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Portfolio submitted in fulfilment of the
Professional Doctorate in Counselling Psychology

BEING UNDERSTOOD:

Client meaning-making within the therapeutic encounter

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August, 2018

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Abbreviations

Improving Access to Psychological Therapies	IAPT
World Health Organization	WHO
Obsessive Compulsive Disorder	OCD
A Repeated-Measures Analysis of Variance	ANOVA
Diagnostic and Statistical Manual of Mental Disorders	DSM
International Classification of Diseases	ICD (11)
Thematic Analysis	TA
Interpretative Phenomenological Analysis	IPA
Discourse Analysis	DA
Conceptual Metaphor Theory	CMT
Cognitive Therapy	CT
Acceptance & Commitment Therapy	ACT
Cognitive Behavioural Therapy	CBT
Motivational Interviewing	MI
Eye Movement Desensitisation and Reprocessing	EMDR

II. Acknowledgements

Firstly a very heartfelt thank you to the therapist participants. As working professionals with demanding schedules you were all extraordinarily busy and yet you were kind enough to make the space in your days to see me – quite literally as in some cases I was booked in as a client - to talk about a topic you had not previously given much thought to so it was not an easy process. I appreciate your time, introspection and generosity in helping to think about this elusive topic and try and help expand knowledge in this area. Although stuckness may not have been an immediate priority in your therapy, the way each of you spoke with care and thoughtfulness about how you approached your client work was in itself a learning for a trainee like myself and I found that I gained much from your overall experience, wisdom and professionalism.

A huge thank you to my research supervisor Dr Daphne Josselin. I know that at times this was not an easy process and I want to let you know that I am deeply grateful for your guidance, meticulous feedback and encouragement to get this project to the finish line. This topic was elusive for the participants and so it was for me also and I thought of you as the sure and steady lighthouse guiding the small boat through what felt like rough seas at times. That you made time to help me to get this to completion is something I truly appreciate.

Finally, I cannot thank my friends and family enough for your patience and encouragement during this long training and thesis-writing process. I feel like I have been missing from your lives, quite literally for some of you as I am far from home, but your love, support and belief in me have been what has gotten me through.

III. Declaration of power

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IV. Preface

The elements in this portfolio represent an amalgam of personal and professional reflections during my three years as a counselling psychology trainee. At an overarching level they bring together broader themes around the unknown blocks that can hold us back and the difficulties of moving forward in life. At a more refined clinical level, they speak to a specific predicament facing our clients, that is, how do they make themselves understood in therapy, in an environment not ideally of their choosing, caught between a psychological world framed by clinical language and diagnoses and a lay world in which much about mental health is still stigmatised and misunderstood.

From the outset of our training, beginning with a person-centred module, we have been asked to reflexively examine our role as counselling psychologists, to consider what differentiates us from other psychological practitioners and what we can uniquely bring to our placements and our practice. The discussions of such matters during our course are a microcosm of the wider debates happening within our field which have examined fundamentals, often contextual, that we might take for granted - for instance, asking what it is to work within the helping profession and even whether counselling psychology should be sitting within a medical field (Woolfe, 2016).

Woolfe (2016) speaks of the role of the counselling psychologist as a reflective practitioner and ponders the impact of current challenges on this aspect of our professional identity. Counselling psychology was founded from a humanistic psychology with an emphasis on empathic engagement rather than pathology and there are questions around how it can withstand or evolve in the face of more recent environmental pressures through foci by organisations such as the NHS on output requirements and performance data, targets and waitlists. Woolfe sees this as our core challenge.

> "central to the success of counselling psychology up to the present time has been the ability to identify a narrative around which all counselling psychologists, whatever their preferred orientations could rally. This offered an identity and a statement of difference

> from other helping professions. It provided a scientific base but at the same time paid allegiance to the relationship between client and therapists. This narrative is the reflective practitioner and there is a question whether it can survive in a world of evidence-based practice (Woolf, 2016, p6)

The openness, reflexivity and very existence of these debates for me characterise the essence of what it may be to be a counselling psychologist, thus establishing the subtle but important difference of our approach.

To me, this humanistic awareness extends to the therapeutic relationship and might be encapsulated in one simple, central refrain - to remember the *person* of the client in all that we do. This seems axiomatic for our profession and applicable to anyone in a therapeutic role. However the simplicity of this statement belies its complexity. As I started upon this training path, working with clients in my first placement in a very service-oriented NHS environment, I began to see how difficult this clinical remit was. Just as the counselling psychology field's debates aim to balance a more reflective, humanistic side with an empirical one, so too on a smaller level it felt like a challenge to me to juxtapose the counselling psychology ethos with the more clinical aspects of client care and service requirements. To adhere to the requirements of NHS settings alongside the needs of individual and unique clients is quite a balancing act, more so for a trainee trying to develop clinical skills whilst upholding the values of our approach. As I progressed through my training, it became clearer to me that without our conscious awareness, our clients' interests can be obscured and lost despite our commitment to do the best by them through a requirement to prioritise an organisation's administrative and target requirements. It was reflective discussions of this nature during our three years on the course that remained with me as a shadow consideration sitting behind all of my work, the realisation that an aspect of our clients could easily be lost if our focus was more on the service than on them, and I have been encouraged by these debates to think at a deeper level about these myriad fringe issues in a much more reflective way.

The portfolio is composed of three parts which I will outline here:

Part 1: The Research Study

This study followed the theme of how we as therapists might understand the position of the client within our therapeutic work by taking a closer look at how therapists make meaning from the language that clients use, in particular, how therapists understand the commonly used lay metaphor of feeling *stuck*. Metaphors are not a unique therapeutic phenomenon but I was interested in *feeling stuck* because it is a term common within the lay vernacular and one often used by therapists, particularly when sourcing new client referrals. As most therapeutic modalities have a requirement for a rigorous clinically-based assessment, it had me wonder why a therapist would begin a new therapeutic encounter by inviting an approach from a client using a lay metaphor.

Overall I found the research topic of stuckness interesting as approached from a counselling psychology perspective – does using a lay term influence our efforts to be more collaborative with our clients and does it enhance reflexivity with our practice? It seemed to me that it might be worthwhile to reflect on the use of a lay term by clinically trained professionals and why they might have chosen to use one or think about clients in this way. I was also interested to explore how this sits alongside our modality approaches and likely clinical requirements and expectations. However just as the notion of staying with the client belies how complex this is in reality, it was equally misleading to think that a common turn of phrase like this lay metaphor was simple.

The choice of this metaphor was also through a personal experience of what I would call stuckness which gave me some insight into the entrenched and intractable nature of this state and how even after clinical training this still seems the best word to explain the experience. It made me wonder what other therapists might make of such a commonly used lay term and if there was even any agreement in psychology circles as to what this experience might be.

Five psychologists and five psychotherapists were interviewed using a qualitative methodology and data were collected through semi-structured interviews which were then analysed using Thematic Analysis. The analysis yielded three main themes – ‘the lay metaphor’, ‘defining stuckness’ and

‘working with stuckness’. The analysis of the research examined how therapists made meaning of this term, how it was used (or not) within the therapy and how therapists considered clients might move on from stuckness. Findings suggest that it is important for us as therapists to be more attentive to the words we use with clients and to do so might bring therapeutic benefits and increased understanding of the client’s world.

Part 2: Professional Practice

The second element in the portfolio is an example of professional practice – a combined case study/process report taking a short 10 minute segment from a last client session which I felt represented a perplexing situation I encountered at times during my clinical placements in time-limited therapy services – how to work at relational depth with clients within service settings where the focus is on meeting client targets and demonstrating delivery of evidence-based therapy for which the service is known. In this example, the client was a 30-year-old man referred to an IAPT service with symptoms of Post-Traumatic Stress Disorder (PTSD); but underlying this problem were experiences of grief within his close family going back to his early childhood. During this segment the client pushes back against the CBT protocol I was seeking to deliver and I found myself trying to balance therapeutic decisions and the clinical remit I was required to adhere to alongside his wishes, as well as absorbing the sudden announcement that this would be his last session. This client and episode of care left an impression on me and seemed an example of how important and necessary those moments are when it is important to stay with the client and really listen – particularly a client with strong trust issues, especially around what people say to him. At one point he said that he trusted me but was this trust merited, for I was very aware that I was not just working with him but was also beholden to multiple others to rationalise my clinical approach to the client and therefore his care – my supervisor, the service and the university. It also touched on how meeting the requirements of a limited-therapy service does not always do justice to what is needed at the client’s level. This reinforced to me the importance of listening to clients particularly when they are trying to communicate something they need but do not have the vocabulary, and how difficult it might be to meet such a need within a clinical environment with multiple focuses and responsibilities.

Part 3: Academic Journal Article

One of the key findings of the research study has been written up as an academic article for publication in the Counselling Psychology Review. This journal invites "submissions of original empirical research using qualitative methods which are relevant to the work of counselling psychologists" (British Psychological Society, 2018).

The first theme – 'the lay metaphor' was selected. This theme was chosen as it seemed to encapsulate the very complexities of working with not just metaphor but all language within a therapeutic context. It also showed that, as referred to above, some of the decision-making that occurs within the process of therapy may not be as consciously determined as we might believe. As half of the participants did not engage with working with the metaphor within therapy, it also calls into question the transparency of a process whereby a client might seek out a therapist who speaks of stuckness and yet, through the complexities of the diagnostic psychological process, may never know if their stuckness is actually being addressed.

Concluding Comments

Together I think these three elements are a composite reflection of the difficulties of holding our clients as individual, unique and central to the focus of our work balanced with the requirement to deliver evidence-based practice that conform to diagnostic standards. Working with theory and application of tools is easier as they have defined parameters and guidelines; working with the subjectivity of client experience and expression is more difficult to evaluate and hold. This is a dilemma faced by therapists of all kinds but particularly one whereby "psychologists are increasingly called upon to justify their practice on the basis of evidence and to demonstrate technical expertise in treating definable conditions and disorders" (Strawbridge & Woolf, 2010, p7).

Overall it seems that there remains a challenge for therapists, particularly we as counselling psychologists, to work with clients through their language and on their terms. Over fifty years ago Carl Rogers (1961, p54) suggested that therapy "is most helpful when I can see and formulate clearly the meanings in experiencing which have been unclear and tangled". There are

many elements that go towards making therapy successful and perhaps, after all, one of the most fundamental of these is simply to be understood.

British Psychological Society, 2018.(https://www.bps.org.uk/publications/counselling-psychology-review)

Douglas, B., Woolfe, R., Strawbridge, S., Kasket, E., & Galbraith, V. (Eds.). (2016). *The handbook of counselling psychology*. Sage.

Rogers, C. R. (1961). On becoming a person.

Strawbridge, S., & Woolfe, R. (2010). Counselling psychology: Origins, developments and challenges. *Handbook of counselling psychology*, *3*, 3-22.

SECTION A: DOCTORAL RESEARCH PROJECT

Therapists' Understanding of the Client-Reported Phenomenon of Feeling *Stuck*

Abstract

Metaphors are a common and highly evocative linguistic motif used to conceptualise experience and communicate thoughts and feelings that are otherwise difficult to express. Literature on the use of metaphors within therapy shows that they are a frequent and spontaneous part of the therapeutic dialogue but are often not interacted with or used by the therapist as a tool within their clinical practice. *Feeling stuck* is a lay metaphor often used to convey a period of stasis causing significant psychological and emotional distress. This study sought to explore therapists' understanding of the client-reported phenomenon of *feeling stuck* and how they make meaning of this term within a therapeutic context.

A qualitative design was utilised. Interviews were conducted one-to-one using a semi-structured interview protocol with five psychologists and five psychotherapists who had each used the term *feeling stuck* in the public arena. The data were analysed using inductive Thematic Analysis.

Three main themes were identified during the analytic phase – 'the lay metaphor'; 'defining stuckness*'* and 'working with stuckness'. These themes were comprised of 13 sub-themes. Therapists acknowledged the strong resonance that this term had for clients and that in many cases it was the primary reason the therapist was contacted. It was found that half of the therapists discarded the term soon into therapy as the idea of incorporating the metaphor into the therapeutic work was not considered. The remaining therapists stayed with the term but turned to favoured therapeutic modalities in order to make meaning of stuckness and to work with the client problem. However many of the participants agreed on common factors underlying stuckness thus identifying a trans-theoretical understanding of this state.

The results of this study generated new understandings of how the phrase *feeling stuck* is understood within a psychotherapeutic context. More generally, the study shed light on how therapists understand lay terms and metaphors used by clients and how they make sense of the way these terms are being used to attract, connect with and ultimately to try to help people. It is hoped that mental health professionals will consider these findings and become more attentive to the words that they use to engage with clients and the impact these may have on the process or outcome of therapy.

2 REVIEW OF THE LITERATURE

2.1 Introduction

The phenomenon 'feeling stuck' is anecdotal, metaphorical, amorphous and indeterminate. Yet it exists sufficiently as an experience to drive people to seek therapy. Therefore as it presents itself and is deconstructed discursively within both the lay world and the therapy room, it exists as a phenomenon for both client and therapist.

Stuck is a metaphorical term for a period of stasis in a person's life, a temporary state of arrest that causes significant emotional and psychological distress – "the emotional experience of a situation that our current adaptations cannot make sense of or handle meaningfully; a block or a prison to escape" (Petriglieri, 2007, p192). Most people experience some kind of serious adversity in their lives (Bonanno, 2004). Without resilience or similar reparative mechanisms, this could result in ongoing psychological distress, but for most people it does not develop into a chronic state (Gilbert & Allan, 1998). However some people can find it difficult to move on and can become emotionally or psychologically *stuck*.

As a metaphor used by both practitioner and client during therapy, feeling *stuck* is a clinical therapeutic phenomenon yet is not a clinical construct. It appears to be utilised as a form of clinical screening prior to engaging clients in therapy and as a discussion point within it – it is a clinical proxy and treatment is conducted as a consequence. Interestingly, while itself not a clinical construct the term *stuck* has been associated with a broad range of psychological difficulties in the mental health literature, something of obvious relevance to the meaning-making process therapists engage in when working with 'stuckness'.

Due to the lack of clarity around this term, the aim of this literature review is two-fold: firstly to explore the clinical literature to understand the contexts in which the concept of stuckness has been applied. Secondly to look at the practical application of this term in therapy and how working with lay metaphor and client meaning-making is approached within a therapeutic framework. The next section will therefore present a review of the

psychological literature relating stuckness to a range of mental health difficulties; a second section will turn to the role of metaphor in meaning-making and communication, and in particular its therapeutic use; finally, a third section will state the aims of this research study and show how it fits in with ongoing efforts to pay greater attention to subjective meanings in therapeutic work, something of particular relevance to counselling psychologists.

2.2 Background

2.2.1 The Uses of *Stuck* in the Psychological Literature

An empirical literature review of this lay term proved challenging as the meaning of feeling *stuck*, even in the common vernacular, is not agreed. A systematic search of the clinical literature was conducted with the objective of trying to establish how stuckness is understood from a psychological perspective. Google Scholar, the PsychoINFO database and the City University online library were searched for articles using the terms or keywords *stuck, stuckness, stuck$, feeling stuck, being stuck.* Articles such as those which used the word *stuck* in an inconsequential way or focused on niche areas such as sandplay therapy (Graham, 2016) or stuckness within therapy as linked to sado-masochism (Coen, 2012) or book reviews for the consumer market which spoke of impasses in life (Butler, 2007) which might be helped by using a bespoke '3D' therapeutic treatment strategies (Yudofsky, 2015) were not included. In order to merit inclusion in this review, the metaphor was required to have been used in the articles in reference to some type of psychological state as experienced by an individual person. It became apparent that *stuck* was a topic that had been little researched and a small collection of articles was found which spoke to this phenomenon and showed how *stuck* is conceptualised across various psychological domains and its links to mental health disorders. The way that *stuck* most commonly appears in the clinical literature is in relation to psychological concepts which depict states in the mind or body in which forward movement is arrested – impasse, freeze, entrapment or resistance which will form the focus for this literature review.

2.3 Review of the Stuckness Literature

2.3.1 Staying Stuck: the Roles of Rumination and Emotional Inertia

Many of the academic articles directly using the term *stuck* link this phenomenon to rumination and emotional inertia. Rumination and emotional inertia are forms of psychological inflexibility – how mood states tend towards intransigence and no longer function in a natural responsive way (Koval, Kuppens, Allen & Sheeber, 2012). Rumination is the tendency to ‘‘repetitively and passively focus on symptoms of distress and on their possible causes and consequences’’ (Nolen-Hoeksema, Wisco & Lyubomirsky, 2008, p400). Studies show that people who don’t recover from negative events seem to keep going over their troubles and get ‘stuck ‘in a mind-set reliving the negative event repeatedly (Joormann, Levens & Gotlib, 2011). Emotional inertia is the tendency for affective states to become arrested in one moment and not carry over to the next (Kuppens, Allen & Sheeber, 2010). Both rumination and emotional inertia are examples of how thoughts and emotions can become ‘stuck’ and separate from regular ‘processes of regulation and control’ (Nolen-Hoeksema et al., 2008; Koval et al., 2012). There are many studies focusing on the role that rumination and emotional inertia play in mood disorders as it has been recognised that both of these constructs contribute to their severity and intractability (Treynor, Gonzalez & Nolen-Hoeksema, 2003).

Several of the articles investigated how people might get stuck in trauma or bereavement. Holman and Silver (1998) examined how a temporal orientation to past traumatic events was linked to higher levels of distress many years after a traumatic event thus keeping adult victims stuck. An article titled “Lost or stuck?” looked at a strategy used by Adlerian therapy which utilised a client’s own unique problem-solving resources. Researchers found that the words ‘lost’ and ‘stuck’ are themselves clues which help the therapist understand the presenting problem and how clients can use a previous experience of being lost or stuck to help them in their current situation (Wingett & Milliren, 2004). Another study, “Getting unstuck”, looked at the relationship between the constructs of hope, rumination and the ability to take meaning from a bereavement in a group

of 158 college students. Each construct had an effect on psychological well-being, with bereavement-related rumination having a negative effect whilst hope and meaning making were positive, the latter particularly when related to recent bereavements, with hope strongly related to finding meaning in life (Michael & Snyder, 2005).

In order to further understand how affective and cognitive states might become stuck, one study has for the first time investigated how rumination and emotional inertia co-occur as complementary tendencies in this regard (Koval et al., 2012). Researchers wanted to examine whether these perseverative conditions were related (study 1) and if they both independently contributed to depression (study 2). In study 1, 95 undergraduate students aged between 18 and 24 reporting with various degrees of depression were examined for 'emotional inertia of subjective experiences in daily life'. Each day for a week they completed an in-laboratory questionnaire measuring rumination and levels of depression. Participants in Study 2, clinically depressed and non-depressed teenagers, were asked to engage with family in a task and then report their negative emotions, particularly the severity of rumination and depression. Using a Palmtop pilot, they were beeped 10 times per day over a 12 hour period and asked to record their feelings at that time. The results of both studies replicated each other and showed links between the brooding element of rumination and the sad/dysphoric aspect of emotional inertia and that both independently indicated depression severity. Limitations of this study could be that as they used mostly non-clinical populations and relied on subjective reports of inertia and affect states, these studies may not be generalisable to a clinical population or replicable. However the studies show that those people whose negative affect states are resistant to change are also more likely to ruminatively brood. This link was strongest to sadness and dysphoria which could therefore be further investigated as it might relate to a state of stuckness.

2.3.2 Freeze and Entrapment

Research into feeling *stuck* has important implications for mental health as "when individuals feel a lack of forward movement or progression in their lives, they have the potential for unhealthy or impaired cognitive and behavioural functioning which… in its severest form, can lead to—or be

compared to—major mental illness" (Bella, 2011, p15; Neufeld & Maté, 2008).

This reference to a stalled state is reminiscent of the psychological construct of entrapment. Gilbert, Gilbert and Irons state that times when traumatic or stressful life events develop into depression can become entrapments – situations where "a person is highly motivated to get away from their current situation (aroused flight) but unable to do so" (Gilbert et al., 2004, p150). This concept of stasis being a state of reaction to our situation or environment is explored in evolutionary terms. It is well-known that animals have developed evolutionary defense responses to perceived threats which are displayed in three ways: flight, fight and freeze. The behavioural response of freeze enhances survival by aiming to reduce the attention of the threat. Animal studies supporting this theory also show how this arrested fight/flight state produces a depression-like immobile or passive state in mice (Dixon, 1998).

A meta-analysis by Taylor, Gooding, Wood and Tarrier (2011) investigated the psychopathological links between defeat and entrapment and the clinical disorders of depression, anxiety and suicide. The article reviewed 51 clinical and non-clinical studies (45 quantitative and 6 qualitative). Quantitative studies employed mostly a cross-sectional or prospective design with sample sizes ranging from 20 to 11,393 participants. Participants were enrolled from clinical groups such as para-suicidal individuals or depressed patients or from the general population (e.g. Korean schoolchildren). Qualitative studies reported sample sizes between 5 and 80 with all participants recruited from clinical groups such as those displaying depressive or PTSD symptoms. Although these studies were diverse in terms of disorders, study designs, sample sizes and measures, results showed a strong convergent link across the studies with effect sizes mostly ranging from moderate to large suggesting that defeat and entrapment are associated with these forms of psychopathology (Taylor et al., 2011). There appear to be several limitations to this research review however. Firstly there is debate about whether defeat and entrapment should be viewed as one construct or two (Taylor, Wood, Gooding, Johnson & Tarrier, 2009). Although internal and external entrapment are established to be different constructs, for the purposes of this study the authors of this review argued that since external studies were shown to be

either in the minority or all PTSD-related, they could be combined with internal ones. This could have skewed results and it would be interesting to see the results for internal entrapment studies only. Furthermore, the large majority of studies were quantitative (45 vs 6) using existing scales and comprising mostly of existing clinical cohorts who had already been diagnosed with disorders such as depression, anxiety and PTSD. Some of these scales were not directly comparable or did not seem sensitive enough to be able to draw the conclusions which led to the authors proposing a theoretical model of defeat and entrapment. Finally, articles referenced in the previous section show a possible link of stuckness to entrapment but not to defeat. If the constructs of defeat and entrapment were to be conjoined in the future, this might skew investigations into emerging psychological phenomena for which both of these constructs do not hold true.

There have been few studies exploring depressed people's own views about these arrested or inhibited behaviours in depression. In a 2003 study, Gilbert and Gilbert qualitatively explored the meanings that people have for this arrested fight/flight state. Four focus groups were recruited from three in-patient and out-patient groups of individuals exhibiting different types of depression and one group of psychiatric nurses. Results showed that participants identified with arrested escape (entrapment) and anger and felt that that this was a central part of their depression experience. They also clearly differentiated between external entrapment (situational entrapment e.g. relationship or place) and internal entrapment (trapped in depression). Although bringing a different viewpoint, the nurses concurred with the patient statements and additionally could see how people might be trapped by their fear of change. In terms of study limitations, two of the participant groups were either psychiatric in-patients or nurses who worked in a day hospital, therefore the concept of entrapment may have been more of a conscious reality for both of these groups. In the introduction to this study, the author spoke of the many ways in which people exhibit coping behaviours in reaction to negative events. A suggestion for further study would be to contrast entrapment with other non-evolutionary methods of coping in order to understand more fully its role as a protective strategy.

2.3.3 Treatment Resistance and Therapeutic Impasse

Oftentimes during the course of psychological treatment therapy can stall and become stuck. In classic psychoanalytic theory, the unproductive behaviours exhibited by clients during therapy are understood as a defense mechanism and collectively known as resistance (Freud, 1926). Clinically, resistance is defined as “a process of avoiding or diminishing the self-disclosing communication requested by the interviewer because of its capacity to make the interviewee uncomfortable or anxious” (Pope, 1979, p. 74). Nearly all contemporary theories of psychotherapy agree on the existence and implications of resistance, with most assuming that it is a dispositional attribute and that a client in therapy will present with suspicion, anger, opposition and irritation. However different modalities offer contrasting viewpoints on the reasons for resistance which leads to widely varying therapeutic approaches to working with it (Beutler, Moleiro & Talebi, 2002). Although some strategies work well with treatment-resistant clients (e.g. non-directive and self-directive techniques), resistance is known to be a barrier to treatment effectiveness (Nemeroff, 2012).

Early psychoanalysts and soon thereafter, individual psychologists, viewed client resistance as a self-protective and adaptive response which enabled the preservation of core assumptions about themselves, others and of life (Watson, 2006). Both of these groups saw resistance as occurring in the unconscious - therefore within the client – and that any client change would be determined upon the success of ‘accessing and disrupting unconscious processes’ (Watson, 2006).

The development of person-centred and existential approaches in the 1940’s and 1950’s saw a shift in how resistance was understood – primarily as a means for clients to avoid feelings that might become permanent blocks to their awareness which in turn could impair ‘holistic functioning’. This refusal to engage with such processes was a means of avoiding any negative feelings or thoughts that might enter their conscious awareness which might ‘diminish their self-efficacy and self-concept’ (Watson, 2006).

Behavioural therapists saw resistance as a block to goal achievement. Clients were understood to either lack the requisite skills or knowledge needed to complete these assignments; displayed pessimistic expectations

with regard to the success of their treatment or were affected by other negative factors within their environment (Shelton & Levy, 1981). Linking resistance to environmental factors located the source of resistance externally to the client, giving the client (and therapist) limited control over the process, outcome and timing of any useful intervention (Mitchell, 2009). From a cognitive therapy perspective, resistance resulted from a client's negative cognitions and was therefore understood to be an internal client issue. While this may be true, a sole focus on the client's cognitive distortions meant that most of the responsibility for the lack of forward progression in the therapy was conferred onto the client with few therapists attending to their own potentially unproductive treatment approaches – potentially indicating a cognitive distortion of their own (Mitchell, 2009). The Cognitive Behavioural Therapy (CBT) approach sees resistance in clients who fail to complete treatment or do not fully respond to CBT as a treatment option and conceptualises it as ambivalence about change. This modality also notes that resistance to treatment arises when compliance with homework tasks is required, for example, in vivo exposure in anxiety-related disorders or behavioural activation for depression (Westra, 2004).

As Watson (2006) states, psychological therapy is often a challenging and confronting process and clients naturally feel a sense of resistance towards it, as evidenced by the hundreds of theories of psychotherapy recognising how often this is observed within therapy as a client response. Therefore "an understanding of how resistance is conceptualized in various theoretical frameworks may help the counsellor better understand the reasons behind a client's difficult demeanor during the counseling process" (Watson, 2006, p3) and thus potentially positively affect therapy outcomes.

Goulding, Goulding and MacCormick (1978) used the word 'impasse' to refer to intrapsychic conflicts within the client. Over time this meaning evolved to describe the therapeutic impasse that develops between therapist and client within the therapy room. Many studies discuss impasse, but Petriglieri (2007) relates it directly to the concept of feeling stuck and explores this from a developmental perspective. The 'moment' of stuckness in the title of his paper is the moment where we confront our inability to change, conceptualised within Transactional Analysis as a roadblock to be overcome. His study used a single client vignette to show how with the help of the therapist, stuckness can be reframed as a developmental opportunity

– a ‘time to change direction and find new meaning’. However Petriglieri’s case example appeared to be characteristic of a typical therapeutic presentation of personal confusion and any unique characteristics pertaining to stuckness were difficult to isolate within this study.

In a report written from a meeting of the American Psychoanalytic Association in 2012 entitled “How to help get stuck analyses unstuck”, Chaplan (2013) described the presentation of three cases in which the stuckness in therapy was seen as a transferential dynamic occurring between analyst and patient in which the patient unconsciously cast the analyst into an assigned role in which they were fully immersed and this countertransference was conceptualised as a way to understand the ‘forces resisting change” (Chaplan, 2013, p591). Stuckness was described as a ‘clinical entity’ which from a psychoanalytic viewpoint overlapped with concepts such as impasse, negative therapeutic reaction, repetition compulsion, enactment, transference and countertransference. The choice of the word *stuck* in relation to these cases was seen as a ‘pragmatic’ choice “that we can all relate to in an immediate way, and that the details of what any one of us considers a ‘stuck’ development in the analytic situation will be both overdetermined and multidetermined” (Chaplan, 2013, p591). Across all three cases several elements were evident that were considered to ‘characterise’ stuckness – an unrelenting cycle of repetitive interactions within the therapy that tested the therapist’s patience and was only alleviated by the analyst identifying a preconscious aspect to bring both out of this pattern. The stuckness was then seen to transition into a slightly different phase, signifying growth or hope in the process. Transferential affect was seen to be anger – either displaced or suppressed - longing, or sexual feelings linked to a key family member. There was an incorporation of the patient’s body in some elemental way, either through fantasy or an alignment with the physical difficulties of another (for instance the medical problems experienced by one patient’s mother). Elements of stagnation, despair and confusion were also identified within this stuck state, as well as a repetition within therapy, for example one patient repeated the same comments each day of therapy. Two of the three cases highlighted developmental traumas related to difficulties with a ‘crazy, tyrannical’ mother, absent father and potential abandonment and it was also in this way that the body had a role. The stubbornness of the client in their stuck state was seen as a strength - a sign of fight and therefore life in the patient

with the analyst understanding that stuckness may have been a defense necessary for their survival.

2.3.4 The Client Perspective

There is only one known published study which investigates the metaphorical, experiential state of feeling stuck. In her dissertation, Bella (2011) undertook a psychological, spiritual and creative exploration of stuckness. Stuck was defined as “moments when a lack of personal progress and an inability to move forward occur… this lack or absence of forward motion can impede growth and development, resulting in feelings of stagnation or ‘stuckness’”(Bella, 2011, p2). This description resonates with other expressions of this state covered in this review.

This research explored the individual, subjective experience of feeling stuck in a present moment awareness and how it might link to depression and Obsessive Compulsive Disorder (OCD). Bella interviewed a sample of 10 participants who self-described as feeling stuck where stuckness was defined as “a sense of cognitive and emotional immovability accompanied with a lack of personal growth and development that limits potential and engenders suffering” (Bella, 2011, p44). The participants had experienced previous episodes of stuckness and were currently self-reporting as stuck. Data were captured through a session of the Touch Drawing arts technique and during a two-hour, semi-structured qualitative interview which was analysed using a heuristic methodology. Themes emerging from the data showed that *stuck* was experienced as an isolating, frustrating, energetic, angry place and a state of ‘not knowing’, an embodied feeling of almost paralysis, a difficulty in taking the next step (Anderson-Nathe, 2008). It was negative and participants spent a lot of cognitive and emotional resource trying to become unstuck.

Another article has linked the word stuck to OCD with regard to symptoms of repetitive thoughts followed by rituals (Key, Rowa, Bieling, McCabe & Pawluk, 2017) but the findings of this study showed no links between stuckness and OCD. However it is suggested that the repetitive behaviours and intrusive thoughts exhibited by participants could benefit from further exploration in order to understand whether these characteristics pertain to other psychological conditions. Additionally other studies have looked at

links between stuckness and depression (e.g. Holtzheimer & Mayberg, 2011; Maiese, 2017) but this research saw a distinction between the experience of feeling stuck and that of depression. While participants experienced symptoms such as low energy, lack of concentration and sadness, Bella found that none showed anhedonia or physiological symptoms such as change in appetite or sleep – classic markers of clinical depression (Nolen-Hoeksema, 1991). Bella suggested that findings by Lipson and Perkins (1990) showing how judgemental thought patterns may keep people stuck in an emotional and cognitive 'state' might provide a framework to begin to understand this phenomenon.

This study explored the phenomenon of *stuck* through a combination of academic and creative approaches, both of which the researcher suggests would be helpful for clinical practice. The research was for a thesis towards a PhD in East-West Psychology – a programme of cross-disciplinary academic study incorporating aspects of Eastern and Western psychological and spirituality – an approach which some might deem as detracting from its impact as a study of empirical importance due to its combination of clinical and non-clinical aspects. A very homogenous research sample was used (Caucasian North Americans of a similar socio-economic group) and they were not pre-tested for existing psychological conditions.

Bella suggests further research into whether stuck is "indicative of serious psychological mental health issues, a by-product of a psychological disorder, separate events that share some common characteristics, or a phenomenon unique to itself" (Bella, 2011, p201) although does not specifically suggest how this might be undertaken. However this is a clear acknowledgement that further understanding of the way that metaphors are used within the therapeutic field, particularly common ones such as feeling stuck, are an important focus for research.

2.4 The Therapeutic Uses of a Lay Metaphor

Feeling stuck is acknowledged to be a widely reported experience (Petriglieri, 2007) and an online search confirms that it appears to be a term

commonly used to indicate a particular psychological state. Google shows millions of links to psychological articles and websites - popularist websites such as Psychology Today and Huffington Post discuss getting stuck and how to get 'unstuck', ordinary people blog about experiencing stuckness and many therapists advertise for clients who are feeling stuck. There may of course be differences between clinical and lay understandings of what it means to feel stuck. Still, exploring the uses of such a prevalent metaphor within a therapeutic setting might shed valuable light on the role of metaphors in facilitating (or hindering) reflection and communication and in promoting a more 'client-friendly' engagement.

2.4.1 The Shift Towards Lay Perspectives

Mental health disorders are common in all cultures and across all life stages and in 2015 depression alone was estimated to affect more than 300 million people worldwide, with an equal number thought to suffer from anxiety disorders (World Health Organization (WHO), 2017). Worldwide, more years of health were lost to depression than any other disease making it the single largest global disability, with anxiety disorders ranked sixth in severity (WHO, 2017).

Only a small number of people receive treatment and of these, a percentage do not improve. The recovery and remission rates for mood disorders vary, with 40% to 60% of people not responsive to initial psychotherapeutic or pharmacological treatments (Mancebo, Eisen, Pinto, Greenberg, Dyck & Rasmussen, 2006). Clients incorrectly assessed spend time and money receiving inappropriate interventions and have low rates of recovery and those in need of mental health support are more likely than not to receive treatment that is inadequate (Nemeroff, 2012).

UK clinicians of most theoretical orientations strive towards an understanding of the client's presenting symptoms through the form of diagnosis, usually via the current version of the Diagnostic and Statistical Manual of Mental Disorders – currently DSM-5 (American Psychiatric Association, 2013) or the International Classification of Diseases – the ICD-11 (in press) (WHO, 2018). The existence of such manuals affirms that psychological disorders can be verified using objective measures of naturally occurring psychological symptoms in a way that they become

international clinical standards. However attempts at categorisation have drawn clinical criticism from academics, researchers and clinicians with the DSM-5 in particular censured for going too far in medicalising naturally expected behaviour and mood patterns (e.g. bereavement) which has been linked to the increasing influence of the pharmaceutical industry. Additionally the DSM has been criticised on philosophical grounds from those opposed to attempts to classify psychological disorders, particularly from constructivists. This is because of an ideological difference in how constructivists understand the organisation of human knowledge. In Tay (2017), von Glaserfield (1996) states that while constructivism has many variants they all have at their heart two common beliefs – that knowledge is not a passive assimilation of existing laws but is actively constructed in the moment and that these constructions help us to adapt to a world that is evolving rather than one that is already pre-determined. Therefore people are regarded as "active meaning-makers who organize their experiential world for the sake of survival rather than to represent ontological reality" (Raskin, 2011, p. 224).

Constructivist theorists such as George Kelly (1955) saw how meaning-making occurs therapeutically if therapist and client take an interpretative approach to a discussion of the problem rather than accepting any description of it as factual. It is this contention that leads constructivists to contest the acceptance of the DSM in particular as an impartial instrument because they "often doubt the human ability to know the world 'as it is' in an objective sense that is independent of personal and social constructions" (Raskin & Lewandowski, 2000, p16). Constructivists believe that human knowledge is in a state of perpetual change because it is actively constructed and within a psychological domain believe that the DSM cannot ever be objective because it ignores the key axiom that any human involvement will automatically render attempts at constructing psychological definitions subjective. For constructivists, "stressing the importance, even the necessity, of human dialogue and negotiation is central to the creation of scientific models of disorder" (Raskin & Lewandowski, 2000, p16).

Constructivists contend that the DSM's constructions of mental illness are often applied pre-emptively, that is, the choosing of one way to understand disorder automatically rules out other possible interpretations, leading to a diminished range of clinical possibilities in the therapy room (Raskin &

Lewandowski, 2000). This constructionist viewpoint aligns with wider opinion in that providing patients with diagnoses helps alleviate therapist anxiety in instances where they cannot make sense of client presentations within their existing clinical knowledge (Kelly 1955). Kelly posits that new nosological categories are developed as a way of increasing clinician's confidence in these manuals thus circumventing any questions that might arise when clinicians are faced with the many diagnostic exceptions that do not conform to the textbook standards outlined. He suggests that these exceptions are 'overlooked' and that therapists 'pre-empt' manualised interpretations over alternatives as a way of mitigating these anxieties and the knowledge that the existing systems of disorder are not as 'predictive and meaningful as they may like' (Raskin & Lewandowski, 2000). This approach clearly negates any opportunity for meaning-making as the opportunity to together search for other alternatives is closed down (Raskin & Lewandowski, 2000).

These findings support the opening up of clinical interpretations and incorporating other viewpoints of meaning making. It seems that the more reliance and trust one has in whichever major classification system one uses, the less likely one is to work with client descriptions or linguistic terms as imprecise as lay metaphor therefore it is imperative that the manual's diagnostic categories are based upon rigorous research and scientific validity. As Raskin & Lewandowski (2000, p34) state, "If science involves systematic efforts at making meaning of lived experience, in the spirit of constructive alternativism, then there are an infinite number of ways to scientifically conceptualize disorder. We do not advocate for extracting science from the study of meaning. On the contrary, we advocate for acknowledgment of human involvement and meaning in conducting scientific inquiry".

This recognition of the need to incorporate broader perspectives, particularly since clinical research is necessarily reductionist, is evident in a shift towards lay perspectives and a growing body of research at primary care level is being undertaken in order to explore how lay people understand and construct their illnesses (Kokanovic, Butler, Halilovich, Palmer, Griffiths, Dowrick & Gunn, 2013), to hold respectful enquiry into client meaning-making in order to determine whether a lay concept might hold clinical validity. This is an epistemological shift towards the view that

“understanding the patient’s lifeworld cannot be reduced to measurable variables designed to identify a psychiatric diagnosis. Rather, the emphasis must be on understanding and interpreting unrestricted personal accounts of particular experiences” (Murray, 1997, p13).

The move towards incorporating lay descriptions within a medical framework is therefore important as psychiatry has been criticised for offering a narrow lens through which mental illness is conceptualised, one which derogates individual subjective experience (Strauss, 1989; Vanthuyne, 2003). Interestingly, in doing so, psychiatry ignores its own theoretical roots in metaphor as many psychiatric disorders and terms are metaphorical in origin (for instance, schizophrenia means splitting; people are ‘derailed’, feel ‘high or low’, ‘deranged’ and ‘obsessed’) (Rosenman, 2008, p393). When doctors and their patients talk about depression, they do this via a range of visual and linguistic metaphors which follow a common theme – ‘darkness, depletion, decline, diminution and stillness’ (Rosenman, 2008, p392).

Within clinical settings “people with chronic illnesses often use metaphors in conventional and creative ways to help them understand their experience and talk about it with others” (Gwyn & Elwyn, 1999, p439). Perceiving what people mean when they use metaphors to describe their conditions is important as clinical interpretation by doctors and therapists can be inaccurate, even for common mental illnesses such as depression. When a practitioner is solely guided by a DSM-5 or ICD-11 framework, it suggests that a clinical phenomenon such as depression can be diagnosed in a straightforward manner and will manifest in similar ways in all patients. However although depression is a global pandemic (Kokanovic et al., 2013), at primary care level general practitioners are able to diagnose depression in only 50% of cases (Mitchell, Rao & Vaze, 2011) and even then many find it difficult to prescribe the correct treatment (Kokanovic et al., 2013), suggesting that the diagnostic labels and descriptions that GP’s are using are not comprehensive enough.

Metaphors are thus a discursive device widely used to convey a subjective experience and provide a language for people to communicate to others feelings and emotions not yet fully understood (Rosenman, 2008). People search for metaphors that hold personal meaning and help them to make

sense of their lives (Lakoff & Johnson, 1980). The clinical meaning behind a metaphor can be unclear and this may be advantageous in that such imprecision defies an exact definition and therefore challenges the notion proposed by the diagnostic manuals that there is only one truth. People try to describe a particular psychological experience that they don't always have the words for so they use more accessible frameworks such as metaphors such as *stuckness*. On the other hand, medical professionals are deferring to established understandings of psychological conditions and these contrasting approaches will not necessarily cohere in meaning, therefore there remains a gap in understanding that existing manuals do not seem to bridge, one that constructivists suggest can be broached by a more collaboratively constructed understanding between patient and clinician.

2.4.2 Metaphors as 'symbolic currency'

Neuroscience, psychology and linguistic studies into human cognition and communication demonstrate the natural inclination for people to think in a metaphorical way. Metaphors are used in conversations about any topic and it is estimated that of every 25-30 words spoken there is one metaphor used (Graesser, Mio, & Millis, 1989). Three out of four metaphors are thought to be 'frozen' metaphors, that is, metaphors so commonplace that they are no longer recognised as metaphoric (e.g. the 'mouth' of the river) (Barlow, Pollio & Fine, 1977).

Harley (2013) states that deriving meaning from our words is the ultimate purpose of language processing. Meaning is represented through semantic networks with semantic memory being our store of general knowledge, quite literally our mental encyclopaedia. Meaning is closely linked to our concept of categorisation – how things are related or categorised as it is thought that all words have an underlying conceptual structure (Harley, 2013). Metaphors help people to find similarities between concepts and objects (known as conceptual metaphors) but also to expand their world views through their ability to connect concepts which initially seem very different (linguistic metaphors). Metaphors have always been considered a regular part of thought and language but Lakoff and Johnson (1980) in their seminal work *Metaphors We Live By* considered that their contribution is much more important - that metaphors allow us to understand one idea or

concept (conceptual metaphor) in terms of another – a theory known as the Conceptual Metaphor Theory (CMT) (Gibbs, 2011). The word 'metaphor' derives from the Greek *meta-pherein* and means to carry over from one place to another, that is, that the image or 'word-picture' utilised in a metaphoric statement carries meaning over to the subject or experience that is being referred to (Kopp & Craw, 1998). In more structural terms, metaphors are considered to be made up of two domains – a 'target' domain (the concept used to explain the metaphor) and the 'source' domain (a concrete subject the target domain links to) (Lakoff & Johnson, 1980). These two domains in a metaphor combine to demonstrate the target domains' properties (Wagener, 2017). In this way metaphors assume a powerful 'symbolic currency' in written and spoken language influencing not only our reflective practices and but also our actions (Coghlan & Brydon-Miller, 2014; Lakoff & Johnson, 1980). Lakoff and Johnson's assumptions on the role of metaphor reinvigorated interest in this linguistic feature and stimulated studies and debate across multiple academic disciplines including cognitive and clinical psychology and the CMT remains the leading academic theoretical framework (Gibbs, 2011; Moser, 2000).

In a recent study of the CMT, Reid (2018) considered that although Lakoff and Johnson (1980) has been highly influential across multiple disciplines, the CMT had been less tested against established experimental memory paradigms in cognitive psychology, an important field as it is "a branch of psychology concerned with mental processes (as perception, thinking, learning, and memory) especially with respect to the internal events occurring between sensory stimulation and the overt expression of behaviour" (Merriam-Webster, 2018). Their study replicated existing paradigms and methodology widely used in previous experimental research on memory in order to confirm whether memory is influenced by conceptual metaphors as indicated in these studies. Lakoff (2008) posits that when one hears or reads a metaphorical expression the conceptual metaphor underlying it becomes activated. Following this principle, the methodology of this study assumed that when a participant read one metaphorical expression the conceptual metaphor associated with it would be engaged and if several expressions linked to the same conceptual metaphor are read this would highly activate the conceptual metaphor, as would be indicated in a later memory test of the original expressions.

The study utilised the DRM false memory paradigm (Roediger & McDermott, 1995) (as below). This task was chosen as it allowed for a hypothesis to be tested whilst also providing for control conditions. During this test participants were shown lists of words which were each strongly linked to a dominant but unpresented conceptual metaphor. This phase of the test was based on the protocol established by Roediger and McDermott (1995) which presented words (e.g. snooze, tired and bed) but not the associated critical conceptual word 'sleep'. This links to the CMT which posited that the "participants should falsely remember a non-presented conceptual metaphor or other metaphoric expressions based on that conceptual metaphor after reading a list of several metaphorical expressions based on this conceptual metaphor" (Reid, 2018, p39). The Roediger and McDermott (1995) study showed that during two tasks the non-presented word had a very high recall of 40% and 55%. Participants in this study were 47 undergraduate psychology students at Western University recruited online. They were shown several sets of metaphorical expressions with each set corresponding to a conceptual metaphor identified by a master list from Lakoff and Johnson (1980). After a short break during which a mathematical distraction task was completed, participants were then presented with a list of items including the expressions they were previously shown plus the linked conceptual metaphor and other false 'lures' similar to the key metaphor and asked to identify the original items. The results supported the extant research literature on CMT in finding that reading a metaphoric expression automatically activates its underlying conceptual structures. A condition that did not appear to be controlled for in this study was ethnicity. Metaphors are considered to vary widely across languages and cultures (Lakoff, 1993) given that source domain entities and events can be more salient in one culture than another (Deignan, 2003). This could therefore impact on a participant's ability to link to a common conceptual metaphor if they were raised in a different culture.

This study has implications for the use of the metaphor as it presents within therapy as a link to a specific underlying conceptual structure signifies some relevance or significance for the client which suggests it may be more meaningful in some way than any other similar term.

2.4.3 Metaphor, Emotion and the Therapeutic Dyad

At the heart of most therapeutic encounters is a focus on assisting clients to recognise their emotional needs and patterns and help to develop greater emotional clarity. Therefore it is important to further understand how metaphors are connected to emotion (Wagener, 2017). Ortony and Fainsilber (1987) found that metaphors appear more frequently when speaking of emotional topics and that with emotional intensity this frequency increases. This is thought to be because intense emotions require references in order to be communicated to others, thus increasing the reliance on metaphoric language when describing these experiences (Crawford, 2009; Smollan, 2014). Metaphors not only provide source domains as a means of expressing these intense emotions but "may be ideal for relating emotional experiences because of their ability to encapsulate specific and content-rich information in a concise and broadly understandable manner" (Wagener, 2017, p145; Fainsilber & Ortony, 1987).

This heightened emotional intensity is able to be expressed through the visual and descriptive terms that people access when making metaphoric comparisons. For instance, to say 'my job is a jail' communicates a deeper, more textured image and meaning than a statement such as 'my job is terrible' (Gibbs & Colston, 2012, p230). We may use metaphoric language to describe affective experience because our literal language is inadequate and because emotions are abstruse and complex to conceptualise (Crawford, 2009) and Lakoff and Johnson (1980) suggest that this is why we adapt more concrete experiential structures as a way to capture and convey our emotions as it makes us able to cognitively express them in a way that is relatable to others.

Recent fMRI studies verify the association between metaphor and emotions as regions of the brain linked with emotion such as the left amygdala are more highly activated in response to metaphoric language when compared to literal language with the same meaning and emotional valence (Bohrn, Altmann, & Jacobs, 2012; Citron & Goldberg, 2014; Citron, Güsten, Michaelis, & Goldberg, 2016).

Research thus supports the influence of metaphor on emotional processing which has implications for therapeutic practice. A study by Fetterman, Bair, Werth, Landkammer and Robinson (2016) compared a control group of participants writing about personal experiences in a literal way with a group who wrote using metaphor, with the latter group showing a significant reduction in negative affect as well as a preference for writing in this way. However a limitation to this study could be that participants were required to log online in order to submit their journal entries and it has been suggested that typing exerts an additional load on working memory thus reducing self-focus and emotional engagement compared to writing longhand which is linked with greater negative affect but also greater perceived emotional benefit (Brewin & Lennard, 1999). Therefore this variable and its possible implications (for instance, that it was the act of typing not the use of metaphor that explained the decrease in negative affect) were not considered and thereby eliminated as a factor by the researchers. However when comparing between control groups, these findings could be held to support the positive benefits of using metaphors within therapy to support emotional change (Wagener, 2017).

Crapanzano (1977) was one of the first to understand the tensions between an individual's personal experience of their mental health issue with the discourses they have available to them. In psychotherapy, "people struggle to find words to capture difficult-to-describe sensations, emotions, psychological states and views of self … and often rely on figurative expressions as a way to convey what they want to say both to themselves and to the therapist" (McMullen, 1996, p252). A practitioner's role and hegemony within the therapy room cannot be overstated and it has been noted how psychoanalysts in particular can often ignore the intent of a client's communication through too directed a focus towards the subconscious feelings hidden therein (Needham-Didsbury, 2013). Manthei (2005) purports that "much existing research into therapy supports dominant discourses that privilege the therapist's view of the experience of therapy over the client's" (Bonsmann, 2010, p31).
For both client and therapist the use of metaphor seems to be instinctive and directive yet it is still not understood and academics have repeatedly reinforced the need for more research into the connection between psychotherapy and the theory of metaphor (Needham-Didsbury, 2014).

Research into therapists' use of metaphors within therapy found that clinicians deliberately use metaphors to support clinical outcomes "heightening the patient's emotional awareness; enhancing recall of significant therapeutic events; increasing memorability for important in-session events, enhancing the therapeutic relationship and elaborating and re-making of meaning" (Rowat, De Stefano & Drapeau 2008, p21). fMRI research supports the use of metaphor within therapy as Rapp, Leube, Erb, Grodd and Kircher (2014) found that metaphor processing activated the region of the brain associated with semantic language comprehension – the left inferior frontal gyrus – which suggests that the use of metaphors in cognitive-focused treatment helps clients to generate new semantic associations, particularly when speaking of difficult experiences as they provide a method by which to convey 'abstract concepts in terms of concrete ones' (Rowat et al., 2008; Stott, Mansell, Salkovskis, Lavender & Cartwright-Hatton, 2010).

Exploring metaphors within therapy often works to strengthen the bond between therapist and client as the metaphor becomes an expression that is worked with together and they begin to 'speak the same language' therefore the client may feel more understood (Stott et al., 2010). Many psychotherapies including Cognitive Behavioural Therapy (CBT) acknowledge their use of metaphor (Mathieson, Jordan, Merrick & Stubbe, 2016) but Acceptance and Commitment Therapy (ACT) is perhaps the most well-known example of a modality that utilises metaphors in its approach to working with clients. Through its development of a 'relational networks theory of metaphor', it prioritises deliteralising psychological content and allowing clients access to a richer language experience through the visual, conceptual nature of metaphors helping clients to be less susceptible to cognitive fusion – the compelling tendency to focus on thoughts and disregard other sensory input in their world (Foody, Barnes-Holmes, Y., Barnes-Holmes, D., Törneke, Luciano, Stewart, & McEnteggart, 2014). There has however been criticism of the empirical research that has been undertaken to substantiate ACT's use of metaphor and other techniques to improve 'psychological flexibility' in clients, arguing that low methodological rigour means that any positive outcomes cannot be generalised to clinical practice (Ost, 2008). However another review comparing Cognitive Therapy (CT) and ACT finds that "although preliminary research on ACT is promising, we suggest that its proponents

need to be appropriately humble in their claims. In particular, like CT, ACT cannot yet make strong claims that its unique and theory-driven intervention components are active ingredients in its effects" (Herbert, 2013, p218).

A Levitt, Korman and Angus (2000) study showed through transformation of the negative aspect of the metaphor into its more hopeful positive position e.g. for a client who may feel 'weighed down by a burden', if the metaphor is taken up and worked with during therapy the burden may be 'lifted' or 'put down' and researchers observed that constructive change could be created through this type of in-session dialogue. Research such as this and "the belief that something unique happens when a patient voices a metaphor" were the impetus behind a Rowat study (Rowat et al.,2008, p22). This research explored the influence of client-generated metaphors on in-session experiencing, that is, how a client's own reflective reference points such as metaphors become a willing focus for both client and therapist within the session. Transcriptions from videoed initial sessions between clients and trainee therapists at a North American university were coded for metaphors and pre- and post-metaphor client utterances. An ANOVA (a repeated-measures analysis of variance) further confirmed by a paired t-test showed that the results were non-significant as the results showed little experiencing difference pre and post-use of metaphors. One of the study limitations noted by researchers was that the variations of valence of the metaphors in the study were not identified which may "have impacted the study results as certain metaphors may not be viewed as deepening in-session experiencing because they are perceived as idiomatic descriptive expressions, more connected with colloquial use than emotional depth" (Rowat, 2008, p25). Given the distinctions already drawn between frozen and novel metaphors in this review, it might have been interesting if this study had identified and selected novel metaphors only as they are considered to have a higher emotional charge therefore the impact on in-session experiencing might have been more easily determined.

These studies show that metaphors are a vital component of everyday communication which allow people to express concepts, thoughts and feelings in a way that others can understand and relate to. The implications for a therapeutic context are highlighted in the research which indicates that metaphors carry emotional depth therefore working with metaphor may be

an additional resource for therapists to work with if they allow them to be understood as “a patient’s shorthand communication of an aspect of his or her psychological or emotional experience” (Rowat et al., 2008).

2.5 Conclusion

During the course of life, adverse events are a common occurrence and while most people move on, some are unable to and get *stuck*. Why this happens is not well understood. An examination of the clinical research found a small and disparate collection of studies all using the stuck metaphor covering biological and psychological aspects of stuckness and showing links to rumination, internal entrapment and maladaptive coping skills. There appeared to be an associated psychopathology which includes ruminative brooding, breakdown and depression causing a significant amount of distress. Only two pieces of literature spoke more directly to the subjective experience of feeling stuck. Chaplan’s (2013) psychoanalytic panel report linked stuckness to repetition, stagnation, attachment and embodiment – a place of fight which was also a sign of hope. Bella’s (2011) thesis also identified stuckness as a place where movement was impeded but as the main focus of her work was to investigate whether stuckness was related to either OCD or depression - subsequently disproven - it is not yet clear whether a subjective experience of stuckness demonstrates any aspects of the psychological phenomena uncovered in the empirical literature. Although the studies attribute different psychological meanings to stuckness, there is one point on which the studies cohere which is that a state of stuckness seems to capture an experience of stasis or immobility which can cause significant emotional and psychological distress.

Emotion is considered to be an “experience that people have little primary language for and necessarily speak of by metaphors of physical experiences that we can apprehend” (Gibbons, 2012). Metaphors are an important way in which people facilitate perceptions of the world around them, process information and formulate their feelings. The metaphor *feeling stuck* is common within the lay vernacular and often used by people as a means to convey a particular type of emotional or psychological experience. As such, it is also used by therapists as a way to engage

clients in therapy. Without an agreed definition of stuckness to work with, it is important to understand how therapists' make meaning of the client-reported phenomenon of feeling *stuck*.

2.6 Rationale for Current Research Study

As psychological or emotional stuckness is a concern that brings people to therapy, a study which examines the experience of working with this phenomenon and the meaning that therapists make from it could help other psychologists and psychotherapists who may be trying to make sense of this little researched but commonly found phenomenon. As was described above, it should also contribute to the emerging literature on the functions and importance of metaphor in therapeutic work. Finally, as Kasket (2012) suggests, focus on a research topic which has applicability to an aspect of professional practice is an important component of a counselling psychology research study. This researcher has attempted to encompass the values and ethos of counselling psychology through a focus on one aspect of our clients' subjective experience which it is hoped will support our understanding of client and therapist meaning-making within this context and enhance the therapeutic alliance.

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3. METHODOLOGICAL OVERVIEW

3.1 Research Approach

3.1.1 Research Aim

This study aims to explore what psychologists and psychotherapists understand the term *feeling stuck* to mean when clients speak of it within a therapeutic encounter. As a metaphor used by both practitioner and client during therapy*, feeling stuck* is a clinical therapeutic phenomenon and this project seeks to examine how a client experience of stuckness is conceptualised by therapists during therapy and what meaning is brought to this. Of particular interest is the choice of this specific metaphor to convey a psychological or emotional state and how therapists interpret this phenomenon and approach it from a treatment perspective.

3.1.2 Research Question

How do therapists understand the client-reported phenomenon of feeling *stuck*?

3.2 Philosophical Considerations

3.2.1 Paradigm and Ontological Stance

Embedded within this research question are assumptions about ‘what constitutes reality’ and a belief that generating knowledge of this kind will be possible (Willig, 2013). It is a statement of intent about ontological, epistemological and methodological viewpoints - of the research itself and of its governing paradigm.

Paradigms are structures of overarching worldviews, elemental belief systems that guide the researcher and are supported and made visible through ontological assumptions about the nature of reality (Guba &

Lincoln, 1994). Paradigms sit on a continuum from scientific to interpretivist and are matched with ontological assumptions which range from realist to relativist (Scotland, 2012). A realist perspective holds that the world and the laws that govern it are already in existence, independent of the knower (Cohen, Manion & Morrison, 2007). A relativist ontology suggests that the world and its phenomena are constructions which are collectively brought into being by a process of mutual agreement.

When thinking about what is believed about the world and what exists, the question that is therefore asked of the research is – what is there to know about the state of feeling *stuck*? A realist might deem the phenomenon as tangible as anything in psychology is possible to be e.g. a diagnosis. A relativist position may be that there is nothing absolute about a *feeling stuck* state because truth is only created through language in that moment. This researcher recognises that from an ontological perspective, there may be various ways one could understand feeling *stuck*, particularly discursively as it is a commonly used metaphor which suggests that at an over-arching level there is some level of agreement of stuckness as a particular type of episode but which at a personal, discrete level might actually be experienced quite differently. From a therapy perspective, clinicians work with people who are reportedly feeling stuck, who present with what they feel is a real issue, so then this moves into the realm of psychological difficulty. It brings up assumptions about the person, about the mind and what someone can feel and experience. People present to therapy with a sense that something is wrong, and that this 'something' is feeling *stuck*, therefore this subjectively exists to the person. An individual subjective experience could be deemed to be constructive, but the collective use of this metaphor in lay and therapeutic terms suggests that it may be a phenomenon that can be positively identified, therefore moving it more towards an essentialist entity.

This researcher approaches the understanding of stuckness from a critical realist perspective and posits that it more than a linguistic device and can be held to be a discernible phenomenon because from a phenomenological perspective, it seems to be 'something' that within particular circumstances and at particular times is able to be experienced by a person (Willig, 2013). This viewpoint is supported by the collective use of the term *feeling stuck* in lay and therapeutic circles, the latter being a domain which acknowledges

that this and other psychological or emotional phenomena can be experienced by individuals in unique and subjective ways.

3.2.2 Epistemological Framework

Epistemology is the theory of knowledge and asks what can be known and how this knowledge is influenced by the relationship between the knower (participant) and would-be knower (researcher) (Guba & Lincoln, 1994). It is similar to ontology in that both are essentially referring to truth and knowledge and the world, if such things exist, but epistemology asks *how* we can know about them. Epistemological positions range from beliefs that knowledge is a 'true' knowledge (positivist) to conceptions that nothing can be held to be true (social constructionist) (Willig, 2013).

3.2.3 The Rejection of Positivism

The positivist epistemology is absolute and uncompromising in its belief in an objective reality and that impartial positivists can go forth into the world and discover 'true' knowledge. "Meanings solely reside in objects, not in the conscience of the researcher and it is the aim of the researcher to obtain this meaning" (Scotland, 2012). Over the years this stance has softened to a post-positivist view which concedes that while purely objective observation may still be possible, there is likely to be some subjectivity on the part of the researcher but this can be minimised through a hypothetico-deductive process when gathering and testing data. However as Willig (2013) states, it is a delusion to think that any study can be truly objective and that a researcher could be exempt from influencing or invalidating it. The hypothetico-deductive approach explores hypotheses linked to existing theories, which has resulted in confining research to a small pool of researchers and scientists familiar with these theories and the mainly quantitative systems necessary to test them. For a long time these research practices seemed so dominant in the social sciences and unchallengeable they were like dogma, and for this reason they were not recognised as simply an alternative epistemological position. There are now other contrasting epistemological stances including social constructionism, a position that stands in opposition to post-positivism and which mandates that a phenomenon, perception or experience does not exist until it is mutually agreed upon and is mediated through culture,

history and linguistics. Willig (2013) suggests that this does not mean that we can never really know anything, rather that there are ‘knowledges’ rather than ‘knowledge’.

This researcher rejects the post-positivist paradigm for several reasons despite its enduring dominance in social science research and its role in forming the very underpinnings of the development of psychology as a discipline. Firstly, quantitative hypotheses must link to existing theories. The phenomenon of feeling *stuck* is not considered to be a clinical construct and has little existing knowledge base within the psychology field to link to. Secondly, *feeling stuck* is a lay metaphor embedded within societal discourse, therefore it lends itself to a study which is able to more fully immerse itself within a paradigm that is more accepting of the exploratory work that can be carried out through qualitative approaches. Thirdly, there is a fundamental epistemological conflict as this researcher tends towards the idea that “knowledge is mediated reflectively through the perspective of the researcher” (Creswell, 2009) therefore contravening one of the key tenets of post-positivism with regard to researcher objectivity.

3.2.4 Critical Realism

This researcher assumes a critical realist position and posits that there is a real world, an external reality that can accessed and agreed upon whilst also accepting that an individual can subjectively experience ‘their own world’. The critical realist paradigm can encompass both ontological realism (that there is a natural world that exists independent from human construction and observation) and epistemological constructivism and relativism (how we understand our world is socially constructed from our own perspectives and viewpoint) (Maxwell, 2012).

Within the proposed study, a critical realist position would assume that the “there is a real, wider world with political and social structures that shape the way both participants and the researcher construct meaning” (Willig, 2012). The inherent flexibility of this epistemological position is thus validated through the use of Thematic Analysis as an approach, as through the researcher’s thorough engagement with the participant’s text Thematic Analysis “can be a ‘contextualist’ method from the theoretical perspective of critical realism” whereby people are able to derive meaning from their

experiences but that this is influenced by the wider social context within which it occurs as suggested by one website (Braun, 2018).

In order to determine how therapists understand the phenomenon of feeling *stuck*, the researcher, by adopting a critical realist perspective, proposes that our social interactions are constructed discursively but that there are material practices that are not reducible to language and that are said to exist; in other words, “while meaning is made in interaction, non-discursive elements also impact on that meaning” (Sims-Schouten, Riley & Willig, 2007, p102). This position mediates between a positivist viewpoint by allowing that a truth can be agreed and a social constructionist view that this truth can be moderated by new information that is uncovered through the research process.

From a critical realist perspective then, there is an assumption of what it is to be a human in the world, what we are all confronted with in the world, where it may be possible for there to be some consensus in terms of economic, cultural and other societal structures but how we negotiate or respond to these is thought to be very individual. So the notion of feeling *stuck* is a response to these structures that exist in that a metaphor can at some level signify a collective view but *stuck* as an experience is very subjective and individual and is not necessarily going to be shared or going to be constructed with others. In other words, it could be argued that an experience like feeling *stuck* remains to be constructed.

The position the researcher takes is that there is no universal truth about the phenomenon *feeling stuck* but that there is a constructed sense of it which seems to come up again and again. In thinking about how it might be possible to find out about this phenomenon through this study, the researcher has used a method that accesses the phenomenological, that assumes that the words that someone speaks give us some sort of access into their subjective world. A true phenomenological stance would assume that the world only exists as constructed by and through a person’s experience. It is here that a critical realist position has utility, for a client’s use of this linguistic term within the therapy room acts as a therapeutic currency; it is used to capture their subjective experience and is offered up within the therapy room in the hope that there exists some common albeit

imperfect understanding in order for it to be, if not fully understood or comprehended, at least taken up and worked with by the therapist.

3.3 Rationale for Using a Qualitative Research Paradigm

As Willig (2013, p8) states a researcher's epistemological stance is more strongly influenced by methodology, not methods.

Qualitative methods are an ideal approach with which to explore the little-understood phenomenon of feeling *stuck* as they are concerned with the complexity and uniqueness of human lives and "reject the notion of there being a simple relationship between our perception of the world and the world itself" as suggested by one website (Braun, 2018). They allow respondents to speak in greater depth about the qualities of an experience or phenomenon (Griffin, 2004). They allow us to understand more fully aspects of social context dynamics – how people live, behave and interact (Strauss & Corbin, 1990) and how people's worlds are 'understood, experimented or produced' (Mason, 2006). This provides a counter to the nomothetic approach of positivist methodologies where qualitative methods are viewed as imprecise - qualitative methods are not concerned with the formulation of universal laws but instead are interested in meaning, how people make sense of the world and experience events and phenomena from their own subjective frame of reference (Willig, 2001). However qualitative research is aware of the tentative nature of its work, how small samples mean that the research is not generalisable, how such research is context-dependent - a snapshot of the meaning that an individual draws from their experience or observation of a phenomenon in that moment. Researcher interference is countered by the transparency brought by personal and epistemological reflexivity.

Qualitative approaches are particularly suited for research into mental health as they allow us to investigate how people make sense of illness (Cornford, 2007) and "many psychological issues require the in-depth focus of qualitative research if they are to be addressed in a meaningful and non-reductionist manner" (Griffin, 2004, p9), particularly explorations around how people psychologically respond to treatment (Biggerstaff, 2008).

As there is no one, accepted reality of what it is to feel *stuck* and this term has not been examined within the clinical literature, this type of enquiry lends itself to qualitative methods as a way of preliminarily exploring this phenomenon.

3.3.1 Rationale for Selecting Thematic Analysis

Given the researcher's assumption that this phenomenon exists through the use of the term in lay and therapeutic circles, the researcher has looked for a method that accesses the phenomenological; an approach that assumes that the words that someone speaks give us some sort of access into their subjective world but is still amenable to a critical realist perspective. As there are no current clinical studies investigating the state of emotional psychological stuckness, Thematic Analysis (TA) was chosen as an analytic technique in order to begin to form a preliminary understanding of the meanings therapists bring to this phenomenon. "Qualitative approaches are incredibly diverse, complex and nuanced" (Braun & Clarke, 2006, p4; Holloway & Todres, 2003) and TA in particular is felt to be a foundational method for all forms of qualitative analysis (Braun & Clarke, 2006).

TA is a theoretical chameleon and able to assume the epistemological position of the researcher (Braun & Clarke, 2006). In its early development, TA was considered to be a phenomenological method and 'still fits well with the assumptions of social phenomenology' (Joffe, 2011). Through a lens of critical realism, 'meaning and experience and language' can be theorised in a relatively straightforward way (Braun & Clarke, 2006) with an assumption that the overlying political and social structures impact upon participant and researcher and influence the way that meaning is constructed (Willig, 2012).

Despite its theoretical atheism it is not without theory – an essential part of working with this approach is that researchers carefully consider and apply a chosen theoretical framework. To do this, Braun and Clarke advise researchers to adhere to four main criteria: consider the broader ontological and epistemological structure that will shape the research. Choose the specific theories that underpin the use of this approach, for example phenomenological or poststructuralist. Decide on a deductive or inductive

analytic approach. Finally, code for semantic or latent meaning (Braun & Clarke, 2014).

TA is unique in that it is a method and not a methodology, unlike many of the other approaches (Braun & Clarke, 2006). This theoretical flexibility allows it the freedom to engage with many types of qualitative research questions including individual experiences; people's views; opinions and practices; social objects representations in specific contexts and how social objects are constructed and associated discourses as suggested by one website (Braun, 2018). While sometimes considered a basic and utilitarian analytic approach, this perception belies its ability provide an account of the data which is detailed and complex as it allows patterns (or themes) to be reported and interpreted across the data set (Braun & Clarke, 2014). While it is not beholden to a defined theoretical 'framework', it does provide a defined set of analytical procedures. Themes or patterns can be elicited from the data inductively whereby the themes derive from the data itself or deductively, a way informed by the researcher's prior theoretical interest in the area. This researcher will aim to identify patterns at a latent, interpretative level and through a critical realist viewpoint, seek to produce simple themes that derive from a semantic interpretation of the data as fits within a relativist ontology (Braun & Clarke, 2006; Boyatzis, 1998). In this way, TA will allow space for preliminary exploration of a little researched topic, allowing the researcher to bring forth themes or commonalities in the data without having to develop theory which may be premature given the dearth of existing research, for instance, as would be sought by using a more developed analytic technique such as Grounded Theory which focuses on social processes or influencing factors of a phenomenon.

This researcher understands the limitations of applying TA to this study. Its reputation as a foundational qualitative approach and relative simplicity has led to debates about whether it can be considered a clear method or methodology or just a set of analytic tools. This is mostly due to its theoretical flexibility and comparative ease of application, which has led to further confusion and uncertainty regarding coding and theme development. Researchers were unsure how to approach codes and themes in a systematic way and the method was seen as lacking this structure and coherence until relatively recently when Braun and Clarke (2006) developed a set of guidelines.

Compared with more robustly stated methods such as Interpretative Phenomenological Analysis and Grounded Theory, TA takes no clear position. However as Holloway and Todres (2003) state, taking a clear epistemological position when using TA will give clear parameters to the research and its empirical claims (Nowell, Norris, White & Moules, 2017).

Finally, TA does not allow claims to be made about language use (Braun & Clarke, 2006). Although this research is investigating the use of a lay metaphor within therapy, the study's aim is to understand therapists' meaning-making around this term and does not seek to define this phenomenon.

3.3.2 A Rejection of Alternative Methodological Approaches

3.3.2.1 Interpretative Phenomenological Analysis (IPA)

As one website (Braun, 2018) states, the results drawn from a TA and IPA analysis can look very similar therefore IPA is an alternative analytic technique that was considered suitable for this study.

As a methodology, IPA is rooted within a phenomenological perspective which has as its central concern a "return to embodied, experiential meanings, aiming for a fresh, complex, rich description of a phenomenon as it is concretely lived" (Finlay, 2012, p6). However TA is a simple method which can also adopt a phenomenological epistemology but supports a number of other diverse theories such as realism and constructualism. While this researcher has taken a contextualist approach to the research by adopting a critical realist perspective - a theoretical framework that can be utilised by both of these methodologies - it is in the approach to data collection and theme development that IPA and TA are most divergent.

A key IPA strength is its focus on close and detailed analysis of people's everyday experiences of reality in order to understand how meaning is created (Sokolowski, 2000) which necessitates small samples which are homogenous in nature. From an analytic perspective, while IPA seeks meaning across participants, its primary aim is to take a strong idiographic focus on the lived experience of each individual participant within the small

sample. This focus on individual experience and the "development of meaningful points of similarity and difference between participants" (Smith et al., 2009, p51) is not the most suitable way to analyse this data. TA offers a method for "systematically identifying, organising and offering insight into patterns of meaning *across* a data set, allowing the researcher to make sense of collective or shared meanings and experiences" (Braun & Clarke, 2012, p2). Larger samples with more heterogeneity are recommended within a TA framework and would provide the flexibility required for the exploratory aims of this research project.

IPA primarily seeks to explore the lived experience of an individual within their personal and subjective world and the meanings that they attribute to their experiences (Smith, Flowers & Larkin, 2009; Smith, 1996). However this research project did not seek to capture accounts of participants' personal experiences of the phenomenon (although elements of this will be taken); it has a broader remit, that is, seeking to understand the meaning that therapists make from their experiences and what they understand *feeling stuck* to be. Also as *stuck* is not clearly understood, it might be premature to suggest exploring experiences without knowing yet which experiences might be worth investigating.

Terry, Hayfield, Clarke and Braun (2017) suggest one of the topic areas that TA is most suitable for is research questions pertaining to 'understandings and perceptions', with a focus on how groups of patients or professionals understand a particular heath, clinical condition or intervention. This is the precise territory that the research question seeks to explore and TA more so than IPA will be able to sustain the more directive interview protocol necessary to obtain data within this framework.

3.3.2.2 Discourse Analysis (DA)

One could consider that the investigation of a metaphor would be suited to a research methodology that focuses on and analyses the language that people use to construct meaning in their lives. Indeed with regard to constructionist or Critical Thematic Analysis and Thematic Discourse Analysis, Braun argues that there is very little to differentiate between in these analytic approaches (Braun, 2018). However TA and DA approach the analysis of data differently. DA requires a more detailed, micro analysis

of language therefore it is advantageous if the researcher has a technical knowledge of language practices. Although TA 'recognises the constitutive nature of language and discourse' it does not generally involve such a close analysis of language use and sees language as 'mirroring' reality whereas in DA 'language is theorised as *creating* reality' as suggested by one website (Braun, 2018).

Braun sees distinct differences in the approach to coding and theme development, with TA applying a more defined and systematic method to analysis within a constructionist theoretical framework whereas a thematically applied DA takes a more fluid and organic approach to analysis and codes themes and discourses in order to identify 'underlying systems of meanings'(Taylor & Ussher, 2001, p297; Braun, 2018). Although it also retains a specific interest in patterned meaning (discourses) within the dataset, coding in DA relies more on the researcher's technical ability of language practice than a high level of analytical ability in order to bring the subtlety required for discursive analysis at this level (Potter & Wetherell, 1987; Braun 2018). Therefore DA is generally applied when looking for a deeper, more nuanced, more contextualised understanding of an accepted phenomenon through language and is more interested in "how people use discursive resources in order to achieve interpersonal objectives in social interaction (discursive psychology) and what kind of objects and subjects are constructed through discourses and what kinds of ways-of-being these objects and subjects make available to people" (Willig, 2013, p117).

This researcher contends that for the state of stuckness, there is much that is not yet understood so a study which looks to generate understandings and perceptions across a group of participants will be more useful compared to a study that focuses on *how* people use language to create their reality.

3.4 Research Plan

3.4.1 Sample

Potential participants were chosen using a purposive sampling approach in order to select therapists related to the phenomenon of interest who might yield information-rich data (Patton, 2002). The selection process was guided by the following inclusion criteria:

a) Familiarity with the concept of psychological or emotional stuckness and experience in working with clients who identify with this state
b) Hold the requisite qualification for their profession e.g. are degree qualified to the level befitting their title and are registered with the relevant UK officiating body for accreditation or international equivalents. For example, psychologists with the Health and Care Professions Council (HCPC); psychotherapists with the British Association for Counselling and Psychotherapy (BACP).
c) Have had a minimum of two years post-qualification experience
d) Demonstrate fluency in the English language

A homogenous sample of therapists who all had a shared experience of using the term was sought as this was thought to be more likely to elicit common themes across the data set (although a shared understanding was not predicated).

3.4.2 Recruitment

In order to identify potential participants who fulfilled the inclusion criteria, the researcher conducted an online Google search of the terms ‘stuck’, ‘feeling stuck’, ‘being stuck’ or ‘stuckness’ paired with ‘psychologist’, ‘counselling psychologist’, ‘clinical psychologist’, ‘psychotherapist’ or ‘therapist’. The researcher also searched websites featuring therapist listings in London and South-West England to add to a list of possible participants e.g. www.counselling-directory.org.uk . Potential participants identified during this search were verified as psychologists or psychotherapists who had been practicing for more than two years and had all used the word *stuck* (or derivatives) in various ways. This term was featured in their professional profiles or biographies on websites as they

advertised for clients who were feeling *stuck*; they featured information on stuckness on their websites or had published blogs or articles around the topic; they had edited books that included the subject or published academic research or they had self-identified as using this term with clients. All therapists used *stuck* in a manner which indicated emotional or psychological stuckness with respect to a client. The details of 25 UK and North American therapists were collated into a spreadsheet along with contact information.

The first ten therapists to be identified were contacted and invited to participate in the research study through a direct approach by calling them on the phone number listed or in the case of overseas candidates sending them an email. Both methods of approach entailed introducing myself to the therapist as a counselling psychology doctoral student, outlining the purpose and focus of study, specifically referencing their own use of the word *stuck* online and closing with a request for their participation in the research. On two occasions therapists during the phone discussion asked for further information about the study to be emailed to them (see Appendix 1). If a confirmation of study participation was not agreed during the initial phone call or email response, therapists were followed up within a week of initial approach to see if they were interested in participating. Once a therapist accepted or declined participation, a new therapist was added to the live contact list from the search list in order of discovery until recruitment was completed.

The interview process began while recruitment was still underway. A pilot interview was undertaken with the first participant – a clinical psychologist – and her tendency to refer to her modalities practised throughout the interview indicated that an even mix of psychologists and psychotherapists might be beneficial for the study to see if this proclivity was isolated to one type of therapist or common to both. Therefore the recruitment process was concluded when five psychologists and five psychotherapists had confirmed interview appointments. The projected sample size was guided by recommendations from Braun and Clarke (2013) suggesting that one-to-one interviews for a Professional Doctorate should be between 6-15 interviews (Terry et al., 2017).

3.4.3 Participants

The sample consisted of 10 participants (8 female, 2 male), seven of whom were UK residents, two from the USA and one from Canada. All therapists were Caucasian although therapists from other ethnicities were approached but either declined to participate or did not reply to the contact or follow-up.

Five psychologists (two clinical, two counselling, one transpersonal) and five psychotherapists (two psychodynamic, one psychoanalytic, two integrative) were interviewed. The therapists ranged in age from 30 to 60+ with five falling within the 50-60 age bracket. Of these, nine were in private practice which may be a feature of a mature therapist and as a result of the recruitment online search strategy which was more likely to capture personal statements and information for private therapists (see Table 1).

	Name	Title	Main Modality	Other Modalities	Age	Years in Practice	Country
1	Kate	Clinical Psychologist	CBT	Motivational Interviewing, IPT	60+	14	UK
2	Rebecca	Clinical Psychologist	Schema	CBT, MBCT, Mindfulness	40 - 50	15	UK
3	Stephanie	Counselling Psychologist	Integrative (CBT, EMDR, Compassion-focused)	-	40 - 50	12	UK
4	Kristen	Counselling Psychologist	Assimilative Integrative (Existential-humanistic & EFT)	-	30 - 40	17	Canada
5	Kelly	Psychologist	Transpersonal	Expressive Arts	50 - 60	17	USA
6	Helen	Psychotherapist	Integrative	Psychodynamic, TA, Gestalt, CBT, Person-centred	50 - 60	6	UK
7	Simon	Psychotherapist	Psychoanalytic		50 - 60	3	UK
8	Christina	Psychotherapist	Psychodynamic	EMDR	50 - 60	15	UK
9	Greg	Psychotherapist	Psychodynamic	Cognitive Therapy, EMDR	50 - 60	28	USA
10	Teresa	Psychotherapist	Humanistic & Integrative Psychotherapy	Body Psychotherapy	60+	25	UK

Table 1: Research Study Participants

3.4.4 Procedure and Ethical Considerations

Given the experiential orientation to TA that this researcher has taken, the data was gathered through 10 one-to-one interviews conducted face-to-face (five), by telephone (three) or Skype (two) as pre-arranged with each therapist. Interviews were scheduled to take approximately a 'therapeutic hour' i.e. 50-60 minutes and all were completed within 47 – 74 minutes. The interviews followed TA guidelines and sought to explore the experiences, thoughts and feelings of each individual following the assumption that language reflects a reality, whether it be a common and universal or personal and subjective one, for each participant (Terry et al., 2017). This was conducted using a pre-established interview protocol with a series of open-ended questions and prompts. The interviewer sought to encourage an open qualitative mode of interviewing by adopting a flexible approach in which participant responses shaped the direction of the interview as the researcher assimilated answers and encouraged the participant to speak further on matters that they deemed interesting or important. The interviews were recorded using two audio devices to ensure the data was captured audibly and securely.

This research followed guidelines set out by the British Psychological Society's Code of Ethics and Conduct (2009) and Code of Human Research Ethics (2014).

Since this research topic may have brought up experiences that were deeply personal or sensitive, the foremost priority was to ensure that the participants were protected from any emotional or psychological harm. In view of this, the project was carefully designed and approved by the City University Psychology Department ethics committee before commencing (see Appendix 2), with any ethical concerns arising through the research process to be discussed with the thesis supervisor (Bond, 2004).

Prior to each interview, all of the participants were emailed the participant information form (see Appendix 3) which outlined the general structure of the research project and interview process. This included the topic areas to be covered and reassured them that they could opt to decline to answer any question without giving a reason. Participants were reminded that their responses would remain fully confidential and that their names and

personal details would be anonymised through use of a pseudonym in the final report. Participants were reminded that their participation was voluntary and that they could withdraw from the study up to three months post-interview. They were also emailed a consent form (see Appendix 4). On the reverse of the consent form was a request for simple demographic information including age range, qualification type, primary and secondary therapeutic modalities practiced and length of time in practice. All participants were asked to fill in and sign the consent form and face-to-face interviewees received a copy to take away with them (telephone and Skype participants retained an electronic copy via email).

After the interview was concluded, participants were either taken through or emailed a post-interview de-brief (see Appendix 5) which explained the objectives of the research and they were invited to share any reflections they had at that point. Additionally, their attention was drawn to the interviewer and supervisor's contact details on the post-interview sheet for follow-up should this be required.
Each interview was transcribed as per the guidelines set out by Braun and Clarke (2006).

3.4.5 Pilot Interview

A pilot interview was conducted with the first participant in order to test the feasibility of the proposed interview protocol with respect to eliciting 'information-rich' data that spoke to the research question as required by both a qualitative approach and TA method. The interview questions were discussed with the research supervisor who reviewed them for relevance to the research question and perceived clarity for the interviewees. The first participant was a clinical psychologist and the interview was conducted face-to-face in her therapy rooms outside of London. This provided the opportunity to gauge the effectiveness of the wording and sequence of interview questions and prompts as required for an effective qualitative and TA study yet flexible enough to meet a fundamental requirement of the qualitative interview which is to "provide a framework within which respondents can express their own understandings in their own terms" (Patton, 1987, p115).

During the process it became apparent that the original protocol of 15 questions and 5 prompts was not flexible enough to allow space for discussion of salient themes introduced by the interviewee. As a result, the interview questions were consolidated to 11 core questions with 3 prompts (see Appendix 6). The pilot interview showed that the viewpoint and understanding of *stuck* could be strongly influenced by the modality practised and this insight led to a restructure of the interview protocol to include a modality influence question and also a change to the recruitment strategy to balance psychologist and psychotherapist participants. The questions seemed to generate thoughtful responses from the interviewee and she said that it had been a useful process which had helped her to think about the use of the metaphor which she had not previously considered. This was an unexpected finding and led to a re-ordering of the interview protocol to begin with a question that related to the clinician's understanding of the metaphor and then to allow, as much as was possible, a free-flowing process which followed the interviewee's lead on responses and which wove in the interviewer's questions in a more natural way.

3.5 Personal and Epistemological Reflexivity

When working from an interpretative position, an awareness of reflexivity becomes important as a reminder that research cannot be considered the 'only true perspective' (Alvesson & Skoldberg, 2005). Adopting a reflexive stance towards the research demonstrates an awareness and need to consider possible intersubjective dynamics that may occur between the researcher and the data (Finlay & Gough, 2003). This is especially important in a qualitative study as while the participant is the focal point of the research, the interpretative role of the researcher means that they also play an important part in the research process. For me, it is my intention to be a conduit for the experiences and meanings that the participants share and that any interpretation is guided by the analysis that comes from the data. However my frame of reference during each stage of the process – from the choice of qualitative methodology to the questions asked can unintentionally introduce bias and narrow the range of participant responses (Maso, 2003).

Therefore to be reflexive is to be aware of the myriad influences affecting the work of data analysis and the impossibility of maintaining a truly objective viewpoint. As such, I hold in mind Woolgar's (1988) continuum and the ideal of reflexivity as an 'explicit evaluation of the self' which construes an interrelationship between people and the world and engaged in an egalitarian dialogue thereby able to construct one or multiple versions of reality. This perspective is important as it allows for the person of the researcher and an acceptance that full objectivity is something that is not ever attainable. But it asks us to take responsibility for our position within the research and debt to the participants to communicate their perspective as accurately as possible.

Negotiation of this tension could involve introspection via a series of questions. Firstly, it might be important to consider the 'implications of the researcher' (Shaw, 2010). "Experts contend that through reflection researchers may become aware of what allows them to see, as well as what may inhibit their seeing" (Watt, 2007; Russell & Kelly, 2002). What might I see in this data that another might see differently? What influences how I see this differently? What measures am I taking to ensure I represent the participants in their true light?

During the analytic process there were several areas which I felt could challenge my researcher impartiality. Firstly, the increased realisation that content derives not just from the interviewers' answers but from the questions asked of them. I developed an interview protocol that I hoped was open enough to work as a guideline for the participant discussions whilst also allowing for the interviewees to bring new perspectives that could be incorporated. I felt that using a semi-structured interview protocol brought flexibility to the interview process by allowing me to respond to points raised by the participants. Furthermore, after conducting the pilot interview I reviewed the protocol and amended it to incorporate a participant-led finding that I had not anticipated. Altogether, these measures generated unique data which I contend supports the quality verification of the analysis. Secondly, I was conscious of responding more positively to some participant's interviews more than others. This was a reminder to myself to be cautious and interpret what I see and not accept it based on my own feeling of their level of understanding of the topic. Thirdly, I am familiar with some client research on *feeling stuck* which included the

researcher's interpretation of the stuck state and I am aware of the need to bracket this information so as not to bias my coding and theme selection as it might mean I inadvertently code semantically rather than latently.

Finally, as someone who has personally experienced a state of stuckness, I am aware I may have conscious and unconscious biases and assumptions with regard to how I might hear and interpret the data and compare participants' experiences and meanings to my own. In order to stay aware of these potential personal and professional biases, I kept a reflexive diary from the development of the interview protocol and continuing throughout the research process. This was essentially a journal kept open on my desk in which I wrote down thoughts and reflections that occurred in relation to the participant interviews, the participants themselves and the analytic stages so that I could not only deepen my understanding of the process and what I sought to achieve but that I might be able to identify more clearly my own assumptions or subjective responses in comparison to more objective responses to the data, and ultimately, develop a sense of how the research itself 'may affect and possibly change me as a person and a researcher' (Willig, 2001). The journal captured the evolution of the analytic process and the reason behind the decisions that I made at each step. This not only gave me confidence that I was adhering to recommended guidelines for qualitative analysis but that my recorded process matched that of the six step process outlined by Braun and Clarke (2006). Additionally, it was a useful way to capture immediate, fleeting thoughts about the transcripts or the participants that might otherwise have been lost. I found that by going back to these notes when writing up particular extracts was very useful as some of these initial reactions to the data helped me to deepen my sense of the participants' statements and expand on possible understandings. I could also identify some of my responses to the extracts as either personal thoughts or links to the previous research project (and therefore research participants) and I was able to bracket these and remove them from this research process.

As this research was a topic that had been little researched previously, I also used the journal to record my difficulties working with the huge amount of data that the project generated and it seemed difficult to know what to retain and what to discard. In order to try and stay close to the participants' meanings, I at times found myself reviewing tens of pages of data, codes,

potential themes and data extracts, often spending many hours with not much to show for my efforts. Writing my struggles in the journal helped me to get clarity on my situation and to separate my personal feelings and frustration from the potential problems that might lie with my analytic approach. Overall within this study, I think I am most visible in the interpretation of the findings and writing up of the analysis – in my attempt to convey the participants opinions, in as clear a way as possible, to support further understanding of how they made meaning of the lay metaphor of *stuckness*.

3.6 Relevance to Counselling Psychology

From at least the late 1990's, counselling psychologists in the United Kingdom have been encouraged to pay more heed to incorporating elements of research within their role so that they can be true adherents to a scientist-practitioner model of practice (Woolf, 1996, Corrie & Callaghan, 2000). This is in response to growing pressures from psychological treatment providers who are becoming more insistent upon funding practice which is evidence-based (Rafalin, 2010). The incorporation of a greater focus on research fulfils a central part of the developing counselling psychology identity as therapist *and* researcher, and gives us a means to more widely champion the unique, subjective experience of the individual within the empirical literature (Rafalin, 2010). and in doing so contribute to a body of knowledge greater than ourselves (Woolfe, 2016). Rafalin suggests that this could be achieved "through a focus on, and appreciation of, difference as a pivotal value within counselling psychology research: taking a different methodological perspective, defining the parameters of our research gaze differently and appreciating different contributions to our research through true collaboration" (Rafalin, 2010, p45).

By exploring and understanding a phenomenon like feeling *stuck* that presents to therapy as a genuine psychological difficulty, this research project presented an opportunity for 'the voice of the client to be heard' within the clinical literature, an endeavour at the heart of our counselling psychology philosophy (Woolfe, Strawbridge, Douglas & Dryden, 2010). This is particularly important when clients are using a little understood metaphor to convey their experience and we are charged with using levels

of interpretation for subjective experiences which might not conform to existing psychological understandings.

3.7 Data Analysis

3.7.1 Analytic Steps and Procedures

Analysis followed the structure set down by Braun and Clarke (2006) following six phases of coding:

Step 1:
This phase was about familiarisation with the data. Firstly, each of the interviews was transcribed verbatim by the interviewer. During this process time was taken to capture any initial thoughts and observations about the interviews in an analysis notebook. Then a close and detailed reading of each transcript was undertaken, with first thoughts on the data annotated in the transcript margins and any further overall thoughts of the research captured in the notebook for further reflection. This stage was about immersion into the data by all means – re-listening to the audio recording, reading and re-reading each transcript and starting to think critically about 'what does the data mean?' (Braun & Clarke, 2012). The 15 point checklist for criteria for Good Data Analysis (Braun & Clarke, 2012) (see Appendix 7) was kept to hand and referred to often throughout this entire process.

Step 2:
During this first phase of the coding process, points of interest within the data and thoughts that seemed to cohere to a potential pattern were captured as initial first-order codes. At this stage I was already thinking about possible themes by attempting to fragment or summarise what I felt was going on in the interview by attempting to break down the narrative into its component parts by applying as short a descriptive label as possible. This took the form of short phrases or key words that were handwritten onto the transcript and then collated separately into a word document with accompanying data extracts. This was done at the latent level of meaning whereby the researcher was seeking to 'move away from the explicit and obvious content of the data' (Braun & Clarke, 2018).

Step 3:

During this stage, the codes for each interviewee were handwritten onto A3 sheets in a mind map format and collated with other similar codes around a central word or phrase that could be a potential theme. This was an iterative process in which codes at times overlapped which necessitated the researcher to go back and tease out the interviewees meaning and re-code so that they sat clearly within one theme and the themes were more distinct. At the end of this phase, a collection of preliminary themes with accompanying codes was identified. These preliminary themes were then collated into a second word document and each of the identified codes with line descriptions of the data extract were gathered into a list for each therapist. In this way, the collation of supporting data extracts seemed a way to verify the cohesion of the themes.

Step 4:

Patton's (1990) criteria for judging categories asks for consideration of internal and external homogeneity and external heterogeneity and the themes were reviewed to get a sense of their distinctiveness and relationship to each other. It was important to go back to the transcripts to verify how the initial codes were attributed and if they adequately reflected meaning across the entire data set. After this process some codes were put to one side (although not discarded), others shuffled into more meaningful groups and in a couple of instances, codes were re-named. The mind map was updated to reflect these amendments. Following this, the codes with corresponding data extracts for each therapist were collated into a third document under the potential themes.

Step 5:

During this stage, the Word document of data extracts was ordered into theme and sub-theme groupings and then re-read and the theme titles further considered. This resulted in a broadening of theme titles to reflect the diversity of each theme cluster. Documentation on the development of each theme was collated and a narrative description was written for each which captured its unique and idiosyncratic qualities within the context of the research data. During this process "researchers may consider how each theme fits into the overall story about the entire data set in relation to the research questions" (Nowell, 2017, p10; Braun & Clarke, 2006).

Step 6:

At this final stage, the process of writing up the analysis of the data began. The analytic and reflective notes taken throughout the process were collated and further reflected upon now that themes had been developed and data extracts compiled. These notes were added to the document to expand ideas around the themes and data extracts and an analysis document began to take shape. The extracts were re-read and the key ones were chosen based on the degree to which they appeared to reflect the overall meaning of the theme and it is hoped, capture the intention of the participant through an interpretative analysis of their meaning.

At the end of the coding development phase, three themes made up of 13 sub-themes were identified within the data set (see Figure 1 below):

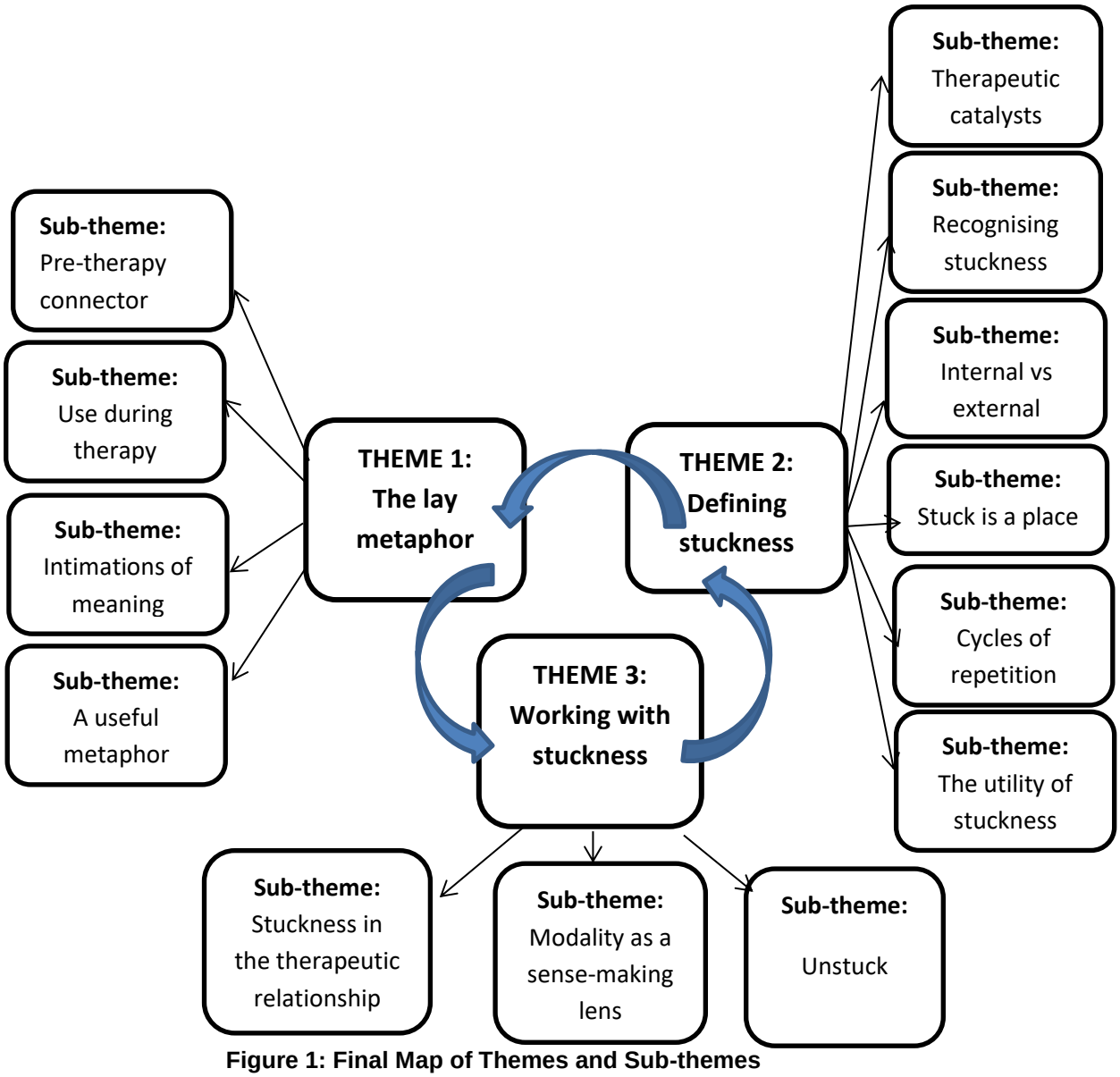

Figure 1: Final Map of Themes and Sub-themes

3.7.2 Data Verification

While validity and reliability are the quantifiable standards of empirical legitimacy sought by quantitative researchers, Lincoln & Guba (1985) suggest that for qualitative practitioners 'trustworthiness' of the findings of the data should be the equivalent measure sought. They define trustworthiness as criteria relating to credibility, transferability, dependability and confirmability (Lincoln & Guba, 1985).

Credibility is determined when readers other than the researcher also recognise the findings in such a way as to verify the "fit between respondents views and the researcher's representation of them" (Tobin & Begley, 2004). Transferability relates to the generalisability of the findings of the study and asks the researcher to provide 'thick descriptions', so that "those who seek to transfer the findings to their own site can judge transferability" (Lincoln & Guba, 1985). As generalisablity is not a claim compatible with the approach of this study, it is hoped that the elements of dependability and confirmability as they relate to a research process are clearly reported in this report and that as much as is possible, each step appears logical and traceable and a theme development process shows sufficient rigour so that the interpretations and findings the researcher attributes to the data analytic process are seen to be 'clearly derived from it' (Tobin & Begley, 2004).

Yardley (2007) refers to criterion by which a qualitative methodological study might be judged. This researcher hopes that by examining the choices of theory, methodology, analytic approach and maintaining a conscious as well as documented reflexivity throughout, that a considered approach to the research has been taken in order to create knowledge through a transparent and clearly documented process so that any findings might be considered 'worthy of attention' (Lincoln & Guba, 1985). In this way it is hoped that they might meet some of the suggested characteristics of good qualitative research – that it has shown sensitivity to context (through displaying sensitivity to participants' perspectives), commitment and rigour through the data collection stage; transparency and coherence through the disclosure of procedural and analytic stages; and that the study meets 'impact and utility' guidelines through its implications for practice (Yardley, 2007, p219).

In summary, TA was chosen as the analytic approach as its epistemological flexibility and consistent analytic style were compatible with the aim of this study investigating the meaning that participants derived from working with a lay metaphor within therapy.

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4. ANALYSIS

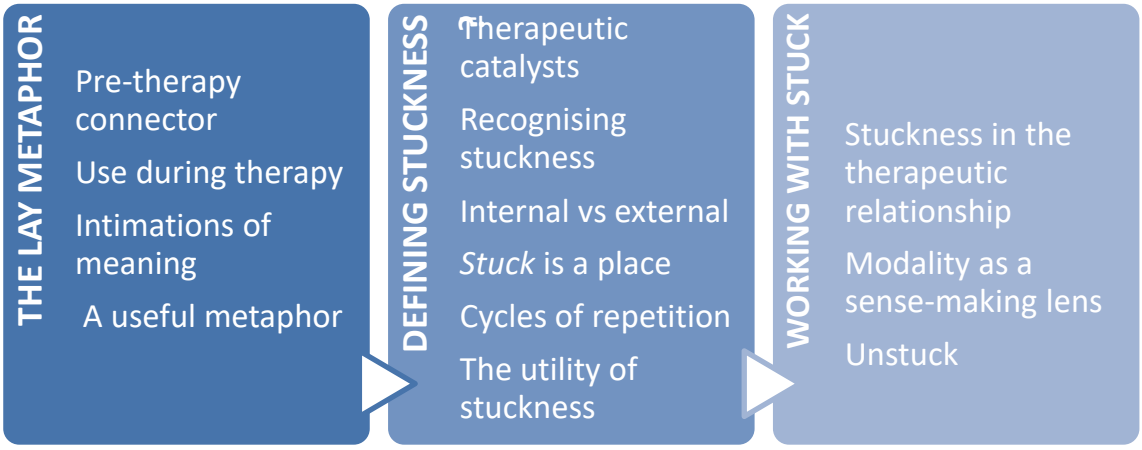

Figure 2: Summary of Themes and Sub-themes

4.1 Theme One: Stuck as a Lay Metaphor

As nine of the participants in this study had used the phrase online or in published material, this theme explores how and why therapists found the term to be useful before and during therapy. They confessed a lack of deliberate motive for using the phrase but said it was commonly used by clients as it seemed to capture a particular emotional experience that was beyond their medical knowledge to describe otherwise. This did not necessarily infer that therapists saw value in it as a therapeutic construct – in fact most did not.

Therapists discussed their understanding of the term and how they worked to derive psychological meaning from it and the impact of working with this and other metaphors within the therapy room.

4.1.1 Pre-therapy Connector

Feeling stuck is widely accepted as a lay term used by people outside the clinical realm to capture a sense or felt experience. The participants in this study were therapists who had used the word online in their professional

profile (seven), in published material they had written or edited (two) or introduced directly within therapy (one). As each of the therapists used the term in this deliberate way, the use of the metaphor within the therapeutic context was considered to have originated with them.

Most of the therapists said that their online profiles were an important source of new client referrals and that they deliberately used lay terms in order to lower barriers to initial engagement in therapy. Rebecca chose this metaphor as she was considering what a client mindset might be and felt that *stuck* was a state in which people might find themselves seeking support from a therapeutic professional.

> *"in terms of writing that profile I was thinking about what people might be feeling if they're looking for a therapist. And I suppose in my experience a lot of people do feel quite stuck at times and that might be a time of their life when they might feel they need someone external to their family to talk to about that." (Rebecca, 1, 7 – 11)*

For Kristen, the choice of *stuck* followed a conversation with a colleague who had used it and the strong resonance they both felt it had for clients – "*it's just such a powerful word it seems for people "(Kristen, 1, 22 – 23),* supporting the view that it seemed to indicate the point at which clients seek therapy – a pre-therapy marker.

Kristen and Helen said that clients had specifically sought them out after seeing this word in their professional profiles as it spoke directly to the feeling state they were experiencing and they felt understood. There is reluctance inherent in therapy as a choice for people which suggests that choosing a term that resonates with clients has a direct impact on lowering some of that initial resistance.

> "*clients seem to go 'that's exactly how I feel' and after I started using the word I got a lot of clients say the same thing to me - 'I saw that word and I-' - they feel understood right, of course they are feeling kind of like - therapy is often not the first choice for a lot of people." (Kristen, 1, 32 - 35)*

Stephanie's clinic used *stuck* as they recognised a dual process in their clients – how people's attempts to make meaning of their often complex conceptual psychological states through metaphorical language can also function as a rejection of mental health diagnostic terms and the stigma associated with them.

> *"I think we are trying to be mindful of why people might come and we're aware of the stigma of mental health problems and emotions generally and vulnerability so I think for us the term feeling stuck felt, felt right and felt like many people might relate to that in some area of their lives." (Stephanie, 2, 52 - 55)*

Kate said that clients saw her website or flyer using the term *feeling stuck* and said *'actually yeah, that's exactly how I feel"* (Kate, 3, 133). She agreed that *stuck* described people who are contemplating therapy and that the word represented a tipping point in a person's psychological health where a state of imbalance has been reached and the resources they have always relied upon are now inadequate and external help is needed. This brings a state of confusion - *"that not knowing where to go or having tried lots of things… that they can't see a way forward" (Kate, 2, 92),* a sense that a shift is required – from reliance on oneself to dependence on another. This also suggests that a move out of stuckness is seen as desirable – that stasis is not an ideal state.

Helen said that she applied the term casually on her profile because she had heard clients using the phrase during therapy to try and capture 'something they don't really understand' which made her think that this was a real psychological concern for people.

> *"I don't think I really thought about it in terms of that it might appeal to or resonate with - it just seemed something that I had heard people you know talk about a lot in therapy, so I thought 'oh this is a very real feeling so it's there'." (Helen, 5, 203-205)*

For Simon and Kelly, the initial consideration of stuckness in relation to client work began with a personal experience of stuckness. Simon said that he had been stuck in addiction – *"very happy to use the word stuck because I was absolutely stuck in that cycle of behaviour" (Simon, 15, 706 -*

707). Kelly's curiosity about stuckness arose during psychological research she was conducting with clients around risk-taking when she realised that she was stuck and began to look into her own experience of it utilising an expressive arts technique as a powerful way 'to access the unconscious'.

Greg and Simon were reluctant to consider this term on behalf of clients. Simon explained that "*the term stuck would have to always come back to my interpretation of feeling stuck, I don't think I could ever sit here and say what my clients' version of that word means" (Simon, 1, 7 - 9)* as he considered there to be 'unique stucknesses' – that stuck could be generic and yet idiosyncratic. He was the only therapist to examine the lack of transparency of therapists using lay terms to attract clientele - "*it's awful isn't it?"* particularly when the phrase seems to be casually applied with no thought given to the deep resonance it holds for clients.

> *"There is a certain, I'm not saying it's conscious, it's probably conscious when we write our resume or whatever you want to call it - to entice people into the room to work with. I'm not sure how the terminology we're using is honest anyway in one respect." (Simon, 2, 48 - 51)*

Simon thought the ease with which therapists applied the phrase was thoughtless, even injudicious. He presumed that others, like him, had seen the word on therapy websites and borrowed it as they tapped in to the desire of people not to be stuck. However he considered that this 'deception' was merited and it was acceptable to use a specific phrase in a less purposeful way as it was a heralding call of sorts – a conduit to bring a troubled client to therapy so that the client's stuckness could be 're-encountered within the sight of somebody'. He held that stuckness might have relevancy when a client walked in the door but as deeper issues arose and the real work of therapy began, the usefulness of this term or any other on one's website would become redundant. He deemed it a fantasy to attempt to describe the process of psychotherapy so whatever therapists did to help bring a client to therapy was a means to an end and ultimately beneficial.

> *"you can't be a poster boy or poster girl for psychoanalysis, you can't create a poster for it. I'm going back to the idea of bullshit on*

my webpage … it's not as you would imagine. What you come here for isn't what you get but you will get something else which hopefully will be useful." (Simon, 14, 648 – 649; 654 – 655)

Rebecca and Stephanie said some clients used the word *stuck* but were more likely to describe their experience – the confusion, their ineffectual coping tools and need for help – in a way that therapists were able to recognise as a stuckness.

***"…** people will either use the term directly or they will say 'I don't know how to get out of this, I don't know what to do' or 'I find myself continually doing this and it's not right and it's not helping me move on' so I'm already thinking of them feeling stuck." (Stephanie, 3, 60 - 63)*

Therapists saw *stuck* as a term that had strong resonance for people and had few qualms in using it to source new clients. There was the sense that clients saw therapy as a last and unedifying resort therefore the use of a non-clinical term was seen to ease the pathway in. There was some recognition of the relative dishonesty of such an approach but that this was balanced by the belief that once in therapy the client would receive help whatever their problem was, thus justifying its use.

4.1.2 Use of *Stuck* During Therapy

Following the initial client contact, the term *stuck* was only occasionally taken into therapy and worked with as a guiding construct primarily because the therapist did not continue to frame the client's problems in this way. The casualness with which the term had initially been applied meant that it could be discarded just as easily.

"it's not a focus of mine but it's just happened to be the wording that I used in that profile." (Rebecca, 1, 12 - 13)

For Teresa, the term *feeling stuck* was sometimes used at the outset of therapy but not often within it and she reasoned that this was due to her client base of women and therapists who 'emote a lot' therefore did not need to rely so heavily on opaque metaphors.

"*in the beginning they might describe their life situation in those terms but not within the therapy in a feeling-sense I don't think they'd very often say I feel stuck." (Teresa, 7, 323 - 325)*

Greg found that a client's use of the word could sometimes indicate more obvious clinical presentations, particularly those with a recognisable relapse cycle.

"many clients don't actually directly tell me that they feel stuck, but some clients do and it's interesting most of the clients who have struggled with addiction have a sense of being stuck." (Greg, 4, 191 - 193)

Stephanie saw that in many cases clients who said they were stuck were those who had received therapy which had been unable to resolve their issues leaving them in need of further help and perhaps a different approach.

"They've had CBT two or three or four times but with - their problems relapse so we are really talking about relapsing and feeling stuck, that they can't, they can't get the long-term effects." (Stephanie, 1, 42 - 44)

However a client's use of the word did not correlate with their desire to discuss it – Kelly felt that her clients only engaged with the term as a way to convey their felt experience in order to get her help to get away from it as *stuck* was looked upon as a place to leave, a feeling to avoid.

"*Most people when they say they're stuck they just want to get out of being stuck and that's it… they don't really explore what it is that they're feeling, that they're experiencing." (Kelly, 2, 52 - 55)*

Kate reflected on how people use terms clinical or otherwise to describe their mental health. She thought the 'power' of stuck was through its role in common parlance therefore as a relatable and adaptable word able to succinctly convey an emotional state without emotion, thus making it less exposing for clients to talk about than a diagnostic term which would

probably be incorrectly applied anyway. In this way she positions it as a stopgap phrase, a place-holder until such time as the therapeutic relationship is more developed and client and therapist can together begin to look at the real issues underneath. Kate says that the term is 'understandable' to many however did not reflect on what this common understanding might be.

> "*it is a quite a lay term almost isn't it? Sometimes people talk about being paranoid in a lay way that it wouldn't be described in mental health services as paranoid. So I think maybe it has the same type of currency as a word that everybody would use in terms of their car or something unemotional so I think that's maybe the power of the term is that it's very understandable to lots of people and people are more likely to come and say 'I'm feeling stuck' as opposed to 'I'm feeling very distressed because this, this and this is happening' so it is a very short-hand neat way of telling people exactly you know, where you're up to without having to give it, go into a lot of detail without you know, until you've worked that out together really."*
> *(Kate, 3, 140 - 149)*

Rebecca suggested that when a therapist used lay or non-clinical terms it was a gentle way of introducing psychological concepts to clients. She agreed that clients had a complex and often incorrect understanding of psychological terms, which when used within the therapy room could often be misunderstood or cause offense. For this reason she believed that a therapist may have a more clinical interpretation of stuckness which was not necessarily shared with the client.

> *"I wouldn't want to use any psychodynamic words like resistance or anything like that or you know because that's off-putting for people I think and doesn't really mean an awful lot to other people."*
> *(Rebecca, 2, 21 - 23)*

This suggested a hierarchy within the room, an ordering of who was permitted to use what language, that therapists could freely use lay terms without consequence or thought given to their incorrect application, but clients were discouraged from using psychological terms and protected from some of their more cogent meanings.

Rebecca acknowledged stuckness as an important part of her work as this is why clients sought her out, but said she would be more likely to think in terms of "*what is the presenting issue? What are the triggers and mediating factors, what is the hypothesis?" (Rebecca, 5, 237 - 238).* She did not see the necessity for stuckness to be a focus for the therapy and considered it to be more likely used by psychodynamic therapists.

> *"I think in the psychodynamic world there's a lot more emphasis on making the unconscious conscious and a stuckness may be made more of in that model. And be seen more as, you know, a normal repertoire in people's defences. Whereas I don't think in defences terms that much in my work and I just felt that it might come up more in someone who is very purist rather than someone who thinks in several different models." (Rebecca, 3, 125 - 130)*

Christina said that overall *stuck* was not a working term within therapy for her clients but on occasion was an appropriate term for her to communicate how their current state was preventing them from making a change, as a dialectic through which to position the idea that they could do something differently.

> ***"****I think with that one guy I could see he had it within his power to make a change, but he wouldn't and in that case, I used it with him just to enable him to understand that the stuckness was to some extent of his own making, even just his attitude." (Christina, 14 643 – 646)*

Stuck seemed to be a term used as a transitional cue into therapy but only occasionally referred to thereafter. That this might be problematic or a mistake was not considered.

4.1.3 Intimations of Meaning – Specificity and Universality

Scratch the surface of this metaphor and *stuck* becomes labyrinthine. Most of the therapists revealed that despite having used it to advertise for clients, the research interview was the first time they had paused to think about the term and what it might represent when applied within a therapeutic context. Many admitted that they had used it without much consideration but that

upon reflection, the term was worthy of further discussion and exploration, an unexplored commodity with depth and resonance.

> "*It's really interesting like you could really talk all day about this word, it's just a word and yet it feels so yeah, it feels like there is so much there." (Kristen, 13, 606 – 607)*

> *"I thought it was an interesting and complex way of looking at people's problems because I sort of thought it could be all-encompassing by the time I had finished thinking about it." (Christina, 17, 808 - 810)*

> *"Quite a philosophical area for one word." (Simon, 16, 751)*

For some, this multiplicity of meanings made the use of the term *stuck* problematic. Christina felt that the difficulty in working with the term therapeutically was due to its lack of a definition in either clinical or lay terms which meant that it was liable to have differing interpretations made of it.

> "*Well I think it's a problematic term because it's clearly not got a definition in either psychology or psychotherapy so it's kind of open to interpretation isn't it? And I know that people do talk about it but I think that is because there's no agreed definition it's a bit vague." (Christina, 1, 7 - 10)*

Teresa supported the view that *stuck* was problematic and she challenged the choice of the phrase itself. She felt there was pressure in the word stuckness, an inherent criticism of it as a position as it suggested that *stuck* was a problem state. Teresa said the word itself gives a shape to what the client is experiencing, not the experience itself and that engaging with it gives us new territory to explore.

> ***"****When you say stuckness there's already - there's already something implicitly in using stuckness which - it implies you should be somewhere else, it implies that you're going somewhere and then you get stuck." (Teresa, 7, 334 - 337)*

Her therapeutic approach would be to challenge a client who said they were in a stuck state as to do otherwise would be to collude with the client's stuckness and distress by buying into the illusory nature of the metaphor. Her use of the term 'conceptual cloak' evokes the image of something masked, but also alludes to the difficulty people have in building conceptual systems using everyday language to make meaning of their emotional worlds. The work for the therapist, she felt, is to be in the stuck place with them.

> *"I would want to know much more about what does it feel like to feel stuck, how - where should you be rather than here? You know, it is a kind of conceptual cloak on something." (Teresa, 7, 341 - 343)*

However other therapists felt that its very openness gave the term therapeutic purchase.

Kristen thought that *stuck* was suggestive of the psychological or emotional difficulties within that state, the not-knowing and inability to free oneself from it, a state where one might feel troubled, confused or anxious - "*it's a very scary word I imagine … to feel stuck in life and to not know how to unstick yourself." (Kristen, 1, 47 - 49)*. She thinks that therapists can hold a more positive interpretation of the word as they know that there are solutions.

Greg said that he was very careful about the language he used with clients as different words can carry different emotional charges but found that *stuck* was a useful term so *"oftentimes I will, I do use the word stuck probably more than anything" (Greg, 11, 536 - 537)* as he considered it generic enough in meaning to not carry any affect making it an easier term for clients to engage with.

So does *stuck* as a metaphor have merit or relevancy within a therapeutic context? Simon thought it did - *"but a client's idea of stuckness - I've got to accept that they're happy with that word I suppose" (Simon, 3, 141 - 142).* Teresa reluctantly conceded the same - ***"****I mean if it's their word it's important isn't it because it's their way of conceptualising" (Teresa, 11, 507 - 508).*

When considering what kind of state *stuck* might represent, Kristen and Teresa disagreed on the intent behind the use of the term. Kristen thought that it sought to capture a feeling whereas Teresa would interrogate the feeling to uncover what sort of state they are describing.

> *"I would be investigating what is it, what does it feel like being stuck - that's why I think it's more of a concept often than a feeling when people say stuckness so that would be my first kind of wondering, is this a - how do you know you're stuck?" (Teresa, 11, 510 - 513)*

Kristen saw the term *stuck* as universal, a catch-all phrase or state that many people could relate to in their life, a signifier of that point at which people can no longer work through their problems on their own and where help is sought, the catalyst or driver to go to therapy. She felt that it wasn't always named and saw stuck as an overarching concept for the point where a client difficulty can no longer be worked through alone.

> *"I feel like it's really a universal experience for every client I work with and it's not always spoken using stuck, you know, using that word by the client or by myself but it's a place where they come in and say I'm struggling and need help." (Kristen, 6, 249 - 252)*

Kristen saw no distinction between stuck people and others and in this way stuckness was considered to be almost the human condition – she thought everyone seeking therapy is stuck in some way – to be stuck is to not be coping with normal human difficulties.

> *"I've never seen a client that isn't stuck because clients come in for a reason and you could reframe every therapeutic goal as a stuckness that a person's in. I do stand by the idea that we are all stuck on something in our life … you could really argue that every human being on the planet is stuck on something." (Kristen, 11, 525 – 530)*

Stephanie agreed with Kristen and saw stuckness on a continuum, a natural phenomenon that happens to us all but thought that individual differences could be why stuckness sometimes becomes more exaggerated or entrenched.

> ***"…** it's got me thinking … about who walks through the door and what it feels like to be a client. It's a, you know, it can be a big deal and I'm presuming that most people feel stuck on one kind of level which is why they are seeking support. I wonder if we can think about people who aren't, do I see people who aren't stuck in some form, I don't know that I do. I've seen a couple of people who have said 'I'm just coming here to be a better person' and that's not been the case, they've been very vulnerable but couldn't admit it… they'll say it's for self-improvement but actually there's a stuckness."* *(Stephanie, 17, 636 – 639, 641 – 645, 647 - 648)*

Along with Kristen, Rebecca held that stuckness could be understood as a substrate to many typical psychological issues: that *stuck* was a generalisable concept applicable to many psychological presentations.

> *"in terms of whether people are coming with bereavement or depression or anxiety you could conceptualise them all as being stuck somewhere so I think it's quite a generic term that you could apply to everyone that comes. I don't see it as a stage of therapy… I'd say everybody is stuck to a certain degree otherwise they wouldn't be coming." (Rebecca, 6, 258 - 259)*

For most therapists this was their first opportunity to reflect on the term and they could not agree on what stuckness was – a construct, a concept, a state, a feeling? The interview seemed to expose something that had hitherto been taken for granted – that *feeling stuck* was already understood therefore did not need to be deconstructed within the therapy room. Asking the question elicited strong opinions from the therapists, mostly around what it was not and how they would approach working with it. This was indicative of the elusiveness of the term but also of a contradiction found in almost all the therapists who said they did not use the term but found themselves formulating it regardless.

4.1.4 A Useful Metaphor

When speaking of the metaphor of stuck, therapists found themselves using further metaphors to explain it that were either similar or described different levels of stuckness that could be present. This conveys the

complexity of metaphor as a linguistic tool but also the very limited linguistic structures therapists have available when not using clinical words and how natural and useful metaphors are for all to use.

Thus when Simon contemplated what his therapeutic approach to stuckness might be, he invoked two further metaphors to talk of the 'journey' the client might take - what might need to be revisited or how someone can go back and rewrite the 'script' of their own life.

Reflecting on her use of stuck and other metaphors during therapy, Helen noted that they were often vague and generic but deceptively so as they cleverly manage to capture not just the client's emotional experience but also an embodied representation of what the difficulty might be.

> *"the other word that is a bit like it is 'flat' - they're not similar in terms of what they mean but it's one of those words that people use and they know it doesn't really - it's very general and it's very vague but it really describes how they are feeling - all hollow, depressed, they just feel hollow - so it describes, I think it very well describes for some people a feeling, a real feeling - a body feeling, an emotional feeling - in their head and they find it very hard to elaborate on that sometimes." (Helen, 5, 205-212)*

Teresa preferred the metaphor of 'lost' over *stuck*, another ambiguous term difficult to define but she considered this lack of precision helpful as if you cannot state where you are then there is less of a pressure upon you to have to change - a therapeutic goal Teresa takes issue with.

> ***"****I think it feels better because it means I can't define where I am if I feel lost and I suppose I was redefining it partly because I was not, not feeling attuned to this sense of stuckness because it describes having to be somewhere other than where you are, you know, having to change." (Teresa, 11, 492 - 495)*

In this way the use of a metaphor was useful in that it required the therapist to push further so it did not remain ambiguous and hidden, it could be exposed and have its reality tested.

Kelly spoke of a client she considered was stuck but who conceptualised their own problems using a different metaphor and isolated it not cognitively or emotionally but physically as a body part that could not move.

> "*I have worked with someone with schizophrenia or had been diagnosed with schizophrenia and talk about stuck all over the place or he - this is a good example - he did not identify it as stuck. But what he talked about were 'I've got this place in my body that just won't move - it's frozen'." (Kelly, 12, 580 - 583)*

Greg focused on the narrative structures that clients reached for in order to express how they felt which might be in the form of words, images or metaphors. He attempted to slow down the work in order to stay close to the client's lived experience – in particular he listened for a vividness of expression which he found indicative of high levels of emotional content relating to seminal experiences and that these words created an experiential image of great depth which a clinical term simply could not illuminate in the same way.

> ***"****Well I think that metaphors and imagery in a very very vivid way have a lot of emotional energy that is connected to them and I think that sometimes these images convey probably more powerfully than a simple word of 'like 'I felt depressed' or 'I felt anxious' - they convey a greater totality of clients' emotional experience and I think that it's in the imagery - that we really take a look at the imagery and how it helps me as a therapist to really identify some of the richness without being reductive. And I think that's really an important part of helping people to get unstuck". (Greg, 2, 95 - 101)*

Indeed, *feeling stuck* and other metaphors are used during therapy because of their ability to convey complex cognitive, affective and social states in a vivid and concise way. They are, in essence, a form of lay case conceptualisation and when used collaboratively between therapist and client may offer a therapeutic pathway, increase likelihood of a client feeling understood and deepen the therapeutic relationship (Stott et al., 2010).

Kate encouraged the use of metaphors during therapy as they encapsulated in a symbolic way a client's experiences and current

situation. She said that she would use *stuck* as a working term during the initial assessment phase and when formulating a client's difficulties. She found that metaphors suggested by clients work better as they are more idiosyncratic and personal – a formulation in a nutshell.

> *"if they fit, they're a very neat formulation aren't they, they're a little thing that that person always has without having a big piece of paper, they don't need much more, I suppose like a short-hand like feeling stuck, it's an explanation about why I do this thing, what I'm working on changing." (Kate, 15, 709 - 712)*

Rebecca also looked at the usefulness of the metaphor from a diagnostic or interpretative level, that it was useful to conceptualise for the client using non-psychological terms so for her this word was taken into therapy and not abandoned at the start of it.

> *"I suppose that's how I'd explain it to a client, that it, I think stuckness can feel like you know, you engage in a certain repertoire of behaviours and that for some of them work well and then when some of them stop working or don't work anymore you can feel stuck." (Rebecca, 1, 42 - 45)*

Helen also used the term as a therapeutic lever to generate assessment information, particularly when trying to illustrate how it might be limiting the person in their life. By doing this, she found she is able to add layers and texture to the metaphor.

> *"I might say, how that feeling stuckness, can you say how that affects you in your day-to-day life, can you think of any examples of things it stops you doing or the way it might affect relationships so I might ask them to try and think of ways to elaborate on it by way of example in terms of how it affects them." (Helen, 5, 222 – 226)*

Christina spoke of the limitations of working with lay terms within the National Health Service – an organisation which uses international diagnostic systems such as the DSM-5 and ICD-10 to classify mental health conditions. She said it would be difficult for stuck people to access the NHS because "*stuck is not a diagnosis, it's kind of lesser order of*

mental disease or unease or problems or whatever" (Christina, 5, 198 - 199). For her, the word *stuck* was suggestive of a less chronic psychological condition simply because it did not come with a clinical diagnosis but she acknowledged that a lack of diagnosis did not necessarily correlate with severity.

> *"well I mean obviously in the Health Service somebody would never get a diagnosis of being stuck so to some extent it suggests to me somebody who's not as seriously ill you know, somebody who doesn't have such serious mental health problems. But actually when I started to think about all my past clients because I thought well if I actually think about the people that I've worked with it might become clearer. And it turned out that the people that I viewed as most stuck were actually the most seriously ill."(Christina, 1, 24 – 30)*

Christina still saw stuckness as a helpful word to formulate a client's problems but said that her understanding of what stuckness was had evolved with the progression of her career and the deepening of her experience and she could now look at stuckness as a useful central organising concept.

> ***"****For me as a practitioner it means all sorts of different things and also it's meant different things at different stages in my career. And also for different clients. So in some ways you could formulate everyone's problems in terms of stuckness and that might be helpful." (Christina, 9, 438 - 441)*

Despite saying that this was a term not taken into therapy, therapists noted the usefulness of *stuck* as a means of formulating and explaining the client's difficulties. Perhaps at this early stage in therapy the use of too many clinical assessment terms can be overwhelming and intimidating for clients therefore a metaphor is used as a more palatable clinical substitute.

4.2 Theme Two: Defining stuckness

Therapists considered that there was usually a trigger event that brought clients to therapy and that part of the stuckness 'presentation' was that clients had attempted measures to become unstuck which had not worked. There seemed to be a sense that mounting difficulties and lack of further options drove people to seek external support.

All of the therapists described *stuck* as being a place from which clients were motivated to escape, a process requiring a forwards and backwards movement, not a place of stasis as the word may imply. From a psychological standpoint, they identified clients re-enacting repetitious cycles of behaviour or coping mechanisms in an effort to free themselves from this place but which only served to make them more stuck. Although causing distress to the client, some therapists saw how *stuck* could be a perversely helpful and chosen state - a place of safety or retreat where one could hide away and not face the real changes that were needed.

4.2.1 Therapeutic Catalysts

A stuck state was seen as a precursor to seeking therapy and at this point the focus on the metaphor began to diminish as therapists, particularly psychologists, began to use words of diagnosis and other recognisable clinical terms of psychological dysfunction. The ease with which many slipped back into clinical mode was perhaps indicative of the difficulty of staying with a lay term.

Therapists spoke of a point of crisis reached by clients as the psychological distress was no longer tolerable or able to be worked through on their own and that "*some come when things feel like they are falling apart, so they might come if they are suicidal"* (Stephanie, 5, 203 - 204). As relied-upon coping strategies became evermore ineffectual and the emotional easement that these provided diminished over time, clinically recognisable psychological conditions begin to appear.

> *"…often people ring when they are very very acutely anxious or very very low. So I think that most people have probably been on a bit of a journey to try and work out what's going on or trying to ignore*

what's going on up to the point where everything - all the resources they've got they've used up and they feel that they just can't manage."(Rebecca, 4, 158 - 162)

Stephanie and Kate both placed clients within the Stages of Change model (Prochaska & Diclimente (1983). Stephanie saw many clients who were in the pre-contemplation stage as they had been sent to therapy by others or were in relapse. Kate's primary therapeutic modalities were Cognitive Behavioural Therapy (CBT) and Motivational Interviewing (MI) and she used this latter model as she viewed it as a useful framework through which to gauge client motivation and readiness for the work ahead, particularly if they were *"feeling quite pessimistic and not sort of very confident about change" (Kate, 12, 559 - 560).*

Other therapists thought that the presenting problem and the degree of stuckness were more evincive as a catalyst for therapy. Rebecca believed that people can oscillate between being a little and a lot stuck and that how one coped with stuck was dependent on how functional other life quadrants were.

"…I think there are certain times in people's lives when they can feel that being a little bit stuck is okay, that they can cope with that they've got enough other areas of their lives that are functioning that it doesn't create too many problems and then there can be other times in your life when things aren't so good and that even being a little bit stuck can feel enormous."(Rebecca, 12, 578 - 582)

The point at which therapy was sought "*can be a culmination of events, it can be one single event' (Rebecca, 4, 178 – 179)* but more usually there was a single trigger. Rebecca thought that these triggers were typically around a broader theme of loss – '*it could be the death of someone they love, it could be the loss of a job, the breakdown of a relationship'.* Helen felt that more specifically it was when the bereavement or loss was not dealt with that the person became stuck.

"it might be something early on that was not - that was avoided, sometimes a bereavement quite often a loss of some kind, not necessarily a bereavement but a loss of a relationship, the loss of a

- the death of a family member the loss of a dream for the future, often loss that was not really addressed at the time." (Helen, 3, 101 – 105)

Rebecca thought that oftentimes this triggering event happened later in life, that up until this point clients have had sufficient resilience to help them overcome other difficulties and that a trigger may not be momentous in itself but was significant in that it hooked into previous undealt with issues which magnified the current impact.

"people can function pretty well and then a triggering event not always an enormous triggering event occurs and it can elicit feelings and memories from that time that can then overwhelm people that they are stuck with it and don't know what to do with it." (Rebecca,7, 330 - 333)

Helen saw that the trigger event impacted their mental health which then affected their day-to-day functioning thus engendering a need for help. She pondered at this point whether stuckness could be considered a presentation in its own right.

"There'll be a trigger, yeah, there will be a trigger… their sense of depression or low mood has become worse so that it's interfering in their day-to-day life. It can be - see that's quite interesting because that does imply that it is a presentation in itself because if they had just come in that would be their reason for coming." (Helen, 6, 255 - 262)

Greg thought that clients came to therapy at a time of crisis when emotions were heightened and that the triggering event held a clue to the real therapeutic issue and ultimate focus for therapy. He saw that the crisis was preceded by myriad contributing factors that all led to a stuck place but that this could be confusing for a client who might not realise that they have reached a standstill, only a recognition that life was no longer working.

"When people come to us they are at a crisis point and something has happened that has magnified distress, magnified a particular issue and so there is a certain level of pain and emotional distress

> *that is present. They also do not identify themselves as being stuck and in fact many clients don't identify that initially, mainly because they often have a hard time being able to describe that while this moment is a crisis that there has been a progression of events or life circumstances that have led them to this point." (Greg, 4, 180 – 186)*

Most therapists were in agreement that a trigger was the stimulus bringing clients came to therapy, possibly something that had not been previously addressed and that the trigger event may allude or be connected to this previous latent difficulty in some way.

4.2.2 Recognising Stuckness

Clients did not always use *stuck* as a descriptor and as most participants agreed that there is no 'one' stuckness, "*they all have their own flavour of stuckness" (Kristen, 7, 333),* therapists had different ways of recognising stuckness in how a client presented.

To Stephanie, clients who didn't explicitly use the term would speak of an inability to move out of something, usually a situation where they were repeating behaviours that were no longer helpful and had now run out of options and to her this pattern was a clear indication of client stuckness.

Greg felt that *stuck* was a relevant word as it could capture the essence of what the client was feeling – unsettled, confused, the desire for things to be different and the recognition that they were in need of help and direction.

> *"the term 'stuck' here … does reflect their subjective experience on themselves. Something is uncomfortable, it's off, they really want to make some change, they don't really know quite how to go about doing it." (Greg, 1, 45 – 47)*

Kelly thought that there were characteristics that could be recognised as being particular to stuckness that "*keeps them trapped and stuck in a certain way of thinking and feeling and behaving (Kelly, 7, 296),* a 'constellation' of factors that when considered together might have important information to give the therapist.

> "*the overwhelm, frustration, irritation, loneliness, so some of the qualities that people speak about when they talk about feeling stuck, they feel that they're alone, I think that's really important to identify how the constellation of these particular characteristics sort of speak to that condition of feeling stuck… this sense of having a heaviness, a sense of feeling a pressure." (Kelly, 18, 848 – 851, 853 – 854)*

Stephanie recognised a case of stuckness when her clients were finding it difficult to implement a simple behavioural activation technique, when they showed intellectual engagement with the process but no emotional shift.

Helen noticed how her clients had aspects of their life that were closed down, often in quite a physical way, indicative of a narrowed view of life and non-engagement with the world. One client's physical presence suggested a kind of developmental arrest - *"she looked like a just a grown-up child now even though she was in her 40's"* and her physical presence in the therapy room reinforced this stuckness - *"she literally stuck herself in the chair… she would sit and completely filled it and didn't, was quite immobile throughout the sessions most of the time" (Helen, 1, 14 - 18).* Helen saw this as a literal, physical manifestation of avoidance, *"she was very fearful of the world and terrified of what it would mean to be unstuck in any way" (Helen, 1, 21 - 22).* She referenced Erikson's life stages and how if people are not able to transition from one to the next they could be immobilised and perhaps be stuck in that stage for 'a long, long time'.

Kelly agreed that how a client presented physically could be indicative of stuckness. She thought that this could show up as limited mobility not linked to an organic condition *"it's how they hold their face, it's how they move, it's how they talk, it can show up in a lot of different ways" (Kelly, 13, 622 - 623).* Kelly saw this as something energetic trapped in the body and that this rigidity of body or mind or emotion was indicative of a rejection of their experiences. She also spoke of a spiritual rigidity and how people could be resistant to different perceptions of themselves that others might have and how it might lead to the dark night of the soul, a well-referenced place of desperation and spiritual desolation.

Christina also felt that there was a physiological element to stuckness, something akin to what she saw in clients with Post-Traumatic Stress Disorder (PTSD) who had experienced a trauma, something stuck in the body as well as the mind. When Helen noticed a bodily stuckness she saw it as an internal manifestation of stuckness that will be apparent elsewhere in the client's life *"I think if they're really stuck in their body then that's going to be really showing itself elsewhere as well" (Helen, 12, 585 – 588).*

Helen said that a commonality in all of her stuck clients was a notable stagnation in other areas of their life, a hoarding problem on some level or *"not being able to let anything go, trying to keep things in some sort of stasis "(Helen, 13, 634).* One client had moved several years earlier and not unpacked boxes – "*she was stuck, it was manifesting itself in quite in quite a concrete way with her with these boxes that she couldn't open" (Helen, 2, 96 - 98)*, an external representation of her internal inaction.

As a body psychotherapist, Teresa understood that what was trapped in the body was an emotion that she released through a somatic technique such as a breathing exercise.

> *"And more often than not it's a lot of kind of weeping and kind of it reaches a sort of you know, it reaches through into an emotional state that is stuck in the body." (Teresa, 5, 225 - 227)*

Therapists could often pinpoint stuckness in a client, particularly as related to a desire for action that was not realised. This also extended to the client's physical space, a sense that the stuckness was embodied and quite literally prevented a step forward from being taken.

4.2.3 Internal Locus vs External Circumstances

Kelly theorised that there were two types of stuckness - a short-term context-specific period of indecision and a deeper stuck state. Indecision seemed to relate to a particular, often external situation whereas stuckness, while it included indecisiveness, seemed to represent "*a particular way of seeing oneself and being in the world that feels like to me a state of being,*

a state of being that has that particular flavour of being stuck" (Kelly, 15, 731 - 733).

Kelly's reference to this distinction was also noticed by other therapists. One factor that Greg saw as a key differentiator was that stuckness was more than a process of working through dilemmas or weighing up options, people had often tried a number of things which hadn't worked which made them feel like they didn't know the way out.

> *"There are a number of clients who have never been in therapy before and have a sense that something is not working quite right. They don't necessarily feel stuck, I think that they often present - it'll trigger their life developmentally where they just recognise that things, the way that they used to do them are not working. But that's a quantitatively different feeling that they present, that something is off and they don't know what to do - that's not quite the same as "I've tried other things nothing is working and here I am." (Greg, 5, 202 - 209)*

Helen reinforced this dichotomy.

> *"there's kind of a sort of more temporary transitional stuckness that might be linked to a relationship or a job, sometimes that reveals a pattern of stuckness in those situations. But there are clients who come with stuckness in a different sense in that they just can't move forward and it's not linked very clearly to external factors." (Helen, 1, 7 - 11)*

Teresa and Christina thought that situational stuckness often functioned as a trigger to bring clients to therapy, that they could be "*generally stuck in a feeling of 'I'm not getting any further forward in my life' or 'I'm stuck in a unhelpful dynamic'" (Christina, 1, 39 - 40).* Teresa felt that this situational stuckness was a diversionary tactic, an often unconscious shielding of the real underlying problem that required therapy – an outer manifestation of a deeper emotional stuckness. She thought that most people are not in tune with themselves enough to recognise an emotional stuckness and that the trigger to come to therapy would usually manifest in an external way through a situational problem.

> *“I guess normally people aren't that introspective that they are going to kind of be with themselves and say 'oh I think I feel an inner stuckness', it's not really what people do. It's usually that they come because they don't know what to do about their job and of course it's really an inner state but it usually is presented as you know, 'should I go or should I stay' this kind of a dilemma.” (Teresa, 4, 172 - 176)*

This lack of self-awareness was protective in that it enabled the client to access therapy by bringing a problem that appeared more tolerable to work with. Another way that clients externalised their problems was by situating the stuckness - and the work of change - in others.

> *“that's kind of an external stuckness - everyone else is stuck around them, might be a demandingness of others to change around them which is interesting.” (Stephanie, 5, 200 – 202)*

External factors were seen to be related to the actions of another, such as a partner being threatening or financially controlling and internalised stuckness related more to self-imposed barriers - it’s something about *them* that’s keeping them stuck.

> *“The internal locus of control vs the external circumstances. So I think that's a pretty good, pretty good distinction of like - being stuck has different dimensions to it.” (Kelly, 16, 783 - 785)*

Christina also saw that external stuckness in clients could arise as a result of a relationship with an irresolute other – a lack of movement by the protagonist leaving the client with ‘no room to manoeuvre’. But no relationship difficulty exists entirely in an external way, problems are internalised as the mind ruminates over the ramifications of external conundrums in a way that can leave the person feeling powerless and quite stuck – “*the internal world perspective which is they're stuck in that relationship inside their head as well as in the real world” (Christina, 2, 52 - 54).*

She reflected that many of her stuck clients were women and that situational stuckness was linked to female dependence often around fundamental issues such as finances and childcare which linked to poorer job prospects - and identity, that societal expectations of who women ought to be created an internal discordance and disconnection and to challenge this in any way was to risk displeasing those setting these ideals – partners, parents, roles set down by the previous generation or expected of those within one's class and social structure. Stuckness therefore linked to self-concept as they were unable to realise personal change or goals. Christina saw that clients could find it simpler to externalise or minimise these problems and therefore to be almost complicit in tolerating a limiting situation that would keep them stuck.

> *"it was quite deep-rooted but not severe enough to sort of make them do anything more drastic. So they didn't see it as about their survival which it actually was - their survival of the person or as a self." (Christina, 5, 242 - 244)*

Stuck as a metaphor was applied to myriad small and large events in life but therapists differentiated between internal and external stucknesses – between more temporary dilemmas versus a deeper, more intransigent inner state. Clients would often apportion responsibility for their problems to other people or situations and it was understandable that they would bring this external stuckness as a 'safe' problem to therapy although some therapists thought this showed a degree of lack of self-awareness. As internal stuckness was where the real problem lay, it was agreed that the real work of therapy "*can start if somebody begins to understand that their dissatisfaction with their situation is not the fault of others you know, it's something that is an inner state" (Teresa, 4, 186 - 188).*

4.2.4 *Stuck* is a Place

When considering what *feeling stuck* might be, from the outset each therapist began to describe it in a way that gave it parameters and shape. The act of the interview itself seemed to help them clarify something that had previously been little considered, was indistinct and elusive, particularly the question of what stuck was.

“I suppose it's a place even though I've said it's a thing.” (Kate, 15, 722)

All therapists considered *stuck* to be a place. For Kate, this took a familiar shape and evoked a common childhood fear from myth and fairy tale. This analogy also suggested its likely solution – to try and find the way out from the darkness although in doing so you may become more lost.

“It feels like they are stuck in a dark forest and they can't find their way out and the thing that they're using is just sort of taking them around in circles almost.” (Kate, 16, 744 - 746)

Kelly suggested that *stuck* was the centre of a storm but not its stillness, instead a place that was simultaneously part of its movement yet separate from its energy and violence, that to synchronise with its motion is a natural process but one which deprives the mover of any release or escape.

“this is interesting when you think about from being a stuck place it can be the eye of the storm and the storm is raging around and they are in the eye of the storm and moving with it so it's not like they can get out of it.” (Kelly, 10, ,461 - 463)

For Kelly, the dynamism of the storm represented the swirl of circumstances surrounding and myriad options available to the stuck person, the confusion and uncertainty of the situation but that release is not happening because decisions are not being made, no action is being taken as the choices are too paralysing.

Clients would sometimes invoke other metaphors or descriptive expressions and Greg found that their words evoked a strong visual, almost visceral sense of the place. These descriptions told of a sense of concreteness, a permanence, a type of arrested movement – ‘*any sense of not being able to move along’,* that change was not happening at the pace required or in the manner that they would like it to happen.

“Everybody describes it differently but it’s usually many clients talk about ‘I feel up against a wall’, you have a sense of hardness, there's a sense of resistance, there is a sense of being unable to

move forward. Again I listen for the language being up against the wall, being between a rock and a hard place. People describe it in various ways but again the images usually give me a sense of what it's like." (Greg, 11, 506 - 510)

To Simon, the word *stuck* implied a type of stasis, of being *"restrained, part of a machine, caged, whatever" (Simon, 12, 585 – 586).* Yet all therapists spoke of their clients fighting these restraints, that *stuck* was an active, dynamic place - there is movement. To him therefore, this movement was at odds with the word *stuck*.

"What type of movement would it be? …I've tried everything - nothing works that's the movement, that's the dynamic part. Stuckness is the frustration, rage, anger, self-hatred, whatever else associated with that word… this is where I get further away from the word stuck in regard of it if we were to think of it as a place of movement – it is dynamic." (Simon, 2, 78, 82 – 84, 480 - 481)

So *stuck*, then, is not an interlude or period of quiescence but rather a place where struggles have not been overcome despite their best efforts.

"It's a place where people find themselves, where … everything they're trying to do to move on from that place feels unsuccessful. They are doing the best they can do."(Kate, 15, 722 - 724)

Greg stayed close to the meaning communicated through the stuck metaphor as he saw meaning in "*the language that they use to locate it in a particular environment".* While he recognised it as a place he also saw it as an orientation in terms of time, suggesting the notion of it being a place revisited and he reflected to his clients *"I have this sense that you feel you've been here before."*

Kate understood this stuckness to be a reliance on old, outmoded coping strategies, that, rather than being neutral or even useful, are detrimental, damaging and exacerbate the feeling and desperation of the stuck state. Again, this notion of a dark place is perpetuated, but here it might be as simple as closing one's eyes to that which is too difficult to face.

“And often people know it's not working but even when they put it down there is nothing else to help them, there isn't another way out… but it's useful thinking about being in that sort of dark place where you can't find your way out.” (Kate, 16, 759 – 760)

Stuckness is moving forward, but not seeing what obstructs your path - why the strategies you have always used are no longer functional.

“They just feel they're stuck and can't move forward on their own so it feels like they've run out of tools whether they've been adaptive coping strategies that … don't work so well now or they've been sort of like self-harm or substance misuse where they, they're short-lived in their helpfulness, they make people feel better for a short amount of time but then create more problems and keep people stuck.” (Kate, 2, 65 - 70)

Kelly agreed that clients felt stuck a difficult place to be and refused to engage with it, not seeing that this closing down of their process was the reason they could not move.

“*they are judging and rejecting their experience… so they shut down the process and that keeps them more stuck.” (Kelly, 2, 93, 96 - 97)*

Kelly suggested that it is risk that dissuades them and that the calm at the centre of the whirlwind is deceptive and ensnaring. She sees that there is comfort in the familiar, how the desire for change is juxtaposed with the impossibility of taking action.

“it's like the risk-taking and… this is part of being stuck too, it's like here's this place of comfort that's uncomfortable … here is this real place of 'yeah, I don't want to have to think about taking a risk to call that person because I really want that job' or whatever it might be. … so I'm just going to sit here and be depressed and feel stuck because there's some way I'm taking myself, some way I'm taking myself to be that I'm not going to take that risk to do it'.” (Kelly, 9, 433 - 441)

It's the notion that it is in the invoking of these coping strategies that the stuckness is created and prevails. The coping mechanisms are so automatic and innate that they are patterns unseen – like the grooves worn smooth on a well-trodden path.

There was the sense that this was a process – one felt stuck, tried all means possible at their disposal to get 'unstuck' then as this was unsuccessful needed someone to help them *"to understand why they're stuck and help them move forward"* (Kate, 1, 20 – 21). Teresa argued that it was important for the therapist not to collude with the client's distress and compulsion to get out of the stuck place. Teresa challenged the need for movement and believed it was more useful to hold the unpleasantness.

> *"Because they want to move on and they don't like where they are. 'I'm stuck here' - well, you know, let's just hang out there and see what it's like (laughs)." (Teresa, 8, 376 - 377)*

She engaged with the client on their stuckness through a thorough engagement at all levels - questioning how it might feel physically, as a feeling, as an image, really interrogating this place to find out precisely what it could be.

> *"is it a concept, is it just an idea that I'm stuck? Is it a kind of way of framing something that obviously makes some kind of sense to the client that they feel stuck but maybe it's 'I don't like this place I'm in, I'd like to be somewhere else'." (Teresa, 8, 369 - 372)*

Therapists quite naturally spoke of stuck as a place, one of discomfort from which the client sought a release that they were unable to secure on their own. Nearly all therapists relied on a second metaphor to describe the first one, again with connotations of weight, heaviness, impenetrability and imprisonment. They were divided on the 'best way forward' – help the client out or not buy into the concept and stay with it.

4.2.5 Cycles of Repetition

Therapists noted that the path out of stuck was not direct, it appeared to suggest repetitive motion and the enacting of familiar behaviours intended

to liberate the person but confusingly seemed to have them more enmeshed.

> *"Maybe not a linear thing stuckness, maybe that's another way of looking at it's not linear, it's cyclical or coming back to this loop idea." (Simon, 4, 154 - 156)*

Therapists had differing viewpoints on how clients might exhibit stuckness in a behavioural or emotional way. Rebecca thought that while stuck responses were repetitive, they were also idiosyncratic and "*very individual to do with who they are and how they view the world and themselves" (Rebecca, 3, 102 - 103).* However there was a sense that going over the same ground was detrimental to the person, that this repetitive process was the key reason that people became stuck. As the patterns of behaviour repeated, they began to encircle and ensnare the once relied-upon modes of coping which became ineffective leading to frustration and even despair.

> "*I guess the word that comes up for me is again this kind of for a lot of people is this hopelessness right? It's this, like, 'I've tried and I've tried different things. I'm exhausted and nothing's working and here I am with you and it's just like', this kind of throw your hands up in the air - 'what can I do?'" (Kristen, 7, 323 - 326)*

Greg also recognised the relevance of the repetitive aspect of stuckness and it formed a part of his initial client assessment as he saw that while each example of stuckness might be individual, the repetitive aspect was familiar to all and happened on multiple behavioural, cognitive and even existential levels.

> *"One of the questions that I will ask is have you ever experienced something like this before, maybe not this exact thing… more often than not even in a situation that may be unique it does usually tap, into patterns of coping, patterns of thinking, of being in the world." (Greg, 11, 588 – 589, 594 - 595)*

Kelly also stayed at the client level, interpreting *how* the client conveyed their difficulties and how to her this was indicative of an intractable

stuckness, particularly through the client's rumination and the overwhelming desire to not be in this place.

> *" 'and I have these thoughts that keep going over and over and over and over again and I can't get away from them'. Okay you know, that's an indicator to me that there's no movement there, this guy is feeling trapped in a very specific particular way." (Kelly, 12, 583 - 586)*

Kelly re-enacted a swirling, cyclonic motion that clients drew on paper to demonstrate the difficulty of their position and what might need to be faced in order to step into its destructive force, how "*people who are stuck will do a lot of spirals and circles and so I see a lot of people doing the whirlwind image when they are talking about stuck" (Kelly, 10, 44 – 46).*

Kate thought that people were for the most part unaware that their cycle of behaviour was keeping them stuck and believed that by understanding this they would be able to begin the work of change. In some cases the coping mechanism is clearly dysfunctional. What is less obvious is the cycle of behaviour a client re-enacts which is a key factor in maintaining the stuckness that the therapist, with objectivity and clarity, can point out in a compassionate way.

> *"I suppose it helps you feel less stuck doesn't it if you can see that it's a pattern … so if you can understand in a compassionate way that, that you do these things to feel better often or they're part of you trying to compensate for what happened in the past by trying to feel better about yourself or to numb the pain of the things that you don't want to remember that there's a pattern to that, then if you understand the pattern it allows you to have some choice about what you change in and how you change in and which part of it you change… it makes sense, it's been a pattern repeatedly in your life." (Kate, 9, 428 - 437)*

For Stephanie and other therapists, it was easier to understand and think about this phenomenon by anchoring it within a client case and considering in what specific ways these repetitive patterns impacted people's lives. She

noted how it could manifest in quite concrete ways and how a stuckness in one area of life could contaminate others.

> *"with one case, someone I've met recently, he after six months he rotates jobs… so the stuckness will be in that because he's now in his late 30's and because of that hasn't progressed in his career and because of that he hasn't been able to secure regular accommodation or get the house he wants so he's then lost relationships." (Stephanie, 10, 353, 356 - 359)*

Patterns can also take a different form – that of replicating one behaviour in another guise.

> *"It's often somebody who finds themselves in that situation in a job might also be somebody who's finding themselves in abusive relationships with people." (Helen, 12, 558 - 559)*

The repetitive cycle can become so dysfunctional that it begins to spiral in other domains of life. A closer examination of the client behaviour showed rejection at every level, ultimately being a rejection of the self.

> *"And it's like 'I'm stuck here, I can't find a way to communicate, we're stuck in this communication pattern'. And so in working with that what she found is that she's rejecting part of her experience when something comes up, she's rejecting, she's rejecting her partner, she's rejecting her feelings about her partner and she's rejecting the rejection." (Kelly, 5, 244 - 248)*

Simon saw this as neurological patterns mimicking behavioural ones. Although reluctant in his interview to step away from more psychodynamic interpretations, Simon nonetheless referenced neural pathways as a way of showing how innate and unconscious these patterns really are.

> *"Repetition might be … like a chemical, almost like a chemical electro-chemical loop in the pathways that have been laid down… there's the idea that there's these pathways both in the head and behavioural things outside … that one can't step away from to look at." (Simon, 2, 89, 93 - 97)*

While a client preferred a direct path out of the frustration and torment, the process of revisiting one's past experiences was seen as a very necessary step. This unwelcome step also foreshadowed the difficulties and pain inherent in the therapeutic process, that of resolution of one's past and those things that have been too difficult to previously address.

> *"The reason why we might have repressed something is informing us and making us more aware and actually giving us life back. It's the idea that it is the repression of it that's caused the stuck."*
> *(Simon, 7, 331 – 333)*

Simon went further and posited that the work of therapy with stuck was paradoxical and that one needed to go back to unstick oneself. He contended that going back, in a psychodynamic way, to one's past - was where the real healing of stuck would be found.

> *"Actually because we're all in reverse gear as I see it, I don't see it as we're going to this place and we'll become more unstuck... that idea of being in reverse to going back to unstick ourselves sounds quite feels quite logical and a sensible way of putting it almost."*
> *(Simon, 5, 231 – 232, 238 – 239)*

Simon suggested that repetition may have a function – "*the idea that we re-encounter certain aspects of our past over and over and over again".* He likened it to a dynamic process used in creative practices, a process of rendering down until you have unconsciously reached a point of clarity, a wearing away of the superfluous, a process of closely examining the familiar but automatic.

> *"… that an artist makes and remakes and remakes until he or she happens across something that seems familiar or makes some sort of sense and then in that moment it makes sense but then it becomes useless and you move to the next. So - there's this sense that the artist in parallel in a loop is looking for recognising something and I would say that's what happens in the room as well."*
> *(Simon, 2, 58 - 63)*

Helen thought that the forward and back movement was representative of one's future and past, that the idea of moving forward required the revisiting of things one held to be true, particularly beliefs about oneself and that a move forward to a new future would mean challenging some of these deeply held truths and required a look at what one might need to change or do differently and "*sometimes you know to have to get unstuck would mean having to acknowledge some very very difficult things" (Helen, 3, 118 - 119).*

All of the therapists spoke of *stuck* as clients enacting familiar coping strategies which were now outmoded and furthermore, the primary cause of their stuckness. Several of the therapists contended that *stuck* was dichotomous – at once a place of misery but also a place to hide away from doing the real work of getting unstuck – that of facing deep personal wounds that needed to be addressed before *stuck* could be overcome.

4.2.6 The Utility of Stuckness

So therapists saw that the compulsion to repeat unhelpful patterns was a key reason that clients remained stuck. Greg and Helen contended that *stuck* was not simply a place impossible to leave but one "*that can become about retreating" (Helen, 12, 568)* - a deliberate withdrawal, a place of refuge from confronting that which needs to be confronted. An avoidance.

> *"It's safer, you know, you say is it safer to be stuck, yes definitely. For some people it feels like it is definitely safer than risking the pain." (Helen, 11, 501 - 502)*

Rather than being dysfunctional, it can be useful not to engage with the world, it may be maladaptive and punitive but it has a purpose. However this purpose can have a destructive outcome.

> *"This idea of not engaging to the next level out. It leads to - it's like a form of dying, a form of suicide I think - addiction, like a slow death if you like that's where the stuckness might be described as actually it's very, very much dynamic but going in a direction that probably isn't very useful." (Simon, 15, 725 - 728)*

Stuck is difficult but preferable to dealing with that which needs to be faced. Stuck has a function and can be defining for the person in some way. Rebecca spoke of a client reluctant to grieve for a lost partner as to give up her guilt would be to accept that he was gone.

> *"you could define some of her guilt as being stuck, being stuck in that guilt and she didn't want to give up all of her guilt, she wanted to keep a bit of it and taking that away from her wouldn't have been helpful for her at that time, it may be another time she would want to but that was losing all of him to take that away." (Rebecca, 13, 616 – 620)*

In some circumstances being stuck was a dam and to open the floodgates might prove potentially damaging. Rebecca felt that it could be an issue of timing, particularly if the person is poorly resourced.

> *"some people might want to carry around stuckness, some people don't want to let things - always let things go in. Often in trauma work some people want to hold onto the trauma because it's too psychologically damaging to take it all away for whatever reason. So I suppose what I'm saying is that you know, you have to tread carefully with people's stuckness because there may be a very good reason for them to be wanting to hold onto it but they may want to understand what it's about rather than do anything with it." (Rebecca, 13, 601 - 607)*

What do people gain from this position, why do they think it keeps them safe? Helen believed that it was a great excuse for people not to face things in their lives, an excuse not to take action - *"avoidance is very big I do think".* But this position is illusory as that which is avoided accumulates, the less that is done the more entrenched one becomes and so it goes on.

> *"if you are stuck, if you have decided you are stuck that becomes a good all-purpose by its nature, it becomes a reason for lots of things that haven't happened in your life or the things that have gone wrong and it feeds back into - it comes out of being stuck but it feeds back into the stuckness." (Helen,14, 654 - 658)*

Kelly spoke of the intolerance we have of non-movement, how we judge it and determine it to be problematic and that fighting to get out mires us in deeper. She suggested that in order to move out of stuck it was imperative to accept the experience of it, to look at what it teaches you, that being stuck can be a necessary interlude.

> *"so someone who doesn't reject their experience can see that place as an incubation period, right, and so stuck isn't a problem until we start judging it and saying 'this is not a good place to be, I want to get out of it'." (Kelly, 7, 308 - 311)*

Christina also saw how stuckness was protective and allowed the client not to ever reach the point where they had to face their fear of changing. She thought that to be unstuck was to unravel a complex belief system and to do so without providing further resources could prove devastating.

> *"Well sometimes it can seem very counter-productive. So sometimes it can be someone saying 'I've still got flashbacks, I still remember what my father did to me, it's all still his fault, I can't help it' and they're afraid that if they don't have that justification, if that ground is taken from beneath their feet they'll feel like, they won't know how they could cope." (Christina, 3, 146 – 150)*

Helen agreed that fear was at the root of stuckness and that for clients who had been stuck for a long time it was very hard to work with as clients had a lot invested in it.

> *"it was going to take an awful lot of unravelling to help enable her to take on what would involve, what would be involved with being unstuck which was very terrifying to her, because she would have to live then." (Helen, 1, 28 - 30)*

4.3 Theme Three: Working with Stuckness

While stuckness was understood primarily as a client issue that suffused multiple domains of their lives, this pervasive aspect saw it permeate other, unexpected realms within and outside of the therapy.

All of the therapists, even those willing to work with the metaphor looked to modality explanations in order to make meaning of stuckness and was most apparent as they formulated the problem in order to suggest its likely solution, showing some unexpected cohesion and overlap in how they understood how a client could become unstuck.

4.3.1 Stuckness in the Therapeutic Relationship

Stuckness did not just affect a client's personal world, it also seeped out into the therapy as a contagion, acting as a pall over the therapy and at times enrolling the therapist into the client's sense of hopelessness and inability to act.

> *"Well it's interesting because quite often as a therapist I think you get stuck in the same stuck feeling with them and often if a patient says 'oh but I can't do such and such' and you know, as a therapist part of you knows that actually they perfectly well could but in the moment that feeling of impotence is so overwhelming that I can end up agreeing with somebody that I can quite see why there isn't anything they can do." (Christina, 2, 58 - 63)*

Therapists reflected on times where the therapy stagnated and referenced psychoanalytic concepts in order to understand this type of stuckness, the transferential aspect of the client and therapist dynamic where they can become locked into a re-enactment of an aspect of the client's life.

> *"you're aware as therapists if this person is often in the transference you feel very stuck as therapists, the work feels stuck and they feel stuck and so that's a common feeling." (Helen, 2, 53- 55)*

Kate also relayed experiences of therapeutic stuckness and took an MI modality approach to understanding it which Stephanie found equally helpful as a way of understanding the interrelationship between client and therapist when the work becomes stuck.

> ***"****It felt like feeling stuck fitted very much with sometimes how practitioners are feeling as well as with clients so Motivational Interviewing can be helpful to have conversations about substance misuse or other behaviour change where the practitioner is feeling stuck also the client is feeling stuck." (Kate, 1, 12 - 15)*

Resistance in the client can be a sign that an aspect of the therapist's approach is creating these difficulties, that a focus on resolution of the stuckness may not be in tune with the client's readiness for this step.

> "*it's like 'oh it's the patient's resistance, they're not able to look at this thing that I am sure is going to help them'. So having a particular agenda can actually get in the way of helping someone with stuckness." (Kelly, 14, 664 - 666)*

Stephanie agreed that an agenda could create blocks between client and therapist. She understood this by taking a Schema Therapy perspective - how a therapist's desire to unstick the client could exert a covert pressure upon the therapy as the therapist's schemas, notably around unrelenting standards for themselves or the client, became activated. She suggested it could be a point of reflection and self-examination for the therapist.

Teresa felt it was important not to have a goal of wanting the client to move through their stuckness and that in recent years she has found herself less inclined to take this kind of approach and finds it is better to give autonomy to the client as it is in being with the stuckness that the therapist can have the greatest impact.

> *"if you are going to play into some kind of game where you want to help them be unstuck then you are obviously playing out a dynamic aren't you, you are the one that is going to get them out of the stuck place and they are putting you in the position of being the one to get them out of the stuck place. So as soon as you start buying into that*

concept you're lost really." (Teresa, 12, 554 - 558)

Greg spoke of stuckness within the therapy as 'therapeutic impasse' and spoke of how it could mirror the client's subjective feeling of how things are not moving forward in their life. He saw that it often occurred when there had been a fragmentation of a person's emotional life which needed to be reintegrated and he would consider where their psychological or emotional development had been arrested. It indicated to him times where he might be getting ahead of the client and the ways his client would let him know this.

> *"I think sometimes where therapeutic ruptures or misattunements can happen, they often happen when I'm a step or two ahead of the client and it's very interesting, they will often enact that by you know being late to the next session or forgetting to pay me, I mean it's very interesting how that really all plays out." (Greg, 9, 399 – 402)*

Teresa thought that client stuckness could trigger feelings in the therapist that they might not feel are acceptable and therefore can stay unacknowledged and in this way therapeutic signals become overlooked.

> ***"****it may be that there is something that's being triggered but often it would be unexpressed frustration, unexpressed boredom all kinds of feelings that therapists wouldn't feel are acceptable to have so they wouldn't acknowledge them." (Teresa, 2, 59 – 62)*

Christina examined her reaction to a client stuck in a relationship who came to therapy each week and spoke of the same thing and how "*it just made him the most annoying patient I've ever worked with. I was so frustrated" (Christina, 3, 107 - 108).* In retrospect she believed his implacability was not helped by her tolerance of it or the clinic's belief in the efficacy of long-term therapy. She affirmed the subtle but important difference between sitting with client stuckness as opposed to buying into it and what this suggested about a client's inability to move forward, what it might say about their fear of change. That for a therapist there is a utility in challenging the stuckness and not being deterred by the distress of it.

> *"And I think, you know, there are a number of people who have been like that to who I should have said, either you change or you stop coming here… I think I carried on working with these stuck people much longer than I should have and I just should have said to them, 'look it seems like actually your situation is good enough and you don't on balance' because something has to change you know, somebody has to decide not just the green is greener on the other side but I'm actually going to step over and see if it really is." (Christina, 3, 113 – 121)*

Kristen and Helen both picked up on signs of stuckness in the therapy when they themselves became stuck. Kristen found stuck a helpful word to use at a meta level in supervision when she might concretely say to her supervisor "*I feel like this person is very stuck*". She found that client stuckness was often a factor when she noticed it was difficult to conceptualise for a client. Helen also found stuckness '*very hard to work with'* and found herself getting stuck with the therapy and feeling de-skilled as a therapist and *"in those cases you would be asking yourself as a therapist is there something I'm avoiding here that means we've got stuck?" (Helen, 6, 297 - 299).* When discussed in supervision she could see that her fantasy was stuckness's opposite – freedom!

> *"I often took her to supervision because it was very difficult and I felt I was not, we were not progressing and I felt responsible for that and I remember my supervisor asking me you know, what was my fantasy for this client and I realised that my fantasy was that we would be running across some hills (laughs) there in the sunshine holding hands we would be running." (Helen, 1, 34 - 38)*

Teresa felt that most clients come with the best of intentions in terms of wanting to cooperate with and engage in the therapeutic process but that impasse would arise some way down the therapy *'willingness is not all that's needed. So when I think when the stuck place is reached that will be a familiar stuck place but most clients don't show that initially to the therapist, they will want to be seen to be cooperative' (Teresa, 2, 82 – 84).* She suggests that this will give the therapist clues to the real underlying problem that should be addressed and she proposed that the impasse should not be brought into.

This sense of stuckness even infused the interview process as quite often participants found the topic difficult to stay with - *“well I actually felt stuck in the middle of thinking about it so to speak” (Christina, 17, 810 - 811).*

> “*I think I might have lost track of what you were saying (laughs).” (Kristen, 2, 53)*

Simon also spoke of the difficulty of staying on track but in contrast his words were not stuck but unfettered and scattered.

> *“Drifting off. I don’t know, it’s just an interesting phrase to use. Sort of highlighted the idea that it’s got dynamics to it - drifting away from what? To what? It’s not stuck, I’m not sitting here dumbfounded, quite happy to babble like a child does.” (Simon, 4, 180 - 183).*

He said that stuck was a difficult topic to explain and how *“when asked to defend a particular word how slippery it all is really’ (Simon, 1, 39 - 41).*

Stuck was a sticky state, pulling in people on the client’s periphery and playing out in myriad ways between therapist and client. As the stuckness was reflected back at them, they considered their own inadequacies as clinicians and how their personal schemas could be activated in ways that were personally and professionally challenging.

4.3.2 Modality as a Sense-making Lens

As apparent throughout this report, as participants began to reflect upon and respond to the interview questions, it was noticeable how many showed an inclination to revert to therapeutic frameworks in order to understand stuckness. As a generalisation, psychotherapists seemed more open to working with the concept of stuckness while psychologists more quickly started to use clinical constructs and ‘translate’ stuckness into more recognisable psychological forms, often in more than one modality. This was sometimes done quite consciously by the therapist. As Kristen reflected on stuckness, she was explicit about using modality as a lens.

> *"I was thinking why do I think that clients get stuck and I do have some ideas on that in terms of my theoretical orientation." (Kristen, 2, 82 - 84)*

Rebecca was aware of how stuckness might be understood psychologically across modalities, how it might be a protection of some kind, that something may be difficult to confront and how coping strategies wear thin over time as they can no longer mask a problem that needs resolution. The act of defining stuckness through clinical frameworks meant that it unequivocally shaped her approach to the work as she believed that it was her role as a therapist to help bring something into a client's consciousness and understand what was behind the resistance to change.

> *"I suppose with my CBT hat on I'd probably think about stuckness as sometimes I might think about it as a secondary gain being in this situation has some payoff for the person even though they may not consciously want to perceive it that way. And I suppose in psychodynamic terms it could be seen as a defence it's protecting them from something, you know I think it could be viewed as that." (Rebecca, 2, 83 - 88)*

Again the demarcation between a therapist working with clinical language and allowing this process to be shown to the client was present "*I think I'd probably think about it in those terms although I wouldn't express that in that way to them" (Rebecca, 2, 90 - 91)*. Rebecca felt that clinical interpretations of stuckness could be alienating for clients and cause them to become defensive, particularly clients who were thought to have secondary gains.

Therapists spoke of an official order and logic of therapy, that it made sense to understand a client's difficulties as early as possible during the assessment and formulation phase - "s*o there's in this unsticking process… it has to be thought out and depending on the presenting issue it has to happen in a certain way at a certain point" (Kristen, 10, 488 - 490).* Kristen relied on an EFT emotion-focused framework to help guide her and conceptualise cases of feeling stuck.

Simon followed psychoanalytic principles in working with clients and he could 'mentalise' his approach - he could hold in mind that psychoanalysis was a modality that was as challengeable as any other and that the process of therapy was reducible to a couple of very simple elements – a client's readiness to face the past and unpack things that haven't been looked at before facilitated by a therapist asking the right questions.

> ***"****I might even have it on the website the idea that there may not be an answer but there might be the right questions you could ask in this room… there are certain things we need to probably unpack if you were to believe in psychoanalysis." (Simon, 6, 294 – 295, 297 – 298)*

Taking a psychodynamic approach to stuckness was popular. Kelly stated that '*I'm not psychodynamically oriented'* but nevertheless found it useful as a framework as she understood stuckness to be a superego attack and that this was a helpful explanation for people as it gave them a way to 'dis-identify' from stuckness.

Kate began to speak of her modality approach within the first minute of the interview and referred to MI and CBT often throughout. She saw therapy as jigsaw pieces and that a modality was a way to work with clients that placed the impetus for change with them and gave them responsibility and autonomy over their own process. There was an interesting ambiguity of a therapist applying an MI technique of 'we're not the expert' which she did not acknowledge.

Kristen was interested in understanding how other therapies might conceptualise stuckness. As she compared modalities she thought that whatever the approach used, the outcome could end up being very similar. She went further in her understanding to suggest that perhaps a psychological approach was not necessary and that what each modality seeks to do is already found in Eastern philosophy – the idea of acceptance.

> *"I think we are all doing the same thing and it's repackaged a little differently like I was trained in EFT Emotion-Focused psychotherapy and we talk about the critic and the internalised critic that talks to*

> *people in that kind of cruel manner that is very derogating and condescending and sarcastic and just annihilating in a lot of ways… but that's very much what CBT is with the automatic thoughts, right, automatic negative thoughts are pretty much the same thing as an internalised critic so I think we sometimes align with one theory and forget that really they're all doing very similar things… instead of deconstructing them like a CBT therapist would or identifying the emotion that comes from the thoughts as an EFT therapist would - maybe the Buddhists have it right, they just notice it and are compassionate with themselves for having it and they don't need to do anything with it." (Kristen, 5, 211 - 229)*

While several therapists spoke of stuckness manifesting in how the client presented, Teresa reflected that standard therapy does not tend to the body, the physical presence – there are no in-between measures.

> *"I always argue that every therapy should be a body psychotherapy because the bodies are always present, the bodies are always participating so we either ignore them or we can include them." (Teresa, 10, 480 – 483)*

Modality was also extended to theoretical concepts as Christina referenced psychoanalytic theory. She saw the Jungian conceptualisation of stuckness as a challenge to one's individuation or identity – about familial expectations limiting one's own self-expression. A Kleinian interpretation would focus on internal objects *"that those people were being persecuted by, you know, bits of their parents or external forces that they had then internalised.'* A Lacanian perspective was that you had to decide what you really want in life as there is a choice to be made, a loss to be endured and in Lacanian terms this loss would be symbolic rather than realised because "*people could follow their dream but they don't because they don't want to pay the price" (Christina, 7, 344 - 345)*.

4.3.3 Unstuck

So how did therapists understand the process whereby their clients could become unstuck? Therapists each worked with stuckness through their preferred modalities but underlying these approaches were surprisingly

similar beliefs about what the stuckness was and what needed to change in the client. Most thought that a client's attachment pattern, core beliefs and coping styles created relational difficulties that kept them self-reliant, isolated and stuck.

Christina defined stuck as an inability to change and when thinking about how past clients got unstuck, she saw that change seemed to require a shift in identity. As core beliefs about the self are intrinsic, to move forward would mean losing a part of oneself which posed a great challenge to clients - *"if they stopped holding onto the way of behaving that they're in, will the whole world fall apart?"(Christina, 3, 137 - 138).* She saw her role as helping the client to replace existing beliefs and ways of coping with more adaptive alternatives.

> *"they've been using it, that belief or that dynamic as a resource and it needs to be replaced by something else - maybe that's what therapy does, it gives people a belief that there are other resources and other ways of relating and other dynamics that might replace what they've relied on all their life." (Christina, 3, 150 - 154)*

Stephanie thought that coping styles – the need to protect oneself from vulnerability, rejection and failure in dysfunctional ways – were what kept people stuck. Letting go as a concept was an important way to get unstuck and she thought that CBT worked 'in the moment' but modalities that accessed the deeper thinking that reinforced these patterns were required for the intransigence of stuckness and she used Schema Therapy and MI. She thought many stuck clients had an upbringing that instilled patterns of subjugation such as tending to others so they never learnt to get their needs met which fostered self-reliance and difficulties in help-seeking in the client. She linked stuckness specifically to a very critical unrelenting parent mode and thought it was important to focus on the mistrust/abuse schema which might arise within the therapeutic relationship.

Most of the therapists in this study felt that relational patterns developed in childhood had a key role to play in understanding why someone got stuck, with half of them directly linking it to the attachment paradigm. Clients with secure attachment were seen as high on resilience, coping, view of self and

the world and that these qualities were helpful in being able to extricate oneself from a stuck situation.

> *"an inherent knowing that you were loved as a child is enormously significant in terms of how you feel able to manage your emotional life and that would obviously have an impact on whether you were stuck or if you could unstick yourself." (Rebecca, 10, 442 - 445)*

This solid base was seen to lead to the development of schemas relating to how well people believed they could cope, with an important one being *'I am somebody that is able to cope, I'm able to manage' (Rebecca, 10, 455 - 456).* Stuckness then, she suggested, is not coping and a need for external help that is difficult to admit to and take up, perhaps due to feelings of vulnerability, judgement or perceived weakness. Rebecca suggested that an ambivalent attachment style and the associated lack of trust in the consistency of relational care meant that a person might become self-reliant as it's the safest course.

> *"I don't think that they necessarily consciously have that belief that I can't cope or can't manage it would be more something about 'I don't want other people to know that I can't cope or can't manage' therefore making it difficult to seek help." (Rebecca, 10, 481 - 483)*

Kate and Kristen also thought that one of the key factors that made stuck problematic was low self-esteem which Kristen aligned with being in 'self-critical mode' which made asking help from others very difficult. Kate thought that you could hide your low self-esteem by using coping strategies but a trigger event – usually one specific to your core beliefs and ways of coping 'lays it bare' and then you are isolated.

Several therapists spoke of the impact of attachment on the client's coping and how transference indicated what kind of attachment style a client might have through their subsequent ability to form a therapeutic relationship. Stephanie felt that parents may have been either narcissistic or not available and that the attachment style might be anxious-avoidant. Christina thought that disorganised attachment, particularly to the mother was problematic for some clients. Rebecca felt that ambivalent attachment

was possibly most prevalent and that it also brought relational complexities which may hinder treatment.

> "*there is so much negativity loaded on this idea of having to seek help from somebody else that it makes engaging in the process of therapy quite rocky I think." (Rebecca, 10, 471 - 473)*

Simon believed that clients could have a background where abandonment was a factor. Greg also thought that insecure attachment or complete abandonment were most problematic and believed that inherent in the difficulty was that attachment issues often pre-dated language, the memories were pre-verbal and Greg suggested that "*we are talking about an architecture that is very very deep very very ingrained and it really kind of creates I think a vulnerability that then gets played out in life" (Greg, 6, 252 - 254).* The schema beliefs he identified were *'I'm not good enough', 'I'm flawed', 'I'm worthless' 'I don't belong'* and suggested that although skills training was useful to build ego-strength, this repair needed to happen relationally within the therapy, that *unstuck* is to do schema work on beliefs within the context of a supportive and understanding relationship.

Greg also believed that for people to get unstuck therapists have to work directly with the emotion. He emphasised how therapeutic skills such as reflection and empathy helped clients get sufficient distance from their problems so that they could tolerate the difficult feelings and look at their problems more objectively. He used Eye Movement Desensitisation and Reprocessing (EMDR) as a way for the client to create some distance between themselves and a distressing memory as the dual awareness helps them balance the memory and feelings of the child with the awareness of their adult coping strategies.

Kelly thought the fundamental problem of stuckness was judgement and rejection of one's own experience, a particular world-view linked to a core belief of 'I'm not good enough'. Kelly thought that stuckness required a repertoire of tools tailored to a client's different states and varying levels of stuckness. She used enquiry and curiosity to uncover clients' thoughts, feelings and physiological responses to the stuck place and applied the somatic-based touch drawing technique which she felt provided the necessary distance so that clients could understand without rejecting or

avoiding. She also used psychodynamic frameworks such as super-ego and gestalt approaches and incorporating physical movement into her therapy.

> "*the body has so much information and many people what I've noticed it's like, when they've identified something that they've been holding onto and feeling stuck about and they are to like feel it in their body and put a word to it - it releases." (Kelly, 20, 972 - 975)*

Teresa also restated the importance of a strong therapeutic alliance particularly with regard to how this aligns with the body psychotherapy approach of encouraging a client to access their inner world as to guide someone though a stuck place required a feeling of safety and trust. She too worked with the body to release the stuckness.

> *"In body psychotherapy there is a way of using the breathing to get through when there's a stuckness, to get through so - you know, the theory teaches us that there's the cycle of expression and that when we are stuck somewhere and unable to express then sometimes body work can help and breathing can help to move on." (Teresa, 1, 7 - 11)*

Kristen thought that people got stuck because in trying to push away or ignore negative feelings they "*dismiss that thing that guides you so to me I really feel like stuckness occurs when you are missing the data that emotions provide you" (Kristen, 9, 433 - 435).* She believed that powerful techniques were required to get unstuck and used Emotion-Focused Psychotherapy (EFT) as exposure work, to help clients listen to what their feelings are saying - facing the fear leads to unsticking oneself.

> *"it's fascinating how, just that surrendering to that thing that they're afraid of can really shift things for people and that's really what I see is as getting someone out of that stuck place." (Kristen, 3, 134 - 136)*

From a relational perspective, Kristen believed that sometimes interventions aren't required, a humanistic sitting with the client can be healing in itself, just acknowledging in an existential way that 'you're okay

even though you're stuck' – the knowledge that we are all stuck, can be an intervention in itself.

Each of the therapists drew upon their preferred modalities to help clients get unstuck. But underlying their choice of approach was a common understanding of the elements that got people stuck, therefore highlighting an unexpected transtheoretical understanding of stuckness. Participants thought that coping became ineffectual over time and often a trigger event, possibly linked to something similar from the past, weakened these last defences. Most participants felt that relational patterns developed in childhood had a key role to play in understanding why someone got stuck and that the associated lack of trust in the consistency of relational care means that a person might become self-reliant as it's the safest course. It seemed that the pathway through stuckness led this way, that to be able to trust someone to help them face their pain was the path to freedom.

4.4 Concluding Summary

Feeling stuck appeared to be a metaphor with both complexity and meaning, an elusive term that was difficult for therapists to conceptualise but one seen to have a strong resonance for clients and was often the bridge to enable them to access therapy and a key reason participants within this study were contacted. However the idea that working therapeutically with this metaphor could be beneficial for clients was not often considered. All of therapists relied on clinical interpretations of stuckness in order to make meaning of it and to work through the client problem. However many of the participants agreed on common factors underlying stuckness thus identifying a trans-theoretical understanding of this state.

The results of this analysis showed *feeling stuck* to be a phrase that was able to capture the complexity and by extension – the humanity – of client experiences in and out of the therapy room, particularly when compared to diagnostic labels and theoretical terms like impasse and resistance.

4.5 References

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5. DISCUSSION

5.1 Introduction

This study sought to explore how therapists made meaning of the term *feeling stuck* and while this exploration elucidated how participants understood this specific term, it also brought to light wider issues around the difficulties of working with metaphor and language in therapy and its influence on the course of treatment – therapeutic issues which may not always be within conscious awareness. Without intention, the interviews loosely mapped a therapist's path from sourcing new clients, treatment engagement, assessment and formulation of the presenting problem and the influence (or not) that working with a metaphor had on this process.

The use of the term *stuck*, particularly in online profiles, was seen as a way for therapists to connect with clients who were considering therapy and participants considered that using a lay term was helpful in lowering the barrier to engagement due to the strong resonance it had for people. Half of the participants continued to engage with the term during therapy as they considered that using lay terms allowed a psychological conversation to take place which was less emotionally charged therefore more tolerable for the client.

Therapists acknowledged the elusiveness of the metaphor and how difficult it was to define in a psychological way and resorted to modality frameworks in order to understand it, thus highlighting an overall difficulty in working with client language alongside clinical interpretations. However they acknowledged the importance of the term, simply because it was the word chosen by clients to frame their issues and how metaphors in therapy could be a form of lay case conceptualisation and therefore a useful way to formulate and explain a client's difficulties.

All of the participants saw stuck as a place of psychological turmoil from which the client was motivated to escape – a place of movement, often enacting repetitious dysfunctional cycles or coping mechanisms and not of stasis as it may imply. Some participants also noted how it might be purposeful – a place of retreat which enabled the client to not to face their problem or the changes that were required. Participants noted that clients had often reached a point of crisis before seeking therapy, likely to be a

triggering event which might be indicative of the real therapeutic problem to be addressed. Some participants spoke of recognising how stuckness might be embodied in the client and distinguished between two types of stuckness – situational external events versus a deeper, more intransigent internal state, although participants were divided on whether to help the client out of their stuckness or not buy into the concept of it at all. Participants noticed at times that they themselves could feel stuck with the progress of therapy with these clients which often necessitated them taking *stuck* to supervision. However a key finding was the automatic way many participants reverted to preferred therapeutic frameworks through which to makes sense of stuckness, identifying commonalities in how this presented in clients thus indicating an unexpected trans-theoretical understanding of this phenomenon .

The findings of this research therefore identified new possibilities for the understanding of stuckness. Wolcott in 1990 spoke of advising his students to “draw upon the literature selectively and appropriately… ordinarily this calls for introducing related research toward the end of the study rather than at the beginning”. Nolen-Hoeksema (2006) suggests that it is important to provide context for the research findings and how it might be necessary to go back to the literature in order to try and understand the meaning of your findings. O’Leary (2017) supports this approach and contends that in the discussion chapter that the literature is worked with iteratively, that is, is revisited and re-examined in light of the findings of the analysis. Therefore, as the participants in this study have generated new findings, the researcher has as necessary reviewed the extant literature in order to understand them within the context of any existing related research and included them in this section.

This chapter will revisit the themes identified in the analysis chapter, beginning with the theme ‘defining stuckness’ which will explore how participants made meaning of this phenomenon; secondly how participants therapeutically approached the phenomenon in ‘working with stuckness’. Finally, ‘the lay metaphor’ will discuss this term from a metaphorical perspective but also draw on wider implications for therapists working with lay terms and language within a therapeutic environment. The modality influence of working with a lay metaphor will be referred to throughout the chapter.

5.2 Theme: Defining Stuckness

5.2.1 The Therapeutic Pathway: Stuck as a Recourse to Stigma

One of the key findings from this study was the resonance that the metaphor had with clients and how influential it was in drawing them to therapy. As one participant said, the client 'felt understood'. How important are the words that therapists use pre-therapy to attract new clients and how much impact do these have on client decision-making when it comes to choosing a new therapist?

Spalter (2014) suggests that clients often have ideas and preferences regarding their treatment but do not know how to match this to a therapeutic modality, and observes that there has been little research regarding how clients might be offered guidance to navigate their way through the therapeutic choices available. Van Audenhove and Vertommen (2000) recommend giving clients information about the range of psychological problems and potential treatment options and how these work within a service setting in order to help the client make an informed choice and correct any disparities between what they may prefer or expect, and the realities of the service and treatment offerings.

Saunders (1993) proposed a four step model outlining how people seek psychotherapy – recognition of a problem; counselling is seen as a solution; a decision is made to seek out counselling; a specific therapist or service is contacted. Saunders (1993) found that the first step – recognising that the negative feelings signified a mental health problem – was the first and most difficult step which took significantly longer than each of the others. A study by Elliott, Westmacott, Hunsley, Rumstein-McKean and Best (2015) of the therapy-seeking process found that people typically experienced mental health difficulties for an average of 10.5 years before seeking therapy, meaning that the problems became chronic and enduring and often the catalyst to seek support was a trigger. This affirms research by Manthei (2005) on how clients seek counselling support which found that clients consider therapy when they can no longer manage their problems effectively and that there may be a trigger prior to help-seeking.

The results from the present study were consistent with this literature as participants found that clients initially spent what was often a lengthy period of time attempting to resolve the problem on their own, with research suggesting that is was the most commonly reported obstacle deterring clients from seeking treatment and that this delay in accessing psychological support can lead to the client suffering years of distress (Elliott et al., 2015; Mackenzie, Pagura & Sareen, 2010; Steele, Dewa & Lee, 2007). For some clients, Manthei (2005) found that therapy was seen as a 'logical step' but for others was a 'final option'. This aligned with findings from this study where help-seeking was described as usually preceded by a trigger stimulus and the client's realisation that the difficulties had become too complex for usual coping strategies and that external support was needed. Furthermore, study participants thought that the trigger event often pointed to what the problem was, perhaps mirroring an earlier trauma or pointing to an early loss that was unresolved. Given the difficulty for clients to acknowledge that the problem is psychological, findings of this research suggest that the use of a metaphor to explain these difficulties is a minimising strategy that enables the client to maintain a semblance of normality – if they are only 'stuck' then it's not mental health, it's a much lesser issue. Browne speculated that "in order to seek help in the first place, people have to overcome the stigma of mental illness and the possibility of being seen to be not coping. The very association with the 'psycho' word (psychotherapy, psychology, psychiatry) is apparently enough to put people off". Browne (2008, p12). Once the stigma has been overcome, people are then confronted with many hundreds of therapeutic options making the process of finding what they need confusing and 'maze-like' (Browne, 2008).

Elliott et al. (2015) found that clients often took over a year to decide that therapy was a solution and approximately a month to contact a psychological service. They suggest that the lengthy time taken to decide to undertake therapy questions the effectiveness of public health messages about availability of mental health support and efforts to reduce the stigma around it. Therapy Today magazine reported on research carried out on behalf of the BACP by Nicky Forsyth and Simon Confino (2008), titled *How to Become More Customer-Centric*, suggesting that therapy "has what the marketing world would call an image problem. Not only is it still associated with sickness, treatment and patients, it is seen very much as a hidden

profession, shrouded in mystery and secrecy and lacking a visible, friendly public face" (Browne, 2008, p10). By choosing to use a metaphor like *stuck* and situating it within a lay not a psychological world, therapists' use of this term appears to be a clever way to circumvent some of these deterrents to therapy-seeking.

With reference to the third step in Saunders' (1993) process, choosing a service, it has been found that "for most clients good match-ups tend to be those that in some way meet their self-perceived needs or demonstrate a similarity to them in some way" (Manthei, 2005, p546; Vera, Speight, Mildner & Carlson, 1999). There is sufficient research to confirm that clients welcome the opportunity to make decisions about their therapist and therapy (Kremer & Gesten, 2003). Sue (1977) defines the concept of consumerism in counselling – how therapists can ensure that clients are made aware of their rights; are seen as active participants in the therapeutic process; that therapists explain how counselling works in order to demystify it; and that efforts should be made to balance the power differential that exists between clients and therapists and ultimately that it is therapist arrogance to think that they alone 'have all the answers and know what is best'. There is much research which examines the decision-making process of private clients seeking therapy, particularly in relation to how potential clients assess the information made available about psychological symptoms, types of therapy and therapist qualifications (e.g. Kremer & Gesten, 2003; Bowman & Fine, 2000; Maione & Chenail, 1999).Some of the information that a therapist discloses assumes a basic working knowledge of the meaning of psychological qualifications and counselling modalities, knowledge it can be assumed that many clients do not have making choosing a therapist a confusing and difficult task (Browne, 2008). Therefore it appears likely that a client will relate more readily to a therapist who is able to speak to them at their level using terminology that is familiar and resonant, particularly when they are using terms that capture their psychological difficulty or distress in a way that is not triggering or stigmatising or tells them that they are mentally ill. Terms like *feeling stuck*.

Therapists in this study who worked in private practice acknowledged that new clients were most likely to find them online hence the importance of the wording in their website profiles. The inclusion of the *feeling stuck* metaphor in these biographies was an acknowledgement of how strongly

this metaphor was thought to resonate with people and therefore how they were likely to actively respond to this term. Winborn (1977) makes a case for 'honest labelling' of therapy services so that clients can make informed choices and points out that most information supplied by therapists is written by them, therefore most often takes their perspective of what they think might be useful for clients to know. In this study, therapists did not consider the implications of including a lay metaphor when referring to a psychological state alongside more clinical descriptions of experience and services, and only one participant alluded to the lack of transparency in therapists doing so but he considered that any effort to assist the process of bringing a client to therapy was ultimately beneficial. However this is only true if it does not create expectations in the client that their *stuckness* will be specifically addressed.

This research raises a genuine concern about the use of a lay term in this way. Browne (2008) states that the circumstances under which many people seek therapy are normally during points of crisis when help is urgently needed, therefore they are disadvantaged when it comes to evaluating therapeutic options and may be less discriminating than they might otherwise be. Quite often people are unaware of the myriad choices available and operate under the assumption that therapy is homogenous therefore do not have the knowledge or means to investigate and choose the therapy or therapists that might suit them best.

Findings from this study suggest that the focus for many therapists is on formulating and resolving the client problem, and that the pre-therapy stage is looked upon as perfunctory or administrative. It was not considered that the therapeutic process might begin the moment a profile is written and placed online or that a client problem might already be being defined in some meaningful way when a lay metaphor is used. This is likely to have implications for therapeutic goals as it could be argued that by using a lay metaphor, therapists are signifying to prospective clients that they understand and are able to work on the specific problem of stuckness.

5.2.2 Stuckness as a Psychological Phenomenon

Participants said that identifying stuckness in a client could be difficult yet all were able to define characteristics that pertained to a *stuck* state and in many instances agreed on how stuckness could be understood.

Stuck was described as being a place, one in which the client felt tethered and restrained, an unrelenting position from which there seemed no escape. All of the therapists situated stuck in this way and the places they described were also metaphorical – the heart of a storm, a dark forest or a cage – places where movement is impeded or stymied. But this was not indicative of stasis, there was movement as clients resisted these psychological restraints and sought their way free.
It is not incidental that participants referenced metaphors from the world around them as they endeavoured to describe *stuck*. Lakoff and Johnson (1980) reasoned that many underlying conceptual metaphors could be traced to an embodied physical experience and Mahoney (2000) speaks of the research around the metaphorical device of adaptational landscapes which can be used to help us to navigate through life. He cites his experience of therapeutic encounters where a client's probabilities and possibilities are metamorphosed into peaks and valleys as metaphors of potential movement are utilised from our experience of the world around us. He quotes client experiences that further reiterate this symbiosis with the living system.

> "there are 'walls' that you may suddenly walk into, there are hard rock floors that you hit when you 'crash' or 'fall', there are tight 'traps' where you feel caught and immobilized, and there are sharp edges that cut you, sometimes superficially and sometimes to your heart. In the metaphorical sense, at least, many life counselors are heart specialists; we often work with 'wounds of being'."(Mahoney, 2000, p51)

This recalls Crawford's (2009) position that people are only able to relate their experiences of intense emotion to others through common reference points, and the instinctive way that individuals use associations from the natural landscape to guide them is the same way that therapists and clients also use these words.

Participants identified two types of stuckness which they differentiated as internal and external states. External stuckness was understood as periods of indecision relating to situational contexts, for example work or relationships, and these served as a useful pretence to enable clients to access therapy and safe positions from which the blame or responsibility could be attributed to others. Internal stuckness was understood to be a deeper more intractable state concerned with the inner self. These internal and external stuck states align with the earlier discussed Gilbert and Allan's construct of entrapment.

> "people are motivated to escape threat or a stressful, unpleasant state or situation but the flight is blocked because of internal (e.g., insufficient coping agency, severe health problems or feelings of guilt) or external circumstances (e.g. no help by others, problems at work, school or in personal relations)". (Forkmann, Teismann, Stenzel, Glaesmer & De Beurs, 2018, p1; Gilbert & Allan, 1998; Dixon 1998; Sloman, 2003).

Entrapment is assessed using the Entrapment Scale developed by Gilbert and Allan (1998). Originally designed to measure the internal and external dimensions separately, subsequent studies suggested that they are so closely related that they could be viewed as a unidimensional construct. This was in contrast to the findings in this study where four participants more clearly differentiated between internal and external stuckness and considered them to be separate states, particularly with regard to the increased amount of emotional impact experienced by those within the internal state. This aligns with a more recent study testing the constructs of entrapment and defeat. This study considered them to be highly related, but entrapment was considered to be a different construct and likely to consist of two sub-scales – internal and external entrapment (Forkmann et al., 2018). Despite the similarities of participant descriptions of stuckness with the existing constructs of entrapment, no participants used the term entrapment which could suggest that they either considered stuckness to be different to entrapment or that the construct of entrapment might be thought of as too specialised a term for use within general therapy.

Despite working with different therapeutic modalities, nine out of ten of the research participants in this study identified the characteristics of repeating

patterns of thoughts, actions or feelings replayed in continuous cycles which served to keep the person stuck. Therapists believed that this prolonged the client's stuckness and some found that explaining the pattern to clients was very helpful for them. In the psychological research literature, repetition is often linked to rumination as the earliest or most identifiable manifestations are affect or cognition-related (Nolen-Hoeksma, 2008). While cognitive rumination was referred to by several therapists, patterns observed by the participants were more clearly linked to repetitious cycles of client coping mechanisms which were no longer effective and participants argued that this was a key element in keeping people stuck. Mahoney (2000) describes these as dysfunctional patterns that people run - a state of disorder versus order - and that people feel stuck when they are unable to return to their routine daily patterns.

5.2.3 Recognition and Advantages of Stuckness

As the term *stuck* was not always used by clients when describing their feeling state, therapists were attuned to other manifestations of how they saw stuckness in their clients - the primary being embodied representations. Therapists in this study were able to observe various non-verbal behaviours in their clients with one participant saying it was a clear sign to her of psychological stuckness and research shows that in general terms this is a well-known psychiatric clinical marker (Brüne, 2014). Brüne (2014) suggests that not enough attention is paid to non-verbal behaviour within therapeutic settings. This is important as he sees gestures such as averted gaze, crouching and self-soothing behaviour as 'non-verbal correlates of defence or ambivalence (fight or flight)', that is, measures of protection or defence. In this study, one participant saw how physical stuckness such as that demonstrated by the client wedged unmoving in a chair was indicative to her of stuckness in other areas of life, particularly an internal stuckness. Another sign was stagnation - evident in material ways such as unpacked boxes which was linked to the psychological disorder of hoarding or their struggle to make any overall meaningful progression in other facets of life. Two therapists saw physical stuckness as emotions trapped in the body which when released would 'unstick' the client. Participants felt that clients were not always able to verbalise their distress therefore taking note of non-verbal cues became important information for the therapist. This links with research from Törneke who states that "our

bodies and our physical interactions with our surroundings are common sources of metaphorical speech" and confirmation that metaphors are embodied comes from previously discussed research which indicated that when a person is processing linguistic information that includes spatial or motor references, these same areas of the brain are activated (Törneke, 2017, p64; Reid & Katz, 2018).

Eight of the participants described stuck as a place where the physical body is up against a solid object from the physical world – a wall, chains, a prison. The other two participants had clients who expressed this restriction as a force or space within the natural world – not something to fight against but something they could not resist or leave. As a spatial metaphor, the word *stuck* is suggestive of physical containment – that the physical body is in a tight space and that movement out of that space is hindered. Therefore it could be construed that *stuck* is about the space around the self – that to be constrained is negatively valenced whilst having space around oneself is viewed as positive and desirable. That which is constrained is prevented from moving - felons are imprisoned, babies are swaddled, psychiatric patients were straitjacketed – all seemingly for their own safety or the safety of others nevertheless denoting a lack of free will which aligns with a finding from Brüne (2014) who suggests that psychological withdrawal signifies a psychological protective mechanism from further harm. Lakoff and Johnson (1980) also draw attention to the clear link between metaphors of affect and the correlation with sensorimotor experience, for example, how good experiences or happiness are connected with upright posture**.** Tolaas (1991) relates this to our early developmental influence of the seemingly omnipotent parents who approach the infant from above and how a relationship between this 'space above the self' and positive affect continues throughout the stages of development (Crawford, 2009). Therefore it could be contended that to shut down and withdraw into a metaphorical small space could be about survival or safety. This ties into the wider meaning of the spatial metaphor and perceptions around how that space is occupied, that is, how it can be predicated on the experience of caregivers who are perceived as unreliable and untrustworthy, leading the child to develop a view of the world as an unsafe place (Brüne, 2014) and to a lack of ability or desire to move out into the world, thus linking with findings of this study in which some participants observed how stuckness could be advantageous to clients at certain times.

While participants agreed that clients experienced stuckness as difficult and distressing, they were divided on this idea of it having utility, with some participants advocating working to help the client out of their stuckness as quickly as possible and others more comfortable to stay in it, to tolerate the difficulty and uncertainty alongside the client. This latter group saw how an episode of stuckness might be beneficial or meaningful to the client in some way as noted above - either protective or shielding - how a place of respite might be a way to escape the reality of a situation or the acceptance of it (for instance, being stuck in guilt about a lost partner enabled a client not to face that he was gone) or how it becomes an excuse for why things have not happened in their life. Two participants warned that sometimes the stuck place had a lot of scaffolding around it - beliefs and schemas intrinsic to the client's view of the world and themselves - and that this would need to be dismantled with care.

Just as the some of the participants recognised how a period of stuckness could be purposeful for their clients, Petriglieri (2007, p188) references Berne's (1972) suggestion of looking to examples from literature, of how 'templates for psychological phenomena' underlie many mythical and fictional stories and show how an episode of stuckness can be enriching and even transformational in some respect. For instance, Wood (2007) (in Petriglieri, 2007) describes Dante's journey through the nine circles of hell as a classic example of how a difficult and testing experience can be recast as a way to gain vital knowledge and lead to personal development. Petriglieri (2007) furthermore argues that the elemental story arc in most nineteenth century literature are stories 'punctuated by moments of stuckness'. The universal references cited within this opinion align with several of the participants' contentions that stuckness can be held as a generic concept experienceable by all of us.

As previously discussed, the meaning-making perspective of the constructivist approach challenges any therapeutic attempts to quash signs of what it terms systemic disorganisation thus also embracing episodes of seeming inaction or progress in a client. They argue that these very expressions of disorganisation are positive signs of reorganisation in progress but acknowledge that some people can get 'stuck in disorder'.

> "Disorder, in the sense of diminished psychological functioning and well-being, becomes the rule for these unfortunate people, and they struggle for years, and sometimes lifetimes, in the same painful patterns. This tragedy contains a central mystery of human development. How and why do episodes and patterns of disorder become important educational 'stepping stones' for some individuals and painful prisons for others?" (Mahoney, 2000, p45)

Mahoney (2000) asks how therapists might be able to differentiate between a client episode of constructive reorganisation and a debilitating and elongated period of stuckness. From a constructivist perspective, he reasons that we should remember our ultimate goal of being in service to the client through helping them and how in stepping back, we might regain our faith in them by "invoking a reverent respect for the wisdom of the living system in having worked out its own way of dealing with its life circumstances" (Mahoney, 2000, p45). Mahoney acknowledges the significant impact on client well-being during this process but affirms that honouring the client as an individual with enough wisdom to be supported in dealing with these complex life challenges is ultimately affirming. None of the participants in this study took such an optimistic viewpoint but some showed more trust in the client's ability to tolerate and work through their stuckness (those that stayed with the client in their stuck place) while others responded to the client's difficulties and pain and desire to be unstuck (for instance, therapists working with clients for whom repeated episodes of therapy did not work).

Participants also spoke of stuck as being a place where the therapist can be caught alongside the client, as one therapist described it – "being stuck in the same dynamic as them" directly referencing countertransferential aspects of working with stuckness.

5.3 Theme: Working with Stuckness

5.3.1 Stuckness in the Therapy Room

Participants in this study considered how moments of relational stuckness could also play out within the therapeutic setting in a transferential way (Erskine, 1991; Shmukler, 1991). This led to much reflection about the therapy and therapeutic relationship but also some self-criticism as several therapists felt uncertain about how to work with these blocks and therefore felt deskilled, thus engendering a need for the assistance of a supervisor or peer - someone who could observe these interactions in a more objective way.

Mellor (1980) in Petriglieri states that “theories of impasses describe moments of stuckness as the manifestation of intrapsychic conflicts rooted in early development” and that from a transactional analysis viewpoint these episodes are seen to be an inevitable consequence of the deepening therapeutic relationship but can be of great therapeutic value (Petriglieri, 2007, p187; Cornell & Landaiche, 2006). This reflects psychoanalytic thinking that “expressions of resistance are assumed to reflect, in a metaphorical or symbolic manner, the unconscious material that the patient is struggling to avoid uncovering” (Beutler, 2002, p208), which aligns with findings of this study whereby several participants suggested that the point of client resistance might indicate the real client problem that needed to be addressed. The cognitive and behavioural viewpoint is that resistance is understood as non-compliance ‘seen as an obstruction to goal achievement’ (Beutler, 2002). One participant in this study challenged these understandings saying that this viewpoint encouraged therapists to buy into the client’s stuckness and the idea of them needing to change. She advocated the opposite position. This may link to Beutler’s claim that “paradoxical interventions, such as discouraging rapid change… are ways of using the patient’s resistance traits in the service of making change” (Beutler, 2002, p215).

Half of the therapists drew upon psychoanalytic terms such as transference/countertransference, impasse and resistance to describe these episodes. While such existing definitions helped to provide structure

to how the participants experienced stuckness, by falling back onto these predefined constructs the range of possible interpretations of what was being played out in the therapy room narrowed, with again the therapists showing a tendency towards pre-emption. This could be problematic as these terms, with the exception of countertransference, tend to confer the problem of therapeutic blocks onto the client. Several of the participants in this study countered this tendency with self-reflection, for example one therapist stating that any misattunements within therapy often came down to moments when he had stepped ahead and away from the client and how the client would show resistance as a response to that. As suggested by one website, moments of therapeutic impasse are linked to client resistance as a response to the positional power held by therapists. He states that one of the ways this power over the client is demonstrated is through the use of language, particularly the authority to determine and label what is normal and what is not and that “the power to define what is normal gives therapists’ social power and control and is reserved to very few others in our society” (Zur, 2010). Therapists are also able to name conscious and unconscious motivations which are further interpreted as a barrier to therapy and client progress. Interestingly, Zur (2010) discusses means by which the client can show their displeasure and take back power and most of these appear to be methods of withholding, for instance being late to session (time), non-payment of account (money), non-compliance with homework (collaboration) and in their refusal to disclose – so of language itself – observations also noted by this research participant. In this study, it was noted that several participants were reluctant to disclose their full assessment or careful to use psychological language with clients and this could be interpreted as a form of therapist withholding – a way for the therapist to exert subtle control over the process of therapy and the language used within it, whether it be psychological words or lay terms like *stuck*.

Gelso and Hayes define transference as “the client’s experience of the therapist that is shaped by his or her own psychological structures and past, and involves displacement onto the therapist of feelings, attitudes, and behaviors belonging rightfully in earlier significant relationships” (Gelso & Hayes,1998, p11). From a constructivist perspective this suggests that clients are unable to experience a therapeutic encounter in the present with pure objectivity and instead experience it as a composite representation of

experiences from the past. When referencing Lakoff and Johnson's (1980) concept of conceptual metaphor, Gelso and Hayes (1998) suggest that past and present can be viewed as conceptual structures which correspond to source and target. From a psychoanalytic perspective, Borbely suggests that psychoanalytic practice provides a framework through which to understand the association between metaphor and transference and that the approach of psychoanalysis itself "relates past and present metaphorically to each other" (Borbely, 1998, p923). This is because the conceptual metaphors of PRESENT IS PAST and PAST IS PRESENT represent at a higher level the very nature of the transferential dynamic and Borbely asserts that "the nature and ways in which this is instantiated in unfolding therapy talk should be of great interest to linguists and therapists alike" (Borbely, 1998, p923). In this way, participants in this study, particularly psychotherapists, believed that to get a client unstuck one needed to go back and revisit earlier difficulties and others considered that the place of stuckness pointed to something important in the past.

5.3.2 Unstuck

When considering how to get a client unstuck, all of the participants, even those who were willing to work with the metaphor, began to summarise the key client problem in a clinical way that showed an unexpected amount of accord. The intractable nature of stuckness was linked to repetitive patterns of behaviours or thoughts which over time had become ineffective and dysfunctional. Participants mooted that this was linked to an inability to change or a tendency to avoid facing their problems. Therapists believed that a client's negative childhood relational experiences were at the core of their self-image or coping styles and that this led to the development of schema beliefs such as 'I'm not good enough' or 'I'm unlovable'. One participant thought that these experiences were often so early they were pre-verbal, creating a very deep vulnerability that was played out in therapy and in life. Half of the participants went further and directly linked these relational responses to the attachment paradigm. Most of the therapists had spoken of the difficulties working with stuckness - how previous therapy had not worked for clients, how it was a complex state to unravel and how it led to relational difficulties within the therapy at times requiring direct supervision support. It is for these reasons that participants considered signs of insecure attachment to be an important implication of working with

stuckness given the centrality of the therapeutic relationship. These participants named different attachment patterns in their clients but tended towards an avoidant style of attachment as many participants noted that for stuck clients help-seeking seemed difficult.

Determining whether clients who report feeling stuck are more likely to display an avoidant or dismissive attachment style is of course beyond the remit of this study. However these findings suggest that participants found relying on existing understandings of theoretical models such as attachment helped them to make sense of their observations of the client's relational styles when working with something that had hitherto only been described using a lay metaphor, an experiential truth which is psychologically undefined and therefore open to interpretation.

Overall this represents a key finding of this research, that regardless of modality participants' understandings of stuckness coalesced as they identified similar elements that they believed underpinned a stuck presentation. Throughout the interviews therapists found stuckness a difficult phenomenon to describe and identify. Although five of the participants were willing to either hold stuckness as a concept or stay with the client in the stuck state and address it, all at some point needed to relate it to some pre-determined psychological construct or theory in order to make sense of it for themselves or explain it to others.

5.4 Theme: The Lay Metaphor

5.4.1 Working with Metaphor

The findings have shown that while participants were open to using a metaphor to initially engage with prospective clients, taking it through into therapy as a useful means of working with the presenting problem had not been considered and there was little awareness that a metaphor could or should be deconstructed in this way. Half of the participants stayed with the term but only three sought to understand the experience of stuckness through metaphoric exploration. In most cases the metaphor was discarded from the therapeutic process soon after therapy commenced as

psychologists in particular began to formulate the client's presenting symptoms according to their chosen modality. This aligns with Kelly's (1955/1991) previously discussed theory of pre-emption whereupon diagnostic aberrations are overlooked as therapists 'pre-empt' manualised interpretations of disorder over alternative explanations. It may be that limitations around working with metaphor are reinforced by clinical contexts which prioritise assessment-treatment models above relationship-building or efforts to align the client's treatment goals with the aims of the service (Griffiths, 2003).

As many of the participants did not include the metaphor in their therapeutic approach, given the frequency with which metaphors occur in language an alternative explanation could be that the metaphor of feeing stuck was 'overlooked as being metaphoric' and thus the opportunity to explore it from this perspective and enhance the understanding of the client was missed (Wagener, 2017). Historically metaphors were viewed only as linguistic phenomena - ways in which speech could be dramatised or embellished for rhetorical or ornamental purposes (Gelo & Mergenthaler, 2012; Black 1962). *Feeling stuck* is a simple but commonly used term (Petriglieri, 2007) and Bruner observes how such terms or behaviours receive less research focus.

> "the uncommon or non-canonical ignites explanatory efforts while the customary and expected behaviours are usually taken for granted. Unexpected and uncommon behaviours set off a search for meanings and causes, which is why most research examines non-canonical, or aberrant, modes of behaving and experiencing". (Raskin & Lewandowski, 2000, p18; Bruner, 1990)

That this commonplace metaphor was disregarded as being therapeutically significant could be attributed to its very unremarkableness.

Of the participants that stayed working with the metaphor, two found it a useful way to explain the clinical formulation to clients and another noted that clients themselves would use the metaphor to conceptualise their problem, reiterating the Stott et al. (2010) assertion that metaphors are 'lay case conceptualisation'. From a constructivist perspective, the consequence of disregarding the metaphor means a missed opportunity for

the therapist to engage in collaborative formulation with the client as this approach emphasises “active meaning making and interpretation rather than pure objective facts about clients and their problems” (Tay, 2017, p165). Butler, Fennell and Hackmann (2008) in Mathieson (2017) suggest that the insights gained through an understanding of the client’s perspective by using metaphor can be integrated into the case conceptualisation. This is because metaphors can be personalised to the individual, are memorable and incorporate in a more creative way information to help people to facilitate change and ‘distil complex conceptualizations into much simpler ones’ (Kuyken, Padesky & Dudley, 2009).

The findings of this study suggest that therapists saw metaphor as a transitional object, a temporary terminology allowing the work of therapy to progress around stigma and the very real confusion of what the client is feeling – often a state, blurred by emotional distress, that is difficult for them to convey. Participants – consciously or not – understood that metaphors enable therapy to progress during the early stages when clients are more uncertain, the therapeutic relationship is less formed and emotions are much less tolerable. Therefore not only are metaphors capable of conveying complex emotional states but they do this in a way that distances the speaker from the distress, that is, a metaphor creates a frame for the speaker to speak about difficult emotional topics unemotionally. As one participant noted, when a client described their problem using a metaphor or image it signified a high emotional content to the issue, thus allowing them a means to communicate when they either do not have the vocabulary to express their feelings or that to do so would be too distressing. This is in line with previous research where Lakoff and Johnson (1980) describe metaphor as “an approach for conceptualising the experience of emotion in a form that is relatable to other individuals” (in Wagener, 2017, p145), which suggests that a client is using whatever resources they have available to them to try and communicate how they are feeling to therapists. As metaphors are a succinct way to convey difficult to express information, this makes them a linguistic necessity rather than simply an elaborate turn of phrase and while emotions can be named, it is much harder to describe the quality of any particular experience of emotion (Ortony & Fainsilber, 1987). This supports previous research linking the increased use of metaphors with discussion of emotional topics, particularly intense emotions (Fainsilber & Ortony, 1987). Ortony and

Fainsilber (1987) talk of emotions as internal states that are unobservable, which leads to a higher percentage of novel metaphors being used when speaking of more intense emotions than frozen ones. Novel metaphors tend to be richer and more vivid, linking to an observation of this study that the more visual the picture painted by a client, the more emotional intensity there was hidden behind it.

As one participant noted, bringing clients to the point where they are able to discuss their emotions is a central aim for most therapies. Wagener (2017, p145) says that "clients' emotions guide the counsellor to what is most affected and important to clients", and if this is central to the work of therapy, suggests that attendance to metaphoric utterances could provide important information for therapists 'who are supporting emotional change in clients'. Four of the participants worked with the metaphor by asking more directed questions of the stuck state in order to obtain details that were perhaps otherwise too difficult to elicit using psychological language. Tay (2010) suggests that working with metaphors that are client-generated is more important because these are likely to have increased significance for the client. Thus it might be concluded that clients reject diagnostic terms not because they don't understand them but because they are affectless, therefore difficult to relate to; a metaphor then becomes an important way to communicate a feeling state in a contained way.

Several of the therapists considered that elements of stuckness were apparent in all clients who came to therapy, therefore it was a universal and generic state, and this rationalisation seemed a justification for discarding the metaphor soon into therapy. This universality aligns with the very composition of metaphors, with Törneke (2017, p14) stating that "conceptual metaphors are based on the experience of our own bodies and the fact that we interact with our surroundings seems to suggest that they are, up to a point at least, universal". When seen as a universal or common phenomenon, it could be contended that this standardising effect may nullify any therapeutic potency the notion of stuckness might have as a term which is psychologically defining; as a result it starts to lose its shape and becomes more elusive as a concept or construct thus rendering it more difficult to work with. However the metaphor *feeling stuck* seemed more than just a general indication of a need for help as participants spoke of the strong resonance that the word had for clients – that it was this one word

out of several paragraphs on the therapist's profile that stimulated the client to contact them. One participant thought that the word was more than a generic catch-all phrase and that it seemed to capture a real psychological concern for people, and might even be a presentation in its own right.

Therefore it seems that there is much merit and therapeutic benefit to be gained by therapists attending to lay metaphors more closely, particularly if the metaphor is client-generated for at the very least, the subtlety of this form of expression might yield more richness of the emotional state of the client when they may have few other means at their disposal to convey it.

5.5 Limitations of this Research

The findings of this study provide further support for the growing importance of research looking into therapists' use of lay language when engaging with clients in a therapeutic context. Still, this research should be examined in light of possible limitations.

Firstly, while the study investigated a metaphor considered to be commonly used and resonant, its findings cannot be generalised to other metaphors or lay terms used in therapeutic situations. Nor can findings based on an inductive, interpretative use of thematic analysis be generalised to all therapists using the term *stuck i*n their practice.

Furthermore, the interviews were only conducted with psychologists and psychotherapists thus privileging their viewpoint of what stuckness is and how it is characterised in clients, therefore the researcher is aware that the research findings are limited in this way and that any client perspective reported in this study has been mediated through a therapist lens. A research study speaking to a client population might return different or alternative viewpoints thus this study cannot be said to offer a definitive answer on what stuckness might be. Additionally, the participants in this study represent one small sample of psychologists and psychotherapists therefore these therapists may not be representative of how all therapists might understand this phenomenon thus again limiting its generalisability. With regard to the recruitment itself, although efforts were made to recruit therapists of different ethnicities, this was unsuccessful meaning that the

participants of this study are all from a Caucasian demographic population and their viewpoints may differ from therapists of other ethnicities.

Moreover, while the researcher conducted the analytic process with a high degree of reflexivity including identifying possible latent personal assumptions about the research findings and keeping a reflexive journal, researcher bias may have influenced the interview and data analysis stages thus impacting the results of this study. This speaks to the inherent difficulty of working with language itself. As Potter and Wetherell (1998, p182) state “how should we deal with the fact that our accounts of how people’s language use is constructed are themselves constructions?”. This brings into consideration the methodological limitations of Thematic Analysis, primarily in that the researcher cannot make any assertions about language use (Braun & Clarke, 2006) therefore cannot contribute to a discourse around how stuckness is constructed. While its theoretical flexibility is a strength, this may lead to inconsistency and a lack of coherence during the theme development phase of the analysis (Holloway & Todres, 2003).

With regard to the interview process itself, the protocol and questions were set by the researcher, a process which automatically narrows the focus on which aspects of stuckness are spoken to. Furthermore, the selection of questions and prompts in the interview protocol will without question direct the participants’ focus with regard to their consideration of how stuckness might be thought about. Although the protocol was amended to incorporate an unanticipated finding after the pilot interview (modality influence) and throughout the interview was flexible enough to be able to follow new perspectives raised, at an overarching level the protocol did guide the interview and was referred to thus prioritising a prior understanding of stuckness that the researcher had. Altogether, dealing with the somewhat elusive nature of stuckness - a lay term that has no agreed psychological definition - might mean that although all efforts were taken to remain rigorously objective with regard to the participants’ findings and meaning-making, another researcher may approach such research in a different way and thus report different findings.

Still, this study constitutes an original piece of research that speaks to our role as scientist-practitioners from a counselling psychology perspective,

our endeavour to maintain our intellectual curiosity, to hold our practice and language to scrutiny, and to be our client's voice within a therapeutic arena in which they have little representation.

5.6 Suggestions for Future Research

The results of this study generated new understandings of how the phrase *feeling stuck* is understood within a psychotherapeutic perspective. It shed light on how therapists understand lay terms and metaphors used by clients and how they might make sense of the way these terms are being used to attract, connect with and ultimately try and help people. Further research to develop these findings could incorporate the following areas:

Firstly, a key finding was the influence that this metaphor seemed to have with regard to connecting a client with a therapist. Future research might look with more depth at the influence that a therapist's use of lay terminology has on the client's decision-making process around choosing a psychological practitioner.

Gallagher (2006) states that a shift in focus for counselling psychology theory and practice is towards relational aspects of the process, suggesting that even collaboration of psychological formulations should be an aim (Wheeler, 2005). With this in mind, research on how this might be achieved in practice could be an interesting focus, particularly how a therapist and client might achieve such a balance using a lay metaphor – a form of language capturing a psychological experience that might sit between them and promote meaning-making.

Thirdly, as Milton, Craven and Coyle (2010, p63) say, "clients use psychiatric discourse and self-diagnoses when approaching practitioners". It may therefore be of interest to look in more depth at the lay terms people use to express their psychological conditions. This could perhaps be approached through a discourse analysis which may increase our understanding on how meaning is constructed and possible functions of such naturally occurring terms. This could focus on one aspect of the use of this lay metaphor, for instance, Foucauldian Discourse Analysis could be used to develop a better understanding of how this lay metaphor might be

constructed as a bridging object between client and therapist during early therapy sessions.

5.7 Implications for Counselling Psychology

It is hoped that counselling psychologists reading this study might reflect on its findings, in particular, the requirement to pay more heed to the words that we use with clients and the impact that these may have on the progression or direction of therapy. As Gillies (2010, p74) states, "counselling psychologists view the therapeutic relationship as central to the therapeutic endeavour and 'engage with' rather than 'do therapy' to their clients". The establishment of such a collaborative frame seems a relatively easy proposition. But Strawbridge critiqued the medicalisation of psychological distress towards pathology and categorisations of 'disorder', and away from a personal or interpersonal realm, and how this sought to undermine the ethos and therapeutic aims of our field which were more motivated to give clients agency and empowerment and restore the 'the dialogue between the individual and the world' (Strawbridge, 2001). As a statement made in 2001, it seems that we still have some way to go to support our clients as true collaborators within their own therapy. But by being more aware of the language that we have encouraged them to bring to the room, we can more deeply engage with it in a manner that prioritises the therapeutic relationship within our practice. This is supported by findings of this research suggesting that a closer focus on client language could have direct therapeutic benefits in that working with metaphors offers an alternative therapeutic pathway through increasing the likelihood of the client feeling understood thus deepening the therapeutic relationship (Stott et al., 2010). We can also continue to support this endeavour through our client advocacy role within the field at large, notably through the development of research studies about matters important to our clients, thereby extending our field's philosophy and reach within the empirical realm.

From a practitioner perspective, participants reflected on their need to take stuck cases to supervision suggesting that at a supervisory level there would be a benefit in attending to working with lay metaphor as a whole and to a wider consideration of lay language, particularly the words that clients use to conceptualise their problems. Furthermore, this could also be

done through therapist training seminars or workshops which focus on broader aspects of how to incorporate working with lay language and particularly the metaphors that clients bring to therapy within therapeutic practice.

An unexpected finding of the research was that despite the theoretical orientations of the participants, there was a coalescing of thought about what stuckness was – a trans-theoretical understanding of this phenomenon, that stuckness might speak to repeating patterns of thoughts, actions and feelings; dysfunctional coping strategies and insecure attachment. As therapists we often work with and adhere to favoured modalities we consider to be quite distinct in their approach. However it has been observed that "often new terms are developed for referents that are already named and explained in other theories, leading to a mismatch between terminological differences and underlying theoretical similarities" (Milton, 2010, p106). This might suggest that the factors that the therapists saw as comprising a stuck 'presentation' are common across modalities and this is important as it might suggest something about stuckness itself, that there might be a fundamental aspect to stuckness that transcends psychological approach or orientation. As Milton (2010, p106) states, "in similar cases new terms are clearly useful as they afford a shared means of reference". It is premature to suggest that stuckness might be a psychologically distinct, however If therapists recognise conceptual similarities of *stuckness* despite using different terms and the theoretical differences of their approaches, this might have implications for treatment that could be helpful for a client even if approached via different modalities.

5.8 Personal Reflections on the Research Process

I began this process with somewhat of a clear sense of stuckness. At Master's level I undertook a dissertation on clients' experiences of stuckness as a purely exploratory piece of work to see if there was anything to this as a topic of psychological consideration. What I found was an unexpected overlap across the participants stories but what was more impactful was the distress they communicated about being in this state which I was very moved by. I felt I wanted to explore the topic further and follow a finding which was unanticipated - that all of the participants had received psychotherapy for this state which had not proved helpful. I

wondered then what was it that the therapists were working with when the client came to them saying they were feeling stuck. How did they make meaning of a lay term within a psychological setting? Did they feel that the term was viable to work with? Initially it was my aim to contrast the meaning of both therapists and clients but practically this would have been too large a piece of work and would not have done justice to either group's findings so as this was an interest which developed through my training I made the decision to concentrate on therapists.

What was most interesting during this research study was the way in which this sense of stuckness pervaded the entire research process. I too felt enveloped by the miasma that surrounded this topic, finding it very difficult for my mind to stay on track as it felt like I was trying to capture or describe something that did not exist or could not be seen. This was exacerbated by the confusion shown by the therapist participants which was in contrast to the first study. During the dissertation research the client participants were clear, coherent and emotional. Therapists on the other hand were imprecise, at times confused yet thoughtful. I had not asked them to speak of a topic of which they were sure, that they had opinions of or was a professional area of focus. As it came out in the interview process, it seemed that I asked of them to discuss a topic that they had thought about very little. Therefore the interviews captured these moments of uncertainty, deep thought and reflection as they made sense of their thoughts. They sometimes contradicted themselves or changed their minds and often I watched them voice aloud their thinking process as they began to understand for the first time something they had never given a moment's thought to as they clarified for themselves their opinions on the topic. Several thanked me after the interview as they said it had been a helpful process for them. However this situation made the analytic stage very difficult as it became not a process of capturing definitive thoughts and statements and bringing them together into a well-formed precis, but instead the much harder task of piecing together sometimes disparate and rambling findings along with expressions of surety and clarity. Also, as there is no previous research on clinicians' understandings of this topic, it meant that virtually every utterance seemed new and worthwhile which necessitated a rigorous and elongated process of firstly collating everything then culling. The analytic process felt onerous and took months to write as I checked back and forth to ensure that I captured their opinions accurately.

Thematic analysis felt like my friend during this process – the topic felt complex and requiring of a sturdy and direct analytic method and gave me the backbone and structure that the topic was lacking due to its elusive nature. This is not to say there weren't many times I rued the choice of topic and wished I had chosen something simpler which was backed by at least a modest research literature. I too got lost and found myself, like the client examples, engaging in cycles and patterns whereby I trod over the same ground repeatedly, at times only moving forward microscopically. This felt never-ending and like the clients, I felt moments of despair, my desire to get out of this process felt overwhelming but impossible. Keeping a reflexive journal helped me to ponder these difficulties in a more objective way and also to maintain an awareness of any possible subjectivity influences (Alvesson & Skoldberg, 2017), particularly pertaining to the previous study.

Overall, it was encouraging to be doing an original piece of work and I hope to do justice not just to the participants of this research study, but also those of the previous one, the clients to whom, at the end of the day, we are all committed to helping.

5.9 Conclusion

The findings of this research contribute to our understanding of the therapeutic use of a lay term by clinicians, particularly in the early stages of therapy when using psychological terms is seen as a barrier to initial engagement. Participants in this study explored how they worked therapeutically with stuck clients and made meaning of this presentation, yet only half of them considered that staying with the metaphor during this process might be useful or even an option. In order to make meaning of the somewhat elusive notion of stuckness, all of the therapists to a greater or lesser degree fell back to using their own clinical models, therefore bringing their own interpretations of it, and it seemed that to do so drew the therapist further away from the client and further away from an understanding of what stuckness might be. Something as simple as working with a common lay metaphor seemed surprisingly complex.

One of the key findings from this study is for therapists to take more care in the words that they use with clients, particularly when accessing the lay

lexicon for psychologically-equivalent terms. By using the stuck metaphor as a case in point, this finding suggests that other terms or metaphors may also be used too loosely and that therapists may at times be working on the basis of a misunderstanding. This is stated with the knowledge that the primary focus within many clinical settings is on an adherence to evidence-based treatments that are delivered within a context of overriding time, budget and waitlist pressures. But as counselling psychologists, we are guided by an ethos that advocates holding our clients' unique experiences at the heart of all that we do, which gives us an opportunity to take a mediating role as client advocates who can support lay voices to be heard, and individual experiences understood, within the research literature as well as the therapeutic realm. Metaphor might give us a means by which we can empower our practice and show us how an awareness of the subtleties of language during the myriad small interconnected moments during therapy can show how the way forward might be negotiated differently. Therefore *stuck*, and by extension other metaphors, can be seen as a vibrant means through which the complexity and humanity of client experiences in and out of the therapy room are captured and therefore a method alongside that of clinical training approaches by which clinicians can enhance their approach to their work, and their understanding of the client.

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6 APPENDICES 1

6.1 Email follow-up to therapist following phone discussion

From: McGoldrick, Marianne
Sent: Monday, 13 February 2017 1:33 PM
To: [redacted]
Subject: Doctoral research on 'feeling stuck' as discussed

Dear [redacted]

Thank you for your time on the phone on Friday and discussion regarding your participation in this research project. As discussed, I am a Year 3 Doctorate in Counselling Psychology student from City University in London and am conducting research into "Therapists' understanding of the client-reported phenomenon of feeling *stuck"*.

The idea came from a search of the literature which showed that the concept of *stuck* has been conceptualised across multiple psychological domains and has links to mental health disorders. However while the clinical research covers biological and psychological aspects of stuckness, there is a lack of consensus amongst the literature as to what feeling *stuck* actually is and it is difficult to know whether these studies describe the same or different phenomena. Empirical research on the experience of feeling stuck is sparse and there is only one known published qualitative study investigating what it might mean phenomenologically to be stuck.

As a term used by both practitioner and client during therapy, *feeling stuck* appears to be a clinical therapeutic phenomenon yet is not a clinical construct. This research seeks to explore therapists' understandings of their clients' experiences of emotional or psychological stuckness and how they might make meaning of this phenomenon. Given the lack of data on this subject, a qualitative approach will be taken using a Thematic Analysis methodology. Thematic Analysis is a flexible, inductive analytic approach which allows the researcher to identify and analyse patterns within the data and is an ideal research method for a study for which there is very little existing empirical literature.

As a clinical psychologist who has referred to this phrase on her website, your thoughts and insights would be invaluable and add to our knowledge in this little researched area. I would be looking to conduct a 50-60 minute interview at a time and place convenient to you.

Thank you for your time and I appreciate your consideration of participating in this project.

Kind regards
Marianne McGoldrick

Trainee Counselling Psychologist - Year Three
City, University of London

[redacted]

6.2 Ethics Approval Letter (City, University of London)

Psychology Research Ethics Committee

School of Arts and Social Sciences

City University London

London EC1R 0JD

21st October 2016

Dear Marianne McGoldrick and Daphne Josselin

Reference: PSYETH (P/L) 16/17 14

Project title: Therapists' understanding of the client-reported phenomenon of feeling *stuck*.

I am writing to confirm that the research proposal detailed above has been granted approval by the City University London Psychology Department Research Ethics Committee.

Period of approval

Approval is valid for a period of three years from the date of this letter. If data collection runs beyond this period you will need to apply for an extension using the Amendments Form.

Project amendments

You will also need to submit an Amendments Form if you want to make any of the following changes to your research:

(a) Recruit a new category of participants

(b) Change, or add to, the research method employed

(c) Collect additional types of data

(d) Change the researchers involved in the project

Adverse events

You will need to submit an Adverse Events Form, copied to the Secretary of the Senate Research Ethics Committee ([redacted]), in the event of any of the following:

(a) Adverse events

(b) Breaches of confidentiality

(c) Safeguarding issues relating to children and vulnerable adults

(d) Incidents that affect the personal safety of a participant or researcher

Issues (a) and (b) should be reported as soon as possible and no later than 5 days after the event. Issues (c) and (d) should be reported immediately. Where appropriate the researcher should also report adverse events to other relevant institutions such as the police or social services.

Should you have any further queries then please do not hesitate to get in touch.

Kind regards

Hayley Glasford

Course Officer

Email: [redacted]

Martin Conway

Chair

Email: [redacted]

6.3 Participant Information Sheet

Title of study: **Therapists' understanding of the client-reported phenomenon of feeling *stuck*.**

We would like to invite you to take part in a research study. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

This research project is being conducted by Marianne McGoldrick, a student at City University, towards completion of a thesis towards a Doctorate in Counselling Psychology.

This aim of this project is to explore therapist experiences of working with clients who have felt emotionally or psychologically stuck and their professional understanding of this phenomenon. As a psychotherapist or psychologist, we are interested in your understanding of this term and the meaning you make of your client's experience.

Why have I been invited?

You are one of ten therapist participants who will be interviewed for this project. You have been selected as you have identified as a psychotherapist or psychologist who has previously worked with clients who have reported feeling emotionally or psychologically stuck.

Do I have to take part?

Participation in this study is voluntary and it is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. You also have the right to withdraw from all or part of the project up to three months after your interview without having to give a reason and you will not be penalised or disadvantaged in any way.

If any questions arise during the interview process that you may feel are too personal or intrusive and you do not wish to answer, you do not have to answer them.

What will happen if I take part?

You will only be asked to meet with the researcher on one occasion. This will take the form of a one-to-one interview on the topic of 'feeling stuck' and will take place either at your therapy rooms, at the Department of Psychology at City University or by telephone. The interview will take around 50-60 minutes to complete and will be an informal and fully confidential conversation about the experiences and the meaning you have made from speaking to clients who have been in a *stuck* state.

On the occasion you meet for the research interview, for five or ten minutes beforehand you will be asked to read through a briefing form and sign a consent form. This will include a short number of demographic questions such as gender, occupation and therapeutic modalities practiced. This will also explain the interview process – that it will include asking you some semi-structured, open-ended questions in order to help guide the interview process. The interview will be voice-recorded so that your responses will be accurately captured.

After the interview, the tape will be transcribed and then analysed using a qualitative technique called Thematic Analysis. This is a flexible method of analysis that is interested in how an individual experiences or views an event and allows for similar themes and patterns to emerge from the data (Braun et. al., 2014).

The research study is expected to conclude on or before September 2018.

What do I have to do?

This research is aiming to capture your experience of working with clients who have felt stuck and the meaning you have made of it therefore you will be asked to speak freely about your experiences in this area. As this discussion will take place within an interview format, the interviewer will ask questions and have prompts to guide you with this.

What are the possible disadvantages and risks of taking part?

As a psychotherapist or psychologist reporting on the meanings you have made of your clients' experiences of feeling stuck, there are few risks to participating in this process.
However if you were to have any feelings of discomfort, please be reassured that the interview can stop at any time.

What are the possible benefits of taking part?

People being interviewed for research projects can report positive feelings from the experience. This process gives them a chance for their opinion and perspective to be heard for the first time and in doing so their words can make a difference to others, particularly other therapists who are trying to make sense of this little researched phenomenon.
This is particularly true if the study goes on to be published in an academic journal and read by psychologists and other therapists. Your contribution to this project will help with research in this area as the outcome will be a study accessible to therapists in the hope that they will understand more about the phenomenon of stuckness when they see it in a future therapeutic encounter. Your contribution will help inform knowledge in this little researched area.

What will happen when the research study stops?

The transcript and recording of your interview will be encrypted and stored securely for up to one year after submission (expected to be on or before September 2018). In the event that the study is published, data will be retained for a period of five years.

Should the study stop before completion, all of the recordings and transcripts gathered for this research project will be destroyed.

Will my taking part in the study be kept confidential?

Yes, your name will only be recorded on your consent form and this will be kept separate from the data and other research materials. The interviewer will be the

only person who has access to this original information. Your name will be anonymised in the data and any identifying information will be altered to preserve confidentiality.

What will happen to the results of the research study?

The research study will be submitted as part of a doctoral portfolio. It will also be written up as an academic journal article and may be submitted for publication after September 2018. (Publications TBC). As per the above statement, all of your details will continue to be anonymised and you will not be identifiable in any way.

If you would like to receive a copy of the finished report, please drop an email to [redacted] and a copy will be emailed through to you when it is completed. This will be prior to September 2018.

What will happen if I don't want to carry on with the study?

As stated above, you are free to withdraw from this study without explanation or penalty by contacting the researcher within three months of your interview.

What if there is a problem?

If you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through the University complaints procedure. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is: Therapists' understanding of the client-reported phenomenon of 'feeling stuck'.

You could also write to the Secretary at:
Anna Ramberg
Secretary to Senate Research Ethics Committee
Research Office, E214
City University London
Northampton Square
London
EC1V 0HB
Email: [redacted]

City University London holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

Who has reviewed the study?

This study has been approved by City University London Psychology Research Ethics Committee, PSYETH (P/L) 16/17 14.

Further information and contact details

Should you need to contact the researcher after participating, please contact Marianne [redacted] or at [redacted] The supervisor for this research project is Dr Daphne Josselin and she can be contacted by email at [redacted].

Thank you for taking the time to read this information sheet.

6.4 Participant Consent Form and Demographics Sheet

Title of Study: Therapists' understanding of the client-reported phenomenon of feeling *stuck*.
Ethics approval code: PSYETH (P/L) 16/17 14

Please initial box

1.	I agree to take part in the above City University London research project. I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records. I understand this will involve: • being interviewed by the researcher • allowing the interview to be audiotaped	
2.	This information will be held and processed for the following purpose(s): To answer a research question seeking to understand how therapists who work with people who have been feeling psychologically or emotionally stuck understand this state. I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation.	
3.	I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw up to three months after my interview without being penalised or disadvantaged in any way.	
4.	I agree to City University London recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act 1998.	
5.	I agree to take part in the above study.	

_____	_____	_____
Name of Participant	Signature	Date
_____	_____	_____
Name of Researcher	Signature	Date

P.T.O.

Demographic information

Participant: _____ (pseudonym)

Gender M_____ F _____

Age range 30 – 40 _____ 40 – 50 _____ 50 – 60 _____ 60+ _____

Ethnicity _____

Occupation _____

Educational qualification _____

Key modality practiced _____

Other modalities practiced _____

Number of years in practice _____

Religion (if any) _____

When completed, 1 copy for participant; 1 copy for researcher file.

Note to researcher: to ensure anonymity, consent forms should NOT include participant numbers and should be stored separately from data.

6.5 Participant Debriefing Sheet

CITY UNIVERSITY LONDON

Title of study: Therapists' understanding of the client-reported phenomenon of feeling *stuck*.

DEBRIEF INFORMATION

Dear Participant

Thank you for participating in this study. The experience of feeling emotionally or psychologically stuck is a situation many people understand and relate to but has been rarely explored qualitatively in psychological literature. The few research studies that exist investigate links to rumination, entrapment and therapeutic impasse, but there is a lack of consensus amongst the literature as to what *feeling stuck* actually is and it is difficult to know whether these studies describe the same or different phenomena. This study aims to specifically explore therapist experiences of working with clients who have felt emotionally or psychologically stuck and their professional understanding of this phenomenon. As a psychologist or psychotherapist, we are interested in your understanding of this metaphor and the meaning you make of your client's experience.

Your generosity and willingness to answer questions and share your experiences with clients will help broaden our understanding in this area and it is hoped that the outcome of this research will help other psychologists and psychotherapists who are trying to make sense of this little researched but commonly found phenomenon.

Thank you again for your participation and we hope you found the study interesting. If you have any further questions please do not hesitate to contact us at the following:

Marianne McGoldrick (interviewer and researcher) – [redacted]

Dr Daphne Josselin (research supervisor) – [redacted]

Ethics approval code: PSYETH (P/L) 16/17 14

6.6 Interview Protocol

1. What is your understanding of the term ‘feeling stuck’?
2. Why did you use this term on your *website/blog/book/with clients etc.*?
3. What is your understanding when clients use this term? What do you think they are referring to?
    a. *Is this different from their understanding?*
    b. *Does it shape their understanding?*
4. How have your clients used this term?
5. Why do you think your clients use this term?
6. If your clients did not use this term, how did you understand that they were stuck?
7. At what point did your client/clients seek therapy?
8. Through the therapy with your stuck clients, did you make sense of what feeling stuck is?
9. How did your clients speak about their stuckness?
10. Did you work with stuckness during therapy?
    a. *How did they work with it?*
11. Is there anything you would like to add? Any thoughts or perspectives on this situation that have occurred to you?

6.7 A 15 Point Checklist of Criteria for Good Thematic Analysis Process

Transcription	1.	The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for 'accuracy'.
Coding	2.	Each data item has been given equal attention in the coding process.
	3.	Themes have not been generated from a few vivid examples (an anecdotal approach) but instead the coding process has been thorough, inclusive and comprehensive.
	4.	All relevant extracts for each theme have been collated.
	5.	Themes have been checked against each other and back to the original data set.
	6.	Themes are internally coherent, consistent, and distinctive.
Analysis	7.	Data have been analysed – interpreted, made sense of - rather than just paraphrased or described.
	8.	Analysis and data match each other – the extracts illustrate the analytic claims.
	9.	Analysis tells a convincing and well-organised story about the data and topic.
	10.	A good balance between analytic narrative and illustrative extracts is provided.
Overall	11.	Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly.
Written report	12.	The assumptions about TA are clearly explicated.
	13.	There is a good fit between what you claim you do, and what you show you have done – i.e. described method and reported analysis are consistent.
	14.	The language and concepts used in the report are consistent with the epistemological position of the analysis.
	15.	The researcher is positioned as *active* in the research process; themes do not just 'emerge'.

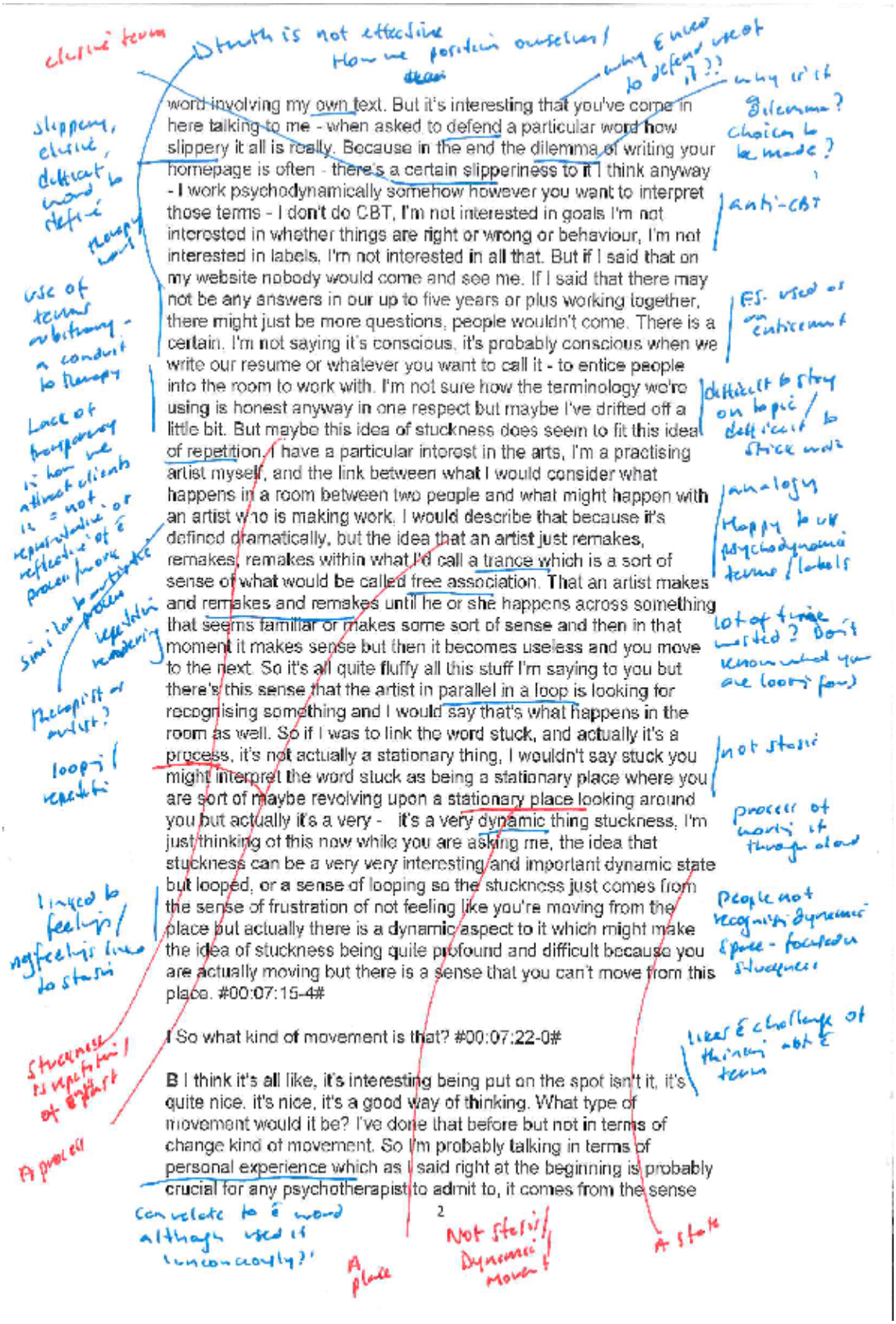
(Braun and Clark, 2006, p36)

6.8 Example of coding: Simon

INTERVIEW: Simon

I So thank you for your time today. So we are talking about feeling stuck which is a term used by both therapist and client so I just wanted to start off by asking you what you understand the term to mean? #00:00:23-0#

B So I think um the term stuck would have to always come back to my interpretation of feeling stuck, I don't think I could ever sit here and say what my clients' version of that word means. Umm it comes out I'd imagine as a term that can fit certain behaviours - I hate that word - but behaviours within the work but each encounter would be unique. But this idea of repetition is an accurate term that I wouldn't put on my website that I'm repetitive but the idea that we re-encounter certain aspects of our past over and over and over again. I might say that's a form of stuckness. That's what's coming to mind now of course rather than having time to think about it. But this re-encounter within sight of somebody else i.e. a therapist I believe can be quite useful with regards looking at things in a different way, thinking of things really. Acceptance, don't like that word particularly, but an acceptance to the way things are, but when I put on my website the word stuck, it's really interesting you are bringing it in here cause it makes me completely think why on earth would I have used that word? I imagine that's your interest, partly your interest in the whole thing but the idea that I could say I was stuck you know and that got me into therapy, got me into training, show an interest in unsticking something but I'd actually find it quite difficult to explain what I mean by that. So as I'm sure you know clients come to therapy with certain presenting problems if we have to use that term but often that can become very much not what is talked about. So even if I put the word stuck, if someone relates to the word stuck on my website that might be a relevant term when they walk through the door but it doesn't necessarily mean that it's a relevant term once the work begins. So my I was talking to a therapist who rents this room off me and she specialises in chemsex addictions and the conversation we had which I thought was quite interesting, and she puts the word chemsex on her website as a specialist subject and in her words it gets people through the door but in the end you end up talking about the same stuff as if you had put the same narrative I had on my website and of course I am simplifying for the sake of the conversation but the idea that we should specialise in anything in particular can often be by relation to that word that the client might see. But actually the reality is something quite different. So I think stuckness is sort of a - my process of coming to that word would probably have been that I looked at other therapists websites unconsciously completely affected by what I read, what I was taking on board and then I owned the word stuckness as being an important



word involving my own text. But it's interesting that you've come in here talking to me - when asked to defend a particular word how slippery it all is really. Because in the end the dilemma of writing your homepage is often - there's a certain slipperiness to it I think anyway - I work psychodynamically somehow however you want to interpret those terms - I don't do CBT, I'm not interested in goals I'm not interested in whether things are right or wrong or behaviour, I'm not interested in labels, I'm not interested in all that. But if I said that on my website nobody would come and see me. If I said that there may not be any answers in our up to five years or plus working together, there might just be more questions, people wouldn't come. There is a certain. I'm not saying it's conscious, it's probably conscious when we write our resume or whatever you want to call it - to entice people into the room to work with. I'm not sure how the terminology we're using is honest anyway in one respect but maybe I've drifted off a little bit. But maybe this idea of stuckness does seem to fit this idea of repetition. I have a particular interest in the arts, I'm a practising artist myself, and the link between what I would consider what happens in a room between two people and what might happen with an artist who is making work. I would describe that because it's defined dramatically, but the idea that an artist just remakes, remakes, remakes within what I'd call a trance which is a sort of sense of what would be called free association. That an artist makes and remakes and remakes until he or she happens across something that seems familiar or makes some sort of sense and then in that moment it makes sense but then it becomes useless and you move to the next. So it's all quite fluffy all this stuff I'm saying to you but there's this sense that the artist in parallel in a loop is looking for recognising something and I would say that's what happens in the room as well. So if I was to link the word stuck, and actually it's a process, it's not actually a stationary thing, I wouldn't say stuck you might interpret the word stuck as being a stationary place where you are sort of maybe revolving upon a stationary place looking around you but actually it's a very - it's a very dynamic thing stuckness, I'm just thinking of this now while you are asking me, the idea that stuckness can be a very very interesting and important dynamic state but looped, or a sense of looping so the stuckness just comes from the sense of frustration of not feeling like you're moving from the place but actually there is a dynamic aspect to it which might make the idea of stuckness being quite profound and difficult because you are actually moving but there is a sense that you can't move from this place. #00:07:15-4#

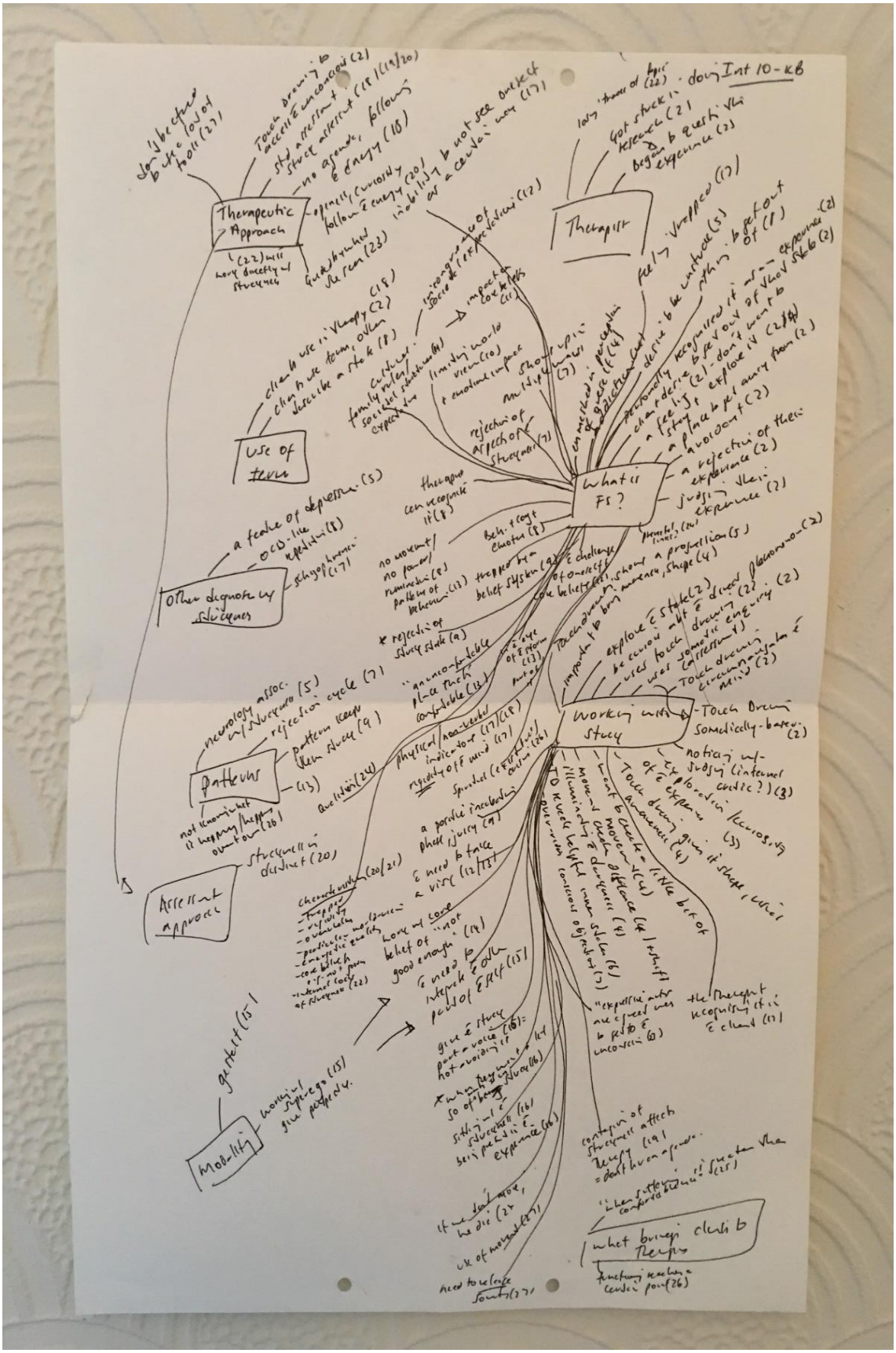
I So what kind of movement is that? #00:07:22-0#

B I think it's all like, it's interesting being put on the spot isn't it, it's quite nice. it's nice, it's a good way of thinking. What type of movement would it be? I've done that before but not in terms of change kind of movement. So I'm probably talking in terms of personal experience which as I said right at the beginning is probably crucial for any psychotherapist to admit to, it comes from the sense

6.9 Step 3: Code, Theme Development and Extracts 'Rebecca'

CODES	POTENTIAL THEMES	DATA EXTRACT
Deliberate use of word stuck to connect with new clients in her profile. Preferring to speak to someone they don't know – why - impartial/neutral/experienced?	?How therapist used the word stuck?	*"in terms of writing that profile I was thinking about what people might be feeling if they're looking for a therapist so. And I suppose in my experience a lot of people do feel quite stuck at times and that might be a time of their life when they might feel they need someone external to their family to talk to about that" (P1, para1)*
Stuckness as a precursor to seeking therapy. Understanding of the point people reach before seeking help.	?What brings clients to therapy?	*"And I suppose in my experience a lot of people do feel quite stuck at times and that might be a time of their life when they might feel they need someone external to their family to talk to about that" (P1, para1)(also used above)*
Use of word in profile not linked to a focus for therapy.	?Structure of client's presenting problem?	*it's not a focus of mine but it's just happened to be the wording that I used in that profile" (P1, para 1)*
A universal term. Commonly understood and used. Origin of stuckness is physical not mental? But helps people to understand the concept of being stuck? Applicable across human domains.	?What is stuckness?	*But I think everybody understand what feeling stuck is like - it's quite a sort of common word and you know people like what it's like to be physically stuck but also I think most people know what it's like to feel stuck emotionally with something." (para 2, p1)*
Difficulty in staying on topic. A slippery term, hard to focus on or grasp hold of.	?Elusive term?	*So what was the beginning of that question, I've forgotten it." (para 2, p1)*
Clients complex and often incorrect understanding of Ψ terms – can be misunderstood or offensive.	?Structure of client's presenting problem?	*"I suppose I mean the word stuck is a lay term, I wouldn't use something like, I wouldn't want to any psychodynamic words like resistance o*

6.10 Step 4: Updated Mind Map for ‘Kelly’

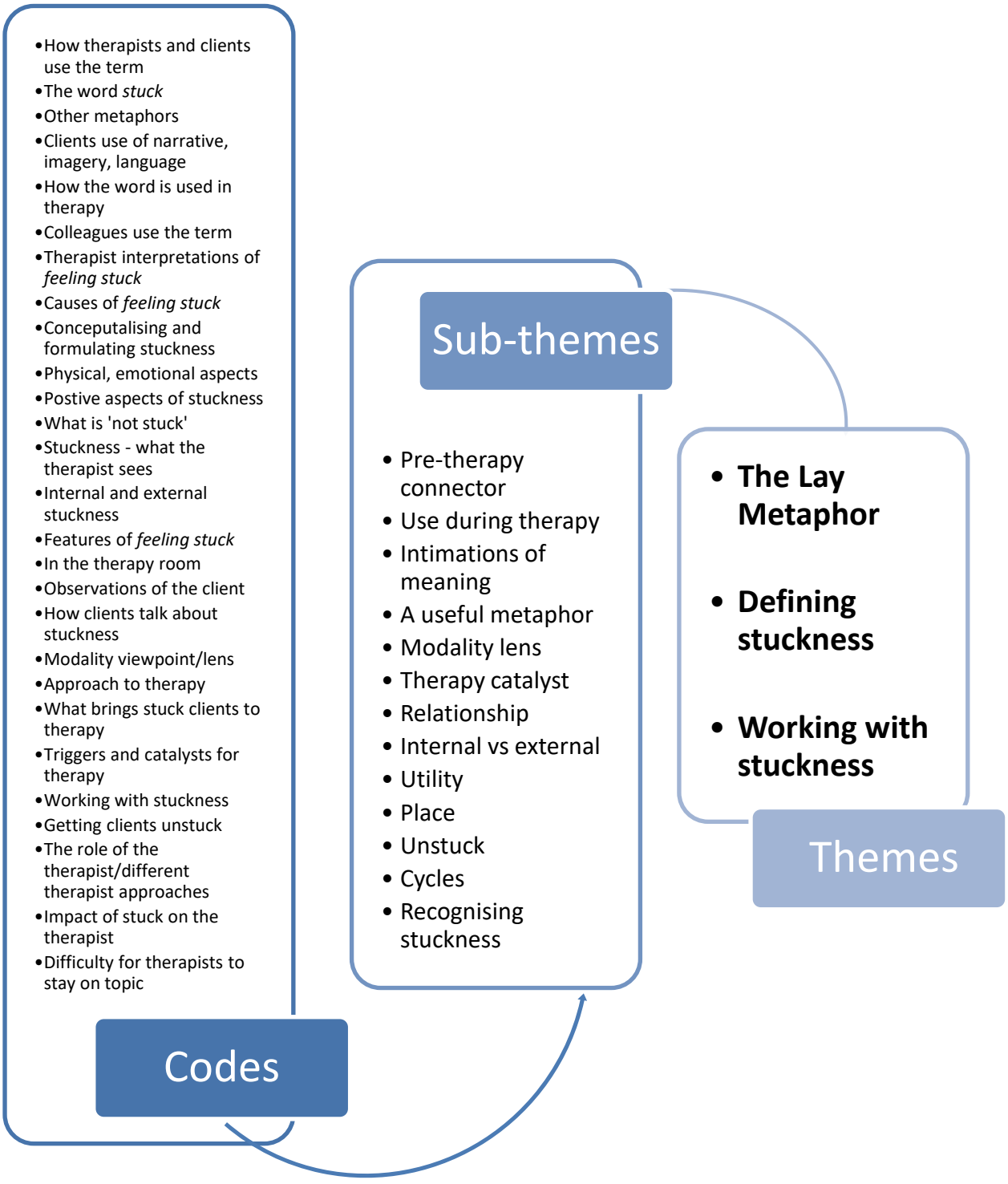


6.11 Step 5: In-process Collation of Participant Narratives for Themes

1. How therapists use the word stuck/how therapists recognise stuckness:

a. Int 8 (Rebecca) – deliberately used in profile as it is recognised as a common term used by clients, so used to attract them to her practice, that she is a therapist that recognises this as a place that people can be. However not intentional in use as a focus for the therapy. The therapist uses the term not the client – a useful 'catch-all' term. Therapists used lay terms as can be cautious using psychological terms with clients – is this way they use lay terms?? Not thought about in this way – as a clinical use within therapy. Thought of as people on a continuum of stuckness. A useful word with so much behind it (P17).

b. Int 7 (Kristen) - a universal term that many people use, understand and can relate to. When used by the therapist, it assumes a shared understanding. Clients begin to feel understood and it is helpful in breaking down the barrier to initial engagement in therapy. That 'Stuck' represents something specific, a point, a feeling, negative and difficult, a place of not-knowing – confusion, frustration and fear that they cannot find the way out by themselves. Not a scary word for therapists as they focus on what tools and techniques they can assemble to help the client towards clarity – where there is clarity, there is resolution?? That stuck feelings correspond with recognisable clinical markers e.g. depression, hopelessness, self-criticism. Thought of as a powerful word "needs something equally powerful to unstick it". Once clients have referenced it in the initial consultation, she is open to other signs of stuckness that are visible or tangible using more cogent clinical markers such as hopelessness or depression, symptoms that can mire and weigh people down. A complex word with depth that could be explored 'all day'.

c. Int 10 (Kelly) – first experienced by the therapist/researcher which started her personal enquiry into this feeling. (P8 middle) recognised by therapist through their description of state and how they present. Recognising physical indications of stuckness – body rigidity. Rigidity as a concept – also seen in spiritual stuckness. Guided by client using the word when first coming to therapy. Will also conduct a stuck assessment (P18)

6.12 Step 5 – Coding, Sub-theme and Theme Development