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A GENUINE ARTIFICE, A SPECIFIC VAGUENESS:
PSYCHOTHERAPY, PERFORMANCE, AND THE PRACTITIONER

A Dissertation

Presented to the Faculty of
Antioch University New England

In partial fulfillment for the degree of
DOCTOR OF PSYCHOLOGY

by

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April 2022

A GENUINE ARTIFICE, A SPECIFIC VAGUENESS:
PSYCHOTHERAPY, PERFORMANCE, AND THE PRACTITIONER

This dissertation, by Chris M. Defossez, has
been approved by the committee members signed below
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Antioch University New England
in partial fulfillment of requirements for the degree of

DOCTOR OF PSYCHOLOGY

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ABSTRACT

A GENUINE ARTIFICE, A SPECIFIC VAGUENESS: PSYCHOTHERAPY, PERFORMANCE, AND THE PRACTITIONER

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The following is a literature review and research project aimed at examining the performative choices psychologists make when interacting with their patients. The goal for this research is to begin to understand the “essence” of a psychologist’s experience as they present themselves in their work. Drawing from published literature on the therapeutic alliance, social constructionism, postmodern feminism, art, and aesthetics, the author argues that the therapeutic frame taken by a particular therapist can be understood as a performative act. This author examines the implications of this idea and what can be learned from conceptualizing the therapeutic alliance through a performative lens. Following this argument and review of relevant literature, the author reviews a qualitative study he conducted aimed at exploring this idea in greater depth. Using interpretive phenomenological analysis (IPA) this writer interviewed various clinical psychologists in order to more completely understand their goals, thoughts, and performative choices as they work. In doing this, the active ingredients of psychotherapy can be better understood, psychological interventions can be improved, and our understanding of both the art and science of psychotherapy is increased. This dissertation is available in open access at AURA (<https://aura.antioch.edu>) and OhioLINK ETD Center (<https://etd.ohiolink.edu>).

Keywords: psychotherapy, performance, psychology, phenomenology

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Table of Contents

Abstract	iv
CHAPTER I: INTRODUCTION.....	1
Overview and Study Rationale	4
Literature Review Preface.....	5
The Therapeutic Alliance is a Demonstrable Catalyst for Healing	6
The Alliance is Dependent on Therapist Knowledge <i>and</i> Patient Perception	8
Choosing a Persona: Bedside Manner as Performative Evidence	9
Supervision: Imitation of Technique Mirrors Performative Development.....	11
Impostor Syndrome: Isolated Malady or Performance Gone Awry?	14
Performance <i>as</i> Intervention: Interpersonal Psychology and Patient Presentation	16
Embracing Critique: Perception, Performance, and Impact	17
Summary and Support: The Performing Psychologist and Social Constructionism	19
Final Points: What are the Implications of a Performative Psychotherapy?	24
CHAPTER II: METHOD	26
Research Paradigm and Rationale	26
Qualitative Phenomenological Design.....	27
Participants.....	28
Interview Protocol.....	29
Analysis.....	30
Research Assumptions	30
Procedure	31
CHAPTER III: RESULTS	32

Summary of Superordinate Themes.....	32
View of Self as Facilitator to Emotional Experience.....	34
Psychologists are “Goal Sherpas.”.....	35
Therapy as “Road Map.”.....	36
View of Self as Auxiliary Ego.....	36
Canvas for Projection.....	37
Explicitly Performative Techniques/Interactions with Patients.....	38
Behavior in Therapy is Client Dependent.....	38
“Standard Spiels,” “Riffs,” and Body Language	41
Client’s Interpretation Supersedes Psychologist Intent	42
“Genuineness” as Strategic Intervention	43
Institutional/Workplace Values and Expectations	45
Teletherapy vs. In-Person Therapy	46
Location of Therapy Office	46
Psychologists in Non-Clinical Contexts	47
The Title “Psychologist” Influences Social Perception	48
Training Impacts Non-Clinical Conversations	49
Training Impacts Non-Clinical Relationships with Friends and Family	50
CHAPTER IV: DISCUSSION	52
Concluding Thoughts and Directions for Future Research.....	52
References.....	54
APPENDIX A: Semi-Structured Interview Questions	57
APPENDIX B: Informed Consent	58

List of Tables

Table 3.1 Superordinate and Phenomenological Themes as a Result of Analysis of Interview Transcripts.....	32
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CHAPTER I: INTRODUCTION

The real secret of magic lies in the performance.

—David Copperfield

In his 2015 text, *Strange Tools: Art and Human Nature*, Alva Noë puts forth the intriguing argument that artistic work is an inherently contemplative tool by which humans can examine activities which come naturally to us. An audience, for example, appreciates choreographed dance not because of its choreography, but because on an unconscious level the audience is reminded that humans are dancers; our social potential is organized through this natural activity. While Noë sticks to traditional mediums of artistic expression to articulate his point, his actual definition of art is broad enough to include practices far beyond the traditional. If an activity exists to facilitate contemplation around those natural organizational activities of human experience, it is an artistic one (Noë, 2015). While some critics (Otha, 2018) have concluded that such a broad definition can seem at times like “an escape from intellectual responsibility” (p. 104), I take the position that it instead opens the door for creative exploration.

This study is the result of such exploration, the goal of which is to examine the relationship between performance and psychotherapeutic intervention. While initially it may seem like there is little to be gained by conducting research on such a topic, I argue that an understanding of the therapeutic frame is incomplete without acknowledging its inherent interpersonal and performative components. While psychotherapy is of course informed by the technique, knowledge, and skill of a given practitioner, it is additionally strengthened by the ability of the practitioner to *convey* that technique, knowledge, and skill to a patient. As I will later argue in greater detail, this places significant importance on a therapist’s performative ability. A clinician is given years of training in therapeutic interventions, psychopathology,

sociocultural influences, and theories of change, but if patients are not positively affected by this training in a therapy session it is of little real use. A practicing psychologist therefore is more than the sum of their academic and clinical training. They must also possess the ability to internalize and express it to the degree that they can emotionally move another human in a live interpersonal context. In short: therapists are *performers*.

The preceding statement is a controversial one and requires some further explanation. Through this study, I do not take the stance that psychotherapy is deceptive or disingenuous. Rather, I argue that by accepting the idea that the practitioner is a performer we can better understand some of the common factors which allow for psychotherapy itself to be effective regardless of theoretical orientation. It is possible, even, that among the common factors necessary for positive psychological change, “performative ability” (that is to say: how well a clinician can use themselves in the room to meet their patients’ needs) may have been overlooked and heretofore ignored. What is more, when the social function of the artistic performance is examined, parallels to the clinical function of psychotherapeutic intervention become apparent. In both contexts, the intended result is not simply the completion of a behavioral checklist or the following of a script. Rather, both the artist and the therapist aim to facilitate emotional exploration and foster a novel experience in their audience which transcends the “scripted” contrivances which created it.

This kind of “art as experience” paradigm is well established and discussed at length in the world of aesthetic study (Dewey, 1934), and its parallels to psychotherapy are both poignant and as yet unexamined. Consider Dewey’s description of the discrete artistic experience, for example, and note how a similar statement might come from a clinician describing the power of psychotherapy. Dewey (1934) writes that artistic experiences are

so rounded out that [their] close is a consummation and not a cessation. Such an experience is a whole and carries with it its own individualizing quality and self sufficiency . . . The enduring whole is diversified by successive phases that are emphases of its varied colors. (pp. 205–206)

Would that all sessions of psychotherapy could be imbued with this kind of transformative power, that when therapy comes to a close the patient has not simply experienced psychotherapy but has instead been moved by an *experience* in both the aesthetic and clinical sense. That said, it is one thing to strive for transcendent experiences, and quite another to conclude that there is something inherent in the psychotherapeutic process which facilitates them as naturally as works of art do. This leads to two fundamental questions: How are transcendent “experiences” nurtured in the therapy room and what role, if any, does performance play in good psychotherapy?

I argue that both of these questions can begin to be answered by looking at how practitioners foster the therapeutic alliance itself, which is the principal focus of this study. Noë (2015) argued that art facilitates an examination of those organizational forces which come naturally to us. From this premise, I argue that one such organizational force in humans is our capacity to feel empathy for one another, and this is reflected in the “performance” of psychotherapy which allows a working alliance to develop. Through the “scripted” displays of empathy in a therapy room, the patient is reminded of their natural capacity to spontaneously support, and be supported, in their everyday lives. When viewed from this lens, the alliance as a whole becomes less mysterious and more accessible to study. The alliance allows for contemplation about how a person naturally relates, feels, and forms social bonds with others. It acts as a scripted microcosm of social connectedness just as surely as choreography is a microcosm of natural human expression through dance. Much has been written about the therapeutic alliance from this relational perspective (see Safran & Muran, 2009) where the therapeutic alliance is understood and experienced as a mindful meeting of two human souls, but

less has been written about how the ritual of the therapy hour itself impacts both the course of treatment, and the therapist's conceptualization of their own social role. As the recital hall impacts and dictates acceptable behavior between audience and performer, so too does the therapy office. Once the therapist becomes aware of how they are shaped by the performative "rules" of the therapy hour, their own therapeutic identity becomes clearer and easier to use in the service of healing.

Overview and Study Rationale

The therapeutic alliance has been studied extensively as a driver of therapeutic change (Krupnick et al., 1996). Research has demonstrated that psychotherapeutic outcomes often hinge on the quality of the relationship between patient and practitioner, and this sometimes difficult to observe aspect of treatment has been a topic of great interest for study. In the past, definitions of the alliance have privileged criteria which are mainly the responsibility of the patient, such as motivation or a more general "readiness for change" (Gaston, 1990). These definitions, where an alliance succeeds or fails principally due to patient choices, strike me as incomplete. While it is important to ensure that patient contributions to the alliance are accounted for, the contributions which practitioners make to the formation of the therapeutic alliance must be additionally acknowledged, as these can be controlled by a skilled clinician. Despite this, while scholars have been able to demonstrate the value of a strong therapeutic alliance (Horvath & Luborsky, 1993), little has been written about the nature of this alliance from the vantage of the practitioners themselves. As academic models of two-person psychology become more commonly accepted (Safran & Muran, 2000), it becomes important to understand the nature of the therapist's experience as they practice their craft. In so doing, the therapeutic alliance can be better understood and therapeutic outcomes improved.

Drawing on literature from the arts, social constructionism, and postmodern feminist thought, I argue that the therapist engages with the patient in a fundamentally performative role. Just as a dancer, musician, or painter operates under a set of socially agreed upon rules which guide appropriate behavior, I argue that a strong alliance is also marked by certain performative norms regardless of the intent or opinion of the clinician. It is not therapist knowledge or level of expertise which impacts clinical outcome, but the patient's *perception and awareness* of that expertise which does so (Ackerman & Hilsenroth, 2003). In this way psychotherapy, like all arts, is as much about attunement with an audience as it is about intent. Exploring how a clinician manages that attunement in the context of psychotherapy is therefore helpful.

Literature Review Preface

The following is a review of literature regarding the therapeutic alliance, privileging studies which present evidence of the clinician's performative role in fostering that alliance. Because my central argument owes much to literature published outside the purview of psychological research, I have incorporated when necessary scholarly literature from other disciplines in the hopes that the full implication of my argument can be understood and supported.

Following this review, I present the results of a qualitative phenomenological study intended to address the current paucity of information on the therapist's performative role and its usefulness in establishing the therapeutic alliance. Using Interpretive Phenomenological Analysis, my goal is to begin to arrive at the "essence" of what the therapist is experiencing as they choose to present themselves to a patient. If we accept the idea that establishing and maintaining the therapeutic alliance is in some respects a performative act on the part of the clinician, further questions arise about the components of that performance for which the

clinician is responsible. Such components include the “self” a clinician chooses to bring with them into the therapy room, changing subtly with each patient, the behavioral choices they make about language, dress, and verbiage during a session, as well as their ability to perceive, anticipate, and meet the needs of their patients. This performance is usually tailored for and evaluated by a vulnerable audience of one. A central question this research acknowledges is: Can the performer ever live separately from their art under these conditions? Is a therapeutic “persona” genuine if it is not lived outside of scheduled therapy hours? These are the questions I wrestle with and hope to begin understanding through this literature review and study.

The Therapeutic Alliance is a Demonstrable Catalyst for Healing

Since the birth of psychotherapeutic intervention at the turn of the 20th century, it was understood that a strong therapeutic alliance was essential to the overall success or failure of treatment (Freud, 2001). While treatment philosophies have evolved in accordance with shifting theoretical trends, it is generally agreed upon that without an adequate alliance between clinician and patient, overall treatment progress will be stymied.

There is ample literature to support this claim. Meta-analyses of therapeutic outcomes have found that the therapeutic alliance itself was responsible for a moderate amount of variability in outcome (Horvath et al., 2011; Horvath & Symonds, 1991). However, a more recent study and statistical analysis has been able to clarify that initial conclusion. While the therapeutic alliance remains an important factor to consider, recent data suggest that it is therapist contributions to that alliance, and not the client’s, which impact the quality of therapeutic change over time (Del Re et al., 2012). Del Re et al. (2012) conclude:

some therapists seem to be consistently better at forming alliances with their patients than others and these therapists' patients have better treatment outcomes . . . it appears that the quality of the alliance between therapist and patient is more a result of therapist actions or characteristics and therefore the therapist's role is the most important for achieving beneficial outcomes. (p. 646.)

This study and others like it (see Zuroff & Blatt, 2006; Zuroff et al., 2010) highlights the need for increased attention on the behavioral and performative choices which therapists make while working with their patients and establishing rapport. As concluded by Zuroff et al. (2010), “there appears to be robust evidence that variability between therapists in the capacity to establish constructive therapeutic relationships is a key predictor of outcome” (p. 692). What, then, goes into the formation of a strong therapeutic alliance?

Ackerman and Hilsenroth (2003) wrote that a strong therapeutic alliance is founded principally upon a sense of bondedness between patient and clinician, which allows for mutual agreement concerning therapeutic goals. If the patient does not agree or “buy in” to the process of psychotherapy and trust their provider, deleterious effects on the overall outcome of therapy have been observed (Horvath & Symonds, 1991). Additionally, research demonstrates that there are measurable actions which a clinician can take in order to ensure a strong alliance during therapeutic treatment. Helpful emotional practices from the clinician included empathy, warmth, and a sense of understanding and patience (Ackerman & Hilsenroth, 2003). Unhelpful therapeutic strategies included overly structured sessions, unyielding or forceful interpretations of transference, and the appearance of certain personality characteristics such as being distant, tense, or distracted in a therapy session (Ackerman & Hilsenroth, 2001). Taken together, it is clear that the clinician's behavioral choices have great influence over the smooth functioning of the therapeutic process. While it is impossible to ensure that all therapists are a good fit for all patients, all therapists can—and should—take reasonable steps to maximize the likelihood of a

strong working bond. The performative implications of this idea will be discussed later on in this review.

The aforementioned characteristics seen as helpful to the therapeutic alliance must be demonstrated often and early in treatment. While it may have been previously believed that initial missteps in therapeutic sessions did not have a disproportionate effect on the alliance in later sessions, research has demonstrated otherwise. Sexton, Hembre, and Kvarme's (1996) research on the therapeutic alliance has shown that most of the reported alliance remains relatively static after just one session with a clinician. While there may be some variance in overall alliance strength due to discrete ruptures and repairs over the course of therapy, it appears that a therapist's ability to "set the stage" for a working alliance is particularly important from the outset of therapy.

The Alliance is Dependent on Therapist Knowledge *and* Patient Perception

An important takeaway from these studies is that the therapist's presentation and personal contribution plays a large role in either the strength or weakness of the working alliance. Additionally, the alliance develops regardless of therapist orientation, attachment style or knowledge base (Black, Hardy, Turpin, & Parry, 2005). This leads to a conclusion with important implications: the strength of the therapeutic alliance is at least somewhat dependent on a therapist's ability to *present* themselves in the room such that the patient accurately *perceives* those operative emotional characteristics which allow for a strong therapeutic alliance (Horvath & Luborsky, 1993).

This conclusion, that the therapeutic alliance rests on a foundation of perception, is supported by a number of studies. In their 2003 study of the therapeutic alliance, Ackerman and Hilsenroth not only demonstrated the transtheoretical value in a strong therapeutic alliance, they

additionally demonstrated that discrete interventions had little overall effect on it. It appears that prescriptive interventions, such as behavioral changes or offering a psychodynamic interpretation, held little to no effect on the therapeutic alliance—even if those interventions were deemed helpful or accurate (Ackerman & Hilsroth, 2003). Rather, the only interventions which appear to affect the alliance itself were those that overtly conveyed emotional support or communicated an understanding of a patient's problems. In short, if a therapist is able to convey to a patient that they are heard, understood, and safe, then the resulting therapeutic alliance will be strengthened. Conversely, when this ability to manage patient perception is unsuccessful or ignored, the alliance suffers.

Choosing a Persona: Bedside Manner as Performative Evidence

Perhaps because effective performance is so integral to being an effective psychotherapist, the field as a whole appears to have given little attention to the idea in research. After all, the statement “one needs to communicate emotional empathy in order to provide quality psychotherapy” seems so basic as not to need further examination. But this, I believe, is an effect of the field's work being so innately tied to, and dependent on, genuine performances—rather than a true justification to let the issue lie. When a concept is ubiquitous among a group of professionals, it often persists without meaningful critique or examination; at best there is no felt need to do so, and at worst examination is halted due to a fear of inconvenient discovery. This, I think does a disservice to quality psychotherapy.

However, not all medical professionals are so innately acclimated to the idea of performing emotional work with their patients. Medical doctors, for example, are primarily evaluated on their ability to carry out the requisite tasks of their specialty; displays of emotional support while doing this have been considered a medically neutral extra. Recently, however,

physicians have been paying closer attention to the relationship between the way they present themselves to patients and overall patient outcome (West, 2012). Because of this, there is substantial research and training among physicians dedicated to looking at the difference in treatment outcomes which effective social performance can have. Additionally, there is literature detailing discrete training regarding how to best present oneself to a patient such that medical outcomes are improved (Silverman, 2012). These, I think, provide evidence for the idea that emotional performance is a component of all healing professions. What's more, they also demonstrate that such a performance can be both operationalized and studied.

Tavakol, Dennick, and Tavakol (2012) performed a descriptive phenomenological study similar in design but different in focus to the one I am proposing, wherein they examined the idea of empathy among a cohort of medical students. While themes of the study indicated that the idea of empathy remained innate to the human condition, in the context of medicine it served a special healing function. This echoes similar studies already discussed regarding the therapeutic alliance as a catalyst for positive psychological change (see Ackerman & Hilsenroth, 2001, 2003; Horvath & Luborsky, 1993), but the study went on to conclude that within the context of their role as medical professionals, the effective expression of that empathy was something that needed to be learned. What's more, students described that the most effective way to learn how to use empathy was by observing their supervising physicians and attempting to imitate and internalize those displays with their own patients. It stands to reason that to provide training on emotional performance is to admit that an emotional performance is taking place. The connection between supervision, modeling, and artistic performance is an important one to which I will return later.

While we may take for granted the importance of being emotionally skillful in the field of psychology, where presenting problems are generally emotional in nature, physicians who contend with diagnoses of a physical nature are also beginning to see the benefit of effective emotional performance. Research in the field of oncology, for example, appears to demonstrate this link (Schapira, 2013). Hendricks et al. (2019) highlighted improvement in cancer patients once a greater appreciation for the psychosocial and spiritual aspects of a patient's experience are respected by their providers. Among diabetics, Hojat et al. (2011) found that displays of empathy by their medical providers when delivering either treatment or news was linked to better overall prognosis. It is clear that effective emotional performance is a valuable skill in both the psychological and the medical world.

The key takeaway from these studies is that while empathy remains a natural human organizational force, the emotion alone is not inherently healing. Instead, its application in the healing world is a practiced, teachable skill. To once again return to Noë's (2015) model of artistic work, empathy itself is the natural organizational force, while the emotional expression of that empathy in structured contexts provides the discerning psychologist and patient with a means for examining it. I additionally argue that the modeling structure which many students use to learn the emotional skills highlighted by these studies is comparable to the process which an apprentice artist uses in the development of their own voice.

Supervision: Imitation of Technique Mirrors Performative Development

The supervisory relationships between a psychologist in training and other licensed professionals are instrumental in shaping the kind of psychologist a student will become (Falender & Shafranske, 2017). Good supervision can ensure that a student is provided with support, expertise, and examples of good clinical practice, while harmful practices in supervision

can make a trainee a less effective practitioner, suffer a wide range of emotional symptoms, or even discontinue their studies entirely (Ellis, 2001). But how might these concepts illuminate the connection between performance and psychotherapy? It is clear that supervision is an important component of any training program in clinical psychology, but this is not the only field in which close mentorships are the norm. Within circles of creative expression, there exists a defined timeline through which students of art pass as they become masters of their craft (Braembussche, 2007).

This timeline, wherein a student of art learns to identify and later imitate those important elements from a more experienced mentor, has been observed to be instrumental in learning discrete artistic techniques. What is more, Okada and Ishibashi (2017) observed that by first learning to copy the techniques of another artist's work, creativity and originality increased when students were later instructed to create a new, un-imitated piece of visual artwork. This process, whereby imitation of a given work leads to integration, understanding, and later divergence from the influences which preceded it, is reflected in medical training research (Tavakol et al., 2012). Particularly interesting about this 2012 study of medical students and their experiences of empathy is that while data indicated that these students unanimously believed that it could be taught, didactic lessons about effective emotional performance and empathy were deemed to be less relevant to their own burgeoning caseloads. Instead, like all work with an element of performance to it, direct observation and experiential practice were the two most suitable methods to aid in learning.

In addition to providing important scaffolding and examples of competent emotional performance, supervisors are also instrumental in helping their trainees ensure that they are able to confront and manage the costs which emotional labor can exact. While such costs can include

feelings of burnout, stress, or anxiety when working with patients for the first time (Falender & Shafranske, 2017), supervising clinicians provide an additional means of support which is of particular import to becoming comfortable in their new professional role: normalization of experience (Barnett, Erickson Cornish, Goodyear, & Lichtenberg, 2007). When beginning to practice therapy, trainees are faced with questions about their choices with patients and whether or not their interventions are effective, but most common are fears that they are somehow “missing” an essential element required for the role (Barnett et al., 2007). By providing their trainees with frank, helpful, and direct insights into their own feelings about their performative role, a supervisor helps to communicate to their trainee what an effective psychologist looks like. While sometimes overlooked in supervision sessions due to more pressing concerns in the caseload, providing effective guidance on the expectations and norms of their new social role can help to increase a trainee’s confidence in their ability to fill that role. This, in turn, leads to a more effective student clinician (Falender & Shafranske, 2017).

The preceding paragraph begins to highlight what I believe to be a particularly important aspect of performative development. When a performance is new, whether artistic or clinical in nature, that performance often exists in a state of “otherness” to the practitioner’s identity. Movements may be clumsy, words less precise, and prevailing feelings of anxiety occur not because of what is happening externally, but because the neophyte performer does not know how their *internal* selves will authentically handle those external experiences. This fraudulent feeling has been coined “impostor syndrome,” and has been described previously as a problem of identity (Chandra, Huebert, Crowley, & Das, 2019). However, I believe an equally compelling perspective is gained when the idea of “impostor syndrome” is viewed as a matter of effective performance.

Impostor Syndrome: Isolated Malady or Performance Gone Awry?

The concept of “impostor syndrome” is not unique to the field of psychology, although it is a common occurrence among psychologists both licensed and in training. Marked by significant fears that they will be discovered by others as either lacking in skills or otherwise incompetent, impostor syndrome saps a person’s confidence and hinders their overall ability to perform at whatever their given job may be (Chandra et al., 2019).

It might be thought that impostor syndrome is generally remedied through experience because prevailing wisdom states that skill and confidence increase over time. But if it were true that both time and experience were remedies to the impostor syndrome, then it would be logical to expect that impostor syndrome as a whole would decrease in frequency as experience increased among any given group of professionals. However, this has not been observed in the literature. In fact, there are many instances where impostor syndrome actually becomes more likely during those times when one’s experience or skill has been recognized and rewarded with either an increase in power or prestige (Chandra et al., 2019).

Why might this be occurring, and what does it have to do with this overarching discussion about performance, psychotherapy, and the therapeutic alliance? Briefly stated, I believe impostor syndrome occurs when someone is required to give a social performance which does not yet feel genuine. Like the actor who reads her character’s lines without yet internalizing that character’s motivation, so too can a psychologist sit with a patient, offer them what appear to be best practices for a given presenting problem, and still feel as though there is something amiss in their delivery. Rather than a performance which feels both genuine and natural, impostor syndrome ensures that a performance feels stiff, cautious, and somehow false. It is an emotional performance which *feels* like performance, comparable to an improvising musician who wants to

connect emotionally to the notes they play but who is instead concerned with remembering their scales. When the anxiety and negative emotion of impostor syndrome are stripped down, the dominant feeling of is one of fraudulence, and who is a fraud, but someone who gives a disingenuous or deceptive performance?

While impostor syndrome can cause a psychologist no small amount of discomfort while they work, we do not yet know whether or not it affects the quality of that work. Consider my previous argument, that the therapeutic alliance is not dependent on the knowledge of a clinician, but instead on the patient's perception of their clinician. So long as a therapist can function in their performative role and effectively facilitate the requisite social requirements, it stands to reason that an adequate therapeutic alliance will develop regardless of a clinician's opinions. While this bodes well for my conclusion that psychotherapy functions as, and can be evaluated like, a performance, it leaves the interested researcher with questions for further examination—especially in regard to how the alliance can be (and often is!) maintained despite possible feelings of fraudulence on the part of the provider. Such questions for study will be discussed in greater detail later on, though I will highlight some of them here:

How often are conversations about impostor syndrome occurring in the context of the supervisory hour, and if so, how are those conversations contextualized? Is there room for discussion of how to both acknowledge the performative reality of psychotherapeutic work while also feeling genuine when working with patients? Finally, what can be done to ensure that regardless of whether impostor syndrome is occurring, *feelings* of a disingenuous performance do not actually lead to becoming a disingenuous performer with patients? In short, how can we use the lens of performance to the collective advantage of both ourselves as practitioners and our patients as individuals?

Performance as Intervention: Interpersonal Psychology and Patient Presentation

If there exist interventions in the world of clinical treatment which require discrete performance in order to be effective, it is important to acknowledge them. As such, I highlight the literature of interpersonal psychotherapist Carson (2009) and his views of treating psychopathology by occupying specific interpersonal spaces with clients. Carson argues that because psychopathology often manifests itself in interpersonal contexts, interpersonal responses by the clinician can work to offset and direct a patient's behavior towards more flexible and healthy expression. In order to do this, he uses Leary's (1957) interpersonal circle in order to assess where his client is operating and to assess effective interpersonal responses to the patient's presentation. In order to be effective, it is paramount that the clinician does not respond to the patient such that reinforcing enactments are perpetuated, but instead to present in such a way that pathological interpersonal behaviors can be corrected. It follows that in these situations the interpersonal psychologist might need to present in a way which is unfamiliar, uncomfortable, or unnatural to how they would normally behave in session. They have effectively been tasked with the requirement to *perform* certain interpersonal roles such that their patient can improve themselves through the process (Carson, 2009).

While not all psychologists practice from this interpersonal vantage, where conceptualization and psychopathology are essentially relegated to the realm of observable behavior, it remains true that all psychologists need to pay attention to how their own presentation may potentiate or stymie their patient's progress. As I have tried to demonstrate through this literature review, performance matters in psychotherapy, and as yet there has been little real study on the subject.

Embracing Critique: Perception, Performance, and Impact

Before continuing on to the details and procedure of my study, it is prudent to review the argument on which it is based and to address those points with which some may take issue.

Though I have attempted to present my ideas in as complete a manner as possible, I remain aware that examining psychotherapy through the lens of performance may seem so controversial as to inspire outright dismissal. However, progress often requires a shift in perspective, and I hope now to answer the most important question for any new study—especially one which rests on a foundational bedrock of potential controversy: *Why do these ideas and arguments matter?*

While I have presented my theoretical case and argued for its legitimacy, the question of relevancy remains an overarching concern. There may be similarities, and even some logic, to viewing the formation of the therapeutic alliance and the practice of psychotherapy as a performative enterprise, but besides being an amusing or novel perspective, where is the clinical utility in adopting these views? My answer to this question gets at the heart of why I began this line of inquiry in the first place: because doing so can help to ensure that more patients receive quality care.

Consider the differences in focus between a therapy founded on the idea of skillful performance and one which is instead founded on the more traditional idea of clinical expertise. In the latter, a psychologist practices from the vantage of their own education. They view presenting concerns through a theoretical orientation (which has, itself, norms regarding acceptable self-presentation) and patients who are not receptive to interventions are often gently guided elsewhere due to an explanation of “lack of fit” with the psychologist’s chosen treatment modality. In contrast, from the vantage of performative psychotherapy the therapist has a greater responsibility not just to provide the kind of care with which they are comfortable, but also to

actively assess the kind of therapist their patient requires, and to work to adequately present themselves in that manner. The excuse of “poor fit” in order to filter patients is no longer as relevant, because from this perspective it is one of the clinician’s primary roles to *foster* an adequate fit with their patients, rather than leaving it up to chance.

As clinicians, it can become easy in the midst of the myriad other stressors present when practicing good psychotherapy to forget the sometimes months-long process it may take for a new patient to enter a psychologist’s office: insurance companies must be navigated, several different clinicians sought out before finding someone who is taking new patients. Even when a clinician is found there may be wait times for an intake of up to and exceeding one month. Imagine the depressed patient who is able to navigate all of these unintentional obstacles for treatment, who is seen by a psychologist for three weeks before being told that it would be in their best interest to start the process over again with a provider deemed to be a “better fit.”

Even if referrals were provided, it strikes me as likely that a depressed patient in this scenario becomes so discouraged as to discontinue seeking out further psychotherapy for their condition. This, I believe, is an unfortunate and largely avoidable series of events—provided the clinician recognizes the importance of their adequate emotional performance. If with each new patient clinicians adopted a mindset of “How can I best increase the likelihood that I am a good fit for this patient,” instead of “Will this new patient be a good fit to work with me?” I believe therapeutic alliances as a whole might become more easily established across the field.

Of course, it is unreasonable to suggest that all practicing psychologists are now fully responsible for ensuring an adequate therapeutic bond with all of their patients. I do not pretend to think that there will be no instances where a poor fit between psychologist and patient will occur. In fact, to do otherwise dismisses the psychologist’s ethical obligation to only practice

within their established competencies. However, in reviewing literature on the formation of the therapeutic alliance, I have found that the onus of a solid working alliance is often placed on factors which privilege patient choices and release clinicians from responsibility of fit. Items such as “readiness for change” or “motivation” are often said to be relevant criteria for establishing a therapeutic alliance (Gaston, 1990). However, studies which offer these explanations do not acknowledge the real possibility of how a clinician might influence those patient factors. “Motivation for change” is a patient factor which undoubtedly affects the likelihood of a solid working alliance to form, and it is also something which a clinician who is aware of their performative power can influence for the better. I return to the first studies highlighted in this review, which demonstrated the importance of therapist contributions to a strong therapeutic alliance. Del Re et al. (2012), Zuriff et al. (2011), Zuriff and Blatt (2006), and others not specifically highlighted (see Baldwin et al., 2007), have given the interested practitioner much to think about regarding the therapeutic self, as well as how they can best maximize their clinical outcomes through consideration of their own respective performances. Arriving at a greater understanding of how the psychologist uses themselves in the room in order to maximize their patient’s likelihood for positive change is a relevant clinical concern, and if this study reveals that psychologists are not currently reflecting upon this topic, I propose that more time in training should be allotted to it.

Summary and Support: The Performing Psychologist and Social Constructionism

Thus far I have attempted to demonstrate that there is proof in the literature which shows that the strength of the therapeutic alliance is a major factor in overall patient outcome. Additionally, I have tried to highlight literature which indicate salient therapeutic factors which help to establish that alliance. The fact that the literature appears to show that an alliance is not

based on a therapist's knowledge, but instead their ability to help the patient perceive a critical level of compassion, empathy, and warmth, leads to the conclusion that the quality of the therapeutic hour is not defined by the depth or complexity of a therapist's interventions. It is instead an hour wherein one person uses themselves in such a way as to facilitate a transformative experience in the other. Using the conclusions of Noë (2015) and Dewy (1934), the therapeutic hour is, in effect, an artistic performance.

This idea presents the interested researcher with several potential avenues of inquiry. How do psychologists handle the issue of performance in their interventions with patients? How might trainees be taught to become comfortable with developing a professionally competent and warm performative self? How do we assess the kind of self-presentation our patients will find most helpful? How can we work to ensure that our performative selves feel genuine to both our patients as well as to our own internal self concepts? And most importantly, are these questions already in the practicing psychologist's mind, and is there benefit to having those answers recorded?

As an aside, it is also important at this point to reiterate that I am not using the word performative to suggest "false" or "disingenuous." It is an unfortunate misconception that paying attention to, and tailoring, one's external presentation is sometimes viewed as a betrayal of a static, genuine, and overarching "self." Rather, as Wynn (2018), Butler (2007), and K. Gergen and Ness (2016) have highlighted, all social roles have an element of performance to them, and different contexts require different performances. The true self is protean, and to claim an identity is to acknowledge and conform to the agreed upon norms of that identity. A person can call themselves a doctor, for example, but without convincing society that they fit the requisite social criteria of the role, they will have a difficult time gaining employment as one (Wynn,

2018). In the case of being a practicing therapist, those social criteria are dictated and enforced by both the field of Psychology as a whole in addition to the patients who seek out services.

While performative expectations certainly exist in every social role (as previously noted, doctors are known to be trained in their “bedside manner”), I reiterate here that there is an inherent connection between skillful social performance and good work as a therapist. A surgeon, for example, may see improved overall satisfaction from her patients if they work hard to maintain a compassionate, empathic stance, but that stance is secondary to their technical skill. No surgery patient wants a compassionate performance at the expense of a skilled technical performance. But in psychotherapy performing compassion *is* technique. Without communicating understanding and the ability to hold a patient’s reported experience, effective psychotherapy simply is not happening. Because adequate social performance is, in effect, essential to the task of psychotherapy, it cannot be relegated to ancillary status, as might our surgeon do with their bedside manner. It therefore behooves the researcher to understand in greater detail how psychologists approach their “performative selves,” both as they work and as they live their lives outside the therapy office.

The argument I am putting forth, of therapist as performer and therapy as performance, is essentially a social constructionist one: Just as social constructionists understand the concept of meaning making as being created within social contexts (M. Gergen & Gergen, 2011), I argue that the meaning of being a psychologist is likewise created within the complex contextual interaction between practitioner and patient. From this perspective, the psychologist no longer occupies a single, objective role which is impartially presented to each of their patients. Rather, the psychologist collaborates with each of their patients to make sense of what their role will look like. A skilled therapist will understand and communicate an understanding of their

patient's needs in the form of skillful emotional presentation. This, I think, is the essence of the therapeutic performance.

In K. Gergen and Ness' (2016) writing on therapeutic practice as social construction, we see many ideas which compliment those I have presented in this literature review. As our understanding of psychotherapy moves away from essentially modernist and diagnostic paradigms of treatment and towards a more context-dependent, collaborative view of mental health, practitioner flexibility will become an increasingly important trait. Meeting a patient "where they are at" is no longer an issue of treatment: it has become an issue of practitioner presentation. As K. Gergen and Ness (2016) argue, "The skilled therapist . . . might be as much at home speaking the languages of romance, the street, the locker room, or the nightclub as mastering the nuances of Lacanian analytics" (p. 7). The patient's needs determine the language of therapy, and a skilled practitioner will alter their presentation such that deeper therapeutic work can take place.

K. Gergen and Ness (2016) have additionally highlighted the idea that it is presentation, and not knowledge, that defines competent psychotherapy. Where previous generations of psychologists were tasked with identifying the root cause of a discrete problem and coming up with a solution based on their years of study, psychology from the social constructionist school need not take such a narrow or authoritative role. Rather, skilled psychologists are possessed with the ability of "knowing *how* as opposed to knowing *that*—of moving fluidly in relationship, of collaborating in the mutual generation of new futures" (K. Gergen & Ness, 2016, p. 10). What K. Gergen, Ness, and other social constructionists are suggesting is that theoretical knowledge as a tool is helpful only insofar as it can be effectively dispensed in the context of each unique therapeutic dyad. Understanding how therapists use the combination of their clinical knowledge

in tandem with their individuality as people is therefore an important, and as yet unstudied, area of academic inquiry.

Additional support for this line of thinking comes from postmodern feminist thought. Gender and gender expression, in particular, have been conceptualized in ways which are easily translatable to the idea of psychological performance. Postmodern feminist Judith Butler (2007) writes that gender is something which a person “becomes,” rather than something into which a person is born. Masculinity, femininity, and related gender expressions are not innate. Rather, they represent a socially agreed upon “identity instituted through a *stylized repetition of acts*” (Butler, 2007, p. 519). A man, for example, is not a man simply because he says so. He becomes a man by “performing manhood” and demonstrating external actions and characteristics which are generally agreed upon as falling under the “male” societal construct. Similarly, one can argue that a psychologist is a psychologist not simply because they say so, but because they have worked with their patients to construct and then perform what it means to be a psychologist in that particular context.

When viewed as belonging to the social constructionist school of thought, these ideas of therapeutic performance become somewhat less radical. Because social constructionism is, at its core, simply a theory of knowledge and does not present itself as an objective truth (M. Gergen & Gergen, 2011), one can examine the utility of viewing the practice of psychotherapy through a performative lens without casting aspersions on those who do not see the necessity of doing so. In writing this argument I am not suggesting that the performative perspective ought to replace or supplant other dominant forms of psychological thinking. I instead wish to explore an aspect of treatment which, up until this point, I have found to be dismissed and understudied. What we do as psychologists—the words we say, why we say them and to whom—comprises the lion’s

share of the important work we do. By the end of this study I hope to have data available for practitioners to examine so that they may present themselves as effectively as possible to their patients.

Final Points: What are the Implications of a Performative Psychotherapy?

If the ideas of K. Gergen, Ness, Butler, and the performative social constructionists are reasonable, then the practicing psychologist is not someone who only possesses a license or a degree. These initial prerequisites are necessary, but insufficient to truly embody all aspects of the performative role. Instead, the practicing psychologist is someone who performs the life of a practicing psychologist. They have integrated and internalized the social expectations of the role and, importantly, those with whom they interact *perceive* this integration to be genuine. In an ideal world, when a therapist conducts a structured interview, displays empathy, or articulates a nuanced understanding of a patient's distress, they do so with the same genuine artifice as the master dancer performing a choreography, or a painter capturing the sunset. Done properly, the audience is left feeling a sense of transcendence after these kinds of performances, as if their life has been changed through the mere act of experiencing them. While the psychologist's job is not simply to elicit emotions for the purposes of enjoyment, theirs is still a task of emotional transcendence.

I have presented a case for what I call the perspective of therapeutic performance. I have highlighted gaps in the literature which demonstrate avenues for potential for study, as well as literature which compliments my line of thinking. Finally, I have addressed what I believe to be likely objections to these ideas and established a level of relevance for study. This review now concluded, I argue that, like all performances, sophistication of technique is facilitated through the careful examination of the performer's experience, and I present the following study as a

means to that end. Briefly summarized, the purpose of this study is to examine the essence of the psychotherapeutic performance from the perspective of the practitioner. While there have been many studies citing the importance of patient perception in the context of the therapeutic alliance, comparatively little has been written about how the therapists themselves go about *fostering* that perception in the therapy room. In this research, I used the idea of psychotherapy- as-performance to study the specific words and presentations which psychologists can use with their patients to foster meaningful change. By examining the therapeutic alliance in this way, the therapist's *in vivo* experience with their patients is revealed in a way which the current literature has not yet considered.

In this study, I am principally concerned with the following overarching questions: Is the clinician's performative experience congruent with their life outside their practice? How does a clinician work to ensure rapport with a patient using their performative stance? And most importantly, does a *desire* to appear genuine interfere with a practitioner's ability to feel as if they are being genuine with their patients? Does this matter?

CHAPTER II: METHOD

Research Paradigm and Rationale

Throughout this literature review, my argument has centered around the idea that psychotherapy as we currently understand it is more than adherence to standardized psychological interventions given to address standardized manifestations of psychological distress. In choosing to view psychotherapy through a performative lens, I argue that there is a social process of attunement between therapist and patient necessary for positive psychological change to occur. I additionally argue that it is the therapist, and not the patient, who is principally responsible for ensuring the effective functioning of this social process. Viewing psychotherapy in this manner necessitates a shift from treatment paradigms which view psychotherapeutic intervention as an objective process over which the clinician has no meaningful influence. Instead, I argue that the “active” ingredients in a given therapy regimen are unique—socially created and experienced between clinician and each new patient. For this reason, this study is structured according to the social constructivist paradigm (Creswell & Poth, 2013; Mertens, 2021).

In my research, I am concerned with better understanding the phenomenology of the psychotherapeutic process, and in order to better understand this process, effective research must open itself up to the myriad socially constructed realities between clinician and patient which allow for change to take place. The social constructionist paradigm is well suited for creative or investigative research pursuits, especially those wishing to better understand how social context creates or influences a given understanding. In choosing the social constructionist paradigm, I am maximizing my opportunity to examine and understand the questions which I have raised concerning therapeutic performance, therapist perception, and the therapeutic alliance. This

study utilized a qualitative research design consisting of semistructured interviews and later interpretive phenomenological analysis of those interviews (see Smith, Flowers, & Larkin, 2012). This is in keeping with my overall goal of the study, which concerns understanding the socially constructed (and socially performed) components of effective therapy, as well as how therapists create and use themselves in the context of their therapeutic interventions with different clients.

Qualitative Phenomenological Design

This study is structured according to a phenomenological design. Phenomenological research is most concerned with a participant's lived, subjective experience of a given phenomenon, and strives to collect data while suspending preconceived scientific or empirical explanations of that phenomenon (Mertens, 2021). Specifically, the phenomenological lens uses reductive reasoning to distill a central truth or theme from among a diverse set of qualitative data such as interview transcripts (Creswell, 2013). Through this process, a nebulous or undefined concept can begin to be understood in greater detail than might have been possible from a strictly empirical or quantitative study design.

In this case, the phenomenological lens is aimed at understanding a therapist's lived experience as they work with a patient in the therapy room. As was highlighted in the literature review, I am particularly interested in those experiences where the therapist feels that the idea of performance affects their decision making process when working with a patient. This performative process is most readily apparent in those situations when there are several potential ways to approach a given presenting problem. In those cases, the clinician must use their clinical skills to suss out and present themselves such that their words are well received. I specifically examined how participating clinicians understand the use of their clinical expertise not simply to

offer interventions, but also how to deliver those interventions to a diverse caseload.

A phenomenological research design is well suited to parsing out nuanced information from participants which may not have been readily apparent by looking only at quantitative data. Among other qualitative approaches, the phenomenological method distinguishes itself due to its ability to analyze data from multiple participants and arrive at a concrete narrative despite different sources of information. This study used phenomenological analysis to both gain new knowledge about the therapist's experience of—and contributions to—the therapeutic alliance, and to examine how the issue of performance affects that alliance.

Participants. For a feasible dissertation project, a convenience sample was used: the participant pool of this study was limited to licensed and practicing clinical psychologists. The sample for this study was comprised of a group ($n = 10$) of licensed clinical psychologists. I used snowball/chain recruiting methods in order to arrive at my desired sample size. While this allowed for the execution of the experimental design without insurmountable logistical hurdles, it nonetheless had an effect on the overall sampling frame, which has in turn impacted the scope of overall results. Due to demographic realities, the sampling frame in this study was comprised of predominantly white participants of comparative means, and this fact should be kept in mind when making more general inferences about any data collected. Additionally, some participants were affiliated with Antioch University New England either as former students or professors.

In order to examine the effect which performative factors have on practitioners across various experience levels, I recruited participants from different stages in their clinical careers. Overall experience levels in the sampled cohort ranged from newly licensed (less than one year) to having over 40 years of clinical experience as a practicing psychologist.

Interview Protocol. The interview was conducted in a semi-structured format, aimed at understanding specifically a participant's subjective experience as they engage in psychotherapy with a patient. In order to ensure both verbal and non-verbal communication was understood and collected, interviews were conducted via secure video teleconference and recorded, except for two instances where technological difficulty meant that only audio could be captured. Initial questions inquired as to the therapist's general stance on establishing the therapeutic alliance with a patient, and later questions built on this idea in order to include how their performative "role" intersects with different aspects of their life. The interview also addressed the clinician's experience of "impostor syndrome," and whether or not such a phenomenon's existence or lack thereof affected the clinician's perception of therapeutic performance. I was concerned primarily with how participants considered their presentation in the context of their several different patients. Based on initial responses, participants were prompted with further questions to ensure that their individual thought processes were best understood. The following standard interview questions were used, with unscripted follow-up questions employed as needed to gather details.

1. When you meet a patient for the first time, how do you present yourself?
2. How do you understand your patient's immediate therapeutic needs in the room, and how do act to address those needs?
3. Do you find yourself following a 'script' during initial sessions?
4. What does "impostor syndrome" mean to you?
5. How does a patient's presenting demeanor influence the therapeutic stance you take with them?
6. How do your therapeutic interventions for the same presenting disorder differ between clients?

7. How does your social role as a psychologist impact your interpersonal presentation outside of work?
8. What does being a psychologist mean to you?

Analysis. This study employed interpretive phenomenological analysis (IPA) in order to make inferences about the collected data (Smith 2011; Smith & Flowers, 2009). Once the interviews were completed, their content was transcribed and reviewed. This qualitative analysis first examined the transcripts for emblematic or definitive statements which were coded according to subject matter. Once all the interviews were reviewed in this manner, the coded statements from each interview were aggregated. Phenomenological themes were then taken from these coded statements, and thematic codes from across all interviews were organized into a table by subject matter, drawing conclusions about the essence of the psychologist's experience while they work with their patients.

In order to maintain, as much as is possible, accuracy in the coding of these statements, a separate document detailing the rationale behind emerging themes, as well as operative quotations was reviewed by a third party. In keeping with the goals of a phenomenological research design, these interviews and subsequent analysis are intended to help provide a foundation of data such that the essence of the phenomenon of performance, psychotherapy, and the therapeutic alliance can be better understood.

Research Assumptions. Assumptions by researchers have the potential to affect the results and relevance of any collected data. While some bias in research is inevitable, its effect can be mitigated through increased researcher transparency. In this case, I come to this research with a background in the performing arts, and while I maintain that the performative factors I have highlighted in this proposal are both relevant and important, my passion and background in

performance itself doubtless influences the perspective I bring to the practice of psychotherapy. I kept a journal of my thought processes as I coded their responses for others to review, so that my line of thinking as I analyze data remains as transparent as possible. The process of coding interview statements will additionally be peer reviewed by impartial peer sources.

Procedure

I first recruited participants using snowball/chain techniques and scheduled interview times. Interviews were recorded and transcribed as they occurred. During the interviews, I attempted to gain an understanding of participants' lived experiences in the therapy room as they worked with their patients. I paid special attention to the interplay between a therapist's perceived expectations of the patient in addition to how the experience of "impostor syndrome" may affect the choices that a clinician makes in the room. Once interviews were completed, they were coded, themed and analyzed. Finally, results of the qualitative analysis were written up and used in the service of understanding the relevance of performative factors in psychotherapeutic work.

CHAPTER III: RESULTS

Table 3.1

Superordinate and Phenomenological Themes as a Result of Analysis of Interview Transcripts

Themes Regarding the Psychologist's Use of Self in Therapy
View of self as facilitator to emotional experience
Psychologists are "Goal Sherpas"
Therapy as "road map"
View of self as Auxiliary ego
Canvass for projection
View of self as someone who understands common human experience, suffering
View of self as guide
Explicitly Performative Techniques/Interactions
Behavior in therapy is client dependent
Client's presenting symptoms
Client intersectional Identity
Client's prior therapy experience
Intentionality in word choice/phrasing/body language
Prepared language "Standard spiel" with clients
Client's interpretation supersedes psychologist intent
"Genuineness" as strategic intervention
Modeling emotions they want client to express
Factors Impacting Therapist Behavioral/Performative Choices with Clients
Institutional/Workplace Values & Expectations
Teletherapy vs in person therapy
Location of therapy office
Psychologists in Non-Clinical Contexts
Clinical training influences social perception
Training impacts non-clinical conversations
Training impacts non-clinical relationships positively and negatively

Summary of Superordinate Themes

Through the combined interviews, four superordinate thematic categories were discovered in respect to the topic of psychotherapy, therapeutic performance, and the

practitioner's use of self. The first group of themes concerned the psychologist's view of their role within therapeutic encounters, with the most commonly reported idea being that the psychologist uses themselves in an emotionally facilitative role with their clients. Additional themes regarding use of self include psychologists as people who understand universal human experiences, as well as the many facets to suffering. The idea of being a guide, rather than a repair-person, was evident throughout interviews.

Participants additionally revealed several themes falling under the category of explicit performative techniques and behaviors. These behaviors and techniques were used to increase the odds of facilitating the aforementioned emotional experiences with patients, and were most often associated with establishing rapport or helping a client to feel seen, heard, or understood. These included shifting their behavior based on a patient's presentation, intentionally and strategically using verbal and non-verbal language in order to align with a patient, and using the expression of genuine affect in order to healthily model and allow their clients to express that same affect.

Throughout the interviews, participants spoke of specific emotions or components to psychotherapy which they believed were their responsibility to deliver to the patient. These emotions included warmth, friendliness, safety, as well as attuning to and aligning with their patients through their behavior in the room. These were often the emotional experiences which psychologists wished to facilitate in their clients through their performative technique and included warmth, safety, empathy, and kindness.

Interestingly, outside of the *in vivo* experience of giving psychotherapy, participants identified several external factors which also impacted their presentation with clients, sometimes to positive and sometimes to deleterious effect. These most often included the workplace culture

of that participant's practice, but also included consideration for third parties such as insurance companies. Additionally, place and the method of therapeutic delivery (i.e., in person vs. virtual services) were believed to have an impact on the way which participants interacted with their patients. While almost all participants acknowledged experiencing impostor syndrome at one time or another, none of them endorsed that this internal experience currently impacted their ability to deliver quality psychotherapy to their patients. Rather, it was most often felt during evaluative situations, such as case presentations or interviews. Participants described potential remedies to impostor syndrome through the use of supervision, self-acceptance, and being genuine with their patients.

A final group of themes concerned the psychologist's experience with others outside of clinical contexts. There was a mixture of positive and negative emotional reactions to this, though the belief that psychological training changed how participants perceive others and how others perceive them was consistent throughout.

View of Self as Facilitator to Emotional Experience

All 10 participants spoke of how, while performing therapy, they understood their role in the room to be a facilitator of some kind of emotional experience with their patient. For some, these emotional experiences were connected purely to building rapport before more concrete skills training, while in others these emotional experiences served as the main driver in their patient's healing. This use of self-as-emotional-facilitator was apparent in psychologists who described themselves as primarily psychodynamic as well as those who described themselves as cognitive/behavioral. Often, before any interventions or skills were offered in therapy, participants were first concerned with facilitating a positive emotional experience in their client, as such an experience would be the foundation upon which the therapeutic alliance would rest.

As interview participant 7 stated:

Their immediate therapeutic need when they meet us is to be validated, to be heard, to experience empathy and to have a sense that things are gonna be alright, that there is some kind of a path forward. And that is true if the person is sitting in front of me with a panic attack, a sexual assault, a, you know, an episode of psychosis, it really is all the same . . . A lot of times they're not ready to give to give all that information or to tell me everything. They want to feel something and experience something and that's what they need. (pp. 2–3)

For some participants, this initial emotional experience of empathy opened the door to more directive interventions, as participant 6 explained, “I think empathy is magical. There's really something to being understood um, and communicating that you're not alone, but then having the next step of that is having skills to try and function better” (p. 3). For others, emotional experiences in therapy were believed to be healing in and of themselves. “I think there is just value in just them telling their story and having the therapeutic experience of us listening or reflecting or summarizing. And that can be more powerful than we realize too” (participant 10, p. 4). The most often repeated phrase regarding the kind of initial emotional experiences that participants wished to convey involved feelings of warmth, empathy, kindness, safety, and openness.

As participants described their views of themselves as they worked in the room with clients, a number of apt metaphors surfaced which highlight the idea of psychologists functioning as emotional facilitators. These metaphors highlighted both key therapeutic functions, as well as how they hoped to be of service to their patients.

Psychologists are “Goal Sherpas.” Participant 2 highlighted that one of her patients called her a “sherpa” in therapeutic work, stating:

I feel like my job is to be their “goal Sherpa” and to show them that they can do it even though . . . you show them imperfect humanity. Like I've known . . . I think that's really important to me. That like yes I can show you where to go, what to do, what works for most people really, or like pitfalls but that like everyone needs that and that doesn't mean

that I don't need a sherpa ... A client actually dubbed me her sherpa and it was such an honor. Like dear diary best day ever. (p. 11)

In this statement, the role of the psychologist is being compared to a sherpa, one who guides, carries, and aids a person as they climb mountainous and sometimes dangerous terrain. Important to note here is that while in the world of climbing, sherpas often use themselves in service to their clients without receiving help of their own, this participant has made it a point to indicate that her humanity and vulnerability also serve a therapeutic function in this context. She is able to model vulnerability such that her clients feel safe enough to in turn be vulnerable with her. This kind of "strategic" genuineness appeared to be one of the key performative tasks of the psychologist, and this is a theme to which I will return later.

Therapy as "Road Map." Participant 9 described therapy as being a kind of "road map" for her patient. She explained:

I have a road map to help them . . . and then that translates when they don't need me anymore they don't have access to me, they can say well what's the map here ... what do I need to be doing . . . the more I practice the more I see us humans as having universal experiences and umm . . . it can be really therapeutic to let clients know like I don't have all the answers...I don't, you know, I might have a map here . . . but a map is still something we need to practice finding . . . like how do you discern which value you're gonna act on right here? (pp. 2, 9)

What was apparent in this metaphor is that, like the previous participant, it allowed for the therapist's fallibility to be acknowledged, not as something to be ashamed of, but instead as a way to facilitate empowerment in the client's own decision-making ability. Thus, through a combination of the therapist's knowledge, confidence, and presentation, she is able to work collaboratively in sessions with her patients such that they feel what they need to in order to move forward.

View of Self as Auxiliary Ego. Participant 3 was more explicit in explaining how she saw herself as a facilitator of emotional experience and client need, stating that she functioned as

an “auxiliary ego” for her clients, from which they can draw strength. “Can they use my auxiliary ego in a way to feel some hope? And I’ll be that” (p. 2). This is an interesting phrase, suggesting that during difficult moments in therapy sessions, clients are free to draw on and experience, not just their own inner strength, but also that of their therapist. In these moments, the facilitative role of the psychologist is inherently tied to their presentation and behavioral choices. In order to “walk the impossible journey” (participant 5, p. 13) with a client in this way, it is imperative they are able to present themselves such that the client understands the significance of the support being offered.

Canvas for Projection. Participant 5 was able to articulate his role of emotional facilitator as a function of his psychodynamic training, stating that he understood his role in the room was a function of the common human experience of turning unknown people into projections of the people they knew. He was then able to leverage these projections in order to arrive at treatment hypotheses and conceptualizations, stating:

So you’re getting both, you’re getting, they’re reacting to you, they’re reacting to you as a function of their own setups, their own object relations their own transference, and they’re seeing you as you really are as well, so there’s two categories there. . . . We dress people and make them actors in our drama, that’s what we do, and that’s the most important piece for me, especially initially. Who I am is less of an issue in my mind. (p. 6)

The concluding statement “Who I am is less of an issue in my mind” is a significant one because it articulates the implicit belief that in psychotherapy, the clinician’s own identity is secondary to the view which the patient has of them. This simple idea is the foundation of the entire suite of performative behaviors and techniques which participants discussed in their interviews, which will now be further examined.

Explicitly Performative Techniques/Interactions with Patients

All participants, regardless of orientation or experience level, remarked on at least some aspect of performativity associated with their work providing psychotherapy to their patients. Even among discussions about the importance of being genuine and authentic, where it could be assumed that no performance was taking place, it was apparent that even these displays were moderated—either with a facilitative goal in mind, or because the act of genuineness itself was performing a healing function. As discussed in the literature review, these “performances” in the room were not intended to be disingenuous or deceptive, and participants highlighted that true deception or dishonesty would be both counterproductive and harmful. Rather, therapeutic performance appears less about a psychologist becoming something they are not, and instead a careful control of which aspects of themselves and their emotions they choose to reveal. The most common way participants utilized performance in therapy was not in deception, but in *intentionality*. What became clear after a close reading and re-reading the interview transcripts was that a therapeutic space is a *curated* space. Psychologists spoke at length about the ways which they utilized themselves, their language, and even their understanding of the client strategically and not at random, all in service to the client’s therapeutic needs. Emerging themes around participants’ relationships to their therapeutic performance will now be examined in greater detail.

Behavior in Therapy is Client Dependent. The most common and repeated theme regarding therapeutic performance concerned the idea that how a psychologist speaks and behaves in a session is at least somewhat dependent on the client who they are currently seeing. Whether a client’s clinical presentation pulls for support, emotional boundaries, or coping skills, it was apparent that participating psychologists believed that good therapy meant intuiting which

kind of specific interpersonal interactions would help them move forward in their own healing processes. Participant 5 had an emblematic quote here, often echoed by others, “I’m attuning to them and their pace and their tempo and I align with that. And as one of my . . . somebody said at some point. You know, you stand next to the patient and one step behind” (p. 2).

On Client’s Presenting Symptoms. One of the main ways which psychologists indicated that their behavior in session changed was based on client diagnostic presentation. The repeated idea here is that a patient suffering from depression may need to experience their therapist differently than might someone suffering from anxiety or another diagnosis. Participant 7 summarized this experience well when asked about this idea.

Interviewer: What I’m curious about is, how does a patient’s sort of presenting demeanor influence or inform the therapeutic stance you take with them in that session?

Participant: It informs it tremendously . . . I mean I’m following their lead completely . . . I think it informs it completely. Because I will be able to tell like if they’re nervous if they’re guarded if they’re frightened if they’re angry and I’ll try to respond that way

Importantly, this responsiveness to patient need did not involve creating a false self to give to the client. It instead appeared more connected with the therapist choosing which genuine parts of themselves would be most helpful to their patients in the moment. From that same interview, participant 7 continues:

I also try really hard to communicate authenticity and not to not to be something that I’m not . . . if you’re talking to me about something I don’t understand I will tell them that I don’t understand it . . . I won’t make them figure it out whether I know what they’re talking about or not. (p. 6)

On Client Intersectional Identity. Several participants indicated that they pay special attention to the many intersectional facets to their patient’s identities, as these identities may have an impact on the best way to proceed over the course of therapy. In cases where a patient may belong to a group who has historically been undeserved by psychotherapy, it was important

for psychologists to make a more concerted effort to ensure they were given the most thorough informed consent possible related to the process of psychotherapy. Participant 8 explains this idea further, which was a repeated theme across several interviews.

But folks who are in groups of people who historically have underutilized therapy I think I also try to make a little bit more room to like explain what to expect working with me and that it can be different and if there's not a good fit or if they want something else that we have a bunch of different counselors we can refer to within the center and outside of the center so I do tend to make a little bit of a difference about that based on just the factors of that client . . . And of course, just like you know age, gender, race, etc. (p. 1)

This participant's use of the word "fit" is interesting and contains a potential avenue for further research beyond the scope of this paper. I wonder about the psychologist's anxiety level when working with historically marginalized or underserved populations therapeutically, and whether or not their compassionate desire to ensure that their patient receives quality care undercuts the confidence they have in their own ability to deliver that care, based on a perceived gap in their ability to facilitate those operative emotional experiences in their patient due to interpersonal difference. I did not ask questions about this, but it appears also to be tied to the issue of therapeutic performance.

On Client's Prior Therapy Experience. The final aspect of client factors impacting participant behavior in session concerned prior therapy experience in the patient. If a patient had substantial therapeutic experience, and that experience was reported to be positive, then it seemed to have a kind of calming effect on participants, who felt less saddled with the need to scaffold sessions and instead move more directly into therapeutic work. As participant 2 stated:

I think there's a rhythm to therapy. For someone who never has been in therapy its funny regardless of what anyone says in terms of the content I can tell almost immediately if someone has been in therapy before . . . There's a kind of give and take in the way that they hear questions, I think is different . . . The rhythm is different. And I'm not trying to put my finger on it. I don't know whether its . . . I think when people are talking they often don't take that pause to stop to hear what the question is. I think part of that is just I think everyday were all a bit rushed I guess, but also people are often thinking more

about what they're going to say next as opposed to actually listening and understanding. Maybe that's the difference. I'm not sure. I should probably listen to it more carefully. I generally have a pretty good idea when someone has been in therapy before. (participant 2, p. 2)

While this is a seemingly minor factor, whether a patient had been in therapy before sometimes had a large impact on how overall sessions were structured, demonstrating again the interplay between a client and the ways which that client can influence the kind of behavior they get from their therapist, oftentimes without even being aware of the influence they are exerting.

“Standard Spiels,” “Riffs,” and Body Language. The first and most often discussed performative techniques in psychotherapy involved communication with the client, either verbally or through body language. This makes sense. If participating psychologists see their roles as facilitators of emotional experiences in their clients, it would behoove them to direct their interpersonal communication with the client toward this end. Specifically, several participants quoted “standard” language they would deploy in certain clinical contexts, such as when establishing initial rapport, or preparing to deliver an intervention. Participant 5 spoke eloquently about this, stating:

I was pretty introverted [laughs]. My wife and I laugh about that. I talk about her. I talk about my wife. I've got standard riffs you know . . . oh I'm sorry I'm going off on a tangent here, I've got a standard riff, one of the things that people don't understand with people in their lives or with couples is that everybody has a different brain. Everybody thinks that you know we're all the same. Most people think that we're all the same. They don't get the variations of brain. So I tell people a personal story I tell them about my wife and how I spent five years trying to teach her how to pack the dishwasher right . . . I'll tell my wife's story right? And that humanizes me. Oh oh he's got a wife . . . oh she's ADD . . . it humanizes me and it teaches them a lesson. (p. 10)

Having, and using, such stories repeatedly in different contexts is a clinically interesting phenomenon, and a common one between participants. It would appear that, while each therapeutic dyad is unique, participating psychologists are able to recognize patterns between their patients such that the use of the same story is appropriate, and also can tailor the delivery of

that story such that the patient does not experience it as sounding trite or recycled.

Participants additionally spoke at length about intentionality in their use of body language when with their patients. This non-verbal attunement reportedly had several benefits to rapport, and an additional benefit to this performative technique was that it could happen without taking up verbal space in the room or interrupting a patient. Multiple participants spoke of the importance of the use of non-verbal attunement with clients. Participant 2 stated, “But we do start to sit in similar positions . . . the cadence of our speech becomes similar” (p. 2), while participant 5 explained:

And posture and the individual stuff . . . so I’m just sitting there trying to get a sense of their pace, where they’re at, and attune to them. Somebody’s coming in chatty I’ll jump in and start chatting with them. I’ll ask questions ... If someone comes in and they’re depressed and they’re quiet I’m gonna sit more quietly with them and just kind of [pauses] . . . so the pace the tempo is completely different. (p. 2)

Client’s Interpretation Supersedes Psychologist Intent

It is important to note that participants were aware that it was the client’s response to their performative interventions which determined their overall level of effectiveness or quality. A psychologist’s intent behind a behavior, phrase, or “riff” was inconsequential compared to how that intervention was received by their client. This meant that therapy was often experienced by participants as an ever shifting, organic process of intuiting and performing, with an understanding that rigidity or an inability to sense a change in their client’s need was often an indicator that progress would be stymied. This was a commonly repeated emerging theme, with participants 2, 7, and 5 providing particularly astute summaries of this process. Participant 5 explained:

You know it’s an N of 1 world. Everybody’s different, each thing unto itself...I pushed too hard. You know? [Laughs] Now I’m creating a polarization. I push they defend. They’re not going to look at it that way, so you know you start to readjust, you re-calibrate you slow it down, you wait for the material to come in over time and then you

ask you know, well how did that feel to you. But I'm not gonna impose my view on them I'm gonna wait for it to come from them. (pp. 2–3)

Said participant 2, reflecting on a therapeutic experience which ended up not being a proper “fit:”

[This was a client] with a significant trauma history and you have to be a little bit careful with people with those kind of histories, and she didn't have great attachment and so ... I was actually probably too friendly and too informal and I think it scared her. And she came back a few times and she had some I don't know, she was not gonna be a good fit. And I think we both kind of knew that and at one point she . . . you know she tilted her head and she said I don't like you. Well thank you for your honesty. And then we talked a little bit, but we did, I did end up referring her, because sometimes its just not a fit and I think my first thought before I learned a little more about her was that, oh she's shy or that she's you know. . . . Although looking back if I'd thought about her history a little more carefully I probably would have been a little more reserved with her. It would have made her a little more comfortable. (pp. 3–4)

Participant 7 also described an experience where her performative intentions were not understood by the client and therefore required editing and a renewed therapeutic focus.

So I think you know following in the client's cues and seeing them as meaningful and not trying to fit them into the box that I might think that they should be in or that I . . . not to just make my first impressions the only important thing about what's happening but to really follow their lead . . . there are times when I think I'm not being at all pushy or . . . you know I'm interpreting in a certain way and then I realize the client is not reading me that way . . . and I'll be like hang on reset . . . like . . . [laughs] . . . and so that's something, that's . . . that has become also like a skill. (p. 6)

Understanding the sway that a patient's interpretation of practitioner behavior can have on the success or failure of an outcome is an important step to maximizing success and strong rapport in psychotherapy. Participants appeared to understand and respect the significance of this idea, working hard to ensure that their intentionality had its intended impact on their patients.

“Genuineness” as Strategic Intervention

The final performative aspect of participants' therapeutic experiences involved the explicit use of “genuineness” as a strategic, rather than random, display. While I have attempted to highlight the fact that the psychotherapeutic performance is not a deceptive one, participants

nonetheless did highlight instances where the emotional experience of clients took precedence over a truly genuine expression of their feelings in the moment. Participant 7 explains, when forming an initial alliance with a patient:

[I try to] stay relational and really focus on building comfort and alliance and essentially communicating that its private and that whatever they're gonna tell me I can help. I might not know how right now . . . and they might not necessarily know what I'm gonna do . . . but whatever it is I can help. . . . Also normalizing, so letting them know that like I've heard everything twice and whatever they tell me is not gonna shock me surprise or disturb me. . . . Which sometimes is not true. There are times that I do feel very worried and disturbed by what I hear. (p. 1)

What appears to be happening in these instances, is that the two aspects of therapeutic work, facilitating an emotional experience in a client, and being authentic, are momentarily in conflict with one another. In these instances, participants deferred to facilitating safety in their patients, and this appears to be related to existing beliefs regarding self-disclosure. There are many aspects of the psychologist's person which are either not relevant to therapeutic work, or may actually hinder it, and in these instances, participants had no difficulty stating that they withheld this information from clients. Interestingly, this did not seem to cause dissonance in participants' ideas of their genuineness or authenticity when working with clients, suggesting that genuineness in therapy is more related to client interpretation than being uncensored in the therapy room.

External Factors Impacting Therapist Behavioral/Performative Choices with Clients

While client factors presented a large impact on the way which participants presented themselves in the therapy room, a number of external moderators to behavior were also highlighted by participants. Specifically, the pressure or culture of a participant's workplace, the method of therapy delivery, and the location where therapy was taking place all impacted the reported behavior of some participants. It would appear from participant responses that, while they may work hard to ensure their therapeutic selves are solely attuned and aligned to their

clients, psychotherapy is often a process which involves the expectations of more than just clinician and client.

Institutional/Workplace Values and Expectations. The most frequent moderator to participant behavior outside of the client was the institution where participants worked, or institutions which participants needed to interact with. Formalized intake procedures, billing codes, and insurance panels all exerted a kind of influence on how participants presented themselves in the room, and the prevailing emotion of participants experiencing this influence was one of frustration or discomfort.

So you know in terms of age of accountability and the way which managed care shapes things, on a very practical level I do think immediately about how will I be documenting what is going on. If I get that out of the way, and I know that in my head, like this is a 90791 initial meeting and we'll have 50 minutes together and I need to put down some code to get compensated even though there might be three 3rd parties before I get paid, then I think it would be wrongful to not acknowledge that those layers have to be part of my conceptualization of the frame to then move on. (participant 3, p. 2)

Participant 1 elaborates on how not being given a choice in presentation or session structure at a previous job was a particularly distressing experience, and one which they found resolved itself once they went into private practice, where there was less institutional pressure.

But one of my sites we had a very formal intake and one of the things that I had to do in the beginning is sit and watch a more senior therapist do the intake and I thought it was the most obnoxious awful off-putting thing I'd ever seen. It made my skin crawl, and so I think you know I really made a very conscious effort to never do that to somebody. (p. 3)

Participant 2 elaborated on this idea as well, explaining how working in a highly structured environment meant that certain clinical behaviors and interventions were not available to her, regardless of whether they would be helpful to the client.

When I worked at the VA I had to unfortunately tell vets that what they wanted, and sometimes what they needed, we just didn't offer. And that was really hard because I knew I could do it, my job just didn't allow for it, so like if I could only see someone once every 7 weeks, we can't do the level of work that you need and like, I know you want to stay at the VA but like, we're not gonna, we can't. And that sucked, I always

wanted to stretch my boundaries in that way because I hate shuffling people around. When there's a bureaucracy issue that's my . . . ough. (p. 9)

Goodness of fit, it would appear, is more complicated than simply being an equation between client and practitioner. Institutional pressures can and do impact delivery of care, and the field would be well served to research this topic in greater detail.

Teletherapy vs. In-Person Therapy. These interviews were conducted during the initial wave of the COVID-19 pandemic, and during that time several practices were making a rapid shift between seeing clients in their offices to instead seeing them remotely. While this was certainly a time of stress for many clinicians, this also provided participants with time to reflect on how the mode of therapeutic delivery impacted how they act with their clients. Participant 5 described his frustration thus:

I hate working remotely. I don't like video screens. I don't like the phone. But I've found screens to be very distracting and people on the other end distracted . . . It's awful. And try doing couples therapy, it's insane. I do a lot of couples therapy and you can't see them reacting, you know, it's just like, kids are running in and out people are looking at their cell phones. No one is looking directly at you, all the non-verbal stuff gets lost, and I prefer to be just on the phone because I can focus my attention on what I hear, and I'm not distracted by anything. But I don't like it. (pp. 3–4)

The idea of certain modes of therapy being *distracting* to this participant is an interesting one, especially in the context of how therapists have described their role in therapy. Distracted clients are ostensibly more difficult to attune to, simply because there is “less” of them involved in the process, both in a literal sense and a metaphorical sense. While telehealth practices are more commonplace now, and are deemed effective, it is nonetheless important to understand how the medium impacts the message, as this participant reportedly understands.

Location of Therapy Office. A final external impacting the way psychologists behaved with their clients involved the location where psychological services were rendered. While most participants described working out of a separate office, participant 3 articulately described how

her experience of therapy shifted when moving her practice inside her home.

So the people that have been strangers who have come to my home, I've been much more guarded with right from the bat. Like I had a male patient who said to me "my wife said I can't continue to come now that you've moved your practice home. She thinks it's odd that I'd be at a woman's house at night." I present that way initially and have said to people hey look there's a couple of rooms in the house that are off limits . . . because there are some male patients who might seek me out for good reason, the assumption that I might be more connected to what they're experiencing, like an assumption on their part . . . but some of the characteristics of those interactions, I want to be highly aware of because they might be having layers, they might have layers of their presentation that don't get to the core of what they want to work on. (p. 7)

At the root of this participant's guardedness is the issue of unavoidable self-disclosure.

While psychologists can take great care in curating their professional offices, this is much harder to do within a living space. Because of the possibility of perceived intimacy of meeting with someone in her home, this participant's presentation to clients shifted accordingly to ensure that she felt comfortable, and that there was no ambiguity in what the purpose of a client's visiting meant. This participant's emotional response to seeing patients in her home was similar to those participants who saw a client while going through a pregnancy. In both cases, there was an aspect of the psychologist's self which was entering the therapeutic process, whether it was relevant to treatment or not. This, I think, illustrates well the many subtle ways which therapeutic performance can shift outside of what the client brings into the room.

Psychologists in Non-Clinical Contexts

The final superordinate theme concerning participant's lived experiences as psychologists involved their interactions and relationships outside of delivering therapy. There was a repeated insistence from participants that training in psychotherapy and case conceptualization changed how they saw the world, and how others saw them. Whether these changes elicited positive or negative emotions was variable depending on the participant and context, though this idea was

repeated enough to conclude that the social role of the psychologist has effects which extend beyond the therapy room.

The Title “Psychologist” Influences Social Perception. Several participants repeated having a conversation with others where, when the person to whom they were speaking discovered they were a practicing psychologist, the dynamic of the conversation changed. Participants 2 and 10 expressed how this can occasionally elicit feelings of annoyance or isolation, especially in conversations where they did not feel like their title or training was relevant to the topic at hand. Participant 2 explained:

So If I’m being totally honest, when people have like a large reaction to [my title] I tend to shy away because to me it signifies like a couple things, either this person is going into protective mode and I want to be respectful of that, or I don’t want to talk to a person who has drank too much and is now making me work . . . we’re probably not going to be good friends. Like if you’ve just lost your mind over mental health stuff and you think I’m a mind reader, I mean it’s such a big part of my life I just don’t, I get dismissive. (pp. 6–7)

Likewise, participant 8 expressed how she often attempts to minimize the impact of her title and role outside of clinical spaces, saying:

In my personal life I’m not trying to highlight any power differential like I’m not trying to like be I’m a doctor. One because of just the social . . . I don’t want to be seen as someone whose like pretentious or . . . um . . . trying to like flaunt or flex you know . . . that I have a doctorate. And I think too just you know the like typical response of, you know, meeting new people and they find out you’re a psychologist or a counselor or whatever and they’re like “Oooh, are you reading my mind?” Or you know just some of those really typical responses that we get so . . . I’ve never been someone who’s like I’m going to introduce myself with what I do for a living because that’s also like not how I conceptualize me enjoying . . . my life is not like . . . psychology is super important like . . . it is . . . but I don’t necessarily broadcast that I guess. (pp. 6–7)

There appeared to be some tension in participant 8’s response here. On the one hand, it is clear that the role and practice of psychology is a large part of her identity, but there is also an understanding of the interpersonal impact that it can have on others. While she is not conducting psychotherapy with people she interacts with casually, it is interesting to see how the idea of

self-presentation and interpersonal performance seems to also be present here. She acknowledges that she is a psychologist, and internally understands it is important to her, but hesitates to openly build her social identity around this fact because of her knowledge of interpersonal interactions.

Training Impacts Non-Clinical Conversations. On the other hand, participants also described how, even without mentioning their title, psychological training impacted how they spoke to and viewed the experiences of others outside of the therapy room. Participant 7, who worked as a clinician and director within a college counseling center, spoke at length about an interaction with a college-aged student while she was on vacation.

There was . . . there's college student age people who were working on the beach helping people with chairs and I um like one of them said one . . . just the same person was helping me multiple days and we just got into this like quick conversation. He said one thing to me . . . and that like belied something about his life . . . and I felt totally just like, ok there's my in. And I'm just going with it and became like a session right there on the beach . . . and so it does affect me that way. I think I see I'm a . . . I think I'm attuned to details and dynamics that other people are not. (p. 10)

Participant 2 echoed this point, and attributed her changes not only to her training, but through the act of accruing years of clinical experience seeing people in vulnerable moments.

We get to see behind the curtain and you know, what the facades of social media, or like the facades of having appropriate boundaries, but we get to see a lot of it and it's like such a gift, but it also changes who you are because you can run into anybody and see them as a complex person. (p. 6)

It is intuitive to conclude that training in psychological theories, as well as working with people in emotionally intimate, often difficult moments would impact a person's lived experience. The lessons learned and the stories which are told in a therapy room cannot be forgotten just because a psychologist leaves their office. Here, we see the complexity and nuance of the psychologist's experience. On the one hand, psychologists work hard to moderate their presentation, using themselves strategically in order to facilitate positive change in another person. On the other hand, this use of strategy appears intimately connected to the psychologist's sense of self. It is

performance. It is intentional, but it remains a genuine, if paradoxical, way of life, one which is seamlessly integrated into their personhood.

Training Impacts Non-Clinical Relationships with Friends and Family. Finally, participants spoke of how their personal friendships and relationships were also impacted by the scope of their training and clinical experience. Participant responses were mixed, with many acknowledging that they had much to offer their friends and family in the way of knowledge, but cautioned against actually using therapeutic interventions on them. As participant 10 said,

I have the background and skills and I can do that and be kind and helpful . . . um . . . on the same vein sometimes I have to check that [laughs] . . . especially with my husband he's like nope don't want to hear it . . . and I respect that I have to be a wife and not a therapist. (p. 9)

On the other side of this coin, participant 7 expressed some pride at being able to instill good foundations of mental health and self-care into her daughter, and remarked that this had a ripple effect within her daughter's social group.

I have a daughter who's almost 13 and she like . . . I've noticed that she asks me for advice and then gives her friends that advice which I see as a huge win. Like the fact that because of my work and my exposure to things and my like sort of down to earth understanding of human problems, because I've seen so many of them that I don't get worked up so much. Like the fact that she trusts my advice to me is like ok like this is very meaningful that like she sees me as a person who knows what they're talking about. And I don't think it just comes from like being a good mom or something. I think the fact that I'm a psychologist and have that skill set is meaningful in that way to her. And so that also is really important to me. And really nice. (p. 11)

Participant 2 also spoke of her ability to give advice to people as a function of her training and clinical experience. She made a distinction between helping a patient and helping someone outside of a clinical context, but highlighted the common elements to both situations.

So I don't feel that I have to know all of it, but I feel like when there's an opportunity for me to share what I know I often want to do that. And to me that intersects like, as a psychologist for my client I want to empower them and help them heal, and when I see these things happening in my daily life, I often see them as empowerment and opportunities to heal. So not everyone is a patient, but just like general humanity, we're

all just like bumbling through. I truly believe people are trying their best, a lot of times information can be helpful, but not always. Like people smoke and everyone knows that's bad for them, right? So information doesn't always help. But I think that's important to me, and then sometimes I'll cross into the clinical role like a little bit, like in my personal life, like if I hear someone's kid is really having a hard time, I'm like it sounds like they could probably use therapy or like that sounds pretty serious or like, you know why not talk about that with their pediatrician? (pp. 5–6)

The preponderance of interview data mirrored the content of these quotations. While being a psychologist can sometimes cause feelings of frustration or isolation in unfamiliar settings, there was nonetheless a belief among participants that they could use themselves for the good of their loved ones without stepping into a clinical or diagnostic role. To be a psychologist, it would seem, is to appreciate the nuance and the complexity within the human experience, and to understand that, as in clinical work, rigidity of thought can hinder the potential good which a person can do for others.

CHAPTER IV: DISCUSSION

Concluding Thoughts and Directions for Future Research

Through this study, I have attempted two goals: first, to establish that there is merit in conceptualizing the therapeutic role from the vantage of its performative components. Second, I have attempted to use this performative vantage point as a lens to better understand the lived experiences of psychologists. I examined how performance and interpersonal intentionality impacts their work, as well as how that performance can sometimes extend outside the therapy room as a result of their training and perceptions by others. While I believe I contributed valuable data to these pursuits, the interviews nonetheless also provided opportunities for future inquiry for the interested researcher. It was beyond the scope of this project to fully document or assess for the full impact which external factors, such as institutional culture or third party payors, have on therapeutic identity and behavior. Indeed, while none of my initial interview questions specifically asked about this phenomenon, it nevertheless surfaced freely from multiple participants. It would appear that, while I initially believed the therapeutic performance was an equation between two people, the reality may have more facets than expected. If I were to continue to conduct interviews on this topic, I would make questions about factors impacting performance more explicit, such that the lived experience of psychologists can become that much more clear.

As it stands, it is my hope that this research demonstrates that psychotherapeutic treatment is more complicated than having knowledge of “evidence based” interventions or psychological wellness. As participants in this study repeatedly stated, the therapeutic role is a facilitative, and not solely directive, endeavor. Without a strong sense of their patient’s needs and which therapeutic presentation will help to meet those needs, a psychologist will likely find

their work to be stymied in some way. This conclusion highlights several potential factors of import for the field of psychology as it continues to grow and evolve.

First, when evaluating potential new students, special attention should be paid not simply to writing acumen or academic competence. While these factors may indicate the requisite intellectual capacity required to form complex case conceptualizations, they do nothing to indicate whether or not a new trainee to the field knows how to be an effective emotional performer. From the collected interview data, it would appear that one of the most valuable things an institution can do when evaluating new doctoral students is to pay close attention to their actions within the context of an interview day with other potential students, for it is here that one is likely to best observe their burgeoning clinical selves.

Following this, clinical institutions and practicum sites would do well to make the ideas of emotional facilitation and empathic performance explicit within the context of clinical training. As of this writing, there are as yet few opportunities for trainees to directly ask questions of professors and supervisors regarding the behavioral choices available to a clinician in a session. Focusing more on *how* interventions can be delivered to patients instead of *what* acceptable best practices are for a given diagnosis will go far in ensuring that the next generation of practicing psychologists are flexible enough to ensure that the most good possible is being done with their clinical knowledge.

No psychologist can reasonably expect to be everything to every patient, but this does not excuse them from the task of being mindful of their performative power, and to use it for the betterment of their clients and their society.

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APPENDIX A: SEMI-STRUCTURED INTERVIEW QUESTIONS

1. When you meet a patient for the first time, how do you present yourself?
2. How do you understand your patient's immediate therapeutic needs in the room, and how do act to address those needs?
3. Take me through the process of an initial session with a client.
Do you follow a script?
4. What does "impostor syndrome" mean to you?
5. How does a patient's presenting demeanor influence the therapeutic stance you take with them?
6. How do your therapeutic interventions for the same presenting disorder differ between clients?
7. How does your social role as a psychologist impact your interpersonal presentation outside of work?
8. What does being a psychologist mean to you?

APPENDIX B: INFORMED CONSENT

Informed Consent

My name is Chris Defossez. I am a doctoral student from the Department of Clinical Psychology at Antioch University New England in Keene, New Hampshire. I am doing a research project as part of my training at school. I am asking you to participate in this research project to further understand how use of self is employed when developing a therapeutic alliance with patients in psychotherapy.

The goal of this study is to better understand how practicing psychologists choose to modify their own behavior or presentation based on their perceived understanding of a patient's clinical needs. Through this research, I am trying to begin to understand the "essence" of a psychologist's experience as they present and use themselves in their work with patients. Research in this area has the potential to increase the field's knowledge about what, exactly, is important about creating a therapeutic bond, as well as the psychologist's personal influence over that creation.

If you agree to take part, I will be conducting a recorded interview with you about your perspectives and experiences while practicing psychotherapy. This interview will include questions about those aspects of yourself which you consider important enough to bring into the therapy room, as well as how your professional self is different or similar to your "private" self outside of therapeutic practice. Additional questions will inquire about your experiences establishing therapeutic bonds with different kinds of patients, such as those who you may not consider to be a good personal "fit" for you to work with.

The information you provide will be combined with information from other participants. Neither you nor anyone else taking part in the study will be named or identified. Your information will be kept entirely confidential. If you do not choose to participate in the study the choice not to participate will also be kept confidential.

It may be that reflecting on the way you choose to present yourself in the therapy room in order to establish rapport with patients will be helpful to you or your self understanding in the future. Aside from this, participation in this study is not likely to be of direct benefit to you personally. However, the information you provide may be of use to psychologists in training, as well as licensed psychologists who may wish to better understand or experiment with their own use of self in the therapeutic process.

Although your identity will be kept confidential throughout the project, and any information you provide will be kept at a separate location in a secure file, this research involves a limited number of participants. Because of that, it may be difficult to guarantee absolute anonymity. If you provide information that reflects poorly on you, there may be some risk that the source of that information may be identifiable. In order to ensure that nothing is included in research that will ultimately be shared with others, you will be given the opportunity to review a transcript of your interview both to ensure its accuracy and to give you the opportunity to identify any information you wish to remain private and not have included in the final research report.

Being in this study is your choice. You can stop being in the study at any time. If you decide you no longer want to be in the study, I will not use any of the information you provide. If you have questions about this study, please contact Christopher Defossez at REDACTED, or my research supervisor, Roger Peterson at REDACTED. Should you have any questions about the research procedures or your rights as a participant, contact REDACTED, Chair of the Antioch University New England Human Research Committee, REDACTED or Antioch University New England Provost, REDACTED.

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___ I consent to participate in this study.

___ I consent for my responses to be audio recorded

SIGNATURE of Participant

DATE

SIGNATURE of Researcher

DATE