Psychotherapy through a lens of courage: A study of experienced psychodynamic therapists

Emily L. Lyman

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ABSTRACT

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A concept originating from the Ancient Greeks, courage has long held cultural definitions from literature, philosophy, and theology. However, the construct of courage has largely been neglected in the extant psychological literature despite a significant influence on the human condition. The Tri-Part Model of Courage (Geller, 2014) served as a primary guiding framework for the present study, conceptualizing courage as comprised of three subtypes: bravery, boldness, and fortitude. This study sought to contribute to the ongoing development of this model through examination of the experience and expression of courage by experienced psychodynamic psychotherapists so as to render the construct useful in clinical and psychotherapy research contexts. Participants were 16 experienced psychodynamic psychotherapists. In-person semi-structured interviews were conducted and analyzed using the Consensual Qualitative Research (CQR) methodology. Ten domains emerged from the CQR analysis and revealed courage to be a subjective experience consisting of private theories, as well common definitional elements. Participants spontaneously endorsed the existence and importance of bravery, boldness, and fortitude in their role as psychotherapists, indicating the centrality of courage to their work.

Authenticity, vulnerability, and staying present emerged as the most salient expressions of therapist courage. Specific patient presentations and therapeutic processes were identified as situations most requiring of therapist courage. Experience was the principal enabling factor to courage, and fear and avoidance were the principal obstacles

to courage, while feelings associated with courageous acts ranged from fear, anxiety, and pain, to positive states of well being. Validation, confrontational techniques, modeling, and skills building were the most preferred clinical interventions to promote courage in patients. Gender analysis revealed that women make meaning of courage as having bases in fear and interpersonal relationships, while men understand courage as a set of abstract principles defined by existential anxiety and bold interventions. Fortitude was highly endorsed across genders, and men were further more oriented to fortitude, while female therapists were more oriented to bravery and boldness. The results are discussed in terms of the empirical support provided for the expansion of the Tri-Part Model of Courage and recommendations for clinical practice and future research.

Keywords: courage, psychotherapy, gender differences

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DEDICATION

I dedicate this dissertation to the psychotherapists, beginning and experienced, who approach their work with dignity, insight, and empathy. Your courage is empowering to your patients and colleagues alike.

Drawn I now realize to this career in order to bolster my own courage, I am also grateful to my doctoral experience which has been infinitely formative in making me believe that I too, am courageous.

"Well, there's only one spot in this world that I feel truly myself… there's this very large boulder right there in the middle of the beach. And I come and I sit in its shadow. And there I'm truly myself. I can't lie to myself. And I see things clearly. And that's really the only place that I can experience that. I can remember it when I'm here, but it's not the same. So that's like courage. You know where you really see yourself clearly - exactly who you are, what you are, and where you're going. Without any embellishment. I know I'm romanticizing the whole thing, but it's a moment of clarity" – Study participant

Chapter I: Introduction and Literature Review

The primary objective of this dissertation is to contribute to our understanding of the ways therapists experience and express courage. First, I will present a summary of the working definitions and hypotheses that comprise Geller's (Geller, 2014; Geller, Farber, & Lyman, 2014; Geller, 2016) evolving theory of courage. Then, I will use his Tri-Part Model of Courage (Geller 2014) as an organizing framework for reviewing previous efforts to conceptualize the origins, nature, and functions of courage. I will then illustrate the ways in which the three forms of courage—bravery, boldness, and fortitude—are manifested in clinical practice.

Finally, I will present a research project that was designed to provide empirically grounded answers to questions that are relevant to therapists of all theoretical persuasions: How do experienced therapists subjectively and experientially define the construct of courage as it applies to psychotherapy? What are the perceived clinical triggers or situations that require courage? What do therapists do to promote courage in

patients? What distinctions exist between male and female psychodynamic therapists in their perceptions of courage?

The Tri-Part Model of Courage

The Tri-Part Model of Courage (Geller, 2014) begins with what Geller calls "protocourage" and branches into three forms of courage that are inherent to therapeutic work. I will present the working definitions of protocourage, courage, bravery, boldness, and fortitude in turn, and then present the hypotheses that have emerged from their development.

Protocourage. The conceptual starting point for the Tri-Part Model is the inborn propensity towards protocourage. Geller (2016) posits that "humans inherit a biologically rooted capacity that seeks expression in the felt readiness to undertake activities that are potentially harmful to the body and/or that endanger one's psychological sense of security," known as protocourage (p. 7). This disposition is enacted during the early stages of childhood and is the "root source" of the three forms of courage that develop over time. He writes, "I take as evidence of the universality of protocourage the fact that human beings, in all cultures, must repeat the cycle of falling down and getting up again…before they achieve the goal of walking upright" (p. 7). In learning to walk, the individual begins to draw upon bravery to risk being hurt, boldness in overcoming fear, and fortitude in tolerating the uncertainty and discouragement of this endeavor (Geller, 2016). The three subtypes are elaborated upon in the sections that follow.

The construct of courage. The definition of courage builds from protocourage as a foundational capacity. The Tri-Part Model conceives of courage as "the psychological processes that move a person in the direction of voluntary 'deciding' to face and deal

with reasonably understood risks, dangers, frustrations, and hardships in order to achieve a personally valued goal" (Geller, 2014). Beyond mastery of walking, these processes include the "dispositional tendency that counteracts the temptation/desire to avoid/withdraw from situations that are likely to evoke painful feelings such as fear, shame, guilt, self-consciousness and defensiveness" (Geller, 2014). Geller adds a caveat to this definition, noting that not all acts of courage will actually feel chosen to the individual. He cites many accounts from objective observers of courageous acts where the doer does not acknowledge that he or she behaved heroically. As such, courage is understood to be informed by behavioral characteristics, inner experience, and subjective experience.

The Tri-Part Model proposes that the three forms of courage—bravery, boldness, and fortitude—exist on a continuum of measurable individual differences and are experienced across a broad range of intensities (Geller, 2014). Each form is conceptualized broadly, as well as specific to the unique context of psychotherapy.

Bravery. The first subtype of courage in the Tri-Part Model, bravery, is the courage to face physical dangers and aggression. Its most extreme form is defined as the courage to intervene in life-threatening situations and/or risk death. Due to such risks to physical safety, bravery is one of the two forms of courage that Geller (2016) conceptualizes as "fear-based." Bravery however, is not fearlessness, but somehow pushing through the fear one feels for a greater good.

In the therapeutic context, bravery is the courage to face physical harm through work with violent or severely psychotic patients (Geller, 2014). As such, therapists' bravery is dependent upon the influence of larger social contexts. Though a therapist

may feel it immodest to consider him- or herself brave, psychotherapies may include moments of physical bravery (Geller, 2014).

Boldness. The second subtype of courage in the Tri-Part Model is boldness, the courage to confront situations that carry psychic risks. Boldness is differentiated from bravery because boldness is the courage to take psychological risks that threaten an individual's sense of security rather than his or her physical safety. Boldness is the second "fear-based" form of courage. The fear is not of physical harm as in the case of bravery, but rather a fear of psychological injury (Geller, 2016). Therapeutic boldness therefore requires that therapists accept reasonable psychological risks to manage "therapy-interfering behaviors" (Dimeff & Linehan, 2001), despite uncertainty of what the outcome will be. More generally, boldness "refers to the felt readiness to accept the psychological vulnerabilities that arise when doing the work of therapy" (Geller, 2014).

Boldness involves confronting these "psychological vulnerabilities" with a willingness to explore the unknown and risk being creative and curious even when up against that which the patient (or therapist) feels pulled to leave unaddressed (Geller, 2014). It is not governed by impulse, but rather by thoughtfully weighed decisions. Therapists must "know" when to titrate, adapt, or reign in their boldness in the moment with well-attuned sensitivity. Further, boldness is necessary when a therapist fears hurting a patient, or in fact does so, and must repair the pain he or she risked causing. Incorporating confrontational elements based on the therapist's belief that something implicit in the work must be made explicit can be done with care but also draws upon boldness (Geller, 2014).

Through bold interventions, therapists acknowledge the resistance and ambivalence that will inevitably manifest during therapy and allow for patients to take new perspectives on themselves. And boldness of mind gives therapists the "inner freedom" to genuinely explore their own emotional reactions to patients (Geller, 2014). As Geller (2014) states, "much has been written about the clinical strategies required to help patients make their experiences fully conscious and verbalize them" and "it is time we devoted more systematic attention to discovering the intra-psychic and interpersonal factors that limit the boldness with which therapists find readiness to do the same."

Fortitude. The third subtype of courage in the Tri-Part Model, fortitude, is the courage to remain committed to difficult and emotionally demanding, but not necessarily frightening or dangerous situations, regardless of what may occur. Therefore, fortitude is not "fear-based" like its fellow forms of bravery and boldness. It is "the capacity to endure rather than psychologically withdraw from adversities and hardships on behalf of pursuing personally valued goals" (Geller, 2014).

In the therapeutic context, fortitude equips the therapist to bear witness to traumatic suffering, persevere in providing hope, and "stay intimately on task" (Geller, 2014). Because each therapy presents new situations, ethical considerations, and uncharted outcomes, fortitude is required of the therapist to endure and work through enormous uncertainty. In order to do so, fortitude relies on three capacities: to tolerate suffering, to sustain involvement in an undertaking with an uncertain outcome, and to manage and tolerate ambiguity (Geller, 2014). As such, it is particularly necessary for therapists to draw upon fortitude when facing existential anxiety or depression in themselves or others. According to the Tri-Part Model, fortitude "serves vital

motivational functions" (Geller, 2014). Fortitude includes forging ahead despite boredom, hate, the overwhelmingness of patients' distress, and the need to balance patients' ever-changing needs, maintain compassion, weather disappointments, impasses, and failures, and non-defensively fight to "stay with rather than psychologically withdraw from" the weight of suffering (Geller, 2014).

The gravity of suffering that demands the most fortitude is to stay by someone contemplating suicide. Terry Wise, a patient who survived a suicide attempt, contends that her therapist saved her with a "tedious, step-by-step approach to the dissection of my beliefs" (Wise, 2004). Geller (2016) theorizes that "unless fortitude is a prominent feature of the personality dispositions a therapist brings to the work it would be impossible to bear the weight of empathizing with the torments of despair felt by patients who no longer believe living is worthwhile" (p. 12). To remain with and contain the dark feelings of a suicidal patient requires the utmost fortitude.

Courage of the patient

Before I proceed in elaborating upon the clinical implications of bravery, boldness, and fortitude, the courage of patients must be explicitly differentiated from that of therapists. There is a modest amount of literature that examines the considerable courage of the patient.

It is has been documented that engaging in psychotherapy can be a challenging, painful, and difficult experience for a patient (Barrett, Chua, Crits-Christoph, Gibbons, & Thompson, 2008; Oldham, Kellett, Miles, & Sheeran, 2012; Principe, Marci, Glick, & Ablon, 2006). And yet, many patients attend therapy week after week despite the inevitable discomfort and pain involved. Seeking professional help when needed, facing

the unknowns of past, present, and future (Diamond, 2011), and bravely attending therapy when it is "still pretty scary" to do so even across time (Hatcher, Kipper-Smith, Waddell, Uhe, West, Boothe,…& Gingras, 2012, p. 9) have all been cited as reasons why psychotherapy patients are courageous.

Not only have psychotherapy patients long been lauded as possessing courage in doing the work required of them, but it has also been asserted that promoting courage should be among the primary goals of therapy itself. Seligman (2002) discussed the strengths that effective psychotherapists should aim to build in their patients rather than delivering simply "specific damage-healing techniques" (p. 6-7). Among these key strengths, he names interpersonal skill, capacity for pleasure, future-mindedness, and courage. By helping to develop the inner, core strengths of the person, including courage, the therapist may then positively influence behavioral and interpersonal functioning. Stated another way by Woodard and Pury (2007), courage "is suggested to be a personal trait on par with love and forgiveness, a buffer against mental illness, and a primary outcome goal of psychotherapy" (p. 135). Thus, psychotherapy requires a deep courage on the part of the patient and may also be a significant desired outcome to patient and therapist alike.

To match similar efforts afforded to understanding courage in patients, the present study aims to submit therapist courage to empirical examination.

Courage of the therapist

Psychotherapists bear witness intimately to human suffering. They are confronted with trauma-laden material as part of their job description. As such, much has been written about the challenges faced by therapists, namely that this profession induces

stress (Hellman & Morrison, 1987), anxiety (Menninger, 1990), potential for burnout (Farber, 1990), and a need to triumph over adversity (Goldberg, 1992). While providing therapy is typically a great source of satisfaction for therapists, it is often personal pain, traumas, and suffering that draw them to their work (Farber, Manevich, Metzger, & Saypol, 2005).

The demands of being a psychotherapist therefore have received a great deal of inquiry, but despite some attempts across time, there is not consensus about how or when these demands might be mediated by courage. Holt (2013) argues that Freud himself felt he was a "tragic hero" who faced ostracism and confrontation based on his own ideas (p. 245). This belief was shared by Poland (2008) who writes, "the courage of which Freud wrote was his willingness to expose and explore whatever unfolded clinically heedless of the personal risks to himself… he was… genuinely brave in setting aside risks to his personal reputation, his standing, even his basic financial security" (p. 556). Freud indeed once wrote in a 1910 letter to Ferenczi: "Self-criticism is not a pleasant gift, but it is, next to my courage, the best thing in me" (cited in Brabant, Falzeder, & Giampieri-Deutsch, 1994, p. 227).

However, Freud not only valued his own courage, but also mentioned the words "courage" and "courageous" throughout his works over sixty times (Parrish, Guttman, & Jones, 1980). Though he alluded to the courageous therapist and courage as a facet of psychotherapeutic technique, he never addressed how to specifically evoke courage during psychotherapy sessions nor did he outline what he believed the benefits of therapist courage to be. In fact, neither Freud nor his contemporaries subjected the concept to more comprehensive examination (Levine, 2006). As such, the construct of

courage remains understudied and essentially undefined in the psychotherapeutic context, particularly on the part of the therapist.

Definitions of courage in the extant literature

There is in fact no consistent, universally agreed upon definition of courage in the existing literature, psychological or otherwise. Geller's Tri-Part Model aims to remedy this problem and reduce the difficulties that have presented themselves in operationalizing the construct for clinical use. What follows is a brief historical review of conceptions of courage from literature, philosophy, theology, and psychology using Geller's work on courage as a theoretical framework.

Defining courage outside of psychology. The word courage is derived etymologically from the Latin *cor*, meaning heart, and connotes innermost feelings, temper, and inner strength. As such, Geller's theory accounts for the psychological and dispositional qualities, as well as the physical, mental, and moral powers of influence that courage possesses.

The ancient Greeks considered courage to be one of four cardinal virtues among prudence, justice, and temperance. They further believed that to possess any one of the four virtues, a person must be able to sustain each in the face of difficulty. An absence of courage was thought to reflect cowardice, and an excess of courage thought of as recklessness. A sense of sustainment through challenge is reflected particularly in Geller's notion of fortitude, while non-impulsive, well-thought out, yet nonetheless daring decisions are captured in his notion of boldness (Geller, 2014). With regard to bravery, Geller also drew upon formulations by the ancient Greeks that incorporated physical risk and moral considerations (Geller, 2014). They held that courage would

prepare an individual for heroic readiness to die in battle. In their efforts to describe the willingness to risk death for one's ideals they identified the influences of morality, ethics, and the knowledge of the inevitability of death.

Next, the ancient Romans were known to covet "the quiet courage of fortitude," which they understood as the ability to endure and face adversity. Geller refines this definition to incorporate the capacities by which an individual achieves this endurance, and by removing the adversity of physical harm (requiring bravery) from the realm of fortitude (Geller, 2014). Through the centuries that followed the early Greeks and Romans, philosophers and theologians dedicated themselves to understanding the nature, meanings, and consequences of reality and existence, contributing further dimension to the ancient formulations of courage.

Another representation of courage—one consistent with ideas tying courage to battle—comes from the grit and gruesomeness of Crane's account of the American Civil War in *The Red Badge of Courage*. Crane (1895/2012) writes: "At times he regarded the wounded soldiers in an envious way. He conceived persons with torn bodies to be peculiarly happy. He wished that he, too, had a wound, a red badge of courage (p. 55). Later in his book, Crane notes the following: "With this conviction came a store of assurance. He felt a quiet manhood, nonassertive but of sturdy and strong blood. He knew that he would no more quail before his guides wherever they should point. He had been to touch the great death, and found that, after all, it was but the great death. He was a man" (p. 211). The soldier's courage depicted here is "manly" and manifest in his willingness to face the devastation of war. He wishes to attain courageousness even at the expense of losing his life. Links of courage to heroism and risk of bodily harm have

therefore persisted from Ancient Greece throughout modern day conceptions. Geller encapsulates these ongoing themes in his bravery subtype of courage.

John F. Kennedy provided a depiction of courage that again arises from American culture. The introduction to *Profiles in Courage* reads, "this is a book about that most admirable of human virtues—courage. 'Grace under pressure,' Ernest Hemingway defined it" (Kennedy & Nevins, 1964, p.1). Courage as a virtue is also a notable historical motif, one that Geller's model honors by recognizing an act as courageous if the doer evaluates the act to be moral and good (Geller, 2014). Furthermore, being graceful under pressure evokes Geller's conviction that courage involves careful deliberation when bold, and the fortitude to tolerate difficult circumstances wrought with uncertainty and ambiguity.

These definitions found outside of psychology all make mention of the elements that form the subtypes of bravery, boldness, and fortitude. Taken together, their influences have contributed to and have been built upon by Geller's theory. I will next chronicle the limited mentions of courage to be found within the psychological literature.

Defining courage within psychology. Multiple definitions and types of courage have been posited in the psychology literature. This section will present writings on courage from three broad categories: closely related fields, writings in psychology, and empirical studies. Throughout, I will discuss the ways in which Geller's Tri-Part Model of Courage both resembles and deviates from other models.

Closely related fields. Osgood (1964) conducted a psycholinguistic semantic differential study that included the word "courage." Results showed that courage was among eleven concepts including mother, truth, fruit, bread, and heart, that had broad

cross-cultural consensus with "high affective intensities *everywhere*" (p. 191, emphasis added). That the concept of courage would persist since ancient times and evoke strong emotional intensity beyond the significant influence of culture suggests its fundamental place in human experience. Geller's efforts at operationalizing courage are for the specific purposes of furthering the applications of this construct for clinical work and clinical research.

A second theory of courage comes from the field of medicine. Shelp (1984) described courage as "a neglected virtue in the patient-physician relationship." He conceptualized four components of courage: that courage requires free choice to accept or not accept the consequences of acting; that risk of danger be present; that courage pursues a worthy end; and that courage occurs when the outcome of one's actions is uncertain.

To decide if courage is present in the context of psychotherapy, Geller (2014) proposes a similar yet distinct four step decision-making process guided by the following considerations: 1) whether or not the person experiences the act as subjectively and willingly chosen; 2) the degree of risk one feels he or she is taking; 3) the subjective experiences that accompanied the act; and finally, only after psychologically evaluating these three steps, to assess 4) whether the act is neutral, moral, or immoral. Both models emphasize choice, risk, personal value, and uncertainty, while Geller also accounts for the individual's subjectivity and determination of the act's morality. In Geller's thinking, the first three steps are distinguished and separated from the fourth so as to preserve the psychotherapist's role as a non-judgmental partner to the patient (Geller, 2014). Once courage is identified, it is further categorized into the three foundational elements.

Writings in psychology. Tillich (1952) in *The Courage to Be* remarks upon the innate difficulties of defining courage that have been mentioned throughout this introduction. He believes courage to be "a concept where theological, sociological, and philosophical problems converge" (p. 1). To this list, I would add psychological dilemmas. In fact, Tillich argued that "the courage to be is the courage to accept oneself as accepted in spite of being unacceptable" (Tillich, 1952, p. 164). This formulation has an underlying religious belief, which he also relates to psychoanalysis. Accepting the unacceptable sinner is achieved through communion with God. In the "communion of healing," such as "the psychoanalytic situation, the patient participates in the healing power of the helper by whom he is accepted although he feels himself unacceptable" (p. 165). The therapist "does not stand for himself as an individual but represents the objective power of acceptance and self-affirmation. This objective power works through the healer in the patient" (p. 165).

However, the courage to accept oneself as accepted and accept one's patient as accepted may also be a strong goal from the perspective of the therapist. Courage may be requisite both to providing the environment for another (a patient) in which such acceptance can take place, and to managing the meeting of the therapist's own needs in this area. Geller (2014) asserts that "therapists who are consistently effective in helping patients make constructive changes in their lives face and deal with the frightening, difficult and painful aspects of therapy, courageously."

In a second psychoanalytically informed paper, Prince (1984) wrote that in fact the "psychotherapist is consistently faced with situations that demand courage (i.e., a spirited, lively, vigorous response in which psychological danger is faced without

shirking)" (p. 47). But what are these situations? What constitutes a courageous response? Or a shirking, non-courageous one? And, how can psychological dangers be identified? The manner and extent to which courage—or the adoption of a courageous attitude—affects clinical practice and patient outcomes has been explored in part throughout psychology's history, but is worthy of more detailed analysis.

With regard to patient outcomes, Peterson and Seligman (2004) suggested several components of the "good life" to be promoted both within and beyond psychotherapy, one of which was courage. The character strength of courage includes 1) bravery and valor; 2) persistence including perseverance, and industriousness; 3) integrity as related to authenticity and honesty; and 4) vitality, encompassing zest, enthusiasm, vigor, and energy (Peterson & Seligman, 2004). Geller's three subtypes map well onto Peterson and Seligman's bravery, valor (whose first synonym is boldness), and persistence (fortitude). Integrity and vitality appear to fall under Geller's understanding of the feelings and "subjective experiences" that relate to courageous acts (Geller 2014). Where they differ most is Peterson and Seligman's emphasis on patients, and Geller's emphasis on therapists.

However, both psychologists agree that by conceptualizing courage as a set of character strengths (Peterson and Seligman), or subtypes (Geller) rather than as a purely moral entity, courage can begin to be measured and explored psychologically without the earlier pressures of religion and morality. These quandaries have led to several types of courage being proposed over time, including: fearful, confident, social (Woodard & Pury, 2007), and existential (Maddi, 2004) courage. Lopez, O'Byrne, and Peterson (2003) also offered three types of courage: physical courage, moral courage, and vital courage.

Putman (1997) adds psychological courage, which consists of confronting irrational fears and anxieties, and facing the fear of loss of psychological stability.

To address these definitional issues, Geller (2014, 2016) does not rely on adjectives as qualifiers for his subtypes of courage. The three forms that he has developed are more abstract concepts, and intentionally not conceived of as domains of functioning in order to render them more researchable. His solution to the questions of morality that have contributed to the stagnation of a universal definition of courage centers on the recognition that there are neutral, moral, and immoral acts of courage. A terroristic act may well feel moral to the individual, despite the judgment of horror by the majority of others (Geller, 2014). The construct of courage requires focus on not only the ethical meanings that have been attributed to it but also its potential psychological meanings.

Further complicating a clinically employable definition of courage are numerous active debates within the psychology literature. One such debate is whether courage is based upon threat (running into a burning building), or outcome (to save the children inside). Situations requiring courage have traditionally been delineated based on threat, including Putman's (1997) psychological courage and multiple conceptualizations of physical courage. However, categorizing courage in this way may be problematic with regard to other types of courage. For example, moral courage is often assigned to situations in which there is a "morally desirable *goal*," rather than those based on threats to an individual's moral integrity (Woodard & Pury, 2007, p. 137). Geller's model subsumes all of these elements: a threat or risk must be present, the desired goal must be

personally valuable to the individual, and the presence of morality, as has been previously discussed, can be assessed along a spectrum.

Relatedly, questions have been raised about whether definitions of courage must be context-dependent, or if courage can be conceptualized across situations. The example of terrorism again suggests that courage can also be villainous and deplorable. For Geller, the individual's subjective perception of the event along with contextual factors characterize whether or not it is courageous. And finally, there is ongoing discussion among psychologists regarding fear. Some definitions of courage require a fear component (Woodard, 2004), while others indicate that fear may or may not be present (Lopez et al., 2003). Geller's model recognizes that in moments of bravery or boldness, fear of physical or psychological harm is involved respectively, while fear is not requisite in moments of fortitude (Geller, 2016).

A final clinical conceptualization is presented by Nemas (2014), who views bravery as a masculine derivative of courage, but argues that courage itself is better defined in relation to Bion's (1962) concept of maternal reverie. From Nemas' perspective, courage is personified by the mother who steadfastly stays with her children, above all else. She persists in their care despite any wavering hope. This more feminine notion of courage complements thinking about courage in strictly life-threatening terms. While psychotherapists may be in physically dangerous situations with patients (in the case of extreme psychosis, for example), psychologically risky moments are even more prevalent (Geller, 2016). A sense of "staying with" patients, as a mother does with her children, is reminiscent of Geller's notion of fortitude in the context of psychotherapy.

Lastly, White (2014) presents a rationale for why therapists need to be courageous in even choosing to pursue this career. In her review of Buechler's *"Still practicing": The heartaches and joys of a clinical career*, she writes that in delving into the "aspects of a therapist's life that dwell in dissociated 'not me' spaces" (i.e., anxiety, guilt, loss), "anyone who has had the 'courage,' in Buechler's terms, to undertake this vividly complex journey into becoming a practicing clinician will, without doubt, find recognition in this psychological drama" (p. 324). The Tri-Part Model of Courage theorizes that psychotherapists depend upon unformulated, preconscious notions of courage that are based on experiences formed before training as therapists. As such, they impart ideas of courage derived from personal experience and "psychological drama" in their work rather than their own assessment of its clinical utility. One of the aims of the current study is for therapists to bring their ideas about courage and the recognition they may find within it to "verbalizable consciousness" through interviews (Geller, 2014).

Empirical studies. The first of the few empirical articles that were found on the topic of courage refers specifically to group therapists. Shapiro and Gans (2008) suggest several themes related to the courage of group psychotherapists including 1) open acknowledgement of one's mistakes; 2) deviation from one's theoretical perspective or standard practice; 3) perseverance in times of personal crisis; 4) confrontation of negative emotions in self or others; and 5) dealing with the unexpected. Geller's model supports themes of discussing mistakes, clinical deviations, and confronting difficult emotions as relating to boldness, and themes of perseverance despite the unknown as characterizing fortitude. Interestingly, the existence of bravery was not mentioned or alluded to in this study of the group therapy situation.

The context of individual therapy was examined by Hatcher et al. (2012) in an exploratory qualitative study on what therapists learn from patients. Their findings reveal the personal and professional effects of these lessons, and it is notable that therapist participants often invoked the concept of courage. First, interviewees gave many examples of how patient courage in turn instilled courage in them. One respondent stated, "people cope with the most unimaginably difficult life situations in a variety of adaptive and courageous ways, using everything from religion to psychotherapy to exercise to creative work to confiding in friends and/or journals and/or some combination of these" (p. 7). Another said, "I have a depressive constitution myself and so my liability in life is to see the glass as half empty...This has been a great career for me...because I see so many people surviving adversity...and being courageous... it has really helped me feel like...if they can do that, I should be able to pull myself up also" (p. 12).

Second, participants spoke of their own courage as psychotherapists. The following therapist narrative makes reference to aspects of both displaying fortitude through an arduous process, and boldly overcoming fear of psychological harm: "it took me a long time to be able to deal with anger and not to be terrified by it...That, I think, takes courage on the part of the therapist" (p. 9). A second participant noted that his work requires courage because being a therapist has made him an "interpersonal risk-taker" as "the good therapeutic response is not necessarily the socially conventional one" (Hatcher et al., 2012, p. 9). Geller would call such responses bold. A final respondent spoke of the challenges of intimacy with patients as both a critical part of the therapeutic

process, and also a frightening one. In Geller's vocabulary, maintaining intimacy and serving as a witness to pain constitutes fortitude. The respondent shared:

> ...I have learned that by watching and experiencing the closeness that happens and doesn't happen between my patients and myself – the way in which that closeness between myself and a patient is empowering or healing but also terrifying...I have a much deeper appreciation of the courage involved in being close to another human being – the vulnerability and volatility of it (p. 6).

Each of these therapists in the Hatcher et al. (2012) study reflected more than the difficulties of his or her profession—they also indicated that courage is a significant aspect of being a therapist, describing a reliance on their own courage, and particularly boldness and fortitude, in order to manage and conduct their work.

The most recent empirical mention of courage in psychotherapy was a pilot study on courage in beginning therapists, developed by Geller, Farber, and Lyman (2014) with the emerging Tri-Part Model as its foundation. The Courage in the Therapeutic Context Survey was designed to assess the extent to which beginning therapists believed that courage was required to face and deal with presented clinical situations. Each of the situations, it was hypothesized, corresponded to bravery, boldness, or fortitude. Part I consisted of a series of demographic variables, and part II listed 36 clinical situations to be rated on a 7-point likert scale.

In the pilot study, the therapist participants, all clinical psychology trainees, rated "Deal with threats of suicide or other self-injurious behavior," "Bear witness to traumatic suffering," and "Tolerate being the target of a client's negative thoughts or feelings," as

the three situations demanding of the most courage. These items were rated highly across demographic groups, including theoretical orientation, age, race/ethnicity, type of program, and number of clients (Geller et al., 2014). Given the consistency of these responses, the present study builds upon these results by exploring experienced therapists' perceptions of therapeutic situations that require courage.

Factors contributing to courage

Notably missing from previous studies that involved the topic of therapist courage are questions related to potential mediators of such courage. Two conceivable mediators of courage within the context of psychotherapy are gender and specific practice parameters.

Gender. The present study aims to investigate the differential perceptions of male and female therapists in regard to the concept of therapist courage. Differences in development and attitudes between men and women may influence their perceptions of what comprises courage. For example, previous research suggests that men are more oriented towards aggression (for a review see Maccoby & Jacklin, 1974), power (Carli, 1999), and authority (Ruch & Newton, 1977), while women tend to focus more on interpersonal relationships (e.g., Burleson, 2003; Gilligan, 1995). These findings lend credence to observations made by Geller (2014) that male icons of courage tend to be combat heroes, athletes, and politicians more so than those of women. Further, he notes that culturally, bravery is attributed to soldiers and athletes, while boldness is assigned to revolutionary figures who upheld their ideals without compromise. Though not the only form, "the ultimate expression of fortitude is bearing the pain of childbirth" (Geller, 2014). Taken together, these existing findings and theoretically driven considerations

suggest that male therapists may tend to align with bravery and boldness and female therapists with fortitude. This study measures emergent gender differences through investigation of therapists' most revered exemplars of courage and their thoughts, attitudes, and perceptions of how courage occupies a space in their work.

Practice parameters. The current study attempts to discern the influence of therapist experience on their perceptions regarding the role of courage in the practice of psychotherapy. The therapists in this study had been practicing for at least 10 years, and many for several decades, and it was thought that their knowledge could further illuminate Geller's ideas.

Bravery, boldness, and fortitude as manifested in treatment: The present study

Geller's model advances our understanding of the construct of courage and offers a guide for its clinical applicability. His framework provides working definitions and a vocabulary, most prominently in formulating bravery, boldness, and fortitude, that have generated hypotheses about the essence and effects of courage in psychotherapy.

Geller's (2014) theorizing implores therapists to consider how their work can be understood from the perspective of the concept of courage, and to examine the personal and cultural influences that underlie the role of courage in their own practice and effectiveness. The Tri-Part theoretical lens is used in this study to evaluate the thematic content of interviews with experienced therapists. It was hypothesized that participants' spontaneous responses would reflect the three subtypes of courage proposed in the model.

The present study aimed to quantify, analyze, and synthesize such expressions so as to develop a language for courage within the psychotherapeutic context and to explore

the psychological meanings and technical applicability the construct holds for psychotherapists. The Tri-Part theory was conceived in order to address a definitional gap within psychotherapy; however, this definition of courage must be validated through clinical and empirical investigation.

Statement of the problem

Therapists face the challenge of sitting with distress and suffering that they are expected to withstand while providing proper care to themselves and others. This entails enormous psychological effort and great personal and professional responsibility. Given the inherent risks, both psychological and physical, of doing the work, the current study seeks to understand to what extent psychodynamic psychotherapists call upon courage and courageous acts in practice. Courage has received mention across the ages as a beloved virtue, as a requirement for patients, and as a goal of psychotherapy (e.g. Seligman, 2002; Woodard & Pury, 2007). However, neither the construct of courage nor the situations that call for it have been studied in the context of therapists' experiences of their work. There is, then, a need for meaningful consideration of the ways in which the Tri-Part model can elucidate the nature, processes, and consequences of courage in clinical practice.

Chapter II: Method

Participants

Interview subjects were 16 therapists who are currently practicing in the New York City area. Eight male and eight female psychodynamic therapists were interviewed. The number of participants in each of these groups, therefore, were within Hill et al.'s (1997) original manual and (2005) update requirements for minimum sample size necessary for a Consensual Qualitative Research (CQR) analysis of eight to fifteen participants, with numbers surpassing fifteen thought to become repetitive and lack new data.

"Psychodynamic therapist" is a broad descriptor that can be applied to a broad range of practitioners, requiring operationalization for the purposes of this study. With respect to theoretical orientation, the present study explores the behavioral manifestations of courageous acts as a function of individuals' clinical understanding and beliefs as psychodynamic therapists. The intent of psychodynamic psychotherapy is for patients to achieve a greater degree of insight into their own psyches. In contrast, cognitive-behavioral therapy, for example, aims to modify problematic behaviors and change biased attributions through explicit, systematic (often manualized) techniques. Given the distinct foci of these approaches, courage may present itself quite differently in sessions with therapists of different theoretical leanings. As an example, it may demand more risk for a dynamic therapist to confront a patient's resistance to understand him or herself, than it would be for a cognitive-behaviorist to address noncompliance with behavioral assignments in therapy. Courage is contingent upon cultural, political, and familial forces, as well as theoretical beliefs and preferences (Geller, 2014) and theoretical

orientation is self-selected and impacts interventions and practice. As such, therapists may display important differences in their expressions of courage based upon a primary theoretical orientation as a psychodynamic therapist.

Therefore, this study understands a psychodynamic theoretical orientation to be characterized by the following in the way that the individual therapists work:

1) Early experiences are believed to have a significant impact on the expression of distress, recurring behavioral patterns, defense mechanisms, and functioning in the present.
2) Exploration of the unconscious is considered to be necessary in order to facilitate change.
3) A major goal is to help the individual develop increasing insight into his or her own inner experience.

When inviting people to participate as interviewees, they had to endorse this list to self-identify as psychodynamic therapists and participate in the study. Those who did not endorse these tenets did not fit the parameters of this study and therefore were thanked but not included as participants.

In order to be included in the study, the subjects also had to have been practicing for at least 10 years as active therapists. The distinction between early career and more experienced professionals is to have completed one's final degree within the last ten years, per the American Psychological Association (APA), The Society for Psychotherapy Research (SPR), and others. Subjects who had not been practicing with an active caseload for 2 or more years during the last 10 years were excluded from the study. Recruitment was conducted through personal networking by sending emails to

colleagues in private practice as well as the snowball technique, as several participants volunteered names of colleagues who might be interested in participating.

Participants were distributed evenly by gender and the majority of participants identified as Caucasian. All sixteen participants endorsed their primary orientation to be psychodynamic. Most participants named a second theoretical influence, including relational, eclectic, family systems, Accelerated Experiential Dynamic Psychotherapy (AEDP), mindfulness, interpersonal, CBT, object relations, existential, and humanistic approaches. These therapist participants ranged between 11 and 41 years of experience. Table 1 presents participants' demographics, and Table 2 presents participant demographics by gender.

Table 1
Participant Demographics

	N	%
Gender		
Female	8	50
Male	8	50
Race/ Ethnicity		
Asian/ Asian-American	1	6
Black/ African American	1	6
Hispanic or Latino(a)/ Hispanic or Latino(a) American	1	6
Multicultural	1	6
White/ Caucasian	12	75
Years in Practice		
10-15	4	25
16-20	2	13
21-25	3	19
26-30	2	13
31-35	3	19
36-40	1	6
41-45	1	6

Table 2
Participant Demographics By Gender

	Female		Male	
	N	**%**	**N**	**%**
Race/ Ethnicity				
Asian/ Asian-American	0	0	1	13
Black/ African American	1	13	0	0
Hispanic or Latino(a)/ Hispanic or Latino(a) American	0	0	1	13
Multicultural	1	13	0	0
White/Caucasian	6	75	6	75
Years in Practice				
10-15	3	38	1	13
16-20	1	13	1	13
21-25	2	25	1	13
26-30	1	13	1	13
31-35	0	0	3	38
36-40	1	13	0	0
41-45	0	0	1	13

Measure

The interviewer collected information about selected socio-demographic and practice-related variables, including gender, theoretical orientation, race/ ethnicity, and number of years practicing (experience).

The Courage in the Therapeutic Context Interview. The Courage in the Therapeutic Context Interview (see appendix C) was developed specifically for this study, in order to assess experienced therapists' perceptions of the nature, extent, and implications of courage in the context of their clinical work.

This 14-question semi-structured interview begins with the following instructional set:

"Thank you for agreeing to participate in our study. As I mentioned, we are trying to learn about the ways in which courage is experienced and expressed in the therapeutic

situation. Towards this end, I'll be asking you about your particular views about courage and its role in the work you do as an experienced therapist. I'd like to tape-record your answers. Do you have any questions about this study? Ok, let's begin."

In accordance with Hill et al.'s (1997) recommendations, these instructions are then followed by a series of semi-structured open-ended questions covering a range of topics about experienced therapists' perceptions of the function of courage in their clinical work with patients. Interview questions were based on the study's research questions, feedback from pilot interviews, and a meeting with skilled qualitative researchers. The interview begins with general questions so as not to influence subjects' responses, and then includes questions specifically meant to represent bravery, boldness, and fortitude. These categories were not named to participants. The interview addresses the following questions:

How do therapists personally define and experience courage? Therapists were asked to first generally discuss their role models and personal definitions of courage, and then to reflect more specifically upon the influence of courage on the therapeutic process.

What are experienced therapists' perceptions of the triggers or situations that invoke courage and their relevance to the work of psychotherapy? That is, when do therapists feel courageous and what is therapists' sense of being courageous (or not) in providing clinical work at present and over time.

Next, these therapists were asked to consider how courage may be helpful technically or emotionally as a tool of psychotherapy. Further, they were asked to speak to their thinking about courage, including what they believe may be the effects of mindfully applying the concept of courage to their work.

Questions nine through fourteen of the interview address the three forms of courage. Boldness is represented in questions 9-11 and questions 12 and 14 evoke bravery and fortitude. This study aims to discern if therapists' personal perceptions of courage coincide with Geller's theoretical definitions of bravery, boldness, and fortitude.

Transcripts of the interviews were analyzed and a CQR coding system was developed.

Procedure

Data was collected by the method of semi-structured interviews. Two pilot interviews were conducted, discussions with colleagues examined these, and the interview protocol was further revised to create a third and final iteration. Sixteen participants who met study inclusion criteria and agreed to meet for in-person participation were then interviewed individually. The interviews were conducted by the principal investigator and every attempt was made to follow the script that was developed specifically for this study (see the Interview Protocol, appendix C). The interview was tape-recorded with participants' consent. Interviews ranged from approximately 38 to 67 minutes long, with most between 45-50 minutes. All recordings were kept on a password-protected computer and following transcription, all recordings were destroyed immediately. The participants were assured of full confidentiality, and informed that their identity would not be disclosed in any manner (see the Participant's Rights and Consent forms, appendix A). Participants were told of the nature and purpose of the study, were debriefed at the conclusion of the interview, and were informed that they may request study results that would be delivered via email.

Data analysis

A transcription service was used to transcribe the participant's speech verbatim. The transcription service provider was presented with the interviews after they had been de-identified by the principal investigator and the service provider had signed the confidentiality agreement (see Confidentiality Agreement for Transcription Service Provider, Appendix D).

A Consensual Qualitative Research (CQR) approach was used to code the qualitative interview questions (Hill, Knox, Thompson, Williams, Hess, & Ladany, 2005; Hill, Thompson, & Williams, 1997). According to Hill, Thompson, & Williams (1997), there are eight components of CQR. 1) Interview questions are open and semi-structured so as not to limit participant responses. 2) Phenomena are described with words (rather than numbers). 3) A small selection of case studies is analyzed intensively. 4) The "context of the whole case is used to understand the specific parts of the experience" (p. 522). 5) Data is analyzed using inductive reasoning. 6) A primary team of three to five researchers will use consensus to make all decisions, so as to extract "the best possible construction" for the data (p. 523). 7) One to two auditors will participate in analysis to ensure that the primary team is capturing important data. 8) The primary team will refer frequently to the raw data to maintain accuracy in their conclusions (Hill, Thompson, & Williams, 1997).

Data is then coded using three overarching steps. First, interview responses are divided into domains. Next, core ideas (main ideas summarized in one to two sentences), are identified per domain per interview. Lastly, cross analysis is conducted by creating categories that "describe consistencies in the core ideas within domains across cases"

(Hill, Thompson, & Williams, 1997, p. 523). Through this process, data is reduced down to extract the essence of participant responses to all interview questions.

This study then included a fourth step, as the categories developed were further examined by grouping them according to male and female gender. Group differences are examined similarly within the CQR literature (e.g. Castonguay & Hill, 2012; Chang & Berk, 2009; Knox, Burkard, Johnson, Suzuki, & Ponterotto, 2003). Though these data could have been divided by gender initially and coded as two distinct CQR samples (one comprised of women exclusively and one of men), this study opted for the less typical approach of analyzing the full sample followed by these two subsamples. The rationale behind this decision was to be able to capture psychodynamic therapists' understanding of courage as a group, as well as to assess the role of gender in their experiences and application of courage in their work.

CQR is the best fit method of analyzing this qualitative data as it allowed for the generation of categories, constructed before looking inside the data to individual responses, and therefore permitting for a study of differences in men and women on the research questions. A widely used methodology, CQR has been used to examine a variety of phenomena including abnormal bodily movements in individuals with schizophrenia (Stanghellini et al. 2014), the impact of international immersion on counselor education and students' development (Barden, & Cashwell, 2014), and psychotherapy outcome research studying therapy engagers versus non-engagers (Huang, Hill, & Gelso, 2013). Further, Hill et al. (2005) describes the nature of CQR and why it lends itself to the type of data of interest in this study:

CQR incorporates elements from phenomenological (Giorgi, 1985),

> grounded theory (Strauss & Corbin, 1998), and comprehensive process analysis (Elliott, 1989). From these qualitative approaches, we adopted the emphasis on consensus among judges to construct findings and the use of words rather than numbers to reflect meaning in the data. We also incorporated some elements from exploratory, discovery-oriented methods (e.g., the emphasis on consistency of data collection across participants, use of multiple judges, and agreement among judges; Hill, 1990; Hill & Lambert, 2004; Mahrer, 1988)… We rely on naturalistic, highly interactive data collection methods. We strive to uncover meaning through words and text… the research team uses consensus to construct their interpretation of the data, trying to set aside their biases so that they fairly describe what the participant has reported (p. 2-3).

Following CQR guidelines, a research team consisting of the principal investigator and two other researchers was formed and an auditor was appointed. A schedule of meetings was created so as discuss all decisions to consensus. Team members were two master's students and one doctoral student (the principal investigator) from Teachers College, Columbia University.

Such an approach was indicated in the study of courage and psychotherapists as well-defined categories and definitions have not been established with consensus. The present study aims to contribute to a robust and useful theory of courage in the context of the psychotherapeutic situation.

Research team. The CQR analysis team in this study consisted of the primary researcher, a Caucasian American, female, advanced doctoral student in clinical

psychology who had, prior to data analysis, approximately three years of experience in providing psychotherapy to majority under-resourced patients in New York City. The second team member was a Mexican American, female, second year clinical psychology master's student who at the time of data analysis was involved in several qualitative research projects, one of which involved coding interviews by a different method. She was previously a teacher and sought a higher degree to pursue research. The third team member was a Caucasian American, female, second year clinical psychology master's student who, during data analysis was part of a CQR team just beginning their analysis on another psychotherapy effectiveness study on the topic of informal supervision. She had originally been an English major and had two years of experience in working in geriatric mental health, and at the time of analysis was assisting in the treatment of children with selective mutism. The auditor was a Caucasian American, male, advanced clinical psychology doctoral student, who due to being in the midst of conducting his own CQR project was well-versed in CQR auditing and procedure.

All three team members were new to the CQR method, and therefore, in accordance with Hill et al. (2005)'s description of thorough training, underwent several sessions of training prior to data analysis. The team learned the method by studying Hill et al.'s (1997) training manual, Hill et al.'s (2005) CQR update, and extant CQR studies. A knowledgeable CQR researcher served as auditor and an experienced CQR researcher and faculty member served as mentor as well to the team so as to carefully uphold CQR procedures.

To begin, as indicated by Hill et al.'s (1997, 2005) guidelines, the three team members explored and shared their individual expectations and biases regarding the

potential nature of the results of the study. This meeting occurred prior to initiating data analysis in order to minimize the effect of these personal expectations and biases on the team's analysis of the data.

Expectations were defined as "beliefs that researchers have found based on reading the literature and thinking about developing research questions" (Hill et al., 1997, p. 538). All three team members belonged to the same university department and community, and as a result, two team members participated in the analysis with previous experience in the study of psychotherapy outcomes and effectiveness research and the third had a significant interest in these topics. The meeting revealed that the expectations of the team included the belief that there would be notable differences between male and female therapists regarding therapist courage. One team member added that she expected the genders to be split such that men would tend to relate courage to physically dangerous situations while women would tend to relate courage to motherhood and/or emotionally taxing situations. Team members also assumed that there would be a wide range of definitions and experiences of courage and that the concept is subjective in nature. One member offered her perception that attributions to courage are based on what each individual would need courage to do him or herself. Further, the team believed that few therapists would have previously thought about courage in depth in the context of their work. The team also agreed that they expected therapists, as part of a helping profession, to be highly empathetic and selfless and perhaps not as likely to readily acknowledge their own courage in their work. Relatedly, one team member shared that she expected that therapists would instead be more willing to attribute courage to their patients than to themselves. Lastly, one team member acknowledged her strong belief in the validity of

Geller's model and her expectation that much of the interview content would support his theory.

Biases were defined as "personal issues that make it difficult for researchers to respond objectively to the data" (Hill et al. 1997, p. 539). Potential biases of the team included the fact that the primary researcher had three years conducting therapy with underprivileged, low resource patients, found this work to be difficult yet highly satisfying, and had cultivated a passion for contributing to greater access to mental health services for this population. She also had a vested interest in this topic based on her own experiences of providing therapy as being challenging, her belief due to shyness and self-doubt that courage is required on the part of therapists, and her deep respect and admiration for seasoned therapists as courageous, including her own supervisors and teachers. Given these feelings, the primary researcher was open about a potential overestimation of courage and the strong belief that psychotherapy can be effective when utilizing courage and in promoting courage in patients. With an awareness of this bias, the other team members indicated to the researcher throughout analysis if they perceived her to be disregarding evidence to the contrary. The researcher was also challenged when others believed that her interpretation of more vague passages of the transcripts relied too heavily upon her previous therapy and research experience.

Another team member mentioned that her dominant association with courage was her father, given his struggle and success as an immigrant to the United States who built a life for himself and his family. As each of the other two team members had significant connections to close family members who had also immigrated to this country, the team acknowledged that they could be potentially biased towards overly identifying with

participants' immigration stories or towards assigning more courage than might be due to such narratives. During the process of analysis, the team discussed in the moment if any member appeared to be applying her own experience with immigration in interpreting the participants' statements. The third team member described similar feelings of sensitivity towards teachers who work with at-risk youth and single mothers, given her personal experiences and therefore tendencies to ascribe courage to these groups. The team challenged her throughout the data analysis to remain objective when analyzing therapist participant responses.

As each of the three team members were women interested in clinical practice and research, the team also identified these qualities as potential mediators of their perceptions of the data. The team therefore committed to challenge one another if their interpretations of participant narratives included the theme of women's and civil rights issues (in addition to those previously mentioned) when they were not explicitly stated. Such a commitment was necessary, as the larger concept of social justice or one's own lived experiences of courage could easily impact interpretations of personal experiences. After the discussion of expectations and biases, the research team was again reminded of the importance of initially avoiding making interpretations about the data so as to properly summarize participants' experiences as reported (Hill et al. 1997, 2005).

Coding data into domains. The first step of this CQR data analysis involved coding data into domains. The research team created a working list of domains based on the content of the interview protocol and the pilot interviews. Once these domains were argued to consensus, each researcher divided one transcript and coded it into the relevant domains. The team next argued to consensus the best fit coding of the transcript. A

second transcript was similarly coded into domains individually and then coding was argued to group consensus. The auditor next reviewed the two transcripts with the team's domain titles and sectioned data. The domain list was amended by the team based on the auditor's feedback. As the domains developed, modifications were made including adjusting the title of domain two to more clearly distinguish it from other domains, and creating domain ten to address the times when participants provided qualities reminiscent of courage yet disavowed the term courage, presented as essentially "not courage, but close." Two transcripts were also set aside from coding as a stability check (described below). The remaining transcripts were then coded into domains.

Abstracting core ideas. Core ideas summarize the content of each domain for each singular interview. The goal of abstracting core ideas is to represent the essence of participants' responses concisely and clearly (Hill et al., 1997). Researchers are to refrain from making interpretations of the data at this stage of the process and focus on capturing the participants' perspectives accurately. The researchers determined core ideas individually and then met with the team to argue each core idea to consensus. The auditor once again reviewed the team's work and provided feedback on the representativeness of the core ideas. The now cored domains were adapted with consensus by the team to include the auditor's feedback, including adjusting certain details and wording to more closely match the essence of participants' narratives.

Cross-analysis. Cross-analysis consisted of examining data across participants to identify similarities in order to achieve a deeper level of abstraction (Hill et al., 1997). Core ideas within the domains were reviewed and the team argued to consensus to cluster them into categories. The auditor was again invited to examine the categories. The

auditor's input helped to combine categories that were repetitive, eliminate one domain that provided little additional information and redistribute its contents, and change domain and category titles to better capture the content of the core ideas.

Frequency labels. As outlined by Hill et al. (2005), frequency labels were assigned to each category. *General* results are found in all cases or all cases but one. A category is considered *typical* if it appears in more than half of all cases up to the cutoff for general. A category is considered *variant* if it applies to three cases up to the cutoff for typical. And a category is considered *rare* if it pertains to only two cases (with at least fifteen cases total). A miscellaneous category included single cases. Findings that were labeled as miscellaneous because they only appeared in one case were excluded from analysis as they are deemed unrepresentative of the sample. Therefore, in this study for the overall sample, general applied 15-16 cases, typical applied to 9-14 cases, variant applied to 3-8 cases, rare applied to 2 cases, and miscellaneous applied to 1 case. For the purposes of gender comparison for each group, male and female, general applied to 7-8 cases, typical applied to 5-6 cases, variant applied to 3-4, rare applied to 2 cases, and miscellaneous applied to 1 case.

Stability check. CQR incorporates a stability check to determine if additional cases would change the results. The two transcripts, one from a female participant and one from a male participant, that were set aside at the start of analyses were analyzed to identify the presence of any new domains, core ideas, categories, or frequencies of categories. Stability of findings was achieved in this study per Hill et al. (1997), as frequency labels were consistent between these two interviews and the rest of the body of interviews.

Chapter III: Results

Ten domains emerged from this CQR analysis and this section details these domains and the categories within them. An eleventh domain, titled "Others' perceptions of my courage" was excluded from final analysis as consultation with the auditor and the team concluded that it yielded overly disparate content including responses about frequency, type, qualities, and situations which could not be analyzed coherently. The data from this domain was then re-categorized within the other domains. As outlined by Hill et al. (2005) frequency labels were assigned to each category and reported. In this study for the full sample, general applied 15-16 cases, typical applied to 9-14 cases, variant applied to 3-8 cases, rare applied to 2 cases, and miscellaneous applied to 1 case. Domains, categories, and their frequencies are presented in Table 3 (p. 130).

Hill et al. (1997) advises that researchers create an illustrative narrative of a typical participant. This “prototype” narrative is influenced by the most recurring categories. Participants in this study were psychotherapists in well-established private practice and hospital positions in the New York City area, as is represented in the narrative below.

The typical participant in this study can be represented as a primarily psychodynamically-oriented psychotherapist with over 25 years of experience. This therapist speaks of challenging and frightening moments during the early and internship phases of training, and now has a thriving private practice. This therapist also contributes to the training of new therapists as an adjunct professor and/or clinical supervisor. For the purposes of this study and its strong focus on gender, it is helpful to further examine typical profiles separately for the male and female therapist participants that are based on

their "general" frequency results.

The typical female participant held political figures as her most prominent models of courage. She admired them for their activism and advocacy, respecting their willingness to confront authority and stand up for what is right. With regard to her clinical work, she felt that her many years of experience and the high quality of training that she had received facilitate her courage as a therapist. However, she was more likely than the male therapists to emphasize that fear is inhibitive of maintaining a courageous attitude or providing a courageous response. Further, she more often associated feelings of fear and doubt with courageous acts than her male counterparts. Lastly, she relied on validation, reinforcement, and normalization as her preferred courageous interventions with patients.

In contrast, the typical male participant defined courage as acting in accord with a deep sense of purpose and personal values. He viewed specific types of patients, holding complicated diagnoses and suffering from severe traumatic histories, as the individuals who demanded the most courage from their therapist. And though he did not as often endorse fear as a feeling that accompanies a courageous act the way the women in the study did, he clearly expressed feelings of anxiety, discomfort, hurt, and pain as connected to behaving courageously.

The representative female and male therapists also presented two equally frequent shared beliefs. The first was that treating patients in the Axis I and Axis II diagnostic categories including those with trauma backgrounds significantly heightens the risks and challenges of conducting psychotherapy. Though they did not always explicitly link providing these treatments with courage in this domain, they often alluded to its presence.

Notably, the second mutually agreed upon truth among male and female therapists is that courage is defined by being brave, taking risks, and possessing fortitude. In other words, all participants regardless of gender consistently acknowledged a role of the three subtypes of courage in their psychotherapeutic work.

Domains and categories

Analysis of the transcripts yielded 10 domains and cross-analysis of these domains determined between 4 and 19 categories. The results of the study are presented below according to the 10 domains that reflected participants' lived experiences with courage, and are displayed as subsection headings. Categories within domains are represented with italics.

Associations to the concept of courage. The first domain encompassed over-arching characteristics of the definition of courage. More specific definitional elements, particularly those related to psychotherapy, are better captured in other domains. By its very nature, this domain elicits personal meanings and perceptions of lived experiences with courage. A typical category that emerged in this domain was *Being brave, having fortitude, and taking risks*. In other words, the majority of participants defined courage as embodying these elements. One participant shared that the concept of courage is "being brave, being vulnerable, having fortitude. Going to places that aren't easy to get to, that haven't been explored before, or pursuing an idea that may expose parts of yourself that may be scary." Another cited the definition this way: "pushing oneself to go somewhere that they don't want to go, risk-taking, with some idea that they'll be better off for having done it. Pushing oneself out of a comfort zone and the discomfort that's involved." A third participant also emphasized the behavioral elements as well as the motivation

behind them noting that courage is "taking healthy risks, decreasing avoidant behaviors, sometimes going against the stream, and you might put yourself at risk for the greater good." Similarly, a second typical category of associations to courage was a sense of *Living in accord with purpose and values*, as described by one participant: "courage involves good judgment and dedication, a defining sense of purpose. It is to do something in accord with your values."

Five variant categories also arose in this domain. The first, *Demonstrating authenticity and vulnerability*, reflected that many participants respected these qualities in therapists as courageous. One participant explained the importance of "being present, breathing, being as aware as one can of everything that's going on intrapsychically and interpersonally." A variant number of participants also believed that courage involves *Facing Opposition*. A participant shared that courage is "standing up for what you believe is right even when it's going to be unpopular. The more pushback you get, the more courage it takes to persist." This sentiment was echoed by another who stated the association of "standing strong against some kind of opposing force, an image would be persevering in the wind or storm, and that force can also be social in being able to stand up to something that people don't agree with."

A variant number of participants also emphasized that courage is *Part of the human experience; for all.* One participant summarizes that "everybody deserves courage when necessary." Another participant elaborates that "courage is part of being human and in general I think of it in big terms: political activism, human rights, but I am also certainly aware of it right here in this room." This said, participants also differentiated courageous act from a rash or negative act, captured by the *Distinguished*

from cowardice and bravado category. One participant noted, "I distinguish it from people who act impulsively and think of it mostly in positive terms, though I can imagine there are situations where I might consider it a negative thing." A final variant category identified courage as *Multifaceted*. Four types of courage emerged including emotional, physical, personal, and professional courage. One participant added that each type can manifest itself in many ways citing, "emotional courage in the face of emotionally difficult experiences" as well as "a whole variety of physical forms of courage."

Associations to the concept of courage in psychotherapy. The second domain reflected broad, general perceptions of courage as it is experienced and expressed in psychotherapy. Similarly to domain one, participants' responses were typical for the category of *Therapist authenticity and vulnerability*. One therapist participant describes the essence of this category:

> Courage is a guiding sensibility in therapy - there's an enormous amount of courage that's required to step outside of our cocoons. It's an act of courage by strategically yet authentically revealing our connectedness to our patients, and by meeting with a patient each time. The act of therapy is very courageous because you have to be mindful of what you are sharing, you often can make mistakes interpreting, revealing something that you hope will illuminate or create movement, a path towards healing, and then you have to go back and own your mistakes or rejoin.

Also typical responses in this domain were associations with *Fortitude* and *Boldness*. For the former, participants described that therapists are "noble, and requiring integrity, strength, and courage in a way to sit with that kind of pain, not flinch, show your care,

and stay present" and reflected upon "how hard it is to bear witness, to really understand the amount of pain that people have and confronting it." A third participant stated simply that there is "endurance in psychotherapy." Regarding boldness, one participant elucidated:

> Part of the therapist's role is to help patients avoid less so they can experience life more, to really find their own voice and their own authentic self, a process that requires a lot of courage. A courageous therapist oftentimes is to be a challenging therapist and not always to be complacent with the patient's dynamics.

Another participant further identified specific moments in which therapists must be bold, stating,

> Saying something the patient doesn't want to hear. In supervision it takes courage to push people into things they find risky. Courage is also needed in group relations in finding the courage to speak the unspeakable. In the work courage mostly happens in the danger to your self-esteem, feeling stupid, being embarrassed.

The sentiment of "speaking the unspeakable" extracts the typology of the boldness category well.

Six variant categories also emerged within this domain. As in domain one, participants again resonated with the idea that courage is *Important for all patients*. One participant noted that "everybody's capable of being in a situation that might require courage on the part of the therapist." Another participant expands upon this idea:

> Therapists' courage is a much more subtle, private that thing that much more often occurs in a consultation room. Courage is a very individual person-by-person experience and I think any good meaningful long-term therapy is going to require courage on both the patient and the therapist's part.

A variant number of participants also discussed the category of *Bravery.* One said:

> I guess in a way it is bravery to sit with somebody with raw emotion and not have to smooth it over and buff and polish it up, just let the feeling be there, it's not comfortable, it's kind of exciting and refueling makes you believe in the majesty of the human spirit and the power of this work.

It follows that a variant number of participants also spoke about the absence of bravery and courage as *Knowable through opposites*. Several participants mentioned acts motivated by narcissism, and another spoke of professional lack of courage: "in the field there are people who are not courageous because they shied away from controversy and go along with the prevailing opinions and theories." Another participant explained his perspective on being less than courageous as a therapist in the room, stating that "I think being lazy, not being responsible, not really working to be present and to be the best professional that we can be, that's cowardly."

Courage as *Not subjected to conscious thought or study in psychology* was another variant category in this domain. Several participants highlighted their feeling that courage is not, as one participant phrased it, "an organizing concept for me." Stated differently by a second participant:

> A word like courage is not used often enough in psychology to describe what happens and in fact, I think it's a very real paradigm in lots of lots of therapy. Therapy has a real merit if it in fact gets to a place where courage is really being wrestled with in a very real way by both the patient and the therapist.

This category reveals that many participants prior to this interview had not processed the concept of courage through conscious or deliberate thought.

Therapist participant responses in this study also led to the creation of a category regarding *Staying present*. One participant explains "being a good therapist means first and foremost being as present as we can be - its not always easy, there are always a variety of internal and interpersonal forces pushing us out of the moment, and to be as open as we can be to the moment takes courage." Lastly, *Fulfilling professional duties outside of sessions* emerged as a variant category. These included giving professional workshops, and according to one participant, "more than therapy, putting myself forth in a leadership position, writing papers, and completing analytic training required more courage for me because I'm putting myself out there and allowing myself to be seen."

Models of courage; prototypical instances. The third domain consists of participants' models of courage, as well as their personal reasons for considering these individuals or groups of individuals to be courageous. Typically cited models of courage were *Political figures*, most commonly Barack Obama, Martin Luther King, Jr., Nelson Mandela, and Edward Snowden. *Family and friends* were also mentioned by a typical number of participants, as were other *Psychologist colleagues* – participants tended to hold people with whom they had personal relationships as their significant role models of

courage and courageous acts. Family members included parents, grandparents, children, spouses, as well as extended family, and colleagues included previous mentors, members of the same private practice, previous therapists, and other psychologists that participants had met or had read about. A variant number of participants also cited *Founding Psychologists* (such as Freud, Anna Freud, Jung, Winnicot, Skinner)*, Other public and literary figures*, *Graduate students and beginning therapists*, and *Heroes* (such as war heroes and political heroes), as their models of courage.

Three typical categories reflected the prototypical instances of courage that came to mind for participants. The first typical category was *Activism, advocacy, and standing up to authority*. Participants in this category shared: "Obama, who seems to be able to maintain a calm demeanor even under heavy, intense, unremitting fire;" "going against the mainstream like that man in China who stood opposite the tank;" "Karen Horney for going against Freud and bringing in the female voice; "Sal Minuchin who immigrated here, challenged the status quo, and developed a systems form of therapy where he took risks and advocated for the poor despite push back;" and "my grandmother and grandfather because they were both inspiring holocaust survivors who coped with trauma, rebuilt, and helped people along the way."

The next typical category demonstrated that participants respected models of courage based on the *Exploration of new ideas and things*. One participant cited "Freud, for the mistakes he made and being profoundly committed to being a learner," while another generalized this sentiment to "everyone who brought something new to the field because the field is very conservative and conformist." A participant appreciated this quality in her mother: "my mom is courageous as a single mom who tried new things all

the time." Participants also emphasized *Fortitude and resilience* as the rationale behind their choice of models of courage. One participant reflected on "people who worked on the front lines of the AIDS epidemic doing hands-on care despite fear and so much unknown about the disease," and another reported that in the context of therapy: "some patients for keeping on going in the face of a lot of anxiety and plugging away at emotional pain to get better."

Multiple variant categories also characterized this domain. The first, *Perseverance in the context of physical and mental illness*, included Stephen Hawking, Michael J. Fox for his struggle with Parkinson's disease, and those with schizophrenia, Down syndrome, AIDS, cancer, or other physical handicaps. Participants also identified *Survival of violence and discrimination*, *Success in the context of* i*mmigration history,* and those in the presence of *Physical risk* as models of courage. Two examples of physical risk mentioned were the actions of Edward Snowden and of "those shielding each other from bullets during the recent terror attacks." A variant number of participants also highlighted *Mentorship, intelligence, and teaching* and the *Demonstration of honesty, vulnerability, and compassion* as rationale behind their courageous models. Lastly, *Writing and work with difficult patients* was revered by participants. One participant expressed that "Ferenczi had the courage to write about complicated and painful places with patients and be muddled," while another admired her colleague "for not being afraid to get into really sticky emotional entanglements with her patients."

Therapeutic situations that require courage. The fourth domain reflected specific therapeutic situations that participants believed necessitated therapist courage. The first typical category that emerged in this domain was *Axis I and II diagnoses,*

including history of trauma. This included depressed, borderline, bipolar, schizophrenic, psychotic, and sociopathic patients; narcissistic, seductive, and sadomasochistic patients; and patients with histories of PTSD, sexual abuse, foster care, hoarding, or frequent hospitalizations. One participant described "taking on patients that a lot of people don't see in private practice, and seeing psychotic patients not on medication through psychosis and anxiety in very extreme states." Another expressed the importance of "communicating to traumatized patients that you have the guts to be exposed to the terror of their experience."

The second typical category in this domain is entitled *Therapist use of self*. One participant explains that it is important to "maintain a psychoanalytic presence and contain negative transference when patients hit you at your most vulnerable parts, and by containing it you help them with it." Examples of specific incidents included acknowledging a patient's anger toward the therapist, admitting wrongdoing in assuming years ago that a transgender patient was pathological, and one participant discussing his personal struggle with shyness with a very shy couple. Another participant shared that "for people who haven't been acknowledged, who have had parenting that doesn't take in their subjectivity including narcissistic parents, it's important for me to be courageous in the way I need to be to acknowledge their experience."

Nine variant categories also were formed based on participant responses. Therapist participants identified the presence of *Sexual material, including sexual abuse* and issues of *Suicidality* to require great courage on the part of the therapist. Participants also described work with *Violent or intimidating patients*, such as those making threats, abusing their spouses or children, or those with access to weapons including guns. Other

participants focused on the difficult nature of the *Delivery of interventions a patient does not want to hear*. One participant described "being more of a pushy therapist to patients who have a high level of avoidance and helping them to avoid less and find contradictions in their narratives." Discussion of saying something difficult is described by another participant:

> Bringing things up that I'm afraid to bring up when I might hurt someone's feelings or make them angry; interrupting the status quo to say the thing that I know I have to say because I'm their therapist, and not just hanging out there. I think whenever you give feedback to someone on who they are, even saying something positive to them, really staying connected and confident about what it is that you have to say and why it's important for them to know that about themselves.

Many participants agreed with the sense that even a small intervention can require courage.

Participants also noted that *Termination of treatment or referral out* and *Policy issues and case management* could create situations that necessitated therapist courage. One participant noted that "there is courage in ending work and in not working with someone out of self-preservation," and others spoke of finding appropriate referrals, conducting phone check-ins with patients, and "confronting a patient who is not paying." To cope with these difficult therapeutic situations, therapists also discussed a *Need for help or supervision*. One participant described the difficulty of "bringing up a difficult patient with a supervisor who sees things differently and whose approach does not feel comfortable," while another echoed the frustration with "not having great supervision

while working with challenging patients." *Court mandated patients and/or testifying in court* was another challenging situation mentioned, such as "advocating for disempowered families, court mandated into treatment, in court, healthcare, and educational systems." A variant number of participants also highlighted work with *Groups and couples*, the former "who can get very stirred up and angry at each other and/or the leader," and the latter described as, "sitting with couples in the midst of shredding each other viciously, and calmly finding a way to intervene in that that will alter the dynamic."

Factors influencing the ability to be courageous. The fifth domain highlighted the many influences that affect the spectrum of the ability or *in*ability to be courageous as described by participants. Two typical categories emerged that could be considered opposing forces: *Experience and training* and *Fear and doubt*. In the former category one participant reflected the need for "lots of experience to get to a point where you trust that something is going to deepen the work that we're doing and how to do it in a way that you don't feel over-exposed or destabilized by it." The same participant also shared content of the latter, feelings about "inexperience and feeling tied up in knots during groups, and not having the courage to name what was going on." Another participant expressed that it is "easier to be courageous when you feel like that you really excel at what you do. Earlier in my career most confrontations and direct interpretations felt like I needed to push myself more, now it is much easier."

In the *Fear and doubt* category, one participant described, "the courage to overcome fear in connection with doing something you feel is important and right and being open to take on a different experience. Obstacles to courage include being cautious,

self-preservation, shame, lack of confidence that I could really be of help." One participant added the “fear of hurting her, fear of doing something that wouldn’t be helpful to her. Being really torn about what the best way to go would be.”

A variant number of participants discussed a *Personal or professional obligation* as a factor influencing their courage. One participant summarizes, "I was profoundly committed. I held onto a moral compass, and knew I have to do what is right." Related to a sense of professionalism, participants also spoke about the significance of *State of being present and self-aware*. A participated expressed that this involves "more awareness of the intersubjective and being more in tune to myself as opposed to just in tune to somebody else" as well as "energy, attention, and staying really present and being with someone, which is hard to sustain that all the time." A variant number of participants also spoke on *Fortitude*. One participant emphasized the "fortitude to stay with it and not give up on people." Another commented on the "ability to sit with pain and not flinch even though there are many times when there’s not a damn thing you can do about the misery in their lives other than to show your care and to stay and stay present."

Therapist participants also spoke about *Personality and background* as impacting their ability to be courageous. A participant described being "acclimated from family experiences to disturbed people and I developed skills for calming people down, knowing what people can tolerate and what would be helpful, mostly not being afraid to go there even with intense affect." A second participant explained his "belief that there isn’t a linear, neat, lockstep pattern in life. I had more instances of people responding courageously in the face of scary things than most upper middle class people who go into

our field, so I think in that sense it's been with me since I was a boy." A third participant expressed:

> For characterological reasons we're all somewhere along a spectrum being very phobic at one end and counter-phobic at the other end. We all have characterological dispositions that make us inclined when we're scared to either jump into the fire or run for the hills – my characterological leaning is to be counter-phobic.

In addition to their personalities, participants also emphasized the influence of their *Own treatment, supervision, and other outside support*. They spoke of *Therapist personal issues and self-care needs* such as fatigue, protecting oneself, and "times of illness, times of family upset, and serious life problems, worrying about myself or loved ones." With regard to *Therapist-patient dynamics*, participants discussed strong countertransference reactions including to boundary-breaking patients, to gender dynamics, and the development of erotic feelings. The final variant category in this domain addressed therapist *Self-interest and self-promotion*, both personal and financial, which at times occluded courageous action.

Feelings involved in courageous acts. The sixth domain contained the emotional associations revealed by participants that occur before, during, and after acts of courage, large or small. The first of the typical categories was *Anxiety, discomfort, and pain*. One participant described the "anxiety that closes your perception of a problem or the situation, because there's a lot of anxiety connected to just opening it up." Another participant, discussing a specific instance of courage recalled his experience as "profoundly disturbing, upsetting, consciously alienating, confused, briefly I was

connected to wanting to run away from this." Similarly, a typical number of participants brought up a feeling of *Fear*. One participant described that "the bodily experience is initially frightening, and I get tremble-y, blotchy skin patches, and my voice gets a little quivery," while another shared that a courageous act he had committed was "scary, frightening, chaotic making. I was scared shitless, it was very useful to me."

In contrast to these negative feelings, participants also typically reported a *Sense of well-being*. A participant stated, "I feel good, stronger, kind of confident in a way that feels wonderful, and like adrenaline is still running in my system." Another participant shared that acting courageously also produces "calmness, gravitas, humor, a sense of profundity, having less concern about how I'm being judged…. Centered." Likewise, a variant number of participants discussed *Authenticity and vulnerability*, such as "being authentic about oneself, one's core feelings, one's core state. Emotional connectedness to oneself." Another positive state identified was *Pride; appraisal as rewarding*. This was described as such by one participant: "I felt proud and relieved. At one point, it was stressful and it has become relaxing because you feel effective; it's rewarding." Participants expressed further feelings of *Relief*, for example one participant stated that "acting courageously provides a release from bad feelings such as fear or doubt in your competency and a return to a sense of well-being."

Situations that intensify the risks and difficulties of doing therapy. The seventh domain is reserved for challenging and difficult therapeutic situations which when described, contained no mention that the therapist believed he or she had been courageous. These moments were risky and would likely seem to others to involve courage, but this domain adheres strictly to the participants' own explicitly stated

attributions to the events shared. This domain produced the only general category that emerged in this full sample analysis, *Axis I and II diagnoses, including history of trauma*. The types of patients and situations mentioned were similar to those mentioned in domain four, with the difference that the participants did not assign courage to themselves in their descriptions. One participant spoke of "patients in hospitals with psychotic features," "people who are severely traumatized and being respectful of their fragility," and "patients who have histories of physical violence and who are dysregulated, disorganized, and disinhibited."

Two typical categories were formed, *Physical violence* and *Emotional violence*. One participant mentioned both, describing "physical violence, the threat of physical violence, and emotional violence and cruelty that I sometimes see with families." With regard to physical violence, another participant expressed that "those prone to violence that make me physically frightened. I had lots of fantasies that abusive husband would get physically violent toward his wife or toward me or both in the session, fantasies about walking to my car and looking around." With regard to emotional violence, one participant stated that "the risk is both to your reputation as well as your own psyche." A second participant expressed that "with that patient who I didn't want to work with - I felt he used sort of emotional intimidation techniques that made me feel really uncomfortable." A third participant declared: "they all scare you emotionally a little bit, if not something is missing."

Variant categories for this domain included *Suicidality*, *Difficult Problems*, and the *Loss of a patient*. One participant shared that "I feel riskier with patients who have a fragmented self and suicidal behaviors or intent." Apart from suicidality, difficult

problems included occupying the role of supervisor, and working with couples, court-mandated cases, and patients whose struggles are layered and complex. One participant also candidly described her concern about losing a patient who was considering terminating treatment:

> I get scared if I am feeling I've let someone down. The last time I lost one of my patients who I had been working with for a long time, it was because I felt out of control and because I was going to lose him as a patient and all the good work we had done wouldn't be able to continue or come to fruition.

This domain set out to capture a variety of intense, risky, difficult situations, and revealed many of these situations to be emotional in nature for therapists and to appear, despite not being said outright, to call for great courage.

Clinical interventions that promote courage. The eighth domain focused upon descriptions of therapeutic interventions in which therapists had the express goal of helping their patients to behave and feel more courageous. This domain involved inspiring, encouraging, and enhancing courage in one's patients. One typical category emerged: *Validation, reinforcement, and normalization*. A participant described such interventions in the following way: "I model courage and I normalize intense affect for people, for people to accept it in themselves and tolerate it. It happens by exuding a sense of calm and acceptance, and I feel like bedrock to them in a way that I think I didn't 25 years ago." Another participant described "commenting, congratulating, and/or validating someone if I thought what they did was really brave or if it was really hard for them.

From time to time I've named what they did." Lastly, a participant explained several of his therapeutic techniques:

> I "glue the glimmer" like LuAnn Piliero speaks of: when you see resiliency, when you see strength, when you see patients taking risks, you constantly move into that direction, support it, stroke it, tell them how impressed you are; it helps to rewire the brain. You can also create a new headline for the newspaper out of some small thing that you pick up in session, you remember from Minuchin, such as a new interaction between family members, or you bring in the brass band and you march around the room.

It was uncommon for therapists to state that they do not in some way intentionally promote courage as part of their treatment goals.

Three interventions produced a variant number of responses. The first, *Confrontational techniques and boldness*, was expressed summarily by one participant as "helping patients know themselves, try to take chances, not give into the fear, be pushed, move, not just wait, be less afraid of failure or success, develop a tolerance for difficult emotions and difficult states, put themselves in different situations." Another participant described therapy as,

> The process by which you invite the other person's experience of themselves to come out and that you attempt in as noble and straightforward a way as you can of creating an environment which fosters the person being brave and being willing to tackle things that ordinarily are quite upsetting.

Modeling was also widely discussed. A participant elucidated, "modeling can be very good for patients, by showing fortitude, strength, boundary setting, and courage - especially for psychotic patients." Another participant discussed simply "being transparent about what I know and what I don't know, in that sense I'm a kind of living model."

Finally, participants also highlighted *Skills building* as a method to promote courage in patients. One participant shared,

> Sometimes I'm the voice of self-care: "slow down, this is really important, we really will get to it, but you don't have to do all the work today. It's okay to take it step by step," or to help a patient recognize the early warning signs to listen to themselves better, take good care of themselves and back away from the cliff.

The coping skills reported in this category were frequently concrete in nature. A cognitive behaviorally informed lens was also common despite the therapists endorsing a predominantly psychodynamic psychotherapeutic stance. One participant expressed,

> A real source of change and growth in one's mental health is the ability to take on certain ideas and take on certain feelings that you've convinced yourself you can't handle. And so much of good therapy is being able to help the patient articulate what it means and what it felt like to be in that circumstance.

Regardless of the theoretical lenses working in each moment, it was important to participants to help patients think through their negative attributions and face frightening choices courageously.

Times when I felt less than courageous. The ninth domain addressed moments when participants identified feeling as though they had lacked courage, or had shied away from doing something courageous during their work. A typical number of participants endorsed one category in this domain for moments when they had *Exhibited avoidance due to difficulty or lack of energy*. Broadly, a participant characterizes this category as made up of "innumerable slight instances when I looked the other way or let things slide with patients." Another participant described a challenging dilemma in therapy:

> I felt [clinical psychology] was just the wrong profession for a patient who was a student, and I didn't push it and I feel like I actually should have - I thought that if I would go very gently with the process maybe I can help her to see something that she can not see, but I think that was just not a courageous approach. It was right in front of me and I had this opportunity to make a difference.

Other participants described "chickening out, "coasting," failing to hold boundaries, and times "when I think I should have gone there," when asked about non-courageous moments.

A variant number of participants also connected feeling less than courageous with having *Made a mistake*. One participant reported, "I had one patient a really long time ago who left treatment, and I think I totally screwed up, and she was telling me I was screwing up and I couldn't hear it at the time." Another participant expressed, "but at the time, I wouldn't have called it courageous - I was worried I'd fucked up basically. Sometimes it's the opposite of courageous because of a need to be liked issue that got tugged at a lot."

The second variant category reflected times when participants *Felt fearful*. As in the seventh domain, this fear was characterized by physical and emotional elements. For the former, one participant stated "a long time ago with the patient who was big, I was mostly just scared." Regarding the latter, a participant recounted that "when I first began to hear about this frank sexual masochistic material, I definitely was connected to wanting to run away from this, that's in a certain sense cowardly. I don't really feel cowardly, I feel like I make mistakes, and I get scared at moments."

Disavowal of courage for alternative constructs. The tenth domain consists of those pieces of participants' narratives that referred to "not quite courage," or something adjacent or similar to courage, or "not courage, but something else." This domain was created to capture the frequently occurring moments when participants believed that what they were describing was not purely courage or simply not courage in their own sense of the definition of the construct. The sole typical category in this domain is titled *Appreciation, admiration, and gratitude*. A participant described this idea as such: "supervisors have been appreciative at how invested I am and being present. I held some supervisors in very high regard and I felt very proud that they were appreciative of me." In the context of therapy, a participant shared:

> I don't know if I can remember a particular time when a person said that. So I don't know if they would have ever called me courageous, but when a patient is grateful to you in a real way, in large part, even though they may not talk about it in those terms, but that you were able to be there with them and didn't run in the face of things that were terrifying to them, makes therapy valuable to them.

This domain was meant to capture participants' sense that they were indirectly being called courageous, and also identified moments when they were being praised for other qualities.

Categories with a variant number of responses included the following: *Fortitude*, *Boldness*, and *Narcissism*. Fortitude is captured by one participant as:

> A patient would say "I never do what you do," which has an indirect allusion to a certain inner strength from listening to people's stories, sitting with their pain, witnessing trauma and depression and anxiety, being emotionally with them one after another, day after day, year after year.

Boldness was seen by one participant as "the effort of getting into the right place to allow myself to be the object of some aggression. Patients comment about what I do mostly when it's something that they don't expect." The therapist participants were eager, however, to also caution against grandiosity: "others' narcissism gets in my way of taking their writing and introduction of new ideas like it's such a courageous thing," and the same was true for narcissism within therapeutic work.

Gender differences

Examining the data set by gender revealed changes to the frequencies of several categories, documented in Table 4 (p. 134). For example, multiple general categories were produced when separated by gender where they had not been present in the analysis of the full sample. For the analysis split by gender (8 females and 8 males), the following frequencies were applied: general to 7-8 cases, typical to 5-6 cases, variant to 3-4, rare to 2 cases, and miscellaneous to 1 case.

The sole emergent general category for both men and women was *Being brave, having fortitude, and taking risks*, as a primary association to the concept of courage. Also emergent as general for women was to name *Political figures* as models of courage and *Activism, advocacy, and standing up to authority* as their rationale behind respecting their models as courageous. Women endorsed the influences of *Experience and training* and *Fear and doubt* on the ability to be courageous and *Fear* to be a prominent feeling associated with courageous acts. Women also tended to describe interventions to promote courage by way of *Validation, reinforcement and normalization*. With respect to men, one emergent general category was that of defining courage with a focus on *Living in accord with purpose and values*. Men characterized the therapeutic situations most requiring of courage as *Axis I and axis II diagnoses, including history of trauma*. In addition, male participants highlighted *Anxiety, discomfort, and pain* as feelings related to courageous acts.

Typical categories also emerged for women that had not existed within the full sample, and which were not classified as typical for men. Female participants more frequently discussed *Writing and working with difficult patients* when explaining their choice of models of courage. Women also tended to express the importance of *Personality and background* as factors influencing the ability to be courageous. The third and final typical category for women was *Suicidality* as a difficult and risky therapeutic situation. For male participants, typical categories were also produced that were not typical for women. Men endorsed a respect for those who demonstrated *Perseverance in the context of physical and mental illness* as role models for courage. They also expressed being guided to act courageously by a sense of *Personal or professional obligation* to

their patients. Male participants lastly emphasized the importance of maintaining a *State of being present and self-aware*, and the *Confrontational techniques and boldness* during the course of therapy.

Some variant categories did not shift when analyzed by gender. However, for women, eight categories that were variant in the full-sample analysis became rare categories for women, and as such are not representative of the women in this study. Women rarely discussed courage as *Knowable through opposites* or named *Other public and literary figures* as their models for courage. Likewise, it was rare for women to discuss *Suicidality*, *Violent or intimidating patients,* or *Policy issues and case management.* Female participants were also unlikely to reference a *Personal or professional obligation* as a motive for courage, or to stress therapist *Authenticity and vulnerability* or *Confrontational techniques and boldness* in their responses.

Eleven categories that were initially labeled as variant experiences for the full sample became rare experiences for men, and thus were also not representative of men in this study. A rare number of men discussed courage as *Facing opposition*, or *Bravery* as an association to courage in psychotherapy. Men also rarely reported *Survival of violence and discrimination* or those who achieved *Success in the context of immigration history* as models of courage. They did not often describe *Delivery of interventions a patient does not want to hear* as requiring courage. Male participants also did not tend to mention their own *Personality and background*; *Own treatment, supervision, and other outside support;* or *Therapist-patient dynamics* as factors influencing their courage. It was rare for men to report feelings of *Pride; appraisal as rewarding* or *Relief* as related to courageous acts, or for them to identify *Difficult problems* as the riskiest therapeutic

situations. They also did not tend to discuss *Validation, reinforcement, and normalization* or *Modeling* as their preferred interventions to promote courage. Lastly, men rarely reported that they *Made a mistake* that made them feel less than courageous, nor did they tend to report *Boldness* with regard to other qualities mentioned when courage was disavowed.

Of note, twenty-two categories changed from variant to rare for both women and men once the analysis was split by gender rendering them non-representative of either gender. These shifts can be reviewed in Table 4.

Chapter IV: Discussion

In this discussion section, I begin by presenting findings in the context of the four research questions in this study:

1. How do experienced therapists subjectively and experientially define the construct of courage as it applies to psychotherapy?
2. What are the perceived clinical triggers or situations that require courage?
3. What do therapists do to promote courage in patients?
4. What distinctions exist between male and female psychodynamic therapists in their experience of courage?

The discussion will then explore the impact of this study's findings on the theoretical usefulness of Geller's Tri-Part Model of Courage as related to the existing literature. Next I will present the limitations of the study. Finally, the implications for clinical practice and suggestions for future research will be examined.

Research Questions

Study findings are examined in relation to each of the four research questions developed at the beginning of the investigation.

Research question 1: How do experienced therapists subjectively and experientially define the construct of courage as it applies to psychotherapy?

Participants' experiences can be understood with regard to this cardinal question through an integrative summary of material from the following four domains: a) *Associations to the concept of courage*, b) *Associations to the concept of courage in psychotherapy*, c) *Models of courage; prototypical instances* and d) *Disavowal of courage for alternative constructs*.

These findings point in the direction of the following conclusions. The first is that courage is often not subjected to conscious thought, and instead individuals depend upon personal definitions of the construct. The second is that during the course of the interview, many participants arrived at definitions in accord with Geller's Tri-Part Model. Their responses determined bravery, boldness, and fortitude to be significant to their work, suggesting a vital role of therapist courage. Lastly, two types of expressions of courage were identified by participants: authenticity and vulnerability, and staying present.

Courage as not previously subjected to conscious thought: a synthesis of private theories. A major finding of this study is that courage, though deeply personal, is not often subjected to conscious thought. Indeed, twenty-five percent of participants explicitly stated that the interview prompted them to form a definition of courage for the first time. The interview as a whole, and the first domain, *Associations to the concept of courage*, in particular, reflected participants' unprimed associations to the construct. Participants' responses illustrated varying elements, suggesting that most individuals had their own personal definitions of the word. Among those who were attempting to formulate their notions of the concept in the moment, individual differences also emerged. Notably, some of the participants mentioned all three of the subtypes of courage, fewer, only two, and far fewer still, only one.

In Geller's (2014) terminology, everyone holds a "private theory" of courage that is individualized beyond the dictionary-denoted definition. In broad strokes, therapist participants in this study described courage as bravery, taking risks, facing opposition,

making the judgment that something must be done, and doing so because the action was right, noble, and good. One participant expressed his definition of courage:

> Well, I guess it's - in a lot of ways, courage is sort of like bravery, but I see it as a really more tranquil cousin of bravery. It's something that has to do - I always think of course, you know breaking down the word - that it has to do with having heart. And having some sort of sympathy or love for the world.

Courage was seen as tied to religious faith, spirituality, morals, and/or personal values. Each therapist represented courage as a unique combination of these fundamental "ingredients."

As the interview unfolded, participants' private theories began to unfold as well. As was stated earlier, one quarter of the therapists in this study revealed that they had not previously subjected courage to conscious thought, much less as a specific factor in their practice. However, one participant reflected the sense of many that "mental health professionals don't typically think about this kind of narrative, this kind of language, and I think retrospectively being courageous is a foundational component of the work." This notion lends further support to Geller's theorizing that individuals in general and psychotherapists in particular develop private theories of courage that unconsciously or preconsciously exert influence over their actions and clinical practice (Geller, 2014).

Also in concurrence with Geller, the therapists in this study conceived of courage as subjective in nature and intimate to one's own experiences. One participant summarized this belief by stating, "an act of courage is any action that flies in the face of things that for that particular person are terribly scary, or frightening, or chaotic making -

it's remarkably subjective." Courage was viewed as having many types, in varying degrees, and depending upon the specific fears and values of the individual. Such individual differences are emphasized in Geller's (2014) theorizing that bravery, boldness, and fortitude vary in intensity in relation to the individual and the situation. Accordingly, therapists identified a wide range of personal models of courage. Those cited in domain three, *Models of courage; prototypical instances***,** most often included close family, friends, and colleagues, as well as historical and political heroes, those with claims to newsworthy courageous acts, and literary figures. The participants also lauded single parents, those struggling with mental or physical illness or having children with these struggles, immigrant successes, and survivors of violence and discrimination. Some also named their younger selves as models for courage.

In the context of therapy, participants provided multiple reasons for electing their heroes. Therapists were recognized as courageous when taking on roles that confronted authority, advocated for their patients, and exhibited activism in the pursuit of improving mental health or defending human rights. Exploring new ideas, particularly that went against the grain of the field and conducting one's work with honesty and compassion was also held in high esteem as courageous. Importantly, beginning therapists were highlighted for all of these roles, and for their bravery in embarking on something new, fortitude in learning and leading the complex processes of psychotherapy, and the boldness to learn to speak even when they often do not feel like they know what to say. These findings compliment the acknowledgment by beginning therapists themselves, across demographic categories, that therapy demands a great deal of boldness to manage

suicidality and self-injury and fortitude to tolerate patients' negative feelings and bear witness to suffering (Geller et al., 2014).

Despite the elusiveness of a universal conceptualization or chosen exemplar, participants also emphasized the role of courage as a part of the human experience for all people in ways both great and small. Several participants expressed the sentiment referred to by one therapist as the existence of "the courage of everyday things." In the context of psychotherapy, another held that,

> Therapists' courage is a much more subtle, private thing that much more often occurs in a consultation room; courage is a very individual person-by-person experience and I think any good meaningful long-term therapy is going to require courage on both the patient and the therapist's part.

Though courage was viewed with a high degree of consensus as subjective, personal, and not often verbalized, it was considered of special importance to the human condition and therefore to psychotherapy. Further, participants made reference to each of the three subtypes throughout the interviews, discussed in turn in the following sections.

Fortitude. The second domain, *Associations to the concept of courage in psychotherapy*, produced categories for bravery, boldness, and fortitude respectively. Within this domain alone, 62.5% of participants mentioned fortitude, 62.5% mentioned boldness, and 31.3% mentioned bravery.

Employing known synonyms of fortitude, therapists discussed "hanging in there," "perseverance," and "endurance" as required in long-term and challenging treatments. They named complex problems, systemic injustices, raw emotions, and particularly the

hopeless feeling that they were endlessly stuck or failing to make progress with a patient as requiring fortitude. The frustration and skill demanded of them in these processes was well documented. One participant acknowledged that,

> There are people that we work with that need real feedback and interaction based on how they're behaving in the moment and we have to find a way to address that and to do it effectively without scaring the person or without triggering defensiveness, and to figure all that out in a split second in the moment.

Fortitude was found in intensive months- or years-long therapies, as well as in moments requiring "sitting in silence" or in tolerating the anxiety of waiting for a patient's narrative. Also held in high regard was the fortitude to persist through "having gone through something difficult with a patient," which is descriptive of most any treatment.

Boldness. Boldness typically was expressed by participants in the forms of "saying something that the patient doesn't want to hear," "being more direct," and "confronting somebody's rage" or other strong emotion. "Saying what needs to be said" was seen as very valuable. This sense persisted despite descriptions in later domains of fear and anxiety as the most common feelings involved in courageous acts—therapists overwhelmingly feared hurting, shaming, angering, or damaging their patients. However, being bold in the face of these significant interpersonal, personal, and professional risks was seen as beneficial and necessary. One therapist explained the delicate balance to the "art" of psychotherapy:

> Part of the therapist's role is to help patients avoid less so they can experience life more, to really find their own voice and their own

> authentic self, a process that requires a lot of courage. A courageous therapist oftentimes is to be a challenging therapist and not always to be complacent with the patient's dynamics.

Participants offered that even boldly "breaking rules to accommodate patients," or pushing professional boundaries might be indicated in the service of treatment progress.

A comparison between the first and second domains reveals the special place of boldness in therapeutic practice. When reflecting upon their associations to courage, participants typically spoke of fortitude and bravery, and when reflecting on their associations to courage in therapy, they began to also frequently discuss boldness. The Tri-Part Model incorporates the idea that while bravery and fortitude are primary definitions of courage, boldness becomes specifically more salient in the context of psychotherapy (Geller, 2014).

Bravery. Nonetheless, bravery was also considered to be an active force in the therapeutic relationship: "we are brave with our clients, this is just part of what we do as clinicians." Bravery was also described as "having guts" to work with patients across the gamut of presenting problems. One participant stated that "very disturbed people, suicidal, homicidal, chaotic, violent personality functioning demands a certain kind of short-term courage which is different from long term work with a very difficult patient." This response brings to life the numerous therapist experiences that can demand physical bravery. The frequencies of responses compliment Geller's hypothesis that fortitude and bravery would be more often cited than would bravery, as bravery in the psychotherapeutic context is most reserved for moments of physical risk and intervention (Geller, 2016).

In sum, once subjected to intentional conscious analysis, therapist participants revealed that their private theories evoke the three subtypes of courage.

Expressions of courage: Authenticity, vulnerability, and staying present. Two other themes in defining courage were derived from interview content, appearing across domains and genders. The first was the power of maintaining an authentic and vulnerable attitude. In fact, nearly half of participants explicitly used the terms authenticity and/or vulnerability to describe the most important expressions of therapist courage. One therapist described courage as "being more transparent, being more authentic about oneself and one's core feelings." Another participant emphasized the intention "to be authentic and spontaneous and careful all at the same time, I guess that's a version of courage, you have to really trust yourself."

Rogers (1957; 1959) described six conditions necessary to bring about therapeutic change using a person-centered approach. One of these conditions is "therapist congruence or genuineness." Such genuineness is achieved by the therapist involving him- or herself carefully, thoroughly, and honestly in the work. The therapist draws upon personal experiences, thoughtfully makes self-disclosures, and remains congruent within interactions to build and deepen the relationship, all of which bears a striking resemblance to participant narratives about being authentic with their patients. Likewise, much research, particularly in the field of relational psychotherapy, has determined the importance of authenticity in the therapeutic process to develop mutual empathy (Walker, 2004) to facilitate movement in relationships (Miller, et al. 2004), and for patients to feel a sense of genuine care from their therapists (Schnellbacher & Leijssen, 2008).

With regard to vulnerability, one participant described "the ability to try to remain connected to your inner life and connected to people around you in the face of all kinds of things in life that can serve to terrify us." Another viewed vulnerability as "being present, breathing, being as aware as one can of everything that's going on intrapsychically and interpersonally." Their responses reflect an intentioned willingness to identify, acknowledge, and accept patients' and their own feelings of vulnerability including having an awareness of multiple internal and bidirectional influences in the moment and in facing things that make them afraid. Their fears, specified in several domains, identified preoccupations with physical and emotional violence, concern with harming patients, and despair over the lack of potential for treatment progress.

The sources of vulnerability can be inferred from Shapiro and Gans' (2008) findings for group therapists. Errors, unconventional choices, managing personal crises, confronting negative emotions in oneself and others including hate in the countertransference, and ambiguity were identified as the five themes of therapist courage. These theoretical themes can be conceptualized as fear-based and fortitude-based sources of vulnerability (Geller, 2016).

The findings also complement Brown's (2012) assertion that "vulnerability is our most accurate measurement of courage." In her thinking, vulnerability is not a weakness, but rather she conceptualizes vulnerability "as emotional risk, exposure, uncertainty." Winnicott (1965) indeed argued, "I guess that the well-behaving professional analyst is easier to come by than the analyst who (while behaving well) retains the vulnerability that belongs to a flexible defense organization" (p. 160). In Geller's terms, this flexibility resides in maintaining a balance of the ebb and flow of boldness and fortitude (2014,

2016). Fortitude encapsulates the incertitude of being vulnerable, and sustaining an ongoing authentic, best-interest orientation toward the patient as a witness to his or her narrative. And boldness is summoned to address the requisite emotional riskiness of embodying authenticity and vulnerability.

The second recurring theme that appeared when defining courage was that of staying present, which was characterized by connecting deeply with others, remaining focused on the present moment, and putting others' needs above one's own. Mindfulness was seen as one way to achieve this therapeutic stance including, "using mindfulness to tune into the connection and whatever my experience is in a given moment, to try to deepen my understanding of what's happening in the work." S. Geller & Greenberg (2012) describe staying present:

> Therapeutic presence is the state of having one's whole self in the encounter with a client by being completely in the moment on a multiplicity of levels — physically, emotionally, cognitively, and spiritually. Present therapists become aware of both their own experience and that of their client through bodily sensations and emotions, and this awareness helps them to connect deeply with the client. Therapeutic presence is not a replacement for technique, but rather a foundational therapeutic stance that supports deep listening and understanding of the client in the moment (from cover).

It was also made clear by participants that there is an inherent difficulty and courage in maintaining this position: "being a good therapist means first and foremost being as present as we can be – it's not always easy, there are always a variety of internal and

interpersonal forces pushing us out of the moment, and to be as open as we can be to the moment takes courage." Remaining present again calls upon a dedicated sense of fortitude in which the therapist must persist in facing that which is psychologically frightening, boring, distracting, or upsetting (Geller, 2014).

The opposites and negative alternative constructs to courage, then, were seen as occurring in moments in which therapists could not hold onto authenticity, vulnerability, and being present. Content of several categories in domain one, and that of domain ten, *Disavowal of courage for alternative Constructs***,** included eschewing controversy, working in ways that were "ordinary" and "rote," and tipping a balance towards narcissism. One participant explained that "there are some clinicians who are courageous in a way that may seem irresponsible or 'out there,' but I'm not sure I admire it." Those who lack sensitivity and humility and exhibit bravado were excluded from many participants' perceptions of what it means to be courageous and in some cases bravado was even regarded as cowardice.

The positively framed alternatives to courage included a sense of being appreciated, admired, respected, and encouraged by mentors, and a sense of gratitude, safety, and holding as expressed in a myriad of ways by patients. Interestingly, some participants were adamant that the quality that they were describing was *not* courage, and yet they chose instead its primary dictionary definitions (and Geller's subtypes) of fortitude or boldness. It is possible that participants preferred at times to allude to courage using terms they viewed as distinct rather than own it because, according to Geller (2016), this would be considered too "self-congratulatory" or "immodest" (p. 4).

Far more prevalent than active disavowals of courage however, were narratives that educe Geller's formulations of bravery, boldness, and fortitude. As such, despite a diversity of responses, participants held some shared consensus of the nature and meaning of the larger construct of courage. This section has meant to synthesize the characteristics of therapists' expressed private theories of courage and their impact on their own courageous practice.

Research question 1: Summary of findings. In summary, the experience of courage specific to psychodynamic psychotherapists appears to be one that is not initially considered in a conscious or deliberate way by the therapists themselves. However, once prompted to delve into their associations to, models, and prototypical instances of courage, and their sense of being experienced directly and indirectly as courageous or not, therapists generated rich personal narratives of their private theories of courage. The two most prominent expressions of therapist courage were defined as exhibiting authenticity and vulnerability, and staying attuned and present in the moment. Overall, therapists conceived of courage as centering on elements of bravery, boldness, and fortitude.

Research question 2: What are the perceived clinical triggers or situations that require courage? The narrative content of five domains encapsulates this central question. Situations requiring courage were examined in the domains of a) *Therapeutic situations that require courage*, b) *Situations that intensify the risks and difficulties of doing therapy*, and c) *Times when I felt less than courageous,* and triggers for courage were examined in the domains of d) *Factors influencing the ability to be courageous* and e) *Feelings involved in courageous acts*.

Findings indicated the following conclusions. Situations that require courage fall into two broad clusters: those that relate to patient presentations including a range of psychopathologies, trauma, and violence, and those that relate to therapeutic processes in the forms of therapist use of self and bold confrontational techniques. Perceived clinical triggers of courage consist of factors that enable or obstruct a courageous response, and of concomitant positive and negative feelings states.

Therapeutic situations requiring of courage. Geller (2016) writes, "I believe a therapist's power to serve as an agent of change expands or contracts in proportion to his/her felt readiness to do the work of therapy courageously" (p. 1). In the fourth domain, *Therapeutic situations that require courage*, therapists detailed moments in which they manifested such readiness, and later domains identified those in which they were unable to mobilize the necessary courage.

Patient presentations. Two clusters of therapeutic situations that call for courage emerged. The first centered upon patient presentation. There were several types of patients and types of cases that therapists named as requiring of courage. Most discussed were patient axis I and axis II pathology and histories of trauma.

At the time of the interviews conducted for this study, the American Psychological Association (APA) had directed its focus to what Geller (2016) refers to as "high risk patients." He identifies the typical stressors adopted by therapists that are caused by these patients:

> The APA Insurance Trust's calculations indicate that therapists face an increased risk of being sued or accused of ethical violations when they provide psychotherapy to patients diagnosed with severe personality

> problems, have complex PTSD, have been abused as children and present a serious risk to harm themselves, and who use romantic seduction as a consistent strategy to express affection or closeness (p. 2).

Participants in this study named each of these diagnostic categories as requiring therapist courage, and they expressed a pointed awareness of the risks they incur by treating such patients. These included issues around termination or referring out, fees and policies, and case management duties, all of which can be magnified by the dynamics of high risk patients.

Therapists identified a wide range of pathologies that carry risk, from working with someone who was "biologically depressed," to a patient suffering with hoarding, to those who are physically violent. One participant described being physically in danger with a patient:

> It's doing something for yourself and taking a risk even when it might harm the treatment, and working patient through extreme states, like with a patient on minimal medication who was very psychotic and delusional. He had three psychotic regressions during treatment and wanted to kill me because I became the embodiment of his mother.

Violence and intimidation by patients was also spoken in terms of threats of lawsuits, bullying, property damage by a baseball bat, fears of retaliation by abusive spouses, and even patients brandishing loaded guns.

Patients with severe trauma histories were seen as particularly in need of a courageous therapist, and often more so than those prone to violence, perhaps given the

fragility of the traumatized patient and the depth of suffering that these backgrounds entail. One therapist elucidated:

> Work with a woman with trauma and really getting into the details of what happened, navigating this together, and worrying that I pushed her too soon or that I'd fucked up and feeling uncomfortable, it turned out to be very helpful. With people who've been traumatized I think both people have to be courageous to be willing to walk through some stuff.

Relatedly, participants also named presenting problems that frequently are comorbid with trauma including sexual material, sexual abuse, suicidality, and homocidality as especially difficult situations that necessitate courage. Further, work with court-mandated patients (and the possible need to testify in court), and the complicated dynamics of group and couples' therapies also were seen as situations of higher complexity and risk, and therefore more requiring of courageousness on the part of the therapist.

Relevant to all of these diagnostic profiles, Geller (2016) states, "I credit psychotherapists with the epitome of fortitude when they take on the responsibility of caring for patients with incurable illness and chronic diseases that cause increasing disabilities and great suffering" (p. 12). The pathology most described by participants was chronic in nature, and therapists recognized the burden of persisting through these treatments. When the patient's presentation or the processes of the work becomes too difficult, several therapists indicated that acknowledging a need for help or for mentor or peer supervision are also courageous acts. Co-occurring with the fragility and riskiness to

the patient, are the risks to the therapists themselves who accept the immense responsibility for their care.

Therapeutic processes: Therapist use of self and confrontational techniques. The second cluster of situations that were viewed as requiring of courage involved two related elements of the therapeutic process: therapist use of self, and the delivery of bold interventions. The therapists' use of self in the room included the use of his or her feelings, the use of self-disclosures, and managing being the object of intense emotion. One participant described the way she incorporates herself in the process of her work as "being supportive of your patient, gently confronting and moving them forward, pointing out contradictions, bringing up avoidant behaviors, communicating your anxiety, helping to challenge them and yourself, and acknowledging a common transferential reaction." Therapists felt that courage was needed to harness one's own feelings about the patient and utilize them in productive ways. A sense of being attuned to oneself in the moment is also reminiscent of the boldness and fortitude of authenticity, vulnerability, and grounded presence that were so central to participants' larger definitions and private theories of courage.

Such attunement also facilitates boldness of intervention, the second process-oriented type of therapeutic situation that calls for courage. Therapists frequently described the need to deliver interventions that a patient does not want to hear. This knowledge was derived from intuition and interpersonal cues, with the therapist "using" him- or herself as a barometer. One participant links these two experiences together relating the importance of "being very true to the dynamics within the room with axis II patients and exploring uncomfortable themes of setting and breaking boundaries. It takes

courage to keep bringing it to their attention and help them understand their impact on other people," including the therapist.

> According to Geller (2016), a bold therapist is more likely to:
>
> 1) Explore patient conflicts that are expressed in absences, cancellations, repeated threats of termination, unpaid bills, and their efforts to gain control over the temporal arrangements of therapy, 2) try new and unfamiliar approaches to therapy, 3) provide patients with unsolicited feedback about how they alienate or antagonize others, 4) ask deep and probing questions about the intimate details of their lives, 5) use self-disclosure as a therapeutic technique (p. 11).

His description is strikingly similar to the spontaneous responses of the therapists in the present study. This is because boldness "offers a valuable way of thinking about a therapists' felt readiness to risk using confrontational techniques, and his/her responses to the ambiguities posed by the improvisational and unscripted aspects of therapy, of which there are many" (p. 11).

Other situations in therapy that inform our understanding of courage. In analyzing the therapeutic situations that participants named as requiring courage, it is also valuable to examine domain seven, *Situations that intensify the risks and difficulties of doing therapy*. It is notable that the therapists described many scenarios that certainly sounded courageous, but were placed in this domain because their courage was only implied, not stated outright. These situations included, just as above: axis I and II diagnoses including histories of trauma, issues of suicidality, complex and difficult

problems, the loss of a patient through abrupt termination, and the presence of physical violence.

New however to this domain were identified moments of emotional violence, labeled as such. An example given was a patient "psychologically harming" a therapist through stalking behaviors, causing her to "smash a gift" because "I was really scared that it had some sort of recording device in it." Other examples included a case of intense sexual masochism, a physically large, angry patient, and the emotional violence in family sessions. One participant also described that a "classic 'hysteric' patient scared me emotionally because I felt like I was getting pulled into things all over the place and not as in control as I usually like." Working with an emotionally violent patient draws upon two of the subtypes—the boldness to confront unhealthy dynamics, and the fortitude to endure the process.

Each of the situations mentioned in this domain certainly contain inherent risk and challenge, and could easily be appraised as requiring courage. Nonetheless, the participants did not explicitly assign courage to themselves in their accounting of events. Geller (2016) notes that it is not uncommon for an individual to disavow courage:

> There are several reasons why a person may not perceive himself/herself as courageous, even if the world agrees that he/she performed an act worthy of being called courageous. There are individuals for whom it is an alien or new idea to think of themselves as having acted courageously (p. 4).

While it may be that therapists believed that these circumstances did not demand courage, it is altogether possible that out of humility or novelty participants were hesitant to

ascribe courage to themselves. Alternatively, they may have felt that the call for courage was implicit in their accounts.

Likewise, material from domain nine—*Times when I felt less than courageous*—can be interpreted as alluding to situations that required courage that the therapist simply could not produce. Most prevalent were descriptions of moments of avoidance. These were attributed to the difficulty of the situation, the therapists' internal states and preoccupations with hurting their patients or worry about personal problems, and moments in which they simply lacked the energy or understanding to be courageous. Some therapists also believed that mistakes, including those linked with avoidance, that they had made represented failures of courage. One therapist explained that, "with a long-term female patient in analysis, in hindsight it was clear that we were acting something out, I wasn't setting boundaries in a proper way and would go along with something for the sake of ease or lack of anger." Another participant shared an instance where, "I let it slide today because I just didn't have it in me to muster up what I thought was necessary and plus he was in pain and I said 'well, we'll get to this next week.'" At times, avoidance was also attributed to gender dynamics such as women feeling silenced by men, or was manifest in faltering in enforcing policy issues. In addition, participants detailed that fear of certain patients' physicality, psychological profile, or interaction style was a force that deterred them from summoning a courageous response in a moment that they believed had called for one.

In sum, situations that require courage were characterized by patient psychopathology and dilemmas inherent to the therapeutic process, including using

oneself as a tool, making bold interventions, and resisting therapist avoidance. I will now outline the perceived clinical precipitants of courage found in this study.

Triggers of courage in psychotherapy: factors and feelings. The clinical triggers of courage in the context of psychotherapy fall into two dimensions: the *Factors influencing the ability to be courageous* (domain five) and the *Feelings involved in courageous acts* (domain six). The influencing factors are best understood when further divided into two types: factors that enable courage, and factors that serve as obstacles to courage. Similarly, feelings were best considered in terms of their positive or negative valence.

Factors that enable and obstruct courage. By far, the primary factor that therapists believe enables them to be courageous is experience. For one therapist, many years of experience allows her "to trust my instincts because I've done things frequently enough to know when a risk is worth taking and when it isn't. And you feel more comfortable because you have seen dynamics over and over." Training was seen as the foundation to all of this knowledge that the therapists draw from in their current work. Several participants subsequently mentioned their sense, oftentimes gained during the course of the interview, that courage should be incorporated into the curriculum of clinical training. Geller (2016) emphasizes the role of courage in one's assessment of which intervention to make in a given moment, particularly when inexperienced: "my supervisees tell me that they find it useful to think about the approach - avoidance conflicts that arise when faced with the uncertainties and ambiguities posed by these questions from the perspective of the concept of courage" (p. 2). Because the therapists in this study expressed such a strong reliance on experience to allow them to be

courageous, it follows that an early introduction to courage may better prepare students for their future work.

The therapists in the present study, ten to forty years into their careers, also described their obligations to their patients, both personal and professional as pushing them to be courageous. This was described as "owing" something to a patient, "not having a choice," feeling "moved" and like the individual's voice "needed to be heard," and being in charge of "running the service" at a hospital. Despite their tenure, their sense of duty extended to seeking additional help and outside support when they were struggling to be courageous with a case. Outside supports took the forms of entering analysis, seeking out colleagues or family members, hiring private supervision, accessing literature and research resources, and relying on spirituality and religious faith.

However, it was internal qualities and strengths rather than external supports that therapists found most enabling of their courage. Each represented recurring themes across multiple domains, and related directly to the participants expressed private theories of courage. The first was the ability to be present and self-aware. Within the current domain, one participant described a strong alliance with a patient that led to "shared courage." Another described a meditative way of navigating stuck points with a patient's mother whom he found "repetitive" and "boring," reminding himself to "enjoy what's occurring in front of you and to think about it as something brand new that has never happened, because it is true, it has never happened before." A second repeated theme of this domain was having fortitude. A participant shared that "with the male patient it was a willingness to be scared and be okay with that, but while feeling still engaged with him, and to be able to sit with the fear and not pull away or back away from him."

Many participants also discussed a predisposition towards a personality that lends itself to being courageous, described by one participant as “being willing to go to an uncomfortable place yourself.” Others felt that they had gained these traits and the ability to be courageous through painful experiences within their own families of origin. Nemas (2014) writes that indeed “courage is a necessary quality in the personality of the analyst and is, in my view, a component of the analytic attitude.” Geller (2016) concurs: “courage is worthy of being included in our growing inventory of ideas about the personal characteristics of highly effective therapists” (p. 1).

Juxtaposed to these courage-triggering factors, were several named obstacles or deterrents of courage. The factors that made therapists unable to respond courageously matched their descriptions of their less than courageous moments described previously. Recall that these were characterized by avoidance, perceived mistakes, and feelings of fear. In the present domain, fear and doubt were among the most powerful obstacles to courage. One participant cited the "fear of not being liked, of patients’ reactions, and of the inner world of patients." Others discussed doubting their competence, doubting the opinions of their supervisors, and “naiveté,” ignorance, and “not knowing what to do.”

Participants also noted that at times their own personal issues or self-care needs interfered with their ability to be courageous at a given moment. They spoke about avoidance due to illness, fatigue, and the worry and distraction of family problems. At times, therapists also acknowledged that they were acting in self-interest in protecting their reputations or running their business, or for self-promotion purposes such as “trying to be acknowledged by others,” or by doing something that “doesn’t necessarily feel like it’s in the best interest of the work.” Similarly, therapist-patient dynamics were often

raised as hindrances to courage. These included gender and power dynamics, and managing potent transference and countertransference processes. Such dynamics were mentioned both as obstacles to courage and as creating therapeutic situations that require a courageous response.

Feeling states as triggers of courage. The second dimension of clinical triggers of therapist courage captured positive and negative feelings. First and foremost, participants were aware that preceding, during, and following an act of courage was often a presence of anxiety, fear, unease, or pain. One participant identified a sense of "discomfort, feeling bad about what the patient is going through, and you know, clearly not sure that it's the right path, and you're nervous about the unknown and have a lot of self-doubt." Others described feelings of "over-exposure," "tremendous anxiety," "shock," "skepticism," and "apprehension."

Fortunately, the resulting feelings after completing the courageous act were overwhelmingly positive including relief, pride, satisfaction, and a feeling of authenticity. A participant summarized: "acting courageously provides a release from bad feelings such as fear or doubt in your competency and a return to a sense of well-being." This spectrum of positive and negative emotions was revealed to not only accompany acts of courage, but to directly contribute to one's ability - or inability - to be courageous.

Geller (2016) offers an explanation for why the factors and feelings reflected in this study are expected associations to moments of courage:

> Experientially courage is almost always preceded, accompanied, and followed by simultaneously operative positive and negative feeling states. When attended to by deliberate introspection the feeling aspects

> (phenomenological properties) of courage are usually embedded within a network of co-occurring dispositions and moral judgments (standards) by which we measure our self-worth (p.9).

To act courageously stimulates ego ideals and deep psychological needs to be worthy and good. Failure to do so in the many risky therapeutic situations that call for courage lead to concern about the treatment trajectory, but also to negative self-appraisals. Achieving a courage act therefore is facilitated by one's personal qualities, skills, and supports, and results in boosts in self-worth and positive feeling states.

Research question 2: Summary of findings. In summary, the therapist participants identified a multitude of therapeutic situations that require courage. These included patients' pathology as well as the process-oriented influences of therapist use of self and use of bold confrontational techniques. Risky situations that were not formally assigned the label of courage were also examined, as many carried an implied sense of courage in the face of significant challenges. Similarly, an exploration of the moments in which therapists felt like they had lacked courage were analyzed as situations that had required courage that the therapist could not offer at the time. With regard to perceived clinical triggers, negative emotions, avoidance, and outside worries and responsibilities were revealed to obstruct courageous responses, while experience, internal strengths including fortitude, and positive emotions were seen as factors that impacted self-worth and facilitated courage.

Research question 3: What do therapists do to promote courage in patients? Material from domain eight, *Clinical interventions that promote courage*, addresses this primary question. The results indicate that therapists rely broadly on four types of

interventions to promote courage: 1) validation, reinforcement, and normalization; 2) confrontational techniques and boldness; 3) modeling; and 4) skills building.

Validation, reinforcement, and normalization. Endorsed by over half of the participants, the most common forms of promoting courage by far were those that are common in therapies in general: validation, reinforcement, and normalization. One participant described the way in which utilizing these methods to enhance her patients' courage is an identified, intentioned goal of hers:

> Well I think it's just a lot to do with supporting them and recognizing their strength and telling them about it. I think it's a big part of therapy actually, is noting moments of courage and strength and making sure that gets owned as well as what the difficulties are.

Results echoed Geller (2016) who writes that "calling someone courageous is a sign of deep respect in our culture and consequently attributing courage to a patient can strengthen his/her self-esteem…being told they are courageous by their therapist whom they trust speaks honestly is a 'corrective emotional experience'" (p. 4).

Further, Geller emphasizes that a goal of therapy should be promoting the leading of a courageous life:

> I want my patients to lead courageous lives… Towards this end I encourage patients to view themselves as courageous. On the one hand I look for opportunities to tell patients they are courageous. And on the other hand, I confront patients with the ways they avoid doing the things they would be doing if they were more courageously facing and dealing with frightening aspects of patienthood" (p. 3).

Therapists in this study described similar opportunities to reflect, "congratulate," "encourage," "support," and "honor" courage in their patients. They also aimed to "normalize intense affect for people" and "recognize the goodness in their natures, and that they can be who they are, because who they are is generally good."

Confrontational techniques and boldness. A second technique for inspiring courage in psychotherapy patients was therapist boldness. This is consistent with the latter part of Geller's strategy for encouraging patients to lead courageous lives, and with the material previously described with research question two as one of the primary ways to manage difficult therapeutic situations. Boldness was manifest in confrontational techniques in therapists' work with defenses, frequently described as "pushing," "confronting," and "challenging" patients in an effort to catalyze courageous change.

Geller (2016) writes of work with defenses in similar terms to those expressed by participants: "the most challenging means of strengthening the courage I am calling boldness is by confronting patients with what analysts called patients' 'resistances' and DBT therapists call 'therapy interfering behaviors'" (p. 4). Courage was viewed as a way to become unstuck or to cause the cognitive dissonance needed for a patient to attempt something new and break unhealthy patterns in his or her life. One participant explains aims to "help them to change the internal balance between safety and pushing themselves. If you can help them see how stuck they are if they're not courageous, you don't really have to cheerlead for courage anymore, they get there on their own." With bold therapist guidance, patients are confronted with the task of trying to re-frame their current situations and fears and become more aware of their problematic dispositional tendencies.

Modeling. Next, therapists described promoting courage by functioning as models themselves. Participants regarded modeling as an intervention that allows patients to witness and experience courage in ways that hopefully will translate into their own beliefs and actions. A participant described this process as acting as a "living model," and another expressed that "sometimes by my acting courageously, it can be empowering for me and for them."

This process occurs per Geller (2016) through interpersonal transmittal. He writes, "fortitude as experienced permeates a patient's being by way of emotional contagion, and registers on a patient's body in the form of somatosensory reaction that may not be brought into focal awareness" (p. 14). Further "the non-defensive way in which therapists endure being accused of empathic failures, mistakes, lapses of caring and concern, offers patients a model to imitate" (Geller, 2016, p. 14). In other words, courage in therapists begets courage in patients.

Skills building. In addition to the more biological, vicarious technique of modeling, therapists described ways in which courage can be taught or practiced through skills building. One participant shared his work in a program for children with histories of abuse, conducting "self-defense and karate with kids who were physically, sexually abused including breaking boards and writing something about being courageous on them, as well as changing body posture by walking around the room bigger to feel stronger."

Other interventions were more cognitive-behavioral in nature as a participant described working on:

> Concrete things, such as help them to identify a downside, worst case scenarios, catastrophes, the terrible things that can happen, and help them to imagine those things and to decide whether or not they feel they could survive that imaginary experience were it to be real.

These instances serve as exposures that approach the possibility of following through with a courageous act in the real world. By way of this exercise, the patient's ambivalence towards pursuing a goal courageously may be diminished.

The notion that courage can be developed and deepened is an exciting one for the many patients who would benefit from being more actively courageous in the face of hardships and transitions. Geller (2016) writes:

> I find that encouraging patients to view themselves as courageous bolsters their belief that they are capable of producing desired effects and achieving their goals however difficult and elusive they may be… strengthening patients' access to fortitude enables them to better tolerate the suffering caused by objective circumstances that cannot be changed…" (p. 4).

Promoting courage in general and fortitude in particular boosts a sense of potential mastery and provides the patient with the ability to acknowledge and rise above his or her circumstances.

Taken together, findings suggest agreement with Geller's (2016) assertion that "the concept of courage offers a unique and valuable perspective on questions that are of vital concern to therapists of all theoretical persuasions" (p. 2). Among the present sample of primarily psychodynamic therapists, most named additional influences

including relational, eclectic, family systems, AEDP, mindfulness, interpersonal, CBT, object relations, existential, and humanistic approaches. Despite the differences in the theoretical underpinnings of their work, therapists' narratives reflected surprisingly similar clinical interventions to promote courage in their patients.

Research question 3: Summary of findings. In summary, therapist participants resonated with a guiding therapeutic goal of promoting the leading of a courageous life. The use of courage was identified to occur in many instances by way of the most well known interventions used in psychodynamic psychotherapies: validation, reinforcement, and normalization; confrontational techniques and boldness; modeling; and skills building.

Research question 4: What distinctions exist between male and female psychodynamic therapists in their experience of courage? The final guiding research question of principal interest to this exploratory study concerned gender differences, which were assessed and found across all ten of the study domains. A central hypothesis was that male therapists would align with bravery and boldness as more masculine forms of courage, and that female therapists would align with the more feminine form of fortitude.

An integrative summary of material across domains suggests of the following conclusions. Women and men differ in significant ways in their experiences and expressions of courage. Women's orientation towards courage is interpersonal in nature and more fear-based, while men understand courage as a set of abstract, depersonalized principles that they relate with existential anxiety and express most through boldness. Both genders evoked the three subtypes of courage. Fortitude was the prevailing subtype

of courage for across genders indicating that it is a primary facet of therapists' definitions of courage. Bravery and boldness appear to be aspirational qualities for women, and fortitude to be an aspirational quality for men.

Courage as experienced and expressed by women. When the data was separated by gender, general categories for women emerged in four domains.

First, among this sample women highlighted political figures as their primary models of courage. The introduction to *Profiles in Courage* reads: "a nation which has forgotten the quality of courage which in the past has been brought to public life is not as likely to insist upon or reward that quality in its chosen leaders today—and in fact we have forgotten" (Kennedy & Nevins, 1964, p.1). The female participants in this study did however honor this quality. They cited the courage of Nelson Mandela, Golda Meir (the first female prime minister in Israel), Edward Snowden, Barack Obama, Hillary Clinton, Martin Luther King Jr., and Robert Kennedy. The women related a respect for politicians for their prototypical instances of activism, including "standing up to so much negative scrutiny," and "putting themselves in the line of fire for all kinds of vilification and criticism." Men in this study tended more often to cite other public and literary figures, such as Stephen Hawking, the characters from the book *Die Alone*, Lord Jim and comrades, Pierre of *War and Peace*, Neil Peart (drummer of the band Rush), Bill Russell and Jim Brown (both athletes who spoke against racism in sports). They appeared to value grit and toughness more than political advocacy.

The heroes chosen by participants and the rationale behind them imply that men and women use these figures as role models and in them seek an increased sense of "felt resemblance" (Geller, 2016). Geller refers to Bandura's work on imitative learning and

the relational acquisition of developmentally appropriate skills (see Bandura (1965) for a review) to understand this process. Through identification with and imitation of his or her most cherished courageous models, an individual too begins the developmental acquisition of courage (Geller, 2016).

Women's value of activism, advocacy, and standing up for what is right, is the psychological analogue of politicians as a category of people. Politicians seek to bring about social change based on their principles, and female therapists may internalize this private theory of courage by way of wishing to emulate their models. Similarly, that men would highly regard athletes is in line with Geller's (2014) predictions about whom men's and women's role models would be. The Tri-Part Model recognizes that there are many synonyms available for each of the subtypes of courage, and constructs such as toughness, heartiness, and grit—often related to athletes and literary characters—are all masculine versions of fortitude (Geller, 2016). Just as for women, men's admiration of these traits formatively catalyzes the development of their own personal, internalized conceptualizations of courage.

The second and third domains that reflected general results for women regarded the factors and feelings that influence the ability to be courageous. Women expressed a greater reliance upon experience and training than did men. Further, women were also more likely to discuss fear and doubt, concerned with "the fear of not being liked," being inexperienced, feeling "torn," and at times a fear of "the inner world of patients." Though men related less fear than women, they described higher rates (at a general frequency) of anxiety, discomfort, and pain as related to courageous actions.

Geller (2016) analyzes these differences first by differentiating fear from anxiety.

Philosophical writing has long considered existential anxiety as a human dilemma (e.g. Kierkegaard, 1849/1954; Sartre, 1957; Tillich, 1952b; Yalom, 1975). While the targets of fear are based upon clear and observable threats, existential anxiety is object-less. Further, Tillich (1952b) identified three domains of apprehension that contribute to existential anxiety. The first is an anxiety about the inevitability of death and one's personal fate. The second is rumination upon the emptiness and meaninglessness of life. And the third domain is guilt and condemnation, which includes angst over threats to one's moral and ethical identity.

The women tended to fear specific risks of physical violence more so than men, and they were more comfortable expressing fear in general. By contrast, admitting fear stereotypically calls one's manhood into question, which might explain why men more readily acknowledged more amorphous, existential anxiety and apprehensions. Geller (2016) also links the men's unwillingness to confess specific fears with Krystal's (1979) distinction between differentiated feelings and feelings in regressed forms. In expressing anxiety that is existential and undifferentiated in nature, the men revealed more regressive, somaticized, global concerns than did women.

The fourth and final general finding for women occurred in domain eight of this study, *Clinical interventions that promote courage*, where gender differences were uncovered in three of its four categories. Women revealed that their most preferred clinical interventions to promote courage are validation, reinforcement, and normalization. They were also more likely to discuss a use of modeling than were men. The male participants preferred confrontational techniques. This suggests that consistent with gender norms, women are more comfortable with managing the interpersonal and

emotional content of relationships (e.g. Gilligan, 1995), which is expressed by female therapists through inspiration and encouragement. The male therapists resonated much more with the masculine, direct, forceful, and aggressive tones that align with boldness..

Women's interpersonally-based approach to courage is likely also attributable to the fact that the socialization process for women tends to emphasize meeting relational needs. Relational Cultural Theory (RCT) expands upon feminist ideals to account for women's strengths rather than qualities that were previously viewed as their deficiencies. Fletcher and Ragins (2007) elaborate:

> RCT calls attention to the gendered nature of mainstream theories of human growth and development, focusing not on the question of differences between men and women, but rather on the masculine nature of the theories themselves. Specifically, Miller (1976) noted that mainstream theories characterize relational attributes as feminine traits associated with women's greater emotional needs. She noted that in Western society, men are socialized to devalue and deny themselves the relational skills needed to survive psychologically, and they rely on women to provide these attributes. Women are socialized to provide these skills, usually invisibly and without acknowledgement that these attributes are needed and valuable. Women therefore become the "carriers" of relational strengths in Western society, responsible for creating relational connections for others and meeting basic relational needs without calling attention to the needs themselves (p. 378).

Women are pulled socio-culturally to "carry" the success of interpersonal relationships, and the development of these skills may well permeate their private theories of how to express courage in their lives and work. Further, Jordan (1991) holds in reference to RCT that "a new understanding of psychological development in women leads to a different definition of 'psychopathology' which ultimately necessitates a new psychotherapy…we are looking at the ways in which we diverge from traditional practice, the ways in which we use empathy, the place that mutuality has in therapy, and many more factors which are just beginning to come into focus" (p.4).

Future research would do well to examine how male and female therapists' differing pathways to coping with different fears and anxieties, and differing choices of courageous role models and interventions translate to their attitudes as therapists and imprint upon their clinical practice.

Courage as experienced and expressed by men. General findings also emerged for men that had been less frequent when examining the full sample. In addition to the finding that men associate feelings of existential anxiety with acting courageously that was presented previously, two other domains produced general results.

In the first of these domains, men tended to emphasize living in accord with purpose and values as essential to their understanding of courage. This corresponds to ancient, abstract conceptions of bravery as acting by a code that is guided by personal principles. Comparatively and with less frequency, women mentioned purpose and values as well as associations of demonstrating authenticity and vulnerability (again interpersonally-based skills) with the construct.

Secondly, men identified that the therapeutic situations that most require courage

are defined by a patient's diagnostic category. They referenced sadomasochism, borderline pathology, and seductive patients, among others. Women mentioned these and interestingly also referenced work with sociopathic patients more frequently. Along with highlighting similar diagnostic profiles to the men, the women also tended to focus more on the therapist's use of self in the room. The men therefore displayed a decidedly more detached, depersonalized, and distancing stance than did the women's narratives, which more often described a specific moment, event, or relationship that had called for them to be courageous.

These findings indicate per Geller (2016) that men tend to have more abstract, depersonalized notions of courage, while women's understanding of courage is characterized by courageous heroes and anthropomorphized categories of people. Geller also believes that this is due to cognitive style differences between women and men. He references Gilligan's (1982) understanding that women have a more immediate, concrete and interpersonal way of evaluating themselves in the moment than do men. In turn, men are more "idea-driven than person-driven," including in the representations they internalize about the nature and meaning of courage (Geller, 2016).

Gender and fortitude, boldness, and bravery. Women and men shared general findings in two domains. First, they agreed that patients with axis I or axis II pathology and/or trauma backgrounds produce situations that intensify the risks and difficulties of doing therapy.

More significantly, the second general finding was that both genders associated being brave, having fortitude, and taking risks with the construct of courage. Therefore, without a fully conscious awareness that they were doing so, many participants evoked

the three subtypes of bravery, boldness, and fortitude. Each subtype emerged as at least one category name. Results by gender amongst these unique categories are discussed in the sections that follow.

Fortitude. Four categories in this study were entitled "fortitude." Across gender, men and women identified fortitude as both a factor enabling a person to be courageous as well as a primary alternative construct to courage. Fortitude was therefore not fully recognized as one of the primary dictionary-denoted definitions of the word, a curious phenomenon that has been noted by Geller (2014, 2016). These findings suggest that people tend to separate fortitude from courage, rather than to understand fortitude as one of the fundamental subtypes that courage is comprised of. As such, if they believe that they have acted with fortitude, they may not ascribe courage to themselves when it is in fact deserved. Further, the diversity of results provides concordance with Geller (2014) that fortitude is the most complex and multidimensional subtype of courage, drawing upon at least three interrelated capacities within the individual.

Gender differences did arise, however, in two other domains. Male participants resonated more with fortitude as an association to courage in psychotherapy and as a quality possessed by their heroic models of courage than did women. One male participant expressed the presence of fortitude in the work: "I think that therapists probably have to persevere, that's a type of courage… it can be courageous to go places and hear dark things."

In choosing a name for his subtypes, Geller explored Shackleton's (1919) book *Endurance*, which detailed the leadership and fight for survival brought upon by a harrowing expedition in Antarctica. He later settled upon the term fortitude as

encompassing the quality of this endurance as well as a host of other definitions including the grit, tenacity, and perseverance described by the ancient Romans (Geller, 2014). The pattern of men's endorsement of fortitude in this study suggests that to face the existential anxiety, discomfort, and pain that they associate with acting courageously, they rely upon "the stoic stance of a Western male" (Geller, 2016, p. 16).

Boldness. Boldness was represented by two category names. Both genders associated boldness with psychotherapy with typical frequency. However, women were more likely than men to prefer boldness as an alternative construct to courage. This is compared with the men's preference for the term fortitude. The female participants also tended to name boldness when exploring their sense of having been perceived as courageous by others. A female therapist shared that she believes a colleague respects her for her "tolerance, boldness, being active in my engagement, and calling someone out on something that prior to that I have not been commenting on." Another woman explained that as a supervisor she focuses on instilling boldness by "encouraging students not to treat patients with kid gloves."

Bravery. Women also more frequently endorsed the sole titular category of bravery as a significant association to the concept of courage. As has been mentioned in pervious sections, this can be explained by Geller's (2016) characterization of bravery as one of courage's fear-based subtypes. Women, in relating fear with courageous acts, unsurprisingly also defined the construct through a lens of bravery, the courage to face physical harm. As a whole, Geller (2016) fears that women's restrictive personal definitions of courage may not serve them well, particularly in excluding some of the rich dimensions of fortitude from their thinking about courage in their lives and work.

Hypotheses and results: a comparison. Interestingly, results did not match this study's hypothesis about which of the three subtypes of courage would be most endorsed by each gender. Given the links of mothering and childbirth with fortitude in Geller's (2014) theorizing, it was hypothesized that women would gravitate more towards notions of fortitude. It was also hypothesized that men would tend towards traditionally masculine images of daring, fearlessness, and risk of death encapsulated in Geller's formulations of boldness and bravery (Geller, 2014).

Across the ten domains of this study, findings indicated instead that fortitude was highly valued by both men and women, and that women also tend to focus on boldness and bravery. Mentions of boldness and bravery, as Geller's (2016) two fear-based subtypes of courage, suggest that women are more afraid than men of both emotional vulnerability and physical violence in their work. The female participants' own responses confirmed that they did in fact endorse more fear relating to courageous acts. Further, Geller (2016) theorizes that whereas men are familiar and comfortable with physical notions of bravery and the confrontational nature of boldness, these are qualities that women seek to strengthen (Geller, 2016).

Fortitude, as the only subtype that is not fear-based, was mentioned across genders, and even further endorsed by the men. Geller (2016) posits that a sense of fortitude for women is inherent as childbirth is a natural and oft-pursued part of womanhood. He further theorizes that for men, fortitude is more of an aspirational quality like boldness and bravery may be for women, which might explain their differing emphases on the three subtypes during the interviews (Geller, 2016). Finally, the universal mention of fortitude suggests that it occupies a special role in the context of

psychotherapy.

In all, the illustrative gender differences identified in this study lend to testable hypotheses for the future in determining the intersection between courage, gender, and a host of questions related to therapeutic effectiveness.

Research question 4: Summary of findings. In summary, when a gender analysis was conducted, multiple significant gender differences emerged. Categories throughout all ten domains shifted in their frequencies and revealed that male and female therapists do in several ways differ in their experiences, and expressions of courage despite some shared conceptualizations. The present analysis suggests that in broad strokes, female therapists were more oriented towards boldness and bravery, and that fortitude was a universal leaning for both genders.

Research Questions and Findings: Overview. A composite view of the present findings indicates that therapist courage plays a nuanced, vibrant, and pivotal role in psychodynamic psychotherapies. Though many therapists had not previously subjected the construct of courage to intentioned, conscious consideration, the interview process produced notable private theories of fortitude, boldness, and bravery with some shared consensus in the midst of individual differences.

Common expressions of courage were through therapist authenticity, vulnerability, and staying present. The situations in which the subtypes of courage were manifested varied by patient pathology and types of process-oriented interventions that were appraised as potentially helpful, including therapist use of self and bold confrontational techniques. The enabling and inhibiting clinical triggers of courageous

acts were positive and negative emotional states including fear, avoidance due to personal concerns or fatigue, and experience and individual therapist strengths.

Courage was deemed not only as aspirational for therapists, but as a therapeutic goal to pursue and strengthen in patients. The tools implemented to promote the leading of a courageous life were those found to be pre-existing in the vast majority of psychodynamic psychotherapies, despite having been previously conceptualized with other language: validation, reinforcement, normalization, modeling, confrontation of defenses, and skills building.

An analytical comparison of male and female therapist participant narratives also established gender differences in their perceptions of the three forms of courage in the context of their work. Women's notions of courage were more interpersonal and based in fear, while men's notions were more abstract, depersonalized, and based in existential anxiety. Women and men also likely aspire to differing subtypes. Fortitude was more ubiquitous and additionally emphasized by men, while boldness and bravery were more salient among women.

Contribution to the Literature

The previously presented review of the extant literature on courage emphasized significant gaps. Most notably, therapist courage has not been submitted to rigorous systematic study to identify its research and clinical utility in the context of psychotherapy despite decades of psychotherapy research. The following discussion will reflect upon the ways in which the present study lends credence to Geller's Tri-Part Model and will examine the contributions of study findings towards reducing long-persisting gaps in the existing psychology literature regarding the construct of courage.

Courage as salient in therapy. The present study explored experienced psychodynamic psychotherapists' "private theories" of courage through qualitative interviews (Geller, 2016). Their narratives contribute some of the first data on therapist experiences and interpretations of courage in their work, moving such personal influences to more conscious, analyzable entry points for the study and application of courage to psychotherapy.

Geller describes the primary aim of his recent unpublished writing on courage thusly:

> …Until recently (academic) psychologists have shied from empirically studying the origins, nature, and consequences of courage. Consequently it is reasonable to assume that, in general, therapists have not systematically integrated the concept of courage into their thinking about what it means to be a therapist and to do the work of therapy. If this is true for a particular therapist then his/ her ideas about courage are likely to exert an implicit, perhaps preconscious influence on the performance of his/ her basic tasks and responsibilities. This chapter can be read as an invitation to bring to awareness one's 'private theory' about courage and it's relevance to the practice of therapy (Geller, 2016, p. 2).

Nemas (2014) concurs that "when speaking of courage, we all certainly evoke shared and private images."

At further consensus with Geller (2014), the private theories that emerged in this study occupied a spectrum of individual differences that ranged in intensity. In their own findings on the concept of courage, Woodard and Pury (2007) explain that "results suggest that types of courage are complex (threat and/or outcome based), life-domain, or

context-oriented conceptualizations. Support for a general, underlying courage is limited" (p.143). The findings of the present study were similar in that conceptions of courage were disparate, dependent upon the individual, and as predicted by Geller (2014), appeared to be often preconscious.

Therapist participants revealed that their definitions of courage, including courageous symbols, models, and archetypal instances were subjective and distinct yet also offered common elements—those of risk, a sense of purpose, bravery, boldness, and fortitude. Often, their thoughts on courage were being formulated in the moment of the interview, rather than a result of prior, mindful consideration. Yet, once they began to discuss courage in their lives and work, they resoundingly believed courage to be a highly salient force in both.

Perhaps out of humility, or due to thorough training, personality disposition, or dedication to their craft, these therapists also tended to emphasize their deep respect for the courage of their patients above their own. Hatcher et al. (2012) offer a reason why in their examination of "What therapists learn from psychotherapy clients:"

> Within this context, however, this study makes it abundantly clear that therapists are simultaneously affected both professionally and personally by their work with clients…Therapists come to value relationships that offer love and understanding, and they acknowledge the power of support and interest that a caring relationship can offer, both in treatment and in personal life. Therapists admire their clients' strengths – their courage, resilience, steadfastness, and their struggles to do the right thing, and

> therapists draw inspiration for their own lives from their clients' example (p.15).

The therapists in the present study expressed this sentiment readily and recurrently.

What the present study can add to the literature is an agreement with Geller that therapist courage is valuable to therapeutic effectiveness and the profound impact that this has personally and professionally for therapists.

The utility of the Tri-Part Model of Courage. I will now outline how Geller's Tri-Part Model can be applied to clinical practice in conjunction with the extant literature on courage.

The present study aimed to substantiate, clarify, and expound upon the references over time, though admittedly few in number, to courage as operating within psychotherapy practice. Freud and the other founders of psychology did not share their specific notions with the field of what these operations may be. Further, debate continues to exist among psychotherapy process experts on the manifestation of courageous work and even the subtypes of courageous acts. Allusions to the concept prompted the questions raised by Geller's work and in this analysis. What has emerged are the positive negative consequences of courageous action and less than courageous inaction.

The negative effects of lacking courage. The collective voice of the therapist participants suggested that there are serious consequences of "less than courageous" moments in their work. Such moments might consist of mild distraction, boredom, or lack of focus or presence, as well as more severe forms including clinging long-term to unhelpful beliefs about the treatment, becoming mired in transference and/or countertransference issues, or failing to live up to personal high professional standards.

Recall for a moment the four components of courage presented by Shelp (1984): the presence of free choice and acceptance of consequences, the presence of risk and danger, a sense of the pursuit of a worthy end, and a sense of uncertainty of outcomes.

Therapists in the present study described each component in turn. They recognized the immense responsibility of freedom of choice, and expressed guilt, remorse, and regret when they had "failed" to choose a more courageous path. They were acutely aware of both psychological and physical harm that may come to themselves or their patients as a result of a given intervention, and this was widely named as an obstructing or enabling factor to their courage. Throughout, they detailed their professional obligations towards their patients, and their understanding that a lack of courage on their part represented missed opportunities, ruptures, and pain. Lastly, more so than the other components, therapists endorsed the enormity of fear, interest, anxiety, elation, doubt, and satisfaction that springs from the inherent uncertainty and ambiguity of doing therapeutic work. Without a measure of bravery, boldness, and fortitude, they felt less able, in agreement with Geller's (2014) view, to manage the intense responsibilities demanded of them as therapists.

While, the therapist participants appeared to relish the challenging nature of practicing therapy, they also paid tribute to the toll taken on them as individuals. The tension between these two competing ideas is described by Nemas (2014):

> In this article, Meltzer discusses a guiding principle that supports the condition for practicing psychoanalysis: 'The aim is stability, the secret is simplicity, but the guiding principle, I suggest, should be 'strain,' balanced but close to the limit' (Meltzer, 1967). This idea of 'strain,' in the sense of

> effort or painful tension, evokes in me the quality of courage I discuss in this paper.

The felt sense that coasting, holding back, or in any way avoiding the courageous approach, whether in an instant or in a series of missteps that was expressed by the majority of therapists in the study speaks to Nemas' assertion. The avoidance of the underlying strain—quite reminiscent of the demand for fortitude—required of the therapist represents a failing of courage.

To add to the intricacies of applying courage judiciously, Geller (2016) believes that there are not only consequences to lacking courage in therapeutic work, but also to an excess of courageous intent. He reasons that:

> If taken to extremes, fortitude and boldness can be counterproductive. For example, overdeveloped fortitude can have an inhibitory influence of 'setting limits' on patients who are 'acting out' – e.g. repeatedly cancelling sessions, consistently arriving late to sessions, accumulating unpaid bills, and regularly threatening to quit therapy (p. 15).

The delicate balance of not overly shying away from a courageous stance towards one's patient, and letting courage overwhelm one's other forms of clinical judgment is a significant finding in this study. Therapist participants warned against recklessness, straying into narcissism, and pursuing self-interest rather than a courageous response. Geller (2016) also cautions that "even if softened by gentleness and tact techniques that confront patients with their resistances are not without risks" (16). The more that can be discovered about a healthy, productive, restorative symmetry of courage, the more clinical practice may mitigate these risks and benefit from its contribution to the work.

The positive effects of acting courageously. Beyond the positive opposites of that which was presented in the previous subsection, the present study indicated overwhelmingly that therapists subscribed to the beneficence of courage. Observable progress towards change, strengthening of the alliance, and the mastery of therapeutic goals could occur as a function of the therapists' intentioned, courageous actions. Boldness could shake an individual free of an entrenched maladaptive pattern, bravery could confront intense reactions such as rage and violence, and fortitude could ensure that the therapist would weather emotional storms and would remain despite treatment ruptures. This led many participants to elevate courage to a therapist quality that *all* patients needed and deserved.

A theme in the literature is that this is in part because a goal of psychotherapy, in Geller's terminology, is the leading of a courageous life. Woodard & Pury's (2007) refer similarly to the role of courage in achieving "a meaningful life":

> Instead, our items seem best characterized as a path to the meaningful life. Although the actions themselves are not pleasant or engaging, the purposes or goals of courageous actions–doing what one thinks is right or necessary, being true to one's self and one's beliefs, and acting for the greater good–are all components of the meaningful life (p.143).

Study results fully corroborated a sense of purpose, values, religious and spiritual faith, professional duty, and therapist authenticity and vulnerability as the founding credos of a courageous psychotherapeutic presence that would in turn promote courage in patients.

These findings also intersect with great similarity to Peterson and Seligman's (2004) edict of the merits of positive psychology. In seeking the "good life," a critical

character strength was courage, denoted by four elements. The first was bravery and valor. Present study participants, as has been described extensively, were quick to offer definitions of courage that involved physical bravery, the risk of bodily injury or death, and heroic acts to defend and protect others. In practice, bravery manifested in the face of psychosis and threats of violence. Valor, whose primary synonym is boldness, was most often described in terms of making bold therapeutic interventions despite the patient's resistances. Peterson and Seligman's second element of courage was "persistence including perseverance, and industriousness," captured within Geller's (2016) conceptualization of fortitude. Participants expressed the strain, and concerted, thoughtful effort that their work entails including being present with a response in the moment, and maintaining the prescribed endurance throughout the situation or treatment as a whole.

Thirdly, Peterson and Seligman described integrity, authenticity, and honesty as contributing to courage. Therapist participants substantively did as well, especially in their repeated mentions of authenticity and vulnerability across domains, calling for boldness and fortitude. In addition, being present was thoroughly and frequently described as another form of courage that can be difficult to sustain—requiring fortitude—and yet defines the therapist's role. Mindfulness, self-awareness, acknowledging mistakes, and abiding by one's moral and professional code are also actions described by participants that fall within this character strength.

Lastly, Peterson and Seligman theorizes that "vitality, encompassing zest, enthusiasm, vigor, and energy" are among the set of strengths that make up courage. Given that the most common enemies of courage, according to the present study's

participants, were fatigue, burn out, boredom, and avoidance, it is clear that they agreed. Participants described many positive emotions – "gravitas," "profundity," "humor," "thrill," and a sense of being "refueled" and "invigorated"—that they had experienced when behaving courageously that restored their sense of well-being, pride in their work, and just this sense of vitality. Geller (2016) differs here from Peterson and Seligman in that he does not include a representation of vitality in the Tri-Part Model—he cites the existence of "grim fortitude," and therefore notes that while it is not guaranteed, one is fortunate if his or her fortitude is accompanied in the moment by such positive feelings.

The clinical implementation of an understanding of bravery, boldness, and fortitude. Synthesizing study results with Geller's theorizing, therapists' felt readiness to perform the duties inherent to psychotherapy varies in part as a function of their relationship to bravery, boldness, and fortitude. Careful application of the subtypes of courage within the work enables therapists to 1) fulfill responsibilities, 2) carry out sound decision-making, and 3) enhance already present personal skills.

Geller (2016) believes that first and foremost, **"**fortitude fosters and sustains a therapists' ability to fulfill the clinical, ethical, and legal responsibilities invested or implied in the therapists' role" (p. 12). Nemas (2014) supports this idea in her own thinking about the construct of courage:

> As psychoanalysts, we think of the analytic process as a road, a search nearing a truth. This aspiration is what leads us to be concerned about our motivations, to think about our emotions, to examine our ethical position in relation to our internal objects and to the other subjects with whom we relate, and to question ourselves about the authenticity with which we

> fight for our passions. However, if we suppose that we have achieved these aims, it is a function of our arrogance. The author proposes that sustaining the struggle to maintain these aspirations, above and beyond achievements, is a function of our courage.

The journey of psychotherapy is facilitated and strengthened when approached courageously by the therapist.

Secondly, a deep understanding of boldness and fortitude, and to a lesser extent bravery, contributes to erudite decision-making. According to Geller (2016), "therapists are more likely to make well informed choices about when to use techniques that heighten the risk of threatening a patient's sense of safety if they understand how variations in boldness and fortitude influence their choices" (16). Given the risks of interventions falling flat or causing harm, a knowledge of courage as a tool can be immensely therapeutic.

Such understanding can also enhance a therapist's existing skills. Geller (2016) writes, "the cultivation of a harmonious relationship between boldness and fortitude can strengthen the introspective capacities and relational skills that are possessed by effective therapists" (p. 16). Further, they are "well prepared to effectively face and deal with the emotional burdens and stressors that inevitably arise when treating patients who reenact these characteristics [of high risk patients] within the context of therapy relationships" (Geller, 2016, p. 3). Courage does not stand alone, it builds upon the therapists' extensive training and natural personality traits.

Lastly, the gender differences that emerged in this study suggest that men and women apply courage differently in their work. While women rely on interpersonal skills and strengths, men rely on boldness and confrontation. Nonetheless, women draw upon notions of bravery and boldness, and men and women draw upon notions of fortitude to compliment their understanding of what it means to be courageous. Geller's Tri-Part Model is also useful in reflecting upon the ways in which gender might influence therapists' ability to meet responsibilities effectively, make informed decisions, and best use their personal skills.

The findings of the present study support and attempt to expand the Tri-Part Model of Courage, and further validate the robust existence and utility of the subtypes of bravery, boldness, and fortitude.

Limitations

Self-report data raise questions of validity and reliability, including the extent to which social desirability phenomena affect responses. In the present study, this methodology raises questions about the extent to which experienced therapists accurately remember the impact of courage throughout their careers, the extent to which they have considered the construct of courage in their personal lives and work previously, and whether the nature of this interview will prime these therapists to over-value the role of courage among the many attitudes and behaviors they bring to their practice.

The sample also had unique characteristics. The majority of participants were clinical or counseling adjunct professors and/or supervisors, and all were in private practice or working in hospital settings in New York City. These proportions may be

unrepresentative of psychotherapists practicing in other settings and in other parts of the country or who are not in the roles of teaching or supervising. Men and women who are involved in these roles by nature tend to be open to working with students and to reflect upon not only their pupils or supervisees' work, but also to reflect upon and improve their own. And it is possible that New York City practitioners differ from others on some characteristics, which may have influenced this data.

Lastly, though an aspect of CQR methodology itself, it should be noted that analysis is also dependent on the subjectivity of the research team. CQR works to control for this subjectivity by employing the stability check, auditor, and the use of consensus throughout the process. In addition, the expectations and biases of the team are identified, reviewed, and continuously referred back to as data are being coded. Our research team meticulously upheld CQR procedures, however it may be possible that certain skewed interpretations or perceptions of the team impacted our understanding of the data.

Implications for practice

Deconstructing and refining the construct of courage for future use. In *The Courage to Be*, Tillich professes that "… few concepts are useful for the analysis of the human situation" (Tillich, 1952, p.1). Study results and the Tri-Part Model of Courage indicate that courage may be one of these coveted concepts. Psychotherapists in this investigation were invited to reveal their personal experiences with courage, including their private theories on the definition of courage and the assessment of an act as courageous with later specificity to its role within their therapeutic work. Therapists unanimously and spontaneously described a felt presence of courage in their relationships

with their patients, motivations to perform well, interventions, case conceptualizations, development of treatment goals, assessment of progress, and in the complexities of psychodynamic processes that drew them to this work. Responses determined the centrality of the construct of courage to psychotherapy, and as such Geller's model provides a much-needed conceptual framework for clinical, research, and teaching pursuits.

Clinically, courage was viewed as supportive of catalyzing change, enhancing insight, and improving life conditions. On the part of the patient, courage was admired and often expressly identified by the therapist and/or patient as an objective of the treatment. As the therapist, courageous actions and interventions were at times instinctive or improvised, and at others, prudently applied due to years of experience and knowledge. The first of the two primary aims of this study—to render the construct of courage useful as a clinical application—was procured by analyzing and distilling this knowledge. It is the author's hope that with validation from the findings of the present study, the definition of courage as consisting of the three subtypes introduced in Geller's Tri-Part Model can be used as a reference in training programs and in the practice of seasoned therapists in the field.

With respect to the second primary aim of preparing the construct of courage for research endeavors, the present study has advanced its operationalization. Bravery, boldness, and fortitude have now been assessed through exploratory survey and interview methods. These subtypes can be used in factor analyses as well as qualitative inquiries as the building blocks for examining courage in a multitude of contexts, and particularly in the therapeutic process. The practical and investigative functions of courage can be

combined to shed further light upon questions within psychotherapy effectiveness research. Given the inherent, ubiquitous, and esteemed reach of courage revealed in this study, there is confirmed need for future use of the Tri-Part Model of Courage towards refining courage clinically and operationalizing the construct for ongoing research purposes.

Pursuing courage in training, supervision, and practice. A number of participants discussed their feeling that courage could be a teachable quality that should be a more integral part of doctoral training and clinical supervision. The hope was that a purposeful mission to do so would promote later courageous practice. Geller (2016) describes an active inclusion of courage in his extensive experience as a clinical psychology professor and supervisor. He writes:

> Psychotherapy supervision is an educational enterprise. But there are decisive moments when I ask student therapists to engage in self-explorations comparable to those expected of patients. I proceed on the basis of the assumption that anxiety inevitably accompanies intimate exposure of one's clinical work, especially when addressing blind spots, evaluation anxieties, failures of empathy, or one's contributions to 'misunderstanding events' (Geller, 1984) and ruptures in the therapeutic alliances (Safran, 1993) (p. 6).

The supervisor has expectations that a student will develop a courageous pattern of responding and confronting these anxieties. The "therapy-like aspects of psychotherapy supervision" are well known to Geller, such that to supervise well and to elicit and cultivate courage would also require the supervisor to be a

courageous model for students in many of the same ways as he or she would for patients (p. 6).

In their study of the knowledge therapists gain from working with their patients, Hatcher et al. (2012) explore the utility of supervisor modeling in this way:

> Many of our participants said they appreciated the opportunity to consider and share their experiences and that they had not thought of their work in this way before. Supervisors and mentors, in a position to model the benefits of learning experientially from their work as psychotherapists, can choose to convey what one can learn from clients, rather than exclusively emphasizing didactic models of learning…If supervision and training were to regularly include explicit discussions of what therapists may learn from clients, novice therapists may become more open to this variety of open-mindedness in their future work (p.16).

They go on to say that beginning and experienced therapists could benefit from hearing a colleague describe experiences of engaging with the courage of his or her patients to "help to obviate aspects of burnout" (p. 16). Participants of the present study shared the most commonalities (i.e. the fewest categories and higher frequencies) in the domain of *Clinical interventions that promote courage*. The therapist participants emphasized as one of the four interventions the benefits of modeling for their patients, for their students, and by founding and present colleagues alike.

Specifically, Geller seeks to train supervisees to hone boldness, to steel themselves with fortitude, and to consider the possibility of reacting within situations necessitating bravery (Geller, 2016). Participants believed that in addition to modeling,

the psychotherapeutic goal of helping their patients to behave and feel more courageous could be achieved through validation, reinforcement, normalization, confronting difficult defenses with boldness, and skills building. Results suggest that these techniques, for many psychodynamic therapists already among their most trusted, can be taught as a function of courage.

Summary. This study explored therapist experience and expression of courage through the framework of Geller's (2014) Tri-Part Model. I have presented the working Tri-Part theory, in which courage takes on three forms: bravery, boldness, and fortitude, each varying on a spectrum of individual differences that can be subject to comparison. This study used a semi-structured interview format to investigate experienced psychodynamic therapists' perceptions of the role of courage in psychotherapeutic work. A primary aim throughout has been to discover the clinical and research utility of courage in psychotherapy.

The present study has several significant implications for practice. Participants' narratives on the phenomena of courage indicated multiple research and technical ways for psychotherapists to use this construct to improve their work with patients. Operationalization of the construct of courage was also significantly advanced. Primarily, participant narratives put out a call for the intentioned teaching and learning of courageousness as psychotherapists. They believed that while some portion of courage is due to personality traits and early lived experiences, a courageous mode of thinking and a willingness to explore one's own courage could increase therapeutic effectiveness. Given that experience was by far the most oft-mentioned factor in the felt ability to be courageous in one's work, the importance of transferring this knowledge to others, to

beginners as well as long-established clinicians, emerged. Overall, this study's findings support the implementation of the Tri-Part Model of Courage with the subtypes of bravery, boldness, and fortitude in clinical practice and the burgeoning field of psychotherapy effectiveness research.

Future directions. The findings in this study indicate several recommendations for future research.

First, results of the present study raise questions about whether or not, as has been suggested by Geller (2016), courage is a trans-theoretical concept. Might cognitive-behavioral or dialectical-behavioral therapists respond differently to the interview than the psychodynamic psychotherapists in this investigation? Or do the three subtypes apply similarly regardless of theoretical approach? If courage were to manifest differently depending on theoretical orientation, what might this mean for treatment effectiveness?

Secondly, future study, rather than relying on self-report, could use observational methodology to further understand the function of courage in psychotherapy (Geller, 2016). Coding session and/or supervision tapes (Hayes & Yasinski, 2015; Moyers, Martin, Manuel, Hendrickson, & Miller, 2005) is a method that may add dimension and offer new understanding of the complex nature of courage as manifested in the psychotherapeutic process. Analysis of these session tapes could quantify individual therapists' ability to be courageous or not during the course of treatment. Tapes of therapists as beginners could even be compared to those from advanced years in clinical programs such that student therapists would be rated on their ability to be courageous at the early and then later stages of training.

Further, given that courage is a goal of many psychotherapies (e.g. Geller 2014, 2016; Poland, 2008; Seligman, 2002), Geller's Tri-Part Model could also quantify and track observable changes that patients undergo. Patient progress could be examined both as a function of therapist courage and by their own development of courage during treatment. Rather than just globally, it would be possible to determine if the individual develops bravery, boldness and/or fortitude over time. Should patients attain these abilities and better the circumstances of their lives, the clinical utility of courage would be further confirmed.

Lastly, the Tri-Part Model of courage could offer unique assistance in a range of treatments. One of the most promising might be the ways in which the three subtypes of courage could contribute to the treatment of phobias. An intervention that targets the growth and maintenance of courageous responses may improve functioning for individuals with these types of anxiety disorders. Bolstering bravery may be useful in confronting the fear of something dangerous and physically risky. Therapist boldness might decrease the disproportional avoidance of the stimulus by the individual by way of challenging beliefs about the true amount of danger posed by the object or situation. Concurrently, fortitude could be strengthened to bear and deal with the persistent, pervasive fear eliciting the phobic response and the process of overcoming this fear. An application to phobias is just one of many possible treatment formulations that could be created using the Tri-Part Model as a framework for intervention.

In sum, while courage has been named as a goal of therapy over time, there is also a lack of theory and direction about how to achieve this goal technically (Seligman, 2002; Woodard & Pury, 2007). In response to this gap in the literature, Geller (2014, 2016) has

created the working Tri-Part Model of Courage in order to define the construct of courage within this context, aid therapists in being courageous themselves in clinically useful ways, and facilitate the development and nurturing of courage in psychotherapy patients. The results of the present study highlight the significance to psychotherapy effectiveness research and clinical practice of viewing the work of therapy through a lens of courage.

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Table 3

Cross-Analysis: Courage in Experienced Psychodynamic Therapists

Domains and Categories	Frequency Label
Associations to the concept of courage; courage as…	
Being brave, having fortitude, and taking risks	Typical
Living in accord with purpose and values	Typical
Demonstrating authenticity and vulnerability	Variant
Facing opposition	Variant
Part of the human experience; for all	Variant
Distinguished from cowardice and bravado	Variant
Multifaceted	Variant
Associations to the concept of courage in psychotherapy; courage as…	
Therapist authenticity and vulnerability	Typical
Fortitude	Typical
Boldness	Typical
Important for all patients	Variant
Bravery	Variant
Knowable through opposites	Variant
Not subjected to conscious thought or study in psychology	Variant
Staying present	Variant
Fulfilling professional duties outside of sessions	Variant

Models of courage; prototypical instances	
Political figures	Typical
Family and friends	Typical
Psychologist colleagues	Typical
Activism, advocacy, and standing up to authority	Typical
Exploration of new ideas and things	Typical
Fortitude and resilience	Typical
Founding Psychologists	Variant
Other public and literary figures	Variant
Graduate students and beginning therapists	Variant
Heroes	Variant
Perseverance in the context of physical and mental illness	Variant
Writing and work with difficult patients	Variant
Mentorship, intelligence, and teaching	Variant
Survival of violence and discrimination	Variant
Success in the context of immigration history	Variant
Demonstration of honesty, vulnerability, and compassion	Variant
Physical risk	Variant
Therapeutic situations that require courage	
Axis I and II diagnoses, including history of trauma	Typical
Therapist use of self	Typical
Sexual material, including sexual abuse	Variant
Suicidality	Variant
Violent or intimidating patient	Variant

Delivery of interventions a patient does not want to hear	Variant
Termination of treatment or referral out	Variant
Policy issues and case management	Variant
Need for help or supervision	Variant
Court mandated patient and/or testifying in court	Variant
Groups and couples	Variant
Factors influencing the ability to be courageous	
Experience and training	Typical
Fear and doubt	Typical
Personal or professional obligation	Variant
State of being present and self-aware	Variant
Fortitude	Variant
Personality and background	Variant
Own treatment, supervision, and other outside support	Variant
Therapist personal issues and self-care needs	Variant
Therapist-patient dynamics	Variant
Self-interest and self-promotion	Variant
Feelings involved in courageous acts	
Anxiety, discomfort, and pain	Typical
Fear	Typical
Sense of well-being	Typical
Authenticity and vulnerability	Variant
Pride; appraisal as rewarding	Variant
Relief	Variant

Situations that intensify the risks and difficulties of doing therapy	
Axis I and II diagnoses, including history of trauma	General
Physical violence	Typical
Emotional violence	Typical
Suicidality	Variant
Difficult problems	Variant
Loss of a patient	Variant
Clinical interventions that promote courage	
Validation, reinforcement, and normalization	Typical
Confrontational techniques and boldness	Variant
Modeling	Variant
Skills building	Variant
Times when I felt less than courageous	
Exhibited avoidance due to difficulty or lack of energy	Typical
Made a mistake	Variant
Felt fearful	Variant
Disavowal of courage for alternative constructs	
Appreciation, admiration, and gratitude	Typical
Fortitude	Variant
Boldness	Variant
Narcissism	Variant

Note: general = 15 to 16 cases; typical = 9 to 14 cases; variant = 3 to 8 cases

Table 4

Gender-Analysis: Courage in Experienced Psychodynamic Therapists

Domains and Categories	Frequency Label		
	All	**Female**	**Male**
Associations to the concept of courage; courage as…			
Being brave, having fortitude, and taking risks	Typical	**General**	**General**
Living in accord with purpose and values	Typical	Typical	**General**
Demonstrating authenticity and vulnerability	Variant	Variant	Variant
Facing opposition	Variant	Variant	**Rare**
Part of the human experience; for all	Variant	**Rare**	**Rare**
Distinguished from cowardice and bravado	Variant	**Rare**	**Rare**
Multifaceted	Variant	**Rare**	**Rare**
Associations to the concept of courage in Psychotherapy; courage as…			
Therapist authenticity and vulnerability	Typical	Typical	Typical
Fortitude	Typical	**Variant**	Typical
Boldness	Typical	Typical	Typical
Important for all patients	Variant	Variant	Variant
Bravery	Variant	Variant	**Rare**
Knowable through opposites	Variant	**Rare**	Variant
Not subjected to conscious thought or study in psychology	Variant	**Rare**	**Rare**
Staying present	Variant	**Rare**	**Rare**

Fulfilling professional duties outside of Sessions	Variant	**Rare**	**Rare**
Models of courage; prototypical instances			
Political figures	Typical	**General**	Typical
Family and friends	Typical	Typical	Typical
Psychologist colleagues	Typical	Typical	Typical
Activism, advocacy, and standing up to authority	Typical	**General**	Typical
Exploration of new ideas and things	Typical	**Variant**	Typical
Fortitude and resilience	Typical	**Variant**	Typical
Founding Psychologists	Variant	Variant	Variant
Other public and literary figures	Variant	**Rare**	Variant
Graduate students and beginning therapists	Variant	**Rare**	**Rare**
Heroes	Variant	**Rare**	**Rare**
Perseverance in the context of physical and mental illness	Variant	Variant	**Typical**
Writing and work with difficult patients	Variant	**Typical**	Variant
Mentorship, intelligence, and teaching	Variant	Variant	Variant
Survival of violence and discrimination	Variant	Variant	**Rare**
Success in the context of immigration history	Variant	Variant	**Rare**
Demonstration of honesty, vulnerability, and compassion	Variant	**Rare**	**Rare**
Physical risk	Variant	**Rare**	**Rare**

Therapeutic situations that require courage			
Axis I and II diagnoses, including history of trauma	Typical	Typical	**General**
Therapist use of self	Typical	Typical	**Variant**
Sexual material, including sexual abuse	Variant	Variant	Variant
Suicidality	Variant	**Rare**	Variant
Violent or intimidating patients	Variant	**Rare**	Variant
Delivery of interventions a patient does not want to hear	Variant	Variant	**Rare**
Termination of treatment or referral out	Variant	**Rare**	**Rare**
Policy issues and case management	Variant	**Rare**	Variant
Need for help or supervision	Variant	**Rare**	**Rare**
Court mandated patient and/or testifying in court	Variant	**Rare**	**Rare**
Groups and couples	Variant	**Rare**	**Rare**
Factors influencing the ability to be courageous			
Experience and training	Typical	**General**	Typical
Fear and doubt	Typical	**General**	**Variant**
Personal or professional obligation	Variant	**Rare**	**Typical**
State of being present and self-aware	Variant	Variant	**Typical**
Fortitude	Variant	Variant	Variant
Personality and background	Variant	**Typical**	**Rare**
Own treatment, supervision, and other			

outside support	Variant	Variant	**Rare**
Therapist personal issues and self-care needs	Variant	Variant	Variant
Therapist-patient dynamics	Variant	Variant	**Rare**
Self-interest and self-promotion	Variant	**Rare**	**Rare**
Feelings involved in courageous acts			
Anxiety, discomfort, and pain	Typical	Typical	**General**
Fear	Typical	**General**	**Variant**
Sense of well-being	Typical	**Variant**	Typical
Authenticity and vulnerability	Variant	**Rare**	Variant
Pride; appraisal as rewarding	Variant	Variant	**Rare**
Relief	Variant	Variant	**Rare**
Situations that intensify the risks and difficulties of doing therapy			
Axis I and II diagnoses, including history of trauma	General	General	General
Physical violence	Typical	Typical	Typical
Emotional violence	Typical	**Variant**	Typical
Suicidality	Variant	**Typical**	Variant
Difficult problems	Variant	Variant	**Rare**
Loss of a patient	Variant	**Rare**	**Rare**
Clinical interventions that promote courage			
Validation, reinforcement, and normalization	Typical	**General**	**Rare**
Confrontational techniques and boldness	Variant	**Rare**	**Typical**
Modeling	Variant	Variant	**Rare**

Skills building	Variant	**Rare**	**Rare**
Times when I felt less than courageous			
Exhibited avoidance due to difficulty or lack of energy	Typical	Typical	Typical
Made a mistake	Variant	Variant	**Rare**
Felt fearful	Variant	**Rare**	**Rare**
Disavowal of courage for alternative constructs			
Appreciation, admiration, and gratitude	Typical	Typical	Typical
Fortitude	Variant	Variant	Variant
Boldness	Variant	Variant	**Rare**
Narcissism	Variant	**Rare**	**Rare**

Note: general = 7 to 8 cases; typical = 5 to 6 cases; variant = 3 to 4 cases; rare = 2 cases.

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525 West 120th Street
New York NY 10027
212 678 3000
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Appendix A.

INFORMED CONSENT

Our research team in the clinical psychology program at Teachers College, Columbia University, is studying the various challenges faced by psychotherapists. We welcome and appreciate your participation, but please read the Informed Consent below before agreeing to be interviewed.

Our research team is investigating "Courage and Psychotherapists." Our semi-structured interview, one part of which is a short series of demographic questions, has been reviewed and approved by the Internal Review Board (IRB) at Teachers College, Columbia University. It should take approximately 50 minutes to complete all parts.

Dr. Barry Farber is the lead researcher and a licensed clinical psychologist. He can be reached at columbia.techsurvey@gmail.com if you have any questions or concerns.

This interview was deemed "low-risk," meaning it is not likely to have a negative impact on people. However, if the questions make you uncomfortable, you may stop participation at anytime, and contact Emily Lyman, M.A., M.S. or Dr. Farber to follow up.

The interview will be tape-recorded. At the end of the interview, we will ask for your email address and you may wish to receive results of this study. Only the researchers will be able to see this information. Your email address will ONLY be used to receive study results. Your personal information will not be given out and will be held in the strictest of confidence at Teachers College, Columbia University. Providing your email address is not necessary to complete the interview, and you may withhold this information if you choose.

Data from the interview may be reported in professional publications and conferences. We plan to report thematic and excerpted de-identified results. By participating in this project, you will be helping to advance knowledge in the field of psychology, particularly in regard to professional training and practice.

If you are currently practicing psychotherapy and have been doing so for at least 10 years, you may consent and we will begin the interview.

With great appreciation, The Courage and Psychotherapy lab at Teachers College, Columbia University

I have read and understand the consent form, and I am willing to participate in the study:

Name of Participant: _____
Signature of Participant_____

Date: _____

If you would like a summary of the findings of the study when they are available, please print your name and email address below.

PARTICIPANTS' RIGHTS

Principal Investigator: ___Emily Lyman_____

Research Title: ___Courage in Psychotherapy_____

- I have read and discussed the Informed Consent form with the researcher. I have had the opportunity to ask questions about the purposes and procedures regarding this study.
- My participation in research is voluntary. I may refuse to participate or withdraw from participation at any time without penalty.
- The researcher may withdraw me from the research at his/her discretion.
- If, during the course of study, significant new information that has been developed becomes available which may relate to my willingness to continue to participate, the investigator will provide this information to me.
- Any information derived from the research project that personally identifies me will not be voluntarily released or disclosed without my separate consent, except as specifically required by law.
- If at any time I have questions regarding the research or my participation, I can contact the investigator, who will answer my questions. The investigator's email address is ell2126@tc.columbia.edu.
- If at any time I have comments or concerns regarding the conduct of the research or questions about my rights as a research subject, I should contact the Teachers College, Columbia University Institutional Review Board (IRB). The phone number for the IRB is (212) 678-4105. Or I can write to the IRB at Teachers College, Columbia University, 525 W. 120th Street, New York, NY 10027, Box 151.
- I should receive a copy of the Informed Consent form and this Participant's Rights form.
- My signature means that I agree to participate in this study.

Participant's signature: _____ Date: ___/___/____

Name: _____

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New York NY 10027
212 678 3000
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Appendix B.

Introductory Email to Participants

Dear Colleague,

We are writing in regards to an exciting project, and we would greatly appreciate it you could give 45-50 minutes of your time in person or on the phone to participate.

We are attempting to reformulate the ancient concept of courage to render it useful to psychotherapists. Towards this end, we are asking experienced therapists

a) to help us study the nature and consequences of courage in the therapeutic context, and
b) to help us identify the behavioral and subjective experiential properties of courage as they manifest themselves in the therapeutic relationship.

In the hopes of obtaining significant information about the ways therapists experience and express courage, we have developed a questionnaire and a semi-structured interview.

The **online questionnaire for beginning (graduate trainees) and experienced therapists (10+ years in practice)** presents clinical situations that may require courage, and should take 5-10 minutes to complete. The **interview for experienced therapists**, approximately 45-50 minutes in duration in person or on the phone, will ask for your personal thoughts and perceptions on the concept of courage in your view and your work. We welcome your participation.

Best,
The Psychotherapy Research Lab, Teachers College, Columbia University

TO TAKE THE SURVEY:
https://tccolumbia.qualtrics.com/SE/?SID=SV_9zcoWLF9WO4PACp

TO PARTICIPATE AS AN INTERVIEWEE: PLEASE CONTACT EMILY LYMAN AT ell2126@tc.columbia.edu

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525 West 120th Street
New York NY 10027
212 678 3000
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Appendix C.

Courage in the Therapeutic Context Interview

Interview Protocol

Thank you for agreeing to participate in our study. As I mentioned, we are trying to learn about the ways in which courage is experienced and expressed in the therapeutic situation. Towards this end, I'll be asking you about your particular views about courage and its role in the work you do as an experienced therapist. I'd like to tape-record your answers. Do you have any questions about this study? Ok, let's begin.

First, I'd like to get some basic information about you and your therapy.

I. Demographic Data

1. Gender: _____
2. Primary theoretical orientation: _____
3. Race/ Ethnicity: _____
4. Years in practice: _____

II. Interview Protocol

I'd like to begin by asking you a few questions about courage.

1. When you think about courage, what thoughts or images come to mind?
   Prompt: What constitutes a courageous act?

2. Have you thought about courage and its relevance to psychotherapy before today?

3. Who comes to mind when you think about courageous people?

4. Are there therapists that come to mind that embody courage for you?
   Prompt: This may be someone you know in person or have read about.

5. If we can, let's back up a step. Who did you think of as courageous
   a. As a child?
   b. Who did you think of as courageous as an adolescent or young adult?
   c. When in graduate school, who were the therapists that you admired for their courageousness?

6. Do you have a sense of what it might mean for you as a therapist to act courageously?
   Prompt: could you tell me a clinical vignette or anecdote that you think illustrates a time in which you felt you acted courageously?

7. What is the most courageous thing you have ever done as a therapist?
   Prompt: In retrospect, what do you think enabled you to act in this manner?
   Prompt: What does it feel like to act courageously?
   a. What did you feel while you were acting courageously?
   b. Once you had performed the courageous act, do you remember your feelings immediately after?

8. Are there types of patients with whom acting courageously is especially important?

9. Are there subtypes of patients with whom you experience an intensification of the risks and difficulties of doing therapy?

10. In your career has either a supervisor or a mentor ever told you that you were acting courageously, or something to that effect?
    a. If no, prompt: if this person did not say courageous, did he or she give a sense that what you were doing embodied the general concept?
    b. Has a patient ever commented that you were acting in a courageous, brave, or bold fashion (or something to that effect) toward him or her?

11. What do you do to help your patients behave and feel more courageous?

12. Tell me about a patient who has scared you either physically or emotionally.
    Prompt: to what extent did the way you handled this feel courageous to you?

13. How is your sense now of what it means to be courageous as a therapist different than earlier in your career?

14. To conclude, I'd like to ask you some questions about whether there are times when you felt less than courageous in your practice of psychotherapy.
    a. Prompt: Please tell me a story about that.
    b. What got in the way of being courageous?

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New York NY 10027
212 678 3000
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Appendix D.

Confidentiality Agreement for Transcription Service Provider

Confidentiality Statement

As the Transcription Service Provider contracted to transcribe interviews for the research project titled "Psychotherapy through a lens of courage: A study with experienced therapists," I understand that my work will involve access to recorded information that is considered confidential.

I acknowledge my responsibility to respect the confidentiality of the research participants, to follow guidelines of confidentiality and to act in a professional manner. I further understand that if I am found acting indiscreet with confidential material or not protecting the privacy of the research participants through my actions, I will be dismissed from this job immediately. I understand this action to be necessary in order to maintain high professional standards of the research project and researchers involved.

_____ _____

Principal Investigator Date

_____ _____

Transcription Service Provider Date

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525 West 120th Street
New York NY 10027
212 678 3000
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Appendix E.

Confidentiality Statement for Research Assistants

Confidentiality Statement

As a research assistant working in a research project titled "Psychotherapy through a lens of courage: A study with experienced therapists," I understand that my work will involve access to recorded information that is considered confidential.

I agree to provide proof of completion of the CITI Human Subjects training and to be listed as a research assistant for this study with the IRB.

I acknowledge my responsibility to respect the confidentiality of the research participants, to follow guidelines of confidentiality and to act in a professional manner.

I further understand that if I am found acting indiscreet with confidential material or not protecting the privacy of the research participants through my actions, I will be dismissed from my job immediately. I understand this action to be necessary in order to maintain high professional standards of the research project and researchers involved.

_____ _____
Principal Investigator Date

_____ _____
Research Assistant Date