6

THE FIRST SESSIONS

The Therapeutic Alliance

There are three parts to the therapeutic relationship. The therapeutic alliance is largely conscious and the part of the therapeutic relationship in which we and our client agree to work together. The unconscious relationship is largely manifest through the transference and countertransference. The real relationship is to do with the personal relationship we have with our clients and the reality judgement they make about us. These three aspects of the relationship overlap, but for the purpose of clarity I have separated them.

WHAT IS A THERAPEUTIC ALLIANCE?

The therapeutic alliance involves the notion that there can be a split in the way your client relates to you. While one part of his ego is caught up in the transference relationship, the other part is available to think with you about what is going on and collaborate in the therapeutic endeavour. The therapeutic alliance addresses the aspect of the relationship that is in touch with external reality. By contrast, the transference relationship is concerned with internal reality. If your client experiences a powerful transference (particularly a negative transference), he can be assisted in managing it, and continuing with the work, if a strong therapeutic alliance has been established. Establishing a therapeutic alliance is a priority in the early sessions, though it cannot be ignored at any stage of the work.

As Etchegoyen (1999) notes, the transference relationship is asymmetrical because we speak to the child in our client. By contrast, the therapeutic alliance should be a symmetrical, equal relationship between two adults. Meltzer (1967) also proposed that the therapeutic alliance should be approached through the client's adult self, arguing that one does not interpret to the adult part, but rather speaks to it.

Psychodynamic practitioners sometimes treat the alliance as though it is an asymmetrical relationship, which can lead to inappropriate and unhelpful interpretations. For example, someone who came to me for a second therapy expected me to interpret her resistance to therapy when, soon after starting, she cancelled some sessions because she had to attend mandatory training at work. Her previous therapist had always interpreted such reality-based difficulties solely within the transference relationship, and she expected me to do the same. I usually treat such situations as a symmetrical issue first; once we have resolved the practicalities I explore the meaning for my client, which will almost certainly include an exploration of the transference implications and the asymmetrical relationship. It is very important for clients to know that we respect and acknowledge the adult part of them; it is this that helps them when the transference relationship becomes more powerful, particularly if they act out.

Etchegoyen (1999) argues that treating the therapeutic alliance as an asymmetrical relationship can interfere with our clients' capacity for perception and critical reasoning. Recognizing that practitioners can feel much more comfortable in an asymmetrical relationship which maintains a power imbalance, he cautions that 'We should take care not to utilize the asymmetry of the transference relation to ease the symmetry of the therapeutic alliance' (1999: 257). This is particularly the case when we have done something that our client pulls us up on. Etchegoyen cites the example of an analytic colleague who cancelled a client's session the day before it was due when he could have done so sooner. The client was angry that, with more notice, he could have done something else with the time. The analyst responded by interpreting the client's separation anxiety. While at some later stage it might have been appropriate to make such an interpretation, Etchegoyen argues that this should have happened only after the analyst acknowledged the client's very real anger with the analyst's very real lack of consideration for him.

Research has consistently found that the quality of the alliance predicts the outcome of treatment. Crits-Christoph and Connolly Gibbons (2003) propose that it is particularly important to the outcome of psychodynamic therapy and counselling. Research has also shown that our contribution is significantly more important in creating a successful alliance than our clients'. Del Re et al. (2012) confirmed previous findings that effective therapists are able to form alliances across a range of clients. Although we don't yet understand the exact mechanisms involved, it is a consistent finding that an effective therapist's clients do better at the conclusion of therapy. They propose that therapist responsiveness, therapist training and institutional working conditions all contribute to client alliance and outcome. However, some of the therapeutic alliance is based on your client's ability to work with another person. When a new client tells me he has not stayed in a job very long, and that his relationships are short-lived, I know it will be difficult for him to build a solid alliance. However, if your client does have the basic capacity to work with you, it is your job as a skilled practitioner to facilitate the development of the therapeutic alliance.

THE ROAD TO THERAPY

The therapeutic relationship starts at the moment that a referral becomes possible in your client's mind, and there are a number of factors that can influence the establishment of the therapeutic alliance before he arrives for the first session.

The referral route

This can have a significant impact on the early therapeutic alliance, since it may determine how long he has had to wait for therapy. Being on a waiting list for a long time can diminish the impetus to do something about problems. Your client may be reluctant to open up painful areas that have begun to heal over, even though the root cause of his difficulties remains the same. This can increase the initial resistance to therapy and if so it needs skilled management to ease him into the work. Your client may already feel that you have neglected him because you were unavailable at the time he really needed you (Howard, 2011). Unless you acknowledge that he has waited a long time, he may feel that you don't know or care that he has been kept waiting. This can increase the possibility of a negative transference before the therapeutic alliance is strong enough to cope with it. The acknowledgement does not need to be complex; the example below is often enough and could be one of the first things said to a new client who has waited a long time:

Therapist: 'You've waited a long time for this; I wonder how it feels to be here now.'

The route taken into therapy can also indicate how comfortable your client is with other people knowing he is seeking help. He may have chosen to find a therapist through an advertisement or a register because he doesn't want anyone else, including his GP, to know he is in therapy. This could indicate a greater-than-usual degree of shame about being in therapy, which might undermine the early therapeutic alliance.

Whose decision is it?

The early therapeutic alliance can be influenced by who decides that your client should enter therapy. Did he decide himself or come as a result of seeking advice? Was he coerced into it, for example by his spouse? Or was he sent for compulsory therapy, for example by a court? Those arriving via the former two routes are more likely to be motivated to use the opportunity and therefore ready to build a therapeutic alliance. However, there is a sharp decrease in motivation for the latter two routes, and your client might be looking quite consciously for reasons that either you or the approach is not right for him. Again, it is important to acknowledge early on how difficult it is for the client if he has been 'sent'.

Therapist: 'Perhaps it is difficult to imagine that you can get anything from a process that you haven't [don't feel you have] chosen.'

Your client may be robust in agreeing that this is indeed the case, and the honesty about his position may in itself be facilitative of a positive relationship and may prevent the development of an early negative transference.

Who is paying?

Whether or not your client is paying for his own therapy is also an important factor in the establishment of the early therapeutic alliance. Clients who pay themselves know they have more scope for choosing a therapist. Having a choice can facilitate an early positive alliance for some clients, though others may hold back, knowing they could go elsewhere. Those who are paid for by a third party will bring particular complications into therapy. If an insurance company is paying, there is usually uncertainty about how long funding will last; if a parent or relative is doing so, there may be aspects of your client's relationship that get played out in therapy, for example by missing sessions that still have to be paid for. It is important to acknowledge the implications for therapy of third-party funding.

Therapist: 'I wonder whether you might find it difficult to feel these sessions are just for you, given your parents are paying for them.'

In the public sector, clients may feel they have little choice about who they see, because they are not paying. This can lead to resentment, particularly among those who are anxious about getting proper care.

Previous therapy

If the road to therapy is one your client has taken before, it can have an impact on how he anticipates engaging with you, even before you meet. Clients who have been caught in the 'revolving door' of the health system will, inevitably, carry with them expectations of therapy based on their previous experience. Those who have seen several previous mental-health practitioners often complain at having to tell their story again and may come to therapy resentful at having to do so. Others may be reluctant to engage with a new therapist after previously making a meaningful therapeutic relationship and having to say goodbye against their wishes. They may then treat us with the lack of consideration they feel they experienced themselves. Such factors can have a significant impact on the therapeutic relationship before we meet them. Again, it is often best to acknowledge the issue at the outset.

Therapist: 'I wonder if it's difficult coming to see yet another person and having to tell your story all over again.'

Barriers along the way

Missing the first appointment can undermine establishing a therapeutic alliance for both therapist and client. The client might be embarrassed or guilty about not attending and then feel angry towards the person who has made him feel uncomfortable. You may be irritated at a wasted session when you have a waiting list and pressure on you to reduce it, or at the loss of income if you are in private practice. Both of you have to get past your negative feelings in order to begin the process of building a therapeutic alliance. Again, it is important to address this issue at the outset:

Therapist: 'It might have been quite difficult to come today after missing the first session.' [If the evidence is there, you may continue:] 'I wonder if you were concerned I might be upset with you for not coming last time?'

Some people still regard needing therapeutic help as a sign of weakness and are contemptuous of those who need it. How the people around the client view therapy can have a significant impact on the therapeutic alliance. If your client has gone against the values and beliefs of his own family, friends or culture, he may be so ambivalent about therapy that it is difficult for him to establish a therapeutic alliance. If he signals that this is the situation, you need to acknowledge the difficulty for him as soon as you are aware of it, in the same way as in the other examples given.

With all the above examples a number of things are happening simultaneously. First, a source of potential difficulty is being attended to near the beginning of the relationship so that any work around the issue can be addressed early on. Secondly, the therapist is giving an early message that difficulties in the therapeutic relationship can be discussed, thus providing an experience the client can model. Lastly, the therapist brings herself into the picture, indicating from the start that the relationship between her and her client can be thought about. This is the precursor to working more overtly with the transference relationship. Your client may find this helpful if he has not had previous experience of working dynamically. You might be concerned that, by inviting your client to tell you how he feels, you are unnecessarily encouraging negativity about therapy. However, being able to express anxiety or concerns about therapy can facilitate the therapeutic alliance as it indicates that we can tolerate our client's negative affect. It also demonstrates that we are in tune with the fact that he might both want help and not want help and that he is ambivalent about the process of therapy.

BASIC SKILLS IN BUILDING A THERAPEUTIC ALLIANCE

Maintaining an open mind is an important skill in psychodynamic work, and is manifest in an underlying attitude of not knowing. It is essential that we remain curious throughout our client's therapy to help us maintain an open mind. Curiosity is conveyed by not making assumptions, or allowing yourself to be rushed into

pre-emptive conclusions. It also conveys a non-judgemental stance, which is important in helping clients cope when they discuss difficult material.

Listening

Clients often comment on how I listen to them, which is different from their everyday experience and a central skill in psychodynamic work. We can prepare ourselves to listen by creating an atmosphere in the consulting room which is calm and unhurried, and by a therapeutic stance that is a mixture of quiet calm and alert attentiveness. This will facilitate your client in feeling that he can tell his story, and that he can listen to it and know he is being listened to by you.

Psychodynamic practitioners' work is much more about listening than talking. As McWilliams (2004) observes, when we listen well, clients can discover a sense of agency and become increasingly confident in their own judgements. She makes the wry observation that 'The therapist is deprived of the illusion that it is his or her clever formulation that has created that change, a frustration that it takes a good deal of training to be able to give up' (2004: 133). Listening is a central competence in building a therapeutic alliance. It involves allowing your client to tell his story without being distracted by external events; not interrupting him unless necessary; communicating interest through your facial expression and body language; and hearing the subtext to a story and the emotions behind the words. We *hear* our clients through the analytic internal frame, which is why how we listen is different from everyday listening.

Analytic listening requires discipline; we do not engage in the normal social conventions of back and forth discussion. It requires holding in check our own need for self-expression in the service of our client's psychological needs. At the same time we need to maintain high levels of attention and concentration. The quality of our listening is also emotionally receptive, which facilitates our client in being able to explore more deeply those issues that are painful for him or previously unacknowledged. We are thoughtful about what he says and convey that we take it seriously. It may look as though not much is happening, but in order to listen properly we have to 'work with our full self-expression throttled back to near-minimum' (Coltart, 1993: 43). Doing so is very demanding and can be exhausting.

Silence

Listening happens when we ourselves are silent, but at times both participants are quiet. The silent therapist of popular culture is mostly a caricature, but there is a reality that part of listening involves allowing silence. For many clients it is the first time they have experienced thinking or feeling in the presence of another without the pressure to fill the space with words. However, it is important early on in therapy not to allow silences to extend for too long until you know your client well enough to understand what silence means to him. At the beginning of my career I learned a valuable lesson with a very vulnerable client who experienced any silence on my part as a punishment and a challenge. In a therapy characterized by a powerful negative

transference she sat in furious silence, challenging me to be the first to speak. Needless to say my mind went blank! Looking back, I am aware that, as a novice psychotherapist, I would have struggled with this client however I managed silences, and may have been unable to prevent the early termination that inevitably followed. Nevertheless, I do wonder whether the outcome might have been different had I been better able to understand and help her cope with her distress about any lapse in discourse. Although she attributed any silence on my part to my adherence to technique, it was also a reflection of her experience of silence being used as a weapon in her own family.

Sometimes a client pours out the distress that propelled him into therapy in his first and perhaps second session but not know what to say in the next one, potentially resulting in painful silence at a time when the therapeutic alliance is not yet established. In this situation I don't allow the silence to continue for too long, but will address it. I usually start by commenting on how difficult it seems for my client to know how to start or what to say. Then I ask if he has any thoughts about why it might be difficult today. Often this is enough to begin the session or unblock it. But sometimes more is needed and an exploration of what my silence signifies to the client usually moves us both forward, not least because by doing so we are ending that silence.

While some clients perceive their therapist's silence as a provocation, others become terrified of it because the analytic space does not represent a place in which they can explore, but rather one in which they will get lost. As a profession we are good at allowing silence, but I think we are sometimes less good at identifying when clients become lost in the space we have created for them. For these clients our silence often traumatizes them.

Such feelings are both more difficult to tolerate and more difficult to talk about at the start of therapy. Sometimes I explain that in the silence I am thinking about what my client has said, and that I don't want to intrude on what he is thinking. This is part of helping him to understand the reasoning behind why I haven't spoken, and is important in helping him to begin to reflect on his own relationship to silence. However, being silent is not something I 'do' to my clients. Some years ago a supervisee told me that she had 'used' silence with her client as a deliberate technique. She explained that her own therapist had 'used' it with her, so she felt this was the right thing to do. She needed to be helped to understand that to 'use' silence goes against the idea of an analytic space in which therapist and client can explore. 'Using' silence implies something much more active than 'being' silent, and might mean we have lost sight of the client as a person.

We need to continue to pay attention to how our clients experience silence throughout therapy. There are times when we are silent because we don't know what to say that would feel helpful. It is important to acknowledge that this is why we are silent, as the vignette below demonstrates.

Rona had my account in her hand and sat down looking furious. 'You might have told me you were increasing my fees', she said angrily. I had given her an account that charged her an extra £5 a session, which was clearly an error and

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I said so. She said 'I know you think I don't pay you enough, but this training is expensive and I can't afford any more.' I was processing a lot of feelings and thoughts: I was pleased that she had been angry with me in such a straightforward way. I was curious about the unconscious determinants of my mistake. I was wondering when to apologize for my error – I didn't want to spike her anger, but at the same time I needed to apologize and in such a way that felt real to her. I was aware that she had taken an enormous risk in being so angry with me and would be dealing with the emotional consequences of that. Possibly at this moment she experienced me as someone who would never be satisfied with what she gave me, for whom, like her mother, she could never compensate me enough for being in my life.

I suddenly became aware that I had been silent for a couple of minutes, and that she may well think that I was angry and had withdrawn from her; she had often described the distress she felt when her mother was angry. I said 'I'm not quite sure what to say to you right now, but I feel I need to say something. I've been silent because I was thinking about what you told me, but I want you to know I am still here with you and have not gone away.' Rona immediately calmed down, and we began to talk about how frightened her anger had made her, and how furious she was with me for doing something that made her angry. Yet at the same time she was relieved that she had felt confident enough in our relationship to be angry. I apologized to her for the mistake in her account, and said that it was something that I would take away and think about.

Talking

If listening can be a challenge for a new therapist, talking can be even more of a challenge. Especially at the beginning of your career, you may well feel you have to talk to demonstrate that you have something to offer your client, perhaps an interpretation or a formulation of his difficulties. Since this is the time when you probably fear that you don't have much to offer, the temptation is to over-compensate by saying too much. You don't need to sit in stony silence, however. Like most therapists, I make 'hmms' and other kinds of noises that indicate I'm interested, I understand, etc. – which helps my client to know that I am fully engaged with what he is saying.

Your job at the beginning of therapy is to communicate to your client that he is safe with you, that you are interested in what he says and that you want to understand. It is important to use ordinary language and not to create a pseudo-professionalism through the use of technical jargon, which only serves to underscore the power differential between you. Finding a common language that you and your client have developed together is an important part of the therapeutic alliance.

There are a number of basic counselling skills that facilitate responding to your client's material. While these are necessary throughout the work, they are particularly important in the first sessions (see Evans, 2013). These include reflecting responses, which help move your client's story along; exploratory responses, which attempt to draw from him

something beyond what he has already said; and linking responses, which set the scene for interpretation by bringing together different elements in your client's story in an attempt to help him make sense of something not previously understood.

Cozolino (2004) makes the distinction between therapist-centred and client-centred interactions. Therapist-centred interactions are those that are to do with meeting the therapist's needs. Trainee therapists are more prone to making therapist-centred interventions, in part because of the anxiety of trying to manage all the elements of a new skill. At other times they can be driven by the therapist's personal internal needs, for example to reduce her own anxiety or by voyeurism. Cozolino cites the example of a trainee therapist who, during a role-play exercise, 'interrogated' a 'client' about the details of a road accident in order to control his own unbearable anxiety. The 'therapist' had had a similar accident in the recent past and had still not processed it. This left the 'client' feeling unheard and distressed and forced to acquiesce to the therapist's needs. Sometimes therapist-centred interactions are driven by the need to get information from the client, for example to assess risk with someone who is known to be suicidal.

By contrast, client-centred interactions are those that facilitate your client in feeling heard and being able to express his feelings. Such interactions are characterized by 'coming alongside' him. It is quite a good discipline to check every now and then how often you make therapist-centred interventions in a session, and whether there are clients you do it with more than others. I have found that such an audit of my work can be quite revealing about my relationship with certain clients.

The last thing I want to think about in this section is to do with how we respond differently to clients according to their individual needs. Although each of us develops a recognizable and fairly consistent style as we mature as therapists, at the same time we need to adapt our response according to individual clients. However, there is no formula for doing so, and usually we are guided by trial and error as we work out what is needed at a given moment. Bollas (1987) distinguishes between maternal and paternal styles of relating to clients. A maternal style involves a more holding and receptive therapeutic stance; a paternal style involves a more active, interpretative stance. The extent to which you choose one stance over the other is partly a function of your own style and theoretical orientation. It is also a function of the client's needs at a particular juncture in therapy.

Rona and Charlie: Building a therapeutic alliance

Rona's task is to begin the process of building a relationship. Because of the circumstances in which she is seeing Charlie, Rona does not have to undertake a further assessment or make an initial assessment of risk, although she will be mindful of ongoing risk assessment. Rona needs her basic therapy skills of being empathic, being authentic and listening to what her client is saying to her with an 'analytic ear'. She also needs to be sensitive to Charlie's responses to her and to observe his behaviour in the consulting room, for example his body language and any hesitations that might indicate a difficulty in saying what is on his mind. At the same time, she needs to be able to contain his anxieties sufficiently for him to feel safe with her.

Charlie is a tall, well-built young man. Although he held himself erect, despair seeped out from him. He had arrived the previous week for his first appointment at the correct time but the following day. As she met him in the waiting area he immediately apologized for his mistake, saying that he found it difficult to keep track of the days at the moment as he isn't working. He seemed vague and confused, and Rona wondered to herself whether Charlie had a tendency to dissociate in stressful situations. Coming to his first therapy session was stressful enough in itself, and perhaps the mistake over the days had contributed to that stress. She and Ralph had already discussed the possible consequences of his traumatic childhood experience on his capacity to remain present at times of stress and whether he might dissociate. Rona also thought about the transference implications of Charlie's error. Given his history with his father, having made a mistake it was likely that his fear system had been activated, with a corresponding decoupling of his capacity to think and feel. Although he had specifically asked for a female therapist, Ralph had explained that Charlie would still experience her as a paternal figure in the transference by dint of the asymmetrical nature of their relationship.

Rona explained how much time they had and that this was an opportunity for Charlie to decide if he wanted to take up the offer of therapy with her. She also explained that she would leave time later in the session for them to agree session times if he did want to continue. She then invited him to tell her why he had decided to come for therapy. Charlie outlined the story of his drug-taking, ending with a very detailed explanation of why he had changed his mind about coming for individual therapy. Rona felt he was trying almost too hard to convince her of his motivation to attend. She made a trial interpretation in which she suggested to him that he might be anxious that she would think that he was not committed to coming for help, given that he had made a mistake over the timing of his first appointment. His relief at this was palpable.

Later in the session Rona took up the possibility that Charlie himself might be anxious about whether he would be able, in the long term, to contemplate life without cocaine and whether therapy would be able to help him. When he reluctantly agreed this was the case, Rona added that it might have been difficult to come if he feared not being able to do what he thought was expected of him.

They negotiated the session time towards the end of the session; Charlie found this more difficult than she had anticipated. Although he had said during his assessment that he would be able to attend during the day, he was actively seeking work and was anxious that a regular daytime appointment would make this difficult. Rona decided to treat this as a symmetrical issue, and had an adult-to-adult discussion with him about when he could guarantee attending, since therapy would continue over a fairly long period of time. She was able to do this as she was planning to offer both evening and daytime sessions.

Rona had a lot of work to do in this first session. By missing his first appointment Charlie had immediately created a situation that was difficult for him, particularly given his childhood experience of being punished out of all proportion for any

mistake he made. Rona had discussed what it might mean with Ralph and talked through in supervision her feelings of anxiety that he may not return. She also needed to confront the frustration that she had been unable to quell her own anxiety about seeing her first client. She needed to be sensitive about how she managed his mistake while still being mindful of its possible implications. By keeping interpretation to a minimum, Rona tried to maintain symmetry in the relationship in order to establish aspects of the frame, such as time and the contract, which needed to be negotiated in the first session. At the same time, appropriate interpretation indicated that things could be thought about together. The interpretations Rona made were client-focused and were to do with the beginning of therapy; they addressed the kinds of concerns that are often present in the first sessions.

Managing shame

Therapy provides ample opportunity for feeling shame and, unless we help our clients with this, it can undermine the therapeutic alliance. Shame can be heightened at the beginning of therapy because your client has a problem that he cannot resolve alone. Starting therapy involves allowing a stranger access to the damaged and needy part of himself, which is something most people want to keep private. The admission that he needs help can result in a narcissistic injury, which is the source of shame feelings. People who pride themselves on being self-sufficient are particularly vulnerable to feeling shamed, seeing starting therapy as an admission of failure.

Shame can also be elicited at the beginning of therapy because attachment needs are heightened as your client seeks help from someone who is stronger than him. This can result in powerful longings for and fantasies about being cared for, which can be sexualized. Adults, who are used to caring for themselves, often hate having such powerful longings, and feel that there is something wrong with them. In addition, the asymmetry of power in therapy lends itself to feelings of shame. Although power is difficult to manage in all therapeutic models, it is particularly difficult to manage in psychodynamic work because of the inherent regressive pull to more early functioning.

One of the reasons it is important to be non-judgemental in the way you explore issues with your client is that being judged elicits shame. While we cannot anticipate every trigger for shame, there are some words or phrases that are particularly shame-inducing and we need to avoid them, particularly 'should' and 'ought'. The use of humour can also be risky, since there is usually an implied aggression and/or denigration in the things we find funny. While laughing with your client at something outside the two of you is generally safer, laughing at your client, no matter how well intentioned and affectionate, is a highly risky endeavour and likely to elicit shame.

The most important way to help clients with shame is to always remember that they may well experience asking for help as shameful. If you keep this in mind, you will find it easier to think of ways to phrase interactions that are potentially shame-inducing so that you minimize it. It is also helpful to review what you are going to say before you say it and think how you would feel if your therapist said it to you. Some clients are more shame-prone, and empathic attunement can be particularly helpful. You might say something like 'I sense that you might really hate having to ask

for help with this' or 'I'm aware that you're a very private person, so letting me see parts of you that you normally keep hidden might be very hard.' These interventions indicate that you are able to empathize with your client's difficulties and may help him in talking more openly about feelings of shame.

EDUCATING YOUR CLIENT TO THE PROCESS

When starting work with a new client, especially one who has not previously experienced psychodynamic therapy, it is important to remember that things we take for granted may feel very odd to him. He may experience your formality and neutrality as unfriendliness, or your unwillingness to answer personal questions or engage in social conversation as a rejection. He may be frustrated by the fact that you don't engage in problem-solving. Paradoxically, because of the exploratory nature of the work, those with experience of therapy in other models can find adapting to the psychodynamic approach more difficult than people who are new to therapy.

Some practitioners make few concessions to their client's unfamiliarity with the way in which the work is conducted. I feel this underscores the asymmetry in the relationship which can both raise anxiety in a counterproductive way and tilt the interaction towards an early negative transference before the alliance is strong enough to sustain it. Giving your client a period of time when he can gradually acclimatize to the way you work can facilitate the therapeutic alliance. 'Socialization to the model' is a cognitive behaviour therapy (CBT) term which refers to explicit teaching about the model of therapy. While such explicit teaching would not be congruent with the psychodynamic approach, clients can benefit from easing their way into a relationship that so markedly differs from all others in their experience.

There has not been much written about how to educate clients regarding what to expect and do in the client role, and therapists find ways that concord with their personality and background. Like many therapists I find using metaphors helpful, since, like other stories, a metaphor can often make emotional sense of something that is otherwise difficult to explain. Many clients believe there is a set way of doing therapy and that we know exactly what is about to unfold. I explain that I am like a guide on a journey who has successfully undertaken similar journeys before and can recognize the landmarks, but the map I am using doesn't identify the precise journey that we will take.

I usually explain the frame in a straightforward manner, making clear that the therapeutic process is enhanced by the sessions being regular – coming at the same time each week. I also explain that one way we can understand some of the difficulties he has identified is through what happens in the relationship between us; that we all have templates of relationships, which become manifest in the ways we relate to people, including therapists. One of the most difficult things to explain is how important the therapeutic relationship can become, and after much trial and error I now leave it to emerge as therapy progresses.

Often clients need educating about the potential therapeutic significance of discussing issues that pertain to therapy but which may not appear to be directly related to it,

such as breaks. In psychodynamic therapy, such discussion should constitute part of the session because it is intrinsic to therapeutic work, and I model giving such information during the session. However, sometimes simply because he is unaware of the potential significance of changes in the frame, a new client will regard informing me about a forthcoming holiday or a request to change a session, as separate from the work of therapy, raising it after the session has ended. Unless he is cancelling the next session, I generally say 'You might not think this makes sense at the moment, but there is often quite a lot to think about when a session has to be cancelled. It can have a meaning that is not immediately obvious, but which becomes more so when there is the time to discuss it together. Can you let me know the dates next time we meet, and then we will have an opportunity to do that thinking.' This kind of approach incorporates symmetry into educating your client about a process which is inherently asymmetrical.

Whatever your approach to easing your clients into psychodynamic working, there is one area where I am clear we should always answer his query rather than immediately seeking to elicit an understanding about the nature of the question. This is when clients ask about our qualifications. Of course such questions have transference implications, requiring elaboration and interpretation in due course. But it is first and foremost an entirely reasonable adult question about who your client is entrusting himself to and should be responded to as such. Asking about your qualifications and experience can be an indication of a functioning adult self. To impose asymmetry on the question by early interpretation unnecessarily reinforces the power imbalance.

It is more difficult to feel confident in answering this question when you are training, though since you have less experience to report, and might fear a reversal in the power balance if your client feels undermined by your trainee status. However, in my view, the client is still entitled to know; his response will be grist to the therapeutic mill. It is important to remember that you will already have experience of therapeutic work through your own therapy and will have done significant preparatory work before seeing clients. You could say 'I am currently at an advanced level in my training. I will be talking about our sessions in supervision, which means that there will be two of us thinking about the work we are doing.' The notion of a parental couple (therapist and supervisor) can be quite containing for clients who are seen by a trainee.

Informed consent

Informed consent implies your client has sufficient relevant information about psychodynamic therapy to understand what he is agreeing to in starting therapy. It means that he understands how psychodynamic therapy works and the potential risks and benefits associated with it. It also means that he has been given sufficient information about other therapeutic models and that he has made an informed choice to undertake psychodynamic therapy. Informed consent is an area of practice that sits between litigation and good practice. The increasing requirement that we gain informed consent from clients in all forms of therapy is largely driven by the need to protect ourselves in an increasingly litigious culture.

Although the move to informed consent is largely driven by defensive practice (Hedges, 2000), there are nevertheless good ethical reasons for helping our clients to

understand the implications of what they are undertaking. Beginning psychodynamic therapy can be quite traumatic; not uncommonly, clients feel worse before they feel better, which can be distressing for them and the people around them. Sometimes therapy can uncover a previously disguised underlying depression, which if serious may necessitate time off work. Family members, friends or colleagues may need to provide greater levels of support than usual. It is not uncommon for major relationships in clients' lives to change as a result of therapy. Such changes can be positive, but there are also losses. Relationships with parents may worsen for a period of time, and sometimes other important relationships will deteriorate; this can include marital/partnership breakdown where the relationship has contributed to or maintained a client's distress. I give a 'health warning' around relationships, that there may be unpredictable changes as therapy progresses. Clients have often said to me later that they have appreciated the warning when relationships changed, particularly when they became more difficult.

The notion of informed consent is inherently complex. How informed can consent be until a client has had experience of therapy? This applies to all therapy, including those overtly working with conscious processes. Psychodynamic therapy is not like surgery, where there can be a clear explanation of the procedures involved, limited outcome options and a fairly predictable recovery cycle. We do not know what will emerge as we get to know a client and work with the unconscious manifestations of his distress. Even if we explain this to him, it is unlikely to mean very much at the beginning of therapy. I feel that there is a real danger that formally obtaining informed consent may actually have a negative effect if it inhibits ongoing negotiation between client and therapist about what they are doing in therapy.

There is also the question of timing regarding consent. Clinical governance requires that clients in the public health system are given so much information in the first session that this can negatively impact on the amount of time they have to talk about why they have come. If a client is in distress, he is unlikely to want to hear about the advantages and disadvantages of different approaches; he wants his distress heard and his needs taken seriously. Having said that, if a client asks about other approaches or the nature, risks and benefits of therapy in the first session, these issues should be discussed.

I advocate obtaining consent following a period of assessment; this gives your client the opportunity to experience what psychodynamic therapy involves. Obtaining consent in this way occurs after several sessions and requires you to think about what you consider as an 'assessment period', since psychodynamic assessment is an ongoing process throughout therapy. In addition, there is an inevitable tension between giving your client sufficient information to make an informed choice, while at the same time not doing anything that will disrupt the nascent therapeutic relationship between you.

I also use metaphor when discussing the risks associated with psychotherapy. These metaphors tend to be based in physical medicine, since it often makes more sense to clients despite the problems inherent in using medical language, which is often more definitive than we can be in psychological therapy. One metaphor concerns the need to re-set a bone which can't properly weight-bear; this requires a splint for a period of time while it is mending, after which it will hopefully work properly.

Lastly, it is important to be realistic in what you tell your client about what he can expect to achieve in therapy. While hope is an important non-specific curative factor, we cannot make absolute promises about therapeutic outcome. You will only begin to understand the real nature of the task ahead of you once you have been working with him for a while. The course of therapy is inherently unpredictable and its outcome does not necessarily reflect the severity of your client's difficulties. Sometimes a person with apparently less severe difficulties may find the work of change more difficult than someone who has more severe problems but is prepared to take greater risks in the service of getting better. If a new client asks me if he will be better at the end of therapy, I generally give a variation on the following reply: 'I can understand that you would like a precise answer to this question, but I'm afraid that I can't give you one. As yet I can't know what difficulties we will face as we work together, and I am only just beginning to find out about you and the kind of help you need. What I can tell you is that I have successfully undertaken similar journeys before, that I have confidence in this approach and that your own willingness to embark on it is very important.'

FURTHER READING

Jacobs, M. (2010) *Psychodynamic Counselling in Action*, 4th edn. London: Sage.