into conflict with the affective practices subscribed within this professional identity. There are contradictory cultural demands put on the psychologist and therefore emotional work is required to embody the 'correct' emotion in the context of the therapeutic relationship.

> **(I) Kate**: ...Recently I had a client who I hadn't met yet ring me and say sorry I've heard your voice mail and your last name sounds like a brown name ((laughs)). I don't want to see you [Helen: oh my God]. And of course I was furious [Helen: yeah]. I was furious [Helen: understandably]. I was actually going to assess this woman so she could get some help [Helen: mmm]. So she was cutting her nose off to spite her face really. But I was very calm on the phone. So this was an example where I had to definitely put my feelings aside [Helen: mmm] and I had to just go well it's unfortunate that you think that way (laughs)….

Among the 'risky' emotions, anger and frustration were the most discussed, and presented immediately problematic. The sheer volume of talk about anger and frustration and its dilemmatic nature suggests that the construction of this emotion in this social context represents a clash of social expectations for the psychologist. In the context of this ADR the expression of anger and frustration became inappropriate, even in response to interactions with clients where anger would likely be seen as justified in other contexts in response to things such as racism, homophobia and sexism. Examples such as the extract above are particularly interesting because therapy is one of the places where people go to learn about

emotions (Wetherell, 2012). Therefore it is possible that the way a psychologist emotes in the therapy session could come to be understood as *the* way to emote by the client. If this is the case the psychologist who stays calm in the face of prejudice is not only involved in her/his own self-discipline, but could also be complicit in the production of more docile subjects.

In this ADR crying or becoming tearful in front of clients was also seen as inappropriate and risky.

> **(I) Sal**: Mm umm, yeah I think that for me definitely my emotional triggers are trauma stories [Helen: yeah]. Yeah I've had several occasions where clients are in the process of disclosing some kind of trauma history [Helen: mm], which you know for me I find really upsetting [Helen: mmm] and had to really mask that. I mean I think, I can think of one specific example in this current role where a client disclosed something in a session and I remember I felt quite tearful [Helen: mmm] but I didn't want to cry in front of my client, but I just shared with him that I felt really sad by [Helen: mmm] what he was sharing with me. But I felt really, really, really sad [Helen: mmm] and when I finished the session I came back to the office and had a big cry [Helen: mmm] to a colleague about it ((laughs)) and everything like that…
>
> **(FG4) Hayley**:…. I personally draw the line at crying. I would never cry in front of a client [Helen: mmm] but I have seen co-workers [Helen: mhmm] leave the offices in tears with the clients [Helen: mmm] and that makes me deeply uncomfortable and I think that that's.. I don't know why I would draw the line there [Helen: yeah] but that's like never for me.

In the first extract the participant spoke about telling a client she felt sad while at the same time holding back her tears. As suggested in the literature review, emotional congruence is curtailed when it comes to certain 'risky' emotions. This will be discussed further below. It is not only tears that are unacceptable but also laughter, as spoken about in the following extract.

> **(FG4) Hayley**: I definitely ..like a strong fondness [Helen: mhmm]. I have some clients [Isabelle: mmm] that I try like, like I know my face lights up when I see them and sometimes I try.. and like when they are being like a real dick, I just love it, like they are such cool people [Pete: mmm]and even when they are being the worst [Pete: mmm]I just have to try really hard not to laugh [Pete: mmm, Isabelle: yeah] when they're being funny.
> **Pete**: That's real hard. (laughter)
> ……..
> **Pete**: Yeah I had a client like that today and she came in and she's got alcohol and drug issues [Isabelle and Helen: mmm] and in the first thing I said "oh how was the week?" and she was like "the ball was good", like umm…no what did she say, no she said "oh that E really helped my ball" (laughter from all) and because she's got such

> spunk [Helen: yeah (laughs)] and she's such a personality that she said it in this way and I laughed. I was like damn, oh I can't do that. (extended laughter from all)
> **Hayley**: I am exactly the same. She will be like I did this great thing and tells this great engaging story [Helen: yeah] and it ends with terrible, terrible behaviours and you are like argh no [Pete: (laughs)], no don't do that, (laughter from all) but you've already got into the story [Helen: yeah] and you are in that pal mode and you are like laughing and it's like shit [Helen: mmm] I just went too far down the fondness route [Helen: mmm]on that one (laughs) [Isabelle: (laughs)]. It's hard to get back from. You can't just like .. [Helen: mmm] poker face.
> **Pete**: It's hard because then it feels un-gen-, there is something like un-genuine about [Hayley: yeah]...

These examples show how finessed the rules and expectations are around the psychologist's emotions. The psychologist is supposed to like the client and feel connected to him/her but not too much. Somehow liking the client too much moves the psychologist out of the 'professional' into the 'friend' which presumably would make it hard to justify payment for the service. I think this brings into focus the emotional labour of the work. It does not count as work if you are looking forward to seeing the client and laughing at his/her 'inappropriate' jokes. It also makes me think of Prodgers' (1991) assertion that psychologists are prone to self-sacrificing schema (see Chapter 2, p. 53). Having fun with a client may not fit with the professional self-concept as the self-sacrificing healer.

As discussed in Chapter 2, loving the client is not commonly mentioned within the behavioural therapies, whereas it is assumed in psychodynamic therapy. While fondness was cautioned against but still able to be discussed, sexual attraction was much more out of bounds. With but one exception all the talk around sexual attraction was around how it would not be okay to express it to a client. While it was acknowledged that it would be possible for a psychologist to feel attracted to a client in an abstract sense, there was a no talk about this on a personal level. One participant said that is was a "real taboo" (Tammy, FG2).

> **(FG1) Fiona**:... the emotional stuff is often the hardest to talk about (Helen: mmm) and going back to the example (Helen: mmm) if you want to sleep with your client, you're not often going to talk to your team mates about (Tracy: yup. Helen: mmm) that and you definitely wouldn't talk to your supervisor about it (Tracy: yeah).

Of all the emotions sexual attraction was constructed as the single biggest threat to the professional identity. This is understandable considering that the Code of Ethics for Psychologists Working in New Zealand states that "sexual relationships with clients, supervisees and/or students are unethical" (p. 10), and this is the only behaviour in the whole

document that is specifically singled out and called unethical. I am not going to argue that this is not the case. I do think that the construction of risk placed on feeling sexually attracted to a client (to the extent that participants said that they would not talk about such feelings even in supervision) could make the unethical behaviour more likely and more difficult to deal with. Clients are expected to acknowledge their emotions in order to manage them. However, when it comes to certain emotions such as sexual attraction, psychologists are not afforded the same opportunity in supervision, to express, process and manage.

Part of the function of containment is that it is an act of differentiation from the client. In the case of these risky emotions it is constructed as important for psychologists to not step over the line to become more aligned with the client. I think this is particularly the case when it is emotions commonly experienced by clients, such as hopelessness, anxiety and anger. There is caution expressed about the client stepping over the line as well. For example a few participants spoke about feeling embarrassed, awkward and vulnerable when clients expressed sexual attraction towards them. This disrupts the power hierarchy and threatens the professional identity.

I have discussed some of the emotions formulated as risky for the psychologist to express. I will now consider how the risks are constructed. What talk is there about the harm that could come about if the psychologist expresses these feelings? What are the costs of breaking the feeling rules and defying the dominant ideology? Firstly, the psychologist's emotional expression was constructed as burdensome. As one participant said it is "almost putting a burden on the client and putting your own emotions on the client" (Amy, FG2). Or, as another participant put it, the clients "are coming to see me to work through that stuff, not to gain external people's baggage" (Jemima, FG3). Here emotions have a certain physicality; they are heavy, baggage or a burden. When emotions are constructed this way it makes it unethical for the psychologist to express their emotions because this would be adding to the client's load rather than helping relieve it. The emotional labour of being a psychologist involves carrying some of the client's emotional load not piling more on to it.

Within this ADR the expression of emotion indicates that the psychologist is not able to carry their own burden, she/he does not have the strength it takes to do the job successfully. The psychologist's emotional expression is constructed as a sign of weakness or inability to cope; and participants suggested that clients needed to be able to see that psychologists could

'handle' their own emotions in order to be able to trust them with theirs. When the psychologist cannot contain their own emotion, the client is less likely to express theirs.

> **(FG1) Fiona**: And again if they can still feel like you can contain them, if you go on for an hour crying about your dog, they're like ooh probably not going to tell you about the death of my dad yesterday [others: (laugh)], might not be able to handle that [Helen and Tracy: yeah] but if you model that you can contain yourself [Helen: mmm] [Tracy: yeah] then they're more likely I think to trust you with theirs….

The clients are constructed as needing to have evidence that the psychologist has the strength to carry the emotional load before they feel able to off-load themselves. The psychologist having a 'handle' on her/his emotions is related to having power and control, because as one participant said "you could lose a lot of credibility if you are perceived by the client as not being able to contain your own emotions" (Fiona, I), or as another participant said "if you are all sad and upset how are you supposed to think clearly about what to then say next" (Kate, FG2). So if the therapist is too emotional they lose control and the ability to take the therapy somewhere. In this construction emotional expression is a messy, sticky swamp that the psychologist gets stuck in, preventing progress. When people see that the psychologist is stuck in this mess of emotional expression they think she/he is not a credible practitioner, she/he loses the ability to move forward and take control of her/his own emotions, let alone those of the clients'.

Another reason participants gave for psychologists not to express their emotions is because if the psychologist expresses emotions and responds to the client in the same way as 'everyone else', this would make the enterprise of therapy pointless because the psychologist is being paid to react differently. The implication is that the psychologist needs to repress her/his 'natural' reaction in order to respond in a way that fits with the professional identity.

Finally the psychologist's emotional expression is constructed as more than just ineffectual or burdensome; it has the potential to cause actual harm. It can "damage rapport" (Fiona, I), "totally invalidate" (Pete, FG4), "can leave the client feeling guilty" (Amy, I), and "it is very confusing and quite damaging" (Frances, I). It could be argued that being ineffectual is also harmful because time and resources are being used for no gain. However, when actual harm is being constructed then there are ethical implications.

The way this ADR is constructed produces and reproduces the idea that emotional expression is risky justifying the practice of containment. This discourse needs to be considered in the context of wider understandings around risk in modern society. Rose (1998) writes about the way language about dangerousness had been displaced to that of risk which is seen to be more objective and robust (i.e. scientific). As a consequence working with clients of mental health services becomes less therapeutic and more administrative in the attempt to try to control future conduct. He argues that this widens the nexus of control so that the troublesome individual is "one who cannot lead a life, who is not attached to the normalising practices of family, work and consumption, who is not engaged in the arts of lifestyle maximization that now define an ordinary life" (Rose, 1998, p. 181). The construction of the psychologist's emotions as potentially risky suggests that they are also subject to this assessment on a continuum. Rose argues that risk thinking "establishes formats for thinking, communicating, deciding and acting in these circumstances" and I would add to this emoting (Rose, 1998, p. 181). When psychology operates 'in the shadow of the law' it shapes professional conduct so that it is oriented to risk management technologies and changes the conditions of possibility for how a psychologist can practice.

Subject Positions – The Container and The Scientist

What subject positions are constituted through this affective-discursive repertoire and are these equally available to the psychologist and the client? While it may seem rather obvious that the affective discursive repertoire of containment produces the subject position of the Container, I did not expect it to be stated as explicitly as it was. Although the action of emotional containment was woven through the data, I was still surprised when participants used the Container as a noun to describe themselves.

The Container

> **(FG3) Frances**: I actually found some of the feedback in the clinic quite helpful as well in terms of just that kind of that idea of being a container [Jemima: mmm] and I mean I'm still getting my head around what that actually means. It was just the feedback was you are a good container. I'm like cool umm what's that (laughs), here I am [Helen: yeah (laughs)]. But I think what he was saying was that kind of holding the emotion [Helen: mmm] and just being with whatever the person is experiencing [Helen: mmm] without over-reacting, without jumping around [Helen: mmm] but being there with them and whether that's with a worried expression on my face

> [Helen: mmm] or whatever but I am not moving [Helen: mmm], I am not jumping around the room [Helen: yeah] but it's not over the top, it's subtle I think [Helen: mmm]. It doesn't have to be bursting into tears [Helen: mmm]. It just has to be here I am and I am feeling this with you [Jemima: mmm] and I'm not uncomfortable with that feeling, I'm tolerating it [Helen: mmm] yeah.
>
> **(I) Jemima**: …I think I am always, maybe I am over-sensitive to it [Helen: mmm], I don't know, but just overly worried that I don't want to give clients [Helen: mhmm] my emotions for something else for them to hold. I want them to know that I am their container [Helen: yeah], not the other way around [Helen: yeah].

The psychologist who is a Container is an emotional receptacle. She/he goes into the therapy session with ample emotional space for the client to full up with all their unruly emotions. The Container sits with emotions, holds emotions without reacting to them in the way that non-containers would. The Container's job is to hold all emotions, the clients' and her/his own. Sometimes the Container can talk blandly about how she/he is feeling but she/he must not 'show' the emotion.

When the psychologist is the Container how does this position them in relation to the client? Does the client become the sieve? The description of clients as "very damaged and emotion is just spilling out all over the sides" (Frances, FG3) makes me think more of a leaky bucket. On the other hand several participants said that psychologists needed to encourage other clients to "experience their emotions, express those emotions honestly to other people" (Pete, FG3). When clients spoke about difficult things in a 'matter of fact' tone, devoid of emotional expression this was called masking, or related to diagnoses such as certain personality disorders or eating disorders. So when clients are 'contained' and talk about their emotions impassively, this is constructed as problematic, and at times pathological. Within this ADR being emotionally expressive (within limits) is something that is encouraged in clients and confessed to by psychologists. The subject position of the Container is exclusively available to the psychologist and it is partly what demarcates the power differentials inherent in the therapeutic relationship.

The Scientist

You would be forgiven for thinking that the Container might resemble an objective and impassive Scientist, however, this subject position is constructed as distinct. While the Container is something to aspire to, the Scientist is vilified. Some participants spoke about

not agreeing with training programmes that taught them to supress their emotions and use "standard robotic" (Isabelle, FG4) responses with clients, or just deny that they have emotions all together.

> **(FG4) Pete**: If the therapeutic relationship is such a foundation of… if the person is going to get benefit out of it how do you have a relationship [Helen: mmm] being a **scientist** [Isabelle and Helen: mmm yeah] [Hayley: a practitioner] rather than a person [Others: mmm].
>
> **(FG1) Tracy**: Even that like when you sit back and think and you get into that, it's like what is empathy, it's like we've got a tick sheet.
> **Fiona**: Like validation and reflection and the six levels of validation [Helen: (laughs)].
> **Tracy**: But like you get a tick sheet with like build rapport and empathy on it [Helen: (laughs)].
>
> **(I) Frances**: ... If they [potential supervisees] were trying to be unemotional perfect little robots who just do [Helen: yeah] manual and weren't prepared to look at their own processes and weren't prepared to look at their own stuff that is going on inside of them [Helen: yeah] I would have major concerns.

The Scientist subject position is constructed as something that is to be resisted. It is said to be taken up by some lecturers who no longer are in touch with what doing psychological therapy involves. It is understood as unsatisfying for the psychologist and alienating for the client, who does not want to see the scientist with her/his tick sheet and standardised responses.

Some Context

The data suggests that the repertoire of containment is a core part of the emotional labour involved in being a psychologist. The need for the psychologist to contain her/his emotions and be objective and in control can be understood in the context of a discipline that attempts to use empirical science to further its legitimacy, influence and control. Since its inception, as an 'applied behavioural science', psychology has attempted to aspire to the legitimacy ascribed to science in order to be positioned as 'truth' producing. Legitimate knowledge is to be gained through unbiased observations and the logic of scientific enquiry. As the profession of clinical psychology attempts to fit therapy into an empirical scientific paradigm, certain practices and technologies such as scientific experiments and statistical techniques become valued and standard, along with the privileging of 'evidence-based practice' and the 'scientist-practitioner model'.

This backdrop provided the conditions of possibility for the affective-discursive repertoire of containment and the subject positions of the Container and the Scientist. The psychologist needs to contain her/his emotions and be objective and in control in order to have her/his knowledge constructed as legitimate.

> **(I) Hayley**: …all the therapies I do are quite behavioural [Helen: mhmm] so if we don't end with a plan that is an error [Helen: yeah] and so if you, you know you lose a lot of your session kind of structure and purpose [Helen: mhmm] if you are sort of just like "oh my god", you know, like spent too much time in the emotion [Helen: yeah]. And I think a little bit of what gives you your respect is your ability to hold the session and to move it along and to kind of shape it… [Helen: yeah] um, cause people aren't good at doing that themselves [Helen: mhmm] and so if you are able to kind of hold that then you get a lot more done [Helen: yeah] and so it's not necessarily that they wouldn't think that you are as powerful but that your power would just exert itself [Helen: mhmm] differently and I think it would just be lots less useful to just get lost in the mess.…

This extract links the practice of containment particularly with the behavioural therapies. It suggests that the focus should be on measureable behavioural change rather than getting bogged down in the 'mess' of emotions. Indeed the Scientist can be equated with the type of therapeutic stance prescribed by early proponents of Behavioural Therapy, where the psychologist is constructed as the knowledgeable expert who is in control of the therapy and ensuring that progress is made and the desired outcomes are met. The cool detached analyst associated with early psychodynamic therapy also fits this bill. These early analysists were meant to represent empty vessels whom the clients could fill with emotions and ways of relating. However, through the second half of the 20th century there was a push back against this cool and detached scientific approach, evident in this data corpus in the contempt for the Scientist subject position. New discourses emerged about the importance of the therapeutic relationship and building a strong therapeutic alliance (Martin et al., 2000). It was no longer acceptable for the psychologist to represent a scientist with a clip board, or an analysist who is an intentionally shadowy figure sitting behind the client lying on the couch. This created a dilemma. Psychological therapy still needed the authority of science to be considered a legitimate agent of social change. However, the 'dehumanising' quality of this approach was no longer considered tolerable. Is the subject position of the Container a repackaging of the subject position of the Scientist for this new context?

There is a long history in the West of emotion being positioned in opposition to reason, with reason associated with authority and masculinity. Since the Enlightenment, reason and control have been idealised and placed in opposition to emotion and associated femininity (Lupton, 1998). While clinical psychology was initially a male dominated profession over the years there has been a trend for higher proportions of women to enter the profession than men (Radford & Holdstock, 1995). The woman as the objective, cool scientist could be seen as subverting traditional constructions of women and their roles. However, the rejection of the Scientist (in favour of the Container) could also be seen as a reflection of a societal discomfort with women who emote in this restrained way. It is possible that this discomfort with the women taking up the 'scientific' role is part of what led to the displacement of the Scientist with the Container, and the creation of space for alternative ADRs discussed. The use of the word containment to describe a certain kind of care can also be linked to psychodynamic theory which talks about mothers needing to be able to contain their babies' emotions (Harris, Bick, & Williams, 2011). This suggests that women can fit neatly into the position of the Container because it is aligned with mainstream cultural understandings (produced and circulated through the psy-complex) of how they are supposed to be as mothers.

Affective-Discursive Repertoire 2: The psychologist's emotions should be natural and not faked or controlled – The Human

This affective-discursive repertoire involves the practice of accepting emotions 'for what they are' rather than trying to control or moderate them. A whole different set of actions are constructed in comparison to the ADR just considered. Being 'real' and being 'genuine' are privileged over being controlled and containing. Advocating the expression of genuine emotion with a client involves formulating emotion as natural and sometimes uncontrollable. It leads to the psychologist both *talking* openly about how she/he is feeling and *showing* emotion (e.g. crying). This ADR produces the subject position of The Human (discussed below) which is pitted against The Scientist, and The Container.

Participants spoke about the importance of being genuine and freely expressing emotion rather than being 'cut off' or emotionally restricted. This talk ran alongside and in and out of the talk about the importance of containment and the tension between the two was immediately apparent. While the talk about the importance of expressing 'real emotions' was

not as prevalent as talk about the importance of containment, it was still present (albeit sometimes at the margins) and constructed as a legitimate practice recognisable to all the participants.

> **(FG3) Jemima**: Well I think you need to be genuine in the room [Helen: mhmm] and if you are always considering every single thing that's going through [Helen: mmm], which I think well I know I certainly did when I started like in the clinic or whatever [Helen: yeah], like every single interaction and word was sort of thought through [Helen: mmm] and it just takes that genuineness out of it and clients need the genuineness [others: mmm].
>
> **(FG4) Hayley**: One of my supervisors was like "this .. (mumble, inaudible) what is wrong?" [Others: (quiet laugh). Pete: interesting]. And so it [keeping a neutral face] was snapped out of me (clicking fingers) real fast [Helen: mmm] and so by the time I started my career I was.. I had learnt to be my authentic self [Helen: mmm], cause they were like what's the priority in the room [Helen: yeah], what your face is doing or what the client is going through [Helen: yeah. Pete: mmm]. Stop worrying so much about what is going on for you and just trust that your reactions will be accurate.. fine [Helen: mmm], they need to talk to a human being….
>
> **(FG1) Tracy**: ... But actually yeah in my clinical practice I find the clients knowing you as a person [Helen: mmm] not just super professional all the time [Fiona: yeah] actually happens really quite quickly often [Helen: mm mm] and I wouldn't necessarily want that to be different but I don't think they [university staff] acknowledge that or model that very well ...

These extracts are thick with talk about the importance of the psychologist being genuine, a human, a person, her/his authentic self. In this ADR the psychologist is expected to genuinely express emotions both 'good' and 'bad'.

This ADR is less tactical than the ADR discussed in the next chapter. The scope is reduced to the binary of either being 'real' which means being present in the moment, connected to what she/he is feeling and what the clients are feeling, **or** being 'fake' which is when she/he is caught up in her/his head and what she/he 'should' be saying and doing, therefore disconnected from the clients and what they are feeling. Within this ADR the clients need the psychologist to be genuine in order to be present to their emotion. The psychologist is a human who experiences stress and other emotions just like the client. To pretend that it is otherwise is constructed as futile because as one participant said "a lot of my clients will see straight through me if I'm telling porkies" (Frances, FG3).

> **(FG1) Fiona**: … but like you were saying before to build rapport and to seem validated [Helen: mmm] and to express empathy like there has to be emotion behind that [Helen: mmm yeah] and you can't really fake that [Helen: mmm]. Well, you'll; be doing a terrible job if you're trying to fake it.
>
> **(I) Frances**: And I think for a lot of people who are unfortunately it's the majority of people that come into this service were traumatised, abused, neglected, they are.. so sensitive to any.. inauthentic-ness [Helen: mmm]. They are.. umm they are alert to that [Helen: yeah] really quickly.. and yeah.. maybe I see this a little bit with the doctors more [Helen: mhmm] than the psychologists because.. umm they.. I guess they are trained to be much more umm inexpressive and.. [Helen: yeah] answer these questions. But for a lot of the clients who are in DBT where this is much more apparent for this population, that sensitivity to umm people not being genuine, they tend to lose trust [Helen: mmm] really, really quickly. ...

Being 'fake' is constructed as unhelpful and futile. This relates to the critique discussed in Chapter Two (pp. 51–52) of psychologists who try to fake sincerity. Morstyn's (2002) account of manualised psychotherapies instructing psychologists how to simulate sincerity and warmth in order to fit into time-limited 'evidence-based' therapies was echoed by a participant who said that there simply is not the space to work with emotions in brief interventions.

> **(FG1) Tracy**: It's just got me thinking like in my workplace there's a huge amount of pressure to do six sessions of CBT [Helen: mmm] with someone and then things are supposed to be better and I find when I have that pressure and I mean one it doesn't work because six sessions isn't even evidence based [Helen: mmm] anyway but that's a different story but I find when I've got that kind of like okay I've got six sessions we need to get through these elements [Helen: mhmm] of whatever we're doing, I don't go to the emotion and it's essentially skills work [Fiona and Helen: mmm] and then I'm kind of like I don't even know if it needs to be a psychologist doing this [Fiona: yup], this could just be anyone who's attended a CBT course and is essentially doing manualised therapy [Tracy and Helen: yup] and so that kind of, yeah I find that difficult to know quite what to do [Helen: yeah]. Yeah there's definitely a bit of pressure to kind of do things brief [Helen: brief] and that means that I don't go to emotion as much as I would.

"Going to the emotion" (both the client's and the psychologist's) is formulated as a fundamental part of the psychologist's job in this ADR. As talked about in this extract, if this is not part of the therapy then it might as well be done by any person, not a specialised type of person who has completed seven years of tertiary education. I think this does interesting things to the social power relations. While the practice of the psychologist expressing emotions in a 'natural and real' way reduces the power imbalance between the psychologist and the client, it also protects the profession from the threat of unqualified interlopers who

have nothing more than a manual and a certificate from a three day course, or worse still from computers programmed with the latest therapy software. It opens up too the idea that the skilled expert might also be better at expressing emotion and be more emotionally skilled and emotionally intelligent than the client.

The Risks

The risks produced in this ADR about the psychologist's emotional expression needing to be natural and not faked or controlled is like the *Alice Through the Looking-Glass* version of the previous ADR. The same 'risks' are constructed, however, they are now due to the psychologist not expressing enough emotion (as opposed to resulting from the psychologist expressing too much emotion). Rather than the psychologist's emotional expression being damaging to the therapeutic relationship, it is the psychologist's lack of emotional expression which is constructed as potentially damaging in that it can be alienating to the client. As one participant said "it would be so invalidating if someone didn't react to your intense emotions" (Isabelle, p. 7). Emotion is constructed in opposition to thinking, and in this ADR emotion is privileged over analytical thinking. The psychologist who is too caught up in her/his thoughts and analyses misses what is going on for the client at the level of emotions.

> **(FG3) Jemima**: I think being neutral would be just as damaging [Sal: I agree. Helen: mmm] in a lot of ways.
> …….
> **Sal**: Yeah for me I think if you're not expressing emotions or having emotion you are just all up in here [points to head] kind of analysing everything- [Helen: mhmm]
> **Jemima**: You are not in the room [Sal: yeah], you are not present, you are not feeling. I mean I don't think it would be possible to be in ... I mean there are some sessions which aren't that emotional but most of the sessions there are emotions in the room [Helen: mhmm] and if you're not at least feeling it [Helen: mhmm], and surely if you feel it there's going to be <u>some</u> expression of it (laughs) [Helen: yeah], whether it's hand movements or facial movements [Helen: yeah] or what you say or something. If you are not feeling those emotions and it all up- I don't see.. [Frances: no] I don't see really how you can create that close enough bond to progress therapy.

In this ADR the psychologist's containment can mean that the client is less likely to open up emotionally. Emotional expression is constructed as a lubricant to help the client express themselves… to confess. One participant spoke about a client who complained that she only expressed two emotions (happy and neutral) and who ended up dropping out of therapy.

> **(I)Fiona**: ... I think people like when even psychologists, when they are too tick boxy [Helen: mmm] and prescriptive [Helen: yeah], and are just asking questions that they expect to know the answer to [Helen: mmm]..um then it can happen then [Helen: yeah] I think.
> **Helen**: Yeah? So you can kind of…see the.. see the client as being "like yeah nah I am just kind of"-
> **Fiona**: Yeah and I think if you don't… um like if you don't get buy in from them and give a good reason why.. [Helen: mmm] they.. they should engage with you they are just like "oh well" they just answer… [Helen: yeah] as less as possible and you don't get to the bottom of anything [Helen: mmm]. You don't get good information.
>
> **(I) Jemima**: … We talk about some quite heavy stuff [Helen: yeah] so if you are not able to respond.. to it.. um then all of these emotions are rising up inside of them [Helen: mmm] and they can just kind of become overwhelmed by it [Helen: yup]. Or the opposite happens and they are like.. they just become… briefer and briefer with their answers [Helen: mmm] and less thought through and less engaged in the process.. [Helen: yeah] um and then probably don't come back.

If the psychologist does not use emotion to make a 'human connection' with the client then the client will not give them the information they need to do their job (of classification and normalisation). It is suggested that the client will give minimal answers, be evasive or even lie. From a critical psychological standpoint, this could be seen as an example of how being emotionally expressive can equally facilitate technologies of social control. Again it is the construction of risk and technical efficiency that holds this ADR in place; the production and reproduction of the idea that not expressing emotions is counterproductive, as it can mean the client is emotionally clammed up. In this ADR psychologists are not only permitted to emote, but urged to as a crucial part of the therapy. Parker (1998) writes about Foucault's theory that the increasing surveillance in Western cultures in the 19th century, by various institutions, including psychology, has meant that the mind has become the target of professional knowledge. From this perspective, this ADR around the psychologist expressing 'genuine emotion' facilitates the access of more material of the mind from the client). Interestingly, as therapy becomes more emotional, it also seems to share some features with the central technology of the self Foucault identified as key to religion and its social power – the confession.

Subject Position – The Human

What subject position is constituted through this ADR? A subject position explicitly spoken about in all the focus groups is that of the Human. This sentient being is standing up in

opposition to the robotic scientist. The Human reminds us that psychologists are but animals with biological drives and emotional instincts. The Human may be fallible and at times vulnerable, but at least she/he is real. In this day and age you can programme a robot to do almost anything, anything that is, but feel emotions. Psychologists need the subject position of the Human to justify their existence over computers.

> **(FG1) Tammy**: I think there might be a time and a place for the occasional tears…[Helen: mmm] and we were talking about that at work today as well whether that's acceptable behaviour or not [Others: mmm]. I think sometimes it's okay.
> **Amy**: Yeah I guess.. in doing that you're.. communicating about emotion with your client [Tammy: yeah] aren't you.. and kind of saying that's okay.
> **Tammy**: Being human.
> **Amy**: Exactly, being human, saying it's okay to feel this way.
>
> **(I) Tracy**: … I can think of times that *I've* gone to see people [for her own therapy] [Helen: mhmm] and they've been very like "oh ..[Helen: ok, yup] isn't that nice" (quiet voice), and I've just been like nah I don't want, you know this doesn't work for me [Helen: yeah], I need a human no a... you know- [Helen: yeah]. So I think it's probably more an experience from that end rather than anything that I've had [Helen: sure] with clients, just because there hasn't been that many times [Helen: mmm] that I would be like that.
>
> **(I) Helen**: You guys spoke about that also in the focus group that being human, the importance of being human [Pete: yeah]. So how do you think being human relates to emotional expression?
> **Pete:**… mmm…How does being human relate to emotional expression?.. Um that all humans feel stuff [Helen: yeah], you know, we all feel stuff you know to one degree or another, or we might all feel it slightly differently but we all feel stuff [Helen: mhmm] yeah.
>
> **(I) Kate**: It [the professional persona] definitely does need to be dropped at times I think [Helen: mhmm] just to show you are human and then.. because I think you are more likely to open up to someone, this is just my perception maybe [Helen: yeah], that you are more likely to open up to someone [Helen: mmm] who is a bit more grounded and human [Helen: yeah] than that cold professional I think.
>
> **(FG4) Hayley**... But I think they probably see me as like a <u>very fundamentally</u> present human being [Helen: mmm], like they know I'm there and that's me.

While the practice of the psychologist expressing 'genuine' emotions reduces the power imbalance between the psychologist and the client, it also does boundary work, protecting the profession from the threat of being replaced by a manual or the latest therapy software. This genuineness is something delicate that cannot be manualised or programmed. When it is

combined with the psychologist's specialised knowledge then the profession becomes more elite.

So the human is to some degree an equaliser. Both the psychologist and the client can fill the Human subject position, it breaks down hierarchies. Both are reduced to two creatures feeling together (or almost). Does this mean that the psychologist may also be getting mended through the mutual process of being human and feeling together? Perhaps… fleetingly, however, I would say on the whole this is not the case. Caveats spring up at every corner; it is only okay to be the Human "to some degree", and "at times". It can be used sparingly, however, psychologists are being paid to be professionals not humans. Too much humanness would be a major threat to the professional identity. This was illustrated in a discussion about the Dialectical Behavioural Therapy idea of 'radical genuineness' when one of the participants pointed out that this inferred that it was radical to be genuine. To be a 'genuine' Human as a psychologist, is to be radical, to be extreme, to exist near the margins.

Some Context

Again this ADR and the construction of the Human subject position can be located in the history of clinical psychology, as it is clearly related to Humanistic or Client-Centred Therapy with its core features of genuineness, unconditional positive regard and accurate empathy. It is interesting how closely this ADR maps onto the descriptions of how a therapist using a humanistic approach should be; the same tensions are clear, that the psychologist should be genuine with her/his emotions and make real connections with her/his clients, but always within limits. Again it is constructs of risk that hold this ADR in place. It is possible that the constraints put on the Human, in some way relate to the association between client-centred therapy's encounter groups and issues around sexual misconduct. There is a fear that too much humanness would result in emotions 'taking over' and resulting in harm.

While client-centred therapy was 'invented' by a man, it came into being at a time when more women were entering the profession of clinical psychology and the way the client-centred therapist is expected to emote is aligned with the emotions that are constructed as more acceptable for women, such as empathy, tenderness and lack of aggression (Lupton, 1998). As previously suggested, it is possible that the increasing proportion of female

psychologists may have influenced the rejection of the cool, detached, analyst or behaviouralist, creating space for the emoting human.

The tension between the Human and the Container is a central ideological dilemma that ran through all the interviews. This will be discussed further below. Given that every meta-picture contains contradiction, it is important to consider how participants worked to resolve this dilemma. Already I have outlined two such attempts, the repackaging the Scientist as the Container, and making space for the construction of the Human, but in prescribed limits – perhaps so prescribed that it ultimately privileges containment over expression. The next chapter will outline a third ADR which can be seen as a further attempt to resolve this dilemma around whether to express or contain.

Chapter Five – Shape Shifting

This chapter starts with an account of a third affective-discursive repertoire – that the psychologist's emotions should be adapted as required to affect change. I then reflect on how participants understood the various functions of their emotions within the therapeutic relationship. Following this I give further consideration to some of the ideological dilemmas within and between the different ADRs.

Affective-Discursive Repertoire 3: The psychologist's emotions should be adapted as required to affect change – The Multipurpose Tool

This affective-discursive repertoire produces the practice of the psychologist modifying the way she/he uses her/his emotions based on a number of variables. The psychologist is expected to move 'skilfully' through various affective practices; adapting the way she/he practices emotions based on what is 'needed'. This constitutes the practice of consciously using emotions in a purposeful way. Like the previous ADR, this ADR constructs emotions as important and the psychologist's emotional expression as something that can be used to help clients, however, rather than surrendering to an inevitable spilling out of emotion, they 'choose' to emote in a more conscious and tactical way. Whereas the previous two ADRs operate with a standard universal biological view of emotion, this is a social performative account of what emotion is – something malleable, contextual, intelligent, imbued with thought as opposed to distinct from thought. Empathy, in particular, is constructed as a prerequisite, a must have, without which the therapy is futile and therapeutic change is unlikely. Once the empathetic ground work is laid this opens the way to expressing other emotions.

> **(FG1) Fiona**: But again that's that balance of like professionalism [Helen] and and like the risk side versus developing the relationship [Tracy: yeah yeah. Helen: mmm]. It's such a fine line.
>
> **(I) Isabelle**: If it kind of takes away from their experience I guess, if it's kind of like you're.. making it about yourself that would be really um really bad (slight laugh) [Helen: mhmm]. And I guess sometimes recognising that you.. to be able to validate them but not kind of try and minimise what they are going through [Helen: yeah] and kind of like you don't actually know what they have been through [Helen: mmm] if you haven't actually been through it yourself [Helen: yeah] so I guess still portraying that in a way… um and you've still got to give them confidence in your ability as a

> psychologist not just as.. someone that will.. you know tell them that it's okay (slight laugh) or validate their emotions [Helen: mmm]. You still have to balance that out with being able to take control of a situation [Helen: mmm] and still do everything you need to do [Helen: yup], not just, validation is one part of it I guess [Helen: yeah], there's still um and I guess if you know if particularly you are really feeling for someone sometimes they still need to hear some hard things [Helen: yup] and you still need to be quite honest and still.. still go I with what you are wanting to do [Helen: mhmm] not just kind of I feel like if you are too sensitive to them at times it could just, you would just get nowhere either.

The contemporary psychologist is steeped in the layers of successive generations of therapeutic traditions. It is generally no longer acceptable for current psychologists to adopt one style of therapy (and its associated practices) and run with it. All of the participants reported that they used two or more therapeutic modalities. There can be pressure or an expectation (indeed a professional obligation in order to maintain registration as a psychologist) to be 'up with the play', constantly 'upskilling'. The eclectic therapist needs to skilfully move in and out of different subject positions to achieve the ideal balance. As one participant stated "therapy is a sort of balance between the instinctual versus actually thinking things through before you act" (Jemima, FG3). Another participant said "I think you've got to give a bit of yourself without crossing the line" (Pete, I). In its essence this ADR, as the extracts above indicate, is about achieving a balance between emotional expression and emotional restraint, or *walking the line* between the two. This need to balance emotional expression and containment was discussed repeatedly through the focus groups and individual interviews, and endorsed by all participants.

When participants adopted this ADR they were faced with the task of negotiating where the line was and this was not always easy or clear cut. I suggest that this is where the emotional labour really hits home. Somehow finding the balance between the personal versus the professional; trusting your 'gut' or your instinct versus thinking things through; validating the client versus promoting change; connection versus control; sitting 'alongside' the client versus the hierarchical structure of the therapeutic relationship. What is the function of achieving the right emotional equilibrium? What are the material (or embodied) consequences for the psychologist and the client, and for broader social power relations? In this ADR the psychologist is adapting her/his emotions in sophisticated ways so that they become a tool in the therapy.

> **(I) Pete**: … Yeah I mean it's all.. it's always filtered through, the authenticity is always filtered through the what's beneficial for this person [Helen: mmm], you know [Helen: yeah], that that's sort of I think one of the most important things probably is that anything is filtered through the how is this going to be of benefit [Helen: mhmm] to this person. It's not just me meeting my emotionally authentic [Helen: yeah] needs (slight laugh), you know, other than my authentic need to be a professional and help this person [Helen: mmm] then everything is filtered through…

In this ADR the psychologist's emotional expression and genuine feeling needs to be not so much contained but constrained, filtered, let out within limits, kept within the boundaries of professionalism so that 'the line' is not crossed.

The Variables

Given that in this ADR what is valued is adapting emotions as needed, how did the participants formulate effective emotional shifting? What variables are seen as important in 'getting emotion right' and 'walking the line'? I outline below the main variables that were talked about, first covering some more general and formulaic variables (e.g. the setting and age), and then how knowledge of the client is constructed as an important factor in deciding what sort of emotional expression will be the most effective.

> **(I) Kate**:.. I do think that the people who come.. um here [a public community mental health centre] don't really want to as much [Helen: mhmm] and therefore I have to give a little bit more of myself [Helen: mhmm] um than I would at private practice where I don't have to do any of that…

Some participants spoke about how the setting of the therapy influences the affective practices. There was a general consensus that psychologists working in private practice used the practice of containment more. Containment is constructed as both more appropriate and what is expected from clients in this setting. Whereas clients in the public mental health setting were constructed as more reluctant to engage in therapy and therefore the psychologist needs to invest more emotional energy into laying the foundations for the therapeutic relationship. One participant said "you can't always be super professional because they're not ready to come, they don't know what a psychologist is in the first place" (Tracy, p. 5). Only one of the participants actually worked in private practice and she said:

> **(FG1) Kate**: Totally (laughs), cos its easy- well whoever I need to relate to [Helen: mmm], so if I see like a doctor in private practice I will up my game [Helen: yeah]

> and be on no emotion at all (laughs) [Helen: yeah, yeah (laughs)] but if I am in public practice with you know a young Maori girl [Helen: mmm] I am definitely going to.. um show myself a little bit more [Helen: mmm]. So maybe it depends on the client and what type of relationship you are trying to establish with them [Helen: mhmm yeah]. So… yeah so the doctor wants professional but I <u>think</u> a young Maori would prefer [Amy: more informal] [Tammy: mmm] someone less professional. So you might adapt to how you show your emotions based on.. on client.

This extract shows the intersection between the setting and other variables that are constructed as being important factors to consider when deciding how to do emotions as a psychologist. Most participants who worked with children and adolescents spoke about needing to be more open, expressive and 'real'. Again the rationale was that that young people typically did not want to attend therapy and therefore the psychologist needed to use her/his emotions to draw them in.

> **(FG4) Pete**:… Like you need to do a little bit more to have a better relationship so they actually want to come [Helen: mmm] and you can help motivate them to get into it [Helen: yeah] because you're- ...well if they don't have a relationship with you they are just going to be like "oh whatever" [Others: mmm]. Um so I think there is a little bit more of a skew to maybe emotional expression [Helen: mmm] maybe with teenagers.

Another participant said "with kids I find if I am more relaxed and using their language and things they disclose a lot more to me as well than perhaps they would if I was more kind of doctor-like or not really on their level" (Isabelle, I). Emotion is performed here to get the maximum amount of information from the client. This is an example of how within this ADR emotions can be a strategic tool increasing disciplinary power.

Some participants suggested that a psychologist might vary her/his emotional expression based on the client's culture, for example one participant said "like Asian patients expect you to have more of the role of being a little less collaborative and that kind of thing so maybe more culturally it might be different as well and Pacific Islanders and Maori would expect you to be a bit more open so there's that comes into it as well" (Tammy, I). Whereas other participants said that they did not identify any clear need to vary emotional expression based on culture and that there was more variation within cultures than between cultures. All but one participant came from the dominant Pakeha culture, as do I. My findings then apply to professional practice in this cultural context only and further research would be needed to

determine whether they extend to the meaning making of psychologists from other backgrounds as they reflect on their practice.

Some participants spoke about the nature of their emotional expression being different if they were doing family work, for example one participant spoke about the difficulty of trying to respond in an emotionally appropriate way to family members who have different emotional responses to events. Some participants spoke about certain types of psychological therapy being prescriptive regarding how emotion should be used. For example a participant when describing Family Based Therapy for young people with eating disorders stated "it describes your manner that you have to be grave, sincere, a bit like it's got a sheet for feelings. And so there is a prescribed way to be and emotions aren't really appropriate" (Hayley, FG4). Other participants spoke about how Dialectical Behavioural Therapy calls for radical genuineness which was interpreted as being more emotionally 'honest' with clients.

The client's 'boundaries' and level of emotional expression were also constructed as guiding factors when it came to the psychologist deciding what to do with her/his emotions. When discussing the clients' 'boundaries' there was consensus among participants that psychologists should share less of herself/himself (including being less emotionally expressive) if the client has 'loose' boundaries or a lack of boundaries. Clients who were considered to have less boundaries were those who were perceived as wanting to be friends, and this was seen by showing an inappropriate amount of curiosity into the lives and feelings of the psychologist. One participant said "the ones that want to be your friends, I have to be much more boundaried and spend much more time, this is our time and this is how much we do. It's focussed on what's happening with you, your presentation issues" (Frances, FG3). Or as another participant said it can depend on "how ready they are to bond with you, and she was like ready to bond with me before I did anything, yeah whereas others are really more stand offish so you do need to sort of be really open" (Tracy, I). A few participants reported that the purpose of this boundary was so that clients did not get confused about the nature of the relationship and start relying on the psychologist as a friend, one participant said "she needs to find actual friends and she needs her own support" (Jemima, FG3).

Clearly this ADR is essential to the maintenance of the psychologist's professional identity. Indeed emotional restraint (the masking of negative emotions and the controlled display of positive ones) is associated with mainstream constructs of professionalism (Kramer & Hess,

2002). But the role of the psychologist differs from other forms of 'being professional' in the expectation of some emotional expression in order to form a therapeutic relationship. The therapeutic relationship in this ADR is constructed as needing to be close but not too close. If the space between the client and the psychologist is too small there is a danger of roles being confused and the hierarchy being broken down, and if they are too far apart then nothing will be achieved because no emotional investment in change has been made.

Several participants spoke of displaying the opposite level of emotional expression to their clients. Such as becoming more expressive for clients who are restricted in their emotional expression. For example a participant said "I have a lot of these young male clients with these negative symptoms [of psychosis] and yeah I do find myself being more animated and bubbly and trying to get some emotion from them" (Sal, p. 19) and another said "anorexia clients tend to suffer more from emotional overregulation but they are the most overregulated people in the world and if I wasn't reacting emotionally to what they were saying there would be zero feelings in that room" (Hayley, FG4). Then on the other hand if clients were assessed as being too emotional then the psychologist's role is to express less emotions:

> **(I) Sal**:… in other roles I've been in where um you've got your more kind of… dysregulated clients and so on that they're kind of all over the place, they just kind of let it all out [Helen: mmm], that's when you kind of do a little bit more of that containment [Helen: yup] and helping them to process those things.

However, the equation is not always constructed as that simple as seen in the following extract.

> **(FG 3) Frances**: I think if you've got someone who is very emotionally restricted [Helen: mhmm], huge big displays of emotion from me can be quite threatening [Others: mmm]..um and yeah-
> **Helen**: So it's kind of matching [Frances: mmm]
> **Jemima**: Well .. not always matching. I think sometimes .. you know… you want them to show a bit more emotion so sort of taking them a little bit out of their comfort zone [others: mmm].
> **Frances**: But not flooding them.
> **Jemima**: Not flooding them [Sal: yeah], definitely not flooding them, but yeah not exactly matching. And again if someone's too over the top you kind of sometimes want them to rein it in a little bit [Helen: okay] and so if you are both over the top (laughs) sort of explosion…

These extracts give the sense of a dance between the client and the psychologist, flow of movement backwards and forwards, always with the aim of achieving a skilful emotional performance. Negotiating a line of closeness, of intimacy. When the client spills over, the psychologist contains, with the hope of showing the client how to contain themselves. However, if the client is too contained or restricted then the psychologist gently tries to encourage them to express more, shows them how this is done, but with caution so as not to overwhelm the reticent client with an overflow of emotion. As the client steps forwards into the subject position of the leaky bucket the psychologist steps back into the subject position of the container to catch the emotion that has spilled out. As the client steps back into an emotionally restricted subject position the psychologist steps forwards into the human subject position to pull some emotion out of the client. This reflects the Western emphasis on moderation (not going too far).

Part of being a psychologist is knowing the moves, knowing when to step forwards and when to step back with emotional expression. In this dance the psychologist is the leading partner. In addition to the more general variables, participants talked about psychological expertise (technologies) that the psychologist should use to guide their emotional expression. Variables such as age and setting are visible to a 'lay person'. You do not need any professional training to know how old a client is or what the setting is. In this ADR the psychologist needs to use her/his psychological skills to access and identify information about the client and then to use this information about the client to inform their own emotional expression in ways that, with practice, then come intuitively. The psychologist is the knower and the client in the known.

> **(FG2) Helen**: … how you strike the right level of emotional expression for that client at that time?
> (period of silence)
> **Kate**: Maybe it just happens instantly [Helen: yeah?]. I think it might just be a natural response [Helen: mhmm], I wouldn't.. yeah-
> **Amy**: Based on your experience [Kate: yeah] and knowledge of that particular client, how they are with you.

> **(FG3) Helen**: … how else do you know what you can do with one client but not with another?
> **Frances**: Trust your gut (quiet laugh).
> **Jemima**: I think a big part is through the relationship [Helen: mhmm] and I think you can get some information through like the formulation and things like that [Helen:

> mhmm], just knowing their history, their story, the way they .. um … yeah, how they experience things.

This extract suggests that there are two types of 'knowledge' that the psychologist can gain about the client (this reflects the balance that needs to be achieved as part of this ADR), the 'thinking knowledge' that the psychologist gains through facts about the client and their technical knowledge of psychological theories, and the 'feeling knowledge' that the psychologist accesses through their gut feeling or their natural response based on this training. The 'thinking knowledge' justifies the training and legitimises psychology as an elite profession, and the 'feeling knowledge' insures that psychologists cannot be replaced by computers or manuals. This thinking knowledge comes together in the technology of the psychological formulation, whereas the technology of clinical judgement relies on both thinking and feeling knowledge.

> **(FG4) Pete**: I think something I am getting out of talking about all this is just that how different it needs to be for all sorts of different people [Others: mmm] and the given situations and given… again I guess formulation [Helen: yeah. Isabelle: mmm] and yeah what is the formulation.
>
> **(FG2) Amy**: And that [being cold and invalidating] could be particularly damaging if you are working with a client whose early experiences of emotional communication in the parent-child relationship was that you don't show emotions [Helen: mmm] and you don't talk about emotions and emotions are weakness, things like that [Helen: mhmm]. You have to be particularly careful with those clients that you are not repeating.. [Helen: mmm] what they have experienced growing up.

A psychological formulation is "the tool used by clinicians to relate theory to practice…It is the lynchpin that holds theory and practice together…Formulations can best be understood as hypotheses to be tested" (Butler, 1998, p.2). Through the formulation the psychologist brings into being the narrative of the client's disorder or problems. It is a technology of mapping the mind, writing the back-story, and in this context using it to guide the way they emote with the client. Some participants spoke about considering their formulation of the client when deciding whether to express a certain emotion. For example in one focus group there was a discussion about considering a client's fear of abandonment or sensitivity to rejection before expressing an emotion such as frustration. Whereas other participants said that explicitly using the formation to consider how they should express emotions was a good idea, but it was not something they were doing. Using the formulation firmly positions the psychologist as the knower and the client and the one who is known about. Even when the formulation is

constructed as ‘collaborative’, it is still the client’s story that is being revealed while the psychologist’s remains opaque.

The formulation is part of what makes up the construct of ‘clinical judgement’; a catch-all term that encompasses both the idea of ‘objectively’ gathering information about the client and the more ephemeral notion of being a professional who ‘just knows’ what to do, based on instinct of a ‘gut response’. Bell and Mellor (2009) write that clinical judgements “are, by definition, based on subjective or intuitive integrations of often diverse data collected using a range of methods (including interviews, observations, and projective and objective testing techniques) that are frequently intended to tap both conscious and unconscious psychological functioning” (Bell & Mellor, 2009, p. 112) . A few participants spoke about being told in their training programmes not to self-disclose (including disclosing emotions), but that in the reality of their practice they used clinical judgement to assess when self-disclosure is going to be helpful. For example one participant said that since leaving university she was “more confident in my own judgements and knowing that I am making the right decision whether I want to display my emotion or how I am going to deal with a certain emotion than I used to be probably” (Isabelle, I). This is also seen in the extract below.

> **(FG4) Hayley**: I think it’s the same with self-disclosure [Isabelle: mmm].. you know like you are taught that you are not supposed to and that dah, dah, dah but then at the same time if you are using your clinical judgement you will know that there are times and places [Isabelle and Helen: mmm] where a small piece of self-disclosure will be a thousand times.. [Pete: mmm] like beneficial therapeutically [Helen: mhmm] and so it’s kind of up to you to be like you know what, fuck it, [Pete: mmm] I am going to say it [Helen: mmm], I am 99% sure that this is going to go well [Helen: yeah]. And so it’s like that gamble of I know we are trained not to do this [Helen: mmm] stuff, we have been explicitly told [Others: mmm] you shouldn’t talk about things but if you get this feeling that... that is actually what is needed and I guess with emotions I just get that feeling every session so…

Clinical judgement is constructed as something psychologists use when clear rules or guidelines are not apparent. It is a fall-back position that brings into focus the murkiness of human interactions. There was a lot of talk about how clinical judgement can be hard. Some participants spoke about how the more subtle interactions between the client and the psychologist can be the hardest contexts in which to use clinical judgement. Participants spoke about clinical judgement being particularly hard when the psychologist is experiencing

strong emotions in the moment when the notion of emotion as a multi-purpose tool gives way once more to the notion of emotion as a non-cognitive and irrational response.

> **(I) Amy**:...of course you don't know how much of your emotional response is clouding your judgement in that moment [Helen: mmm], so yeah you are obviously far better to (breath in) to take some time to think it through properly [Helen: mhmm] and take it to supervision and then… [Helen: yeah] go from there.
>
> **(FG 1) Fiona**: … I used to get really frustrated I remember like talking [during class at university] about these really easy examples [others: murmur], like don't, like don't go sleeping with your clients, yes that's a no brainer [others: laughter]. I have to write that one down (laughter). But there's some incredibly grey areas [Helen: mmm] within any relationship but within that therapeutic relationship that you will never see coming [Helen: mmm]. That's the worst kind …

Emotions are constructed in opposition to reason; as clouding the psychologist's judgement. The practice here is to pull back and contain when this happens, not to risk being taken over by emotions. Sometimes the line is so blurry the psychologist cannot see where it is and does not know if she/he has crossed it or not, complicating the practice of walking the line between emotional expression and emotional repression.

The Risks

In this ADR the risks are constructed in both directions, both in being too emotionally expressive and too contained. The intelligent choreographing of the dance of emotional expression needs to result in the balance and the grace to move in the right direction at the right time. This makes it either a particularly 'risky' activity, or one where any 'risky' emotional expression/repression can be justified based on the opposing ADR. When clinical judgement is constructed as murky and ill-defined it could either make the practice of negotiating the right sort of emotional expression impossible or limitless in its possibilities. That is of course if all the ways of practising emotion are constructed as equally valid, if the 'risks' are comparable. If some of the ways of emoting are dominant and others marginalised then certain affective practices will be constructed as more 'right' than others.

In this ADR being too far on the emotionally contained side of the line means that foundations of the therapeutic relationships may not be adequately laid, therefore jeopardising all subsequent therapeutic work. As one participant said the psychologist who is

too professional risks "alienating your client and not developing a helpful relationship" (Fiona, FG1). In addition to this the psychologist who does not form a connection through emotional expression, and/or does not acknowledge her/his own emotions is not able to get the same amount of 'knowledge' about the client, with which to work. This is illustrated in the following two extracts.

> **(I) Jemima**: ... I think if they're (psychologists) not.. if they're not picking up on any emotions [Helen: yeah] in the clinic room then they are not connecting [Helen: mhmm] and they're not getting a good- I mean we are working with people [Helen: yeah]. We are not working with diagnoses or.. um problems. We are working with whole people [Helen: mhmm].. um and you have good and bad reactions to people you can have a good and bad reaction to the same person…
>
> **(I) Frances**: ...And a lot of the work comes from.. your gut, it comes from that this is what I have to do right now for this person [Helen: mhmm]. If you don't listen to that you are just going to be a manualised therapist [Helen: mhmm] and that I think has more dangers than benefits [Helen: yup]. You will miss things. You won't hear things [Helen: mm]. You won't see things. And I am not saying at all that I have got this absolutely right [Helen: mmm]. I am still learning but I would be worried.
>
> ……..
> But you would also be blind to [Helen: mmm] when this stuff happens, to when... you are in countertransference. You would be completely blind [Helen: mmm] to it and then acting in that, you would be.. creating what is happening out there within the room and that is really dangerous [Helen: okay]. That is not okay. All sorts of different things can happen… Very rarely but you know sometimes with people who have been abused you can have kind of a sudden sexual feeling towards them and you have to know what that is [Helen: mmm].. Umm or you might have someone who is very passive and you can get quite angry or frustrated with them [Helen: mmm] and you have to know that's what's happening for them out there and empower this and if you are not aware of that you are going to get into a really dangerous [Helen: mmm] place and you know…

If the psychologist does not express emotions in order to connect with the client on an emotional level then she/he will miss out on valuable information that is crucial for the therapy to progress. Whereas on the other hand within this ADR if the psychologist is too emotionally expressive then they risk through countertransference making the therapy about her/his emotional needs instead of the clients'. As one participant said "I think the main thing is just whether it's about you or about the client. If you are expressing emotions with clients who is that about" (Tracy, I). Another participant said "I am pretty sure the person knows they don't have to rescue me" (Pete, I). The 'rescuing' is unidirectional.

> **(I) Tammy**: Yeah. I think also I guess by not letting people into your life so much it means it's still about them [Helen: mhmm] and it doesn't end up just being about you and your experiences [Helen: yeah]because that's not always that helpful [Helen: mhmm].
> **Helen**: So by.. kind of keeping that distance it.. means that it's more focussed on them [Tammy: mmm] and less-. So what's kind of not helpful about kind of talking about your own experiences or your own struggles?
> **Tammy**: You may not always have the same ones [Helen: mhmm] and you might get too … well yeah, you might get too connected to your own examples [Helen: mhmm] and actually they're not quite the same situation [Helen: yeah] and you might be making a lot of assumptions based on that [Helen: true, yeah]. So I guess that's yeah one of the problems with it.

> **(I) Hayley**: … possibly … I guess if they [potential supervisees] are, the number one thing would be if they are reflecting an emotion that is not in the room at all that seems to be coming from elsewhere in their life [Helen: mmm], you know if they were sad during a happy session [Helen: mmm] or you know whatever.. Um if they were tired or stressed or something and that was being transmitted in their therapy [Helen: yeah] and it was completely not at all related to.. actual emotion in the room that would be one of my biggest concerns.

Throughout the interviews there was a discourse about therapy needing to be about the client's needs and not the psychologist's. The client is the one who is there to be fixed, the one with the problem and the psychologist is the one with the solutions. This functions in multiple ways, for sure the client is the one receiving the treatment so the focus should be on them, but it is also important to acknowledge that this imbalance in emotional expression gives the psychologist more power and authority so that they are the agents of social control who gets to say what is 'normal' and what is not.

Subject Position – The Multipurpose Tool

The psychologist is required to manipulate her/his emotions in a sophisticated way so that they become a tool in the therapy. Therefore, I suggest the subject position of the multipurpose tool who is able to finesse the type of emotional expression required for the job at hand. The tool is an exemplar of self-discipline, the psychologist who works on her/his emotions so that they can be used productively. I'm not talking about an agentic individual making the decision to modify her/his emotions, rather I suggest that the conditions of possibility within this professional identity are such that to fit this subject position, the psychologist is compelled to do this work on the self.

> **(FG3) Jemima**: And I guess you are a tool within the therapy setting as well, so you as a person, you as an individual, yeah so use it [laughs].
>
> **(I) Amy**: It might be, and I have certainly done this with, um I mean, um, I have certainly thought about this with other emotions, but with something like anger it could be, like I know that other psychologists as well will actually say to the client look I'm kind of feeling angry right now [Helen: mmm] and you just kind of acknowledge that you're feeling that way and then that can be an opportunity for some open [Helen: mmm]conversation and discussion about why that might be and where has that come [Helen: mmm]. from, just kind of use it as a tool.
>
> **(I) Pete**: …I was thinking about in terms of in the therapeutic relationship where it's almost like we are always trying to, well I find anyway, speaking for myself [Helen: mhmm], we are always trying to transmute.. things, like change or.. if I'm, hopefully I am right but my understanding of the word transmutation or something, I could be wrong, I could be totally off track, (inaudible comment from Helen) anyway my definition of this would be, and there is probably a way better definition [Helen: yeah], ah but we are always trying to.. transmute like any potential emotion into something higher or more positive, that is going to be helpful [Helen: mhmm], ah so it's like well what's my reaction to this and what that person is saying [Helen: mhmm], how can I turn this around.. and make this helpful.

When the psychologist takes on the subject position of the tool, the subject position available to the client is that of something that is broken and in need of fixing. The client is positioned as requiring work to run more smoothly. It is often inferred that the damage is done early in the client's life, through a paucity of warmth, validation, and emotionality in the client's early relationships. Some participants suggested a sort of re-parenting for clients who have not had a 'healthy' model of relationships.

> **(I) Pete**: But I also think.. like… part of therapy if someone hasn't had a good.. no good is the wrong word, but if they haven't had a full experience of what a relation- of a relationship [Helen: mmm], you know a caring kind of relationship [Helen: mmm] where emotion, different emotions are expressed or emotion is expressed or sadness is expressed [Helen: mmm] or that where sadness isn't okay and that kind of stuff [Helen: yup] um then I think.. ah yeah I think especially in longer work with people, my idea anyway, that you know some emotional expression, whether it be a bit of a little frustration or a little bit of sadness or that kind of thing, it is sort of like modelling in a way [Helen: mhmm].
>
> ….
>
> **Pete:** Yeah and have that responded to in a way that.. I don't know, cause I guess I hope as therapists we are representing a.. what a balanced.. person [Helen: mmm], or I don't know, part of it is I think that you are being like a.. well-rounded kind of individual and how a well-rounded individual might.. um respond to things [Helen: mhmm] while also having your professional hat on [Helen: mmm] and being the person who can offer some skills and techniques [Helen: yup] and guidance as well.

The Multipurpose Tool is expected to use their knowledge of the client to guide their affective practices within the therapeutic relationships in order to provide an alternative, 'healthier' model for relating. Through this 're-parenting' the psychologist has to make sure they do a better job than the client's actual parents. The psychologist has to be balanced, well-rounded, genuine and warm. She/he guides and the client follows, learning to self-regulate and control her/his emotions over time. The psychologist changes her/his form over time, adapting her/his affective practices in order to produce the desired change in the client.

Some Context

This ADR reflects the progression from Behaviouralism, and Humanism to Cognitive Behavioural Therapy and then the 'Third Wave' behavioural therapies, which can be seen as attempting to use the 'best of both worlds'; claiming the rigor and objectivity of science, whilst acknowledging the importance of the therapeutic alliance (which is more subjective). This ADR echoes discourses from the CBT literature about the therapeutic alliance (see Chapter Two, pp. 50–51) where change is seen to happen in therapy only when the psychologist is perceived to be empathetic, affirming and collaborative. It differs from the discourses in the client-centred therapy literature which produces the idea that being genuine and empathetic as a fundamental good in and of itself, whereas the CBT literature talks more about how empathy and a strong therapeutic alliance are important for the therapy to be effective (to affect behavioural change). The practice constructed in this ADR of adapting emotional expression and achieving balance of opposing forces (e.g. emotions versus thinking, the professional versus the personal) also reflects the discourses constructed in the 'third wave' behavioural therapies such as Acceptance and Commitment Therapy (ACT) and Dialectical Behavioural Therapy (DBT). This practice of finding a balance also reflects how 'unbalanced' emotions can come to be understood as pathological from the perspective of the third wave behavioural therapies. In the case of ACT psychopathology is said to result from either trying to avoid emotions or becoming completely fused with then, and DBT was developed to treat emotional dysregulation.

I think this ADR can be understood in the wider context of the contemporary postmodern milieu. This moving between different ways of practising emotions and adapting as required to affect change reflects the postmodern idea that there is no single objective reality, truth or knowledge, rather from this perspective there are multiple 'truths' that are always local,

interpretive and relational (Gemignani & Peña, 2007; Gergen, 1999). The postmodern self is decentred and relational, and this contrasts with the modernist, empiricist view of self which is individual, cognitive, internal and knowable (Gergen, 1991; Misra, 1993). Zimmerman (2001) writes "the once-venerated romantic and modern ideals of authentic selfhood are being displaced by the "saturated self"" (Zimmerman, 2000, p. 124) [referring to Gergen's (1993) construct of the saturated self]. Some authors lament the way postmodernism rejects the possibility of a unified self, suggesting that the postmodern self is dizzy and disorientating, ineffectual, splintered and overestimates the differentiation of self (M. B. Smith, 1994; Zimmerman, 2000). Postmodernity provides the conditions of possibility in which this ARD of manipulating and managing emotions can be constructed.

So what of the postmodern emotional chameleon of a psychologist? Given that I am working from a postmodern social constructionist perspective in this research, this ADR aligns to some extent with the theory I have chosen to use. Should this not fill me with a sense of boundless hope and possibility for how I can practise as an intern psychologist? Somehow it doesn't. This valorising of change, adaptation and multiplicity still operates within limits dictated by the social power relations that exist within clinical psychology and beyond. Secondly, as stated above, the pressure to achieve the perfect balance of emotional expression and constraint and 'to walk the line' without wobbling can be constructed as difficult and risky in itself. The work on self that this requires will be discussed further in the next chapter. Thirdly, as discussed in Chapter One, the sort of self which is open, effective and worked over, can be seen as a reproduction of how the middle class self is currently constructed, and the privileging of this sort of self can mis-present highly specific, classed emotional practices as universal (Wetherell, 2012). Finally, it is possible that the practice of the psychologist adapting her/his emotions as required is an example of neoliberal forces co-opting the multiplicity of postmodernity to produce more effective agents of social control. Walkerdine (2003) suggests that it could be argued that "there is a way in which the discourse analytic project emphasising a multiple subject, plays into the neoliberal fantasy that everything has somehow been freed" (Walkerdine, 2003, p. 137). On the other hand it is also possible that the construction of psychologist's emotional flexibility could support clients in recovery and reduce suffering. Either way this movable line which leaves psychologists in a precarious position of constantly renegotiating their affective practices, along with their role in the management of risky individuals (potentially themselves included), means that psychologists

are in the perilous position of constantly renegotiating their affective practices based on calculations of risk.

The Functions of the Psychologist's Emotions

It is interesting to consider how participants spoke about functions of the affective-discursive identity negotiations described. Four key functions of the psychologist's emotional work were discussed in the interviews; building a foundation of personal investment and social connection, motivating the client to work harder on themselves, educating about the correct way of emoting through modelling, and using the psychologist's emotions to assist diagnosis.

Building a connection – the foundations

Participants spoke about the importance of psychologists using emotional expression to connect with the client, which is seen as the 'foundation' of the therapeutic relationship. As discussed in Chapter 2 (p. 49) the quality of the interactions early in therapy is said to predict the outcome of the therapy. Staying too much in the professional persona can be risky, as a participant said there is a risk of "alienating your client and not developing a helpful relationship" (Fiona, FG1).

Empathy is said to build a connection between the psychologist and the client resulting in an emotional and social bond. It is about the client liking the psychologist enough to want to keep coming to sessions and engaging in working on herself/himself as directed. A more docile subject it produced.

Motivation – building on the foundations

Once the psychologist and the client form a social bond, the psychologist starts fulfilling some of the client's needs, for example the need to feel connected or to feel liked. This gives the psychologist leverage to induce change (and possibly vice versa in some cases?). Then from this firm foundation the psychologist is able to express other more 'risky' emotions such as frustration (e.g. when clients do not do their homework) and "shake them up a bit" (Jemima, FG3) so that they will start doing the work on themselves without them leaving therapy.

Modelling – the emotional apprenticeship

Another aspect of forming the emotional connection and social bond is that it lays the ground for the process of modelling to be constructed. The practice of modelling how emotions should be expressed and managed was constructed in all the interviews.

> **(FG1) Fiona**: … I think you're modelling like good communication [Helen: mhmm] about your emotions, you're teach- you know yeah I think just modelling, being able to talk about that is really good.
>
> **(FG2) Amy**: And I guess in doing that you are also modelling a healthy way of.. expressing frustration to the client [Tammy: yeah] aren't you.
> **Kate**: True, that you are allowed to feel that way [Amy: yes]. It's just how you.. [Amy: express it] communicate it to the other person.

Modelling being able to talk about emotions, even 'negative ones', is understood as needing to be based on the firm and established foundations of a therapeutic relationship. The psychologist needs to have enough relational credit in the bank in order to do some more of the hard emotional work such as talking about 'therapeutic disruptions'. As one participant put it talking about these can be a way of "modelling how to do repair work, how to talk about it, how to mend, yeah" (Tracy, p. 23). Modelling is about displaying the "appropriate emotions" (Isabelle, p. 15) (in contrast to the client's inappropriate emotions) and "modelling your limits, your boundaries, what you can tolerate from them" (Frances, p. 25). A participant said modelling is "not just coming back and on the attack or- using it- or then- and I think it's [not] like in a blaming way, it's modelling that sort of responsive when you did this I noticed that I felt like this" (Pete, I). Modelling will only work if the client looks up to the psychologist, sees them as someone to aspire to. It is reminiscent to Western discourses around parenting and forming a 'secure attachment'; the parent who has the 'healthy' relationship with her/his children, who shows them how to behave – sets a good example, who is warm but promotes her/his children's individuality. The parent is expected to give unconditional love and to not get her/his emotional needs met by the child. The parent-child dynamic also carries with it obvious hierarchy and power dynamics.

The construction of modelling is a clear example of how psychologists are both disciplinary agents and subject to their own self-discipline. The psychologist embodies what it is to

manage emotions 'well'. This is an example of how disciplinary power goes beyond what is purely discursive and acts on bodies.

Diagnostic criteria – the warning siren

Some participants spoke about the importance of listening to their own emotions to assist with assessment and diagnosis, for example one participant said "processing my emotions about a client is really, really helpful in diagnosis and like formulation. What our emotions say about someone I think is great. We have to listen to that. It's really, really important" (Fiona, I).

> **(FG2) Kate**: Yeah of course. They are the ones… yeah like I'm thinking… cos and they also lie- there's a lot of lying [Amy: yeah, deceitful kind of thing] [Tammy and Helen: mmm], deceitful kind of thing, so that's what would elicit annoyance from me [Helen: annoyance, yeah]. Yeah… um.. but I always say, you know when you can feel something's not right, there's some personality stuff underneath (laughs) [Helen: yeah]. So you gotta- you rely on those emotions [Helen: mmm] to kind of assess, you know, make the right assessment [Amy and Tammy: mmm] [Helen: that's interesting]. You kind of use your emotions. Yeah if you are feeling frustrated or angry it must mean something.
> **Amy**: Mmm, yeah a colleague of mine was telling me that the other day [Helen: yeah], like when she gets emails or texts from clients if it kind of makes her go "grrr" (quiet laughter) and get really frustrated it's because they have borderline personalities (laughter from all).
> **Kate**: Or narcissist. A bit of antisocial [Helen: yeah], it does, it's not just a pure depression [Helen: mmm] or pure anxiety [Amy: no, no]. I guess that's the transference countertransference [Helen: mmm] type of stuff going on there.

The psychologist's emotions are constructed as a diagnostic tool, or a warning siren for certain 'disorders' and if the psychologist is not in touch with her/his emotions then they run the risk of missing out on this valuable information about the client. This links to the psychodynamic constructs of transference and countertransference, where the psychologist's emotions are considered an important part of the therapy in that they give the psychologist information about the client which may not otherwise be apparent. A participant spoke about this when she said "like I don't want to put up barriers around that transference because I think that transference is really helpful and important information, especially when people are unable to verbally talk about stuff" (Jemima, I). So for the psychologist, emotions become one of the technologies used to calibrate and classify.

Ideological Dilemmas

The analysis thus far has presented some ideological dilemmas in the way the psychologists' emotional expression is constructed, which I will elaborate on here. I am interested in the function of these dilemmas, what work is done to try to resolve them, and what ultimately is privileged.

Ideological Dilemma 1 – Psychologists should feel all emotions but are not allowed to acknowledge certain emotions, even in supervision.

Psychologists are constructed as experiencing the whole raft of human emotions on the one hand, and on the other hand certain 'taboo' emotions are constructed and then immediately negated. In the analysis participants spoke about the psychologist needing to be aware of and connected to their emotions in order to both connect to the clients and gain information about them. However, certain emotions were understood as needing to be disconnected from rather than connected to.

> **(FG1) Fiona**: I actually think it's hilarious because everyone talks about, like in the training, that and they try and act and say I feel so sad for your client, the amount of frustration actually I think is a big one.
> **Helen**: So frustration is way bigger than sadness?
> **Tracy**: Yeah.
> **Fiona**: It's way more frequent.

While there is a pervasive discourse about psychologists experiencing all emotions and especially frustration, this runs alongside another discourse about anger not only being unacceptable to express, but it also being unacceptable to experience anger towards a client. There is an oscillation back and forth between these two competing discourses. There was one participant who was quite candid about feeling angry with clients, and who suggested that the denial of experiencing anger towards a client is modelled by staff in the training programmes. However, as discussed in the introduction, in the other three focus group discussions, feeling anger towards a client is constructed and then immediately contested. The participants were not phobic of anger per se, many of them talked about feeling angry at other people in the work context, such as the client's family, colleagues and professionals from other organisations, and some spoke about how anger is not a 'bad' emotion in itself and how they encourage some clients to 'get in touch' with their anger and express it. At

times it is also said to be acceptable to feel angry along with the client, or about things that have happened to the client. The taboo exists around feeling angry *at* the client.

As discussed in Chapter 4 sexual attraction towards clients is also constructed as unspeakable. The psychologist's anger and sexual attraction can exist only in the realm of the hypothetical. Participants distanced themselves from having experienced these themselves and said that if they hypothetically ever did it would not be something they would be able to talk about with their supervisors. This is related to the dilemma identified in the Chapter 2 (p. 55) with the construction of psychologists' emotions (other than empathy and warmth) as distracting and something that should be dealt with, repressed and minimised, so as not to have a detrimental impact on client outcome. Which comes up against the construction of psychologists' emotions as ever-present and something that needs to be understood and utilised in order for effective therapy to occur. Psychologists are being asked to both deny certain emotions and to understand and learn from emotions. An attempt to resolve this dilemma was talking about the taboo emotions as hypothetical. That a psychologist could potentially feel them, but the psychologist speaking has not.

If we look at the psychologist – supervisor relationship as parallel to the client – psychologist relationship, what would be the potential 'costs' of denying and repressing certain emotions within this way of understanding emotion? The task of therapy (and supervision) is constructed as helping clients (and supervisees) to recognise and acknowledge their emotions, in order to be better able to tolerate, regulate and manage them. From this perspective if psychologists refuse to acknowledge certain emotions because they are not part of their professional identity, then they would presumably be ill-equipped to tolerate, regulate and manage them.

Ideological Dilemma 2 – The tension between emotional expression and containment.

Related to this is the central ideological dilemma running through this research, the tension around whether to be authentic and emotionally expressive or professional and emotionally restrained. We can see that clinical psychology is drawing on two competing modes of truth production; scientific knowledge and 'instinctual' knowledge. This dilemma is evident in the way that the subject positions of the Container and the Human embody contradictory sets of affective practices and construct the associated 'risks' in diametrically opposite ways. From

the perspective of the Container, expressing emotion, such as being tearful, is constructed as harmful to the client, whereas from the perspective of the Human, not expressing 'real' emotion, is constructed as harmful for the client. This reflects the dilemma identified in the Chapter 2 (p. 55) about whether psychologists should be 'truly genuine' and 'authentic' with their emotional expression regardless of what that emotion is, or whether 'genuine' emotional expression needs to be limited just to the expression of 'genuine empathy'. Boundary work happens on both fronts, as the profession of clinical psychology needs both the 'professional' containment to maintain its standing as a science, and the 'personal' emotional expression in order to not be replaced by computers or manuals. This boundary work becomes an imperative when the profession is seen as under threat from other professions. Both containment and expression are also needed in order for psychology to be a more effective disciplinary power, backed by the authority ascribed to science and arising from forming a social bond with the client (via emotional connection) to become an effective agent of behavioural change. Some ways of attempting to resolve this core dilemma are outlined at the end of Chapter 4. I would suggest that containment is often privileged over expression. To start with containment was spoken about more frequently by participants. When emotional expression was constructed as important this was often qualified with a limit or boundary, the expression itself needed to be somewhat contained. The inverse of this happened less so – containment was not always hedged with the need to also express.

As discussed in Chapter 4 this tension is evident in the guiding principle of clinical psychology; the scientist practitioner model which was originally conceptualised as the "union between the art of clinical intuition and logical empiricism of science" (Phares, 1998, p. 54). Science claims to be rational and objective and unswayed by subjective constructs such as emotions, values and politics. As Ussher (1992) points out there is a "seemingly inherent contradiction of a caring profession adhering to rigorous rational objectivity" (Ussher, 1992, p. 45). In the early years of clinical psychology (in Britain and North America) the emphasis on the clinical psychologist as a scientific researcher did important boundary work in differentiating it from other professions. Over the years there has been less emphasis on the science and research side of the ledger, yet for the majority of clinical psychologists the scientist practitioner model has a strong hold in defining their professional identity and it still is the basis of clinical psychology training programmes (Cheshire & Pilgrim, 2004; Weisz, Ng, & Bearman, 2014). This may be what is used to justify the greater pay and hence status of clinical psychology compared to other allied health professionals

(hence the reluctance to shed this identity, even if it does not align with the reality of the clinical work). There has been some critique of the scientist practitioner model as the core orthodoxy of clinical psychology, from alternative therapeutic models and methodologies. These divisions in clinical psychology reflect deeper unresolved tensions in the academy between objectivism and subjectivism in the discipline of psychology (Cheshire & Pilgrim, 2004).

This ideological dilemma is related to the gendered emotional constructions. 'Professional' emotional displays in general have been associated with constructions of masculinity and emotional restraint and this has been a way of keeping women in their 'place' at home. Women have long since left the home and entered the workplace (albeit for less pay), but professional emotional displays still entail the masking of strong emotions (both positive and negative) (Kramer & Hess, 2002).

This dilemma of how to balance the emotional containment and the emotional expression brings focus to the plight of the 'professional woman'. Female psychologists are expected to be not just a professional, but a high status, post-graduate educated, scientifically informed professional *and* they are expected to draw on all their 'femininity' by being nurturing, empathetic, self-sacrificing (so that they never become the sort of 'bad' woman who gets angry or has a sex drive). They are expected to be 'like men' in some ways without the same freedom to do things like 'playing hardball' or 'speaking your mind', because this does not fit with mainstream constructions of femininity. It is possible that psychologists' acceptance of the pseudo mothering role which is caring yet contained is maintaining gendered emotional identities by re-enacting and re-feeling the emotions that are 'acceptable' for women.

Ideological Dilemma 3 – Compulsory emotions that are not felt.

Another ideological dilemma is around the construction of empathy. Empathy is constructed in participants' discourse like other emotions as biological and innate, however, it is also presented as compulsory. It is seen as a fundamental part of any therapeutic relationship. So the dilemma lies in how an emotion which is supposed to be genuine and spontaneous might also be manufactured as required.

A few participants denied ever struggling to feel empathy for a client, whereas others described struggling to feel empathy for a variety of reasons, such as when clients are entitled and narcissistic, when clients have a diagnosis of Borderline Personality Disorder and are manipulative, and when clients do not do what has been recommended in order to get better. The next chapter of the analysis considers how participants constructed way of working on their emotions in order to feel the correct and required empathy as an attempt to resolve this dilemma. Again, I am not suggesting that there is some 'real' biological emotion that needs to be worked on, rather that there is a clash between the psychologist's histories of emotional practices when interacting with people perceived as entitled, manipulative or non-compliant and the practice of unconditional empathy and positive regard expected of the psychologist.

Ideological Dilemma 4 – Being close but not too close. The precariousness of walking the line.

The 'catch all' ADR about the psychologist adapting her/his emotions as required is an attempt to resolve the dilemma around whether to express or contain emotions. However, as discussed earlier, it also creates another dilemma or tension in walking the tightrope of being close to clients but not too close. There is some contestation about the virtues of having a deep connection with clients, which can start to feel like a long-term relationship. While it is constructed as necessary in order to do that work of modelling the correct emotions, tensions are constructed as arising when this long-term, pseudo-familial relationship means that the client starts to see the psychologist 'warts and all', and this reduces the psychologist's power and ability to control the therapy and make the 'hard calls'.

> **(FG1) Tracy**: I can't think of ones that I've kind of emotionally gone over the line but I've definitely got some where it's just, I've worked with them for such a long time they've seen me in these different environments [Helen: mmm], they've seen me when I've been in silly moods and I've acknowledge that [Helen: mmm mmm] and when they've been in silly moods and you know and and it's not always- and I think in some, you can lose your credibility [Fiona and Helen: mmm] a little bit so then when it comes to .. making recommendations or having to be real hard [Helen: mmm] about actually really need to do this [Helen: yup] or .. yeah when you've got to do other things that are difficult [Helen: mmm] in the relationship, it can be harder to do that if you've lost some credibility because they know you way too much as a person [Helen: mmm] and they know way too much about what you care about, yeah I think that can be a challenge [Helen: sure Fiona: yeah].

This reminds me of discourses about the transition from parenting a child who looks up to and idealises her/his parent to parenting an adolescent who starts to see her/his parents as fallible and question their authority. The preferred subject position for psychologists is the parent of the child, where the power hierarchy is both established and accepted. Where the psychologist is 'looked up to' and can model good emotional management. Things get "cloudy" when this structure breaks down and authority is questioned.

These ideological dilemmas represent back and forth dialogues about the nature of the psychologist's affective practices, where contradictory constructs are both taken-for-granted or understood as 'common sense'. This movement back and forth between contradictory positions happens within the context of work environments where managing risk is paramount and attempts to resolve these dilemmas reflect this. It is possible that in this time when the institution of clinical psychology is seen as under threat from other professions and from accusations of being ineffectual, there are particular efforts made to obscure or deny the dilemmas inherent in psychologists' emotional practices.

Successive Layering

The three affective-discursive repertoires outlined – the psychologist's emotions should be contained and not expressed, the psychologist's emotions should be natural and not faked or controlled, and the psychologist's emotions should be adapted as required to affect change – and the associated subject positions suggest that there are different ways of doing emotion as a psychologist. The analysis also considered how these ways of practising emotions could be associated with various different types of psychological therapy. The different theoretical orientations in psychology are socially and historically located, in that they are to some degree a product of the broader social conditions that were/are at play. What psychologists are expected to do with their emotions in the therapeutic relationship is not fixed, scientifically proven, or objectively correct, but a reflection of the wider social and political context at the time when different psychological theories were developed.

The data suggests that the successive generations of therapy and their associated affective practices are layered within the contemporary psychologist rather than replaced. That is, it is more than just current trends for eclectic practice that results in the multiplicity of possible affective practices, the remnants of past practices stay within the bounds of current

possibilities. This can be seen in the construction of the Human subject position in the second ADR, so closely aligned with client-centred therapy, yet none of the participants reported using client-centred therapy. It is likely that this layering (rather than replacement) takes place because the of the psy-complex; the successive generations of psychological therapy spread out into the public psyche and feedback into the conditions of possibility for what the psychologist can be.

We can see that the psychologist's ADRs are historically and socially located and some are more privileged than others. While there is movement between the various ways of making sense and guiding practice, each still contains its own set of feeling rules and associated risks. The analysis shows us that there is a variety in what the psychologist can express, and that it depends to some extent on what subject position they are in. However, this should not be equated with a notion that psychologists can express any emotions, that the multiplicity of professional subject positions makes the possibilities for emoting limitless. It is important to remember that what holds the ADR's in place are constructs about the risks. Deciding how to emote involves a weighing up of risks. When answering the question who gets to feel what, the psychologist seems to get to feel whatever the least risky emotion is. The talk about the risk of expressing emotions was more prevalent than the talk about the risk of containing. Some emotions such as anger at the client or sexual attraction were too risky even to talk about when psychology operates in the 'shadow of the law'.

Chapter Six – The Work on Self

Chapters 4 and 5 produced an account of three different affective-discursive repertoires and associated subject positions. While there was tension between and within these accounts and a degree of haziness as to exactly when to do what, on the whole these represent the current range of formal discourses about what psychologists 'should' be doing with their emotions. The contemporary psychologist 'should' be able to fill the position of the multipurpose tool, for example, moving skilfully in and out of various affective practices as required to produce the desired effect in clients. Running alongside these accounts, were also some more informal narratives of the emotional life of the psychologist stressing aspects other than the professionally sanctioned. This chapter turns now to look at participants' accounts of the 'underside' of their working lives, their accounts of when professional emotions go awry, creating a tension in their self-concept as a contained professional, their experiences of unwanted and non-professional emotions, their stories of how work seeps into their personal lives, and episodes of off-loading about clients to colleagues. I look too at their descriptions of how they manage these emotion troubles. I consider why these troubles might be particularly disturbing for a psychologist's self-concept, and the challenges of conducting professional work in contexts where any 'time-off' from a managed persona tends to become problematic.

In effect, I focus more now on what Gilbert and Mulkay (1984) described as 'contingent' rather than formal accounting. In their analysis of scientists' discourse, Gilbert and Mulkay (1984) argued that scientists' talk about their working lives characteristically weaves together the formal and informal. Formal accounts stress the importance, for instance, of replication, the role of evidence, systematic procedures applied impersonally, and the priority given to truth and objectivity above all else. While the informal accounts paint a more contingent picture stressing luck, serendipity, derring-do, biased dogmatism, laboratory politics, competitive duels to be first, and so on. For clinical psychologists troubled talk around wayward emotion has some of the same features as scientists' contingent discourse and there is the same kind of weaving backwards and forwards between informal accounts of the contingencies of working lives and retreat back to formal remedies and prescriptions for how to deal with these contingencies. The difference though, as I shall try to demonstrate, is that for the clinical psychologist the contingent is rarely light-hearted or celebratory, and reaches particularly deeply into the construction of personhood.

One of the difficulties of discourse analysis is that our attempts to critically interrogate the resources available to participants can be read as attacks on their authority and integrity. This may be especially so when the focus is on participants' more informal accounts and talk of troubles. I want to re-emphasise, then, that what follows is in no sense a critique of my participants who do their best to manage the contradictory resources and demands of their profession. My interest is in the overall pattern, in professional privileging and marginalising, and the interaction with the broader webs of social power relations in which these positions and repertoires are embedded. The intention it to create space for more awareness of and critical reflection on how emotions are used in this profession.

Confessions, Intrusions and Trouble

> **(FG3) Helen**:…I was just thinking about like what emotions psychologists commonly experience when they are in the therapeutic relationship. So I've heard anxiety, I've heard shock, I've heard.. what else have.. sadness, [Jemima: frustration] frustration (laughter from participants) [Sal: yup that's a big one sometimes] Just frustration or anger?
> **Jemima**: Oh yeah some anger. Not as much.. for me, me it's more the frustration, occasionally hopelessness.
> **Sal**: Yup hopelessness.
> **Frances**: I think as well there's that kind of oh my God am I even helping them. Like I know that's hopelessness, but that kind of sense of.. just that banging your head against a wall [Helen: mmm] and is anything I'm doing… working [Helen: yeah].
> **Jemima**: And then related to that sometimes I just feel useless (laughter from all).
> **Frances**: Yeah useless.
> **Jemima**: It's like "well I suck" (laughs).
> **Frances**: That's when I go off and get good supervision and lots of reassurance (laughter), all of that. That comes in waves I find.
>
> **(FG4) Pete**: I think that is part of being professional [Others: mmm], and to be honest there's certainly days where I am really tired, I've got a bad headache, I don't want to be down in [location of clinic] [Helen: mhmm] (inaudible) [Haley: that's every damn day] (laughter) you know and um I don't want to be down there, I want to be at <u>home</u> [Helen: mmm] like and I've got four clients to see back to back, yeah I mean that's kind of.. when it's like.. it's time to put on my professional hat now [Isabelle: yup. Helen and Hayley: mmm] and ask the questions and be empathetic and <u>feel</u> it and so know... so am..[Isabelle: mmm] so I think there is times when.. ah I don't want to do it all [Others: mmm] but but you have to pull it off [Helen: yeah]. And I think, and I think it still works (laughs) [Isabelle: yeah yeah]. They still feel that, I think.. I think feel listened to.

While participants were able to form detailed descriptions of what the affective dance they 'should' be practising within the therapeutic relationship, there was concurrent talk about this

not always being easy. Running alongside the formal discourse about the complex emotional manoeuvres involved in being a psychologist, there was the informal contingent discourse where participants spoke about feeling useless, hopeless, anxious, frustrated and bored, among other things. Participants also spoke about some emotions being particularly hard to contain, for example a participant spoke about "frustration that kind of leaks out" (Sal, FG3). Some participants spoke about having to resist the urge to say what they were thinking to clients, for example telling the client that they are being a "shit", or saying things like "buck yourself up" (Pete, I) or "look you just have to get on with things" (Frances, I). It seems that this contingent, informal space is not all that comfortable, participants only entered it briefly then typically retreated to the formal. As illustrated in the two extracts above, participants 'confessed' to having these 'unprofessional' feelings, but hedged them with the professional or formal discourse; putting on the "professional hat" and performing empathy, or sorting it out in supervision.

These contingent 'unprofessional' feelings are constructed as bubbling under the surface, unable to be released at work, as they would pose a threat to the professional identity. As part of this sort of construction of emotion, participants spoke about these feelings bubbling up into other parts of their lives, emotions following them home from work, interrupting their sleep, and impacting on their personal relationships. They also spoke of the possibility of work with clients bringing old hurts to the surface, for example one participant said "you take on the clients' emotions and feel everything that they feel, and so that can trigger a lot of stuff" (Amy, I).

> **(FG3) Frances**: During the internship it was like everybody came home with me [Helen: mmm] and it was so exhausting and it was so hard to get them out of my head and stop. I had this feeling of really being really, really responsible for them [Helen: yeah] and it was really hard to shake that.
>
> **(FG2) Kate**: During my first year I <u>particularly</u> remember on a Friday night just feeling like I was carrying.. [Amy: oh yeah, yeah] carrying lots [Others: mmm]. And it took me <u>ages</u> to wind down and I remember just being irritable all the time [Helen: mmm] and yeah- so that has definitely gone. I think the last maybe, three years actually, I think it was a good year of that [Other: mmm] and then I realised I am not even thinking about my clients on the weekend or after work anymore [Helen: mmm]. I had <u>somehow</u> managed to, to cut it off [Amy: mmm]. So I think you kind of learn on the job (laughs) [Amy: you learn with experience] unfortunately. Is that the same as you?
> **Amy**: Yeah similar to Kate I remember on- for some reason on Fridays, it was Saturdays [Kate: yeah] [Helen: mmm], just being really tearful [Helen: mmm] on

> Saturdays and not really understanding why [Helen: mmm] and then finally kind of working out that.. yeah maybe everything during the week was taking its toll [Kate: yeah] more than I really realised [Helen: mm mmm]. And it's not too relaxed at the weekend it kind of comes.

Participants spoke about these emotions impacting them outside of work hours in a number of ways; feeling stressed, being emotional (irritable and sad), ruminating about clients, having difficulty sleeping, poor concentration, low energy, changes in appetite, and feeling wound up and on edge. One participant said "if I've had a big day, I get home I can hardly even talk I'm just so exhausted" (Tammy, I). They constructed experiencing their emotions from work at home as unwanted intrusions. Often this intrusion took the form of involuntarily thinking about clients or feeling emotionally impacted by clients outside of work time.

> **(FG3) Jemima**: It's changed. I think that there are always those clients or those people that are hard to … um.. leave at work for different reasons [Sal: yeah] or ones that you know you deal with it, that's fine and then .. you know just randomly in your life, it might be a few months later that you haven't seen that person for ages [Helen: mmm], they will just.. just pop up… um… yeah
> **Sal:** I had in my previous role I was working quite intensely with a young woman ..and.. for about ten months [Helen: mhmm] and I would sometimes have dreams [Helen: mmm] about her [Helen: yeah]. And I remember the first time it was like yeah, I don't know if it was shocking, but it was kind of like the ultimate intrusion I guess (laughter from all).
> **Jemima**: It's like an invasion of privacy eh, you're like get out.
> **Frances**: It's my time.
> **Sal:** Yeah, so I think it does, even though you might process it and deal with it and not be kind of at home going oh you know, it still is with you in some way [Helen: yeah].

> **(FG1) Tracy**: …I can keep real calm when I'm with her.. [Helen: mmm] mostly calm in terms of the demeanour [Helen: mm] but I try to tell myself that I'm like fine with it later in the day (slight laugh) but I'll find that I'm more easily set off [Helen: mmm] into other emotions later in the day or more angry at other things [Fiona: yeah] or just more likely to get quite upset [Helen: yeah, yeah] at night with somebody asking me how my day was [Helen: mmm] and I'll.. you know.. (slight laugh) be a bit upset about it.

These unwanted emotions are constructed as troublesome, invasive, sticky and sometimes as lying dormant threatening to erupt at odd times. Because embodying the correct affective practices is constructed as such a fundamental part of being a good psychologist, participants spoke about how their emotional capacity became mobilised for work, leaving less emotional capacity for personal relationships. Most participants spoke about how becoming a psychologist impacted on their personal relationships. For example a participant said

"friendships took a beating during my training because it was so gnarly and so time consuming" (Pete, I). Some participants spoke about not being able to be as emotionally available for people in their personal lives. Examples of this included not doing as much voluntary work, not being as empathetic to friends and family, and needing to make social engagements at a time when they felt like they had sufficient emotional capacity. Some participants spoke of sometimes having to 'fake emotions' with people in their personal lives, for example one participant spoke about "trying to summon enthusiasm for trivial life difficulties when actually you've just heard about someone go through a world of shit and you're just like I don't care" (Hayley, FG4). In the extract below a participant speaks about how the invasion of emotions from work into her home life damaged a personal relationship.

> **(FG2) Kate**: … And I was thinking because I ended a, a really long term relationship a year into my first um job [Helen: mmm] and when I went to see an EAP [Employee Assistance Programme] lady about it she actually said to me "did you realise how much the impact of you being at your first year of job had on you?". And I had never thought about the fact that maybe I was just so down about my job [Helen: mmm] that I was taking it home and it was ruining my relationship [Helen: mmm] [Amy: yeah]. So it can actually have a big impact on.. you know the rest of your life [Amy: mmm] if you are not properly prepared for it...

A key thread in this contingent discourse was talk about the impact the work with clients had on psychologists' personal lives. This reproduces the construction of a divide between the public and the private. The notion that the social world is divided into contrasting and incompatible separate spheres (e.g. public/private, communal/individual, rational/sentimental, domestic/work for pay) has been prevalent since the 19th century (Gal, 2002). With this division, comes narratives about the "dangers of mutual contamination by public and private spheres" (Gal, 2002, p.78). While there has been much feminist critique which challenges the separation and incompatibility of the private and the public and shown that most social practices are not limited to one or the other, the separation of the public and private is still ubiquitous in our everyday lives and underpins much of our social reasoning (Gal, 2002). We can see here that participants are drawing on the taken-for-granted notion in our capitalist society that the public professional life should be separated from the private personal life, and that it is pathological to not be able to make this separation. Infiltration or seepage was constructed as something that participants needed to work on and, as illustrated in the extracts above, there was talk about this sort of work on self getting easier over time, the skin gets thicker, allowing less emotion to get in at work or leak out at home.

What resources do psychologists have for talking about and understanding intrusive unwanted emotions emerging in the private sphere? Especially when they are constructed as becoming unmanageable? What does it mean when it all gets too much and the emotions are spilling out all over the place? The discourse of stress (leading to burnout) is one of the resources available. The literature about burnout constructs it as a reaction to on-going work stressors and emotional demands, which involves emotional exhaustion, depersonalisation, and a lack of a sense of personal accomplishment (Rupert & Kent, 2007). In the extract below participants construct needing to 'perform' the professional emotions as a sign of burnout. Sal had previously described her first job after graduating as 'soul destroying', and while she spoke about an unsupportive work environment, she ultimately framed her experience in the individuated construct of 'burnout'.

> **(FG3) Helen**: …. I'm wondering if that kind of feeling perform- of having to perform the required emotion is something you can relate to at any point in your career or-?
> **Frances**: When I know I need a break [Helen: mmm]. If that starts to happen I know I need some time off and I probably need to go off and be alone [Helen: mhmm] for a little while... To me that's an early warning sign of burnout [Sal and Jemima: mmm] [Helen: yeah] is that kind of feeling time [Helen: yup] pressured and performing [Sal: yup, yup].
> **Jemima**: I think for me.. what I am sort of thinking about is going back to that sense that sometimes you do get bored or tired in a session (laughter) and performing [Helen: yeah] being interested [Frances: (laughs) true] [Sal: yeah there is that]. Um but I can't think of, to date, I am there is and there will be times in the future when I.. feel a bigger need to perform the empathy in things [Helen: mm] that you were saying. I would agree with you saying that- to me that would be quite a big warning [Helen: mmm] that things aren't okay with me. Um.. yeah to date I've been okay [Helen: yeah] but still very early in my career (laughs) so it's not-
> **Sal**: That happened.. at the- towards the end of my first role out.. [Helen: mhmm] of uni which I did actually resign from because I was feeling close to burnout [Others: mmm], which was in the first year of leaving which was very exciting (sarcastic). And I, I think I had a lot of high risk.. [Helen: mmm] suicidal.. adolescent clients and my team was really unsupportive around that [Helen: mm]. It was terrible [Others: mmm] actually and I was in such an extreme state of anxiety, just like all the time [Others: mmm], that I did feel like I had to.. [Helen: mmm] kind of perform I guess with some of the emotions [Helen: yeah], especially you were sitting there in the session going oh my gosh are you, are you safe, do we have a good plan in place [Others: mmm], am I doing the right thing. I think that is the fear around.. the risk and safety is...
> **Helen**: So you are feeling this kind of intense anxiety [Sal: mmm] and you are trying to present as.. as what?
> **Sal**: Kind of just calm.
> **Frances**: Empathic, interested.
> **Sal**: In control as well (laughter)

> **Frances**: It all goes out the window when you are in that anxiety burnout fog [Sal: yeah] [Helen: mmm], yeah I've been there as well [Sal: yup, yup], yeah you are acting.
> **Sal**: Yeah, just holding it together.

When psychologists talk about having to perform the required emotions, this is constructed as a sign that something is wrong. External pressures are discussed but 'burnout' is ultimately located within the individual. Participants' constructions of professional emotions are related to the way they construct their sense of self and sets up an unliveable contradiction. On the one hand participants reproduce the view that the personal should be separated from the professional, and yet also they are expected to 'actually feel' the required emotions (as performing them is constructed as a sign of pathology). While at times work conditions are acknowledged, the construction of burn out is essentially diagnosed as a problem of self. When the problem is located within the individual it follows that the solution must also be enacted on or practised by the individual. It becomes the individual's personal responsibility to do the work required to ameliorate burn out, rather than the responsibility of the institution to change working conditions.

Hochschild (1979) suggested that feeling rules are more salient for those middle class professionals who are less likely to perceive the social circumstances governing their 'deep acting', and more likely to experience the emotional labour as part of the self. She suggests that those in working class jobs are said to be able to detach from the feeling rules, and experience the emotional labour as part of their job. For psychologists the requirement to be genuine, means that they need to work on themselves so that they 'genuinely' feel the required emotions. The emotional labour does not consist in displaying the correct emotion in exchange for remuneration, it involves embodying the required emotions and integrating them in to construction of who one is as a person. It is possible that the 'depth' of the emotional work required is even greater than that of other 'middle class' professions, as genuine empathy is constructed as so integral to the success of the therapy.

The next section outlines the professionally sanctioned practices of emotional coping and management which are part of the formal discourse. First, however, I want to note a practice of coping with these unwanted and intrusive thoughts and feelings, which makes up part of the more informal contingent domain; the practice of talking things through with colleagues. At times this sort of informal interaction between colleagues was constructed as like a

supervision relationship (calling it "on the spot supervision") providing objectivity, containing emotion and being the "devil's advocate".

> **(FG3) Jemima**: … the team itself is getting itself together really well and I think that that's been invaluable [Helen: mmm] [Frances: yeah] in lots of different ways, being able to express the emotions that are sort of contained a little bit, also when there is all that anxiety being able to go even in the session saying okay I just need to go and consult with someone [Others: yeah, mmm] and there is always someone there that can talk it through. [Helen: that's really big] [Frances: that's huge] I think that has been hugely helpful.

At other times the practice of talking to colleagues was constructed as something more informal than supervision, more like a friendship than a 'professional relationship'.

> **(FG1) Fiona**: … we're a very tight team [Helen: yeah] and I think that's really, really important [Helen: yeah, Tracy: mmm], that's been the biggest thing, so like I'll go up and have a massive cry [Helen: mmm] whether it's about personal stuff or about client stuff and it will probably be half and half [Helen: yeah] or have a massive bitch.

These informal discussions with colleagues involve being able to feel sad about a client, feel anxious about competency, or feel angry towards a client and say things such as, "I am just feeling pissed off about something" (Frances, FG1) and trusting that her/his colleagues will validate her/his feelings without judging. Feeling "safe" enough to say things such as "fuck that was such a hard session" (Pete, FG4) or "I fucking hate this kid" (Fiona, I). This sort of practice is constructed as liberating and existing outside the bounds of the official guidelines. Participants said that it can be a relief to find out that other psychologists also feel these 'unprofessional' feelings, for example a participants said "Oh yeah and realising other people say it as well, it's like I'm not the only one, but I am not like some cold hearted bitch but actually this is hard work" (Fiona, FG1). The relationship between colleagues is constructed as offering a special sort of support because colleagues really understand the emotional labour in a way that family and friends outside of the work environment cannot. Participants also spoke about how this collegial support can be missing when there is too much time pressure and everyone in the service is under too much stress to be able to support each other.

This informal talk about off-loading to colleagues contrasts with the formal rehearsing of what they should be doing according to various institutions of authority (the universities, the New Zealand Board of Psychologists) discussed below. Informal offloading sits within a

contingent discourse and it is marginalised within formal accounts of psychologists' emotions. Almost all participants stressed the importance of having colleagues they felt able to be 'real' with and express their emotions to, however, this is not included in Core Competences for psychologists in New Zealand, and in most services there is no time set aside for this informal offloading, in the way there is for supervision. Colleague to colleague support would flatten the power dynamic compared to the supervisor relationship. Perhaps if it was more actively encouraged it would broaden the ways psychologists make sense of their emotions.

Reflection, Distance and Self-discipline

Given that it is problematic to simply perform and not feel the required emotion, and offloading to colleagues exists at the margins of practice, how else do psychologists do the required 'deep' emotional work on themselves? The activities spoken about most frequently by all participants can be grouped under the umbrella construct of reflective practice. In addition participants spoke about skills for self-management during therapy and self-care outside of work time. Each of these sets of practices have their own ideal positions, knowledges and forms of failure. These are part of the formal discourse about how to do the affective identity negotiations required as a clinical psychologist. How to patch up the cracks to prevent any unintended emotional leaks. This formal repertoire also largely reflects the sort of work psychologists do with clients, it is like an inverse rehearsing of the core practices of therapy, starting with gaining introspective awareness through confessing to a more powerful other, followed by the much heralded, although perhaps ultimately elusive use of 'skills'. It is important to remember that in the process of being interviewed participants were engaging in identity work, they were largely rehearsing what one should do in order to construct oneself as a professional in the profession.

Reflective Practice

Reflective practice is one of the core competencies for psychologists working in New Zealand.

> "[Reflective practice] covers the steps involved in the attainment and integration of information regarding one's practice. It includes critical and constructive self-

> reflection and seeking external review of one's practice (including supervision). Reflective practice and professional development in psychology is viewed as a continuous process of accurate self-assessment, understanding the skills necessary to be a psychologist and undertaking activities for professional development. This is often done in consultation with a supervisor" (New Zealand Psychological Board, 2011).

Participants' discussion of reflective practice rehearsed this formal account; they spoke about the psychologist taking the time to identify her/his own emotional responses when working with clients and constructing an understanding of where these have come from. This process of 'discovery' and increased self-knowledge is constructed as making it easier for the psychologist to then manage their unwanted emotions, and elicit the required ones. This parallels the sort of work clients themselves might do during psychological therapy. I would argue from my standpoint, in both cases the emotions are being at least partially constituted through these practices (therapy and supervision) rather than being discovered through them.

The first step was constructed by the participants as becoming aware, as one participant said "you're sort of trying to make very quick decisions as to where those emotions are coming from" (Fiona, FG1). This implies an understanding of emotions as something bubbling underneath the surface, often operating on an unconscious level, and needing special attention in order to be brought into the realm of conscious awareness. Emotional awareness is constructed as vital to the practice of deciding what to do with the emotions. If the psychologist constructs their emotion as a 'normal' reaction to the client then they are able to displace the cause of the emotion onto the client (the client makes everyone feel like that) rather than being a reflection on the psychologist's competency.

> **(I) Tammy**: Yeah.. yeah cos I guess.. because it allows me to separate it a bit more, oh yeah that's just part of them it's.. [Helen: mhmm] it's not that I'm responding.. [Helen: mhmm] really badly because I'm a terrible person [Helen: okay] and I don't like them [Helen: yeah], it's just oh that's how they are and so.. [Helen: mhmm] I have to get past it.

This understanding (that the client elicits this emotion in a lot of people) is constructed as giving the psychologist some emotional distance. By 'rationally' identifying some external cause for her/his emotion it has less on impact on how the psychologist perceives herself/himself. She/he is able to construct herself/himself as still essentially companionate and empathetic in the face of less warm emotions. If on the other hand the psychologist

constructs the emotions as being something that comes from her/his own 'issues' then this necessitates some more active work on self in order to not let their personal issues affect the therapy.

> **(I) Amy**: I think self-reflection, working out why.. [Helen: mhmm] that client has triggered such a response [Helen: yeah] because it might be something to do with.. the psychologist's own personal history [Helen: mhmm] that is being triggered and obviously if that is the case then it's going to be something that keeps coming up as an issue that's- [Helen: yeah] and it's important to work through why that is happening [Helen: mhmm] and find some way of managing it. …

Some participants spoke about how this awareness in itself can help with the process of boxing off unruly, undesirable emotions. For example a participant said that having an awareness of where in her personal life her feelings towards a client were coming from put some distance between the her emotional response and her beliefs, saying "it kind of just gives you the space to chuck it out or side it versus just believing it and up in it" (Hayley, I). There is repeated talk about a separation of self from emotions; getting space, putting it to the side.

The psychodynamic constructs of transference and countertransference were used by some of the participants to describe this process of deciphering where their emotions came from and whether it was their 'stuff' (subjective countertransference) or the client's 'stuff' (objective countertransference), for example a participant said "in terms of countertransference that you are acting from potentially your own issues as well and just doing more damage than good" (Jemima, I). Another said;

> **(FG1) Fiona**: … I think it does largely come back to like that objective or subjective counter transference and if it's subjective then … [Helen: yeah] it's probably not that likely to be helpful for them [Helen: mhmm], well it's not (laughs) [Tracy: yeah (laughs)]. And if it's more objective and you think it's you know going to be helpful at that time to talk about it then .. it might be I think that emotion .., yeah I guess your emotions are there for a reason, they're telling us something [Helen: yeah] that's usually quite helpful in the room...

The constructs of subjective and objective countertransference limit the options for attributing the cause of emotions to either being inside the client or inside the psychologist, eclipsing discourse about the impact of wider social structures on emotions. Participants often constructed subjective countertransference and objective countertransference as definable and

distinct when discussing them in the abstract – again this is rehearsing the formal professional discourse. However, when asked how easy it was to differentiate them in practice, the construction often changed to these phenomena being hard to pull apart and elusive. It was also suggested that countertransference reactions can go undetected by psychologists, for example a participant said "and at the point you think you don't have any subjective countertransference, check again because that's the time you'll get tripped" (Fiona, I).

There was a lot of talk about gaining emotional awareness and insight through talking about emotions with someone. Some participants spoke about the possibility of a psychologist engaging in their own psychological therapy or counselling to 'work through' these issues, and three participants spoke about their own experiences of having done this. Other participants also spoke about having supportive people in their personal lives (in particular intimate partners), who could 'put up with' their emotions, help them identify when they were stressed and encourage them set limits.

All participants constructed supervision as the 'right' place to talk about emotions that arise in the therapeutic relationships. Supervision was constructed as a pseudo therapy relationship that mirrors that of the psychologist and the client. The supervisor is constructed as being able to help the psychologist name her/his emotions, understand them and figure out where they are coming from. Again I suggest that rather than their emotions and their aetiology being revealed through supervision, that their emotions are constituted through the practice of therapy and supervision.

> **(I) Fiona**: ... So I've quite often gone into supervision sessions where like I am just so confused and I and he said this and I don't really know what this is and dah, dah, dah, [Helen: mhmm] and then if you get a good supervisor they will "say um you sound really frustrated and like angry like when you are talking about this client, like what is going on emotionally for you", [Helen: mmm] and that's really helpful [Helen: mmm] because if you sit there and you are like confused and they help to nut out just like the presenting problems [Helen: yeah] and ignoring your sort of emotional [Helen: mmm] reactions then that's probably less helpful, I think [Helen: yeah]. You can get to the bottom of it, if you have someone who can reflect on your emotions that's quite often much more helpful.

In this context the supervisor is assigned more reason and the psychologist receiving supervision more emotion. The supervisor is in the position of power and is therefore constructed as being able to give an objective opinion on the origins of the psychologist's

emotions, for example one participant said "I guess that's why supervision is so important so you can have an objective viewpoint and someone to reflect stuff back to" (Amy, p. 12). Some participants suggested that if psychologists do not take this time to reflect, their emotions can get muddled and displaced, for example the emotional strain from the previous client can be transferred on the next client.

> **(I) Sal**: Umm.. I think just talking to people about it is really helpful. I think using supervision [Helen: mhmm]. I know that at times when maybe you've gone like weeks and weeks between supervision sessions for whatever reason [Helen: yeah], like I've noticed say last year when I had that [Helen: mmm] I- that's when it starts leaking through more in your life [Helen: yeah], your day to day, like I mean your out of work life, that's when you start getting more of the emotional leaks I guess [Helen: yeah] because you haven't had that chance to kind of discharge or kind of offload…

Here the supervisor is in the position of the Container as she/he is constructed as holding the psychologist's emotion and patching up any emotional leaks. A good supervisor is described by one participant as "someone that can see your gaps, someone that knows where your blind spots are." (Hayley, FG4). Participants spoke about needing to feel that their emotions are validated in supervision and the supervisor needing to strike the right balance between processing emotion and practical advice. Again, like the psychologist, the supervisor needs to be the Container. Not the cold invalidating scientist, or the messy leaky bucket.

Self-Management at Work

In addition to reflecting on one's practice, the professional discourse also suggests a set of practices to be used within the therapeutic relationship. One such strategy is to try to ignore one's own emotions by shifting the focus onto the client's emotions. In this strategy the psychologist is constructed as putting aside or "parking" their own emotional needs and as one participant said "focussing on the client and what it is that they are wanting really" (Sal, p. 5). Formulations were constructed as being helpful in inducing empathy, compassion and understanding in psychologists, when these emotions were not coming 'naturally'. There was talk about this being particularly useful when the psychologist is looking for a way to subdue her/his anger or frustration. As one participant suggested it is "shifting the blame" (Sal, p. 24) both away from the client and away from her view of herself as a "bad therapist".

> **(I) Frances**: Oh yeah (sigh) (both laugh). Very, very entitled clients, narcissistic clients I.. really, really struggle with [Helen: mmm]. I have to work and I have to keep reminding myself of that kind of inner.. hidden wound, low self-esteem, early trauma, early neglect or early, early bad stuff happening [Helen: mm] that has meant that this is how they cope and it is and… they I find really hard. Really, really hard work.

Other participants said that using a formulation to guide their emotional practice was a good idea, but not something they consciously do. Participants spoke about modifying their emotions by using various psychology skills on themselves. Again this reflects the two pronged approach of most contemporary psychological therapies, both gaining an understanding of why they feel certain emotions and then learning skills to manage these emotions. Some participants spoke about using skills from the third-wave behavioural therapies such as acceptance, or the DBT skill of 'pushing away'.

> **(I) Kate**: ... So I do actually use the skills that are taught [Helen: mhmm] just to try them out [Helen: yeah], and that whole acceptance you know idea is awesome [Helen: yeah]. So if someone at work is really awful to me or whatever or doesn't have-, it's just about acceptance and that kind of thing [Helen: mmm]. So we do use the skills.

The skills of self-talk and mindfulness came up repeatedly, reflecting core components of the second and third wave behavioural therapies respectively. Several participants said that they needed to be mindful of their emotions when working with clients. The self-talk included telling themselves how to behave to display the 'correct' emotion, for example a participant said; "Like okay Jemima, deep breaths, keep looking relaxed, it's okay" (Jemima, I) and another recalled telling herself "I am frozen back in my chair, I need to move forward, I need to more forward because I am acting in a way that maybe isn't appropriate for them" (Frances, I). It can also be monitoring self-talk, constantly questioning and evaluating her/his practice, for example a participant recalled thinking "why am I asking this, or this is an important question, is this question important now, what is this emotion going to do?" (Pete, I). Or it can be talk that is meant to reduce their anxiety about not knowing what to do, for example a participant recalled thinking "Let's just see where this is going. Let's just get some details first" (Jemima, I).

Participants also spoke about managing their emotions by limiting clinical work. One participant had taken on a part time position that did not involve clinical work, to balance her other clinical position, another spoke about using annual leave throughout the year to have time off clinical work. Participants spoke about managing caseloads (or trying to) by; not

taking on too many clients, taking regular breaks, and managing when they saw clients (e.g. for example not booking clients on Friday afternoons, and not seeing 'difficult' clients back to back), and balancing therapy work with assessment work (because assessment is an "emotional break" compared to therapy). There was an acknowledgement that taking on too much clinical work can impact the psychologist's ability to do the required emotional work. However, participants said that it was not always easy within the context of certain workplaces, for example one participant said "I guess it's also the culture of the workplace as well, like I don't really feel like within my workplace self-care is really encouraged" (Amy, FG2). It was suggested that it was especially hard to keep to boundaries around caseloads and not doing too much over time when everyone in the workplace feels overworked, for example a participant said "it's not easy because everyone, if lots of people are feeling stressed and everyone is under pressure it's not easy to keep your boundaries" (Pete, I).

Self-Care Outside of Work

> **(I) Amy**: … and of course I exercise and eat well [Helen: mhmm] and all those basic kind of things [Helen: yeah] because I just know that I am so much more emotionally vulnerable [Helen: mhmm] if I am not taking care of myself. And even things like sleeping well and that kind of stuff [Helen: mhmm]. All the basic things that.. you know you inherently know but certainly weren't encouraged [Helen: mhmm] or emphasised in the training.

The construct of 'self-care' came up at different points in the focus groups and again in the individual interviews when I asked participant's how they managed the emotional labour of the job. The talk about self-care generally referred to things that psychologists do to work on themselves outside of the work environment to be better able to do the affective-discursive identity negotiations at work. There was an overall acceptance that the work to embody the professional self extended beyond the parameters of the working day, and became work on the self as a whole.

The most talked about self-care practice, practised by all but one of the participants was exercise. Other self-care practices that came up with more than one participant were socialising, eating healthily, getting enough sleep, meditating, and having 'alone time'. Some participants said that there was explicit teaching around self-care in their training programmes, while others said that there was none. I asked some participants whether they

would feel the need to take part in these self-care practices if they were not psychologists and generally they said probably not to the same extent.

Participants also spoke about setting boundaries between their work and home lives and the practical steps that can be taken to do this, such as dressing up to fit the professional role, and getting out of that professional role at the end of the day, for example getting changed out of work clothes, leaving her/his diary at work, and not checking work emails at home. There is a tension between the desire to compartmentalise the professional self and the personal self on the one hand, and on the other hand the discussion about how this can be hard, and how the work as a psychologist starts to change the person 'as a whole'. The use of on-going, self-care practices outside the confines of work hours calls into question the separation of the professional and the personal, or at least constructs it as a one-way street; this work goes on in their personal lives to make them better professionals (aka 'better people'), but the seepage of emotions formed at work back to home is prohibited.

Learning About Distances

Psychological therapy is one place where patterns of affective practices are established. Certain affective ruts are formed relationally between the psychologist and the client and the inverse relationship of the psychologist and the supervisor. Certain types of affective practice are talked about and privileged over others. For example again and again we see strong emotions are equated with incompetence. In the formal discourse the psychologists' strong emotions need to be suppressed or stored up until she/he is in the 'right' sort of relational setting (therapy or supervision). Alternatively strong emotions can be managed with practices such as breathing deeply and talking to oneself in order to achieve a degree of emotional detachment. However, there was also a counternarrative – the construction of the informal or contingent discourse where participants constructed emotions from work invading their personal lives, and spoke about the importance of being able to "bitch" to colleagues and how it was comforting (although sometimes surprising) when colleagues also expressed negative emotions towards clients. There is a tension running between with two, with the formal discourse being constructed as more legitimate and the informal discourse being more of a guilty pleasure.

Where do psychologists learn about the formal and contingent ways to manage emotions? I asked participants about their experience of learning about how to emote professionally within the clinical psychology training programmes. While participants' reports of how much their emotions were discussed within the training varied, there was a general consensus that the emotional work involved in being a psychologist could (and should) have been discussed more candidly.

> **(I) Amy**: Well for starters I guess just acknowledging.. how difficult the work is [Helen: mhmm] in terms of its drain on your energy [Helen: yeah] and emotional resources [Helen: yeah] and for the lecturers facilitators to listen and be open to students' experiences while they are on placements [Helen: mhmm, yeah] and.. not judging students for having particular experiences because that is something that I felt [Helen: mmm] did happen [Helen: okay], is that if you.. talked about.. feeling particular ways while you were on placement that was kind of seen as you weren't coping.
> **Helen**: Mmm and then what would be the repercussions of that?
> **Amy**: Um.. well.. not positive. Um ultimately you are kind of asked about whether you should continue or whether you are struggling [Helen: mmm]... Like it really was seen as.. something that wasn't ... it was a sign that you weren't going to be a good psychologist basically if you were having emotions about being on placement and having clients for the first time.
> **Helen**: Mmm and what sort of emotions are you thinking of?
> **Amy**: Oh anything really but just like I was referring to before, mainly the- how much.. it drains your emotional resources.
> **Helen**: (overlap) Draining, overwhelming, stressed [Amy: yup], anxious.
> **Amy**: Yup and how you take on the client's emotions [Helen: mmm] and feel everything that they feel, and so that can trigger a lot of stuff [Helen: mmm] in the psychologist and … I didn't really feel like we were allowed to express that safely [Helen: mmm] with those that were teaching us [Helen: mmm]. So that is a massive thing I think, is just <u>open</u> communication [Helen: yeah], asking us how we're doing and not judging us for our responses [Helen: yeah] and for it not to affect our um our grades [Helen: mmm] or our… the perception of how well we were coping.

Participants who said that their emotions were discussed in the training programmes, said that the range of emotions discussed was limited, excluding more taboo emotions such as anger or disgust. On the whole is seems that the contingent discourse is excluded from training programmes and that the unruly and intrusive emotions come as a surprise. While the formal discourse (with its focus on reflection, self-management and self-care) is privileged in the training, the contingent repertoire in marginalised. Participants spoke about not having been prepared in the training programmes for the emotional toll of the work for them personally and on their relationships. They also spoke about feeling unprepared for the extent of emotion and trauma experienced by clients. Most participants spoke having learnt more about how to

do emotions as a psychologist during internships, than through the training programmes and there was talk that the emotional work was something that could only be learnt through experience. Either way there is a taken-for-granted assumption that the emotional toll is a result of a lack of knowledge, skills and/or experience. The onus is on the individual psychologist to work on themselves in order to remedy these intrusive and troubling emotions. Alternative assumptions are not considered, for example it was not suggested that the emotional toll could be a result of being part of an uncertain profession that may or may not be fulfilling a social role, or that the emotional toll comes from working with clients within wider systems that maintain inequality, limiting what can be achieved in psychological therapy. Given that the problem is located within the individual psychologist, it follows that the 'solutions' for managing these troubling emotions are also located there.

While the contingent discourse is employed it seems that it struggles to find a firm place to stand. The organisation of who one should be as a psychologist is around two ideals – a public work-facing self that is calm, in control, measured and appropriate, and a private ideal self that is balanced, leaves the emotion at work, takes care of self, relaxes and 'has a life'. So there is nowhere to 'put' the emotions described in the contingent discourse because they are constructed as inappropriate everywhere except as a sign that one has not yet 'learnt how to be'. It becomes a confession and a sign of trouble. The contingent discourse poses a particular kind of identity threat for psychologists. Given that the profession is now so enmeshed with the concept of risk management, I would suggest that the threat of being too emotional (of emotions being invasive or over-whelming) gets its teeth from the idea that this might mean the psychologist is not able to manage the risk posed by the clients' risky emotions. Risk management is constructed as objective, so that is positioned in opposition to subjective emotions. Perhaps the force which compels psychologists to do this work on self is the threat of being accused of not managing the risk objectively, of letting emotions 'get in the way'. The risk culture is so pervasive it can be hard to even imagine a form of psychological practice where this is not at the forefront.

Given that it is so marginalised, what could the function of the contingent discourse be? In the case of their research with scientists Gilbert and Mulkay (1984) suggest that both the formal and contingent repertoires work together in various ways to sustain modern science. In addition to the formal empiricist repertoire science needs the contingent repertoire to account for variability, acknowledge human error, and to discredit others' research. They provide

examples of scientists employing the formal repertoire to validate their own research by speaking about it as an unproblematic and unmediated representation of the natural world, and discrediting others' research by characterising their error in contingent terms (Gilbert & Mulkay, 1984). It is possible that the contingent repertoire serves a similar function in this analysis, creating space for variability, humanness and 'being real' with colleagues, and – while participants generally did not use it to discredit others – it was used as a point of comparison to show how far they had come on their own journey of restructuring the self.

The Restructured Self

While still drawn on, the convention of separating the public from the personal is less available to psychologists because, it creates a tension with the emphasis on forming *genuine* emotional connections with clients. Therefore when there are unwanted emotions invading the therapeutic relationship and the psychologist's wider life, manufacturing professional emotions is not sufficient. Psychologists are constructed as needing to engage in the practices outlined above, so that their 'true' self is transformed. While this is a continual project of self-improvement (illustrated in the extract below), participants spoke about this transformation largely taking place in the early stages of their career.

> **(I) Kate**: It can be a drain I think [Helen: yeah, mmm]. The over- the analysing things all the time [Helen: mmm] and always wanting self-improvement and stuff [Helen: yeah]. Sometimes I'd.. it would be nice to not have any of that knowledge and see what life would be like [Helen: yeah]. I would never know would I? (laughs)

Participants spoke about doing this 'work on themselves' through their own therapy, supervision or just through experience. A few participants constructed this work as resulting in them being able to connect more emotionally with clients and people in their personal lives, and being better able to manage their own emotions. For example one participants said going to her own therapy had "been really helpful in terms of my understanding of emotion and learning to kind of tolerate when I do feel something" (Frances, I). Other participants spoke about how hearing a lot of difficult things in their work as psychologists had had the effect of desensitising them to things that they would have previously been emotionally impacted by, such as in the extract below.

> **(I) Sal**: ... but I think you change as a person. I just think it's inevitable [Helen: mmm]. And um.. yeah I think, I know I changed as a person during my internship [Helen: yeah]. You know and I think that I am not as sensitive to things as I used to be [Helen: mmm] and um I think that just kind of continues as you work. I mean I don't think- I think you do get desensitised a little bit [Helen: yeah], not to the point where you become kind of numb [Helen: mmm] and are like a robot, but you are not as- like things that I hear now that when I started out [Helen: mmm] doing my first placement five years ago [Helen: yeah] would have been like oh you know [Helen: yeah], oh that would have been just absolutely devastating to hear [Helen: mmm]. Now I am like okay yeah that's sad but you know.. [Helen: yeah] I can kind of manage.
> ….
> I think it's definitely changed me outside of work as well [Helen: mhmm]. Umm.. I think it's been a good and a bad thing. Like I.. I had this thing with my mum and my sister where they were both really upset by something and I wasn't upset by it [Helen: mmm]
> …..
> I was like wow it felt weird [Helen: mmm], like oh maybe I should feel upset by this and why don't I feel upset by this and that kind of worry…

This sounds like becoming 'hardened off' to emotions in their personal lives due to the emotional storms they weather at work. While participants constructed this as reducing the emotional toll, I wonder what else might be lost through this process of hardening off? While most of the participants said that they welcomed the changes they noticed in themselves since becoming a psychologist certain tensions were also evident. Some participants spoke about a tension between people in their personal lives expecting them to fulfil the role of the psychologist – the designated listener and advice giver, someone to go to when you are having a hard time – but wanting to resist taking on this 'professional' role outside of work for a variety of reasons. They spoke about having done enough of that sort of emotional labour at work and finding it hard to be empathetic about trivial issues. Whereas as other participants spoke about no longer being able to define where the professional identity ended and the personal one started.

> **(FG4) Hayley**: Yeah its always been your role [Pete: yeah yeah], it's like am I psychologising you [Pete: yeah] or am I just being my genuine [Isabelle: yeah yeah yeah] kind empathetic self and so I think it's okay because my genuine kind empathetic self is slowly dying (laughter from all), so I can tell when I am being a psychologist.

This statement from Hayley encapsulates so neatly many of the dilemmas here. Firstly "its always been your role", talks to the idea that psychologists are drawn to the profession because there is something innately empathetic and caring about them, they have always been

the person their friends and family go to. So there is this sense of self and identity which reproduces the construct of the 'true self' with genuine emotions. Then this produced again in the next part of the sentence "am I psychologising you or am I just being my genuine kind empathetic self". This extract also reproduces the idea that the psychologist self is different to the true self. This is a dilemma – I want to be 'me' but I have been doing so much of this other 'psychologist me', that I do not know who the 'real me' is anymore. In the next part, "I think it's okay because my genuine kind empathetic self is slowly dying", the true self is constructed as dying. The psychologist self is like some sort of empathy parasite who has sucked the life out of the true self. The last part of the sentence "so I can tell when I am being a psychologist" implies that the only sort of empathy she can do anymore is this manufactured psychologist empathy. The construction of self and emotion in this account is consistent with the construction of emotion that has been present in much of the analysis, with the manipulated emotional expression being layered on top of the true authentic emotional experience. I think this construction of emotion is limiting and particularly dilemmatic. I suggest that a relational, affective practices theory of emotion could be used as a rhetorical tool to help psychologists reconceptualise what they do with their emotions. This will be explored further in Chapter 7.

For psychologists their emotional labour is more of a personal project. The exchange of certain emotions for remuneration is hidden within their subjectivity. Part of being a member of this relatively high status profession is embodying this perfect, worked over, emotionally limber, post-modern self. The pressure for the psychologist to be emotionally 'sorted' may be heightened in this time when the profession is seen to be under threat. But what could the costs be? When does this become troubling? Like the client, the psychologist is required to partake in self-surveillance and subject herself/himself to the surveillance of others, in order to gain knowledge about her/his emotions and how to manage them. Therefore both the psychologist's and the client's bodies and 'minds' become the target of interventions, from others and from themselves. In order to engage in the affective-discursive identity negotiations described Chapters 4 and 5 the psychologist needs to be committed to this work on self. This reflects what Skeggs (2004) called the middle class commitment to self-improvement which will be explored further in the discussion chapter that follows.

I'm not arguing that aiming to be emotionally sorted is necessarily a bad thing or that I am immune to the pressure to be emotionally well-tuned (I go to my own therapy for this

reason). However, I think that it is troubling in a number of ways. This pressure to embody 'healthy emotions' does not seem to be being discussed in training programmes and possibly is not being discussed anywhere. The closest thing I can think of from my training is talk about the 'imposter syndrome', where someone who is successful feels like her/his achievements are due to luck rather than ability and that they are incapable and unqualified to do the work (Laursen, 2008). The usual solution suggested for the imposter syndrome is "don't worry lots of people feel it". But everybody is feeling it in isolation. It is a guilty secret that many psychologists early in their careers (and possibly at other times in their careers), feel like frauds helping others manage their emotions when their own emotions can feel unruly. This expectation that psychologists will be the poster people for healthy emotions can make it professionally 'risky' to discuss times when they do not feel like they are living up the ideal (e.g. the contingent discourse is confessed). Then the options psychologists have for understanding these emotions are reduced to the constructs such as stress, and the options for managing strong emotions are limited to the work on the individual self. What options were not discussed/suggested? For example, there was no talk about things such as union membership, collective action to improve working conditions, or advocacy for social change.

Chapter Seven – Discussion

This research has produced a complex account of psychologists' emotions; it has become clear that practising psychologists draw on different affective discursive repertoires at different times, based on various assessments and evaluations made about the client, the context, and professional expectations. I suggested that the different affective-discursive repertoires used by participants, at least in part, reflect the successive layerings of psychological theories and interventions over time, which in turn reflect wider socio-political trends – disrupting the notion of a single, objectively correct way of emoting as a psychologist. I have considered what the function of the affective practices described might be, both at the level of the participants' formulations, and considering the wider social functions. I have also produced an account of the participants' talk about when professional feelings go awry, the impact of this on psychologists' construction of self, and strategies used to resolve this threat to the professional identity.

In this final chapter I will expand on my reflections about how the affective practices described feed back into the circulation of power. I then reflect on the way I have chosen to theorise emotions; what can be inferred about the way participants understood emotions; and consider what might be gained if psychologists adopted an affective practices understanding of emotions. This is followed by some final reflections on possible further implications of this research.

The Psychologist's Emotions and Power Relations

The affective-discursive repertoires of psychologists, as described by the participants in this research, are fundamental to the way power is disseminated in psychological therapy. The psychologist's emotions are constructed as vital to get buy in from the client and the nature of the emotional display adapted to maximise the level of investment from the client (bolstering the psychologist's power and control), while at the same time maintaining enough professional distance. At times the client is expected to emote in the opposite way to the psychologist, 'opening up' rather than containing, and at other times the client is supposed to learn from the psychologists' affective practices in order to be able to replicate the 'correct' way of emoting. One could argue that when psychologists model the correct way of emoting, their emotions become embodied representations of moral judgements. Rather than liberating

the individual as it claims to do the psychologist's disciplinary knowledge (in the Foucaultian sense) creates a form of restricted experience (Cheshire & Pilgrim, 2004). The psychologists' emotional self-discipline is fundamental to being effective disciplinary agents.

The psychologist's patterns of emoting are held in place by constructs of risk. Expressing too much of the 'wrong' emotions is said to potentially increase the level of risk as it can damage the client and the therapeutic relationship. Whereas not expressing enough of the 'right' emotions is said to also damage the therapeutic relationship and result in the psychologist not getting enough information to be able to adequately survey, evaluate and manage the client's risk. It is constructions of risky emotions – both the client's and the psychologist's – that keeps the ADR's in motion, because nobody wants to 'drop the ball' when it comes to risk management.

From a neoliberalist perspective the purpose of life and society is constant economic growth, based on the ability of each person to get ahead and 'succeed' (to produce and consume more). Various authors have written about how the psy disciplines (including psychology) produce technologies which play a crucial part in the construction of the autonomous, self-determined subject on which the neoliberal project relies (McAvoy, 2015, Rose 1985, 1996). These modern 'technologies of the self' lock social problems inside the individual (Cheshire & Pilgrim, 2004). Psychological therapy both relies on and is pivotal in this construction of the self. McAvoy (2015) writes that "the psy disciplines provide the means for both expert and self to act on the self by taking up circulating psy discourses and affective practices" (McAvoy, 2015, pp. 25-26). The ADRs constructed by the participants in this research produce and reproduce this autonomous self, who is able to choose, and is responsible for that choice. Psychologists are held "psychologically and morally accountable for the control of the body and therein control of the self" (McAvoy, 2015, p. 26). They are involved in the circulation of this sort of self who can choose how to emote, and for teaching clients how to hone this capacity – to work oneself in order to meet the needs of the labour market, rather than consider alternatives, such as collective action against the casualisation of the workforce.

Neoliberalism remains the dominant political and social ideology in contemporary society with increasing globalisation altering its form and modes of control. Walkerdine (2003) suggests that globalisation has resulted in a shift away from traditional affiliations based on class and gender, and towards a new expectation that we are all able to choose from an

infinite selection of possible identities. The nature of work has also changed and in the new labour market everything is in flux. This demands the construction of not only of an autonomous self, but one that that is flexible and able to adapt to constant changes in work, income and lifestyle (based on the demands of the market), and a self who has the ability to cope with constant insecurity (Walkerdine, 2003, p. 137). The subject position of the Multipurpose Tool reproduces this sort of commodification of self. The self as a commodity that is "no longer simple labour power but a 'shape-shifting portfolio person'" (Walkerdine, 2003 p. 135). As discussed in Chapter 5, postmodernism, partly at least, has provided the conditions of possibility for the construction of this sort of transforming subject, which sustains the neoliberal ideology in this globalised era. Could it be that part of the contemporary psychologist's role is evangelising this worked-over, post-modern self? A tutelage in how to make the self a more desirable commodity in the free market?

It also needs to be considered whether this post-modern self is as ubiquitous as those in academia may think it to be? Post-modernity largely refers to the experience of the Euro-American elite (M. B. Smith, 1994). Perhaps psychologists through their academic training (and likely middle class social backgrounds) are socialised in an emotional habitus where emoting in this adaptable way is part of their emotional milieu. As discussed in Chapter 1, Skeggs (2004) suggests that the 'late modern self' which is open, reflexive and 'worked over', is actually just the middle class self and the re-construction of this self is rewriting the working class as deficient. This working over, understanding, regulating, and modifying of emotions could be equated with a middle class type of emotional capital. Fundamental to the various ADRs produced by participants (although less so in ADR Two) is the assumption that the work on self is an individual choice. This relies on a construction of choice and an agentic psychologist with the ability to choose how they are going to emote. Skeggs (2004) suggests that access to choice is a resource which is not distributed evenly, and that choosing is a particularly middle class way of operating in the world which relies on access to recourses and a sense of entitlement over others. Skeggs (2004) cites authors who write about the contemporary middle-class selves as 'cultural omnivores'; "a mobile and flexible body that can access, know, participate and feel confident about using a wide variety of cultures (from high to low)" (Skeggs, 2004, p.144). It is suggested that this reflects a shift from the middle class defining itself through access to 'high culture', to now defining itself through access to a multiplicity of cultural resources (e.g. listening to both opera and gangster rap). This is similar to the way the construction of middle class emotions have changed over the years.

Whereas being middle class was once practised through emotional restraint and decorum, it is now practised through emotional flexibility and adaptability.

Skeggs (2004) argues that the culturally omnivorous middle class does not represent a democratisation of culture, because it is still the middle class who have the resources to convert cultural capital into other sorts of capital, for example economic capital and social capital. Sayles (2011) suggests that contemporary commentators make class-blind descriptions of contemporary society where everyone has the equal opportunity to endlessly reinvent themselves to adapt to the rapidly changing world, ignoring the social inequalities that continue to exclude working class subjects. Those who make their cultural knowledge work for them are more likely to be middle class because they have access to recourses and have "learnt how to convert themselves into subjects with exchange value" (Skeggs, 2004, p.150). In addition to this, working in an era of globalisation and neoliberalism means that there is less security in work across the social strata, and so the ramifications are more severe for those who are already struggling to get by and do not have layers of intergenerational wealth to cushion their fall when they do not adapt quickly enough to the changing of market forces (Walkerdine, 2003).

What could this mean for the emotional capital exchanged within psychological therapy? Sayles (2011) suggests that middle class subjects are produced as self-governing, whereas working class subjects are produced as needing to be governed by outside forces, and that this is seen in therapy where middle class subjects can choose to engage in therapy in order to work on themselves, whereas working class subjects are more likely to be mandated to engage in therapy through various social services, or through the failure of a system which is geared to meeting the needs of the middle class. If we were to conceptualise the psychologist's ability to move in and out of the various affective practices and the work they do on their own subjectivity as the accumulation of emotional capital, how would this translate to Skeggs' theory about cultural capital? She suggests that it is a distinctly middle class thing to be able to appropriate these various forms of culture and integrate them into a sense of self, which – if applied to affect – could suggest that the enterprise of therapy (increasing affective adaptability) could be futile if the clients are not middle class. She also suggests that those who are middle class are more resourced to convert cultural capital into other sorts of capital so, if this was the case with emotions, the middle class therapist has more to gain from her/his work on self, than the working class client does. In a way this was

reflected when a few participants spoke about a sense of frustration at not being able to change the wider social situations that are causing the client's difficulties. Perhaps because the strategies offered (both to psychologists and clients) are limited to this work on the self, it means that psychological therapy is part of the system which reproduces class inequalities. It is worthwhile to consider whether this is necessarily the case, and whether there could be a form of psychological therapy that actively resists the reproduction of such social divisions?

We can also look at how the formulated multiplicity of the post-modern self impacts on constructs of gender within clinical psychology. As discussed in the Chapter 4, the psychologist is expected to be both the scientific, professional *and* the caring, healer. Some of constraints on emotional expression (even with the construction of the infinitely changeable self) have already been discussed. Despite these constraints does the scope for multiple understandings of what it means to be a professional woman in psychology not offer some hope that gender roles are not as rigidly defined as they once were? Is it not an achievement that women are now in the majority in this esteemed and competitive profession? Should this not equate to equal pay, conditions and opportunities for advancement (aka the fulfilment of the neoliberal dream)? Evidently not. The gender pay gap (which has been static in New Zealand for the past ten years), exists in psychology and this is particularly so in health settings, with an American Psychological Association study finding that male psychologists working in health settings in the United States earn on average $39,648 per annum more than their female counterparts (American Psychological Association, Center for Workforce Studies, 2014). Women in clinical psychology are proportionately less likely to receive promotion or move into management positions (Nicolson, 1992). The fact that women are disproportionately taking up the junior and mid-level positions suggests that there are institutional barriers to gender equality within the profession. So while women dominate in numbers in psychology, there is still a long way to go when it comes to breaking down patriarchy within the institution of psychology. If this is the case, I wonder how psychologists go in supporting their female clients address their subordination.

Something this research has not considered is how psychologists' constructions of emotions could relate to the emotional practices of the dominant Pakeha culture. Indeed, in New Zealand class and ethnicity intersect profoundly so discussion of middle-class selves are inevitably discussions of whiteness. It is possible that the affective practices within the therapeutic relationship are part of the system which perpetuates the subordination of

minority cultural groups. In a New Zealand context it would be particularly important to consider how the privileging of certain understandings and practices of emotion could be part of what maintains the on-going ill effects of Pakeha colonisation of Maori (including higher rates of mental health issues and suicide).

The way psychologists practise emotions within the therapeutic relationship, is neither benign nor innate, rather it is a technology that reproduces dominant ideologies and social divisions, while at the same time locating the difficulties caused by these inequalities within the individual. What does this mean for the client engaged in psychological therapy? How might alternative modes of meaning making and practices broaden the scope of understanding of psychological problems and their causes? What could be gained by having more explicit discussions about how psychology reproduces social power relations? What might resistance to hegemonic forms of emoting look like in the context of the therapeutic relationship? These questions and more are opened up by this research and could be used by practising psychologists to extend the parameters of their reflective practice.

While thinking about disciplinary power in the therapeutic relationship is important, it can also feel overly defeatist or deterministic. No institution is free from disciplinary power and even forms of resistance can always transform into new forms of hegemonic power, if they become dominant. The purpose of discussing the disciplinary power enacted through psychologists' emotions is not to portray psychology as all bad and in need of eradication. Compared to the major alternative available – the biomedical model of medicating distress – psychological therapy seems favourable. However, I think that all too often people within psychology readily critique the biomedical model without considering how power operates within their (our) own practice. A practice-based approach to emotions allows for *both* the consideration of how affective practices are regulated through regimes of power *and* allows space for movement and change.

The Construction of Emotions

Given my epistemological assumptions I need to be wary myself of evangelising one way of constructing emotions. I need to critically reflect on my decision to privilege an affective practices understanding of emotions, and to consider both what it allows me to do and what

the limitations are. While it is a way of understanding emotion that has been useful for this research I am not suggesting it is the only legitimate or 'true' way of understanding emotions.

Understanding emotions as affective practices produces its own dilemmas, particularly when it comes to methods of research. From an affective practices perspective emotions are understood as an assemblage of brain/body responses, of meaning making constituted both in the moment and through histories of practices, all within broad regimes of power which construct legitimate and illegitimate social actors. Therefore, the study of affective practices should use research methods that can empirically study emotion at all these levels. Ideally research on affective practices would not be done solely using the methods of researchers who attempt to find ways to study the 'pre-discursive hit' of affect, nor by using forms of discourse analyses which focus solely on language and how it constitutes reality. How does one find a method that empirically researches both the embodied emotion and the meaning one makes of it? Certainly I do not believe I have been successful in achieving this, as my research has focussed on the meaning making side of the ledger. Discourse has been privileged over embodied experience. The participants' in this research were to some extent rehearsing formal discourses about what psychologists 'should' be doing with their emotions.

It would be fascinating to do a similar sort of analysis using footage of actual therapy sessions. However, while this would remove a layer of abstraction, in that it would be researching the practices themselves (rather than accounts of the practices), it would still be largely a study of language and meaning making. Even the inclusion of body language and facial expressions, would not fully capture the internal component of emotion. We cannot research a world without meaning. It would also be interesting to do a similar research project with clients of psychological therapy, exploring their understanding of the affective practices expected of them within the therapeutic relationship.

Given that I have privileged the discursive, why bother with all this talk of affective practices? The focus on practice has allowed me to reconsider my taken-for-granted understanding of emotions as an innate force (something you just feel) and to conceptualise emotions being constituted as they are practised in relation to others and/or the world. This understanding of emotions has let me to consider participants' meaning making around their professional emotions, both at the level of identifying patterns in the individuals' accounts, and at the level of considering broader social political trends which reproduce certain forms

of work, success, gender and class. It has allowed me to produce an account of the broad patterns within the participants' talk, while also attending to the inevitable points of tension and dilemma. I have been able to consider how participants spoke about working with these dilemmas, such as constructing a lack empathy for some clients as a personal flaw that needs to be worked on, and to consider what points are privileged over others, such as emotional containment being privileged over expression. I like the way affective practices break down the divisions between cognitions, emotions, practices and ethics. It has challenged my assumptions around such separations, and let me consider my own practice with clients as a place where patterns of affective practice can either be replicated or resisted.

While it might be easier to walk on the well-trodden ground of either the discursive or the affective, combining the two has meant that I have been able to produce an account where both are implicated in the constitution of emotion. Even if I do not yet have a method which adequately reflects this ontological melding, taking this sort of understanding into my research of psychologists' emotions has been beneficial in the way it has allowed me to talk about emotion. Given that it I have found it helpful I would like to consider whether an affective practices understanding of emotions could be used as a rhetorical tool for psychologists seeking to form an understanding of their professional emotions and to consider what kind of questions are opened up by this way of constructing emotions. First I will consider the ways in which participants constructed the nature of emotion as a topic in itself. While this varied between the ADRs some general themes can be distinguished.

First, there was a pervasive view that some real or innate emotions do essentially exist. The idea that emotions are either genuine or faked relies on the construction of there being some sort of objectively understood actual authentic emotion. This is aligned with a sort of basic emotions understanding of emotion where we are all born with a universal set of emotions which have an evolutionary function (described in Chapter 1). While this was obvious when participants spoke about emoting from the subject position of the human, it is also implicit in the other ADR's that beneath the contained or modified emotions lie the real emotions (which often threaten to spill over). What varied across the ADRs was the degree to which it appears possible, and indeed desirable, to modify these innate emotions.

Within ADR Two some emotions such as sadness, embarrassment, frustration, and disappointment were constructed as being, at times, hard to suppress or control. Often tears

were spoken about in this way. However, even from the position of the Human, this 'uncontrollable' emotional expression still needed to be limited. As in the extract below it was still important that the expression did not over power the client's experience. Another participant spoke about sometimes not being able to control his tears, but qualified this by saying "not letting it [sadness] get like [drawing in breath] ... so I just lose my shit you know, but again trying to channel into something therapeutic" (Pete, p. 10). Even within this ADR that constructed the inevitability and utility of an occasional crack in the professional surface, an all-out flood of emotion was not permitted.

> **(FG1) Tracy**: I think crying is one that I often can't control if it happens [Helen: mhmm] and so you just kind of, you either own it and say it out loud [Helen: mm] or you know sometimes it doesn't need to be spoken [Fiona: yeah] and you can just say like man that's a <u>really hard</u> story [Helen: mmm] and that makes me really sad that that's happened to you [Helen: mmm] [Fiona: yeah] and I think that's a really fine way but I think it's really important that you don't make your emotion more important than theirs [Helen: mm mmm], they're the one that went through it and you're just like man I didn't even go through it and that's got me teared up….

At times emotions were constructed as contagious. Some participants spoke about emotions such as joy, relief, humour and sadness being contagious.

> **(I) Hayley**: But in terms of like.. other things that are <u>super</u> contagious I think.. lightness is- … also I think whatever mood you are already in [Helen: mmm], like if you are having a bad day and someone else is having a really bad day then everyone is having a bad day- you know like it's much easier to kind of.. [Helen: yeah] take on their stuff as well whereas if you are having a good day it's less likely for the sadness to be contagious [Helen: mmm] because you are kind of like this is not at all where my head is at [Helen: yeah] or um if your last client was very different [Helen: mmm], from a very light session to a- it can be harder to get that contagion effect …

This contagion goes both ways, the psychologist and the client (or both) can be carriers of the contagious emotion. Although, as illustrated in the extract above, emotions are not constructed as actually all that contagious, they are more like a weakened immune system, so that one can be predisposed catching the other's emotion if one's emotional capacity is already weakened for that particular emotion.

Some participants spoke about how emotions (both their own and the clients) are influenced by past experiences. One participant spoke about how her family of origin's history of emoting made her feel uncomfortable with clients' expressions of anger. Whereas another

participant spoke about a realisation of how her family's feeling rules made her feel uncomfortable when clients cried. It is not surprising that psychologists would use this sort of construction of emotion, given that almost every branch of psychological theory relies on the idea that our current behaviour is based on our past experiences. This sort of construction tips the hat to this idea that emotions are patterned across time through layers of practice. However, it is still limited in that it draws too clear a line between past and present and does not acknowledge that these patterns of affect are continuing to be constructed and reconstructed with every interaction. It is also usually limits the understanding to include familial patterns of relating, ignoring how they are situated with in broader social patterns of relating.

Regardless of whether emotions were constructed as; caught in the moment or learnt in one's family of origin; as needing to be expressed within limits or totally contained; as being volcanic or elastic, the over-arching theory of emotion drawn on within all the ADRs was most aligned with Hochschild's notion of emotional labour – trying to induce or suppress emotion in order display the outward countenance that produces the required state of mind on clients. In particular it reflects the construct of 'deep acting' where the work is said to be done on the producing the actual emotions rather than just the emotional displays.

> **(I) Kate**: Yes yeah, to actually.. I don't allow myself to experience it [sadness] or I don't think it's helpful [Helen: yeah] for the client and you kind of don't want them to think that they, they've got to be careful about what they say in case they upset their therapist.

In a way the construction of deep acting entails its own concealment. As discussed in Chapter 6, constructions of emotions and selfhood merge and this removes the option to understand the professional emotions as emotional labour, because emotions become subsumed in constructs of the self (Hochschild, 1979). This can be understood through Rose's (1990) suggestion that the nature of work has changed from being something that is done for financial reward, to something that is done for personal fulfilment and the identity it offers. Certainly being a clinical psychologist offers a certain type of high status professional identity, the identity of one who knows and sees what others cannot. In terms of personal fulfilment, there is an expectation that psychologists will find the work with clients rewarding and feel good about the difference they are able to make in clients' lives. I think this expectation may contribute to the tension expressed around the 'unprofessional emotions'

produced in the contingent discourse (discussed in Chapter 6). Hochschild (1979) might see this as the psychologist becoming an 'emotional proletariat', estranged from authentic feeling, and the quote from Hayley on page 134 replicates this notion. Again we see the formation of a split between the authentic real emotions and the inauthentic professionally manufactured emotions.

How does this differ to an affective practices understanding of emotions? Could an affective practices understanding of emotions be used as a rhetorical tool for psychologists trying to form an understanding of the function of their emotions within the therapeutic relationship? Rather than understanding the psychologist's emotions in the therapeutic relationship as a modified version of some sort of genuine and innate emotional experience, a more complex and nuanced understanding of psychologists' emotions could allow for emotions to be understood as being constituted both as psychologists practise emotions in sessions with clients, and through past histories of practice. Instead of understanding emotions as either biologically innate or predisposed to through the psychologist's early experiences within their individual family, an affective practices understanding of emotions would allow psychologists to understand their emotions as multi-faceted, so that biological processes are entwined with their personal histories of practice, as well as being influenced by the shared expectations for practices within the professional identity. Furthermore, it would allow psychologists to consider how the professions expectations around emotions relate to the wider culturally available understandings of emotions that maintain hegemonic social and political power relations.

An affective practice understanding of emotion would allow space for talking about points of tension and dilemma, instead of attempting to manufacture a façade of cohesion. Rather than necessarily trying to resolve these dilemmas it would enable psychologists to construct an understanding of the challenges faced in the emotional work associated with the profession as going beyond the individual. Perhaps as a product of the inconsistencies related to the layering of successive therapeutic interventions (which themselves reflect wider social trends rather than being objectively correct). Perhaps related to being in a profession which tries the 'have the best of both worlds' by employing disciplinary technologies of both containment (to maintain power structures) and expression (to get client 'buy in'). Understanding emotions in this way could provide more space for articulating points of resistance against

mainstream constructions of emotions that are used to maintain the suppression of marginalised groups on the basis of gender, class or culture.

Conceptualising emotions in this way could both provide an alternative way of understanding the professional restructuring of self, and open up the options for how to do this work. It is possible that broadening the understanding of the how the professional emotions are constituted (to include the individual's history of practice and an acknowledgment of the professional expectations for practice complete with inconsistencies and competing demands), could mean that psychologists' 'unprofessional' or 'unruly' feelings are not understood as purely personal failings, helping to reduce blame or stigma in talking about them.

Further Implications

It is my hope that this research could be used by psychologists to help conceptualise their emotions differently and, as discussed above, that this new way of formulating emotions could broaden the perspective on what constitutes emotion and ways of working with emotions (both their own and the clients') in the context of the therapeutic relationship. I hope that this critical social account creates discursive space for discussions about the dilemmas and points of tension endemic in the understandings of what psychologists' affect 'should' be, which are currently obscured or shrouded in a threating mist of unprofessionalism and personal failure. Broadening the perspective to conceptualise how these inconsistencies and dilemmas are located within a wider social, political and historical context creates space for alternative possibilities for resolution, beyond the disciplinary restructuring of self. I hope that this research could be used as a tool for psychologists to consider how ideology operates through their affective practices in therapy, rather than accepting that what they do with their emotions is 'common sense' or innate.

Participants said that they would have liked for there to be more discussion in the training programmes around the emotional work involved in becoming a psychologist. Possibly this research could help facilitate such discussions, including an explicit acknowledgement of the pressure to be emotionally sorted (and the impossibility of this). The contingent discourse could be openly discussed in classrooms and staff meetings, rather than confessed to colleagues behind closed doors. There could also be a consideration of what might be lost if

all psychologists take the form of this perfectly worked-over, emotionally sorted self. What new possibilities, opportunities and forms of resistance are being kept at bay through the reproduction of this type of selfhood?

Taking on an affective practices understanding of emotions, could also change the way psychologists work with clients, possibly enabling a more contextual and relational understanding of the clients' emotions. If psychologists were to take up an affective practices understanding of emotions it could slowly infiltrate 'mainstream' understanding of emotions, because psychological therapy is one of the places where emotions come to be understood, formulated and distributed.

Clearly I am hopeful about the possibilities for what could be gained by adopting a critical social position on psychologists' emotions. It is also important for me to consider what the some of the costs might be. I have positioned myself in a critical stance towards the profession I am expending so much effort to be a part of. While I am invested in critical theory, I am also invested in the clinical work. Until recently I thought that the dilemmatic nature of positioning myself as both 'clinical' and 'critical' was a form of resistance. I comforted myself with the image of entering the profession like a Trojan horse, so that I could launch my attack right from the very heart of it, as opposed to shouting from the margins. However, through the process of conducting this research I have started to think about how my dilemmatic rhetoric may in fact be perpetuating and strengthening the mainstream discourses of clinical psychology I seek to resist. So I find myself in the perhaps inevitable end point of a post-modern stance where I have become critical of my critical position.

When I started on this critical journey some years ago, the absurdity of constructing human psychology in purely scientific terms seemed evident, perhaps so evident that it eclipsed a more complex view of the array of technologies used within psychology. Through this research I have considered the possibility that constructions of the multiplicity and subjectivity of psychologists' emotions may *both* be a form of resistance against the dominant objective scientific paradigm *and* a more effective and insidious way to achieve the same ends of normalisation and the production of docile subjects. Likewise the way participants moved back and forth between positions, creating opposing accounts of the risks and benefits associated with each may *both* be a form of resistance *and* be part of the

enlightenment game which maintains the hegemony of science and of psychology as an institution of social conditioning and control (e.g. both by employing multiple affective technologies to widen the net of social control, and by using the marginalised contingent discourse, to bolster the privileging of formal discourse).

Is it possible that the voice that suggests a marginalised construction of the psychologist's emotions creates an opportunity for dominant discourses to restate their construction of the 'correct' way to emote with added force, and affords them greater claims to legitimacy now that they have been subjected to debate? Or can alternative repertoires and affective practices make a dent in those that dominate over time? Perhaps as an aspiring third wave behavioural therapist I will have to settle with both/and.

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Appendix I – Interview Schedule for Focus Groups

I'd like to keep the discussion today broad, so that we are talking about psychology as a profession, rather than going too in depth into personal experiences of expressing emotion in the therapeutic relationship. I'd like to have a chance to do that in the individual interviews, and I felt that in the group setting it would be better to talk more generally. It's important that you keep confidential what is shared by other group members. I realise the sensitivity of talking about clinical work and encourage you to employ your usual practices to ensure confidentiality for both your clients and your colleagues.

Could we start by just going around the group and saying your name and what sort of service you work for, without naming the actual service.

It would also be useful to know where you did your training and what sort of teaching you got around managing your emotions when working with clients (if any).

Expectations for the emotional psychologist

What emotions do you think clinical psychologists commonly experience when they are working with clients? I'm not talking at the moment about what clinical psychologists should feel but what they actually feel day to day (get specifics).

Okay, clinical psychologists clearly are going to feel a lot of things, so how does this tend to come across to clients? Again I am not talking so much about what it should be like, more what it is usually like from the client's perspective.

Moving on now from what actually happens day to day to thinking about professional ideals and good practice. One of my classmates said to me the other day that there are differing expectations about what she should do with her emotions when working with clients; her own expectations based on her personal values, the expectations of the supervisor and the expectations of the university tutors. What are your thoughts on this?
> Can you remember what your expectations were before you started your training?
> What about the expectations of tutors and lecturers at uni? Were they consistent?
> How about the different supervisors you have had in the work place?

> What emotions do you think it is okay for a psychologist to express when working with a client? How might this look?
> Is it okay to cry/ raise your voice/ bang the table/ look impatient/ yawn?
> What emotions do you think it's not okay for a psychologist to express? What are the reasons for this? What could happen if a psychologist did express those sorts of emotions?

Practices – what the emotional psychologist does with her/his emotions

Let's go back to the first question I asked you about your training. I read somewhere that training programmes don't prepare therapists for the despair some clients express and that the client's emotional impact on the therapist is the most neglected area in therapist training. What are your thoughts on this?

How do psychologists learn what emotional expression is acceptable within the therapeutic relationship?

If a psychologist is experiencing an emotion they think is inappropriate to express within the therapeutic relationship, what can they do to try to manage this? What strategies can they use?

How do you think a psychologist's theoretical perceptive and the type of therapy they use might affect the way they manage emotions within the therapeutic relationship?

How does the client's emotional expression impact the psychologist's emotions?
> I've heard the more intense the client's emotional expression is, the more likely it is to trigger a emotional reaction from the therapist. What are your thoughts on this?
> How does the client's emotional expression affect the therapeutic relationship?
> Is there an optimal level or type of emotional expression for a client in therapy?
> Do certain types of client tend to elicit stronger emotional reactions in psychologists?
> From a more psychodynamic perspective the psychologist's emotions are often seen as a reflection of the client's dominant feeling states and modes of relating. What are your thoughts on this?

Being genuine vs being professional

From reviewing the literature I get a sense that there is a tension between being truly 'genuine' regardless of what the emotion is and reserving the expression of 'genuine' emotion for 'genuine empathy'. What are your thoughts on this?

In a study with nurses they suggested that a degree of 'emotional attunement' was essential for them to be able to perform their jobs, but that this had to be combined with 'professionalism' so that they were not 'too close'. Can you relate to this? How do psychologists balance being emotionally attuned with being professional?

The nurses were more conscious of 'performing' the required emotions when they were under stress. Are there times when you are aware of 'performing' emotions as a psychologist? Can you tell me about them?

I read somewhere that manualised psychotherapies instruct therapists on how to simulate sincerity and play the role of the warm and seemingly genuine therapist. What are your thoughts on this?

Appendix II – Transcribing Conventions

I will outline some of the conventions I used in my transcribing. A capital I after the participant's name indicates that the extract came from an interview and capital FG after the participants name indicates that the extract came from a focus group. I have numbered the focus groups 1 – 4 in the order that they were conducted.

Sounds such as laughter, coughs, and sighs were put in parentheses followed by the text, for example (laughs). Likewise overlapping speech and inaudible speech are also indicated in parentheses, for example, (overlap). A short pause is signalled by . and a longer pause is signalled by ….

Non-verbal utterances were written phonetically, for example mmm. Cut off speech is indicated by writing the sound I could hear followed by a dash, for example we-. Emphasis on a particular word or words is shown by underlining. Quotation marks were used to indicate when a participant reported or mimicked another person's speech. Myself as the interviewer and other participants in the focus groups often made encouraging noises and brief comments when a participant was speaking, these are included in square parentheses within the body of the speaking participant's text, for example [Helen: mm-hm].

When I started or finished an extract mid-statement (to keep on top of the word length) I indicated this with … at the start of end of the extract. When a section is missing mid-extract I put … on a separate line.