Authenticity: How do counselling psychologists know who their clients really are?

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SECTION A: PREFACE

"Honesty and transparency make you vulnerable.

Be honest and transparent anyway." — Mother Theresa

This portfolio explores an issue that is central to counselling psychology: authenticity within the therapeutic relationship. The Random House dictionary (2010) defines the word authentic as "not false or copied; genuine; real" and states that the words "authentic, genuine, real, veritable share the sense of actuality and lack of falsehood or misrepresentation. Authentic carries a connotation of authoritative certification that an object is what it is claimed to be". Beyond this basic definition, more sophisticated and nuanced takes on the concept of authenticity are offered by different theorists and therapists.

Roger's (1951) seminal distinction between an individual's 'actual-self' and his/her 'true-self' will be adopted for the purpose of this thesis. Roger's true-self portrays the person and characteristics an individual considers that he or she possesses, but may not be exhibited in social interactions, whilst the actual self is the one that is currently presented in social situations (Sheeks & Birchmeier, 2007). Authenticity can be further understood as involving the way that "one acts in accord with the true self, expressing oneself in ways that are consistent with inner thoughts and feelings" (Harter, 2002, p.382).

The intriguing question of 'How do counselling psychologists know who their clients really are?' can be interpreted very differently, depending on one's epistemological position. It is beyond the remit of this thesis to explore the wider philosophical debates regarding topics such as realism and relativism.

Counselling psychologists place a central emphasis on the therapeutic relationship (Gelso & Samstag, 2008). Gelso and Samstag (2008) pointed out that the therapeutic relationship is often considered from the point of view of the therapist i.e. whether the therapist is carrying out Roger's (1951) core conditions, e.g. empathy and genuineness. This thesis considers authenticity from the perspective of the client being authentic in relation to the therapist i.e. how genuine the client is being in the relationship and whether he/she is being his/her 'true self'. Nevertheless, this portfolio also reveals very interesting points about therapists' authenticity in relation to their clients.

The 'real relationship' between therapist and client can be described as consisting of two key, interrelated elements: genuineness and realism (Gelso *et al.*, 2005). Genuineness has been vividly defined as "the ability to be one who truly is, to be nonphoney, to be authentic in the here and now" and realism as "the experiencing or perceiving the other in ways that befit him or her, rather than as projections of wished for or feared others (i.e., transference)" (Gelso, 2002, p.37). In his relevant research Gelso (2004) identified the real relationship as "the personal relationship existing between two or more people as reflected in the degree to which each is genuine with the other and perceives the other in ways that befit the other" (p.26).

Some may question whether it matters if therapists and clients have a 'real relationship', however research has found that the effectiveness of therapeutic treatment is directly linked with how strong the real relationship is (Gelso & Hayes, 1998). Gelso (2002) eloquently answered criticisms of the term real relationship being arbitrary by stating that "what is real is perceptual and is co-constructed by the dyad...the concept of real relationship is no way negated by the fact that we can never fully know what is real. In the human sciences, no theoretical construct is or probably can be fully known" (Gelso & Samstag, 2008, p.277).

Rogers (1967) ascertained that "If in a given relationship I am reasonably congruent, if no feelings relevant to the relationship are hidden either to me or the other person, then I can be almost sure that the relationship will be a helpful one" (p.51). Indeed Wood *et al.* (2008) asserted that "in many mainstream counselling psychology perspectives, authenticity is seen as the most fundamental aspect of well-being...as such, departures from authenticity are seen as involving increasing psychopathology" (p.385). Consequently, it can be inferred that the subject of authenticity within the therapeutic relationship is highly significant to the practice of counselling psychology.

This portfolio consists of four sections (including Section A: Preface), with each section linked to the theme of 'authenticity' in a different way:

Section B: Research

The research section of this portfolio consists of a qualitative study exploring how trainee counselling psychologists experience mandatory personal therapy and how counselling psychologists experience having trainee counselling psychologists as clients. Counselling psychology trainees are obliged to undertake at least 40 hours of personal therapy as part of the

course requirements. The reasons for choosing to research this topic were varied. On a personal level, as a trainee counselling psychologist I experienced 40 hours of mandatory personal therapy and found that the nature of mandatory personal therapy was a reoccurring theme discussed amongst my trainee peers. There is a paucity of literature investigating the unique relationship between trainee counselling psychologists and their therapists, although understanding the significance of the therapeutic relationship is central to counselling psychology (Strawbridge & Woolfe, 2003). My findings, using Interpretative Phenomenological Analysis (IPA), suggest that as the therapeutic relationship develops, trainee counselling psychologists move from an 'inauthentic' to an 'authentic' self. Despite both groups stating that the mandatory nature of the therapy initially impedes the process, neither trainees nor qualified therapists articulate this belief within the relationship, often resulting in ***'an elephant in the room'***. Nevertheless, over the course of therapy there is a process of both trainees and their therapists entering into a genuine relationship as the therapeutic relationship becomes established. Recommendations and implications for counselling psychology are discussed in light of the findings.

Section C: Professional Practice

This section includes a Cognitive Behavioural Therapy (CBT) case study exploring the difficulties of accessing emotions in substance misuse. It focuses on my work with Kate, a 37-year-old female. I frequently felt that Kate was using CBT tools to evade discussing feelings, by engaging thoroughly in homework such as thought records, whilst avoiding any discussion concerning her inner emotions. This caused me to reflect on how authentic Kate was being, both with herself and me, regarding how she felt about herself and her drug use. Kate's habit of disengaging when her emotions were close to being accessed made the therapeutic process challenging. Conceivably, owing to her constant disengagement, I began to approach emotional themes hesitantly, apprehensive that she might disengage. This caused me to reflect on my own authenticity within the therapeutic relationship. This case draws attention to the importance of continual attention to reformulation when therapeutic goals are not being met.

Section D: Critical Literature Review

This review evaluates the literature on e-mail therapy and considers whether electronic communication is an appropriate medium for counselling psychologists to use in their practice, either as an adjunct to therapy or as a replacement for face to face (FtF) therapy. Part of the

review evaluates the authenticity of online therapeutic relationships, and questions whether clients are more or less likely to be genuine in an e-therapy relationship or a FtF relationship. After reviewing the literature, it can be inferred that it is feasible to develop a genuine relationship online that may, in some cases, even surpass the authenticity of a FtF therapeutic relationship. Despite current gaps in knowledge and research, I am of the opinion that, upon reviewing the literature, online therapy (specifically e-therapy) is a resource that counselling psychologists can benefit from utilising in their practice. The review discusses recommendations for further research for practitioners who wish to carry out e-therapy.

My own clinical and professional identity as a counselling psychologist

In considering my own clinical and professional identity as a counselling psychologist I reflected on the philosophical foundations of counselling psychology. These foundations provided the reasoning behind my decision to train as a counselling psychologist as opposed to a different branch of psychology. Influential thinkers such as Carl Rogers were of the opinion that human beings should be seen in a "holistic manner, rather than as a collection of psychological parts" (p.3, Strawbridge & Woolfe, 2003) and this stance is fundamental to counselling psychology. Woolfe (1990) suggested that there are key factors which make counselling psychology differ from other areas of psychology which include: the significance of the helping relationship as a key factor in assisting the therapeutic process; increasing doubt of the effectiveness of the 'medical-model' of therapist-client relationships; a shift towards a more humanistic stance and a rising concentration on aiding well-being instead of reacting to pathology and sickness.

Deurzen-Smith (1999) argued that the philosophical foundations of counselling psychology lie in "the immense gap left open by a psychology too devoted to narrow scientific principles to pay proper attention to what it is to be human" (p.11). These differences in counselling psychology make working within the NHS a challenge for me at times, especially when the use of medical terms and diagnostics is common place. The Division of Counselling Psychology (DCoP, 2008) states that as opposed to proposing that clients yield obediently to treatment stipulated by 'experts', counselling psychology promotes "an interactive alternative that emphasizes the subjective experience of clients and the need for helpers to engage with them as collaborators, seeking to understand their inner worlds and constructions of reality".

I have found that there have been particular challenges in keeping to my own identity as a counselling psychologist. As I reflect on my training I have realised how important I see it to treat each client as a unique individual. The use of the word 'patient', for example, is often used in multidisciplinary meetings. I am adamant about always calling the 'patient' a 'client' and will explain if challenged why I am doing so. This is because in regards to the philosophy and values of counselling psychology it is important to recognise the significance it puts on developing self-determination in the individual. I strongly agree with this because as Strawbridge and Woolfe (2010, p.18) state in the Handbook of Counselling Psychology "this contrasts with powerful cultural assumptions that go along with being diagnosed as ill, identified by Parsons (1951) as the 'sick role'...this removes responsibility from sufferers who can't help being ill and re-defines them as patients with limited personal resources and in need of specialised help".

I believe in the autonomy of the individual and my opinions regarding the subjective worlds of the self are central to the way I work as a psychologist. It is vital to recognise as a counselling psychologist the impact of self in the therapeutic relationship and the significance of supervision and reflection of oneself as a practitioner. I am in agreement with Vanaerschot (1993, p.49) who stated that "the important part of the therapist's attitude is not the fact that, in his contact to the client, the therapist eliminates himself as a person, but the very way in which he applies himself". Satir (1991) ascertained that there are numerous capabilities that are required to be a competent therapist but they can only be employed through the channel of an authentic self (Baldwin, 2000).

My interest in working with chronic illness was cultivated by my experience in the NHS as part of the HIV psychology service at the Royal Free hospital. As a result I spend much of my time in medical settings. This involves challenging the use of the medical model in a psychological setting with other medical professionals e.g. psychiatrists and consultants. "The notion of *doing something* to clients is replaced by that of *being with* clients" (Strawbridge & Woolfe, 2010, p.11). Furthermore, the DoCP is of the opinion that the approach taken in therapy (including the number and frequency of sessions) varies according to the particular needs of the individual client and the context in which the therapy takes place. This is difficult in the NHS where there are often a set amount of sessions that can take place and NICE guidelines are widely used. I have been fortunate to have had excellent supervisors in the NHS

settings within which I have worked, who have been willing to discuss clients as individuals and extend sessions if necessary.

There is an increasing focus on the use of CBT in the NHS. Whilst I predominately use CBT when working within NHS settings I do not align myself with a particular model ; I endeavour to use the best model and approach for each particular client. Whilst this has been challenging in some settings, I have found that on the whole I have been able to suggest why a certain model should be used with a client and have not been told that I must rigidly adhere to one model. Strawbridge and Woolfe (2010, p.14) stated that "When we consider counselling psychology's approach to practice and inquiry we can find some strikingly postmodern characteristics. Its recognition of competing therapeutic theories and refusing to align itself with a single model indicates a resistance to a meta-narrative particularly that of the prevailing model of scientific rationality".

As a counselling psychologist I have to be very aware of the implications of being asked to give a diagnosis within the NHS. Giving a client a diagnosis could also impact on the therapeutic relationship with the client, as many clients have reported negative effects on their lives from having received a diagnosis. The therapeutic relationship is a key aspect of counselling psychology with many studies stating that the therapeutic relationship is one of the most crucial things in the counselling room (Martin, Garske & Davis, 2000; Bachelor & Horvath, 1999). In a survey of "the stigma, taboos and discrimination experienced by people with mental health problems" (Read & Baker, 1996) there was a summary of key findings from the 778 people who completed the questionnaire. A third of people stated that they were dismissed or forced to resign from jobs, 25% turned down by insurance or finance companies and 50% felt unfairly treated by general health services. The majority of people in the study had been given a formal psychiatric diagnosis. One respondent stated that "because I am labelled a schizophrenic I am treated as a second class citizen in all respects" (p.3). Consequently, I am very careful whilst working in the NHS to highlight that an individual remains unique and it is not just a set of diagnostic criteria.

In conclusion there are numerous implications and/or dilemmas for me as a counselling psychologist in trying to keep my own clinical and professional identity e.g. use of therapeutic model, challenging medical terms and being aware of the significance of giving diagnosis. Nevertheless, by having a strong belief in the philosophical foundations of counselling

psychology I am able to keep my identity and continue to attempt to develop as a counselling psychologist.

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SECTION B

'The Elephant in the Room': a study exploring how trainee counselling psychologists experience mandatory personal therapy and how counselling psychologists experience having trainee counselling psychologists as clients

ABSTRACT

Counselling psychology trainees are obliged to undertake a minimum of 40 hours of personal therapy as part of the course requirements. This qualitative study explores how trainee counselling psychologists experience mandatory personal therapy and how chartered counselling psychologists experience having trainee counselling psychologists as clients. Phenomenological methodology - specifically, Interpretative Phenomenological Analysis (IPA) - was employed to access the lived experience of both trainees and qualified psychologists. Analysis of the results suggests that as the therapeutic relationship develops, trainee counselling psychologists move from an 'inauthentic' to an 'authentic' self. They use mandatory personal therapy to learn and grow both professionally and personally. Whilst many trainees feel that therapy should remain a compulsory course requirement, they also highlight that it costs them both emotionally and financially. The qualified therapists notice a difference when working with trainee counselling psychologists, as opposed to their other clients. The therapists are aware of the mandatory nature of the therapy and their own worries about being judged by the trainees. They find it difficult to maintain the 'role' of therapist. The therapists both empathise and sympathise with the trainees, which often results in concessions being made.

There are four overarching categories common to the two groups: i. impact of mandatory therapy on therapeutic process, ii. the therapeutic performance, iii. the value of therapy and iv. boundaries. Despite both groups stating that the obligatory nature of the therapy initially impedes the process, neither trainees nor therapists communicate this belief within the relationship; often resulting in ***'an elephant in the room'***. Recommendations are discussed including the value of providing preparation for both trainees and qualified therapists before entering the unique trainee therapeutic relationship, extra funding, and other personal development ideas.

CHAPTER ONE: INTRODUCTION

The British Psychological Society's Division of Counselling Psychology (DoCP) was established in 1994. Counselling psychology places a strong focus on evidence based research, whilst endeavouring to remain focused on the use of the self, and the personal and interpersonal dynamics that exist in the therapeutic relationship. Strawbridge and Woolfe (2003) highlighted the difficulty in distinguishing counselling psychology from other psychological disciplines, namely clinical psychology. Nevertheless, they cited the key distinction as the "focus on the quality of the relationship" (p.4). Counselling psychology training courses vary from all other divisions of the British Psychological Society (BPS) in that trainees are required to undertake a minimum of 40 hours of personal therapy as part of the course requirements. Different conditions are placed on this by various university courses. Presently some universities allow students to see United Kingdom Council for Psychotherapy (UKCP) or British Association for Counselling and Psychotherapy (BACP) accredited therapists as well as counselling psychologists, whereas others have required that all trainees see fellow chartered counselling psychologists for therapy.

Literature Review

This review evaluates the literature on personal therapy for therapists. It begins by examining the debate on whether personal therapy should be a course requirement for trainee therapists. The review progresses to investigate whether personal therapy makes therapists 'better' therapists and questions whether therapists have found their own personal therapy beneficial. It then explores how therapists have experienced undertaking personal therapy whilst training to be therapists. The review proceeds to examine whether mandatory personal therapy is a useful or beneficial option for personal development in training. It further investigates therapists' experience of treating fellow mental health professionals and working with 'involuntary clients'. It concludes by summarising the literature and providing a rationale for this study including the research aims and questions.

A debated topic

The subject of personal therapy for therapists is a controversial one, with conflicting views on whether it is a core component of training or non-essential (Macaskill, 1999). Norcross, Strausser-Kirtland and Missar (1988), eloquently outlined that the subject is "shrouded in

mystique, defensiveness and anxiety sometimes bordering on the irrational" (p.37). They proposed that this is both due to therapists' resistance to acknowledging personal obstacles, and the profession's unwillingness to acknowledge the particular burden that is an inevitable accompaniment to being a therapist. Clinical practice can have a negative impact on therapists by contributing to anxiety, emotional withdrawal from family members and low mood (Norcross *et al.*, 1988). Therefore it may be a positive idea for trainees to have personal therapy as an outlet for their own reactions to clinical work, separate from supervision.

Nevertheless, the rationale for mandatory therapy has remained unclear. Professional difficulties are not given as a primary rationale by counselling psychology courses. If they were, the question remains unanswered as to why therapy (like supervision) does not remain mandatory throughout therapists' careers. The notion of whether personal therapy should be mandatory has been questioned frequently by those in the therapy profession. Glass (1986) noted that the debate concerning mandatory personal therapy has been present for years; it was debated by the American Psychiatric Association in 1953 and again in 1983.

Amongst the reasons given for the necessity of trainees having personal therapy are that use of the self and interpersonal abilities are seen as key factors in the therapeutic process (Woolfe, 1996). Henry, Sims, and Spray (1973) reported that "the accumulated evidence strongly suggests that individual psychotherapy not only serves as the focal point for professional training programs, but also functions as the symbolic core of professional identity in the mental health field" (p.14). Arguably, if trainees are not required to have mandatory personal therapy, there are no assurances that they will address the parts of their personality which could possibly be problematic (Thorne & Dryden, 1991). Barnett and Hillard (2001) added that factors such as embarrassment frequently stop psychologists from voluntarily attending therapy. It can be inferred that being 'told' to go to therapy can reduce the shame factor for therapists in undertaking their own therapy. Common benefits associated with trainees having therapy include resolving personal conflicts, becoming more empathetic towards clients as a result of being in the clients' 'shoes', improved psychological health and a firsthand opportunity to observe another therapist's clinical methods (Grimmer, 2005). Particular therapeutic approaches would argue that without therapy trainees can be at risk of projecting their unconscious/unprocessed problems onto their clients.

By way of contrast to the above, Glass (1986) postulated that mandatory personal therapy could have negative consequences on both the trainee's client and the trainee, as the trainee may become immersed in his/her own psychological problems. Another potential disadvantage of making therapy a necessity is the possibility of continuing with therapy that is not satisfactory because 40 hours of therapy are required in a certain time frame (Grimmer & Tribe, 2001). It may be argued that the optimum psychotherapeutic experience is achieved by trainee therapists choosing a therapist from the same theoretical orientation, or indeed from the same branch of psychology, as some university courses now make a prerequisite. Conversely, Norcross (1990) controversially argued that although undergoing therapy from a fellow therapist could improve personal validation and professional socialisation, it could also endorse professional indoctrination. "The theoretical identification may slip into conversion, might discourage experimentation with different schools of thought, and might prevent the opening of minds" (Norcross, 2005, p.846).

In their thought-provoking discussion on mandatory personal therapy, Williams, Cole and Lyons (1999) noted that therapy "has not been empirically established to benefit therapists' mental health, change the nature of their therapeutic interactions or lead to better outcomes with clients" (p.545). They further posed a contentious point that "it does not allow choice, which is generally considered essential for productive therapy...matching treatment to individual needs is violated by insisting on a single modality of uniform length" (p.546).

In summary, whilst some studies would argue that personal therapy is key in training to become a therapist, both in addressing problematic areas of their personality and understanding therapy from the perspective of the client (Thorne & Dryden, 1991), others have maintained that there has been no empirical evidence to endorse these claims (Williams *et al.*, 1999). Furthermore, it has been suggested that there could be negative consequences to trainees embarking on personal therapy, such as trainees becoming distracted by their own issues, staying in therapy that they are ready to end because they need to complete the therapeutic hours that are required of them and professional indoctrination (Norcross *et al.*, 1999). Nevertheless there has been research suggesting that personal therapy improves therapists' practise, which is explored in the next part of this review.

Does personal therapy make therapists 'better' therapists?

Greenberg and Staller (1981) expressed surprise that the value of personal therapy as part of psychotherapeutic training is mainly accepted, despite the lack of research evidence showing its effectiveness. Over two decades later, Rizq and Target (2008) reported that the function of personal therapy has been the subject of growing examination by numerous people in the profession, who wonder whether clinical efficacy is improved by mandatory personal therapy. The impact of psychotherapy has been described as being positively associated with the therapist's ability to display empathy, warmth and genuineness and his/her increased focus on the personal relationship in therapy (Norcross *et al.*, 1988). In her engaging debate about personal therapy as a training requirement, Macaskill (1999) questioned whether personal therapy is the only way to address these goals. She argued that "there is no evidence to support some of the putative benefits of personal therapy claimed by its supporters are indeed necessary skills for effective therapists" (p.151).

Much of the debate regarding whether personal therapy should be a course requirement has concentrated on whether personal therapy improves treatment outcome, i.e. whether it has 'improved' the therapists (Daw & Joseph, 2007). Strupp (1921-2006) carried out the vast majority of analogue studies in this field but his findings have been inconsistent and plagued with methodological shortcomings. He conducted a variety of studies of therapists' reactions to situations in a laboratory intended to be equivalent to 'real-life' psychoanalytic therapy. In his original laboratory study (Strupp, 1955) he found only minor disparities between therapists who had been 'analysed' and those who had not. Interestingly, the small differences that were noticed (analysed therapists making more 'active' as opposed to silent responses) were in conflict with his 1958 study, in which the opposite was true. The inconsistent findings of his studies suggest that it is difficult to measure outcomes in this modality, and that no conclusive results can be taken as to whether personal therapy improves therapists' work. Other criticisms of his studies include small sample sizes, low amounts of statistical significance and the questionable external validity of analogue studies (Grimmer, 2005, Wampler & Strupp, 1976). There also remains uncertainty as to whether the psychoanalytic definitions of effectiveness as a therapist can be generalised across other modalities.

In Kernberg's (1973) interesting contribution to the research, he discovered that experienced therapists who have finished analysis achieved superior improvement in their patients than

therapists with less experience who were still experiencing their own analysis. Nevertheless, he failed to specify whether the noted improvement was due to the experience of the therapist, the impact of their own personal therapy, or even a combination of the two factors. Garfield and Bergin (1971) studied the outcome of the clinical effectiveness of 18 advanced psychotherapy graduate students. They divided the therapists into three groups of therapists: one group with 175 hours or more of personal therapy, a second group with 175 hours, and a control group who had no personal experience of therapy. Somewhat surprisingly, they found that the clients of those therapists who had no therapy consistently showed the greatest amount of change (measured by psychological testing and therapist rating) as opposed to the clients of therapists who had experienced the greatest amount of personal therapy. The results of both studies must be interpreted with caution, as it is debatable as to whether 'improvement' and 'change' can be measured in psychoanalytical therapy.

MacDevitt (1987) surveyed 185 doctoral level psychologists (who had on average 16 years of experience) regarding their personal therapy histories. They gave their reactions to 25 hypothetical psychotherapy situations. He found that recognition of countertransference issues was highly significantly and positively linked to the quantity of personal therapy the therapists had experienced. These conclusions suggest that a lengthy amount of personal therapy is required for therapists to be able to pick up on countertransference issues. If these findings can be generalised to other modalities, they imply that short courses of mandatory personal therapy (i.e. 40 hours) are of little clinical value in psychotherapy work. In spite of this, it is not definite that psychotherapy was the cause of improved recognition of counter transference as it may have been due to other factors, such as those who chose to have longer psychotherapy being more reflective than those who chose shorter term therapy (Macaskill, 1999). These studies must be interpreted with caution; they are experimental analogues and may not represent real life situations, i.e. the therapists that responded 'better' may just fare better in experimental settings than those who perform better without being observed (Greenberg & Staller, 1981). Additionally, these studies used small sample sizes and did not yield clear and consistent findings.

A rare study examining the relationship between therapeutic alliance and personal therapy yielded a contentious finding (Wheeler, 1991). Wheeler (1991) investigated BACP therapists' perceived therapeutic alliance with patients who had eating disorders. She discovered that there was a significant negative correlation between therapists' prediction of the therapeutic alliance

with their clients and the amount of personal therapy the therapists had experienced. Wheeler proposed that "this implies that the more personal therapy the therapist has had, the more negative they have predicted the alliance with their client to be" (p.196). The reasons behind this finding are unclear, and the study would have benefited from an additional qualitative element i.e. a group interview, in which these findings could have been explored further. Whilst interesting, the study had a small sample size and it is possible that the therapists who responded (less than 10 per cent of who were asked) were particularly doubtful about their therapeutic skills.

In contrast to the previous studies, Macran, Smith and Stiles (1999) performed a qualitative study. They interviewed seven therapists from different professional backgrounds about their personal therapy and how it impacted on their clinical practice. Using IPA, the authors found that the therapists believed that they were more able to impart helpful conditions for their own clients after experiencing them in their own therapy. Three domains were found: a) "orientating to the therapist: humanity, power, boundaries, b) orientating to the client: trust, respect and patient and c) listening with the third ear" (p.419). The participants largely felt that personal therapy had made a constructive and distinctive impact on their professional performance. Nevertheless, all of the respondents came from a psychodynamic/analytic/humanistic persuasion. It is plausible that the language used by participants, and the domains that were found, reflected this. It would have been useful to have included therapists from different theoretical orientations e.g. systemic/Cognitive Behavioural Therapy (CBT). It is questionable whether lectures or supervision could have had the same impact as personal therapy. Although this may be true for some aspects, personal growth and role learning may be more of a challenge via academic study (Macran *et al.*, 1999).

Gold and Hilsenroth (2009) investigated the effects of therapists' personal therapy on therapeutic alliance with their own patients in the initial stages of treatment. The authors discovered that there were no significant differences in patient-rated therapeutic alliance. Conversely, significant differences were found in therapist-rated therapeutic alliance, in addition to variables such as therapist confidence and goal setting agreement. Importantly, significant differences were observed in the amount of therapy sessions attended; patients attended twice as many sessions with the therapists who had received personal therapy. Conceivably, having therapy gives therapists confidence in their clinical skills and ability to address the process in the therapeutic relationship, as opposed to those therapists who have

never received therapy. The authors suggested that the assessment tool they used (the therapeutic model of assessment) could have moderated any disparities that may have existed on patient-rated therapeutic alliance. Nevertheless, the therapists used in this study were trainee clinical psychologists in the latter stages of their doctorate course. Plausibly, the results may have been different using more experienced therapists. Nonetheless, this research is valuable in showing the positive effects of personal therapy for therapists.

Clark (1986) reviewed the empirical research on personal therapy and found that in the vast majority of the studies there was no connection between patient outcome and whether the therapist had/had not undergone personal therapy. His seminal finding was echoed over a decade later by Macran and Shapiro (1998) and Macaskill (1999); they found that the available research failed to show that therapists who undertake personal therapy are 'better' therapists. Orlinsky *et al.* (2005) stated that due to the poor quality of the studies it is not possible to determine whether receipt of personal therapy is positively or negatively related to client outcome. Consequently there is no clear answer to the question of whether or not personal therapy is advantageous to therapists or trainees, and therefore whether it should be compulsory for trainees. This has implications for those who design counselling psychology courses and whom outline the rationale for the inclusion of mandatory personal therapy.

Have therapists found their own personal therapy beneficial?

An informative study conducted by Norcross *et al.* (1998) involved psychologists, psychiatrists and clinical social workers filling in a questionnaire reporting on the processes and outcomes of their personal psychotherapy experiences. The most commonly given reason by participants for undertaking personal therapy was to address personal rather than professional issues. Over 90 per cent identified improvement in behaviours, emotions and cognitions as a consequence of the experience, although several covariates of harmful treatment were also indicated. The research could have been improved by the researchers enquiring what the harmful treatment was, which could have potentially led to changes in the way therapists conducted therapy. Instead they asked the respondents if they had generally found the experience harmful in any way, and if so, to rate the severity of the harmful treatment. Norcross *et al.* (1988) found that psychologists were significantly more likely to convey negative effects than social workers. This implies that psychologists are more critical about their personal psychotherapy experiences than people from other professions. Arguably this finding is due to psychologists

knowing more about psychotherapy, as it is their own profession, as compared to the other participants who employ different roles in their livelihoods. The high level of reported improvement in this self-selected sample might suggest the possibility that people who found therapy useful were more likely to respond to a questionnaire. Nevertheless, Bike, Norcross and Schatz (2009) replicated and extended the study conducted by Norcross *et al.* (1988) and found for a second time that over 90 per cent of therapists reported positive outcomes across various domains. This suggests that 20 years later their study is still reliable.

In their extensive survey of 1018 graduate students of clinical psychology courses, Holzman, Searight and Hughes (1996) found that 74 per cent of the students who had received therapy did so during their training, and reported positive experiences. The main reason for going to therapy was for personal growth (over 70 per cent), followed by a wish to improve as a therapist (65 per cent) and lastly for depression (38 per cent). The reasons given by those who did not go to therapy included feeling that they did not need to (56 per cent) and finances (53 per cent). This raises the issue of the financial situations these students would have faced if therapy had been mandatory, and indeed whether they would have still chosen to attend the clinical psychology course if they had to fund personal therapy.

Pope and Tabachnick (1994) discovered that 84 per cent of the 476 psychologists they surveyed had been in therapy and interestingly, that 61 per cent had undergone at least one incident of clinical depression. 85.7 per cent of the 399 respondents stated that their experiences in therapy were exceptionally or very helpful, with only two recounting that it was a completely unhelpful experience. 88 per cent of the respondents were in favour of personal therapy as a training requirement, including 69 per cent of those who stated they had negative effects. Only 6 per cent said that therapy should not be mandatory. These findings suggest that personal therapy adds to trainees' well-being, eases the stresses involved in the profession and serves as a model for learning how to be a therapist (Pope & Tabachnick, 1994). Problems with the study include the fact that the researchers interviewed psychologists once they had qualified, who may not have been in the same mindset as when they were trainees.

A considerable amount of data was collected by Orlinsky *et al.* (2005) regarding the personal therapy experiences of more than 4000 therapists of different theoretical orientations in a range of countries. They found that 88 per cent of psychotherapists rated their personal experience positively and that personal therapy consistently ranked among the top three sources of

personal development. Nevertheless, the authors acknowledged that none of the studies were controlled or randomised. There were also relatively small samples of participants and unsophisticated assessments of client outcomes (Daw & Joseph, 2007).

A study performed by Williams *et al.* (1999) involved 84 counselling psychologists completing questionnaires about their views on their own experiences of personal therapy. 27 per cent reported negative effects i.e. disrupted marital relationships, increased emotional withdrawal, destructive eating and heightened psychological distress. Limitations of this study include the therapeutic relationship not being a prominent part of the questionnaire, despite its significance in counselling psychology. Additionally, assessing process and outcome of therapy on a quantitative scale i.e. scoring the process and outcome of therapy on five point scales, does not allow much room for elaboration. Although the researchers reported that 88 per cent recorded positive effects of their therapy (on an assortment of factors including professional and personal development) for some participants it had been three or four years since their experience of personal therapy and time could have affected how they remembered their experience.

Daw and Joseph's (2007) investigation into qualified therapists' experience of personal therapy involved 48 therapists completing a questionnaire. Two thirds of respondents had participated in personal therapy. The two main reasons for having personal therapy were personal growth and personal distress. Those surveyed found that personal therapy was useful as a tool of personal development, self-care and as a type of experiential learning from being in the client position (Daw & Joseph, 2007).

On the whole, the studies suggest that therapists do find their personal therapy beneficial. Nonetheless, there is uncertainty as to whether it is mainly people who have had positive experiences of their personal therapy who responded to invitations to participate in research. There was also quite a low response rate in some studies (Daw & Joseph, 2007, Orlinsky *et al.*, 2005). It is unclear whether this relates back to the taboo (Norcross *et al.*, 1988) of therapists partaking in personal therapy.

Personal therapy whilst training to be a therapist

Rachelson and Clance (1980) surveyed the attitudes of psychotherapists towards the 1970 American Psychological Association (APA) standards for psychotherapy training. They found

that graduate school was rarely named as a learning experience; instead many therapists specified personal therapy, supervision, and their own practice as essential experiences. 64 per cent stated that they would include it in their 'ideal' training. The study would have benefited from further exploration as to why the other 36 per cent would not have included therapy in their training. Ralph (1980) conducted one of the primary qualitative studies on this subject. He asked 36 graduate students and eight supervisors in clinical psychology graduate programmes about their thoughts regarding how they 'learned' psychotherapy. Similar to Rachelson and Clance (1980), Ralph (1980) found that students frequently stated that their own therapeutic experience was a central factor in learning how to use themselves as a resource in therapy, and that it allowed them a practical demonstration of the work of experienced therapists.

In their seminal research, Kaslow and Friedman (1984) used an open-ended, semi-structured interview format in asking 14 clinical psychology graduate students about their experiences of being in training. They also interviewed eight psychotherapists who had treated clinical psychology graduates. This study is significant in that it is the only study that has asked both students and qualified therapists that see trainees, their opinions on personal therapy whilst training. The authors found that many students chose to go to therapy for personal rather than professional reasons. Kaslow and Friedman (1948) discovered that there was pressure on many students to regress "appropriately" in psychodynamic treatments (p.43). They reported that some of the trainees found that their therapist played many roles, i.e. teacher, supervisor and role model, and that there were unclear treatment boundaries. Despite this, they found that trainees and therapists were of the opinion that the interrelatedness of trainees' professional training and personal psychotherapy experiences provided a unique character to their experiences.

In their survey of therapists who had experienced personal therapy as a component of their training, Macaskill and Macaskill (1992) found that 87 per cent of 25 senior psychotherapy registrars reported that their personal therapy had a moderate to very positive effect on their therapeutic work and in their personal lives. Helpful effects included increased self-awareness (76 per cent), increased self-esteem (47 per cent) and reduction in symptoms (43 per cent). Nevertheless 8 per cent reported several unfavourable effects from their therapy, including psychological distress (29 per cent) and marital/family stress (13 per cent). These findings suggest that for some trainees, personal therapy can have an adverse effect.

McEwan and Duncan (1993) conducted a survey of 185 clinical and counselling psychologists asking them their opinions regarding personal therapy as an aspect of professional training, and about the circumstances under which therapy had been given to them whilst they were studying. 88 per cent found at least one benefit (e.g. having a role model) from the experience and 83 per cent thought there was at least one risk (e.g. indoctrination). Although this could indicate a certain ambivalence towards the subject of therapy for trainees, this may have been a reflection on the nature of the survey; two out of the three types of items included questions on the major benefits and risks of having the experience of being the client in therapy.

Interestingly, many respondents in the McEwan and Duncan (1993) study who had experienced mandatory personal therapy stated that they had not been given information prior to therapy, explaining the possible risks and benefits of the therapeutic experience. Nearly half of the participants stated that the goals of mandatory therapy were not made explicit and two thirds reported that their training institute provided nominal or no observation on the impact of therapy on students. The participants who had experienced mandatory personal therapy valued its significance more than those who had not, which Holzman *et al.* (1996) also found in their study. Plausibly, because there is no clear rationale, the benefits of mandatory therapy only become clear once it has been experienced. Indeed, "one of the main problems with the foregoing literature...is the almost total absence of explicit referral to a clear underpinning theoretical rationale guiding research in the field" (Rizq & Target, 2008, p.133). McEwan and Duncan (1993) found that there was no consensus as to whether personal therapy should be a course requirement, perhaps reflecting the persistent debate on this topic.

Grimmer and Tribe's (2001) refreshing qualitative research allowed 14 trainee/recently qualified counselling psychologists to discuss the impact of mandatory personal therapy on their professional development. The main question in their research was "What is your response to the inclusion on the course of a mandatory personal therapy" (p.290). They found that participants who had not previously had a vast experience of therapy, and were originally hesitant to attend, often came to consider it significant that practising counselling psychologists have the experience of being a client. Four key types of experience emerged: contemplation on being in the 'client' role, socialisation experiences; support of the budding professional; and interactions between personal and professional development. A limitation of this study is that the participants were only taken from one counselling psychology course.

In 2005 Murphy carried out a small scale semi-structured group interview investigating the experiences of trainee and experienced counsellors who had undergone 40 hours of mandatory personal therapy, as a requirement of a MA course rooted within a humanistic orientation. Five participants attended a group interview. A form of grounded theory was used and four fundamental processes emerged: reflexivity, growth, authentication and prolongation. Murphy (2005) reported that participants were of the consensus that personal issues came into the foreground during training, and their professional work and personal therapy was used to work through this. The respondents also recounted that they had grown in empathy towards others after experiencing their own therapy and experienced confirmation of the self as a suitable and adequate tool for practise. The participants all seemed to have a positive view of mandatory personal therapy. Nonetheless, it may have been beneficial to have carried out some individual interviews as well as group interviews, in order to learn more about the participants' individual experiences.

A valuable contribution to the grey literature was made by Playford (2007), who researched the influence of experiences in personal therapy on attitudes taken by 12 trainee counselling psychologists in their clinical practice. She identified both positive and negative aspects of mandatory positive therapy. Four main themes emerged: power, genuineness, endings and self-disclosure. The issue of power was raised in many ways i.e. payment of therapy fees, and competiveness between client and therapist. Playford (2007) suggested that "the fact that the participants were not ordinary clients but in training to take up careers as therapists will also have influenced how they felt" (p.39). She proposed that further research could focus on how power is viewed and processed in therapeutic relationships from the perspective of both the therapist and client.

Rizq and Target (2008) explored how counselling psychologists describe the meaning and significance of personal therapy in clinical practice and training. They found that the majority of participants were of the opinion that personal therapy should remain a mandatory element of the training requirements. In spite of this, participants were ambivalent about identifying its aims or assessing its outcomes. The participants used in this study had vast clinical and training experience and were aged from 42-65. It had been a long time from their own training and it is possible that they may have forgotten some aspects of the experience. They may have been reflecting on it from the perspective of an established professional, rather than how they felt

during their experience of being a trainee. A further limitation is that none of the therapists interviewed were from a CBT background which would have given a different perspective.

In general, the studies established that trainees found personal therapy to be a positive experience whilst training, both professionally and personally. Notably, most of the studies found that participants were uncertain about whether therapy should be a mandatory course requirement. Possibly this was due to some of the negative aspects that were also identified. Nevertheless, conflicting methods, samples and professional groups used in the research make it difficult to establish how useful personal therapy is as a training requirement.

An ongoing debate is whether mandatory therapy is ethical; alternative personal development exercises have been suggested, including therapy as an option (Mearns, 1997, Norcross & Halgin, 2005). Eminent psychologist Professor Robert Bor stated that "The present requirement for personal therapy goes completely counter to everything that we teach - which is really about autonomy and giving people choices" (Palmer, 1998, p.357). It is questionable whether personal therapy is vital in therapist training and should be a key activity; perhaps other activities in training (e.g. membership of a therapeutic group) may fulfil the tasks which personal therapy is there to accomplish (Atkinson, 2006). Although acknowledging that there should be substantial opportunities for personal development in the training of therapists, Atkinson (2008) vividly described mandatory personal therapy as "neither intellectually nor ethically coherent" (p.408). The next section of this review examines whether mandatory personal therapy is necessary for personal development in training.

Personal development in training - is mandatory personal therapy the best option?

Donati and Watts (2005) highlighted that in recent years there has been an increased meeting between the chief theoretical approaches in the counselling field regarding their opinions concerning the fundamental role of therapists 'use of self'. They reported that this is depicted by the prominence given to some type of 'personal development' work in the training of counsellors and counselling psychologists (BACP, 1996; BPS, 2002). Despite this prominence originating from the principle that therapists need to be psychologically 'healthy' if they wish to assist their clients to the best of their ability, personal development remains an inadequately defined aspect of training, on which there is a paucity of literature (Donati & Watts, 2005).

Other options instead of personal therapy include personal development exercises (Beutler & Consoli, 1992), a healthy lifestyle, co-counselling, self-reflective diaries, peer counselling, role plays and the videotaping of sessions (Beuter & Consoli, 1992, Rowan, 1983, Williams *et al.*, 1999, Macaskill, 1999). Muller (2004) questioned whether it is arrogant to assume that it is only through counselling that one can get to know oneself.

Debatably, "when the resource is yourself and you are encountering a vulnerable 'other' you need to have the key tool of our trade as honed as possible" (Sinason, 1999, p.158). Gilroy, Carroll and Murra (2002) sent a questionnaire to 1000 members of the counselling psychology division of the American Psychological Association. 425 were returned and, similarly to the study conducted by Pope and Tabachnick (1994) a remarkable 62 per cent self-identified as depressed. The authors concluded that psychologists are a professional group at risk of depression and argued that "the key to prevention lies in establishing a professional ethos in which self-care is viewed as a moral imperative" (p.406). Personal therapy was highlighted by Gilroy *et al.* (2002) as being a vital mandatory requirement. Nonetheless, there is little conclusive empirical evidence as to whether mandatory therapy is beneficial for trainee therapists, and there are opposing views about whether it should be included as a mandatory part of a training course. There is also a lack of research concerning qualified therapists' opinions on whether therapy has been useful to their trainee-therapist clients, and indeed their experience of having therapist-clients. The research that has been undertaken has mainly been by authors aligned to psychodynamic/psychoanalytic therapy (Geller, Norcross & Orlinsky 2005). There is even less research on having trainee therapists as clients. The following part of the review will explore the literature that is available.

Therapists' experience of treating fellow mental health professionals

Kaslow and Friedman (1984) interviewed eight psychotherapists regarding their experience of having mental health professionals as clients (including trainee clinical psychologists). Although the therapists initially maintained that there was no difference between having therapist-clients and non-therapist clients, as the interviews progressed they acknowledged that there were some differences. The therapists relayed that they had multiple roles with the trainees, including being a supervisor and role model. They further stated that they thought that trainees were easier to work with than more experienced therapists, due to their enthusiasm towards the process, and their "less rigid character defences" (p.46).

Similarly, Aponte (2005) articulated that in group therapy for therapists in Gestalt therapy training, trainees are ready for personality change as opposed to merely finding answers to their problems. He attributed this openness to change in personality as being linked to the assumption that most psychotherapists are "relatively healthy in a psychological sense" (p.311). Nevertheless, he stated that an added stressor in this client group is fretting about the boundary between shaming and challenging a trainee. He suggested by shaming the trainee, he/she may model this and shame his/her own clients. Aponte (2005) emphasised the responsibility he felt for ensuring that the trainees became good Gestalt therapists, making a clear link between the quality of therapy and the quality of future therapists.

Norcross, Geller, and Kurzawa (2000, 2001) conducted informative research on therapists' experience of treating fellow mental health professionals. They examined responses to a questionnaire from 349 psychologists of the American Psychological Association Division of Psychotherapy. Psychologists reported that their therapy styles and therapy processes were mainly similar for both psychotherapy patients and non-therapist patients. They felt less removed from and more comradeship toward their therapist-patients. In spite of this, they were more anxious about treatment effectiveness and more insecure of their techniques when the patient was also a mental health specialist (Norcross, 2005). Heery and Bugental (2005), who used an existential-humanistic approach to psychotherapy with psychotherapists, highlighted that special attention must be paid to the transference and counter-transference relationship with psychotherapist - clients.

In contrast, Beck and Butler (2005) maintained that "there is little difference in our cognitive therapy treatment of therapist-patients versus other patients" (p.254). They argued that issues that may be seen as unique to trainees, such as the possibility of dual relationships, that occur with other patients as well. A possible reason for the disparity between their views, and those of the previous studies, is the difference in theoretical orientation. Beck and Butler (2005) used CBT in their treatment of therapist-patients, which is arguably more protocol orientated than psychodynamic therapy, which is more process focused. This may explain why they noticed little distinction.

Working with 'involuntary clients'

Cingolani (1984) examined the social conflict perspective on working with involuntary clients and found that the helping process with involuntary clients frequently deteriorates at the very

beginning of the working relationship. She suggested that previous research has shown that the development of a relationship is particularly challenging with involuntary clients. A multitude of empirical research has shown that both the therapeutic relationship and the personality of the psychologist explain as much about outcome variance as the type of treatment utilized in therapy (Norcross 2005, Jarrett, 2008).

Nonetheless, Cingolani is talking about involuntary clients as those "who are a continuum ranging from prisoners and other institutionalized populations to... the problem drinker whose employer is pressuring him or her to seek help" (p.442), and one could argue that trainee psychologists are not involuntary clients as they choose to enter a course in which they know therapy will be mandatory.

Research has highlighted that even therapists who seek help are more critical of their therapist's abilities and knowledge, show more resistance to interpretations made by the therapist and are more competitive (Kaslow, 1986). Friedlander, Escudero and Heatherington (2006) discussed therapeutic alliances in couple and family therapy. They suggested that when it is clear that the client has come to therapy to fulfil an obligation, the therapist is able to prepare suitable tactics to foster the therapeutic alliance. Nevertheless, they also stated that when therapy appears to be voluntary but it is not (as some would argue is the case when making therapy a course requirement) it is improbable that the client will form a connection with the therapist initially or readily engage with the therapeutic process. They suggested various techniques for trying to establish a therapeutic relationship and state that "the objective is to generate an atmosphere of collaboration and avoid contaminating the therapeutic relationship with coercion" (p.200).

Summary of the literature and rationale for this study

There is no consensus, and little empirical evidence, as to whether personal therapy is advantageous to qualified therapists or trainee therapists, and therefore whether it should be compulsory for trainees. Methodological limitations include a lack of controls, poor design of the studies, and unclear definitions of treatment outcomes. Often research has taken place in the form of a questionnaire which only allows for answers on a continuum. These survey based studies also have relatively low response rates.

In recent years there has been an increase in qualitative studies, allowing more detailed responses from both therapists and trainee therapists on their experiences of personal therapy. On the whole, the studies suggest that therapists do find their personal therapy beneficial. Various studies concluded that trainees found personal therapy to be a constructive experience whilst training. Nevertheless, the majority of the studies found that participants were unsure about whether therapy should be a compulsory course requirement.

Those authors who have publicly discussed and written about the idiosyncratic features of treating fellow therapists are largely from the psychodynamic and psychoanalytic persuasions which affects the external validity of the research (Norcross *et al.,* 2000). Additionally, the research in this field has predominately occurred in the USA, whereas less culture-specific research has been undertaken in the UK (Grimmer, 2005).

There is a substantial amount of research on therapists treating other therapists, and therapists undergoing their own personal therapy. Despite this, there is far less research on trainee psychologists and their personal therapy. Although there have been some papers on this (e.g. Kaslow & Friedman, 1984, Grimmer & Tribe, 2001) few have addressed the mandatory aspect of trainees having to have therapy as part of their training requirements. The only research which asks the perspectives of both trainees undergoing therapy, and qualified therapists giving therapy in the same study, is the research conducted by Kaslow and Freedman (1984) over 20 years ago. Much of this research is relatively old and as training is a constantly changing field, it is essential that research is current and keeps abreast of changes in the profession.

As an increasing number of people apply to counselling psychology courses, the impact of the lack of information given to students about the rationale for mandatory therapy and/or process of possibly starting therapy for the first time, assumes a greater significance. Many studies state that the therapeutic relationship is one of the most important factors of therapeutic 'success' (Martin, Garske & Davis, 2000; Bachelor & Horvath, 1999), yet there have been no studies conducted looking at the unique relationship dynamics between counselling psychology trainees and their therapists. There has been a lack of research about counselling psychologists and their therapy in general excluding Rothery (1992), Williams *et al.* (1999) and Grimmer and Tribe (2001).

As a trainee counselling psychologist who had experienced 40 hours of mandatory personal therapy I found it interesting that there was a lack of research on a topic that was a frequently

discussed theme amongst my trainee peers. I wondered how my therapist felt knowing that I was coming to her as part of my course requirement. Indeed, Williams *et al.* (1999) suggested that further research could be carried out on the effect of therapists having trainee therapists as clients, and whether trainees' expectations and assessments of therapy differ from those of other client groups. Grimmer (2005) wondered whether "it may be more fruitful to pursue process rather than outcome issues because of methodological problems and because receipt of personal therapy may be confounded with other therapist characteristics" (p.283).

The Present Study: Research Aims

The purpose of this study is to explore how trainee counselling psychologists experience their personal therapy, and how counselling psychologists experience having trainee counselling psychologists as clients. The main topics within this research include: the nature of the therapeutic relationship between the trainees and qualified counselling psychologists, the uses of mandatory personal therapy, and the value of therapy as a course requirement. This study aims to provide information for trainee counselling psychologists when entering therapy. Additionally, it endeavours to provide an insight into the mind of the trainee psychologist for their therapist. This research could provide guidelines for both parties before beginning therapy.

The BPS website (2009) states that "The practice of counselling psychology requires a high level of self-awareness and competence in relating the skills and knowledge of personal and interpersonal dynamics to the therapeutic context"; consequently counselling psychologists should not be afraid to reflect on and challenge what is part of the training to become part of this unique branch of the profession.

CHAPTER TWO: METHODOLOGY

Rationale for using a qualitative methodology

"Qualitative analysis is concerned with describing the constituent properties of an entity, while quantitative analysis is involved in determining how much of the entity there is" (Smith, 2008, p.1). Both vary in regards to how the information is analysed; whilst the vast majority of quantitative research starts with verbal information, the verbal data is typically required to be altered into numbers. In contrast, Smith (2008) highlighted that analysis performed during qualitative research is textual, and the emphasis is on investigating the meaning of the text. In reality, Hayes (1997) suggested it can be hard to differentiate between the two methods. It can be argued that during analysis, qualitative research frequently evokes some aspects of quantitative methodology, i.e. the implicit or explicit judgements of a category being reported, and the comparison of participants with each other on different aspects (Hayes, 1997). Similarly, quantitative analysis typically entails interpretation by the researcher, which is fundamentally a qualitative process (Smith, 2008). Nevertheless, they vary widely in their theoretical foundations and in regards to research questions, epistemological and ontological positions and subsequent methodologies.

Qualitative research has been defined as "the interpretative study of a specified issue or problem in which the researcher is central to the sense that is made" (Parker, 1994, p.2). Psychology has previously been mainly influenced by positivist[1] research paradigms and related quantitative methods (Ponterotto, 2005) and arguably this has restricted the development of counselling psychology to progress in specific ways. A key difference between qualitative and quantitative methodologies is the degree to which our comprehension of the world can be regarded as objective knowledge or 'true' (Willig, 2001). Positivism implies that there is a clear-cut association between the world and our perception and comprehension of it (Willig, 2008). Willig (2008) argued that the reality is that few people are 'pure positivists' and for the most part it is recognised that description and observation are discriminatory.

Although the field of counselling psychology cultivated phenomenological models of research, in contrast to the prevailing ideas of scientific psychology, it has been criticised in the past for avoiding single case research designs (Galassi & Gersh, 1993). This is despite its philosophy of being entrenched in humanistic and existential-phenomenological psychology, in which both

[1]Simple relationship between the world and our understanding of it (Willig,2008)

meaning and the search for understanding are fundamental, and the emphasis is on beliefs, principles and subjective experience (Strawbridge & Woolfe, 2003). Whilst Barkham (2003) expressively argued that counselling psychology should aim to be methodologically 'plurist', i.e. integrating both qualitative and quantitative approaches, he also suggested that it is vital that the researcher chooses the approach which is most suitable to the research question. Accordingly, my research question led me to choose IPA as a research methodology.

What is IPA?

Interpretative Phenomenological Analysis (IPA) is "a version of the phenomenological method which accepts the impossibility of gaining direct access to research participants' life worlds" (Willig, 2001, p.53). Although this methodology attempts to investigate the participant's experience from his/her perspective, there is an acknowledgement that this exploration inevitably involves the researcher's own outlook, in addition to the type of interaction between researcher and participant. Its key theoretical foundations are phenomenology, hermeneutics and ideography. Insights generated are a consequence of a thorough and comprehensive engagement with the participant (Finlay, 2002). Phenomenological research in general and IPA specifically, necessitates the researcher to enter the participant's world, as it is interested in the way in which individuals perceive the world.

IPA's concern with cognitive psychology is strongly associated with Bruner's (1990) initial insight regarding cognitive psychology being the science of meaning and meaning making (Smith, 2004). Whilst IPA affirms that cognition plays a key part in our thinking, it does not view cognitions as remote distinct functions, but as a feature of being-in-the world. Smith (2004) proposed that IPA differs from conventional psychology in the way that it investigates these mental processes, implementing detailed qualitative analysis, as opposed to experimental and quantitative methods of analysis.

Theoretical Underpinnings of IPA

Phenomenology: Husserl (1859-1938) has frequently been described as the "father of phenomenology" (Laverty, 2003, p.3). Willig (2008) defined phenomenology as being "concerned with the phenomena that appear in our consciousness as we engage with the world around us" (p.52). Husserl began by investigating how it was that events or objects could appear to people, as he believed that speech and observations could only occur via one's

consciousness (Giorgi & Giorgi, 2008). Husserl rebuffed the idea that there is something more essential than experience and maintained that our exploration should start with what is experienced (Smith, 2008). Laverty (2003) stated that Husserl saw phenomenology as a method of obtaining "true meaning" (p.5), through infiltrating further and further into reality. Phenomenology was viewed as a movement "away from the Cartesian dualism of reality being something 'out there' or completely separate from the individual" (Laverty, 2003, p.5).

Smith (2008) argued that Husserl's description of the lifeworld is fundamental to phenomenology, in that he rejected the scientific approach, and maintained that each individual perceives the world differently. This is referred to as 'intentionality,' which allows objects to appear as phenomena. Subsequently theorists have suggested the perceiver and object are integrated in mutual co-formulation (Finlay, 2002), and reality is comprised of peoples' intentionality, i.e. how they consider the world and the meaning attached to these thoughts/beliefs. The process of bracketing is vital to Husserl's 'phenomenological reduction' (Giorgi & Giorgi, 2008). Husserl's transcendental phenomenology acknowledges that perception can be permeated with one's own ideas and opinions but suggests that people engage in the 'epoché', bracketing these prior views (Husserl, 1970).

Hermeneutics: Giorgi and Giorgi (2008) proposed that the fundamental difference between Heidegger (1889-1976) and Husserl is that Husserl believed that description is foremost, and that interpretation is a unique kind of description. This differs from Heidegger's belief that interpretation is principal and that description is a distinctive mode of interpretation (Giorgi & Giorgi, 2008). Heidegger (1927) believed that bracketing is impossible as he did not think that it was possible for individuals to completely separate their *a priori* knowledge and history of experience. In contrast to Husserl, Heidegger maintained that consciousness is not separate from the world. Heidegger stated that "we live in an interpreted world and are ourselves hermeneutic, we are interpreters, understanders" (Smith 2008, p.19). Dilthey (1976) inspired Heidegger in his thinking that hermeneutics is not just a method and actually just 'being' in the world is hermeneutic. Ricoeur (1970) differentiated between two different types of interpretation (hermeneutics). The "hermeneutics of meaning-recollection" involves informing other people about characteristics of an experience; it aims at "faithful disclosure" (Smith, 2008, p.18). In contrast the "hermeneutics of suspicion" attempts to realise a further reality, beyond the thing that is being analysed. The purpose of this is to permit a deeper interpretation to be produced, which can dispute the account that is seemingly apparent (Smith, 2008, p.18).

Eatough and Smith (2008) suggested that IPA can be used as the methodology to perform Heidegger's "hermeneutics of factical life" (p.180). They proposed that objects and events which individuals are directed towards can be understood by investigating how the individual experiences and makes sense of them. Furthermore, IPA addresses how a *Dasein* (way of being in the world) is actually studied, as it cannot be examined in a straightforward manner (Eatough & Smith, 2008). Smith (2007) argued that a double hermeneutic circle occurs when a researcher is using IPA, as the researcher takes an active role in trying to get access to the participants 'personal world'. This process is complicated by the researcher's own ideas, which are in fact necessary, in order to make sense of the participants trying to make sense of their world.

Idiography: Allport (1940), a central figure in promoting idiography, suggested that "psychology shouldn't neglect the unique in individual experience and behaviour. The individual can be studied as a unique case" (p.17). This idiographic emphasis is central to IPA and outlines rationale in how the transcripts are analysed.

Rationale for choosing IPA as the qualitative method

Smith and Osborn (2008) described IPA as being "especially useful when one is concerned with complexity, process or novelty" (p.55), such as with my own research. A further reason for choosing IPA was because this research hoped to highlight the quality and texture of individual experience (whilst understanding that such experience is never directly accessible to the researcher) which is a central aim of IPA. I also felt that this methodology is the one that is most fitting to my epistemological position - IPA affirms that to be human is to be a "cognitive, linguistic, affective and physical being and assumes a chain of connection between people's talk and their thinking and emotional state" (Smith & Osborn, 2008, p.54). I firmly agree. McLeod (1996, p.6) stated that "As a counselling perspective that has been strongly influenced by existential philosophy, the person-centred approach employs a *phenomenological* approach towards understanding and knowing". Consequently, in using a person centred account of the notion of self and authenticity I chose IPA as my method.

Although both Grounded Theory (GT) and IPA adopt an inductive 'bottom up' approach, I chose IPA for its idiographic, descriptive and hermeneutic emphasis. IPA demonstrates its idiographic commitments by endeavouring to achieve insight into the psychological world of each individual, whereas GT attempts to recognise and clarify social processes. GT would

attempt to create theories from the interview data, whereas this was not a key aim of my research. I was interested in the description of what participants thought/felt, rather than using the data to provide explanation or to theorise. I also favoured how IPA, unlike GT, allows the researcher to engage hermeneutically both with current theoretical constructs (Larkin *et al.*, 2006) and with reflexivity. I appreciated the opportunity to work more reflexively given my own personal commitment to the topic, and personal experience of mandatory personal therapy.

There are two main versions of discourse analysis: discursive psychology and Foucauldian discourse analysis (Willig, 2001). Discursive psychology (including the methodology of conversation analysis) questions how participants employ language in order to conduct and negotiate social interactions in order to accomplish interpersonal goals. Psychological phenomenon such as identity, motivation and perception are conceptualised in terms of 'language games' and discursive actions rather than as cognitive-affective processes. Willig (2008, p.96) stated that: "The focus of analysis in discursive psychology is on *how* participants use discursive resources and with what affects...discursive psychologists pay attention to the *action orientation* of talk". I was more interested in the experiences my participants were describing and assume that any 'talk' links (in various ways) to underlying mental processes and individual predispositions. In contrast to the discursive position that is critical of "the existence of a psychological interior" (Finlay and Madill, 2009, p.152), I believe in the relevance of psychological processes and how perceptions, thoughts and feelings can meaningfully be explored.

Foucauldian discourse analysis attempts to portray and evaluate the discursive worlds individuals occupy and to investigate their connotations for experience and subjectivity (Willig, 2008). A key difference between IPA and discourse analysis (DA) is the phenomenological importance placed by IPA on the participant's experience, whilst discourse analysts believe that responses are socially constructed and that one should place prominence on the active nature of talk (Larkin *et al.*, 2006, Willig, 2001).

IPA has some similarities with Foucauldian discourse analysis, in that they are both interested in the role of discursive constructions on individual subjectivities. At this macro-level, discursive analysis aims to explore the representations and ideologies circulating in every day discourse and how these impact on the way people position each other. The IPA position, in

contrast, is more focused on how the wider historical and cultural context impacts on individual experience (Eatough & Smith, 2008). Whereas IPA also recognises the significance of language, it disagrees that language is the sole or main constructor of reality (Breakwell, Hammond, Fife-Schaw & Smith, 2006). I preferred the IPA approach of attempting to look past the restrictions of cultural/historical linguistic discourse, in order to engage with each individual's intentionality of the phenomenon they experience (Eatough & Smith, 2008).

I do not think that either methods of discourse analysis were suitable for this study as they entail exploring the role and influence of language in certain contexts, which is not the focus of this current study. IPA aligns itself with symbolic interactionists such as Mead (1934) and Blumer (1969) in that they believe that meanings take place and are interpreted in, and as a consequence of, their social communications. Consequently, people have a part in their reality. I was interested in exploring the personal lived experience, thoughts and perceptions of trainees having mandatory personal therapy and therapists having trainees as clients. Therefore a phenomenological study was required rather than another qualitative approach like discourse analysis. Accordingly, discourse analysis was not chosen as my methodology.

There has been frequent debate regarding how to carry out phenomenological research and there are numerous phenomenological research methods to choose from (Finlay, 2009). Two types of phenomenological methods at either end of the spectrum are those proposed by Giorgi (1985, 1994, 2000) and Smith (1995). Giorgi's methodology takes on a more descriptive 'Husserlian' approach whereas IPA does not use key Husserlian techniques such as reduction and bracketing. Indeed, some critics say IPA is not deemed to be phenomenological because there is inadequate or weak use of phenomenological philosophy/theory e.g. the use of epoché. I agree with Smith that his method is phenomenological in respect to its emphasis on individuals' lived experiences and perceptions. I favoured Smith's IPA, as opposed to methodologies such as Giorgi's (Giorgi & Giorgi, 2008) approach as I feel that the latter's methodology is less focused on the individual. Smith's focus on individual perceptions and his alignment with hermeneutics and interpretation are the most fitting with my research. I agree with Eatough and Smith (2008) who argued that Giorgi and Giorgi (2008) "seek the general structure of phenomena" whereas they "seek idiographic information about individuals" (p.182). Whilst there are numerous versions in-between (such as Ashworth's life world slant, 2003, 2006) many other methods are more Husserlian theoretically, and emphasise the

importance of bracketing, whereas I do not think it is possible to set aside my own experiences and understanding of the world.

In conclusion I concur with IPA's epistemological values and critical realist position taken. Additionally I value the idiographic approach taken by IPA and appreciated the structured approach with IPA as suiting a novice researcher. I chose IPA because it is accessible, well-researched, and it fits with my epistemological position and research.

Epistemological Position

Willig (2008) succinctly defined epistemology as "a branch of philosophy concerned with the theory of knowledge... this involves thinking about the nature of knowledge itself, about its scope and about the validity and reliability of claims to knowledge" (p.2). My own epistemological position does not correspond with the positivist correspondence theory of truth which is more closely aligned with quantitative methods (Willig, 2008).

In subscribing to the position on IPA outlined by Larkin *et al.* (2006) in their paper "Giving voice and making sense in interpretative phenomenological analysis" my opinion is that analysis can never produce an indisputably first-person account, as both the researcher and participant construct the account. This coheres with the philosophy of counselling psychology as it disputes the objective examination of behaviour and stresses "the acceptance of the subjective world of the client as meaningful and valid in its own terms...and the need to negotiate between perceptions and world-views without assuming an objectively discoverable truth" (Strawbridge & Woolfe, 2003, p.8).

I believe that human beings are a part of reality - not an ego which is kept apart from the world. Inevitably the researcher forms some of this context and the interview itself can influence the constitution of reality that the participant experiences (Larkin *et al.*, 2006). Madill, Jordan and Shirley (2000) named this 'contextualism'. Larkin *et al.* (2006) proposed that it is not possible to truly and objectively access a participant's 'inner experience' as the description is always created by both researcher and participant. Nevertheless a third person account has the possibility of revealing something about a respondent's "relatedness to the world" (Larkin *et al.*, 2006, p.110), as if one defines an objective reality as being somewhat reliant upon methods of "intellectual construction" (Larkin *et al.*, 2006, p.110), then arguably every analysis of any of one's intellectual constructions can portray a little bit of an objective reality.

Thus it is possible for one's account to reveal 'something' about oneself but as Larkin *et al.* (2006) stated "**only** that person's **current** positioning in relation to the world of objects" (p.110). In accordance with Smith's (2007) 'hermeneutic circle' I interpreted the participant's interpretation of their reality, therefore playing a key part in the construction of the account. Madill (2000) stated that "critical realism admits an inherent subjectivity in the production of knowledge and ... has much in common with constructionist positions" (p.3). Therefore the restraints of an interview taking place in a certain context in accessing a 'true reality' and the constraints of the language used in describing how respondents perceive their reality are acknowledged.

Finlay (2002) argued that "To increase the integrity and trustworthiness of qualitative research, researchers need to evaluate how intersubjective elements influence data collection and analysis. Reflexivity - where researchers engage in explicit, self-aware analysis of their own role - offers one tool for such evaluation" (p.531). By being reflexive about my research and acknowledging the role of language and context I hope that subjectivity has been turned "from a problem to an opportunity" (Finlay, 2002, p.531).

Recruitment and sampling

Three trainee counselling psychologists and two counselling psychologists were recruited for the pilot study. They were my peers and colleagues. The purpose of the pilot studies was for me to become accustomed to the procedure, and pinpoint any changes that needed to be made. Further reasons were to gain feedback from the participants on the interview process and the interview schedules used, and to have the ability to begin engaging in the process of reflexivity.

For the main study four trainee counselling psychologists and four qualified counselling psychologists were recruited. There are no 'correct' number of participants for an IPA study but generally IPA "is concerned with the micro analysis of convergence and divergence within a small set of accounts" (Eatough & Smith, 2008, p.182). A key aspect of IPA is its dedication to a thorough interpretative analysis (Smith & Osborn, 2008) and I felt that this was a manageable number to engage with, in the amount of time that I had.

The reasons were varied for recruiting counselling psychologists and not other divisions, i.e. clinical psychologists. Firstly, it is believed that, via purposive sampling, a more closely

defined group is formed for whom the research question will be more relevant (Smith & Osborn, 2008). Secondly, counselling psychologists will have also undergone a similar experience in their own training, conceivably enhancing their understanding of the research topic. Lastly, counselling psychologists are trained in a diverse range of models and a criticism of the existing literature on personal therapy for therapists had been that it tended to be model-specific. Although not an initial aim, I wondered if counselling psychologists would reflect on their own personal therapy experiences. This could potentially fill a void in my research of a possible third group: chartered psychologists reflecting on their experiences of mandatory personal therapy. It transpired that this was the case, with most of the counselling psychologists reflecting on their own experience of therapy. My preference was to recruit counselling psychologists who had seen more than one trainee. Nevertheless, they were not excluded if this were the case, as long as they had seen the trainee for at least six sessions, as I felt that otherwise the interview may not be rich enough.

Trainee counselling psychologists, undertaking their doctorate in counselling psychology, were recruited from the second year of their training. The second year was chosen because, similarly to my reasons for recruiting solely counselling psychologists, I wanted as homogenous a group of participants as possible (Smith et al, 2009). Conceivably, a trainee in their first year may experience therapy very differently to a trainee in their third year, who is much nearer to chartering as a psychologist. Consequently, I reasoned year two was a good mid-way point. The trainees seemed able to reflect on their experiences of personal therapy (i.e. in the first year), whilst also talking about what they would want in future therapeutic experiences (i.e. in the third year) which brought depth to the interviews.

The participants were required to have had a therapeutic relationship for at least six sessions, as this still allowed for the analysis of the therapeutic relationship in short-term therapy. Any theoretical orientation was considered as counselling psychology incorporates different modes of therapy. Lastly, the participants had to have finished therapy no more than three years ago so as to make the memory of the experience of mandatory personal therapy as fresh as possible. I did not specifically recruit trainees who had seen counselling psychologists as their therapists because at the time, some counselling psychology courses permitted trainees to see UKCP and BACP registered therapists.

The trainees were recruited by emailing the administrators at four of the London universities that offer the counselling psychology doctorate course and asking them if they would send an email to all counselling psychology students in their second year. More people replied than were required. I chose the first four participants who had replied and who fitted the inclusion criteria, whilst replying to the others to thank them for getting in contact.

The initial stage of recruitment involved recruiting chartered counselling psychologists, and not specifically counselling psychologists who had doctorates. I began by placing an advert in The Psychologist (Appendix A). No replies were received, possibly because it was placed in the August edition when many people were away. I utilised my own university website and contacted counselling psychologists who had placed adverts offering personal therapy. One reply was received from there.

My main resource for recruitment was the BPS website. I went to the 'Directory of Chartered Psychologists' (2000) and selected the psychology work area of 'counselling'. I then entered my post code and selected a search radius of 25 miles. When the results emerged there were 317 matches. Once I had identified someone as being a counselling psychologist I sent them a uniform email (Appendix B) informing them about my study, asking them if they had seen trainees and if they would be willing to participate. The initial emails were sent out to the psychologists who lived closest to me, purely for practical reasons (travelling time and expense). Three responses were received and subsequently interviews were arranged with these participants.

After conducting these interviews I reflected that the counselling psychologists that had been recruited were chartered counselling psychologists, who did not have a doctorate in counselling psychology. I wondered if counselling psychologists with doctorates would have different experiences of seeing trainees, as compared to counselling psychologists without doctorates. In the interest of getting as deep a level of analysis as possible, a second stage of recruitment was conducted involving solely recruiting chartered counselling psychologists who had doctorates. In retrospect, this should have been done originally as all the trainee counselling psychologists participants were on doctoral courses, and the two samples should be as homogenous as possible, in keeping with IPA (Smith, Flowers & Larkin, 2009). Using the same method as previously (recruiting from the BPS website) I emailed only psychologists who had doctorates and accordingly received four responses, all of whom were interviewed.

The psychologists with the doctorates tended to be more forthcoming in their interviews. This may have been due to several factors. On the whole the doctor psychologists that participated had been qualified as psychologists for longer. They seemed to empathise with the process of undertaking a doctorate more and appeared more willing to reveal their own anxieties about seeing trainees. Perhaps having completed the doctorate themselves, they felt more comfortable being interviewed for a doctoral research project.

Semi- structured interviews

Consistent with the theoretical guidelines of IPA, semi-structured interviews were employed. Eatough and Smith (2008) stated that "the real time interaction with the participant gives major flexibility for the researcher in facilitating the participant in exploring their lived experience" (p.188). This inductive 'bottom up' approach permits the participant and the researcher to partake in a discussion in which preliminary questions are changed after receiving the participant's response. It also allows the researcher to have the chance to be able to investigate significant subjects which surface and to ask the participant for clarification (Smith & Osborn, 2008). Willig (2008) explained that, in comparison to structured interviews, the order of the questions is less significant, and the interviewer has more flexibility in pursuing the interests of the participants. Although there are other forms of enabling participants to talk about their experiences i.e. journals, audio tapes etc (Willig, 2008) I felt that a dialogue would be better facilitated using semi-structured interviewing. It is also the most widely used method in IPA for data collection. Nevertheless, one of the counselling psychologists emailed me after her interview with some more of her thoughts, which I analysed alongside the interview that took place between us.

Constructing the interview schedules: It is imperative to create an individual schedule prior to beginning to interview participants (Smith & Osborn, 2008). Smith and Osborn (2008) stated that interview schedules enable interviewers to explicitly think about what they hope the interview might include. It also permits the researcher to consider any potential complications i.e. terminology used and delicate areas which would require sensitivity.

There were two interview schedules (Appendix D): one for interviewing the trainee counselling psychologists and one for the counselling psychologists. This was because different questions were asked to both groups although the interview schedules revolved around the same main research topics. The interview schedules and research topics changed

significantly after my pilot study process. Initially, the main topics were: a) the therapeutic relationship, b) power imbalance and c) 'forced' moments in therapy (Appendix C). After feedback from my pilot study participants and my own reflections, I realised that the terms 'power imbalance' and 'forced' moments were quite leading and would perhaps be too laden with my own expectations. It is common for the initial stages of constructing the interview to result in questions being too specific and "loaded" (Smith & Osborn, p.61). After piloting, the research topics were changed to a) therapeutic relationship, b) content of sessions and c) mandatory therapy as a course requirement.

Additionally 'prompts' were constructed for the interview schedules (Appendix D); Smith and Osborn (2008) stated that these can be used when the issue is quite complicated or the question asked is too unclear. The technique of 'funnelling' was used when constructing the schedules (Smith & Osborn, 2008). This procedure allows more general questions to be asked of the participant first, hopefully allowing the respondent to discuss the subject without too much difficulty. Smith *et al.* (2009) recommended that "primary questions should also avoid imposing too many *a priori* theoretical constructs upon the phenomena" (p.47). After discussion with my supervisor, a constructivist approach was used to ask the first research question (Appendix D). It was hoped that this would both eliminate the 'predictability' of what could occur in the interview, and keep the question as open as possible, whilst remaining focused on the research topic. This approach allowed me to follow the recommendations of Smith *et al.* (2009) of making the questions "open" not "closed" (p.47).

I felt that the revised topics worked much better in the interviews. Nevertheless, participants were asked (at the end of each interview) if there were any questions that they had wished they had been asked but had not been. Many stated that they felt that the questions had been open enough to allow them to speak about their experience. One interesting suggestion from a qualified therapist-participant was to ask the qualified therapists if their experience of personal therapy had impacted on how they conducted therapy with trainees. Smith and Osborn (2008) stated that "the interview can follow the respondent's interests or concerns" (p.58). Accordingly, this topic was explored with the therapist that proposed the question, and it proved very interesting.

Procedure: During the pilot study and the main study the participants were fully informed both verbally, and in writing, about the nature and purpose of the study (Appendix E). They

were told that the interview would take about an hour and that there would be ten minutes for feedback at the end of the interview. The type of questions asked during the feedback centred on the questions that were asked, the way in which they were asked and prompts used during the interview. From this feedback changes were made to the subsequent interview procedures. Participants were seen at a place and at a time of their choice; this varied from my university to their homes. When the interviews were over the participants were debriefed both verbally and in writing (Appendix F) and thanked for participating in the study.

Transcription: The interviews were recorded on several digital recorders (in case of one malfunctioning) and transcribed by me. The interviews were also saved on to a memory stick. This was kept securely in a locked box in my home. The verbatim transcripts have not been included in the appendices due to my concerns that the participants would be identified, in the relatively small world of counselling psychology. Potentially identifying details of the respondents have been changed to avoid anyone being recognized.

Analysis

IPA is "not a prescriptive methodology" (Smith & Osborn, p.66). I adapted it by using two groups of participants and looked to see if there was any connection in the themes between the two. Whilst my main research interest was on the individual experiences of the trainees and the qualified therapists, I also wanted to determine if there were any similarities, or indeed differences, in the experiences of both groups. The interviews carried out with the counselling psychologists without doctorates were excluded from the main research, and instead incorporated into the pilot study, as the sampling criteria had changed. Although it is not common in IPA to compare themes across groups, it has been done before and used by Smith in his research with Michie, Henry, and Adshead (2004) and de Visser (2007). IPA's idiographic foundation prescribes that it is only in the later stages of the analysis that insights produced from individual cases are integrated; consequently I did not lose the idiographic focus of IPA.

In accordance with the idiographic element of IPA I looked very specifically at the transcript of the primary interview before starting to look at the other interviews. Although in IPA one can use the themes from the first interview analysed, to inform the subsequent interviews, I chose not to do so, in the interest of attempting to analyse the individual experience. There are several stages to carrying out IPA analysis for an individual case.

Searching for themes: The first step involved reading and re-reading the transcript to get a general 'feel' of the interview. Smith and Osborn (2008) stated that this is near to being "a free textual analysis" (p.67). At this point they suggested using the left hand margin as an open form of documenting issues. The second stage involves the researcher distinguishing and labelling themes (using the right hand column) that typify each segment of the text. The aim is to capture "something about the essential quality of what is represented by the text" (Willig, 2008, p.58). For example a descriptive comment on the left hand column for the trainee-participant Natalie: 'knowing the rules of therapy allows 'appropriate' client behaviour' would be shown in the right hand column as the theme 'acting the part' (Appendix H).

Linking the themes: The third stage investigates how the themes are associated with each other. This stage requires incorporating more organisation into the analysis (Willig, 2008). The emergent themes were organised chronologically (Appendix I) as suggested by Smith *et al.* (2009) and then moved around by being copied and pasted into groups of associated themes (Appendix J). This process involves ensuring that the lists of themes that are being organised are grounded in the text that produced them in the first instance.

The term 'abstraction' is used to describe the basic way of distinguishing connections between the emergent themes and finding a 'superordinate theme' (Smith *et al.*, 2009). This encompasses placing similar themes together and finding a name to define the cluster. Nevertheless, as Smith *et al.* (2009) stated "it may be worth examining transcripts for the oppositional relationships between emergent themes by focusing upon difference instead of similarity" (p.97) - they named this "polarization" (p.97). An example of polarization can be shown in the superordinate theme **"The Ambivalent Self"** in Natalie's interview. It included the following subthemes (written in bold) and emergent themes: **i. "Shopping for a therapist**: 'seeking similarities' *and* 'wanting a challenge', **ii. "Wanting therapy but feeling forced**: 'theoretically a positive idea' *and* 'I guess forced is the word', **iii. Authenticity**: 'being genuine' *and* 'acting the part', **iv. Playing the game:** 'being a good client' *and* 'breaking the rules' and finally **v. Being in control but recognising lack of control**: 'desiring control' *and* 'feeling out of her depth' (Appendix K).

This is an iterative type of analysis, and involved the hermeneutic principles of being aware that I was calling upon my own interpretative resources, in order to attempt to understand what the respondent was saying and then examining whether this was actually what the respondent

had experienced (Smith & Osborn, 2008). Although it is necessary for the superordinate themes to be grounded in the data it is essential to find *implicit* meanings- i.e. it can be something the participant has not said explicitly but that has been implied throughout the interview. Although Natalie did not explicitly mention that she felt ambivalent about mandatory personal therapy, it was evident from the data, and from my own feeling during the interview, that ambivalence seemed to be a key aspect of Natalie's experience.

To ensure that this is evident, the fourth stage is to produce a list of the structured superordinate themes, alongside quotations that demonstrate each theme. At this point some of the themes were made redundant because I did not feel that they were illustrative of the participant's experience, e.g. if a theme was only mentioned once. Themes were only included if they portrayed something about the quality of the participant's experience of the phenomenon under investigation (Appendix K).

The same process was performed for each interview. I endeavoured to adhere to IPA's idiographic principles and attempted to bracket off any budding ideas from the first interview, whilst analysing the second and so forth. Whilst recognising that this is never fully achievable, the risk was minimised by following the steps rigorously (Smith *et al.*, 2009).

Finding patterns across the interviews and integration of themes from all the cases: This entails producing a list of master themes which depict the quality of the participants' shared experience of the phenomenon under investigation and subsequently tells the reader something about the characteristics of the phenomenon itself. The list should include terms of the superordinate themes and the themes which are components of them. Smith and Osborn (2008) stressed that although researchers will not know how many themes will be generated, they must not finish until all subordinate themes have been integrated into or removed from the analysis.

I did this by producing a lengthy spreadsheet of all the superordinate themes and the themes that they comprised (see Appendix L for a section of the spreadsheet for the trainee counselling psychologists). The rationale behind including all of the emergent themes was to ensure that the idiographic nature of the work was not lost by discarding the emergent themes from the process. Analysing which themes were the most frequent required my taking each theme individually and seeing how relevant it was for each of the four participants. Themes can be selected by the frequency within the data, and also because of "the richness of the particular

passages that highlight the themes" (Smith & Osborn, 2008, p.75). My decision was to focus on the pervasiveness of themes within the data, and to also highlight both the similarities and differences between the participants in my analysis.

In IPA interpretation is expected and can involve dealing with implicit meaning. It is not essential to be completely anchored in the words said, especially as the data includes non-verbal communication. IPA is distinct from grounded theory in that IPA is more accepting of intuitions and the researcher's insight. There is a fine line in balancing this and ensuring that the themes remained grounded in the participants' experience. Therefore, I constantly referred back to the text to check that my themes did so. This process involved re-labelling and reconfiguring some of the themes as suggested by Smith *et al.* (2009). These patterns of themes were then grouped under a master theme title, for example the first master theme for the trainee counselling psychologists is named ***"Being and Becoming a Trainee Client"*** (see Chapter Three: Analysis).

Comparing the groups: The master themes were found by looking at each individual interview from the trainee counselling psychologist group and performing all of the steps above. This process was then repeated for the chartered counselling psychologists. The next step involved looking at the summary table for each group (see Chapter Three: Analysis). I noted that there were four overarching categories that clearly emerged (see Chapter Four: Synthesis). The four categories are simply that, and they are not my 'themes' related to the lived experience and meanings. Whilst creating themes/categories at ever increasing levels of abstraction I was careful not to lose the individual and their lived experience by pondering whether this was really what the participant thought/felt.

Levels of Interpretation: Eatough and Smith (2008) affirmed that doing IPA entails steering between various levels of interpretation. They stated that there are two different levels. One is a more empathic and descriptive level, permitting the researcher to step into the respondent's world. The other is a more critical questioning interpretation, moving beyond the participants own words and understandings, whilst acknowledging the hermeneutic foundation of this purely being the researcher's interpretations of the respondents' interpretations. I used both levels of interpretation in my research.

Ethical Considerations

Any research (regardless of the paradigm) involving human participants will unavoidably face choices regarding acting morally towards participants, whilst fulfilling research requirements (Ballinger & Wiles, 2006). Ballinger and Wiles (2006) highlighted that qualitative research can evoke specific challenges. This is due to the open acknowledgement of the researcher's position being essential in the nature of this type of research. Fundamental to counselling psychology is the relationship between practitioner and those that they have a professional relationship with (Shilito-Clarke, 2003). Consequently, it is essential for the researcher to have a competent comprehension of ethical behaviour. Barker, Pistrang and Elliot (2002) argued that "ethical principles are concerned with protecting the rights, dignity and welfare of research participants" (p.88) and that one should abide by the fundamental principles of "informed consent" (p.88), "avoidance of harm" (p.88) and confidentiality. This section aims to reflect how I have tried to abide by these principles. I kept to the BPS Ethical Principles for Conducting Research with Human Participants (BPS, 2000). As part of my initial research proposal, my ethics form (Appendix G) was approved by my university.

Recruitment: My initial intention was to recruit 'dyads' of trainee counselling psychologists and their therapists. This was because there has been less research asking both the trainee undergoing therapy, and the therapist giving therapy, their perspectives in the same study. Nevertheless, I later realised that in practise this would become very difficult, both ethically and practically. Assuming four dyads would have been found, the trainee or therapist might not want me to know who their client/therapist was. If I was unable to know which trainee had a relationship with which psychologist, there would have been little point in using dyads. It may have been possible to have recruited four dyads who would have agreed to let me know their connection. Nonetheless, there would have been very difficult ethical implications in analysing the data. By omitting many details from the transcripts (in case the trainee/therapist could identify their relationship) the deepness of the analysis would be affected. There could also be negative connotations if participants managed to identify their 'relationship' and there was something they did not like about what the other said, perhaps damaging a previously good therapeutic relationship.

Ethical considerations after the pilot study and during the process: From the beginning of the recruitment period, the participants were informed both verbally, and in writing, (Appendix

E) about the aims of the research and the method in which it would be conducted. Furthermore, they were told that they would be allowed to withdraw from taking part in the study at any time, including when they had already been interviewed. The idea of informed consent is fundamental to the rules of research within the UK and more generally to the Declaration of Helsinki (the report that presents the international structure for research behaviour) (Balinger & Wiles, 2006). The participants were also informed about the estimated time that the interview would take. I reminded the respondents that their interview would be tape recorded and asked if they had any questions regarding the way in which the interview would take place. They were not informed about previous literature in this area so as not to influence their answers.

Whilst planning my research I was aware that, for the participants, talking about their therapy experiences could potentially be upsetting. It was hoped that by making the participants fully aware of the nature of the study before they participated in it, psychological/physiological distress would be avoided (as much as possible). McLeod (2003) stated that "doing qualitative research is similar to doing therapy. The good therapeutic researcher uses empathy, genuineness, and acceptance in developing relationships with informants" (p.89). Intrinsically, the nature of the interview topic is a very personal one, perhaps especially for the 'trainee therapist' group who often talked about the issues that they brought to therapy.

A particular ethical challenge that I faced when conducting the research was asking the questions regarding the 'content of sessions'. The aim of these questions was to allow the participants to discuss what they had used their mandatory sessions for, and how they experienced their therapeutic relationships. Nonetheless, it was sometimes difficult, as a trainee therapist myself, to hear about peoples' issues without turning into the 'therapist' as opposed to the 'researcher'. IPA encompasses asking key questions of the texts from participants i.e. sometimes the researcher can have a feeling that there is something going on in the interview that the participant is not conscious of, thus leading to a deeper analysis (Smith & Osborn, 2008). I found that it was imperative not to confuse the boundaries and indulge my own personal curiosities and tried to remain focused on the research questions during the interview. Nevertheless, I trusted that my questions were open enough that participants would not feel that they had to disclose personal information about their sessions if they did not want to. I continually attempted to be sensitive to any signs that the interview was having unforeseeable

negative effects on the participant. No obvious signs were perceived of this, nor did any of the participants report any.

When the interview was finished I debriefed the participant both verbally and in writing (Appendix F). In the debriefing form a list of relevant journals resources was supplied, in case the participants required them after the interview. Resources such as the Samaritans were not included as the participants were trainee and qualified psychologists who it is assumed would be aware of these services. All the participants had my contact details, and the contact details of my supervisor, if they wanted any further information. The tape recordings of the participants' interviews will be destroyed when the research has been completed. Pseudonyms were used so that none of the participants can be identified. All data was locked away in my home and only I was able to access the information on the computer used to keep some of the information.

Evaluating quality and validity of qualitative research

The principles employed to consider the quality of qualitative research are substantially dissimilar from those used in quantitative research (McLeod, 2003). This is due to the more positivist assumption in the established notions of validity that an 'objective reality' is plausible. In contrast, my epistemological position to the research will not allow me to assess this research in the same way, as I acknowledge that I am part of the construction of the respondents' accounts, and that my own interpretations will influence how the information is analysed (Smith, 2007). Additionally, results will differ, depending upon the context in which the information was gathered and analysed (Madill *et al.*, 2000). In terms of reliability (consistency of measurements/ results), "qualitative research does not seek to be consistent or to gain consistent results; rather, it seeks to elicit the responses of a participant or researcher at a specific time and place and in a specific interpersonal context" (Finlay, 2006, p.320).

Generalisability: Qualitative researchers are concerned with showing that "findings *can* be transferred and *may* have meaning or relevance if applied to other individuals" (Finlay, 2006, p.320). IPA does not attempt to verify or falsify particular hypotheses established on the foundation of the existing literature, i.e. it is idiographic as opposed to nomothetic, and more concerned with understanding the meaning in an individual's life than concentrating on casual law. Nevertheless, this does not mean that one has to choose between the two; "the logical route to universal laws and structures is an idiographic-nomothetic one" (Eatough & Smith,

2008, p.183). Smith *et al.* (2009) argued that a deep exploration of the particular (i.e. individual case studies) can result in a better understanding of the universal by allowing people to contemplate how they would relate to the issue being explored. He stated it can allow one to see how "at the deepest level we share a great deal with a person whose personal circumstances may at face value seem entirely separate and different from our own" (Smith *et al.*, 2009, p.32).

Many authors (e.g. Henwood & Pidgeon, 1992, Barker *et al.*, 2002) have attempted to establish a more exact method for assessing the level of quality in qualitative research, and this is an area of continuing development. Pidgeon and Henwood (1997) outlined several factors to take into consideration when contemplating the production of knowledge: the participant's own comprehensions, the researcher's interpretations, and cultural differences that can impact upon both the researcher's and respondent's interpretations. I tried to take all of these into consideration. Smith *et al.* (2009) suggested using Yardley's (2000, 2008) criteria for evaluating the quality of qualitative research as "they attempt to offer criteria which can be applied irrespective of the particular theoretical orientation of a qualitative study" (p.179) Yardley (2000) proposed four main principles for considering the quality of qualitative research (Smith *et al.*, 2009):

Sensitivity to context: Yardley (2000) suggested that sensitivity to context is an indicator of high-quality qualitative research. IPA researchers display sensitivity to context throughout all the phases of carrying out the research (Smith *et al.*, 2009). I believe that I showed empathy to my participants and recognised the dynamics that existed between us (see Chapter Five: reflexivity). Smith *et al.* (2009) argued that "Because such care is taken with the collecting of data from participants and with grounding analytic claims in the data obtained, a strong IPA study will thereby be demonstrating a sensitivity to the raw material being worked with" (p.180). By including verbatim extracts from the interviews in order to authenticate the argument being made in the analysis section, the reader is able to assess my interpretations of the interviews. I have carried out a thorough literature review and connected the pertinent literature to my work, thus showing a further sensitivity to context (Smith *et al.*, 2009).

Commitment and rigour: "A demonstration of commitment can be synonymous with a demonstration of sensitivity to context" (Smith *et al.*, 2009, p.181). Whilst IPA has been criticised for its perceived lack of generalisability (i.e. small number of research participants)

the depth that the analysis requires, especially its case by case analysis, shows a great deal of commitment and care to the data. 'Rigour' in qualitative research, is evaluated by assessing how 'thorough' the study is (Smith *et al.*, 2009). I believe that I have been rigorous by choosing as homogenous a sample as possible, which included a second stage of recruitment and interviewing.

Transparency and coherence: Researchers need to bring a "critical self-awareness of their own subjectivity, vested interests, predilections and assumptions and to be conscious of how these might impact on the research process and findings" (Finlay, 2008a, p.17). I strived to be as reflexive as possible about my own position, thoughts and ideas and outlined my epistemological viewpoint (see Chapter Three: epistemological position) which would have influenced how I viewed and interpreted the data. Qualitative research should be transparent and coherent (Yardley, 2000, 2008, Smith *et al.*, 2009). I have explicitly documented my research process, by explaining my analytical procedures in detail. This has ensured that decisions I have made, regarding my analysis, are transparent. The analysis has been safeguarded by my being aware that the insights that are generated from the research are interpretations, and not absolute truths. Moreover, my research supervisor further ensured that my own views did not negatively affect the analysis. The reflexivity sections (Chapter Three and Chapter Five) will explore my transparency in more detail.

"Triangulation refers to the use of multiple researchers, research methods, sources, or theories in order to assess the consistency of findings" (Tindall, 1994). I asked a fellow IPA researcher to look at a section of my data and examined what themes she generated from the information. They were similar to my own. I concur with Fielding and Fielding (1986) who wrote that although triangulation may result in a more 'full' level of analysis it is not necessarily a more objective one. After all, I believe that the very nature of the analysis is interpretative. Madill (2000) highlighted that "the goal of triangulation within a contextualist epistemology is completeness not convergence" (p.10).

In terms of coherency I think that the themes fit together logically and hope that the audit trail I have included (see Appendices) will allow the reader to see how the themes have been generated. Smith *et al.* (2009) argued that "coherence can also refer to the degree of fit between the research which has been done and the underlying theoretical assumptions of the approach being implemented" (p.182). This IPA research has endeavoured to be harmonious

with the core principles of IPA. In doing so I have outlined the principles of the double hermeneutic and how this has been applied to this research conducted (Smith *et al.*, 2009)

Impact and importance: Yardley (2000) argues that 'real' validity can be judged by whether the research informs the reader of "something interesting, important or real" (Smith *et al.*, 2009, p.183). I believe that this research has uncovered significant information for the counselling psychology profession (see Chapter Four and Chapter Five)

Reflexivity

"The ways in which we theorize a problem will affect the ways we examine it, and the ways we explore a problem will affect the explanation we give" (Parker, 1994b, p.13). Madill *et al.* (2000) stressed the importance of researchers being open about their own viewpoints, in reference to how they view the material. I accept that I have brought in my own perspectives; however I see my involvement in the data analysis as a positive resource and not as a problem. Banister (1994) remarked that it is insincere to 'pretend' to be neutral as all research is carried out from a certain position.

A contextualist standpoint to research acknowledges the certainty of taking one's own cultural and personal viewpoints into the research process (Madill *et al.*, 2000). The fact that I am a trainee counselling psychologist who has experienced mandatory therapy as part of my own course requirements is significant. I am a 25 year old, white British female, and I am completing my doctoral level counselling psychology training at City University. Several participants mentioned that they speculated that I must have had a significant reaction to my own experience of mandatory personal therapy, to have chosen it as my research project. Nevertheless, I do not feel that it has been a particularly contentious issue for me.

The reason for this choice of topic was because I found the process of going to therapy for the first time, in this unusual circumstance, interesting. Over the three years of training I had the same therapist and feel that we enjoyed a good relationship. Although I did talk freely to my therapist, I was aware at times that I did not want her to think that I was an incompetent therapist. My opinion is that personal therapy is a useful course requirement but that other personal development exercises on the course would also be useful. Choosing not to see a counselling psychologist in the first year when I started therapy, was a decision made purely because at that time we were doing a person-centred module and I chose a local therapist who

was person-centred, and was at the right price range for me. The decision to stay seeing the same therapist for three years was because I found my therapist helpful. In my opinion, it was not possible for me to completely 'bracket' any pre-conceptions of mandatory personal therapy. Nonetheless, by being aware of them, I hoped not to allow them to negatively affect my research.

CHAPTER THREE: ANALYSIS

This analysis section of the thesis will explore my understanding of the participants' sense making of their experiences of mandatory personal therapy. As Smith *et al.* (2009) recommended, this analysis chapter is comprised of extracts from the transcripts, with my analytic interpretations of the extracts. There is no 'set' way to write up IPA analysis (Smith *et al.*, 2009) and I have chosen to connect themes with the existing literature in this section. The tables below show the master themes and sub themes that emerged from the analysis of the interviews. The quotes used within the analysis session have been taken verbatim from the transcripts. Three dots have been used to signify any omitted text i.e. any word repetition, or expressions such as 'hmm' and 'um'. It may also refer to text taken out that may not have facilitated the reader's understanding of the theme.

Trainee counselling psychologists' experience of therapy: master themes

Master Themes	Subthemes
Being and becoming a trainee client	Performing: Being the 'good client' and 'good trainee therapist' Masked self: awareness of therapeutic rules impedes process Forced self: being a reluctant client Lifting the mask: from inhibited trainee to 'letting go'
Learning and growing	*In vivo* learning Understanding and respecting the client's experience Working through personal issues
Investing and committing	Shopping around for a therapist Embracing the challenge Therapy Costs Wanting a return on investment

Counselling psychologists' experience of having trainee counselling psychologists as clients: master themes

Master themes	Subthemes
Settling into roles	Mandatory therapy initially impeding process Trainees become clients
Being 'Good-Enough'	Getting it 'right': judgment by a peer Therapeutic compensation
Holding the boundaries	Being wary and vigilant Keeping therapy therapeutic Temptation to intellectualise therapy
Empathising with the trainee client	Resonating with own personal experience Concessions : special treatment for the trainee client

The Trainee Counselling Psychologists

The trainee counselling psychologists experience a journey during their mandatory personal therapy. As the therapeutic relationship develops they move from an 'inauthentic' to an 'authentic' self. Most of the trainees use mandatory personal therapy to learn and grow both professionally and personally. The trainees appear ambivalent towards mandatory personal therapy. Whilst many feel that therapy should remain a compulsory course requirement, they experience therapy as both emotionally and financially costly.

Master Theme One: Being and becoming a trainee client

The theme 'Being and becoming a trainee client' explores the journey experienced by trainee counselling psychologists during their mandatory personal therapy. They are initially wary about showing their 'true' selves to their therapists. They want to present themselves both as competent therapists and as 'good' clients. From this emerges the theme of 'masked self'. Here trainees display a unique awareness of the 'rules' in which to engage in therapy, which sometimes impedes the therapeutic process. The development of a therapeutic relationship and

trust tends to allow the trainees to let go of self imposed 'rules' and become a client as distinct to being a trainee or fellow therapist.

'Being and becoming a trainee client' is divided into four sub themes:

- Performing: Being the 'good client' and 'good trainee therapist'.
- Masked self: awareness of therapeutic rules impedes process.
- Forced self: being a reluctant client.
- Lifting the mask: from inhibited trainee to 'letting go'.

Performing: Being the 'good client' and 'good trainee therapist'

Eckler-Hart (1987) found that success or failure in the psychotherapy training process, and in delivering psychotherapy, was frequently considered by trainees as an overall indication of whether they were an all-around success or failure as individuals. Webb and Wheeler (1998) discovered that trainees were significantly less able to reveal sensitive matters linked to their clients and counselling in supervision than those supervisees who were fully qualified

> *Natalie: My personal tutor...she was saying that, sometimes people would come and she never really got what they were talking about because they never really got to any depth.*
>
> *Sara: Basically what she was saying...if I was coming purely for the course, then perhaps that wouldn't be quite as useful for me and for her and it'd feel like...artificial superficial relationship.*

The above quotations from Natalie and Sara reflect their feeling of anxiety regarding wanting to ensure that the therapy was not a superficial process, purely as a mandatory course requirement, but a worthwhile process for client *and* therapist. They feel under pressure to 'conform' to their perception of other people's expectations. Both trainees discuss this as coming from an outside force, (the course tutor and therapist); they feel a 'responsibility' to reach the appropriate profundity in their sessions. Thompson (2006) explained that "The greater part of my self's authorship derives from what others make of me... I am so obsessed with what others think of me and how they want to see me that I want to make myself into the person they expect me to be, and to a significant degree, this is who I am" (p.150). This

message is implicit in the above extracts; Natalie's use of the word *"depth"* conjures up the metaphor of a duty to become fully immersed in the therapy. Consistent with the findings of Kaslow and Friedman (1984), the trainee participants give the impression of feeling under pressure to be 'good clients' and 'good therapists'. It seems that Natalie and Sara believe that the onus for the 'success' or 'benefit' of therapy is on the client, and therefore, themselves.

> *Robert: I wanted to present myself in a particular way, being a trainee , I guess I wanted to present myself as someone who was competent in what I do...*

Goffman (1959) stated that "regardless of the particular objective which the individual has in mind and of his motive for having this objective, it will be in his interest to control the conduct of others, especially their responsive treatment of them" (p.15). Robert's employment of the word *"present"* reflects a sense of not showing a genuine self and a desire to show a self that is *"competent"*, and that will be approved of. In the context of the trainees wanting to initially present themselves as good trainees/therapists it can be understood that there is a sense of incongruence in the early stages of trainees' relationships with their therapists

Masked self: awareness of therapeutic rules impedes process

Participants question the authenticity of their behaviour in the therapy room. The trainees report that being aware of 'therapeutic rules' initially impedes the process between themselves and their therapists.

> *Natalie: If the clients know the rules of therapy too much do you really get anything done or do you just start behaving in a way that's appropriate for the therapist?*
>
> *Robert: It was just the first few weeks when I felt I wanted to present this facade... it was particularly because of the age that perhaps I wanted to present myself in a particular way.*

Natalie and Robert convey an ever-present implicit anxiety about 'breaking' the rules, which is possibly linked to the desire to be the 'good client'. Natalie states that there is an *"appropriate"* way of being for the therapist - almost as if she were to be 'herself' her behaviour would be unsuitable. This is not unique to her - Geller (2005) stated that therapists are "more likely to be aware when they themselves deviate from behaving like a 'good patient'" (p.381). Natalie's use of the third person *"if **the clients** know the rule of therapy too much"* as opposed to using the first person in her conversation (e.g. *"if **I**" know the rules of*

therapy too much) suggests a depersonalisation/ defensive intellectualising of the therapeutic experience. Conceivably, this highlights an apprehension about having personal therapy.

Robert's narrative throughout the interview indicates that he equates age with experience and subsequently there is heightened anxiety about appearing as an inexperienced 'novice'. It appears that for Robert, a young man whose therapist was an older woman, it is *"particularly because of the age"* that he wants to present a competent self. His use of the word *"facade"*- defined by the Random House Dictionary (2010) as a "superficial appearance or illusion of something" and the American Heritage Dictionary (2010) as "an artificial or deceptive front" highlights a presentation of an inauthentic self.

Both Natalie and Robert's knowledge of the 'rules of therapy' led to an initial performance of a masked self. Describing individuals as "performers" who adapt to changing environments Goffman (1959, p.29) argued that when the individual presents themselves before others, she/he may want them to think favourably of them or to believe that they think favourably of them. He stated that "it will be in his interests to control the conduct of the others, especially their responsive treatment of him" (p.15). The fear of negative consequences of admitting to personal problems (e.g. embarrassment, loss of status and clients etc) often prohibits psychologists from seeking personal therapy (Barnett & Hillard, 2001). The fact that personal therapy is a course requirement that has to be passed may exacerbate the desire to appear competent for trainees as opposed to qualified therapists.

For some of the trainees knowing the rules of therapy impeded on their ability to relinquish control in the sessions and be 'part' of the process as opposed to governing the process.

> *Sara: So I'm thinking, you know, I'm aware of the learnings that have taken place and where issues come out for me. For example, one issue is, I'm constantly looking at the clock. If it's five minutes then I know I'm going to stop... often, a few of my clients, specifically the OCD client, I find, I'm like, oh G-d, I know you, you're now coming towards the end of a session and you're telling me something really crucial but I have to tell you to stop. It's hard, you know.*
>
> *Natalie: When you know the rules of therapy...that changes the conversation that you have when you're the client...I think it got in the way because I was not able to be irrational in the way that you need to be.*

The extract from Sara's interview suggests she fears letting go in the therapy session, almost as if knowing the 'rules' of time incapacitates her. She refers to finding it *"hard"* having to tell her own clients that time is up in the session. From the tone of her voice when speaking, it can be inferred that she also finds it difficult in her own sessions to make sure that she does not begin to tell her therapist something *"crucial"* before the end of the session. The expression on her face indicated that she would be embarrassed if she were to put her own therapist in the same situation. By saying that she is *"constantly looking at the clock"*, it appears as if she is unable to fully engage in the session.

Natalie seems to contradict herself, highlighting the ambivalence that was prevalent through her interview towards mandatory personal therapy. On one hand she suggests that the *"rules of therapy"* inhibit one from being irrational. Conversely, by Natalie saying *"irrational in the way you **need** to be"* it can be inferred that she believes that a rule of therapy is to be irrational. This may be linked to a paper she refers to earlier on in the interview in which the author states being irrational is required for therapy. It is ironic that 'insider knowledge' can be disabling as opposed to enabling. Perhaps for trainees, who may be relatively new to seeing clients themselves, the rules can appear confusing. Whilst still learning they may be rigid with 'therapeutic rules' with their own clients and subsequently have an expectation that their therapists will be the same with them. Mearns (1996, p.306) stated that "most of our relating as humans is not conducted openly and at depth but carefully with a screen between us and the other person". It can be understood that in the early stages of trainees' relationships with their therapists a screen has been put in place in order to protect them from external evaluation and judgement.

Forced self: being a reluctant client

Similar to the participants in Risk and Target's (2008) study, participants display differing amounts of ambivalence in regards to the mandatory elements of the therapy. Holzman *et al.* (1996) found that the rationale many clinical psychology graduate students gave for not going to therapy was that they did not personally need to and/or because of finances. Although the trainees seem to value the concept of therapy as part of a training requirement, there is a certain amount of negativity expressed concerning the specific requirements of the mandatory element, i.e. some courses require trainees to see a counselling psychologist as opposed to a therapist from any professional body (e.g. BACP). The following extracts highlight the

difference for some of the trainees between 'choosing' to have therapy and having it as part of a course requirement.

> *Natalie: You're coming because it's a requirement, you're not coming because you thought I would really like to have therapy and it does make a difference ... I guess forced is the word.*

> *Sara: Once she slept on me in the session for a few seconds and I caught her...since then I just felt, oh G-d, I'm just going there because I have to.*

Earlier in the interview, Natalie expresses surprise that many people in the course appeared unenthusiastic about attending therapy, having observed that applicants to her course were made aware of the mandatory therapy requirements. Despite this, the above excerpt from her interview emphasises that she herself views mandatory therapy as a *"forced"* requirement. The use of the word *forced,* a strong, powerful word, implies that she was going to therapy against her wishes. This extract suggests that her reaction to mandatory personal therapy surprised her and that she was more uncomfortable about it than she had initially thought.

Williams *et al.* (1999) highlighted the potential for therapy not going well and trainees feeling obliged to continue therapy as part of the course requirements. For Sara it seems that when there is a rupture in the therapeutic relationship, it makes her feel that she is going because she 'has' to, due to course requirements, as opposed to having the choice to leave. Sara's cry of *"Oh G-d"* signifies a feeling of frustration with her therapist. It appears that when there are difficulties in the relationship it reinforces Sara's ambivalent feelings about mandatory therapy, and reminds her that this is not her own decision as such (*"I'm just going there because I have to"*).

Pope and Tabachnick (1994) stated that about one fifth of people who had been to therapy reported that they had kept secret something significant from their therapist. They argued that clients who are in training, or who already are therapists, may have increased worries about confidentiality. They found that a recurring theme was the fact that the patient was a therapist-patient, which allowed many chances for vague boundaries and dual relationships. Natalie describes her worries about this matter:

It just reduced my choice...and also you're going to be working with counselling psychologists, so what happens if a couple of years from now, you go into a job and there's someone who used to be your therapist...

Natalie asking *"what happens if..."* highlights her uncertainty about the small world of counselling psychology and 'having' to see a counselling psychologist.

With my current therapist who I know knows people that I know I made that explicit the first time ...that they were never going to be in a supervision session with the person that we both knew in common.

Natalie has a desire to make it *"explicit"* to her therapist that she does not want her to be in a session with their mutual contact. This hints at her underlying worry regarding being discussed by others. Knowing that therapy is confidential is not enough for Natalie. This displays an initial lack of trust and indicates a desire to safeguard her professional integrity as much as possible. This is not something unique to her; Kaslow and Friedman (1984) also reported that some clinical psychology trainees felt constrained by the small world of psychology. They were concerned about the blurring of their own and their therapists' worlds i.e. by the possibility of having friends/colleagues in common. Nevertheless, participants in this study did not endorse Kaslow and Friedman's (1984) finding that some students regarded their therapist's personal knowledge of important people in their world as helpful to the treatment process.

Claire: At the beginning, our relationship wasn't great because I was really reluctant to go to therapy as part of the mandatory requirement because I had already had four years of therapy and it was a completely different experience.

Claire finds that an obstacle to establishing a relationship is the fact that she has to change to a new therapist (as her previous therapist was not a counselling psychologist). This is something she resents having to do. As shown in her words she was *"really reluctant"*. She acknowledges that her resentment impacted upon her relationship with her new therapist (*"our relationship wasn't great")*, as she compared the way in which they worked, sometimes unfavourably. Her account also reflects an underlying anxiety about starting afresh with her story. Comparing the ways in which her past and present therapy worked, sometimes to the detriment of the latter,

Claire acknowledges that she finds it difficult to have to go over sensitive areas that had already been discussed in the past.

Lifting the mask: from inhibited trainee to 'letting go'

Gelso *et al.* (2005) described the "real relationship" (p. 641) between therapist and client as consisting of two key, interrelated elements: genuineness and realism. Genuineness is described as "the ability to be one who truly is, to be nonphoney, to be authentic in the here and now" (Gelso, 2002, p.37). As the therapeutic work progresses, Gelso *et al.* (2005) suggest, so should the amount of genuineness. Web and Wheeler (1998) found that when the perceived level of rapport was high in the supervisory relationship, the barriers were lower in regard to making sensitive problems known. For many of the trainees in this study, there is a sense of change, of a greater authenticity, as the relationship progresses.

> *Robert: It really was how she allowed me to understand that it was okay to not be perfect, it was okay not to present myself as this competent therapist, that it's important, particularly during my own personal therapy, to just be me.*
>
> *Natalie: I said okay, I'm going to give up the thinking and I'm just going to be irrational and really try to let go and I did and it was fantastic.*

When Robert says *"she allowed me"* he is expressing his feeling that therapy allows him to reveal his true self. Robert feels that because his therapist is more experienced and older than him, that she is in the more powerful and knowledgeable position in the relationship, shown by him saying *"**she** allowed me"*. Indeed, Tracey and Ray (1984) discovered that successful outcome versus less successful outcome cases were typified by less of a power struggle, with the client conceding power to the therapist. It would seem that Robert attributes the change in how he presented his 'imperfect' self to be due to his therapist's skill in making him understand that "*it is okay not to be perfect*". He credits therapeutic 'success' in their relationship to her. Interestingly, he does not acknowledge his own role in this, perhaps signifying some idealisation of his therapist. This was further hinted at by his tone of voice when he spoke about his therapist, and his earnest intonation.

By Robert saying "*it was okay not to present myself as this competent therapist*", it appears that Robert's experience changes from putting on a 'performance' to lifting his 'therapeutic' mask, due to the strength of the therapeutic relationship. Rogers (1961, p.54) stated that "A

very practical issue is raised by the question: Can I act with sufficient sensitivity in the relationship that my behaviour will not be perceived as a threat...if I can free *him* as completely as possible from external threat, then he can begin to experience and to deal with internal feelings and conflicts which he finds threatening within himself". It appears that Robert's therapist manages to free Robert from feeling he was being evaluated as a trainee therapist and he feels at ease in their relationship to be himself.

Natalie, in contrast, chooses to be a 'good client' by being *"irrational"* and releasing herself from the role of the trainee. It seems that she moves from resisting being the 'client' to deciding she feels secure enough to be in that role. Ironically, trainees' perception of what constitutes a good client (observing rules) runs counter to the experience of being an authentic/genuine client. Eckler Hart (1987) posits "When there is anxiety about the vulnerability of one's true self, the false self takes over for protection. It is the task for psychotherapy trainees...to find a way that the true self can be sufficiently protected without being hidden" (p.685). Robert, Natalie and Sara have found a way of doing so, as Sara describes in the following extract:

> *Sara: It's about using that time, really wisely rather than just going in there and talking about what I'm going to cook which I have in the past... I painted a picture which was quite inconsistent with the way that I am now which was probably another defence.*

For Sara, therapy has been a journey. Initially she approaches therapy as a means to an end, rather than for personal development. She started out being defensive and was less prepared to commit to the therapy or the relationship. This changes over time as she became more ready for therapy. Sara discusses how she initially used therapy sessions to talk about *"what I'm going to cook"*, indicating that it was being used in a 'safe' way, with her 'real' issues not being addressed. Mills (2003) describes idle talk as representing "inauthentic anonymous chatter" (p. 154), which perhaps was synonymous with some the content of Sara's earlier therapy sessions. Her use of the word *"defence"* brings to mind an image of Sara feeling 'under siege' with therapy representing a battle. She initially felt vulnerable, both as a trainee and as a person coming to therapy for the first time. Now she indicates dedication to therapy and the therapeutic relationship by both the content of her speech and the passionate way in

which she spoke. Nevertheless, this has not been the same journey for all the trainees. Claire, for example, still feels some resistance:

> *Claire: I might be a bit more open to that now I'm a bit more aware that I don't want to tell my story over and over again.*

Claire's use of the words *"a **bit** more open"* implies that, unlike the other trainees, her mask has not dropped significantly. The physicality of the word *"open"* implies that previously she has been closed, like an inner shut door, to therapy. Her anger at having to change therapists and relay her story, at an emotional and financial cost, hindered her therapeutic process and progression. Macaskill and Macaskill (1992) similarly found that 38 per cent of psychotherapy trainees reported that there were negative effects from their personal therapy, including psychological distress.

Master Theme Two: Learning and growing

Consistent with much of the research (Macaskill & Macaskill 1992, Macran *et al.*, 1999, Williams *et al.*, 1999, Grimmer & Tribe, 2001, Wiseman & Shefler, 2001, Daw & Joseph, 2006, Rizq & Target, 2008) this second master theme depicts how most of the trainees use mandatory personal therapy to learn and grow both professionally and personally. They observe how their therapist worked. Some use their therapists as a model for their own therapeutic work. Others learn what did not feel 'right' for them, and how they would not want to be with their own clients. Therapy aids them in developing empathy for their clients and understanding the therapeutic experience from another angle. The trainees generally find that having personal therapy allows them to address their own personal issues, separate from issues that have arisen from their client work.

'Learning and growing' is divided into three subthemes:

- *In vivo* learning
- Understanding and respecting the client's experience
- Working through personal issues

In vivo learning

Numerous studies have discovered that therapy provides trainee therapists with a model for their own professional practice (Williams *et al.*, 1999, Norcross *et al.*, 1998, Grimmer & Tribe, 2001, Rizq & Target, 2008). It is often cited as a key reason for having mandatory personal therapy (Grimmer, 2005). Grimmer and Tribe (2001) found that having mandatory therapy was an experience of socialisation. They described this as comprising modelling the therapist and validation. Validation is defined as "an explicit use of personal therapy to evaluate the efficacy of a particular approach" (p. 293). The majority of the trainees reflect that both validation and modelling occur in their sessions:

> *Natalie: I just like the way he handled it...they're a little bit like rubber...you make an impact but they flex back, they're not changed in that way. I think that, that's important that we don't, that we're not hard with our clients but we don't give into them, but that we have that sort of rubbery barrier that can accommodate, that still stays complete.*
>
> *Sara: With psychodynamic there's a clear contract, I suppose I like all that kind of stuff, I like boundaries.*

Initially Natalie finds it difficult not to be in control of the relationship. She tests her therapist i.e. purposefully crossing boundaries, to see if he was 'good-enough' at enforcing them and following the 'rules'. The word *"impact"* can be used to describe both a personal and physical impression and Natalie's use of the description of *"rubber"* and *"flex"* indicates her perception of an 'elasticity' of her therapist. This evokes an image of a rubber band being pulled, but refusing to snap and bouncing back. In the context of Natalie's words (*"I just like the way he handled it"*) it seems that her therapist passes her test of not breaking boundaries and she makes herself vulnerable by relinquishing the therapist role. It can be inferred that she both admired and respected her therapist and aims to have the same *"rubbery barrier"* with her own clients. Macran *et al.*, (1999) found that therapists both consciously and unconsciously imitate their therapists' behaviour and techniques in sessions. This can take the form of inadvertently assuming ways of 'being' in the session (i.e. unintentionally assuming the same type of quiet manner as their therapist), visualising how their therapist would have done it or deliberately imitating techniques.

Sara had a negative and even traumatising experience with her first therapist. This experience has made her cautious in regards to finding the 'right' therapist for her. Sara found her first experience of therapy anxiety-provoking and unsettling. Perhaps because of this she likes the boundaries (*"I like boundaries"*) that the second therapist offered. It allows her to develop a great knowledge of psychodynamic therapy, and 'validates' a model that she does not use in her own clinical work.

Orlinsky, Botermans and Ronnestad (2001) discovered that personal therapy consistently ranked among the top three sources of positive influences on professional development.

> *Natalie: If I had to pick the person to emulate in therapy, she would definitely be it and it would be quite a mentoring relationship.*

Natalie had two therapists and she used both as a model. The above extract highlights that she has thought about and compared the styles of her therapists, picking her first one as one she would want to "*emulate*". Natalie's use of this word implies that her therapist has made a strong impression on her and that she aspires to be like her with her own clients. A recurring finding in the literature regarding how therapists' own personal therapy impacts on their client work is that it presents an '*in-vivo*' chance to view clinical techniques (Norcross *et al.*, 1988).

Although undergoing therapy from a fellow therapist can improve personal validation and professional socialisation, there is a possibility that it can also endorse professional indoctrination (Norcross *et al.*, 1999). Rizq and Target (2008) stated that a disadvantage of using the therapist as a role model is that therapy becomes more of a professional, rather than a personal, learning experience.

> *Robert: We began to use things like thought records and I just sort of observed the way that she used them on me...the way that I was taught the model, I just couldn't grasp it at all...*

Robert's use of the word *"observed"* suggests that he was not always 'in' the process of being a 'client'. At times he used therapy as a learning tool, viewing Cognitive Behavioural Therapy (CBT) techniques that he was unsure how to use. Robert tends to put his therapist in the role of the expert. This may have been due to his feelings of vulnerability, and anxieties about using CBT as a novice therapist. His use of the expression *"used them **on** me"* implies that he is a passive recipient in the process and that therapy is governed by his therapist's skills.

In stark contrast to Robert, Claire examines her therapist critically. For her, therapy has shown her what she does not like, and how she would not want to be as a therapist:

> *Asking for feedback at the end of sessions...my therapists haven't done that with me...it's really important that when I become a therapist...it's definitely taught me something that I haven't learned in lectures.*

For Claire, unlike the other participants, therapy represents unmet desires and a place of struggle; she desires collaboration, validation and support but does not feel understood or 'heard'. Nonetheless, by saying "*it's **definitely** taught me something*" she expresses her belief that the therapeutic experience had been useful in some ways, even if it is to show her how not to be with her own clients.

Understanding and respecting the client's experience

Strupp (1973) found that personal therapy does not have any influence on therapists' skills at empathising with their clients - in fact undergoing therapy and doing psychotherapy at the same tim may be anti-therapeutic. Reviewing the literature, Macaskill (1999) and Macran and Shapiro (1998) stated that there was a lack of evidence showing that therapeutic effectiveness is notably enhanced by the therapist having had personal therapy. Nevertheless, consistent with much of the research (Wogan & Norcross, 1985, Norcross *et al.,* 1988, Murphy 2005, Rizq & Target, 2008), the trainees, without exception, find that personal therapy allows them to empathise with their clients and appreciate the complexities/difficulties of being the client in the relationship. This is depicted by Natalie:

> *What it really gives you is true empathy to have sat in their place, to take on what it's like to be them.*

Natalie's use of the word *"true"* indicates that, for her, therapy has given an authentic/genuine understanding of the experience of being a client, which she may not have gained otherwise. This would illustrate that the challenge of 'taking on' therapy has been worthwhile for Natalie. Possibly if she were not to have experienced therapy she would have had a 'false' sense of empathy towards her clients.

The impact of psychotherapy is positively associated with the therapist's ability to display empathy, warmth and genuineness and his/her increased focus on the personal relationship in

therapy. (Wogan & Norcross, 1985, Norcross *et al.*, 1988, Rizq & Target, 2008). Macran *et al.*, (1999) also proposed that therapy made therapists more sensitive to how they related to their clients. These points are reflected in the following extract from Claire:

> *Claire: It's really teaching me to think about what it would be like for the clients that I'm working with in terms of how they might feel if they are struggling with money and also how they might feel if I'm not collaborative with them...I think asking for feedback at the end of sessions...my therapists haven't done that with me. I think it's really important that when I become a therapist and if I offer therapy to trainees, to really do that, and I think because my therapists haven't asked me, I've become more aware of it when I'm with my own clients.*

Claire stated in her interview that she had a negative experience of her own personal therapy. Claire's account suggests that having therapy has reinforced for her the significance of the *process* of therapy ("*how they might feel*"); something which she had not felt had been addressed with her own therapists. She mentioned several times in the interview that her therapists had not been collaborative with her ("*You know my therapists haven't done that with me*", "*I think because my therapists haven't asked me*") which has impacted on her own work with her clients and aided her in becoming more aware of the importance of collaboration in therapeutic work. Payne (2004) discovered that dance movement therapy (DMT) trainees who experienced DMT whilst training found that their experience increased their empathy with clients, especially when they recalled moments in their own therapy i.e. when engaging with the session was hard.

Working through personal issues

With the exception of Claire, the trainees are able to drop their 'trainee masks' in order to use the personal therapy to explore long standing personal problems, issues derived from course - related experiences, and problems that have arisen from the therapy sessions with their own clients. This echoes the findings of Williams *et al.* (1999) who found that participants made a "distinction between three factors, learning about therapy itself, issues arising out of training and dealing with personal issues" (p.545). Robert and Sara used therapy to discuss issues that had arisen for them in their own work with clients.

Robert: I went in there with so much bias against him... in therapy we addressed what it was that kind of stopped me from wanting to say those things to him.

Sara: I once discussed having these feelings of attraction towards my male client and I took that to my personal therapist.

Robert and Sara both were able to move forwards in their client work, once they had engaged with their therapists and discussed the personal impact their client work was having on them. The trainees predominately use client problems to discuss how issues with clients affected them personally, as opposed to using their issues with their clients as an excuse to turn therapy into 'supervision'.

Robert states that his issues with a particular client were "*addressed*" indicating that he finds therapy useful in aiding his client work. Robert settles relatively quickly into being comfortable enough to be open about difficulties with client work, whereas Sara is more wary about bringing her personal problems from her clinical work to her therapy. She talked about her dilemmas in a hypothetical sense- "*if I experience a rupture...I **might** discuss that*". Despite Sara's personal barriers (perhaps due to her previous negative experience of therapy and/or worry about being judged by her therapist), she does use therapy to discuss her anxieties. Consequently she is able to move forwards on her therapeutic journey. The following extract depicts this:

It's not only about professional development, it's about personal development, it's about understanding myself and my relationships.

Robert and Sara's comments support Murphy's (2005) qualitative study investigating the experience of trainees undertaking mandatory personal therapy during a Masters (MA) in counselling. He discovered that all the participants found that personal issues became highlighted during their work as therapists or in their training. Personal therapy was helpful for them in addressing these issues. Dearing, Maddux and Tangney (2005) similarly described how both trainee and experienced therapists made clear the significance of psychotherapy for aiding personal problems.

Robert is also ready early on in his therapy to talk about issues that had troubled him the past:

The things that I kind of brought to the therapy were things that had been long-standing.

Robert uses therapy to address *"long-standing"* personal problems, highlighting that he sees therapy as an opportunity for both personal and professional growth. He both believes in it and wants to make the most of the opportunity, and challenge himself to develop in both areas.

Sara realises that therapy can be used for more than just professional development and allows herself to be open with her therapist about her personal life. At first she approaches therapy as an obligatory part of professional development, and then she dedicates herself to it, and to personal growth. Now she is really committed and passionate about it. Rizq and Target (2008) found that several respondents depicted the importance of personal therapy in accommodating an emotional experience as separate from academic or intellectual insight. Natalie shares Sara's change in using therapy for personal issues:

I actually had one crisis, er family crisis and I had actually called and I had said, you know, I'm really sorry, I know you're not supposed to do this but I'm just wondering if I could..."

Natalie is surprised when she uses therapy for a *"family crisis"* which is shown by her use of the word *"actually"* twice. She has been very concerned about boundaries *("I know you're not supposed to do this"),* and keeping to the rules. The transition of her being able to call her therapist, out of the therapy hours, highlights a trust in the therapeutic relationship and a strong bond with her therapist. This enables her to be more real and spontaneous within the relationship.

Master Theme Three: Investing and committing

At times, therapy is treated as a commodity by the trainees. Therapists are picked with specifications in mind. They do not always go for the 'easy' option by picking a therapist that they feel that they would be the most comfortable with. Quite the opposite; they set out to challenge themselves, working with different models, gender and ages. There remains a certain ambivalence about mandatory personal therapy. Whilst many spoke favourably about the inclusion of therapy in the course, therapy costs the trainees both emotionally and financially, and they want a 'return' on the investment.

'Investing and committing' is divided into four subthemes:

- Shopping around for a therapist
- Embracing the challenge
- Therapy Costs
- Wanting a return on investment

Shopping around for a therapist

Kaslow and Friedman (1984) investigated what the criterion was for trainee clinical psychology students when they were choosing a therapist to engage with. They found that until the end of the second year of training, trainees' requirements for a therapist were the same as non-therapists. Nevertheless, they discovered that this changed during training; trainees begun to have specific requirements for finding therapists such as theoretical orientation and gender. This contrasts with the trainees in this study. They have specific and unchanging requirements from the very beginning of their first year, which arguably distinguishes them from clients with no prior knowledge of therapy. Trainees emphasise the importance of finding the 'right' therapist.

In contrast to the Kaslow and Friedman (1984) study, trainees in the present study did not articulate that they preferred therapists with DPsychs, although both groups of trainees were looking for a professional to model.

Both Natalie and Sara use the words *"shop around"* when referring to choosing their therapist:

Natalie: I always tell people that they should shop around...never just pick the first one that you talk to ...you should actually have a phone conversation with a few.

Sara: I'd also first say, to really shop around.

The use of this phrase signifies that Natalie and Sara see themselves as consumers, choosing the appropriate 'product'. For them, picking a therapist is an important choice, and not a decision to be taken lightly. Natalie's use of the phrase *"**never** just pick the first one"* is quite an absolute statement, the use of the world *"never"* depicting that for Natalie, this is something crucial, and more than just a course requirement. Oteiza's (2008) study of Spanish therapists' experience of personal therapy echoes this notion of 'shopping around'. The Spanish therapists highlight they followed their "intuition" (p.7) when choosing a therapist. Participants in this study reported that they had several sessions with a therapist before deciding who to see on a regular basis. Nonetheless, that is not to say that trainees in this study did not have an intuitive feeling about which therapist to choose. This is depicted by the following vignette:

Claire: I think it is really important to find somebody that gets you, I think the fact that this lady is offering half the price of a therapist means that she already gets me. She already understands that it's difficult for trainees to pay for personal therapy when they're on the road to getting to where they want to be in terms of getting qualifications and I think that the fact that she's lowered her price shows that she's congruent in her behaviour as well as in her words and that she gets it at a deeper level.

For Claire, ethics are expressed by the price the therapist charges (*"she's congruent in her behaviour as well as in her words"*. She believes that by *"offering half the price"* the therapist understands her psychologically before starting therapy (*"she already gets me"*). The word *"get"* (also understood as 'acquire') may also suggest that in Claire's mind, there has been a fair exchange: she (Claire) has been purchased in return for a discount.

Claire's narrative, suffused with anger towards the 'unethical' and 'inhumane' nature of the requirements of mandatory personal therapy, supports Atkinson's (2006) assertion that it is "neither intellectually nor ethically coherent" (p.408) for therapy to be a training requirement. Comparing the training requirements for clinical and counselling psychologists, Claire laments:

We don't have the same rights as clinical psychologists... trainees get all their fees paid for a full time course for three years...It really makes me sick to the bottom of my stomach...it irritates my whole body, my mind, everything.

The embodiment of Claire's anger expressed with her words *"it irritates my whole body, my mind, everything"* highlights the importance for her of being understood by any potential therapist. Other trainees had different reasons for picking a particular therapist. Robert chose a therapist based on theoretical orientation:

I chose to work with someone who used a CBT approach because I was struggling with that model.

In choosing a therapist Robert prioritises course-related matters, linked to his anxiety and struggles regarding the CBT model, over choosing the most appropriate therapist and model for his long standing personal issues. Robert chose a therapist, after considering his *present* course-related anxieties and how they were affecting him. His use of the word *"struggling"* depicts an active battle with the model, internally and externally. By Robert picking a therapist who specialises in CBT, Robert alleviates his anxiety on both a personal and professional level. Although many of the studies have illustrated how trainees use therapy to model and learn from their therapist (see Master Theme Two: Learning and growing), few have investigated whether this was the primary reason for the choice of therapist, or indeed specified what the trainee's reasons were for selecting a particular person.

Embracing the challenge

Yalom (2002) stated that it is vital for therapists, early on in their careers to "avoid sectarianism and to gain an understanding of the strengths of all the varying therapeutic approaches" (p.42). Most of the trainees did not want an 'easy' therapeutic experience. They wanted to challenge themselves and go for the therapists that they would not necessarily find it easy with. This is highlighted in the following excerpts from Natalie and Sara:

Natalie: If I had continued with her where I just loved it all the time I wouldn't have gotten that feeling of having been the reluctant client.

Sara: My previous therapist, who was female, it was easy...so I was looking for a white male psychodynamic person.

The above excerpts highlight that neither Natalie nor Sara want to be too 'comfortable' in a therapeutic relationship. Natalie feels that therapy should be a challenge. Her use of the words *"the reluctant client"* is interesting; it seems that Natalie believes that for mandatory therapy to be useful, one must be out of one's comfort zone.

Kaslow and Friedman (1984) found that many of the female students in their sample had chosen to engage with female therapists, perhaps because there were few women on the training course, and out of desire for a role model. Interestingly, Sara challenges herself by looking for the opposite. She declared that seeing a female therapist was *"easy"* leading her to look for *"a white male psychodynamic person"*. These specific criteria suggest that Sara wants to look for the 'opposite' of what she is: a black female CBT trainee. Participants' accounts indicate that to grow as a person/therapist, one must find therapy difficult. Robert makes this explicit in his interview:

> *If we stay with someone that's comfortable, that's convenient then it would be harder to grow...I think we will only become competent if we allow ourselves to be.*

Robert wants to make the most out of mandatory personal therapy and challenge himself to be the best therapist he can be. By saying *"we will only become competent if we **allow** ourselves to be"* Robert indicates that he believes that it is a personal responsibility to use therapy as a tool to grow personally and professionally. This contrasts with his use of *"allow"* previously (see: Master Theme One, Subtheme Four: Lifting the mask: from inhibited trainee to 'letting go') where he previously attributes his comfort in the room to the skills of his therapist. Paradoxically Robert suggests that he becomes more empowered by allowing himself to feel more vulnerable. Many of the trainees seem to believe that if therapy is too comfortable it is not really therapy, almost as if there is 'no pain no gain'.

Therapy Costs

Mandatory personal therapy comes at a price, both emotionally and financially, for the trainees. The financial implications of mandatory personal therapy were spoken about passionately during the interviews. For trainees on courses that cost a significant amount of money, the additional cost of personal therapy causes significant financial, and therefore also emotional, stress compounding the emotional experience of therapy.

Bor, Watts, and Parker (1997) investigated the financial and practical implications of counselling psychology training. They found that 32 per cent of the students had taken out a loan to pay for the course and that some trainees had acquired debts of up to £10, 000 during their training. Bor *et al.* (1997) suggested that some people may be discouraged from applying for a training course due its cost. It can be argued that the financial requirement of mandatory personal therapy adds a further obstacle. Grimmer (2005) stated that it is "a sad irony that personal therapy, which is seen as (amongst other things) a remedy for the occupational stress of practising therapy, can become a significant emotional burden for the trainee" (p.280). This has certainly been true at times for Robert and frequently for Claire.

> *Robert: The therapy is a big part of the course fees....on one hand I could see it as being an essential part of the course, in the other hand I could see it as being a component of the stress ...perhaps it is counter- productive.*

Robert finds personal therapy very useful, and throughout his interview reiterates that he finds mandatory personal therapy a positive requirement. Nevertheless, the above extract reveals greater ambivalence on his part, due to the financial impact, than he previously states. Whilst he describes therapy as *"an **essential** part of the course"* he also states that it can be *"counter-productive"*. Robert's ambivalence raises questions about the relative costs and benefits of therapy. Phillips (2006, p.283) stated that "The analyst is a charlatan because he can't tell you what it would be to get your money's worth from an analysis...to have got one's money- worth can be to betray an uncertainty about how to value one's experience (what something is worth to me may be incommensurate with what it cost me in money)". It seems that for Robert, he is at times uncertain of whether the experience is worth the cost.

Williams *et al.* (1999) published a study in which 84 counselling psychologists completed questionnaires about their views on their personal therapy. They found that only 15 per cent of 192 counselling psychologists were in favour of starting personal therapy at the start of training. They found that 27 per cent of participants reported negative effects of personal therapy i.e. disrupted marital relationships, increased emotional withdrawal, destructive eating and heightened psychological distress. The authors concluded that it may not be beneficial to have therapy for the first time at the beginning of training. Their study endorsed earlier research by Macaskill and Macaskill (1992) who advised against being complacent regarding

the advantages and disadvantages of personal therapy for trainees. This theme is illustrated in Claire's interview:

> *I hated having to have therapy at the beginning of the course because of finances... I found myself getting quite angry having to pay for it... I was taking my anger out on her ... I was so keen at the beginning because I wanted to get on the course that I was prepared to take that on. But having to work and study at the same time is a real strain on me personally and emotionally.*

This quotation offers an indication of the strength of Claire's emotional response to mandatory therapy. By using the expression *"having to have therapy"* Claire implies that she has no choice in the matter, and that an early financial commitment was something that she *"hated"*. This strong expression was mirrored in her impassioned tone of voice. Claire feels resentful and resistant to having therapy because she disagrees, both at a financial and ideological level, with its mandatory nature. She is angry at the counselling psychology profession and rails against its training system for her financial difficulty. Claire's words *"I was taking my anger out on her"* reveal how her anger seeps into the therapy, and taints the experience, thereby affecting her ability to form a working therapeutic relationship. In spite of this, Claire acknowledges that although she knew therapy was a course requirement, she had underestimated the toll it would have on her:

For Claire the *"strain"* of working and studying was taking a toll and spilling out into her therapy, echoing her early comments about the physical embodiment of her anger regarding mandatory personal therapy. Dearing *et al.* (2005) highlighted that psychotherapy trainees often have other stressors, aside from course requirements, including financial worries. This is certainly true of Claire, as she says the cost of working and studying was affecting her both *"personally **and** emotionally"*. In separating the personal and emotional, Claire hints at her difficulties in integrating these two areas of her life.

Investigating stresses reported by UK trainee counselling psychologists, Kumary and Baker (2008) found that "counselling psychology trainees report stress levels and associated distress levels that are unacceptably high" (p.26). They questioned whether training programmes submit trainees to intolerable stress levels while simultaneously advocating the importance of being prepared to be vulnerable and being open to experience.

In Shapiro's (1976) study of analysts' evaluations of their own personal therapy, many respondents noted that the training analysis and the training setting imposed substantial, and at times, insurmountable emotional burdens. Perhaps the implications of expensive personal therapy need to be considered in all the training courses. In a letter to the BPS, Mearns, Dryden, McLeod and Thorne (1998) coined the term a 'financial scam' regarding the introduction of 40 hours of personal therapy for accreditation. They suggested that there was no empirical evidence that personal therapy really did achieve the personal development dimension for counsellors in training.

Wanting a return on investment

It is clear that mandatory personal therapy comes at a price for the trainees. This fourth subtheme describes their desire for a return on their investment. They want value for their financial and emotional input. This can be seen in the following extracts from Sara and Robert:

> *Sara: I just think to myself, right I am paying for this, I am paying more... and I'm really conscious... I'm committed to the therapy.*

> *Robert: If I am not as open as I can be then I'm not going to benefit from the time that I'm spending there and to be fair it's not particularly cheap so I think I just kind of, began to realize that I wanted to use the time there the best I could and to use the money that that I was paying the best I could so I just began becoming as open as I could be.*

Both Sara and Robert link their wish for value from the therapy with the amount of money that they have invested in it. Sara's investment in the therapy (*"I am paying more"*) strengthens her dedication to it (*I'm committed to the therapy).* Robert also highlights the fact that the onus is on him to ensure that he is rewarded for his financial commitment. It is important to him that he obtains maximum value from the sessions. Perhaps, despite the negative financial costs, 'having' to pay makes the trainees attach greater importance to therapy than if it were being offered for free. With the exception of Claire, trainees feel that despite the negative financial and emotional implications, the return of having personal therapy outweighs the costs. This supports the findings of Williams *et al.* (1999), as the majority of their participants believed that therapy should be obligatory for counselling psychology trainees, including 69 per cent of those who reported negative effects. It appears that, despite the noted disadvantages, the trainee

counselling psychologists in this study consider that they have made a profitable investment. As Sara says:

> *I know we have to pay for it but I think it's money worthwhile...it's quite precious to me my whole therapy experience.*

Her use of the word *"precious"* implies that Sara calculates that therapy is a valuable commodity. She depicts it as a positive opportunity despite the strong emotions it evokes. Williams *et al.* (1999) stated that "it could be argued that considering how much time, energy and money trainees invest in personal therapy... they would hardly be expected to say that therapy was not helpful" (p.533). In contrast, the trainees in this study clearly distinguish the positive from the negative aspects of mandatory personal therapy. Overall they express the view that the return was worth the outlay.

> *Claire: If we could get funding in the way that clinical psychologist trainees get funding, I wouldn't mind doing mandatory personal therapy. I'd actually love it because I think it's great to have personal therapy but it's just the fact that I think it seems to have gotten in the way a little bit in terms of me being able to develop a relationship with my therapist.*

Claire feels that the return of mandatory therapy would be very positive if she were able to *"get funding"*. She goes as far as to say she would *"love it"* which was a very different take from the rest of her narrative. Again she reiterates the interweaving of the emotional and financial, by suggesting that if the financial burden was eased the therapeutic experience would be something that she would *"actually love"*. Although previously in the interview Claire sounded and appeared outraged about the inclusion of mandatory therapy, it seems that it is the self funding of the mandatory therapy that contaminates the experience for her and impacts on the therapeutic relationship (*"it seems to have gotten in the way a little bit in terms of me being able to develop a relationship with my therapist"*).

The Qualified Counselling Psychologists

The qualified counselling psychologists notice a difference when working with trainee counselling psychologists, both due to the mandatory nature of the therapy and their own worries about being judged by fellow therapists, both as a peer and a role model. They want the trainees to have the therapeutic experience that they would have liked to have had whilst

training. The qualified therapists find it difficult to keep therapy 'therapeutic' and to maintain the 'role' of therapist, as opposed to a supervisor and/or peer. They both empathise and sympathise with the trainees which often results in giving them special treatment, as distinct from other client groups.

Master Theme One: Settling into roles

For the therapist-participants, the process of seeing trainees is different from working with other clients. They attribute this difference to the mandatory nature of the personal therapy. The therapists feel that mandatory therapy initially impedes the process of therapy for both the therapists and clients. They find that it takes longer for the trainees to 'settle' into the role of client and longer for them to settle into the role of being the therapist. Nevertheless, this is only an initial obstacle and over the course of therapy there is a process of trainees becoming 'clients', therapists becoming 'therapists' and therapeutic work is resumed.

'Settling into roles' is divided into two subthemes:

- Mandatory therapy initially impeding process
- Trainees become clients

Mandatory therapy initially impeding process

The question of whether there are inconsistencies between making personal therapy a requirement for trainees and the profession's code of ethics has been discussed by multiple authors (McEwan & Duncan, 1993, Grimmer & Tribe, 2001, Jarrett, 2008). In this study, the therapist-participants find that the mandatory element of the therapy initially impedes the therapeutic process for both themselves and the trainees. They believe that the trainees may be unwilling or ambivalent about 'having' to have therapy in addition to feeling some guilt/discomfort regarding trainees being required to come. These thoughts and feelings surrounding the mandatory element of the therapy hamper the process of settling into their 'role' as therapists.

> *Brian: The type of relationship is quite different from a direct therapeutic relationship when someone is coming and saying I have got these difficulties and I want help with them...it is something that isn't voluntary.*

By Brian saying *"it is something that isn't voluntary"* he acknowledges that not all trainees may want to come to therapy and that they may be coming only because they 'have to' as part of a course requirement. He finds the relationship is altered (*"the type of relationship is quite different"*) for both himself and the trainees. The absence of a 'presenting problem" is also noted; Brian is used to working in the NHS with CBT where there are clear goals. Conceivably seeing trainees is outside of his comfort zone. Brian's own views on mandatory personal therapy means that he initially feels uncomfortable having trainees as clients:

> *If you're making it a requirement, you're forcing someone into a relationship and I think to a certain degree that's unethical and it's for everyone to choose that relationship...I suppose it's unethical, you know, to make someone talk to another person whoever that is to have an expectation to complete a course is a bit directive in a non-directive profession.*

Brian believes it to be somewhat *"unethical"* to make therapy a mandatory requirement. As a consequence of thinking that the trainees are 'forced' into the relationship it seems as if at times he feels that he is almost collaborating in an unethical activity *("I suppose it's unethical...").* Brian's experience is consistent with research undertaken by McEwan and Duncan (1993). Their survey of 185 clinical and counselling psychologists in British Columbia focused on the participants' opinions on personal therapy as a constituent of training to be a therapist, and the conditions under which they had received personal therapy whilst they were in training. Some of their respondents felt that the mandatory part of therapy created some risks for trainees i.e. feelings of "personal violation" regarding being "forced" to engage in therapy (p.191).

Williams *et al.* (1999) noted that mandatory personal therapy does not permit choice, which they point out is broadly deemed as necessary for therapy to be beneficial. Several therapist-participants concur:

> *Henry: Sometimes the trainee feels constrained....it's been put on them, rather than that they really chose to do it...you may have to overcome some initial, uh, misunderstanding or reluctance, or obstacles of one kind or another.*

Alyssia: It takes me a little perhaps a little bit longer to settle into where this is going and it might do with someone who says "I've chosen to come to you because I've got this problem".

Henry and Alyssia acknowledge that the trainees may not want to attend personal therapy. Henry's use of the physical words *"put on them"* and *"obstacle"* implies that the mandatory element of therapy can initially feel like an obstacle course. Norcross *et al.* (2001) found that fellow psychotherapists were more challenging or resistant to change, as well as more critical consumers of psychotherapy. Alyssia's tentative manner in saying "*it takes me a little **perhaps** a little bit longer* highlights the sense of 'parallel process' that may have been occurring in the interview. She seemed to react to me (the interviewer) in a similar way to how she reacts to other trainees - initially uncertain and having performance tensions before relaxing. Alyssia has mixed views of the mandatory aspects of therapy - she feels that it is preferable if the trainees can 'choose' to have therapy for their personal development. These views initially slow down the therapeutic process as, like Brian, she feels uneasy about trainees coming because they have to.

Trainees become clients

The therapists find that, despite the initial obstacles for both themselves and the trainees in providing mandatory therapy, they were, in time, able to settle into their respective roles. One of Roger's core conditions in the counselling relationship is congruence (Rogers, 1961). He defined congruence as meaning that "the feelings the therapist is experiencing are available to him, available to his awareness, and he is able to love these feelings, be there, and able to communicate them if appropriate" (p.61). Rogers considered that therapists would be unlikely to aid their clients to become aware of their own thoughts processes/feelings if they themselves were not open to knowledge of their own (Kahn, 1997).

Brian: I suppose for the first few sessions, the 'elephant in the room' was felt...we talked about it a little bit...and we've moved on from that.

For Brian, the obligatory aspect of the therapy is *"the elephant in the room"*. This vivid idiom for an obvious truth/problem that is being evaded is founded on the idea that it would be impossible to fail to notice (Cambridge Academic Content Dictionary, 2009). Mearns (1996, p.308) stated :"Therapists may think that they can fool clients with

incongruent portrayal and that may even be fairly effective at superficial levels of psychological contact, but clients are not going to be prepared to meet therapists at relational depth when the therapist is not willing to go there himself or herself". It can be inferred that, although Brian feels the imposing presence of the 'compulsory' element of therapy, he did not feel able to talk about it openly at the beginning of establishing the relationship. This indicates that, early on in the relationship, there is an element of incongruence. Conceivably, this early incongruence is due to Brian's inexperience at seeing trainees.

Friedlander *et al.* (2006) proposed that when therapy seems only ostensibly to be a choice, as arguably is the case with mandatory personal therapy, the therapeutic relationship is adversely affected. Nevertheless Brian explains that as the sessions progressed they were able to talk about the *"elephant in the room"* in the earlier sessions. Brian states that *"we moved on from that"* highlighting that, although he was initially very aware of the fact that the trainee 'had' to come to therapy, he was able to put that aside as the therapy progressed and he settled into his role as therapist. He was able to discuss it *"a little bit"* which suggests that he becomes more genuine in the relationship as it progressed. His use of the word *"we"* twice highlights his feeling that the trainee was also about to settle into his/her role and they move forwards together.

Alyssia also feels that over time the relationship changes with the trainees:

> *It often starts off as feeling like a different relationship but usually I find over time it settles...you almost forget that they're trainees...Initially perhaps, initially, it might be just about support and it might be they just, largely, need to come to express their anxiety about the workload and the everyday nitty-gritty of that. And then, over time...I think in every case we've gone beyond that.*

By stating that she *"almost forgets"* that they are trainees, it is apparent that even though she has gone *"beyond that"* it is hard for her to forget completely. Nonetheless, she feels that not only does the relationship change but so does the actual *content* of the sessions. Alyssia feels that *"initially it might just be about support"* which implies that although therapy begins with aiding trainees with their training journeys, it becomes a more 'normal' therapeutic relationship with trainees' personal issues being worked through. This suggests that as Alyssia and her trainee-clients established a stronger therapeutic relationship, the content of the therapy

changed. Indeed Norcross *et al.* (1988) found that psychotherapists who had their own personal therapy, reported that the therapeutic relationship was fundamental in their own treatment.

While most of the therapist-participants find that seeing the trainees is initially different from non-therapist clients, not all feel this as strongly. Henry, for example, works hard to ensure his trainee clients are just clients. Rogers (1961) described the importance of comprehending clients as they see themselves, and to cast aside all outside perceptions from the "external frame of reference" (p.29). This is because "although we share the same physical world we all experience it in different ways, because we look at it from different perspective or 'frames of reference'" (Mearns & Thorne, 1999, p.41).

> *Henry: They just come along every now and then, and, um, it's just another set of initials in my diary... the same way I work with anybody else, just sort of, wait for the person to come up with something.*

Henry tries to abide by these core counselling principles and believes it is important to treat trainees as 'ordinary clients'- indeed they are another *"set of initials in the diary"*. Whilst Henry recognises that there may be a need to overcome *"reluctance"* in the sessions with the trainees, he himself does not feel guilty or therapeutically 'impeded' by the fact that the trainees that are coming to see him are required to do so. In fact, he feels that perhaps the 40 hours are not enough for trainees:

> *I think it should be even more of a course requirement than it sometimes is...this thing about 40 meetings... I think it's stupid and arbitrary...I think it does not make much sense, and I think people should be in therapy throughout the course, however long the course is, because the course is going to throw up stuff that they might well need to work on in a therapeutic manner.*

Yalom (2001) recommended that "the therapist must strive to create a new therapy for each patient" (p. 340) and it appears as if that is what Henry endeavours to do for each client he sees, regardless of whether they are a trainee.

Master Theme Two: Being 'Good-Enough'

This theme explores the therapists' implicit and explicit anxieties about having trainee counselling psychologists as clients. Although many of these fears could potentially emerge

with any therapist-client, there were specific worries regarding the client being a *trainee* therapist. Particularly significant worries included the perceived responsibilities of being a role model, and awareness that this may be the trainee's first and only experience of therapy. The therapists wanted therapy to be a good experience for the trainees; they wanted to 'get it right'. Most of the therapists had experienced mandatory personal therapy as part of their own training and there had been aspects that they had found unhelpful. Due to this, there appeared to be a 'therapeutic compensation' whereby therapists were more flexible with trainees, almost as if to make amends for their own experience.

'Being 'Good-Enough' is divided into two sub themes:

- Getting it 'right': judgement by a peer
- Therapeutic compensation

Getting it 'right': judgement by a peer

It can be assumed that clients who are therapists will enter therapy with a better knowledge of language, theoretical principles and the 'norms' of practice than lay patients. They are subsequently more prone to noticing instances in which their therapists stray from 'the therapeutic rules' (Geller, 2005). On the whole, the therapists interviewed in this study assume that they will be judged by the trainees on their therapeutic skills. This frequently leads to feelings of anxiety. Glickauf-Hughes and Mehlman (1995) proposed that therapists often have narcissistic tendencies and posited that they will frequently experience insecurities about being the 'perfect' therapist.

> *Brian: I was comparing my own experience of therapy whereby I was kind of like assessing and judging my own therapist ... I was a bit more anxious about getting it right...being judged by a peer at some level as well.*

Brian often found giving therapy to a trainee-therapist anxiety-provoking. For therapists who have therapists as clients, it is to be expected that they will be fearful of criticism and wish to safeguard professional self-worth (Bridges, 1993). It is clear from therapist-participants' words that seeing a trainee-therapist can induce an additional set of worries for them. For Brian, seeing a trainee evokes memories of his own mandatory personal therapy. In contrast to his negative experience he wants to ensure that the trainees have a good experience. He also

worries that the trainees will be judging him as he did his own therapist (*"I was kind of like assessing and judging my own therapist"*). Perhaps this was due to his relative lack of experience in seeing trainees. Mearns (1996, p.309) suggested that "when working at relational depth the therapist is making himself or herself much more vulnerable in relation to the client because any judgements which will be made by the client are being formulated on the basis of the therapist's congruent functioning and cannot easily be dismissed. In a sense, the therapist is putting himself or herself 'on the line' in the work rather than merely risking a superficial portrayal". Bridges (1993) suggested that the therapist's increased levels of anxiety and feelings of vulnerability can be reduced and overcome as experience is gained.

Most of the therapists describe being nervous about being judged by fellow therapists. This concurs with the research undertaken by Norcross *et al.* (2000). They drew attention to therapists' experience of treating fellow mental health professionals by examining responses to a questionnaire from 349 psychologists of the American Psychological Association Division of Psychotherapy. Norcross *et al.* (2000) found that the main stress linked with having fellow therapists as patients seemed to be the trigger of anxieties and qualms about their own capabilities as therapists. They were also more worried about the effectiveness of treatment and more unconfident regarding their techniques (Norcross, 2005).

Brian uses the expression *"getting it right"* which insinuates that there is a 'right' and 'wrong' in therapy, and alludes to a self-pressure that he puts himself under to achieve the *"right"* result. Nonetheless, Thériault and Gazzola (2006) suggested that psychotherapy is frequently an obscure process and it is not unusual for therapists to experience feelings of insecurity. Perhaps for Brain, the ambiguous nature of therapeutic 'success', arguably especially with trainees, is at contrast with his categories of getting it 'right' or 'wrong'. Brian states that he felt that he was being *"judged by a peer"*, the use of the word *"peer"* signifying that he feels on the same 'level' as the trainees. It can be inferred that he views the trainees as other therapists assessing his work. This 'judgement' increases his anxiety more than if he was seeing a non therapist client (*"I was a bit **more** anxious*"). This anxiety was shared by Alyssia:

Alyssia: There's a slight tension within me about this person...knows this stuff...some of my own issues will be dealing with this feeling that I've got to, perform well or make sure I'm really professional

Both Brian and Alyssia play down the level of anxiety that they felt: Brian: *"I was a **bit** more anxious"* and Alyssia: *"there's a **slight** tension"* indicating an underlying embarrassment about admitting to feelings of inadequacy. Norcross *et al.* (2000) found that psychologists reported using the same techniques with both therapist-clients and non-therapist clients. Despite this, they were more self-conscious of their methods, and worried more about the successfulness of treatment and criticism from their therapist-clients (Norcross *et al.*, 2000).

Alyssia has insight into her need for approval which is revealed in her worries about the trainees knowing *"this stuff"*. She states that she knows that part of her worry stems from her *"own issues"*. Alyssia's self- awareness allows her to recognise that she feels a need to *"perform well"* and make sure that she is *"really professional"*. This suggests that she does not feel as comfortable in her own therapeutic style as she is with non-therapist clients. At times her feelings of having to perform cause her to have feelings of anxiety. Alyssia monitors these performance tensions during her work with the trainees. Kahn (1997) stated that therapists "must have ongoing access to their own internal process, their own feelings, their own attitudes and their own mood" (p.40) if they are to aid clients in gaining access to their own inner processes. Alyssia seems able to do this but is not always about to drop her 'therapeutic mask' (Goffman, 1959) perhaps suggesting that like Brian, there are times of incongruence (Rogers, 1961) in her relationship with the trainees.

Similar to Brian and Alyssia, Marion has a strong desire for therapy to be a 'success':

> *For a number of people it is their only experience of therapy...I want to present that therapeutic experience as one which is a valuable accompaniment to periods of change or development.*

Marion's narrative often reflected her feelings of responsibility to be an 'ambassador' for the profession of counselling psychology. It is very important for Marion to be a responsible mentor for the students and the future of the profession. Marion's use of the word *"present"* indicates a need to exhibit or represent therapy as a worthwhile activity for the trainees, which is highlighted by her use of the words *"**a valuable** accompaniment"*.

Not all the therapists felt that trainees were any different from other clients, as can be seen in the below vignette from Henry's interview:

> *Henry: Broadly speaking, it's exactly the same as seeing anybody else,*

Henry describes his experience of giving therapy to trainees as *"exactly the same"* as *"seeing anybody else"*. It appears that he does not feel any more anxiety concerning his therapeutic performance than he would do with any more clients. It is possible, that due to him being qualified for far longer than the other therapists interviewed, and not using CBT as compared to many of the therapists, he feels more used to seeing trainees and does not feel a difference in having them as clients. Nevertheless, Henry also stated that he gives papers to trainees at the beginning of the therapy session:

> *Henry: One of the things I do very often is...trainees who come for counselling is, I give them a short paper which was published on the value of counselling for counselling psychologists and others who have to actually practice... I give it out at the end of the session... I feel it helps in saying, well actually, there is a value in doing this....and this is what you can get out of it.*

I had felt a sense of Henry being defensive in the interview, and very keen to stick to boundaries with me. In fact, he would not speak to me before I entered the room we were conducting the interview in. I wondered if he did the same with the trainees he saw in therapy. In keeping trainees as 'clients' with very clear boundaries, he is exposing them to the 'real thing' which he seemed to feel is important in the interview. It was interesting that Henry was quite insistent in trainees being the same as other clients, yet gives them papers he would not give other client groups. He seemed to want the trainees to feel positive about going to therapy and the therapeutic experience, which is indicated by him both giving trainees a paper on the purpose of counselling for therapists and saying *"I feel it helps in saying, well actually, there is a value in doing this....and this is what you can get out of it"*. By saying this it made me wonder if Henry felt a desire and responsibility, similar to the other counselling psychologists interviewed, for therapy to be a valuable addition to their course experience.

Therapeutic compensation

Much of the literature suggests that therapists own experience of having personal therapy increases their empathy with their own clients, and allows them to see what they both did and did not like about how their own therapist worked (Macran *et al.*, 1999, Pope & Tabachnick, 1994). As seen in Brian's words earlier, many of the therapists interviewed in this study did not have an entirely positive experience with their personal therapists whilst they were training. The impact of this has been long-lasting and the memories are re-activated when they

work with the trainees. As a consequence, there is a strong desire for therapy to be a better experience for their trainee clients, almost a 'therapeutic compensation'. Bridges (1993) discussed that "over-identification with therapist-patients and the potential for unconscious re-enactments from the treating therapists' own personal treatment...hold the potential for creative, caring treatment as well as for harm" (p.34).

> *Brian: I am also mindful of not making quick interpretations and judgements...my therapist was good in some ways but very clumsy in some other ways... I used that experience as something that I wouldn't want to give the trainee that I am working with.*
>
> *Alyssia: I didn't have quite such a relaxed...I wasn't able to...it was more difficult to ever miss a session...I'm very aware of these sort of things with other people...it's not reluctance.*

Brian's own experience of mandatory personal therapy influences how he conducted his sessions with trainees. His use of the word *"mindful"* indicates a constant 'internal supervision' regarding making *"quick interpretations and judgements"*. He is concerned about not making the trainees feel as judged as he did by his therapist. Macran *et al.* (1999) described the vast majority of the participants in their study remembering times when their therapists had "got it wrong" (p. 425). Similarly, Pope and Tabachnick (1994) found that 79 per cent of respondents in their study stated that they believed that their therapists had made therapeutic and clinical mistakes.

Brian feels responsible for giving trainees the positive mandatory personal therapy experience that he never had; illustrated by him describing his experience as something that he *"wouldn't want to give the trainee"*. It is interesting how he places the onus of responsibility for the trainees having a good experience on his shoulders and does not mention their role in this outcome."Fears of criticism, issues of therapeutic narcissism, and protection of one's professional self-esteem are likely to accompany any treatment with a therapist-patient" (Bridges, 1993, p.34). Although this may be true for Brian, he does seem to view trainees as special and he wants to protect them from going through what he has in the past. Grimmer and Tribe (2001) researched counselling psychologists' perceptions of the impact of mandatory personal therapy on professional development. They found that respondents spoke about

adverse experiences of therapeutic interventions, which they attempted not to repeat in their own therapeutic work.

Alyssia wants to be flexible according to the trainees' needs. She does not feel that she experienced this adaptability in her own therapy sessions, which is portrayed by her saying *"I didn't have quite such a relaxed... "*. Alyssia aspires to be responsive and open; she cares about the trainees and wants to support them. She is careful not to assume trainees missing sessions is *"reluctance"*; Alyssia's words indicate that she believes that her therapist presumed that she was 'reluctant' when she missed a therapy session *("I wasn't able to...it was more difficult to ever miss a session...it's not reluctance")*. In Rizq and Target's (2008) study, the therapists mention that personal therapy was useful in seeing aspects of their therapists' work that they would not want to replicate themselves, in their work with clients.

Whereas Brian is more tentative about challenging trainees, Marion feels the opposite:

> *Marion: In my therapist that I saw...I felt that she could have pushed more...it has encouraged me to be more...aware... if someone has come for a whole lot of sessions and I felt that we've just not really challenged them then I have had a sense of failure.*

She believes that she did not get the most out of her therapeutic experience (*"I felt that she could have pushed more"*). As a result Marion feels a responsibility to challenge trainees and for them to 'work' in the sessions. Her application of the word *"failure"* when describing how she would feel if the trainees were not challenged is an indication that, similar to Brian, she assumes full responsibility for a 'successful' therapeutic relationship with the trainees. Fleischer and Wissler (1985) stated that "The therapist may experience strong wishes to collude with the patient's need for perfection and omnipotence in the treater, resulting in excessive and unrealistic expectations about one's capacities as a therapist, and marked pressure to perform with exceeding skill, expertise, and knowledge" (p.589). Conversely this may be how Marion relates to all her clients, not just the trainees. Her responses in the interview seemed to be very thoughtful. There is an impression she was a 'good client' and now she wants to be a 'good therapist'.

Master Theme Three: Holding the boundaries

The third master theme describes the difficulties experienced by the therapists in 'holding the boundaries' between the many different roles they could enact i.e. being supervisors, peers and,

of course, therapists. The therapists were largely wary about mixing/blurring the boundaries. This causes feelings of anxiety and stress, unique to having trainees as a client group. Despite their awareness, it is a struggle to keep therapy 'therapeutic' and to maintain the 'role' of therapist. There is also a temptation to intellectualise therapy, i.e. to be observers looking outside at the therapeutic process as opposed *being in* the process.

'Holding the boundaries' is divided into three subthemes:

- Being wary and vigilant
- Keeping therapy therapeutic
- Temptation to intellectualise therapy

Being wary and vigilant

Intrinsic in the process of treatment of patients who are therapists, whether trainees or otherwise, is the possibility for blurred boundaries and the confusion of roles (Bridges, 1993). Webb and Wheeler (1998) stated that previously in psychoanalysis training it was customary that "the training analysis encompassed the function of supervision" (p.509). Conversely, in counselling psychology the roles are intended to be distinct, with courses requesting a certain number of supervision hours, with a supervisor and likewise a certain amount of therapeutic hours with a therapist. Indeed the Division of Counselling Psychology's (2008) guidelines for supervision specifically mentions that "supervision is not therapy" (p.4).

Without exception the therapists mention a cautiousness/watchfulness about how they were in the sessions and an awareness of the potential for the therapeutic relationship to turn into a supervisory relationship or one of a peer.

> *Brian: It's full of anxiety about the duality of the relationship... both of you are in the same profession ...it's about keeping a very boundaried relationship and not suddenly turning into a peer... talking about your thoughts on counselling psychology.*

For Brian, seeing a trainee is unique to seeing other clients. He is aware that there may be a tendency for him to treat the trainee as a *"peer"* as opposed to a client. His use of the words *"full of anxiety about the duality of the relationship"* indicates that the anxiety encompasses

him. Brian is nervous about getting it 'wrong' and acts as his own 'internal supervisor' monitoring his potential to discuss *"thoughts on counselling psychology"* as opposed to entering into a therapeutic relationship. Norcross *et al.* (2000) describe how one of the most frequently listed stressors of conducting therapy with fellow professionals is concern about breaching the boundaries i.e. entering into a dual relationship.

The boundary between supervision and personal therapy is frequently ambiguous (Glass, 1986). The literature concerning this subject is also conflicting regarding what supervision should be used for as opposed to personal therapy and vice versa. As Donati and Watts (2005) eloquently illustrated, this reinforces "conceptual fuzziness, as well as practical and ethical problems for trainers and trainees" (p.476). Accordingly, it is almost no wonder that it can be confusing for the therapists seeing trainee clients, to differentiate between the roles.

> *Marion: The personal development aspect of personal therapy clearly overlaps with professional development...these are the tricky areas.*
>
> *Alyssia: I find I have to be very careful not to get caught up in talking about the work, but staying with how they feel about the work.*

For Marion the therapeutic relationship with trainees encompasses holding ambiguous boundaries which she finds *"tricky"*. For Marion, therapy is a 'balancing act' of being a teacher/mentor and therapist. Alyssia is cautious in the therapy too. She finds it is easiest having the 'therapist's' hat on. She is concerned about keeping the boundaries in the relationship clear, and not giving advice in the form of supervision regarding the trainee's clients. As she articulates in the above vignette she is *"very careful"* to differentiate between discussing clients as colleagues (*"talking **about** the work"*) instead of using therapy to discuss emotional reactions from seeing clients (*"how they **feel** about the work"*).

Skovholt and Ronnestad (1996) articulated that for students at the beginning of training, professional and personal development are so tightly associated they are impossible to differentiate. This suggests that it is never possible to keep completely to one role. Henry is also wary about mixing therapy and supervision as demonstrated below:

> *Henry: I take care not to mix those two things up...one's about professional issues and the other's about personal issues and that's the therapy*

Henry feels strongly that it is important to treat trainees as ordinary clients. He insists on not mixing up personal and professional issues and simply keeping therapy for personal issues. He is cautious about his own boundaries as is explicit in his words *"I take care"*. Henry is clear about what he sees therapy for (*the other's about personal issues, and **that's** the therapy)* and relays that to the trainees that he sees.

Keeping therapy therapeutic

Despite the therapist's awareness of the potential for blurred boundaries, it is a struggle at times for the therapists to keep therapy 'therapeutic', adding an extra challenging dimension to the work. Research has depicted the dual relationships trainees and therapists can experience within their relationship (Kaslow and Friedman, 1984, Norcross *et al.*, 2000).

> *Marion: It can be quite hard work for me...trying to keep my therapeutic role therapeutic rather than turning into being a supervisor, a tutor or any of these other things.*
>
> *Alyssia: On occasion I have found myself slipping into more of a supervisory rather than a therapeutic role.*

Marion describes the complexity of keeping to distinct roles when seeing trainees, articulated by her saying *"it can be quite hard work for me"*. Norcross *et al.* (2000) highlighted the difficulties that therapists have seeing therapist-patients: "the opportunity to treat a fellow therapist is usually experienced simultaneously as a professional privilege and a burdensome responsibility" (p.204). In this way, Marion takes her role as therapist seriously and enjoys the work, yet finds it demanding and challenging.

Alyssia's use of the word *"slipping"* above can be interpreted in many ways: The Random House dictionary (2010) defines it as to: "make a mistake or error to fall below a standard or accustomed level, or to decrease in quantity or quality; decline; deteriorate". For Alyssia, slipping relates to both these definitions. When she crosses roles she chastises herself for falling below the standard that she has set herself. She is very accommodating and supportive, and it is difficult for her not to help as a supervisor when a trainee requires advice. Wilkins (1997) argued that there is no obvious distinction between personal and professional development and that even if these two features of development can be divided, the boundary

is indistinct and moves constantly. He asserted that to insist on a definite division between them would be contrived (Donati & Watts, 2005).

Research has shown that therapists frequently enjoy being with therapist-patients more than with non-therapist patients (Geller *et al.*, 2000, 2001). They identify with their trainee clients and feel more connected with them.

> *Brian: There are parts of me that want to jump in and say "oh yeah, I experienced that"...*

Brian often finds that seeing trainees caused him to reminisce about his own experiences and he feels a special connection with the trainees. His use of the word *"jump"* signifies a desire to be less constrained by the role of the therapist and able to have a conversation about their experiences of training. Geller *et al.* (2005) stated that due to having had the experience of being therapist-patients themselves, therapists feel more caring and connect more with their therapist-patients.

Nevertheless not all the therapists indicated that they struggled to keep therapy therapeutic:

> *Henry: I might say, well I think that's more for your supervisor than for me, and the supervisor might say to them, well I think that's a therapy issue. Take that to your therapist...*

Henry is quite pragmatic about any potential obstacle to keeping therapy 'therapeutic'. As illustrated above, he views the role of supervisor and therapist as distinct, and does not discuss any instance when there has been a blurring of boundaries. Implicit in Henry's narrative was the understanding that trainees need to be handled and managed, and guided to focus on personal issues.

Temptation to intellectualise therapy

The therapists are tempted to 'intellectualise' the therapy process. For many, the combination of two therapists being in the room, risks the possibility of an 'inauthentic' relationship, with both taking a bird's eye view over the process as opposed to being involved in the process. Mearns and Thorne (1999) define congruence as a "state of being" (p.84) of the counsellor in relation to the client and it can be argued that by taking an outsider's perspective there is a lack

of congruence early on in the relationships (discussed earlier in Master Theme Two: Being "Good-Enough") .

> *Brian: I'm also aware that we don't...this has happened a few times...start getting into an intellectualised approach i.e. with both counselling psychologists thinking psychologically about what's happening in the room.*
>
> *Marion: It is tempting, and I had this experience in my own personal therapy, to intellectualise the whole process... one of the overriding challenges is developing the ability to stop doing that and to participate more fully.*

Brian finds that giving therapy to trainees provides him with an opportunity to learn and to develop his own skills and experience. The trainees are seen as equal professionals to him *("**both** counselling psychologists")* and a combination of curiosity and anxiety leads to him wanting to discuss *"what's happening in the room"*. It can be inferred that this was partly due to his apprehension about seeing trainees; he wanted to check in and discuss how the therapy was going from the perspective of the trainees. There is an interesting dynamic at play here, of not only the potential for trainees to use therapy as supervision, but also the therapists using the trainees as supervisors of the therapeutic work between them. Consequently this highlights the importance of the therapist's own supervision when seeing trainees.

Marion's use of the word *"tempting"* indicates that there is an inner struggle not to break out of the mode of therapist, and to *"intellectualise the whole process"*. This was similar to the interview where she appeared to be in a type of intellectual mode. Marion finds giving therapy to trainees a constant balancing act of holding ambiguous boundaries i.e. being teacher/mentor and therapist. Her words *"one of the overriding challenges is to...participate more fully"* indicate that a barrier to both trainee and therapist engaging in the therapy is a propensity to look at the process together, as intellectuals, as opposed to participating in it. Beck and Butler (2005) stated that one of the problems that can arise with therapist-patients is that they "overintellectualise" therapy and can become "overly detached during the therapy session, attending too much to process at the expense of content" (p.260-261).

> *Alyssia: I bring the models more into the room when I'm with a trainee...I want to make sure I don't get locked into that and neither do they.*

Alicia is nervous about the trainees knowing more recent information about the therapeutic models than her, and she begins to think about the therapeutic models she is using. This can leave her unable to 'be' with the client as much as she would like. It can be understood that she has a need for approval from the trainees. Like Brian and Marion, it can cause her to have a detached view of being in the room, as opposed to being a participant. Alicia saying *"I want to make sure I don't get locked into that"* implies that she feels that there would be a potential for feeling constrained by focusing on the models instead of the presentation of client. This endorses the work of Norcross *et al.* (2000) who found that the most frequent advice psychotherapists would give to other therapists who see therapist-patients would be to behave the same towards all patients, keep distinct boundaries and evade dual relationships, and attempt not to over relate with therapist-patients.

Master Theme Four: Empathising with the trainee client

The therapists predominately feel a connection with the trainees. Having mainly trained on similar counselling psychology courses, they are aware of the unique experience of completing a doctorate whilst learning how to be a therapist. They both empathise and sympathise with the trainees. They care about the trainees, and this frequently leads them to making concessions for the trainees, for example, by reducing prices or increasing self-disclosure.

'Empathising with the client trainee' is divided into two subthemes:

- Resonating with own personal experience
- Concessions: special treatment for the client trainee

Resonating with own personal experience

The therapists have strong memories about their own training journeys, and being with the trainees triggers emotions and brings back memories of their own personal experiences.

> *Brian: It brought back a lot of memories about... like you're at the beginning of your programme, quite a journey to go through yet.*

Brian's own experience of training seems to have been a turbulent one, filled with mixed emotions. He is well aware of the demands, both academically and personally that the course

makes, and this is indicated by him saying *"quite a journey to go through yet"*. He feels and sounds empathic about the training experience for the trainees and it reawakens his own feelings regarding the training course. Wosket (1999) stated that many authors have written on the subject of therapist's latent issues being activated when seeing therapist-clients. "Counsellors in training are hindered by time constraints, financial constraints, unhealthy working practices and conflictual demands for excellence. It is an extraordinary load, yet one which these counsellors are often expected to carry without compromise." (Jensen, 1994, p.191.) Marion's experience shows something of this complexity:

> *This is something that I have been through and had to deal with and yeah, actually that is part of my role, sort of helping people to keep their balance.*

Despite Marion wanting the trainees to use therapy and to challenge themselves, she discusses in the interview that she is aware of the challenges the trainees are facing in the process of becoming a counselling psychologist. Seeing trainees causes her to reflect on her own experience of training. Her choice of words *"something that I have **been through**... had to **deal with**"* implies that Marion had found her training experience taxing and that years on from qualifying as a therapist, the difficulties of the experience remain in Marion's mind. Kumary and Baker (2008) proposed that the stress levels reported by trainee counselling psychologists in the UK "presents a great challenge to the status quo of training" (p.62). Perhaps the fact that the therapists still remember the negative aspects of their own training highlights the need to assess whether trainees are being put under an intolerable amount of stress. It has been argued that making therapy a mandatory requirement can harm its effectiveness, and that the trainee could continue with therapy that is not suitable because it is part of the course requirement (Grimmer & Tribe, 2001)

> *Alyssia: I felt that this was not what she'd be doing if she didn't have to...I could really sort of understand her perspective...*

Again, Alyssia's mixed view about therapy as a training requirement is apparent here; her use of the words *"really"* and *"sort of"* illustrates her ambivalence towards it. Conceivably this is how she felt in her own personal therapy, which is suggested by Alyssia saying she can *"understand her perspective"*. She makes the assumption based on her feelings (*"I felt that*

this was not what she'd be doing... ") that the trainees are only attending therapy because they *"have to"* as opposed to that being something the trainees have articulated. Nevertheless she later discusses in her interview (see Master Theme One: Settling into roles) that she experiences the trainees as having changing feelings regarding mandatory therapy. It can be understood from her words that it moves from a chore to a choice for them. Grimmer and Tribe (2001) found that trainees and recently qualified counselling psychologists who were originally hesitant about attending, frequently began to believe that it was vital that counselling psychologists have an understanding of being a client.

Concessions: special treatment for the trainee client

The therapists care about the trainees and felt both sympathetic and empathetic towards them. This can alter how they treat them as compared to non-therapist clients, i.e. more self-disclosure, lower financial costs and allowing them to cancel when they had work due. Norcross *et al.* (2001) found that therapists enjoy being with therapist-patients more than with non-therapist patients and feel less detached from and friendlier towards their therapist-patients.

> *Marion: With trainees I am more...confessional...I will bring in personal stuff to a greater degree... self-disclosing, yeah... Because part of my role as therapist is to you know, I am sort of the role model to a degree... I'm still careful, mindful of the boundaries... there's a closer identification and community of purpose really So people ask me about my personal therapy occasionally or ask me about my training and what I have found and you know, all that sort of stuff particularly, it's generally that, not my personal life.*

Marion's use of the word *"confessional"* portrays an image of someone who has sinned. Her increased self-disclosure is a decision she makes because she thinks she is a role model for the trainees. Geller (2005) pointed out that the issue of whether to self-disclose with a therapist-patient is a subjective decision and should only be done in order to achieve a therapeutic goal. This is relevant to Marion using self-disclosure in order to aid the trainees in their developments as therapists. Whilst she is still cautious about the therapeutic boundaries (*"I'm still careful, mindful of the boundaries"*), she will treat the trainees differently, due to her feelings of responsibility for and identification with the trainees (*"there's a closer identification and community of purpose really"*). Dryden (2005) (a rational emotive-

behaviour therapist) stated that during his personal therapy with Albert Ellis (founder of REBT therapy) a particular part of the therapy he appreciated was Ellis's use of self-disclosure. He reported finding it greatly beneficial that Ellis respected his difference from non-therapist clients (Dryden, 2005).

> *Alyssia: Perhaps I'm a little bit too accommodating, but the three year doctorate is so demanding. I know myself, the pressures I was under.*

Alyssia wants to be flexible according to trainees' needs/wants which is depicted by her use of the word *"accommodating"*. She tries to be responsive and open. Alyssia cares about the trainees and wants to support them; she remembers what her own training was like *("I know, myself the pressures I was under")*. At the same time she is a little bit wary of being abused by trainees and them taking advantage of her softness. Her awareness of this is illustrated by her saying *"perhaps I'm a little bit **too** accommodating"*. Due to previous experiences with trainees, she is cautious about taking trainees given their particular and complex needs. For example, Alyssia mentioned that she will no longer give trainees an 'evening slot' which she has few of, as a result of her previous experience of losing money due to sessions being cancelled by trainees.

> *Brian: They are not saying anything is wrong with them at all, therefore, it's not my role to say, oh I think there is something wrong with you, And so I would be very much more tentative in the suggestions about the things that we reflect on.*

Brian is very aware that the trainees have not chosen to come to therapy, with a 'presenting problem' which is shown by him saying *"they are not saying anything is wrong with them at all"*. He treats trainees as 'special' clients. It is interesting that he states that he differs in how he conducts sessions with trainees; being less directive in his sessions with trainees *("I would be very much more tentative in the suggestions...")*. Collins dictionary (2008) defined tentative as "hesitant, uncertain or cautious" (p.913). It can be inferred that due to Brian's anxiety about the trainees having a good experience, and his empathy towards the fact the trainees 'have' to come to see him, that he sometimes assumes that trainees do not 'need' therapy. Consequently he is worried about analysing them. By him saying *"it's not my role to say...I think there is something wrong with you"* it can be understood that he, at times, does

not feel it his role to be the 'therapist' in the relationship. His empathy and concern for the trainees may actually hinder therapeutic work being done.

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In summary, this chapter has discussed the themes that I have generated from the research interviews, and has examined how they relate to the existing literature in this section. The themes indicated that mandatory therapy is an emotive experience for both trainees and qualified counselling psychologists and a subject that has been under-explored in the past. The next chapter will explore the similarities and differences between the experiences of both groups of participants and discuss the implications of the findings for counselling psychology.

CHAPTER FOUR: SYNTHESIS

The purpose of this explorative, qualitative study was to explore how trainee counselling psychologists experience their personal therapy, and how counselling psychologists experience having trainee counselling psychologists as clients. Analysis of the experiences of the participants in the two groups revealed four overarching categories. The synthesis aims to discuss both similarities and differences between the two groups of participants. The four categories (used as headings for this section) are: impact of mandatory therapy on therapeutic process, the therapeutic performance, the value of therapy (positive and negative) and boundaries. Incorporated within these categories are recommendations and implications for counselling psychology.

Impact of mandatory therapy on therapeutic process

Both trainee and qualified counselling psychologists note the impact of the 'mandatory' element of therapy on the therapeutic process. The trainees display varying degrees of ambivalence towards the mandatory elements of the therapy and at times articulate that they are only going because they 'have to'. The therapists also communicate that there are moments in which they feel uneasy about trainees 'having' to come, and empathised with them due to remembering their own experiences of mandatory therapy. They find the process of seeing trainees different from seeing other clients and partly attribute this difference to the mandatory element of the personal therapy. The therapists reflect that the mandatory nature of the therapy slows down the therapeutic process. The irony of this observation is striking in the light of the trainees' emphasis on wanting to obtain the maximum value, financially and personally, from their therapeutic experience.

Brian describes that *"there is an elephant in the room"* that neither trainee nor therapist initially communicate within the relationship. It is ironic that this is primarily left unaddressed, considering that counselling psychology, in part, distinguishes itself from other branches of psychology by concentrating on the importance of the therapeutic relationship (Strawbridge & Woolfe, 2003). The interviews suggest that in the early stages of therapy the core condition of congruence is sometimes forgotten. The absence of this fundamental counselling skill early on in the therapeutic relationship is a hugely significant finding. Rogers (1957) maintained that "for constructive personality change to occur, the therapist is congruent or integrated in the relationship" ...certainly the aim is not for the therapist to express or talk out his own feelings,

but primarily that he should not be deceiving the client as to himself" (p.96-98). He further recommended that if the therapist's feelings are blocking him/her from expressing core conditions they should talk to a colleague and/or a supervisor and indeed the client (Rogers, 1957).

Nevertheless, the respondents' accounts suggest that this is only an **initial** obstacle; over the course of therapy there is a process of both trainees and their therapists entering into a genuine relationship. They transcend the 'mandatory' aspect as the relationship develops and trust grows. Similarly, Webb and Wheeler (1998) found that there was a positive correlation between the perceived amount of rapport in the supervisory alliance and the likelihood of being able to divulge sensitive issues. The importance of a strong therapeutic relationship is vital for therapy with all clients, trainees or not, but it can be inferred from the interviews that the mandatory aspect of the therapy makes it even more significant.

Aspects of Prochaska and DiClemente's (1982) model of change can be applied to the trainees. Prochaska and DiClemente (1982) described change as being a cyclical process that involves five steps: precontemplation, contemplation, preparation, action and maintenance. The trainees appear to move backwards and forwards between these steps. For example precontemplation is the stage at which there is no intention to change behaviour in the foreseeable future; often precontemplators, like the trainees, only come for therapy because others have pressured them into it. Although they seem to have contemplated mandatory therapy before the course, some of the trainees do not seem ready for the action stage (in which individuals alter their behaviour, experiences or environment in order to overcome their problems) at the start of therapy.

Nonetheless, as the therapeutic relationship progresses the trainees become more action orientated. Prochaska and DiClemente (1986) maintained that it is vital to calculate the stage of a patient's willingness for change and to tailor the therapeutic interventions appropriately (Freeman & Dolan, 2001) as the majority of people do not advance linearly through the phases of change (Beck, Wright, Newman & Liese, 1993). Some of the trainees had never had therapy before and likewise, some of the therapists had not seen many trainees. Despite this, the therapists seem aware of the trainees' feelings and do not seem to push the trainees before they are ready to engage. When there is a therapeutic rupture the trainees may move from an action stage back to a precontemplation or contemplation stage regarding mandatory personal

therapy. Although the therapeutic process changes over time in all therapeutic relationships, (Heppner, Rosenberg, & Hedgespeth, 1992) the impact of the mandatory aspect resonates within the process in these participants' relationships.

Although there is a multitude of research explaining the benefits of mandatory personal therapy, this information is generally not relayed by counselling psychology courses. Preparation can alleviate anxiety; reading this research will provide knowledge to both trainees and qualified therapists who have trainee-clients of what others peoples' experiences were. Hopefully it will help to ease any worries that they may have. Likewise it is anticipated that this research will give both the trainee-therapists, and the qualified therapists who see trainee-clients, an insight into each others' experiences and common fears. Potentially this would reduce the size of the 'elephant in the room' and result in a more authentic relationship early on in therapy.

It would be beneficial if personal therapy was integrated further into the courses as opposed to it being viewed as a separate entity. It is noteworthy that counselling psychology courses, which place a strong emphasis on process within the therapeutic relationship, largely do not explore the subject of mandatory personal therapy. It is unclear if this relates back to the 'taboo' of therapists having their own therapy that Norcross *et al.* (1988) discussed. Perhaps because the mandatory element of therapy has largely been unacknowledged in the therapy room it has not seemed relevant to discuss it in a university environment. Williams *et al.* (1999) found that 70 per cent of counselling psychologists in their study had not experienced a forum on their course to explore the aims of therapy but stated that they would have found it helpful. Before trainees enter personal therapy it would be helpful if they could participate in a forum in order to discuss its significance and purpose (Williams *et al.*, 1999). A considerable amount of anxiety was expressed by trainees and qualified therapists regarding both having mandatory personal therapy and being the therapists that trainees see. Indeed, qualified therapists discuss negative aspects of their own experiences many years on from therapy. Consequently, I recommend that a forum is also created at the end of the counselling psychology course, to enable trainees to debrief about their experiences of mandatory personal therapy, if they so wish.

The therapeutic performance

For both the supervisor and supervisee, supervision can be an anxiety provoking experience, in which both sides can be fearful about being judged by the other (Webb & Wheeler, 1998). It may be argued that the same applies for trainee counselling psychologists and their therapists. The trainees articulate how they wanted to impress their therapist with being the 'good client' and 'good therapist'. Correspondingly, the therapists want to be 'good enough' therapists and to make sure that the trainees have a valuable experience of therapy. The therapists partly attribute this to not having always enjoyed their own experience of mandatory personal therapy. Participants discussed the 'small world' of counselling psychology; perhaps it is only natural that both sides want to put across the best of themselves. Despite trainees' expressing concern that their therapists would judge them (both as clients and therapists) none of the therapists criticise the trainees. Paradoxically some of the trainees were explicitly judgemental about their therapists' abilities.

Research has suggested that trainee therapists are especially conscious of the possibility of danger in the 'real' emotional meeting with their therapists and feel the need to ensure safety and clear limits (Rizq & Target, 2008). Rizq and Target (2008) used the metaphor of scuba diving to refer to the feelings of danger participants felt towards "authentic emotional engagement" (p.43) with their therapists in order to avoid being overwhelmed by the process. This finding is similar to both the trainees and therapists in this study who initially were quite guarded in the sessions. Knowing the 'therapeutic rules' and the 'textbook' ways in which to behave resulted in both sides wearing 'therapeutic masks' at the beginning of therapy. Goffman (1959) stated that "Sometimes the individual will act in a "thoroughly calculating manner" and sometimes "the individual will be calculating in his activity but be relatively unaware that this is the case" (p.17). For the therapists and the trainees, both of these applied. This is interesting in relation to Baldwin's interview with Rogers in which he stated that "by being real, and congruent and genuine, the therapist is modelling that kind of behaviour for the client" (Baldwin, 2000, p.31) - by the therapists occasionally being incongruent with the trainees it can be questioned whether this would lead the trainees to model unhelpful therapeutic traits. Despite this, as the therapeutic relationship progresses and the therapeutic work begins, both trainee and therapist are actively involved in the process and let their 'masks' drop. They move from a performance to an authentic engagement.

Consequently, it is not just the trainees that are affected by mandatory personal therapy. Preparation should be not be exclusive to the trainees. It would appear that it would be helpful if the courses provided information about the rationale for personal therapy for trainees to give to their therapists.

The value of mandatory therapy (positive and negative)

Previous research has discussed whether or not therapy should be a mandatory requirement and the positive and negative consequences of the experience (Macaskill, 1999, Grimmer, 2005). McEwan and Duncan (1993) stated that benefits include resolving personal problems, modelling the therapist and heightened self-awareness, whilst the negative aspects include emotional and financial stress for the trainees. This corresponds with the findings in this study; both groups articulate these positive and negative aspects of mandatory personal therapy.

Despite trainee and qualified counselling psychologists reporting some negative aspects of the experience, both groups find mandatory positive therapy to be a positive experience and believe it should be a requirement, a finding that supports the literature in this field (Williams *et al.,* 1999, Murphy, 2005). There was a lack of consensus from participants in both groups regarding the required number of hours of therapy trainees should have; with some feeling that the prerequisite of a minimum amount of 40 hours is arbitrary and inflexible. Some participants commented that more hours of therapy should be required whereas others believed that there were already too many hours involved.

Both groups highlight the synergistic emotional impact of the monetary and mandatory aspects of trainees' compulsory personal therapy. The financial implications of mandatory personal therapy were spoken about with considerable passion during the interviews. This was notable in the absence of discussion about the financial impact of attending a course that is self-funded. For the trainees, therapy is an emotional experience, not just because of working through personal issues, but also because of the stress of combining work load, therapy and financial costs.

It is worth nothing, however, that it is not just trainee therapists who can find the financial aspect of therapy difficult. Herron and Rouslin Welt (1992, p.8*)* stated that "patients accept the idea of payment...they may even feel grateful and praise the therapist but they would prefer not

to pay...". Additionally unlike other commodities "money is a different currency within the context, within the setting, of a psychoanalytic treatment...the patient is paying for something but he can never know what the product will be... (Phillips, 2006, p.284). Consequently, people have to trust that they money they are paying will be useful for themselves, without a guarantee.

Nevertheless, for the trainees it appears that the mandatory aspect of the therapy, and the perceived lack of choice in having to finance it, causes a strong emotional reaction. Arguably this adds an extra element to the contentious issue of financing therapy that affects the general population. Phillips (2006, p.284) affirmed that "A psychoanalyst is someone you pay to not tell you what you will get, not because she *won't* tell you, but because she *can't* tell you". Whilst the trainees were initially wary about the worth of mandatory personal therapy the trainees feel (with the exception of Claire) that despite the negative financial and emotional implications, the return of having personal therapy outweighs the costs.

For the therapists there are both positive and negative financial implications of seeing trainee-clients. Feeling empathic towards the trainees can have a negative impact on the therapists; for example, Alyssia speaks about lost earnings when trainees missed sessions due to coursework deadlines. Conversely, for others, having trainees as clients is an attractive prospect. As the therapy is a course requirement, Brain acknowledges that seeing trainees normally ensures a relatively long financial commitment

Although it may have been supposed that the emotional effects would mainly be felt by the trainees, as they are the clients undergoing therapy, there are also significant emotional implications for the therapists. Therapist-participants reflect that memories of their own less than positive experiences of personal therapy are re-activated when they work with the trainees. There appears to be a strong desire for therapy to be a better experience for the trainees. The therapists occasionally feel guilty as they contemplate whether they are involved in something unethical: seeing trainees who are required to see them. Herron and Rouslin Welt (1992, *ix)* stated that "Money has always been a peculiar issue for psychoanalysts and psychotherapists. Like their patients, they also need it for physical and psychological well-being, but beyond that, they need to get it from their patients...The presence of a fee is imagined as obliterating the positive helping image in which most therapists sincerely believe and that they want to convey to their patients...". For therapists seeing trainees there is the

additional burden of being aware of the financial struggle faced by the trainees; indeed the therapists discuss their own financial stress when training.

Herron and Rouslin Welt (1992) discussed the issue of transference and counter-transference in the financial transaction between therapist and client. They highlighted that instead of being viewed as a negative issue it can instead by used as a way of defining boundaries e.g. that the therapist is not there in a social/friendship role but instead "what the fee purchases is a professional relationship" (p.112). They further stated that "because patients' projections are the content of most psychotherapies, it is easy to see why consumers get confused, and that increases the need for therapists to be clear and explicit about their professional roles" (p.113). Perhaps in the case of the relationship between trainee psychologists and their therapists the fees are of even greater importance in defining the therapeutic boundaries which have been both highlighted in this research and that of other studies. This research has emphasised that is essential to make the aims of personal therapy and the commitment that is involved explicit to trainees prior to starting the course. This could occur at the time of interview and again at the start of the course. By outlining the financial and emotional commitment that is involved for trainees entering therapy, courses would allow candidates to consider fully whether they can afford it, as opposed to potentially just agreeing out of their desire to be accepted onto the course. If potential trainees have personal reasons for not wanting to go to therapy it will also allow them to consider if it is the right course for them.

An additional proposal would be for counselling psychology directors to ask trainees in their final year of studying if upon graduation they would be prepared to offer a discounted therapy to trainees as part of a reciprocal procedure, i.e. the newly qualified therapists would have access to clients and the trainee-therapists would have qualified psychologists as a reduced price. A list could be provided to trainees both with recommended therapists (perhaps therapists that have seen trainees in the past) and those who offer student rates. Although some trainees may not want to have therapy at university, perhaps it can be arranged that therapists can see trainees at the universities in order to alleviate their own room hire costs, and improve convenience for trainees in terms of both location and time. Employers, training bodies and placement organisers play a key role in alleviating needless burdens for trainee counsellors (Jensen, 1994).

It was interesting that Claire evaluated potential therapists on the prices that they charged trainees. It appears that when she picks a therapist, it is not just due to the matter of whether she can afford the price the therapist charges, but what the price suggests about the therapist as a practitioner. Therapists therefore should take into account when setting their prices the fact that they might be being judged on how ethical they are as therapists. This may differ from the wider population as Herron and Rouslin (1992) suggested that patients who are offered lower prices from therapists are often more suspicious about the 'quality' of therapy they will be receiving. They suggest that clients receiving 'cheaper' therapy "may well devalue it unless they can be convinced that the therapists involved are sufficiently knowledgeable" (p.9). This is in contrast to Claire who believes a therapist setting a lower price is in fact a more ethical practitioner. I suggest that a stronger rationale is provided for the required 40 hours of mandatory therapy by the BPS, given the further financial stress that therapy puts trainees under.

The trainees discuss being under a huge amount of stress during the DPsych course both emotionally and financially. Perhaps in the first year of training trainees could have 'mentors' i.e. trainees who are in the year above them on the course. Interestingly Stokes (2003) stated that professional counsellors and mentors use many of the same skills i.e. empathy and reflection. In Siegel's (2000) study, in which he researched the use of peer relationships at times of uncertainty, he found that informal peer relationships can assist in encouraging professional development and adjustment at various career stages. Although his study is in relation to a business merger, trainees entering training are also faced with considerable uncertainty. Potentially informal mentoring would be of benefit to the trainees.

Trainees discussed the idea of introducing a peer discussion group. Although many courses offer 'tutorials' often course facilitators are present. Arguably, having trainee groups would allow trainees more freedom in their conversation, i.e. less fear of judgement in which to discuss their therapy or indeed any other matters. Personal development groups can provide chances for consideration on interactions and other significant learning of counsellor abilities and processes (Payne, 2004).

Boundaries

Geller (2005) affirmed that "in the psychotherapy of therapist-patients...inherent tension [is] created by straddling the interpersonal boundary between the formal roles of patient and

therapist and the collegial aspect of the relationship" (p.397). Boundaries have frequently been referred to in other research concerning personal therapy for therapists (Grimmer & Tribe, 2001, Rizq & Target, 2008). Both trainees and the therapists refer to therapeutic boundaries. Although in some cases the trainees tried to push the boundaries, they were learning from the therapists and respected strong boundaries. Ironically some of the therapists, in efforts to be accommodating to the trainees, loosen these boundaries. Their empathy and consideration can collude with the trainees' initial reluctance to engage in the sessions. Both sides were cautious and at times experienced feelings of anxiety, regarding their 'roles' in the relationship. Shillito-Clarke (2003) highlighted the issue of dual and multiple relationships: "when boundaries get blurred or confused, mistakes and ethical issues become more likely...it is the counselling psychologist who must take responsibility for the relationship" (p.631). By and large the counselling psychologists were very aware of the potential for blurred boundaries. Although there may have been increased flexibility for trainees, they attempt to maintain their roles as therapists. Both trainees and therapists articulate that therapy is mainly used for personal development and personal issues as opposed to turning into supervision.

Trainee participants discuss the small world of counselling psychology. Natalie states that she was uncertain about 'having' to see a counselling psychologist. Part of her hesitation was due to the relatively small pool of counselling psychologists that see trainees, increasing the potential for her peers to have the same therapist as her. She also expresses anxiety about the possibility of encountering a former therapist within a future job environment. Claire expresses unhappiness about 'having' to change a therapist she had been seeing and had established a relationship with because he is not a counselling psychologist. Although therapists empathise with trainees due to their own experiences of mandatory therapy, this can result in concessions being made and looser boundaries kept. Consequently, I would suggest that all counselling psychology courses consider allowing trainees to see therapists from other registered bodies, (i.e. BACP and UKCP) giving students a greater choice of prices, perspectives and allowing them to continue with therapists with whom they may already be in a relationship with. Another recommendation is that therapists who see trainee-clients place importance on arranging their own supervision to discuss their own emotional response, and any potential boundary issues.

CHAPTER FIVE: EVALUATION

This evaluation section assesses my research in terms of reflections on the findings and my own reflexivity. It will proceed to evaluate my use of the research methodology and appraise the strengths and weaknesses of the research findings. It ends with recommendations for future studies and a conclusion to the research.

Reflections on the findings

This research intended to fill a gap in the current literature and produce information for the counselling psychology profession about the unique relationship between counselling psychology trainees and their therapists. It hoped to illuminate how trainees used their personal therapy, i.e. personal/professional development or both. Additionally, it aimed to illustrate how trainees and their therapists felt about therapy being a mandatory course requirement.

Nevertheless, as Smith *et al.* (2009) stated "it is in the nature of IPA that the interview and analysis will have taken you into new and unanticipated territory" (p.113) and that is true of this research. I had not included questions regarding finance in my interview schedules and did not anticipate that both trainees and therapists would mention finance so often and so fervently.

A finding that emerged was that of trainee counselling psychologists' beliefs that if therapy is too comfortable it is not really therapy. I have found no other research that explores trainees' beliefs about how therapy 'should' be, and thus view my research as potentially offering a unique contribution to the literature in this field. In researching whether clients in general tend to operate from a discourse that therapy should be hard I did not find that this was to be the case. As Dew and Bickman (2005, p.23) stated "expectancies have been more widely researched, and appear to have been more accepted and adopted in physical health than in mental health". Taylor and Loewenthal (2001) researched one client's experience of preconceptions of therapy using discourse analysis. They did not find that the client had preconceptions that therapy should be difficult. Instead they found that the client had preconceptions such as other people thinking she is 'mad' because she has gone to therapy.

On the contrary to trainees believing therapy should be difficult, Tinsley, Bowman and Barich (1993, p.50) surveyed counselling psychologists about unrealistic client expectations, and found that "A majority perceived some of their clients as having unrealistically high expectations about the need for concreteness; the likelihood of counsellor nurturance,

directiveness, and empathy; and the probability of a beneficial outcome." (p.46). Kamin and Caughlan (1963) interviewed former Veterans Administration clinic clients regarding their experiences in therapy. They found that that nearly 75 percent began therapy with no clear idea about what it involved. Perhaps because the majority of participants had no experience or knowledge about the nature of therapy, they did not have the same expectations as the trainees. Conversely, they did not seem to have preconceived ideas about how therapy 'should' be.

Walborn (1996) stated that there are varied expectancies regarding clients' beliefs about psychotherapy. These include that "some believe that the therapist is going to tell them what is wrong with them and will fix them...some clients seeing a cognitive therapist may expect to lay on a couch and to talk of childhood memories. Some clients going to see a psychodynamic or experiential therapist may be distraught at the lack of input from the therapist" (p.122). Nevertheless, he did not find an expectancy that if therapy is not uncomfortable then it is not really therapy, as I found with the trainees in this study.

Garfield and Wolpin (1963) conducted a questionnaire regarding outpatients' expectations of psychotherapy. They were individuals who were applying for outpatient therapy who had no previous therapy. The researchers found that "they tend to say that there is nothing about therapy that frightens them, while admitting to expected discomfort over recalling and revealing certain things" (p.360). It can be inferred therefore that participants in this study did expect therapy to be uncomfortable at times.

In Dew and Bickman's (2005) review of expectations literature they did not mention that clients tend to operate from a discourse that therapy should be hard. Instead they found that "there are two primary types of expectancies described in the literature: role expectancies and outcome expectancies" (p.22). Role expectancies refer to clients' expectations of patterns of behaviour deemed as appropriate of themselves and their therapists and outcome expectancies can be defined as beliefs that therapy will result in change (Dew and Bickman, 2005). Consequently, whilst it seems that people are aware that therapy can be difficult it can be supposed that, from the available research literature, it is somewhat unique to the trainees to operate from a discourse that therapy should be hard. Most studies in this area have been quantitative; perhaps a qualitative study could be carried out in order to get a more detailed idea about what is and what is not distinct to the trainee population.

One may only be aware of one's preconceptions once the interpretation is already occurring (Smith, 2007). I was surprised by some of the participants' responses, especially in regards to one participant who appeared furious about mandatory therapy. One of my own preconceived thoughts, that I had not realised I possessed, was that by choosing to attend a counselling psychology course, one had made a choice to have therapy. This encounter made me realise that for some people it had not seemed a choice, but rather a condition. "Researchers must wage a continuous, iterative struggle to become aware of, and then manage, pre-understandings and habitualities that inevitably linger" (Finlay, 2008a, p.29). Accordingly, whilst I was not always aware of all of my pre-conceptions I feel that when I did become aware of them I managed to use them as a way of generating deeper insights.

As a trainee, I had some understanding of wanting to present myself in the 'best' light and so was not surprised about the therapeutic 'mask' some trainees put on. Nevertheless, I was taken aback by the feelings of anxiety expressed by both groups. It was remarkable that the very nature of the mandatory element of therapy had such an impact on the process, including both groups largely moving from a therapeutic performance to an authentic relationship. I also found it fascinating that the mandatory nature of therapy was not discussed between trainee and therapist, especially in a profession that emphasises process and authenticity in the therapeutic relationship. Indeed, my own therapist, a BACP counsellor, brought it up during our first session.

Reflexivity

Finlay (2002) suggested that the influence of the researcher and the researcher-participant relationship is far-reaching in qualitative research. She stated that reflexivity is more than stating one's subjectivity and interests, and is in fact linked to the counselling process, in regards to being aware of the dynamics of the relationship between two people. (Finlay, 2008b). I wondered if the dynamic of myself initially interviewing counselling psychologists who did not have doctorates led to the data being more 'guarded'. Specifically, participants were asked how it felt to have a trainee counselling psychologist interview them. They all said that it did not present any issues. Indeed, a couple of the trainees said that knowing my trainee status made the interview process more comfortable. Interestingly, one counselling psychologist said that she had initially been worried about how I would judge her practice, but that she soon felt at ease.

Finlay (2002) highlighted that reflexivity is a particular challenge, in allowing oneself to use it for insight and interpretations as opposed to indulging in subjectivity. I endeavoured to use reflexivity as a 'mutual collaboration' (Finlay, 2002). As part of this I asked the participants their opinion about topics that I thought had been prominent in their interview, and on the whole, they agreed with them. I think that I had an additional advantage due to many of the participants having been trained in reflexivity and analysis, as part of their therapeutic work.

A key challenge in carrying out phenomenology is to embody opposing positions of being "scientifically removed from" participants whilst attempting to interact with research participants at the same time (Finlay, 2008a, p.3). I had my own views of mandatory personal therapy which are impossible to bracket completely (Ashworth, 2006). Nevertheless I have attempted to adopt the phenomenological attitude of empathic openness as much as possible (Finlay, 2008a). I have self-reflected before, during and after carrying out the research. By taking time to step away from the research, I have critically evaluated my initial pre-understandings (Finlay, 2008a). On reflection, I could have used reflexivity more deeply by including myself as a participant and asking a peer to interview me with the same questions I asked the trainee counselling psychologists.

Smith and Osborn (2008) suggested that "people struggle to express what they are thinking and feeling, there may be reasons why they do not wish to self-disclose, and the researcher has to interpret people's mental and emotional state from what they say" (p.54). I noticed on several occasions, with both groups of participants, a sense of a parallel process in their descriptions of a 'therapeutic performance' with each other. I wondered if both the participants and I put on a performance on occasion, and whether I always received an authentic account of the therapeutic experience. At times I felt that some of the respondents were keen to show me that they were good trainees/therapists. The use of 'therapy' language by participants in both groups sometimes struck me as trying to impress me. This could have been because the trainees were not as advanced as me on the course (I was in my third year as opposed to trainees in their second year) and because the therapists were mirroring the process of feeling nervous about having a 'peer' interviewing them. After the first couple of interviews, I speculated whether my being a trainee and a researcher might be another 'elephant in the room'. Nonetheless, the fact that I asked the participants how they felt having a trainee counselling psychologist interviewing them, allowed the participants a chance to voice any opinions that they may have had on the matter. Alternatively, they may have played down their

worries to anyone that interviewed them regarding their professional roles, in their desire to appear as competent professionals.

At times, interviewing peers and therapists that were qualified was anxiety provoking for me, especially as I am a novice interviewer with my own worries about doing a 'good-enough' job. It is my belief that none of the interviews were adversely affected by this. Smith *et al.* (2009) stated that "the underlying qualities required of the IPA researcher are: open-mindedness; flexibility; patience; empathy and the willingness to enter into, and respond, to the participant's world" (p.55). I think that I have these qualities and to the best of my abilities have accessed the participants' experiences.

Reflections on my use of the methodology

I chose IPA because it fitted with my epistemological position and research. Using IPA for the first time has been both challenging and exciting. I believe that both the strengths and weaknesses of IPA lie in its lack of 'rules' governing how it should be carried out. Smith *et al.* (2009) stated that "there is no clear right or wrong way of conducting this sort of analysis, and we encourage IPA researchers to be innovative in the ways that they approach it" (p.80). Whilst the absence of direct regulations has allowed me room for flexibility and originality, on occasion it has also caused me (as a novice researcher) to feel unsure if I was carrying out the analysis 'correctly' and if I was doing justice to my participants' accounts. Nevertheless with the help of supervision and peer support my worries were eased.

"The truth claims of an IPA analysis are always tentative and analysis is subjective" (Smith *et al.*, 2009, p.80). At the same time Smith *et al.* (2009) noted that "subjectivity is dialogical, systematic and rigorous in its application and the results of it are available for the reader to check subsequently" (p.80). It is hoped that the presence of direct extracts from the interviews allows the individual experiences of the participants to be accessed by the reader. For ethical reasons, I would have liked to invite my participants to look at the themes generated, in order to see if they felt that the analysis did capture their individual experiences. Due to time constraints this was not possible. Furthermore, I was aware that asking participants to 'validate' my analysis is a backwards glance at positivist ideals. As this study is based on interpretation, it would not be unexpected to find my own understandings differ from my participants so their validation might not prove entirely useful.

During the phase of more critical questioning interpretation (i.e. moving beyond the participants' words), I wanted to ensure that when creating themes/categories at ever increasing levels of abstraction, the essence of the individuals lived experience was not lost. IPA is idiographic in its focus and it is important not to lose a sense of individuals' meanings and experience. I endeavoured to highlight the quality and texture of individual experience, whilst understanding that such experience is never directly accessible to the researcher, which is a central tenet to IPA. In my opinion, I have not 'lost' the individual when discussing shared themes between the participants. This has been done by acknowledging differences, as well as similarities, in experiences.

Finlay (2009) explained that "while all phenomenology is descriptive as it intends to describe as opposed to explain, various researchers and academics make a distinction between descriptive phenomenology compared to hermeneutic or interpretative phenomenology" (p.10). I believe that, in keeping with IPA, my analysis is interpretive and that I was able to engage in the "double hermeneutic" (i.e. attempting to make sense of the participant seeking to make sense of what is occurring for them) (Smith *et al.*, 2009, p.3).

Nevertheless, I found steering between different levels of interpretation challenging. Van Manen (1990) differentiated between "interpretation as pointing to something (interpretation suited to phenomenological description) and interpretation as pointing out the meaning of something by imposing an external framework (such as when offering a psychoanalytic interpretation)" (Finlay, 2009, p.11). As a trainee counselling psychologist I had to distinguish between interpretation originating from external theory (as I would do in a counselling psychology session) and the interpretations I made when embracing a phenomenological method, which involves being intuitive and dwelling with meanings. Indeed during the interview with Henry, I felt a sense of resistance from him, and a feeling that he did not relate particularly well to me. He often gave quite short answers to questions, which I found difficult to expand upon as the interview continued. It is possible that he feels slightly self-conscious that he is not entirely 'legitimate' (i.e. trained via an official course) and this is something he might be challenged/criticised about - hence a suggestion of defensiveness. This is very much an outside perspective as I am analysing, as opposed to describing, his experience. When writing my analysis, I initially included this perspective, until a peer challenged me on this. It is inevitable that my ability to stay with epoché and the phenomenological description would

sporadically slip. Despite this, I endeavoured to recognise when this occurred and when interpretations came from outside theory as opposed to my own intuition.

I feel that I have described my participants' experience and meaning to the best of my ability. Inevitably I, as the researcher, formed some of the context of the interview and I have taken part in co-creating the results. As Larkin *et al.* (2006) pointed out, the interview itself can influence the constitution of reality that the participant experiences. Mindful of this point I have endeavoured to be reflexive throughout the research. Furthermore, I tried to be as clear as possible about my epistemological position following Finlay's (2009) suggestion that researchers should be transparent about which philosophical and/or research traditions they are adhering to.

Strengths and limitations of the research

This research has sought to shed light on the relationship between counselling psychology trainees and their therapists. I would argue that this study has the potential to deepen understanding of the complexities involved. The fact that the findings reveal elements found in the wider literature discussed in Chapter Three is reassuring. Furthermore, this research has illuminated the range and complexity of participants' responses in response to the subject of mandatory personal therapy. These points should be considered in light of the recommendations and implications for counselling psychology that I have made throughout the previous chapter (see Chapter Four: Synthesis). I suggest that a particular contribution of the research has been that it has take the 'elephant' *out* of the room and there is now an onus on course directors to address the financial and emotional implications of mandatory personal therapy. A significant finding of this research is that mandatory personal therapy is perceived by both qualified and trainee therapists to be incompatible, at least in the early stages, with one of Rogers (1961) core conditions of congruence. Mandatory therapy initially impedes authenticity within the therapeutic relationship. Acknowledging the importance of these findings is indeed part of the process of being authentic.

There are also limitations to this study. Firstly my research question is broad and by using two groups of participants I almost have two research projects. Despite this, I feel that researching the experiences of both the trainees and qualified psychologists has given my research an added dimension and relevance to counselling psychology. After all, there are two people in a therapeutic relationship and I think that trying to access the experiences of both makes the

research more interesting and informative. There has been one other study that has attempted to do so, and that was over two decades ago (see Kaslow & Friedman, 1984).

Secondly, one key methodological limitation is the sample size, which is relatively small and also self-selecting. Perhaps the participants who volunteered to participate have particularly strong ideas about mandatory personal therapy, whereas there may have been other people who did not feel passionately about it, hence why they did not choose to participate. For example, Claire was particularly angry at the BPS about funding in particular, and the disparities between the way she perceived the treatment of counselling and clinical psychologists, which might imply a bias to the way she viewed mandatory personal therapy.

The participants were also all from London universities. The themes and analysis produced from this study may have been entirely different if I had interviewed trainee counselling psychologists and their therapists from different university courses all over the country. Nonetheless, my research sample consisted of participants from a range of cultures and I hope that added to the depth of the study. It is also important to note that IPA differs from methods such as grounded theory in that it does not aim to produce theoretical claims from the interviews, and instead "is concerned with the microanalysis of individual experience, with the texture and nuance arising from the detailed exploration and presentation of actual slices of human life" (Smith *et al.*, 2009, p.202).

Recommendations for further research

Future research could include a quantitative survey sent to counselling psychology trainees in all the different years of every counselling psychology course in the country. It would be interesting to see if responses vary in terms of what stage the trainees were in their studies, and also their location. Questions could include asking if they wanted the inclusion of mandatory therapy, their opinions on the number of hours required and other personal development ideas. It could also be sent to trainees on other courses such as UKCP courses that also include personal therapy as a course requirement.

A study could also be undertaken to explore trainee counselling psychologists' experiences of participating in the counselling psychology DPsych course. It appears that trainees are under many different demands and it would be informative to see if there can be any further adjustments that can be made to aid this process. Interviewing course directors and exploring

their perspectives of running a counselling psychology course could also be worthwhile. Additional valuable research could include interviewing clinical psychologists who have chosen to have therapy whilst training, and the psychologists they have seen, exploring the extent to which the analysis yields similar or different themes.

Conclusion

This research suggests that therapists, trainees and course directors may all have to own some responsibility with regard to the inclusion of mandatory therapy:

Firstly, trainees have a responsibility for evaluating, before committing to a counselling psychology training programme, whether they can commit financially and emotionally to a course which requires mandatory personal therapy. Mandatory therapy involves the trainee in a potentially significant personal journey which may be unexpected. One particular outcome is the shift from being inauthentic to authentic when it comes to owning one's own emotions. Trainees also have to cope with additional pressures when it comes to the mandatory nature of therapy given the emotional intensity demanded and the financial burden involved.

Secondly, it is significant that therapists both identify with and sympathise with the trainees, which can results in special considerations being made. The fact that qualified therapists perceive a disparity when working with trainee counselling psychologists, in contrast to other client groups, is significant and should be acknowledged. The therapists' lack of acknowledgment during therapy of the demands involved from both trainee and therapist can result in not always keeping to Roger's (1961) core conditions in the counselling relationship. It is hoped that therapists reading this research will reflect on the importance of acknowledging early on in the relationship the 'elephant in the room'. Furthermore, as trainees respect boundaries from the therapists, it is important for therapists to maintain their roles as therapists as opposed to peers and/or supervisors and also for them to handle any concerns about being judged by the trainees.

Finally, there is an onus on course directors to be more explicit, both pre-interview (in the course information) and during the interview, about the rationale and potential impact of mandatory personal therapy.

Despite reported negative and challenging aspects of the experience, both trainees and qualified therapists feel that mandatory personal therapy should remain a key feature of the course.

The elephant has now left the room.

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Appendices

Appendix A

Recruitment advert in The Psychologist

Are you a Chartered Counselling Psychologist who has provided therapy to a Trainee Counselling Psychologist?

As part of my Doctoral Project at City University I am conducting a qualitative study exploring the experiences of Chartered Counselling Psychologists who have, as a part of their work, provided therapy to trainee Counselling Psychologists. Taking part would entail an interview lasting about one hour which will be recorded and transcribed.

If you are interested please contact: Tami Avis at tamiavis@gmail.com

Project supervised by: Dr Don Rawson (don.rawson.1@city.ac.uk)

Appendix B

Recruitment email to psychologists recruited from BPS website

Dear Dr

I am a Counselling Psychology trainee at City University and as part of my Doctoral Project at City University I am conducting a qualitative study exploring the experiences of Chartered Counselling Psychologists who have, as part of their work, provided therapy to trainee counselling psychologists. This research is being supervised by Dr Don Rawson.

I found your details from the directory of Chartered Psychologists on the BPS website and wondered whether you have worked with trainee Counselling Psychologists before, and if so whether you would be interested in taking part in my study? Your participation would entail an interview lasting about one hour which will be recorded and transcribed and we would be able to meet at a location convenient to you.

If you have any queries regarding this research please do not hesitate to contact me (tamiavis@gmail.com) and/or my research supervisor (don.rawson.1@city.ac.uk). I would appreciate it if you could confirm or not your interest in participating in this study by no later than the 16th of September.

Best Wishes

Tami Avis

Trainee Counselling Psychologist

Appendix C

Provisional interview schedules

Trainee Counselling Psychologists

Therapeutic Relationship

How did you experience the therapeutic relationship?

Could you describe to me if there were any ways in which the fact that therapy was mandatory impacted on the relationship?

Was a contract negotiated taking into account the unique dynamics of the relationship? *Prompts: expectations, knowledge*

Did you ever see your therapist in a professional context and did it have any effect on your relationship?

Power Imbalance

What does the term 'power' mean to you?

Was a possible power imbalance discussed at the start of therapy/during therapy?

Did you feel that there was a power imbalance and if so did this impact on the quality of the therapy/therapeutic relationship?

What strategies were used to overcome these moments when the therapeutic relationship/therapy was being affected by the power imbalance?

Was the information you disclosed influenced by any fear of being judged inappropriate to be on the training course?

'Forced' Moments in Therapy

Did therapy feel forced and if so how did the participants recognise a forced moment?

Is it an internal or an external force? If it is an internal force what internal dilemmas does this set up?

How does this forced aspect of the relationship influence you in therapy?

What strategies were used to overcome any forced moments in therapy?

D. Alternative/Additions to mandatory therapy

Could you describe to me your opinions about whether therapy should be mandatory?

Would you carry on with the therapy after the mandatory 40 hours are up?

What aspects of the experience were positive and which were negative?

Do you feel that there should be alternatives to personal therapy as part of the course requirements?

What possible alternatives could there/should there be?

Counselling Psychologists

Therapeutic Relationship

How did you experience the therapeutic relationship?

Could you describe to me if there were any ways in which the fact that therapy was mandatory impacted on the relationship?

Was a contract negotiated taking into account the unique dynamics of the relationship? *Prompts: expectations, in therapy as part of a course requirement*

Did you ever see your client in a professional context and did it have any effect on your relationship?

Power Imbalance

What does the term "power" mean to you?

Was a possible power imbalance discussed at the start of therapy/during therapy?

Did you feel that there was a power imbalance and if so did this impact on the quality of the therapy/therapeutic relationship?

What strategies were used to overcome these moments when the therapeutic relationship/therapy was being affected by the power imbalance?

Did you feel that there were times when the client stopped themselves disclosing information for fear of being judged unfit to practise?

Did the therapists feel more judged knowing that the trainees were perhaps modelling their therapeutic technique?

'Forced' Moments in Therapy

Did therapy feel forced and if so how did you recognise a forced moment?

How does this forced aspect of the relationship influence you as therapist?

What strategies were used to overcome any forced moments in therapy?

Alternative/Additions to mandatory therapy

Could you describe to me your opinions about whether therapy should be mandatory?

Would you carry on giving the trainee therapy after the mandatory 40 hours are up?

What aspects of the experience were positive and which were negative?

Do you feel that there should be alternatives to personal therapy as part of the course requirements?

What possible alternatives could there/should there be?

Appendix D

Interview Schedules Revised

Trainee Counselling Psychologists

If you were talking to fellow trainee Counselling Psychologists who were about to have therapy for the first time as part of their course requirements what would you say to them about your experience of having therapy as a trainee?

Therapeutic Relationship

How did you experience the therapeutic relationship between you and your therapist?

Could you describe to me if there were any ways in which your experience of this therapeutic relationship affected the way you worked with your clients/would affect the way you worked with future clients? **Prompts: role reversal, modelling of therapist, personal development.**

What were the advantages/disadvantages to having a fellow counselling psychologist as a therapist?

How did you find having therapy whilst also seeing clients yourself?

Content of Sessions

What did you hope to gain from personal therapy? **Prompts: personally, professionally**

From your point of view as a trainee could you tell me your opinions about whether this therapy was able to work through problem issues/personal development issues?

What type of content do you bring to therapy sessions? **Prompts: personal/professional**

Therapy as a course requirement

After your experience of personal therapy, could you describe to me your opinions about whether if you were designing the course you would make therapy a course requirement? **Prompts: additions/alternatives to personal therapy.**

What aspects of the experience were positive and which were negative? **Prompts: emotionally, practically.**

What is your opinion about the number of hours trainees are required to have therapy for? Prompts question: Is 40 hours satisfactory? Is the way that the hours are split up divided over the three years beneficial? **Were there any questions that you wish I had asked today that I didn't? How did it feel having a trainee Counselling Psychologist interviewing you on this subject?**

Counselling Psychologists

If you were talking to fellow Counselling Psychologists who were about to give therapy to trainee Counselling Psychologists for the first time what would you say to them about your experience of giving therapy to trainees?

Therapeutic Relationship

How did you experience the therapeutic relationship between you and your client?

Could you describe to me if there were any ways in which your experience of this therapeutic relationship affected the way you worked with other clients/would affect the way you worked with future trainees?

What were the advantages/disadvantages to having a trainee counselling psychologist as a client? ***Prompt question***: How did this therapeutic relationship compare to working with clients who did not work in the mental health field?

Content of Sessions

What did you hope the trainee would gain from personal therapy? **Prompts: personally, professionally**

From your point of view as a therapist could you tell me your opinion about whether you think the client was able to use therapy to work through problem issues/personal development issues?

What are your thoughts about the type of information trainees bring to the therapy sessions?

Therapy as a course requirement

After your experience of giving a trainee personal therapy, could you describe to me your opinions about therapy being a course requirement? **Prompts: additions/alternatives to personal therapy**

What aspects of the experience were positive and which were negative? **Prompts: emotionally, practically.**

What is your opinion about the number of hours trainees are required to have therapy for? Prompts question: Is 40 hours satisfactory? Is the way that the hours are spit up over the three years beneficial?

Were there any questions that you wish I had asked today that I didn't? How did it feel having a trainee Counselling Psychologist interviewing you on this subject?

Appendix E

Information and consent forms

Trainee Counselling Psychologists

My name is Tami Avis and I am conducting research on the mandatory personal therapy that is a requirement for trainee counselling psychologists to undertake, as part of the course requirements, for my D.Psych in counselling psychology at City University, supervised by Dr. Don Rawson.

The purpose of this study is to explore what the impact is of mandatory personal therapy on trainee Counselling Psychologists and their therapists. As a trainee Counselling Psychologist who recently has undertaken mandatory personal therapy your views will be essential in understanding this experience. By giving your consent to take part in this study, you will be asked to partake in a tape-recorded interview that will take about one hour. The reason for this is to explore your opinions about the particular experience of having mandatory therapy. The possible benefits of taking part are contributing to research that may help Counselling Psychologists as well as future Counselling Psychologists benefit as much as possible from therapy.

Your participation is completely voluntary and you are free at any time during or after the study to remove your contribution to it. As this research is self-funded there will be no compensation for participating in this research. The researcher assures you that the study abides by the Ethical Principles for Conducting Research with Human Participants as set out by the British Psychological Society. The researcher thereby guarantees the anonymity and confidentiality of any information you provide. You will be identified only be the use of a pseudonym and the researcher will not transcribe material that could possibly identify your therapist or clients. Additionally the interview recording will be destroyed when the research is complete. When the research study stops you will be fully debriefed and contact details of various organisations will be given if further support is needed.

Prior to taking part in the interview, the researcher asks you to sign this consent form depicting your compliance in taking part in this study and agreeing for your interview to be tape recorded. Please initial the following statements and write your name below to show that you have read the information in this Information and Consent Form and keep a copy for your own records. Any complaints about any aspect of this research can be made to City University.

Please initial box

1) I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and had these answered satisfactorily ☐

2) I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. ☐

3) I understand that there is a possibility that this research could be published. ☐

4) I agree to take part in the above study ☐

5) I understand that the interview will be audio-taped and then transcribed verbatim by the researcher or typists approved by City University ☐

---------- (Name)

---------- (Date)

---------- (BPS membership number)

Thank you for agreeing to take part in this study.

Counselling Psychologists

My name is Tami Avis and I am conducting research on the mandatory personal therapy that is requirement for trainee Counselling Psychologists to undertake, as part of the course requirements, for my D.Psych in Counselling Psychology at City University, supervised by Dr. Don Rawson.

The purpose of this study is to explore what the impact is of mandatory personal therapy on trainee Counselling Psychologists and their therapists. As a Counselling Psychologist who has given personal therapy to a trainee Counselling Psychologist your views will be essential in understanding this experience. By giving your consent to take part in this study, you will be asked to partake in a tape-recorded interview that will take about one hour. The reason for this is to explore your opinions about the particular experience of seeing someone who is obliged to come to therapy. The possible benefits of taking part are contributing to research that may help Counselling Psychologists as well as future Counselling Psychologists benefit as much as possible from therapy.

Your participation is completely voluntary and you are free at any time during or after the study to remove your contribution to it. As this research is self-funded there will be no compensation for participating in this research. The researcher assures you that the study abides by the Ethical Principles for Conducting Research with Human Participants as set out by the British Psychological Society. The researcher thereby guarantees the anonymity and confidentiality of any information you provide. You will be identified only by the use of a pseudonym and the researcher will not transcribe material that could possibly identify your therapist or clients. Additionally the interview recording will be destroyed when the research is complete. When the research study stops you will be fully debriefed and contact details of various organizations will be given if further support is needed.

Prior to taking part in the interview, the researcher asks you to sign this consent form depicting your compliance in taking part in this study and agreeing for your interview to be tape recorded. Please initial the following statements and write your name below to show that you have read the information in this Information and Consent Form and keep a copy for your own records. Any complaints about any aspect of this research can be made to City University.

Please
initial box

1) I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and had these answered satisfactorily. ☐

2) I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. ☐

3) I understand that there is a possibility that this research could be published. ☐

4) I agree to take part in the above study. ☐

5) I understand that the interview will be audio-taped and then transcribed verbatim by the researcher or typists approved by City University. ☐

---------- (Name)

---------- (Date)

---------- (BPS membership number)

Thank you for agreeing to take part in this study.

Appendix F

Debrief Form

Thank you for participating in this interview. The purpose of this study has been to explore the experience of mandatory personal therapy on trainee Counselling Psychologists and their therapists. By doing this it intends to fill a gap in the current literature and produce some information for the Counselling Psychology profession about the unique relationship between Counselling Psychology trainees and their therapists. If you would like to receive information concerning the conclusions of this study upon its completion, please provide your e-mail address below.

---------- (Email address)

If after reading this Debrief Sheet and finishing your participation in this study you have any additional remarks, would like withdraw your input or mention any matters concerning the management of the interview, please contact Tami Avis at tamiavis@gmail.com or Dr. Don Rawson at don.rawson.1@city.ac.uk

The following resources are available for those with an interest in this particular subject:

Pope, K.S., & Tabachnick, B.G. (1994). Therapists as patients: A national survey of psychologists' experiences, problems and beliefs. *Professional Psychology: Research and Practice, 25*, 247-258.

Macaskill, A. (1999). Personal therapy as a training requirement. In C.Feltham (Ed.), *Controversies in Psychotherapy and Counselling.* (pp. 142-155). London: Sage Publications.

Norcross, J.C. (2005). The Psychotherapist's Own Psychotherapy: Educating and Developing Psychologists. *American Psychologist, 60*, 840-849.

Muller, V. (2004). Counselling trainee counsellors. *Counselling and Psychotherapy Journal, 15*, 14-15

Thank you for participating in the research

Appendix G

Ethics release form for psychology research projects

All students planning to undertake any research activity in the Department of Psychology are required to complete this Ethics Release Form and to submit it to their Research Supervisor, **together with their research proposal**, prior to commencing their research work. If you are proposing multiple studies within your research project, you are required to submit a separate ethical release form for each study.

This form should be completed in the context of the following information:

An understanding of ethical considerations is central to planning and conducting research.

Approval to carry out research by the Department of Psychology does not exempt you from Ethics Committee approval from institutions within which you may be planning to conduct the research, e.g.: Hospitals, NHS Trusts, HM Prisons Service, etc.

The published ethical guidelines of the British Psychological Society (2004) Guidelines for minimum standards of ethical approval in psychological research (BPS: Leicester) should be referred to when planning your research.

Students are not permitted to begin their research work until approval has been received and this form has been signed by 2 members of Department of Psychology staff. Section A: To be completed by the student

Please indicate the degree that the proposed research project pertains to:

BSc ☐ MPhil ☐ MSc ☐ PhD ☐ DPsych ☐ n/a ☐

Please answer all of the following questions, circling yes or no where appropriate:

1. Title of project

"Forced therapy"...What is the Impact of Mandatory Personal Therapy on Trainee Counselling Psychologists and their Therapists?

2. Name of student researcher (please include contact address and telephone number)

Tami Avis.

3. Name of research supervisor

Dr. Don Rawson

4. Is a research proposal appended to this ethics release form? **Yes** No

5. Does the research involve the use of human subjects/participants? **Yes** No

If yes, a. Approximately how many are planned to be involved? **Twelve**

b. How will you recruit them? **Both pilot and sample participants will be recruited from the 3-year counselling psychology doctoral level course at City University using personal contacts, posting notices around the City University Social Science Building and also by the researcher going into lectures (if given permission), explaining the nature of the study and asking if anyone would be interested in hearing more about participating in the research. As I cannot directly ask Counselling Psychologists to disclose information about their former clients I will have to ask the trainees recruited to contact their former therapists with a letter (that I have drafted) explaining the nature of the study to them and asking if they would be willing to be participants**

c. What are your recruitment criteria? Participants are trainee Counselling Psychologists (of either gender) currently in training across their 3-year doctoral level courses, belonging to either Year 1, 2 or 3 and qualified Counselling Psychologists (also of either gender). The participants will have had to have had a therapeutic relationship for at least six weeks as this still allows the analysis of the therapeutic relationship in short-term therapy. Any theoretical orientation will be considered as Counselling Psychology incorporates different modes of therapy.

Lastly, the participants will have had to have finished therapy no more than three years ago as the researcher wants to diminish the risk of memory problems. Phase two of the recruitment will occur if the researcher is not able to recruit sufficient numbers of participants. If the researcher cannot find enough pairs of therapists and trainees she will have to review her wish to use only trainees and therapists that have been in a therapeutic relationship together. Furthermore, if the researcher cannot find enough pairs of participants in which the therapist was a Counselling Psychologist then the participants who are therapists can also be UKCP or BACP qualified.

(*Please append your recruitment material/advertisement/flyer)*

Advertisement that I plan to post around City University:

Are you a trainee counselling psychologist who has had mandatory personal therapy as part of the course requirements in the last three years? Did it last for six weeks or longer?

As part of my Doctoral Project at City University I am conducting a qualitative study exploring the impact of mandatory personal therapy on trainee counselling psychologists and their therapists.

If you are interested please contact Tami on tamiavis@hotmail.com

d. Will the research involve the participation of minors (under 16 years of age) or those unable to give informed consent? Yes **No**

e. If yes, will signed parental/carer consent be obtained? Yes No

6. What will be required of each subject/participant (e.g. time commitment, task/activity)? *(If psychometric instruments are to be employed, please state who will be supervising their use and their relevant qualification).*

Each participant will be asked to come to City University and be interviewed for an hour. No psychometric instruments will be used.

7. Is there any risk of physical or psychological harm to the subjects/participants?

Yes **No**

If yes, a. Please detail the possible harm? **I do not think the participants will suffer from psychological harm; however there could be a psychological impact from discussing experiences of therapy**

b. How can this be justified? **The participants will be fully informed on the nature of the study before they agree to take part in it and can withdraw at any point.**

8. Will all subjects/participants and/or their parents/carers receive an information sheet describing the aims, procedure and possible risks of the research, as well as providing researcher and supervisor contact details?

Yes No

(Please append the information sheet which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

9. Will any person's treatment/care be in any way compromised if they choose not to participate in the research?

Yes **No**

10. Will all subjects/participants be required to sign a consent form, stating that they fully understand the purpose, procedure and possible risks of the research?

Yes No

(Please append the informed consent form which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

11. What records will you be keeping of your subjects/participants? (e.g. research notes, computer records, tape/video recordings)?

Signed consent forms will be kept. Tape recordings of the interviews will be also kept, as well as computer records, as they will be transcribed onto electronic documents.

12. What provision will there be for the safe-keeping of these records? **The forms and tape recordings will be locked away in the researcher's house. The computer will have a password that only the researcher will have.**

13. What will happen to the records at the end of the project? **All the records will be destroyed**

14. How will you protect the anonymity of the subjects/participants? **Pseudonyms will be used and any identifying information about the participants will be modified.**

15. What provision for post research de-brief or psychological support will be available should subjects/participants require?

A debrief sheet will be given to participants which will include lists of resources should there be any adverse psychological consequences, i.e. the Samaritans. There will also be a verbal debrief.

(Please append any de-brief information sheets or resource lists detailing possible support options)

If you have circled an item in bold print, please provide further explanation here:

Signature of student researcher ---------- Date ----------

Section B: To be completed by the research supervisor

Please mark the appropriate box below:

Ethical approval granted ☐

Refer to the Department of Psychology Research Committee ☐

Refer to the University Senate Research Committee ☐

Signature ---------- Date----------

Section C: To be completed by the 2nd Department of Psychology staff member *(Please read this ethics release form fully and pay particular attention to any answers on the form where bold items have been circled and any relevant appendices.)*

Appendix H

Exemplar of annotated transcript: Natalie

	R: So it sounds like you're experiences of being in supervision groups with other people that see clients and hearing what they say about their clients made you think about what your therapist could possibly (P: yes!) say about you (P: exactly). Did you feel that in any way that did or didn't affect the therapy sessions or…
Embarrassment/ Change Empathy for clients	P: Well it just, the thing is that I brought it out, something that I thought was fear, that I was actually a little embarrassed about, and I brought it to the therapy, and it was good to see how it was responded to and you know you really can't have a close relationship with somebody if you're not going to tell them the embarrassing bits. I mean I got to have that experience, and also I think that helps me in turn privilege my clients when they tell me the things that they're ashamed of or they think is silly or whatever. I think that that allows me to respond to them more empathetically.
	R: Having been in that position yourself?
knowing the rules of therapy allows "appropriate" client behavior Right + wrong way to be in therapy	P: Where they've told me things that they're embarrassed of, yeah, I mean somebody when they want to turn off the tape, or there's lots of things, like a client tried to give me a gift which of course I couldn't accept. The thing is that I could understand it, because every once in a while as I grew to know my therapist, knowing things that my therapist might like, you might see something and think oh, they would think that article was good or whatever, so I could understand that desire. I think that allowed me to not pathologise it, because for example, in the case where someone tried to give me a gift, somebody in supervision said something about it being inappropriate, and I'm like, well, how did they know that that's inappropriate and how do you know what it means? You don't know what that client means by doing that action, and how were they supposed to know that these are the rule of therapy? To be honest if the clients knows the rules of therapy too much, like we as counseling psychologists know the rules of therapy, we know how it's supposed to be, do you really get anything done or do you just start behaving in a way that's appropriate for the therapist. I think about that sometimes when things are going really well with a client and, you might, this is the thing you never know, they might not show you change that's happened. Change might happen longer after they've stopped seeing you, they might not want to tell you and if things are going really well and you think "oh wow" we are moving through these stages, or they really get it, and yet you realise that there's no change in their behaviour. that they're not actually changing their lives, which generally is why people come. Maybe it's just because they get therapy and they get how they are supposed to respond. I think that impacts it, I think that is something that you learn also from being the client, you understand what it might be like for them, that it might be difficult but also, how, when you know the rules of therapy, how that changes the conversation that you have when you're the client.

Trust gained by therapist impermeability

Identification with client

Acting the part

Masked self

Appendix I

Initial list of themes in chronological order: Natalie

Therapy important for understanding of self, and self in relation to clients

Forced therapy: a shared experience for clients and trainee psychologists

Conflicting feelings/ambivalence about personal therapy/cognitive dissonance

Forced therapy relationship versus voluntary therapy relationship

Lack of control over choice of therapist

Anxiety regarding "small world" of counselling psychology

Ambivalence about therapy

Self-induced pressure to 'succeed' at therapy

'Right' way to be in therapy

Fear of being discussed/judged by therapist

Increased understanding and identification with clients

Conflicting self of trainee (dual roles)

Defence of clients

Therapy as a game with rules to manipulate

Power struggle between trainee and therapist

Desire to be perfect client/succeed at therapy

Awareness of trying to be the therapist and client

'Special' client with insider knowledge

Fear of therapist judgement

Therapy as game/power struggle

Assumption of shared experience with clients

Defence of self

Fear of judgement

Defence of client's being judged=defence of self being judged

Lessons from therapy taken outside

Rebellion against 'rules' /pushing the boundaries

Different therapists; different type of relationships

Therapist as mentor

Importance of trying different therapists

Trainee=special client

Therapy as a rule book

Desired equality with therapist

Modelling therapist

Playing multiple client roles

Lowered defence against therapy

Chameleon client – many roles to play depending on therapist/model

Learning to be the 'good client'

Therapy as a challenge

Desired incorporated therapist and supervisor

Perceived external expectation to be a 'good client'

Self-realisation

Therapist rejected dual role of therapist/supervisor

Anger at herself for breaking the rules-projected onto therapist

Increased connection with clients

Swopping of roles- trainee analysing client

Self intellectualisation of therapy

Identification with own clients

Therapist analysis trainee, trainee analysis client- bidirectional analysis

Fears judgment of therapist, yet judges him

Impressed with therapist's robustness

Fear of therapists discussing trainees, yet trainees discuss therapists (peer discussion of therapy)

Tested her therapist- and he passed

Self-justification for testing boundaries

Assumption that she used therapy 'correctly'

Appendix J

Clustering of themes: Natalie

A vulnerable self

Self-protection against being vulnerable

Fear of therapist judgement

Defence of self vulnerability, on guard

Fear of judgement

Anxiety provoking: Rebellion against "rules" /pushing the boundaries: self protection

Desired equality with therapist Protection and projection

Swopping of roles- trainee analysing client- challenge

Bi-directional analysis

Protection and projection- Fears judgment of therapist, yet she judges him

Scary but secure experience

Protection and projection again- Fear of therapists discussing trainees, yet trainees discuss therapists (peer discussion of therapy)

Therapy as a test of trust

Invasion of protection of self

Ambivalence

Tension generated by "small world" of counselling psychology

Therapy as a chore

Lack of control over choice of therapist- generating anxiety

Identification with clients

Alignments with clients

Conflicting self of trainee

Defence of clients

Assumption of shared experience with clients

Increased connection with clients

Positive Experience: understanding of self, and self in relation to clients

Forced therapy: a shared experience

Self-pressure to be 'good client'

Internal pressure to "succeed" at therapy

Therapy as anxiety provoking

Experience of being a Chameleon client

Therapy as a challenge

Therapy as an internal and external learning experience

Perceived external expectation to be a "good client"

Experience of internal development

Therapy as anxiety provoking: Desire to be perfect client/succeed at therapy

Trainee=special client

Therapy as a rule book

Forced therapy relationship versus voluntary therapy relationship

Therapy as a requirement

Therapy as a game

Therapy as a power struggle

Therapy as game/power struggle *"It's a relationship that's real, but it's not a relationship in reality"*

A learning experience/ an experience of relief

Positive experience> Learning/modelling

Therapy as a supportive experience/relief

Modelling therapist

Therapy as positive, relief

Appendix K

Superordinate themes: Natalie

1) THE AMBIVALENT SELF

i. **"shopping around for therapist"**

seeking similarities*....* *"finding a counselling psychologist ...that worked in the modality that I wanted to work in (2:26).*

yet

wanting a challenge*...* *"I wanted to choose a m,, the part for me as a therap, as a trainee was the fact that I wanted a man and I wanted something that was as far from what I did" (9:10).*

ii. ***wanting therapy but feeling forced***

theoretically a positive idea : *"I think I would say that, you know, it's a good idea for any therapist regardless of modality, that they have an understanding of their own patterns and um (R: yeah), their own patterns, their own um prejudices".*

yet

I guess forced is the word (2:19)*:* *"You're coming because it's a requirement, you're not coming because you thought I would really like to have therapy, and it does make a difference" (2:20).*

iii. ***authenticity***

being genuine*...* *"Therapist um authenticity and transparency is quite important to me... so that was quite important for me that, that um that's what I got back and then that's what I give" (4:43).*

...Or acting the part*...* *"If the clients knows the rules of therapy too much, like we as counselling psychologists know the rules of therapy, we know how it's supposed to be, do you really get anything done or do you just start behaving in a way that's appropriate for the therapist" (4:4).*

iv. playing the game

being a "good client"*....* *"You know that's the rule, you're not allowed to ask where they vacationed" (6:39).*

...And breaking "the rules"*...* *"I would ask him, just to see what he would do..." (6:40).*

v. being in control but recognising lack of control

desiring control: *"I would also watch the clock, so that he never had to say we're finished, um, if I forgot...and he had to say that we're finished, I would have felt like I'd lost". (4:27)...Because then he would have to, then he'd say that the time was end and then he was like in control (5:1).*

but feeling out of her depth: *"Well as clients we only tell the therapist what we want to, that we probably leak and tell them more than we think".*

2) THE VULNERABLE SELF

Anxiety regarding:

Future career

What happens if a couple of years from now, you go into a job and there's someone who used to be your therapist..." (2.30).

Small world of counselling psychology

"Like with my current therapist who I know knows people that I know, I actually made that explicit the first time was that they were never going to be in a supervision situation with anyone that I, with the person that we both knew in common ". (2:37).

Potential of being the subject of discussion

"I wondered how my therapist would talk about me if I wasn't there... it's still a really touchy point for me"(3:10).

Uncertainty regarding:

'Opening up'

"I realize that I do know where to start but I don't really wanna start there because it's the uncomfortable bit" (8:33).

"As clients we only tell the therapist what we want to (5:10).

Trainee's perceived obligation to be a 'good client'

"My personal tutor...she was saying that, that you know, sometimes people would come, um, and, you know, she never really got what they were talking about because, they, they never really got to any depth" (9:40).

"I have been reading about, reading some psychoan, psychodynamic book and it was saying that the client, one of the clients' responsibilities is to be irrational (9:1)

The firmness of boundaries

"Thinking about my desire to want to test the boundaries... you feel secure when you've tested them".

Shame

Regarding revealing of self

"I remember thinking one day when I had just been bitching and moaning basically, and I thought you know, gosh, what if he thinks that I'm like this ***all*** *the time" (5.28).*

"I felt sorry for him sometimes because of the fact that I'm all, you know like, because I'm was all the things we've been doing, that's exactly what I'm like, it's like you know, bringing everything out".

3) FROM RESISTING TO LETTING GO...MAKING THE LEAP

From trainee self

Inhibition affecting

i. the nature of communication

"When you know the rules of therapy...that changes the conversation that you have when you're the client". (4:23).

ii. personal goals

"I think it got in the way because I was not able to be irrational in the way that you need to be" (2:45).

iii. therapeutic process

"If the clients knows the rules of therapy too much, like we as counselling psychologists know the rules of therapy, we know how it's supposed to be, do you really get anything done or do you just start behaving in a way that's appropriate for the therapist" (4:4).

To client self

Security as a result of therapist's competence

"I just like the way he handled it" (12:17).

Surprise at letting go

*"I **actually** had had one crisis, um err family crisis and I had **actually** called (7:20).*

Release of self imposed rules

"You really can't have a close relationship with somebody if you're not going to tell them, the embarrassing bits "(3.29).

"I was opening myself up to not really knowing what the questions about, what was behind them" (8:26).

"I, I said okay, I'm I'm going to give up the thinking, and I'm just going to be irrational and just, really try to let go and I did and it was fantastic" (8:41).

4) MULTIPLE SUBJECTIVITIES: THE CHAMELEON SELF

Identification with client

"As clients we only tell the therapist what we want to, that we probably leak and tell them more than we think "(5:10).

"I notice that clients would say "I'm not sure where to start", and I find myself sometimes going in and wanting to say that" (8:32.

"What it really gives you is true empathy to have sat in their place, to, to take on what it is like to be them" (5:37).

"You don't only get some understanding about yourself but you get real understanding of that person, and I think that's what happens by the experience of having been a client" (5:40).

Security in being trainee counselling psychologist self

"We as counselling psychologists know the rules of therapy" (4:4).

The reluctant client

"If I had continued with her, where I just loved it all the time I wouldn't have gotten that feeling of having been the reluctant client, or the client who was worried about how someone else might think about them, or who didn't really know the rules" (8:22).

Frustration at blurred roles

"I wanted to talk about this thing that had happened with the client he he I think he just jumped in too early and he said something about well, you know, isn't that something for supervision and I got mad because I said you don't, you don't know yet because you don't know what it is, and I just wanted to, I wanted to talk about you know, me in this relationsh, in that relationship with the client" (10:21).

Dual self: client and trainee

"He joked a couple of times, like 'do you want to sit in my chair'...sometimes I was trying to do both"

5) SELF AS PART OF A THERAPEUTIC RELATIONSHIP- feelings regarding/relationship with therapist

Relationship altered by mandatory requirements

"It did make a difference for me between um, in terms of choosing to go and what kind of relationship to have" (2:22).

Wariness?

"It's a relationship that's real, but it's not a relationship in reality" (5:2).

Desire for equality

"He, he didn't have any problem saying where he's going , because he knows that I'm not going to suddenly start prying into his life" (7:12).

"we were two idiots in the room having a conversation" (7:45).

Embarrassment /shame

"One time I said something and I was wondering whe...and I was really surprised that he, his face showed no reaction whatsoever...I felt that was a little uncomfortable... (7:39).

Requiring security

"Therapist um authenticity and transparency is quite important to me... so that was quite important for me that, that um that's what I got back and then that's what I give" (4:43).

Bi-directional analysis- security gained by analysing therapist

"I had gotten a feeling of what he kind of, the things he liked to talk about, the things he didn't like to talk about" (11:5).

Defensive intellectualisation

" I said even if it's my transference you can't object to it because it is my experience, but even if you don't agree, it's still my, it's still what I experienced, even if I am wrong" (11:9).

Testing insecurities

"I just wanted to see what he would do, how would he handle it, yeah know, and err and my, and I was really satisfied with the way he did that".

Trust gained by therapists being impermeable

"I just like the way he handled it, I generally have to say that, I think he was like, um, and obviously this is true also for my, what they had in common is that they're a little bit like rubber, so it's not that they don't move at all, but they kind of bounce it, not bounces back on a hard way on you... you make an impact but they flex back, they're not changed in that way".

Trust gained/learning

"It was good to see how it was responded to" (3:29).

Seeking a mentor- admiration?

"If I had to pick the one if, the person to emulate in therapy, she would definitely be it, and it was quite a mentoring relationship" (6:44).

"I think the thing that I most got from him was how he reacted to criticism was he always took it on.

Appendix L

Example from spreadsheet of the trainees' superordinate themes

	Natalie	Robert	Sara	Claire
MAKING THE LEAP				
Inhibited trainee>secure client	X	X		
Nature of Communication	X			
Personal Goals	X	X	X	
Therapeutic Process (changes)	X	X	X	
Becoming Client Self	X		X	
Security as a result of therapist Competence	X	X	X	X
Release of rules	X	X	X	
MULTIPLE SUBJECTIVITIES	X			
Identification with client	X		X	X
Security in being trainee/CP self	X	X		
Reluctant client	X		X	X
Frustration at blurred roles	X			
Dual self: client and trainee	X	X	X	
SELF AS PART OF RELATIONSHIP				
Relationship altered by mandatory Requirements	X	X	X	X
Wariness	X	X	X	X
Desire for equality	X	X		
Embarrassment/shame	X	X	X	
Requiring Security	X	X	X	X
Bi-directional analysis	X			
Defensive intellectualism	X			X
Testing	X	X	X	X
Trust gained by therapist being impermeable	X	X		
Learning	X	X	X	X
Seeking mentor	X	X		X
Increased empathy with clients	X	X	X	X
Strong association with client	X		X	X

SECTION C

Beyond the mask: A CBT case study exploring the difficulties of accessing emotions in substance misuse

Introduction and the start of therapy

Rationale for client choice

I chose to present Kate[2] with whom I had 12 sessions over a six month period to address her substance misuse. In that time she disengaged twice without notice, before finally abruptly disengaging after our twelfth session. She has not been in contact since. I frequently felt that Kate was using Cognitive Behavioural Therapy (CBT) tools to avoid discussing feelings, by engaging thoroughly in homework such as thought records, whilst evading any discussion involving her inner emotions. This caused me to reflect on how genuine Kate was being, both with herself and me, and how authentic our work was. I feel that this case study shows the difficulty that can be faced in working with clients with substance misuse problems as these clients commonly avoid emotions (Padesky & Greenberger, 1995). Kate's pattern of disengaging when her emotions were close to being accessed made the therapeutic process challenging. This case demonstrates the significance of continual attention to reformulation when therapeutic goals are not being reached.

Martens, Neighbors and Lee (2008) stated that "considering the prevalence, personal costs, and societal impact of substance abuse disorders, it is important that counselling psychologists work to help combat problems in this domain" (p.533). Consequently, by choosing to present this particular client I hope to illustrate the many learning opportunities that this case offered me and portray the significance of implementing theory correctly into therapeutic practice.

The context of the work and the referral

Counselling took place in an in-house psychology service in London which offers NHS treatment services for people with substance misuse problems. Kate was referred by her key worker for help in preparing her for in-patient detoxification at a hospital (see Appendix A for details on detoxification), and for relapse prevention after detoxification. She had experienced CBT a year earlier with another therapist before suddenly disengaging. Kate told her key worker that she had found CBT useful and wanted to engage again. The key worker referred Kate a week prior to her attending detoxification; consequently we only had the opportunity to

[2] All names and some specific biographical / personal identifying information have been changed for the purpose of maintaining confidentiality.

have one assessment session prior to this event. Supervision took place fortnightly by an internal supervisor.

Biographical information

Kate was a 37-year-old white female. She was attractive, well-presented and had been in prescribing services since 2006. Kate did not seem to want to elaborate on her childhood but described it as *"normal"* and told me that she had a good relationship with her parents and older brother. Kate lived with her partner (who also had a substance misuse problem) of eight years. She had a 12-year old son from her ex-husband and reported a good relationship with both her son and ex-husband. Her son lived with her ex-husband and she saw him at weekends. Kate's key worker told me they deemed her responsible enough to do so. She stated that they had divorced because they grew apart after meeting when they were young. Kate reported that she worked part-time in an administrative job.

Initial assessment, presenting problem and formulation

Kate was friendly, had a sophisticated use of language and appeared to have a clear understanding of CBT. She did not appear under the influence of drugs during the sessions i.e. her speech was at a normal pace and she did not display any disturbances of orientation. Kate and I collaboratively conceptualised the rationale underpinning her current drug use (Padesky & Greenberger, 1995).We assumed that some triggers for use were time (e.g., evenings), physical sensations (e.g., feeling tired), emotional sensations (e.g., feeling anxious) and situational factors (e.g., being with her partner who was using). Kate confirmed that in those situations she would experience thoughts such as *"Why not?", "I'll abstain tomorrow".* I conceptualised that these thoughts operated as permissive cues to her engaging in drug use (Beck, Wright, Newman & Liese, 1993).

Kate agreed with this conceptualisation and explained whilst not using she would think negatively of herself. I hypothesised that we might focus on removing or changing some triggers (e.g., situational). We would need to engage in a process of cognitive restructuring with regards to her permissive thoughts and simultaneously introduce techniques to manage aversive emotional experiences.

Kate said that her drug use started when she was younger and in *"the club scene"*, but it moved from recreational drug use into an addiction. I hypothesised that there were more extensive

precipitating and predisposing factors (Curwen, Palmer, & Ruddell, 2000) behind her addiction, as she stated she started using LSD[3] at the age of 14; I wondered how Kate had accessed a class A drug and why she had sought it at that age. She maintained that she had experienced a happy childhood and could not identify any triggers for use related to her upbringing. Kate reported the only people who knew she used drugs were her partner and her ex sister-in-law. I speculated that she was highly accomplished at being secretive and I wondered if this would affect our relationship.

Kate told me that in her adolescence and twenties she used cannabis, ecstasy and cocaine and had been using heroin (see Appendix B) for eight years and crack cocaine (see Appendix C) for under a year. She recounted her use of these drugs had increased, due to their highly addictive nature, resulting in her using heroin and crack most days of the week. Kate said that the time of day she used crack varied but that she mostly used heroin in the evenings *"to relax"*. She was on a prescription of methadone and was using about £20[4] of crack and heroin a day. Kate informed me that since she had started using heroin she did not use any other drugs apart from crack and that her alcohol consumption was moderate. She stated she was seeking help now as she felt that drugs were beginning to impact on many aspects of her life, i.e. concentrating at work/socialising.

Kate recounted three periods of abstinence. The first was 15 years ago when she stopped using drugs for a year, realising that she was becoming too reliant on them and that it was an increasingly expensive habit. She recounted relapsing when she met her ex-husband who used cocaine socially. Kate affirmed her ex-husband did not use any drugs now, and had never had a substance misuse problem. The second occasion was 13 years ago, when she trained in martial arts over a 12 month period; the third time was during pregnancy. She said after her son was born she started using cocaine again. Kate recounted her heroin and crack cocaine use only begun after her divorce when she met her current partner; she said that she had been "*curious*" about these drugs.

I asked her what tactics she had employed in order to abstain for the aforementioned periods as CBT emphasises building on the clients coping mechanisms (Padesky, 2007). She said that the

[3] LSD or Lysergic Acid Diethylamide is a hallucinogenic drug, frequently called "acid". The experience is recognised as a 'trip' and these trips can be positive or negative. A trip can take from 20 minutes to an hour to begin and normally lasts about 12 hours. Once it's started it cannot be stopped (www.talktofrank.com)
[4] This is considered moderate use in drug services.

first time she stopped using drugs she began drinking alcohol and that the second time exercise had made her focused and given her an *"alternative high"*. This was useful in building into my plan awareness about potential unhelpful behaviours emerging when Kate was abstinent from drugs i.e. drinking, and what would be useful in replacing these behaviours i.e. exercise.

Given that Kate had disengaged from therapy before, I asked some questions based on Miller and Rollnick's (2002) informative Motivational Interviewing (MI) techniques, in order to assess her level of motivation to engage in therapy. Westra and Dozois (2006) proposed that "brief pretreatments, such as MI, may enhance engagement with and outcome from CBT" (p.1). I asked Kate to measure both how important it was for her to change her drug use and how confident she felt that she could achieve this on scales of 1-10 (Miller & Rollnick, 2002). This questioning incorporated a process of assessment along with allowing Kate to consider her readiness for change; Kate reported being motivated for detoxification. Realising that Kate was about to embark on a week-long detoxification I invited her to engage in a decisional balance intervention with the intention of enhancing her motivation for change in view of the challenge ahead. This MI technique is recommended for the early stages of therapy (Miller & Rollnick, 2002). I conceptualised that having engaged in this structured intervention, Kate could take her written exercise with her and refer to this when feeling tempted to use whilst in detoxification services. She said that this was useful and could only identify benefits of giving up drugs i.e. good health.

Nevertheless, I wondered if she had considered all the potential ramifications of stopping using. Kate told me her partner was going to attempt a *"home-detox"* whilst she was undergoing in-patient detoxification but if her partner used drugs whilst she was *"clean"* she would leave the relationship. I speculated that it would be difficult to return home from detoxification with the possibility of drugs being in the house. In Cavacuiti's (2004) valuable discussion regarding couples in which both partners have problems with substance abuse, she outlined that substance abuse by a client's partner can significantly influence their treatment and recovery. Kate said she had *"only"* used crack for eight months and I wondered if the use of the word 'only' implied that she was not ready to abstain from it for good.

Initial Therapeutic Plan

We agreed to embark upon a 12 week CBT relapse prevention programme (open to review) and agreed that I would see her once whilst she was in detoxification. Kate reported booking to

enter detoxification the following week; I felt worried as we had only had one initial assessment session. Despite my stating my reservations, Kate was adamant about going. Our initial plan for treatment was to maintain her motivation for abstinence after detoxification, to explore potential triggers for re-lapse and to plan interventions to prevent this from occurring.

Rationale for choice of theoretical orientation: CBT

I initially chose to use CBT with Kate both because she requested it and this form of therapy is recommended by the National Institute of Clinical Excellence (NICE) guidelines (2007). These guidelines recommend that CBT should be considered for people who have achieved abstinence or who are stabilised on opioid maintenance treatment. Although research remains unclear as to which treatment is most effective for the treatment of substance abuse, consistent support has been found for the effectiveness of CBT, as compared to other interventions (Martens *et al.*, 2008).

Although Kate was still using drugs on top of her opioid maintenance treatment I felt that she met the four main criteria for CBT use outlined by Curwen *et al.* (2000): 1) the person's issues are able to be plainly recognised, 2) the client has reacted optimistically to the kind of therapeutic model being offered 3) the person has enough comprehension to work within the structure presented and 4) there are no significant contraindications.

I used Beck, Wright, Newman and Lieses' (1993) seminal cognitive model of substance abuse, which is based on Beck's (1976) cognitive model. CBT is based on the foundation that thoughts, emotions, behaviours and physiology are part of an integrated system; consequently a change to one aspect of the system will be linked with changes to the other components (Curwen *et al.*, 2000). Beck *et al.* (1993) stated that CBT aids clients to better manage the problems linked to emotional upset and to obtain a wider outlook on their dependence on drugs for release from distress and for enjoyment. Moreover, they ascertained that particular cognitive techniques can assist the client in decreasing their urges and creating a firmer foundation of internal controls. CBT for substance misuse attempts to weaken the underlying beliefs that link to the strength and regularity of the urges and to teach the client precise methods for handling their urges.

I also integrated some aspects of Marlatt and Gordon's (1985) influential Relapse Prevention (RP) model (see Appendix D). Their model integrates a theoretical model of relapse and a

series of cognitive and behavioural techniques, assisting clients to replace addictive behaviours with the development of more adaptive coping behaviours (Larimer, Palmer & Marlatt, 1999, Marlatt, Parks & Witkiewitz, 2002). Although the models are similar, Marlatt and Gordon (1985) arguably provide a more exhaustive account of technique and theory in working with RP.

The development of the therapy

Key content and main techniques used

After the assessment session I visited Kate once in hospital whilst she was undergoing detoxification; she appeared positive about being drug free and said that she was well supported by the resident psychiatrist. We discussed behavioural changes she could make when returning home utilising the CBT technique of 'activity scheduling'. Beck *et al.* (1993) highlighted that clients who use drugs normally engage in activities and behaviours that sustain their drug use and tend not to uptake activities that encourage "prosocial life goals" (p.147). We discussed introducing small levels of exercise into her daily routine and removing triggers for drug use (such as drug paraphernalia). We planned more activities in the evenings, although I wondered how effective these would be if her partner was still using drugs on her return. Additional homework was to fill in a craving diary by documenting when cravings were occurring, and what automatic thoughts were associated with this. The purpose of this homework was to assist Kate to self-monitor and eventually develop techniques to assess and manage these thoughts (Beck *et al.*, 1993).

Upon completing detoxification Kate reported finding the behavioural strategies useful but completing the thought records hard work, as it made her realise some distressing thoughts about her son. Kate affirmed the main thought that was bothering her was that she had been a *"neglectful"* mother as she had previously not given her son her full attention when spending time with him (although she maintained that he had always been well cared for). Shame is an issue that both contributes to the growth and maintenance of addiction problems and is a consequence of addiction problems (Wiechelt, 2007). Beck (1995) reported that although automatic thoughts commonly involve 'cognitive distortions' others may actually be valid. Keeping this in mind, I did not challenge Kate on her thought that she had been emotionally neglectful because perhaps whilst using drugs she had been. As an alternative I used Beck's (1995) helpful recommendation of discussing the *usefulness* of thinking she was a bad mother.

We discussed ways of responding to these thoughts including reminding herself of all the positive steps she was making to improve this relationship. Kate said that she found this intervention useful, however after this session she disengaged without notice.

Despite being disappointed with Kate's non-attendance, I attempted to incorporate this information in my formulation. I considered how Kate had been using substances since she was 14 and that this was a rare occasion where she faced difficult emotions without drugs; this could potentially make her feel very uncomfortable. I noticed that I had failed to emphasise this information in my initial case formulation. As an alternative I could have discussed with Kate the possibility of emotionally charged situations being a risk for relapse earlier in our work and discuss coping strategies, rather than merely focusing on cognitive triggers. Interestingly, Beck *et al.* (1993) stated that a key approach to RP is "the development of control beliefs that reduce vulnerability to lapses and relapses" such as "I can cope with unpleasant emotions without using drugs" (p.299).

Rogers (1951) differentiated between an individual's 'actual-self' and their 'true-self' (see Section A: Preface). He expressively described the disparity between the real self and the ideal self as being incongruous, and suggested that a fully congruent person can lead an authentic and genuine life. My supervisor and I talked about the possibility that Kate's authentic discussion about feeling that she had been a *"neglectful"* mother may have been too difficult for Kate to face. Nevertheless, my supervisor pointed out that it was probably due to the strength of the therapeutic relationship that Kate was able to articulate these feelings at all, revealing her 'true-self', without fear of judgement from me. We discussed whether Kate's abstinence would highlight an underlying depression; patients with substance misuse disorders are two to three times more likely than the general public to be diagnosed with dysthymia or major depression (Bannan, 2005).

Kate re-engaged a month later. She was prescribed subutex (see Appendix E) instead of methadone and was using crack frequently but not heroin. Consistent with the useful recommendations made by Beck *et al.* (1993) we discussed the events that had led up to her lapse. I used guided discovery (Padesky & Greenberger, 1995) to explore Kate's sense making of the fact we had been exploring difficult emotions prior to her disengagement. Kate did not notice a link and explained that her partner had begun using again and she had succumbed to temptation. I considered inviting Kate to reflect on whether her lapse was related to the quality

of her relationships (e.g. her partner and son) as I suspected that these relationships triggered difficult thoughts and emotions that Kate was managing via her use. Nonetheless, I was worried that I would push her away from therapy by pursuing topics she often avoided. As an alternative I focused on exploring Kate's automatic thoughts as written in her weekly craving diaries (Beck *et al.*, 1993). I hoped that over the course of therapy Kate would feel more comfortable in discussing these issues.

As our work progressed, and through processing the craving diaries, a pattern emerged suggesting that Kate commonly used under periods of stress. Conceivably this was because she believed that she could *"cope better with using"* which is a common belief in this context (Beck *et al.*, 1993). She also often used *"as a reward"*, which Beck *et al.* (1993) described as a 'permissive belief' (see Appendix F). During our tenth session Kate stated:

> *"I need to get over this whole thing of feeling that in a crisis I have you know, I have to turn to, there's two things, there's in a crisis and there's as a reward there's those two things that I seem to sort of lean on a bit"*.

At the start of therapy Kate had not revealed that she used heroin to cope; she normally tended to say that she could cope with everything that was occurring. I remember thinking in the session that by Kate revealing that one reason for her drug use was in order to cope, that we had taken a step forward towards our therapeutic goals. I hoped that Kate was beginning to be more honest, with both herself and me, in regards to the reasons for her drug use.

Stress is a well-known risk factor in the development of addiction and in addiction relapse vulnerability (Sinha, 2008). Therapists should help clients to foresee and react flexibly to stressful situations so that they could learn to be better at dealing with the everyday triggers that tempt them to misuse substances (Beck *et al.*, 1993). In retrospect, I wonder whether Kate ever used our sessions as a permission to use. Possibly in the realm of 'permissive beliefs' Kate considered our sessions as hard work and as a consequence she was entitled to a reward. It would have been beneficial if I had explored this question with Kate as this would also have delved into the therapeutic relationship

Despite Kate filling out a plethora of craving diaries, I felt that we were not discussing any emotional triggers; any attempts I made to approach this topic were being blocked by Kate referring back to situational triggers written in her homework. I realised in this instance

cognitive restructuring was not facilitating progress, as Kate's crack use remained unchanged. I conceptualised this as a therapeutic impasse. In an effort to change this dynamic I used an 'advantage-disadvantage analysis' (Beck *et al.,* 1993) and asked her to consider her crack use in those terms. This was a key point in our work as Kate stated that a central advantage was dealing with uncomfortable thoughts. She said that she had been:

> *"Avoiding something for such a long, long long long time, I always thought I need to get to the bottom, of, of what I am running away from".*

Using Burn's (1999) 'downward arrow', I asked what would be the worst thing about confronting these feelings and she replied it would be *"frightening"* having to address issues she had been avoiding, such as dissatisfaction with her current relationship. We discussed what it would mean to be 'overwhelmed by emotion' and how she had coped with emotions at other points in her life i.e. when she had not used drugs for a year. Kate stated that writing a diary had helped, as had the discipline of martial arts.

Kate did not attend the following session but contacted me to re-arrange an appointment a month later. When we met I spoke to her about the process of our sessions and how I felt that sessions were often being used to avoid discussing emotions. She concurred and stated:

> *"That's that's what I always thought therapy would be...finding out what it is that I am trying to avoid, or what is that I've been trying to mask".*

I found Kate's use of the word mask interesting. In the form of a verb it could be taken to mean "disguise or conceal" and in the form of a noun as "a covering for all or part of the face, worn to conceal one's identity" (Random House Dictionary, 2010). Nevertheless, both imply a presentation of an inauthentic self. Goffman (1959) proposed that "When the individual presents themselves before others they may wish them to think highly of them, or to think he thinks highly of them" (p.15). It seemed that for Kate, she had been putting on a mask in both senses of the words, concealing her true emotions from herself and putting on a 'mask' in her interactions with others, including at times with me.

Gelso *et al.* (2005) suggested that as the therapeutic work develops, so should the amount of genuineness (see Section A: Preface, for definition of 'genuine'). In the following sessions Kate spoke more about her emotions, stating therapy was making her re-evaluate her beliefs about her childhood being *"idyllic"*. Kate recounted that at the age of 13 she was rebellious -

"getting into trouble" and *"craved attention"*. She reported having been in a *"heavy destructive relationship"* from the age of 13 to 16 and experiencing an abortion and several miscarriages at a young age. Kate said that this resulted in her believing for ten years that she would be unable to get pregnant. I thought this was key content in realising the pre-disposing factors (Curwen *et al.*, 2000) for her drug use, and Kate revealing her authentic self.

Due to Kate's previous disengagements I knew that she found it difficult to cope with accessing difficult emotions. Consequently, I considered ways of teaching Kate how to manage upsetting emotional experiences. I spoke to her about using mindfulness techniques, demonstrating these in the session. I felt that this could be beneficial as Kate was a Buddhist and had told me that she enjoyed meditation in the past. She stated she really liked this idea and reacted well to it in the session. Harris (2008) named this approach "expansion" (p.39) - making space for difficult feelings and sensations and, as an alternative to suppressing them, allowing room for these feelings. The aim is that in time emotions are no longer conceptualised as a barrier to living but rather as a natural experience. These practices have been closely linked with Buddhist traditions and are increasingly being integrated into CBT (Allen & Knight, 2005). Interestingly, Kate disengaged in the following session, making this our final encounter. I wondered whether Kate found the exercises difficult to manage as they involve paying attention to emotional experiences. In retrospect I notice that an alternative intervention could have been explicitly discussing Kate's tendency to discontinue when emotions arose and we could have discussed how she could notice and better manage this pattern in the future.

The therapeutic process and difficulties in the work

Kate was sporadic in her attendance; she was often late and rarely called to cancel when unable to attend. This may have been part of a pattern of seemingly seeking control. Perhaps because of my motivation to have a strong therapeutic alliance I was not firm enough with my timing boundaries. Alternatively, I could have approached the issue directly as this could potentially convey the importance of investing in therapy. Although I initially thought Kate's intelligence would make working with her an easier process, I actually found it a hindrance as I thought Kate tried to control the therapy sessions by bringing in copious amounts of homework and using it as a distraction whenever we came close to talking about feelings.

Conceivably, it made Kate uneasy that she could not 'control' therapy as with other aspects of her life. Indeed her need for control/the answers was illustrated when she asked me:

"What can you see that I can't see?".

I occasionally felt that Kate would try to pre-empt questions to potentially avoid uncomfortable feelings. Perhaps it made her uneasy not knowing in which direction the therapy was going. I responded by saying:

> *"No I don't think it's about, you know, my seeing something, that you can't see, I think it's about us both trying to see together, what's going on...because you definitely always seem to have the motivation to do it but there's something else going on... I wonder, how much do you believe you can do it?".*

The purpose of my response was to reiterate that CBT is collaborative (Beck, 1976). By highlighting that we were working together; I wanted Kate to feel understood, because a supportive therapeutic relationship will improve clients with drug and alcohol dependence commitment to therapy (Joe, Simpson & Broome, 1999).

Nonetheless, Kate was adept at changing the nature of the conversation, for example her response to my question about how much she believed she could reduce her drug use was:

> *"You see, deep down I know I can do it, because I know as human beings we are capable of anything we want to do... umm, something has just sprung in my mind then, I think probably work was my trig, the stress of work was my trigger for everything crumbling around me because it just was, it didn't work out how I'd you know, I couldn't cope with it at all".*

On reflection I think that Kate was avoiding the question and blocking my attempt to explore it, possibly to refrain from talking about her emotions. She seemed to avoid talking about whether she **personally** believed that she could do it and then potentially diverted me by talking about work. I am unsure if she was aware that she was doing this - it could have been a habit she had become used to in her everyday interactions with people, not just me. I understood this as a barrier between us, as if she was not 'letting me in'. I felt that it had been hard to get close to Kate and I wondered if this was due to our relationship or if this was the way she reacted to anyone when they became close to finding out her inner feelings. She was very accomplished at keeping people at arm's length which could be confirmed by the fact that barely anyone knew of her long-standing substance misuse problem.

I found the constant engagement and disengagement exhausting. Kate often displayed what I perceived to be nervous laughter upon her return as if she ashamed that she had disengaged. She stated:

> *"I talk a great talk, I write loads about it but I don't, and sometimes I act on it but I don't seem to get to the acting on it stage quickly enough... I'm quite mortified about it, I've been thinking about it a lot (laughs), I've been contemplating it a lot (laughing tone)...I've always been known by family and friends as someone who starts a lot of things with good intentions and doesn't finish an awful lot."*

In hindsight I wonder if Kate was *"mortified"* in front of me because I frequently found that she seemed to want to impress me with her psychological knowledge and homework. Kate's laughing tone of voice was incongruous with her words, potentially signifying embarrassment. Often Kate had impressed me and I felt a bit embarrassed when reflecting that perhaps I had ignored Kate's avoidance in my happiness about having the 'perfect' CBT client. In retrospect I am more aware of her pattern of disengaging upon discussing difficult emotions; conceivably therapy seemed to fit the pattern of being another one of Kate's unfinished projects. Possibly, due to her constant disengagement I started approaching emotional themes hesitantly, fearful that she might disengage. Kahn (1997) argued that it is not just the client's obligation to be genuine within the therapeutic relationship; the onus is also on therapist to examine their own thoughts and feelings. In the future I hope to address my own therapeutic avoidance earlier, perhaps through being more direct in my approach I can demonstrate that discussing emotions is natural and not threatening. Despite this, I do not think my slight apprehension diminished my ability to work with Kate and I feel she that noticed and talked about some of her feelings.

Conclusions

Kate's final disengagement: the unplanned therapeutic ending

Arguably, it was our proximity to uncovering difficult feelings in previous sessions and her possible unwillingness to give up crack that made Kate disengage. I was disappointed that she did not return after our last session as she had seemed eager to return. In supervision I spoke of feeling despondent about Kate's disengagement and of my worry of not accessing her 'true' emotions. Oyefeso, Clancy, and Farmer (2008) articulated that psychological morbidity and burnout is elevated amongst substance misuse professionals and that addictive behaviour

problems are particularly difficult for therapists. On reflection, I think a part of me was also worried that she had disengaged because of the potential that I had missed something in our previous work together on relapse prevention. Nevertheless, it is often difficult to engage and keep clients who misuse substances in therapy, and drop-out rates are high in therapy with this client group (Meier, Barrowclough & Donmall, 2005, Beck *et al.*, 1993). My future practice would benefit from a gradual emotional exposure early on in therapy; this can be achieved by more in-session exercises but most importantly by exploring how clients would manage difficult emotions in their daily life if they emerged.

Evaluation of the work

In my initial formulation I thought that Kate was at the 'action' stage of change (Prochaska, Norcross, & DiClemente, 1994) but as therapy progressed I realised that there was more ambivalence than I had initially realised. It is vital to calculate the stage of a patient's willingness for change and to alter the therapeutic interventions appropriately as the majority of people do not advance linearly through the phases of change (Prochaska & DiClemente, 1986). Beck *et al.* (1993) highlighted the significance of continual reflection and attention to reformulation when working with a client over a period of time.

After Kate's final disengagement, I re-visited my conceptualisation which is vital when trying to "overcome 'stuck' points when standard interventions fail" (Beck 1995, p.137). Perhaps Kate felt an internal pressure to attend therapy and appear as if she was attempting to reduce her drug use, as at her weekly meetings with her key worker (to receive her methadone/subutex prescription) she was asked if she continued to attend therapy. Indeed, every time she disengaged with me she also disengaged with the service as a whole.

This work has taught me to address avoidance earlier, and to frequently assess what stage of change my client is at in my future work with substance misuse. In reviewing our therapeutic work, I think that, despite Kate saying otherwise, she was not ready to give up crack as she frequently said she had not used crack for long. For some people drug-taking supplies fleeting respite from boredom (Beck *et al.*, 1993) and my supervisor suggested that Kate appeared to like having drama in her life; perhaps fearing that without drugs she would just be an 'ordinary' person. Interestingly in one of our sessions Kate brought in a drawing entitled *'insignificant'*, noting *"we're so miniscule in the scheme of things"*.

Our goals had been to address relapse prevention. Although Kate had relapsed throughout our work she had nevertheless succeeded in reducing her drug use. Moreover, she had returned to work after being signed off early on in therapy (her G.P. said that she had work-related stress). Debatably, Kate also gained insight into her addiction. Prochaska *et al.* (1994) stressed that relapsers rarely give up on their decision to change and I hoped that the therapeutic work would aid Kate in the future, if she chose to re-engage with psychology.

"Numerous potential factors interact to create an almost adversarial relationship between the therapist and the drug-abusing patient at the beginning of therapy and during the course of the treatment...patients are often not very open and honest, at least at the start of therapy" (Beck *et al*, 1993, p.54). Although at times I had found establishing a therapeutic relationship difficult with Kate, I had felt the process between us was changing, particularly in the last few sessions where she was less avoidant in our work. In group supervision we reflected that it was almost as if she had a hand up pushing me away and this hand was being lowered slightly. Perhaps the fact she disengaged again meant she had raised her hand once more and was not ready to drop it presently. Park (1950) proposed that "it is probably no mere historical accident that the word person, in its first meaning, is a mask. It is rather recognition of the fact that everyone is always and everywhere, more or less consciously, playing a role...It is in these roles that we know each other; it is in these roles that we know ourselves" (p.249). Perhaps Kate was not ready to drop her mask yet.

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Appendices

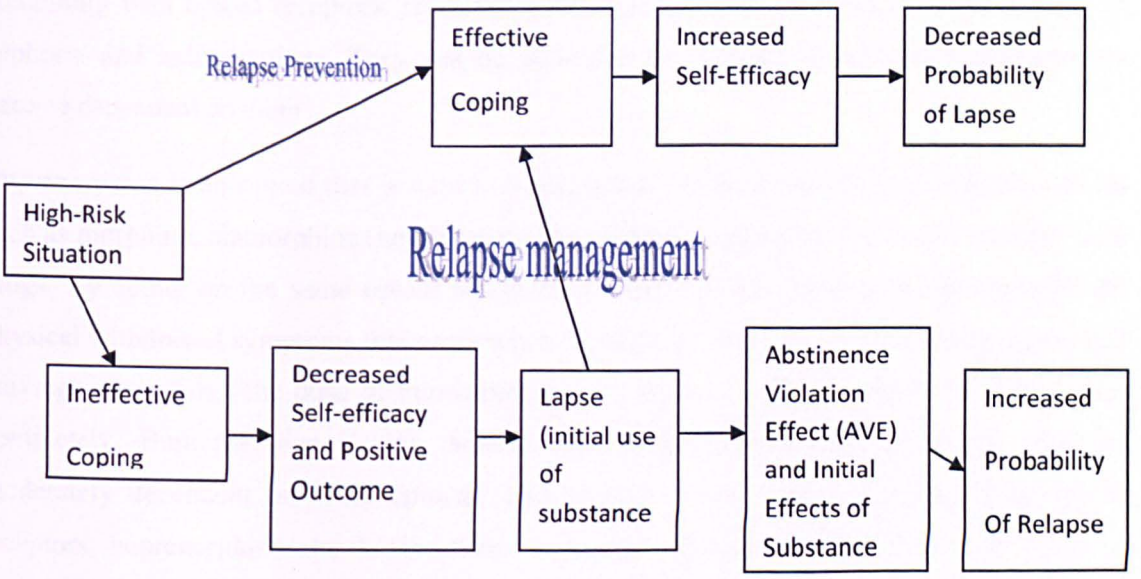
Appendix A

Appendix B

Appendix C

Appendix D

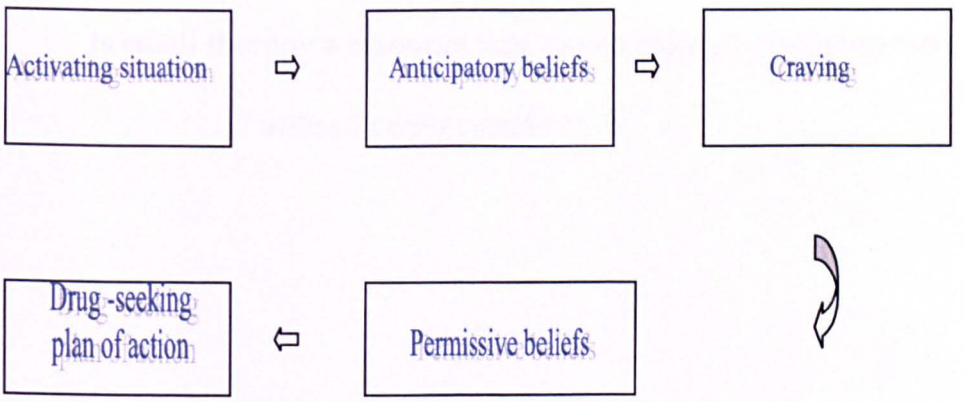
Marlatt and Gordon's (1985) Relapse Prevention (RP) model- taken from Marlatt, Parks and Witkiewitz, (2002).



Appendix E

Appendix F

Sequence of anticipatory and permissive beliefs (Becks *et al.*, 1993, p46)



SECTION D

Is email therapy a resource that counselling psychologists can utilise in their practice?

Introduction

This review evaluates the literature on e-mail therapy and considers whether electronic communication is an appropriate medium for counselling psychologists to use in their practice, either as an adjunct to therapy or as a replacement for face to face (FtF) therapy. Chester and Glass (2006) found that although there have been developments in the type of online communication available, e-mail is still the most popular choice for online counselling services. Nevertheless, there are no absolute definitions of online therapy (Caspar, 2004). In this review the term 'e-therapy' will be used to exclusively describe the therapy that occurs between a therapist and client who are in separate places and are using e-mail to communicate with one another. It is asynchronous, which means correspondence takes place when the participants are free to reply to each other, as opposed to synchronous online therapy which is less common, occurs in real time and often uses free, chat-based interfaces (Rochlen, Zack & Speyer, 2004a). This study will both look at email therapy as the sole communication between therapist and client and email therapy as an adjunct to FtF therapy.

The review begins with an explanation of the development of online therapy and assesses its general advantages and disadvantages. This is followed by an attempt to identify the most suitable population for whom online therapy would be the most beneficial, and analyses its efficacy. The review progresses to explore whether it is conceivable to have an authentic 'virtual' therapy relationship, and if so, whether counselling psychologists can utilise e-therapy within their therapeutic practice. It then examines the legal and ethical implications of e-therapy. It ends by discussing the limitations of the existing literature and making proposals for further research in this area.

In the fast moving technological world in which we live, understanding e-therapy is necessary, especially as counselling psychologists aim to combine psychological theory and research with therapeutic practice (Strawbridge & Woolfe, 2003). Mallen, Vogel, Rochlen and Day (2005b) highlighted that at present most counselling psychologists do not offer online therapy and consequently may be neglecting chances to engage with new clients. They added that "Counselling psychologists are in a unique position not only to extend their services to online modes of treatment but also to conduct research in this area to determine whether online-counselling practices are therapeutically beneficial for clients" (p.820).

Development of online therapy

Rochlen *et al.*, 2004a proposed that "the integration of technology with the practice of psychotherapy has arguably been one of the most vigorously debated topics among mental health professionals within the last 15 years" (p.269). Arguably, those who work in the field of mental health are unprepared for the prospect that in the near future people are just as likely to look for professional therapy via the Internet as FtF (Alleman, 2002).

Non FtF therapy is not contemporary. Jones and Stokes (2009) pointed out that Freud communicated with clients in a non FtF medium, and furthermore in 1972 there was a display of a virtual therapy session between two computers in two universities in America. Debatably, the establishment of online therapy arose from the numerous discussion groups that developed on the Internet leading to therapists setting up their own websites to offer advice/behavioural services (Griffiths, 2001, Skinner & Latchford, 2006).

In the 1960s, Weizenbaum created an interactive program entitled Eliza which was intended to appear as if a real conversation was occurring i.e. specific phrases and words were input to aid ostensibly suitable replies. Although Weizenbaum did not intend for Eliza to replace 'real life' therapists, increasingly therapists are using the Internet to conduct therapy sessions. This number remains relatively small: 2 per cent of psychologists affiliated with the American Psychological Association (APA) report using online psychotherapy. Nonetheless, 15 per cent use email for psychological assessments (Whitty & Joinson, 2009).

Although online counselling is more prevalent in the USA and Australia than in the UK, it is a counselling method that is increasing worldwide (Jones & Stokes, 2009). Nevertheless, it is only relatively recently that online counselling training has been available in the UK, so there is no certainty as to how popular it will become (Jones & Stokes, 2009). Caspar's (2004) comprehensive research on the technological developments and applications in clinical psychology and psychotherapy, led to his argument that therapists cannot ignore these developments. It has even been debated whether there will still be a need for human therapists as online therapy continues to develop (Bloom, 1992; Lang, Melamed & Hart, 1970; Marks, 1999). In the most recent American handbook of counselling psychology, Gore Jr and Leuwerke (2008) expressively recommended that as "online counselling is likely to continue growing in popularity and application...it is critical that counselling psychologists become

knowledgeable about the potential benefits, risks, and challenges that will accompany this growth" (p.39).

Online therapy is given in a range of modes, e.g. electronic discussion boards (Tate & Zabinski, 2004); online self-help multimedia packages, real-time "chat" in chat rooms, and e-mail (Chester & Glass, 2006). Tate and Zabinki (2004) suggested that online therapy can be used as a replacement for FtF therapy, or as an addition to FtF therapy. Computerised CBT (CCBT) is included as an option in the stepped-care model presented in the NICE clinical guidelines for the management of depression in primary and secondary care and for the management of anxiety in adults in primary, secondary and community care (NICE, 2006).

Advantages and disadvantages of online therapy

Rochlen *et al.,* (2004a) overviewed the most frequently cited benefits and challenges of online therapy. One key advantage is that the Internet is accessible to a wide range of people, and can be especially useful for people who live in a remote location, do not speak the language of the country they reside in, are agoraphobic, physically disabled, elderly, and have speech or hearing problems. It is also beneficial for males who struggle with expressing their emotions, LGBT (lesbian, gay, bisexual and transgendered) clients who feel stigmatised, or people who come from sensitive populations such as prison inmates (Rochlen *et al.*, 2004a; Tate & Zabinski, 2004; Chester & Glass, 2006; Griffiths, 2001; Rochlen, Land & Wong, 2004b; Magaletta, Fagan & Peyrot, 2000). As online therapy is not dependent on time, it enables clients to correspond in an uninterrupted and considered way, as they can write and read over their messages before sending them (Tate & Zabinksi, 2004). It is also useful for clients who have an unusual work or domestic schedule (Mallen *et al.*, 2005b). Furthermore, online therapy allows both the client and therapist to keep a log of the sessions, allowing both to note any therapeutic changes (Whitty & Joinson, 2009).

In his valuable research into e-therapy, Griffiths (2001) suggested that the privacy of e-therapy can be advantageous as some people may not go to therapy because of the stigma they attach to it; e-therapy can reduce this feeling of shame. It can be relatively inexpensive (Cook & Doyle, 2002; Lange, Van de Ven, Schrieken, & Emmelkamp, 2001). Additionally online clients may feel less inhibited (Joinson, 1998). Interestingly, Rochlen *et al.* (2004a) reported that online therapists discovered that corresponding through text can generate a high degree of closeness from the first email exchange. For some clients the feeling of the therapists 'presence' may be

more powerful than when the therapist is physically present (Suler, 2000). Murphy and Mitchell (1998) suggested that the contemplative process of writing about one's problems or conflicts may be therapeutic for some clients. It may be that e-mail therapy is found to have the same benefits as narrative therapy, or diary keeping as recommended by CBT practitioners (Murphy & Mitchell, 1998).

Challenges for therapists working online include misreading or misinterpreting what is written (Rochlen *et al.*, 2004a) and missing non-verbal cues which can obstruct the development of the relationship (Alleman, 2002). DeGuzman and Ross (1999) reported that some clients suffer from the lack of comforting visual and auditory cues. Nonetheless, Sheeks and Birchmeier (2007) expressively argued that the absence of visual cues can actually be used as a resource for people who are occasionally stigmatised by a handicap or facial deformity etc. They proposed that another advantage of online therapy is the lack of 'gating features' which are unavoidably present in FtF therapy such as stuttering or social anxiety. As with any technology there may be problems with computers or the Internet connection which might impede the progress of therapy (Griffiths, 2001). Griffiths (2001) suggested that an additional challenge may be referring clients when they live in a different country or a distant town. There is also the question of whether the client could be certain that the therapist is completely qualified and allowed to practise.

Considerable difficulties could emerge if a client becomes suicidal/homicidal or the therapist is worried about some other aspect of the client's safety (Murphy & Mitchell, 1998). Nevertheless, there is no evidence suggesting online therapy cannot be done with clients in crisis; similar concerns were probably raised when telephone crisis hotlines were first established (Fenichel *et al.*, 2002). Although it may be preferable for clients in crisis to seek FtF help and have immediate access to emergency treatment, it is better that clients have a medium such as online therapy to communicate their distress rather than deciding not to access any help at all. With appropriate training and guidelines therapists can be trained to manage their own anxieties and follow set procedures to respond to clients in crisis (see Ethics). Indeed, Fenichel *et al.* (2002) highlighted that the Samaritans received and responded to over 37 thousand emails as part of their emotional support service in the year 2000. Although the Samaritans offer a different role to counselling psychologists this highlights a growing population of clients who are seeking help online.

Who is appropriate for e-therapy?

Stofle (2001) argued that online therapy is ideal for clients in outpatient settings and possibly intensive outpatient settings, specifically clients with agoraphobia, anxiety disorders or social phobias. The medium seems to be best suited to those who value written self-expression and have the creativeness it takes to hold up at their end of the written dialogue (Mitchell & Murphy, 1998). Arguably, online therapy is not suitable for people who have been hospitalised or with severe psychiatric disorders, or appropriate for people with suicidal ideation, thought disorders, borderline personality disorder or unmonitored medical issues (Stofle, 2001). Peterson and Beck (2007) eloquently suggested that "if the patient exhibits borderline pathology, utilising e-mail dialogue may be viewed as too clearly a window to the soul" (p.173). Perhaps a disadvantage of e-therapy for certain clients is that the therapist is unable to be as subtle using written communication as in a FtF dialogue and cannot as easily judge the impact of an intervention without visual cues. For some clients this potential lack of delicacy may be too difficult to manage.

Nonetheless, Magaletta *et al.* (2000) found that participants with thought disorders, who arguably could be assisted the most from therapy, had very positive opinions on online therapy. Caspar and Berger (2005) proposed that the supposition that online therapy cannot be used for more severe or enduring mental illness is flawed. They suggested that online counselling may be preparatory for FtF therapy. There is no clear consensus in the literature as to whom e-therapy should be aimed at and more research needs to be established as to whom it would most suit.

Is e-therapy effective?

Grohol (2000) stated that "Online relationships are just as real and intense as they are in the real world. So it's no surprise to me that people are trying to establish therapeutic-type relationships over the Net...Whether it's therapy or not I do not know" (p.40). Numerous researchers have tried to establish whether e-mail therapy is actually successful (Griffiths, 2005; Yager, 2003; Hsiung, 2002; Robinson & Sefarty, 2003; Leibert *et al.*, 2006). This section will review the literature on the various clinical populations that have utilised e-therapy and will examine how beneficial it has been to these clients.

Rochlen *et al.* (2004a) reported that varieties of different methodologies have been used to research the effectiveness of online therapy. Generally the studies have investigated whether online therapy interventions have resulted in clinical progress compared to control groups. Overall these studies have produced fairly reliable and promising results endorsing the efficacy of online therapy. Nevertheless, many of the studies had small sample sizes and lacked appropriate controls (Rochlen *et al.*, 2004a).

Butcher, Perry and Hahn (2004) addressed the issue of expanding the availability of psychological assessment applications on the Internet. They concluded that although these measures showed substantial potential, there remains a variety of problems linked with psychologists providing psychological tests on the Internet before it can become a key means for delivering a psychological science.

In their informative research into email as an adjunctive tool in psychotherapy, Peterson and Beck (2003) found that there are a broad variety of possibilities for incorporating email into psychotherapy. They proposed that an adjunctive model is suitable for most situations in which both therapist and client have some technological competence and feel at ease with electronic interaction. Furthermore they stated that e-therapy is a positive addition to therapy, as long as unambiguous boundaries are put in place. The researchers suggested that "it is imperative that the therapist convey to the patient that when fluid dialogue between therapist and patient is not achievable by email the therapist will call a face-to-face session" (p.178). Nonetheless, their research fails to suggest what a therapist would do if it were not possible to provide a FtF session promptly i.e. if the client or therapist were in another country. Nor do they clearly outline what constitutes 'fluid dialogue'. Disagreement about the meaning of the term might result in the breakdown of the therapeutic relationship if the client felt that she/he was honouring the boundaries of an e-therapy relationship but the therapist disagreed. The authors argued that the "possibilities and boundaries of the working alliance must be clearly established before introducing email" (Peterson & Beck, 2007, p.173). Whilst interesting, the study was based on a single therapist's experience of conducting e-therapy. Both expanding the number of therapist participants and including feedback from clients would have enhanced the results of their study.

Georgiades (2008) conducted a four-year therapeutic intervention consisting of both in-person and email communication with a 13-year-old who both observed and was the victim of serious

domestic violence. He found there may be value in integrating solution focused interventions and email therapy in clinical work with youth clients suffering from domestic violence. Nevertheless, the instruments used lacked validity and reliability (Georgiades, 2008). Furthermore there were a lack of controls in this study and as with Peterson and Beck's (2007) study, Georgiades analysed only one client and one relationship, indicating a lack of generalisability. Additionally, it is unclear whether the therapeutic relationship owed more to the FtF interactions at the start of therapy or to the e-therapy. Despite this, the study provides promising indications of potential uses for e-therapy with both teenagers and those who have experienced domestic violence.

An interesting contribution to the research was carried out by Yager (2003), who examined the prospects and limitations for e-mail therapy as an accompanying treatment to FtF treatment for anorexia nervosa. He stated that there were only positive consequences to the addition of e-mail therapy to the treatment. Yager (2003) argued that e-therapy allows patients to be able to articulate themselves without being interrupted and without feeling that they have to react to therapists' non-verbal signs. By using his own clients for the research, he may have been biased in his assessment of its effectiveness. Correspondingly, clients gave feedback on the e-therapy to Yager directly which may have resulted in them being hesitant to criticise the therapy they were given. There were only three examples of participants providing an appraisal of the role that e-therapy played in their overall treatment. It is uncertain whether Yager's (2003) findings may be generalised to other populations. He emphasised that this type of supplementary e-therapy may be especially suitable for women with anorexia nervosa. It is not possible to extrapolate the suitability of using e-therapy as a primary treatment from Yager's (2003) investigation into its use as an adjunct to therapy. Nevertheless, the study is useful in pointing out the possible potential for e-therapy in the treatment of anorexia nervosa.

Murdoch and Connor-Greene (2000) investigated two case samples in which e-mail was used as an addition to therapy in order to increase both patient involvement in treatment, and to improve therapeutic impact and the therapeutic alliance. From the reports of patients, they found that therapeutic impact and alliance were superior after the use of e-mail homework reporting. The clients reported that using this medium enhanced self-disclosure and kept them on track in-between sessions. They further commented that e-mail correspondence between client and therapist seemed to improve the therapeutic impact and working alliance, specifically constant cognitive challenges and encouragement. Nonetheless, it could be argued

that it would not be practical for many therapists to engage in e-mail correspondence with their clients every day, as well as see clients FtF, due to time constraints. Therapists should clarify at the outset of therapy that they may not always be able to answer the clients' emails. Although these case studies are useful in showing some of the implications of e-therapy it would be beneficial to expand this study to randomised controlled clinical studies, to include other client groups.

Robinson and Sefarty (2003) recruited 23 individuals with bulimia nervosa (via email) from a college of the University of London. They were offered online therapy by one of two clinicians who were knowledgeable in the treatment of eating disorders. After three months of e-therapy, the returned questionnaires indicated considerable reductions in outcome scores of depression and bulimic symptoms. Limitations to the study include the small sample size and lack of a control group.

In 2008 Robinson and Sefarty expanded their original study by conducting a pilot randomised controlled trial of email therapy for bulimia nervosa. 110 people in a university population replied to emailed eating disorder questionnaires. 97 were randomly assigned to therapist-administered email bulimia therapy (eBT), unsupported self directed writing (SDW) or waiting list control (WLC). No significant changes were found in Beck Depression Inventory (BDI) and Bulimia Investigatory Test (BITE) scores. Nevertheless, for eBT participants there was a significant positive correlation between words written and improvement in BITE severity scores. The researchers acknowledged that a follow up rate of 63 per cent means that results have to be looked at with care. Both studies imply that e-therapy could be beneficial as it may be more acceptable to clients who might not seek treatment otherwise (Robinson & Sefarty, 2003). Participants in Robinson and Sefarty's (2001) study stated that they wanted to have additional treatment after three months of e-therapy, chiefly FtF therapy. Consequently e-therapy might be a useful beginning to therapy, in engaging clients who would not choose to attend FtF therapy primarily but should not necessarily replace FtF therapy.

Unusually, marital therapy has been conducted using e-therapy. In their seminal research, Jedlicka and Jennings (2001) recruited 11 anonymous volunteer couples from a website on the Yahoo search engine. The longest duration of weekly continuous participation in therapy by both spouses was 14 weeks although the clients were accepted for five months. This study used an integrative theoretical approach to the counselling. The therapy with the 11 couples was

analysed using Mead's (1934) theory of symbolic interaction (Jedlicka & Jennings, 2001). The researchers found that the couples who acknowledged the importance of problem solving and thinking made significant gain from e-therapy. Remarkably, Jedlicka and Jennings (2001) discovered that for some couples e-therapy can achieve the same means as FtF therapy in a quicker time. Nonetheless, there are disadvantages to this study; notably that the most complex cases were removed in the screening process. Many of the clients had experienced therapy previously so it is difficult to assess the specific contribution of e-therapy to their progress. Despite this, the findings were encouraging in particular for clients who appeared to be actively participating in the problem-solving, cognitive outlook of the therapy (Rochlen *et al.*, 2004).

Leibert *et al.* (2006) collected sociodemographics of 81 self selected participants who had used or were using online counselling. They compared their self reports of therapeutic alliance and satisfaction with online counselling with past studies of clients using conventional FtF counselling. The authors do not concentrate solely on e-therapy, as participants included those who used other types of online therapy, but nonetheless found that e-mail and instant messaging were the most common mode of communication. Interestingly, they discovered that whilst the participants were satisfied with their treatment online, they reported lower levels of satisfaction than clients who had experienced FtF therapy. Nevertheless, they found that clients reported that the disadvantage of the absence of non verbal communication was countered by the advantage of anonymity when disclosing to their therapist intimate information (Leibert *et al.*, 2006). This study yields significant implications for therapy i.e. the anonymity of being online may reach a certain client group who would not come to therapy normally.

Sanchez-Page (2005) warned that "there is a lack of clear evidence about online services proving appropriate or effective... counselling psychologists should be hesitant to rely on the Internet as a primary counselling tool unless future studies conclude otherwise" (p.891). Conversely, this author argues that whilst research has been limited so far on the efficacy of e-therapy, and the studies are poorly designed, there has been promising indications of its usefulness, especially in the eating disorder client group.

The therapeutic relationship

In his thought-provoking argument, Griffiths (2005) stated that since it can be claimed that online therapies are just as 'real' as FtF therapeutic relationships it should almost be expected that clinicians would be moving towards establishing online therapeutic relationships. There is

strong clinical evidence to suggest that the relationship between therapist and client is one of the most important factors in forecasting the successful outcome of counselling (Wampold, 2001).

Caspar (2004) stated that "psychotherapy is traditionally seen as a matter of human encounter" (p.224). He questioned whether some clients miss having someone to talk to about their problems because of being too embarrassed to reveal them in FtF therapy. Arguably the comparative anonymity of Internet communications lessens the risk of disclosing information about oneself because one can share one's innermost thoughts with less fear of condemnation and punishment (McKenna *et al.*, 2002).

In their informative investigation into mens' perceptions of online versus FtF counselling, Rochlen *et al.* (2004b) found evidence indicating that men who experienced discomfort communicating their emotions preferred the option of online counselling rather than FtF counselling. Nevertheless, as the study used participants who were not accessing online therapy its findings are of limited application. Despite this, their research highlights the potential use of e-therapy for a range of populations. Furthermore it points to the need for further research into client expectations and preferences for different types of online therapy styles

Rogers (1951) distinguished between an individual's 'actual-self' and their 'true-self' (see Section A: Preface). Arguably, true-self characteristics can be displayed more easily online as there is less fear of being judged (Griffiths, 2001). McKenna (2007) suggested that "on the Internet, people are often able to interact with others under conditions of relative anonymity...these conditions facilitate the sharing of important inner or 'true' aspects of self that are often difficult to express in 'real life'" (p.205). She further proposed that the Internet can allow clients to work towards finding their true self, in keeping with Rogerian principles. This is due to the Internet enabling people to circumvent obstacles to self-expression that occur in other methods of communication e.g. FtF (McKenna, 2007).

In contrast Whitty and Joinson (2009) stated that due to the exceptional features of cyberspace, it has been suggested that it is challenging to instigate and cultivate 'real' relationships within this arena. They proposed that the way individuals choose to present themselves in cyberspace partly determines how successful their online relationships will be. The onus therefore, in regards to a strong therapeutic relationship within an e-therapy medium, would be on the client

to present an authentic self. Still, it can be argued that authenticity from all clients, FtF or online, is fundamental to establishing a 'real' therapeutic relationship (Gelso & Samstag, 2008).

In their useful addition to the research, McKenna *et al.* (2002) investigated whether individuals who are more adept at revealing their 'true' selves online than offline are more capable of developing close relationships online and further developing these relationships offline (Whitney & Joinson, 2009). At random they chose 20 Usenet news groups (Internet newsgroups devoted to a variety of topics). They requested that the participants answer questions about their online relationships and how they presented themselves. Their initial study revealed that not only can close Internet relationships develop when people convey their 'true' self online, but can also endure; many were still intact two years later (Whitty & Joinson, 2009). Although these relationships are not therapeutic relationships, the research suggests that therapeutic relationships can be formed, and maintained over the Internet.

In a valuable contribution to the literature, Reynolds, Stiles and Grohol (2006) compared the session impact (measured by the Session Evaluation Questionnaire, SEQ) and the client-therapist alliance (measured by the Agnew Relationship Measure, ARM) of the communication between clients and therapists who were engaged in e-mail therapy, with previously published results on FtF therapy. The researchers found that the dyads viewed the therapeutic alliance and sessions as positive (Reynolds *et al.*, 2006). Preliminary results suggested that the online clients rated the therapeutic alliance and session impact similarly to FtF clients. Alike results were found for online therapists although, interestingly, they assessed aspects of the sessions and therapeutic alliance (e.g. depth and positivity) more favourably than FtF therapists. The authors suggested this may be due to therapists' ability to modify their inventions i.e. editing unclear phrasing, which could potentially improve their confidence in their therapeutic work. This promising study would benefit from being replicated with a larger number of participants.

Studies conducted by Bargh, McKenna and Fitzisimons (2002) have shown that aspects of the true self become more mobilised and apparent online, as compared to FtF communication. Furthermore the studies showed that the participants can both articulate and successfully communicate these true-self traits in online as opposed to offline exchanges (Mckenna 2007, p.214). Nevertheless, the studies were three laboratory experiments and it is unclear how much external validity they would have.

McKenna, Buffardi and Seidman (2006) performed research that revealed (similar to the study by Bargh *et al.*, 2002), that true self characteristics are activated further in online interactions. They discovered that people are frequently oblivious to the fact that they are revealing more of their true self characteristics during online communications than FtF. Indeed they found that in their Internet exchanges, participants were articulating and conveying features of self that were less positive than those characteristics being expressed by those who communicated FtF (McKenna, 2007). In terms of e-therapy this may indicate that clients would feel more able to express the more shameful or embarrassing aspects of self in their therapeutic relationship. Conceivably, this would lead to a more authentic relationship and more effective therapeutic interventions.

Nonetheless, Rogers, Griffin & Fitzpatrick (2009) found contradictory results. They compared differences in emotional self-disclosure between young adult Internet users who favour FtF as opposed to Internet Therapy (IT). They found that 263 participants preferred the idea of FtF therapy, in comparison to 65 respondents preferring the option of IT. There were significant differences between the FtF and IT groups, with the FtF group more frequently inclined to reveal emotions such as jealously and fear to a therapist than the IT group. Nevertheless, the participants in this study had not necessarily been to either FtF therapy or used IT therapy; the study merely asked them what their preferences would be. Although the Emotional Self-Disclosure Scale (ESDS) was used to measure the participants' willingness to emotionally self-disclose to a range of people (i.e. parents, therapists, spouses) this was hypothetical. Additionally whilst 60 per cent of the respondents had experienced FtF therapy in the past, only 0.6 per cent had experienced IT. The results may have been different if there were an equal number of participants who had experienced IT therapy. The study also lacks generalisibility as all the participants were recruited from the same social networking site and also may not have fully comprehended what IT consisted of, having not experienced it themselves (Rogers *et al.*, 2009).

Cook and Doyle (2002) investigated whether a working alliance can be cultivated when participants are geographically separated. They defined the working alliance construct as "collaboration between therapeutic participants to facilitate healing" (p. 96). The researchers compared disparities in the ratings of the working alliance from 15 online therapy participants and a similar FtF counselling sample. All the participants had individual counselling for at least three sessions, either communicating with therapists via asynchronous e-mail or online chat.

The participants were given a Working Alliance Inventory (WAI); a 36-item self report questionnaire with 12 questions in each subscale that participants answered on a seven point Likert scale from never to always. All WAI subscales and the composite score were higher in the online sample than the representative sample of traditional FtF therapy clients (Cook & Doyle, 2002). The only subscale that was significantly higher than the FtF comparison group was the therapeutic goals subgroup, perhaps because a written record of goals is less vague than a verbal agreement in FtF therapy. This underscores the value of a written list of goals and its importance in shaping therapy. Consequently, it is important both in FtF and e-therapy to have an agreed contract/clear objectives between therapist and client. This research conflicted with the findings of Leibert *et al.* (2006), possibly because both studies failed to randomise their client sample and additionally relied on a different participant self-selection process. It should also be noted that Cook and Doyle (2002) used a much smaller sample than Leibert *et al.* (2006).

Although Cook and Doyle's (2002) findings are promising in regards to establishing that a comparable therapeutic relationship can be made online compared to traditional therapy, there were several problems with the study. Participants were primarily white and well-educated; subsequently these results may not be representative of the general population. Measurements are more reliable when the samples of individuals vary substantially from each other than if they only differ by a small amount (Shaugnessy, Zechmeister, & Zechmeister, 2003). 13.3 per cent of the participants spent more than 20 hours online per week and one could question whether e-mail therapy is appropriate for individuals who already spend long periods of their day on-line. Nonetheless, studies of this nature will potentially give the discipline of counselling psychology more precise answers on the process and result of counselling online (Mallen *et al*, 2005b).

The WAI has also been used to evaluate the working alliance in asynchronous therapy in a study by Prado & Mayer (2004). The 373 client participants were mainly females, graduates, and were experienced users of computers and the Internet. The 20 psychologists who took part in the study had at least four years of clinical experience and demographic features similar to the client participants. Therapy was carried out by asynchronous e-mail in a discussion forum. Prado and Meyer (2004) discovered that by the fifth week of therapy the working alliance had been established and remained stable. Significantly, they reported that the working alliance was comparable to studies investigating working alliance in FtF therapy. There was no

difference in the working alliance in regards to the type of therapy used; perhaps implying that e-therapy can foster a working alliance despite the mode of therapy. The authors suggested that their research showed the likelihood of being able to form a solid relationship between client and therapist over the Internet. The participants in the study tended to use the Internet daily, with a minimum of five hours spent online per week. Older people, who are not proficient in Internet use, might find it more difficult to establish a working alliance. Indeed an independent survey conducted for British Telecom (Future Foundation, 2004) on the digital divide in 2025 revealed that "80 per cent of 55-64 year olds are not confident in using all the functions on a PC. 75 per cent of 55-64 year olds are not confident in using all aspects of the internet" (p.14).

Ainsworth (2002), co-founder of the International Society of Mental Health Online, described her experiences as an e-patient. She stated that although she and her therapist were physically removed by five US states, she felt more connected to him than if they were in the same room. Remarkably, in regards to the relationship with her therapist, she reported that it "grew into one of the most profound I have ever known" (p.198). Ainsworth recounted that when she met him in person there were things she could not say, which she would have been able to say in e-mail. She asserted that although she now has another therapist whom she sees FtF, when she has something especially difficult to discuss she returns to e-therapy. Although one has to keep in mind that this is an idiosyncratic account of an experience with e-therapy it highlights the argument that e-therapy may be beneficial as a forum to express one's true self and difficulties.

There is a lack of literature exploring how 'real' therapeutic online relationships are during e-therapy but many papers have revealed that 'real' romantic relationships and 'real' friendships begin online and can indeed progress to become successful offline relationships (Whitty & Joinson, 2009). This suggests the potential for authentic e-therapy online relationships. From the literature it can be inferred that it is possible to develop a genuine relationship online that may, at times, even supersede the authenticity of a FtF therapeutic relationship.

Ethics and legal issues concerning e-therapy

Numerous papers have been published discussing the ethics of online therapy (e.g. Rochlen *et al.*, 2004a, Mallen *et al.*, 2005b, Chester & Glass, 2006). Various guidelines have been produced, including a document published in 1999 by the American Counselling Association

(ACA) regarding Ethical Standards for Internet Online. In 2005 the British Association for Counselling and Psychotherapy (BACP) revised the guidelines they had developed in 2001 (Chester & Glass, 2006). Key ethical issues with online therapy include client confidentiality, domain names that reveal professional identity, inability to act in an emergency and liability insurance (Mitchell & Murphy, 2002). In particular, it is difficult to guarantee e-therapy will be completely confidential as there is no definite assurance about the protection of e-mail information whilst it is being sent.

Spielberg (1998) recommended that therapists should discuss the advantages and disadvantages of conducting therapy electronically with potential clients and should gain informed consent from their clients for the communication. Jones and Stokes (2009) suggested conducting a primary assessment of clients' appropriateness for online therapy. This present literature review questions what would happen if a client in a different country were to talk to a therapist online in the United Kingdom and state that they were going to harm themselves or others - it may be more difficult to ensure their or others' safety. Additionally, the therapist may be under different legal and ethical rules in their own country than the client is in theirs. Breaking confidentiality is a delicate issue and is often discussed in the therapy session; with the absence of non-verbal cues in this situation it may be more difficult to convey that in most cases the therapist is breaking confidentiality because they are worried about the wellbeing of the client. Shapiro and Schulman (1996) argued that if a therapist engages with a child online they should ensure the child realises that if any communication between the child and practitioner is saved online their parents would have a legal right to access these interactions.

It is advisable that plans should be made for technological failure which could result in the client feeling abandoned (Mallen *et al.*, 2005b). Mallen *et al* (2005b) highlighted the potential impact of the "digital divide" (p.795) which depicts the discrepancy between peoples' access to the Internet as a result of socioeconomic issues. Steps should be taken to make sure that the majority of clients have access to the Internet to ensure that e-therapy does not become exclusive. In Britain, procedures are being put in place to narrow the digital divide; in September 2008, at the Labour Party conference, Gordon Brown revealed plans for a £300 million scheme to offer every schoolchild broadband internet access at home. Furthermore, he stated that for the 1.4 million children in Britain living in homes without a computer, parents would be offered vouchers worth up to £700 to buy computers and internet connection

(Guardian Newspaper, 2008). This would result in more adults having access to Internet for e-therapy than ever before.

"It is critical that online practitioners provide their full name, degree, licensure and the professional organisations to which they belong. Practitioners should also obtain and attempt to verify every client's name, address, phone numbers and age" (Gore Jr & Leuwerke, 2008, p.41). Gore Jr and Leuwerke (2008) further recommended that in case of an emergency, therapists need to inform local service providers, and give them precise information to provide emergency treatment or to tell appropriate authorities in "duty-to-warn" (p.41) situations. They highlighted the importance of finding out the client's age as it may be unethical/illegal to give therapy to a minor without permission from their parents. Populations such as prisoners could potentially be dangerous for therapists and client, i.e. if the emails are used in court against the prisoner. Consequently, there must be legislative security for both therapist and client (Sanchez Page, 2005).

Informative research conducted by Chester and Grass (2006) investigated the growing practice of online counselling in a study using 67 online counsellors. The counsellors were integrative or CBT therapists who merged online work with FtF practice. E-mail was used in 71 per cent of the online counselling. The authors stated that some ethical worries that previous research had raised remain unresolved. 90 per cent of counsellors gave information to clients about the limits of online counselling. This implies that 10 per cent did not give clients any information about the possible risks which highlights the need to tighten the regulations on e-therapy. 76per cent referred clients to FtF counselling when they thought that this would be more suitable and 89 per cent thought there were some problems not suitable for online counselling, perhaps showing that online therapists are aware of some of the limitations of online therapy. One third did not have any plans in place to resolve technological failure and 42 per cent did not use any type of encryption software to protect the confidentiality of the conversations. This study had a small sample size and quite a low response rate. In spite of this, this literature is interesting in showing a lack of compliance to basic ethical issues i.e. not having the appropriate encryption software to attempt to secure confidentiality. Nevertheless, it can be argued that that not all FtF therapists adequately inform their clients about confidentiality and this is a problem amongst all therapists, not just online therapists.

Administering psychological tests online has revealed issues that need to be dealt with, including numerous submissions of the same test by one person (Pasveer & Ellard, 1998). It cannot be assumed that Internet-administered assessments and booklet-administered assessments are equivalent (Buchanan & Smith, 1999). This supports the argument that for the moment e-mail should be used as an adjunct to FtF, not as a replacement. Still, equivalence between assessments has been found for some tests; Butcher *et al.* (2004) reported that there is nearly 100 per cent equivalence for the Minnesota Multiphasic Personality Inventory (MMPI), which one could argue yields potential for future online assessment.

Limitations of the literature

Notwithstanding the relative scarcity of the literature regarding the efficacy of e-therapy, there have been some promising results, particularly in the field of eating disorders (Murdoch & Connor-Greene, 2000; Yager, 2003). Nonetheless, the studies are often anecdotal accounts with poor controls. Studies frequently compare their results on the efficacy of e-therapy with similar studies which use FtF participants and therefore are not always directly comparable. Sample sizes tend to be small, and wider research needs to be conducted in order to arrive at clearer conclusions about the benefits of e-therapy. As Gore Jr and Leuwerke (2008) stated "the research on the therapeutic benefits of online counselling is in its infancy and its effectiveness has not been clearly demonstrated" (p.39), although the authors also noted that studies have revealed promising results concerning clients attitudes towards, and satisfaction with, online counselling.

Mallen *et al.* (2005b) reported that any study which investigates the process of online experience should assess the electronic competence of participants. They argued that it takes practice to converse successfully using asynchronous e-mail. Furthermore, it is noteworthy that the discussion on the type of people that would be most suitable for online therapy fails to address the issue of Internet addiction, although there is a now growing amount of research on this topic (Young, 1996; Young & Rodgers, 1998; Griffiths, 1999; Chou, Condron & Belland, 2005; Suratt, 2006). Ivan Goldberg created the term "Internet addiction" in 1996 to describe "pathological compulsive Internet usage" (Watson, 2005, p.19). There is no formal diagnosis for Internet addiction; researchers such as Watson (2005) have compared it to the DSM-IV-TR (American Psychiatric Association, 2000) pathological gambling disorder. Nevertheless,

Walther and Reid (2000) argued that labels such as addiction should not be used to discuss something about which so little is understood. As Morohan-Martin (2007) stated, many argue that the problem is not the Internet but rather the addictive behaviours that people pursue on the Internet. One option would to be to provide a potential e-therapy client with an Internet addiction test, such as the Internet Consequence Scales (Clark & Frith, 2005) before embarking on an e-therapy relationship.

There is as yet no long-term analysis of behaviour and mental health services delivered by online therapy (Mallen *et al.*, 2005b). It is important that research now focuses on online assessment to ensure that co-morbidities are not ignored in therapy. This literature review also argues that the British Psychological Society need to draw up more stringent ethical guidelines concerning e-therapy, and also address crisis procedures as this could also have legal implications for counselling psychologists. Further research is needed on the efficacy of e-therapy for common mental health problems such as depression and anxiety. Castelnuovo *et al.* (2004) have already suggested that the disinhibition effect of online therapy makes it particularly suitable for anxiety disorders.

Conclusions

The review of this literature highlights positive and negative consequences of e-therapy and these should be kept in mind so that counselling psychologists continue to act in a legal and ethical way. The research suggests that it is possible to have an authentic e-therapy relationship. Accordingly, this literature review concludes that, despite current gaps in knowledge and research, online therapy (specifically e-therapy) is a resource that counselling psychologists could usefully utilise in their practice. It is clear from the literature that the field of online therapy, especially e-therapy is expanding, and is a field that counselling psychologists cannot afford to ignore.

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