Where is the therapist in the therapy?

By

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Submitted in fulfillment of the requirements of the Top up Doctorate in Counselling Psychology

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July 2016

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THE FOLLOWING PARTS OF THIS THESIS HAVE BEEN REDACTED FOR DATA PROTECTION/CONFIDENTIALITY REASONS:

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Acknowledgments

I would like to thank the eight counselling psychologists who participated in this piece of research, and generously gave their time and shared their stories. I would also like to thank the client who gave me insights and opportunities to grow as a therapist. Also, thank you to Professor Carla Willig and Dr Jenny Hunt who offered support, encouragement and guidance throughout this challenging and thoroughly enjoyable journey. And finally, to Jools and Evie – the centre of my world.

Declaration

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Foreword

The research component of the portfolio is mostly written in the third person. However, throughout the thesis personal accounts are included. This will hopefully provide the reader with a better understanding of the experience of conducting this study, and the rationale behind some of the decisions made. In the reflective accounts I have used the first person narrative.

Part One:

Introduction to the Portfolio

Part One: Introduction to the Portfolio

Overview

This portfolio consists of four parts. Firstly, this introduction to the portfolio, which aims to pull together the following three parts which consist of: an original piece of research, an example of professional practice in the shape of a case study and finally, a critical review of a related aspect of the existing literature.

Although there are three separate components to the portfolio, they have each been chosen for a reason. Each piece links together through a shared theme, and so fitting together as a single body of work. The main theme of each section of this portfolio is the exploration of the counselling psychologist's own process and what influences their psychotherapeutic interventions. Given that each counselling psychologist is providing something different, in a room that is usually attended only by the therapist and the client, it is interesting to have the privilege to be able to explore psychotherapeutic practice and its: influences, techniques, processes, therapist; opinions, personal and professional experiences, knowledge and so on. It is also good practice for every counselling psychologist to reflect on how his or her therapeutic interventions may change and evolve and what factors may influence such change. Therefore, the overall aim of this portfolio is to enhance chartered counselling psychologist's awareness of firstly, what influences them in the therapy room and secondly, how they may continue to evolve and improve therapeutic outcome.

Part Two: Research

Where is the therapist in the therapy?

The research section of the portfolio consists of an original piece of research. It is a qualitative study of counselling psychologists, using thematic analysis to explore what they believe influences them in their choice of psychotherapeutic intervention. The research consists of interviews with eight

counselling psychologists. The criteria for participation are: practitioners who are at least five years post counselling psychology chartership and have been consistently and currently practising providing one-to-one psychotherapeutic intervention. The interview procedure encouraged the participants to reflect on all the aspects that they believe influence them when practising psychological intervention. The findings are analysed using Braun and Clarke's, (2006), model of thematic analysis and the findings are presented. The resulting themes are then discussed and the over-arching conclusions of the findings are presented. There is also a critique of the study and recommendations for future study.

The research aims to provide an insight to the array of influences that are identified by counselling psychologists in their psychotherapeutic practice. On a broader level, the aim is to progress the discipline of counselling psychology in proving its uniqueness of approach to psychological intervention, whilst offering insights that may lead to the enhancement of clinical supervision and training courses.

Part Three: Professional Practice

Psychotherapeutic Interventions That Contribute to Healing

This part of the portfolio consists of an example of clinical work, presented in the format of a case study. The focus of the case study is on the variety of interventions that were implemented during the course of the therapy, and how these were therapeutically valuable to the client's healing. The case study illustrates what influenced the choice of such interventions, drawing from; knowledge of human behaviour and the client, training, supervisory experiences and my own life experiences.

The client is a female whose transition from a non-sexual adolescent to being a sexual adult female, has been arrested. This particular piece of clinical work was chosen to write about as it captures such a myriad of therapeutic interventions, including what appears to be a contentious intervention,

deliberate therapist self-disclosure. The aim of presenting this particular piece of client work was to highlight the breadth of interventions available to therapists and also how much, during the course of the therapy, I reflected upon my own past and current transitions.

This particular piece of clinical work took place whilst I was experiencing two significant transitions, one in my professional life and one in my personal life. In my professional life, I was experiencing the transition from being a newly qualified counselling psychologist to an experienced practitioner. I had been B.P.S. chartered for five years and was beginning to reflect on my practice and how it had developed, evolved, changed and hopefully improved in the five years since gaining B.P.S. Chartered Counselling Psychology status. Whilst reflecting on these aspects, I had become interested in what other established counselling psychologists were doing in their clinical practice. It was these reflections that triggered the process of research in this area and therefore my embarkation upon the beginning of this portfolio. In addition, whilst working therapeutically with this client I fell pregnant and subsequently became a mother of my first child, and so the process of embarking upon two hugely influential and transitional experiences was found to be particularly useful to this piece of clinical work. I believe this piece of clinical work reflects the process of development within me as both a woman and an established, practising counselling psychologist.

Part Four: Critical Review of the Literature

Therapeutically Beneficial Deliberate Therapist Self-Disclosure

The fourth part of the portfolio consists of a critical review of the literature. The aim of this section is to present a critical appraisal of a particular topic relevant to the other two sections of the portfolio, and the practice of counselling psychology. The topic chosen is that of deliberate therapist self-disclosure.

The critical review begins by exploring exactly what consists of therapist self-disclosure. The review then continues to specifically focus on what the literature has to offer on the topic of deliberate therapist self-disclosure. The review highlights how the literature has evolved and developed, moving somewhat away from the dictatorial discouragement of deliberate therapist self-disclosure, to recognising its worth. However, the review casts a critical eye over the seeming contradiction of the literature when exploring the: with whom, what to disclose, when and how best therapists can offer deliberate self-disclosure in a confident, competent manner. The review also highlights the methodological issues and therefore the conclusions drawn from the research conducted exploring deliberate therapist self-disclosure.

In terms of my journey with the portfolio, the critical review part of the portfolio explores deliberate self-disclosure. This review was researched and written following the interviews for the research part of the portfolio. Once I had transcribed several of the interviews, I found the remarks made around the subject of deliberate therapist self-disclosure had been very interesting. I believe this interest had been present in my pre-occupations and reflections on my own practice before I began the portfolio.

The portfolio represents the entwined personal and professional life of a counselling psychologist. Whilst presenting the professional and personal journey I have travelled to be the counselling psychologist that I currently am. It also aims to provide an insight into how these counselling psychologist's journeyed to the point they had arrived at the time of participation in this study. In addition, the portfolio intends to build on the understanding of what influences practising chartered counselling psychologists and thereby the understanding of the profession, both by members and non-members of the discipline. Allowing the discipline's uniqueness to prevail and for new insights to be gained for; enriching, enhancing and improving, the clinical practice experience for both therapist and client.

Part Two: Research

Abstract

This qualitative study uses thematic analysis to explore what eight experienced counselling psychologists believe influences their choice of psychotherapeutic interventions. Individual interviews were conducted with the resulting data analysed using thematic analysis. The process of thematic analysis was followed as outlined by Braun and Clarke, (2006). The themes and sub-themes were identified and a summary is captured in a final thematic map. The eight counselling psychologists all described there being an over-arching theme that contains three sub-themes that are enduring and consistent core influences to their psychotherapeutic practice: the psychotherapeutic theoretical models, the client and the therapeutic relationship. With these as the ever-present cornerstones influencing their practice choices, the participants also identified influences that are captured under the theme of them being interchangeable in their strength of influence. These sub-themes are listed in order of their strength of influence: personal aspects of the therapist, professional aspects of the therapist and external factors. The exploration concludes with a discussion of how this information is of theoretical worth, whilst providing helpful insights that can inform counselling psychology practice. There is a critique of this study and suggested avenues for future research.

Chapter 1: Introduction

Overview

This opening chapter begins by introducing the broad aspects of the present study. This study is interested in what influences the therapist's choices made in the delivery of psychotherapeutic intervention. The chapter outlines and explores some of the more pertinent and relevant literature, as this topic is vast, the review of the literature is divided under thematic headings. The studies and writings chosen for inclusion are based on their relevance to the issue being investigated. By outlining the limitations, critically appraising the existing research in this area and identifying the gaps in the studies, the chapter concludes by identifying the rationale for exploring this particular chosen area of psychotherapeutic provision. A reflexive summary acknowledges the personal motivations for the study.

Whilst acknowledging that counselling psychology has its own unique identity, and due to the discipline's infancy and its similarity to other psychotherapeutic professions, this review of the literature was not exclusive to the writings and research of just counselling psychologists. The discipline of counselling psychology is a relatively recent one, but has gained huge presence on the professional psychology scene. Its identity was constructed in two main ways: '… by differentiating it from one particularly well-established related profession (clinical psychology) and by pointing to similarities and links between counselling psychology and other well-established related professions' (Pugh and Coyle, 2010, p.88) and so literature focusing on the development and psychotherapeutic styles of: psychotherapeutic therapists, practitioners, counsellors, counselling and clinical psychologists, are all explored. The terms used to refer to the practitioner are used interchangeably throughout the study.

Before reviewing the literature it is worth considering what is to be reviewed. The interest lies within exploring the provision of psychotherapeutic intervention and what influences the therapist to provide their chosen

intervention. Therefore, the literature that provides insight to what influences psychotherapeutic practitioners shall be reviewed. Prior to this review, there will be a brief exploration of what influences choice, what constitutes a psychotherapeutic intervention, and why counselling psychologists are important contributors to this area of investigation.

Influences upon choice

Within the literature there are decades of debate focusing on what are the factors that influence decision-making. These range from instinct, (Maslow, 1943), obedience, (Milgram, 1963) and subtle unconscious influences, (Payne, Samper, Bettman and Luce, 2008). Yet, the overall debates seem to settle on the belief that making decisions is a constant evolving state of being an individual and many decisions are made routinely without substantial conscious consideration on our part. For the purpose of this study it is accepted that what influences people is complex, however assisting therapists in improving their conscious awareness of what influences them in the provision of psychotherapeutic intervention, appears a valuable contribution to improving therapeutic outcome.

A psychotherapeutic intervention

Most forms of psychotherapy use spoken conversation. Some also use various other forms of communication such as the written word, artwork, drama, narrative story or music. Whatever the form of communication, there is a commonality across them all, a psychotherapeutic intervention occurs within a structured encounter between a trained therapist and client/clients.

A psychotherapy intervention can be defined as a therapeutic procedure implemented to accomplish a particular task or goal (Cooper, 2008). For this study it is this particular type of psychotherapeutic intervention that is under scrutiny, and what influences the therapist in choosing to implement one particular intervention over another. For example, if they chose to respond to a

client encouraging an exploration of their upbringing, this could be an intervention that is influenced by what the therapist knows about the theory of the human condition, or what they have experienced in their own life, or a combination thereof.

Studying Counselling Psychologists

There is a large amount of literature exploring what influences someone to become a therapist, (Fussell and Bonney, 1990, Bager-Charleson, 2010), what influences the therapist's development, (Rønnestad and Skovholt, (2013), and how specific therapist attributes influence a good therapeutic outcome (Farber and Lane, 2002). However, there is an absence of focus upon U.K. based, experienced counselling psychologists and the influences upon their psychotherapeutic practice choices. As a counselling psychologist, I see the discipline as being unique and the influences upon the practitioners as therefore being unique. I am most interested in other counselling psychologists and I am also interested in further establishing the aspect of the discipline that promotes and aligns itself with the reflective scientist practitioner paradigm, (Corrie and Callahan, 2000).

Corrie and Lane, (2011), highlighted how counselling psychologists are operating in an ever-changing landscape and their need to continue to evolve. Two decades earlier, Einhorn and Hogarth, (1981), noted that the task facing practitioners is one of judging situations that are constantly evolving, and within such situations, practitioners are frequently required to devise innovative ways of practicing in order to respond effectively to client need and service requirements (Barlow, 1981; Long and Hollin, 1997). It is therefore understood counselling psychologists need to continue to be innovative and insightful into the range of options of intervention that are available to them when providing psychotherapeutic practice. As innovative interventions are encouraged within the discipline, it would be interesting to gain the unique opportunity to take a

look at what some counselling psychologists are doing in the therapy room, and what they believe influences their practice choices.

The process of reviewing and having the potential to understand what influences the professional practice of counselling psychologists also assists in improving both conscious practice and potentially therapeutic outcome. Whilst further highlighting their unique, flexible and comprehensive understanding of what it is to be human, and to work with others in order to relieve suffering.

Review of the literature

On first exploring the literature pertaining to influences upon therapist's psychotherapeutic choices, it became apparent that there is a divide between those who see the therapist as an important influence upon psychotherapeutic intervention, and those who see techniques/skills as important influences upon their intervention choices and outcomes.

Duncan, Miller, Wampold, and Hubble, (2010), dedicated an entire book to discussing what is at the centre of successful therapeutic outcome. One of their concluding comments being that the therapeutic profession would be better served by attending to 'therapeutic factors'. What they assert is that the debate about which of the therapeutic models is most effective is redundant, and what is relevant to explore is which of the 'therapeutic factors' contribute to individual practitioner's effectiveness. Whilst Gelso, (2011), used a wide variety of examples drawn from current research, as well as his own extensive clinical experiences, to conclude that it is the real relationship that is relevant in successful therapeutic outcomes. Norcross and Wampold, (2011), took a slightly different slant in their review of therapeutic outcome; they explored which relationship attributes were essential for an effective therapeutic outcome. Such attributes were: alliance, cohesion, empathy, collaboration and positive regard.

Although the alliance has been found to play a large role in the outcome of therapy, so have; technical proficiency, therapeutic model and process. Elliott, (2010), researched critical events that led to change and Doss, (2004), explored the change mechanisms within therapy sessions that contribute to treatment outcome. For this particular review, Norcross and Lambert's, (2011), writings are being held in mind: '… the most pernicious and insidious consequence of the false dichotomy of treatment versus relationship has been its polarizing effect on the discipline' (p.4). It is therefore not, just the influence of either: the therapeutic relationship, or the skills, attributes and techniques of the therapist that are being reviewed here, but also the potential influence of these and any other factors to the therapeutic process.

As the general literature on what may influence a therapist's psychotherapeutic practice is vast, it has been arranged under the themes that emerged during the literature review. These themes and the literature cited here, are not exhaustive, and the more peripheral themes, such as age of the therapist, political views, physical appearance, have, due to the word limitations of the study, for the most part, been omitted.

Core Influences upon Psychotherapeutic Practice

The extensive literature exploring what influences psychotherapeutic practice, repeatedly and very positively identifies three particular aspects. These influences were recently highlighted by Moltu and Binder, (2014). They used a qualitative methodology of data collection exploring how skilled therapists contributed to change and how they integrated therapy techniques. They concluded that skilled therapists created a space that was grounded in the following three therapeutic activities: firstly, 'tailoring the frame to suit the patients relational vulnerability' Secondly, 'using embodied experiences to get emotionally close enough', and thirdly, 'creating meaning from their theoretical perspective'. In summary, therapists use their skills to assess the needs of the client; they then use themselves, their skills and their client's level of functioning to create intervention which is likely to be therapeutically valuable.

To summarise, the general consensus across the literature repeatedly identifies that three of the greatest influences upon the therapy process are: the theoretical models, the client and the therapeutic relationship. It therefore appears essential, in this review of the relevant literature, to begin by exploring these three aspects a little further.

The Influence of the Theoretical Models upon Psychotherapeutic Practice

The theoretical orientation is a multifaceted construct that is deemed as providing the foundations of psychotherapy training and practice. The literature surrounding the theoretical models is vast. There are numerous orientations that have been devised in the provision of psychotherapeutic intervention. Some therapists choose to interpret a theoretical model and apply it in its purist form. Whilst others would draw from several theoretical models of intervention, and from which create an integrated or eclectic model of psychotherapeutic intervention. The minimum competency for a counselling psychologist is being proficient in one model and cognizant of another - British Psychological Society (B.P.S.), (2001); Health and Care Professions Council (H.C.P.C.), (2007). Inevitably, counselling psychology training courses, all have an emphasis on the use of the theoretical models as an important guide to clinical practice.

Although professional training and the governing bodies of psychotherapy give therapist theoretical orientation considerable attention, previous research has not consistently found it to have a meaningful and direct effect on treatment outcome (Beutler et al, 2004). This seems to be one of the greatest debates across the literature. A significant body of research supports that empirically supported treatments such as the cognitive-behavioural methods are more efficacious, when applied to certain types of distress, than some of the non-evidence based models (Chambless, 2002; Hunsley and DiGiulio, 2002). Yet there is counter evidence, with some findings arguing that the different therapeutic approaches are equal in their overall efficacy, (Hubble, Duncan and Miller, 1999; Wampold, 2001). These studies' findings reveal that

the difference in outcome across the various models is negligible. This dichotomy in the evidence about model efficacy is a complex one and more recent studies seem to lean more towards the therapeutic model having little effect on outcome.

Okiishi, Lambert, Eggett, Nielsen, and Dayton, (2006), measured client outcome, via an Outcome Questionnaire, and they found no significant relationship between therapists' primary theoretical orientation and outcome. Whilst extensive exploration by Stiles and colleagues (Stiles, Barkham, Mellor-Clark, & Connell, 2008; Stiles, Barkham, Twigg, Mellor-Clark, & Cooper, 2006), investigating therapy outcome in UK NHS settings, also found no meaningful differences in outcome between three primary orientations, and little difference when accounting for whether a therapy was 'pure' or integrated with another form of therapy. In addition, a recent meta-analysis found that therapist levels of adherence and competence to prescribed techniques have little impact on client improvement during treatment (Webb, DeRubeis, & Barber, 2010). This body of research fails to identify what aspect of the therapy process does effect outcome.

The subject under scrutiny in these studies outlined above and many others is the efficacy of the different theoretical models. What may add a valuable insight to the literature, would be how therapists themselves identify the extent to which theoretical models influence their psychotherapeutic practice. Asay and Lambert, (1999), devised an interesting estimated percentage pie of therapeutic factors. They estimated that the percentage split was 40% client variables, 30% the therapeutic relationship, 15% technique and theoretical model and 15% placebo. It therefore appears important to acknowledge that the theoretical models influence the therapy process.

Of more specific interest, when exploring the concept of theoretical models and their influence upon the therapist, Rønnestad and Skovholt's,

(2013), developmental phases may hold some insights. They were interested in the development of the therapist over the course of their professional life, believing that influences upon the development of their psychotherapeutic practice, would change across their career lifespan. Drawing from their own extensive research and that of others, they devised a series of five phases, which they suggest the therapist moves along during their professional career. The phases were: the novice student phase, the advanced student phase, the novice professional stage, the experienced professional phase and the senior professional phase. Within each of the phases they explored the different sources from which the therapist was influenced. The sources of influence were plentiful, including: imitation of more senior therapists, supervision, social/cultural environmental influences, peer influence, personal life, personal therapy, clients, satisfaction, burnout and working style. However, one of the most consistent and enduring influences upon development and learning, identified across all five phases, was the theories.

Yet, there is also an argument that the strength of influence of the theoretical model on a therapist's practice is variable, depending on the experience of the therapist. Over the last twenty-five years Jeffrey Kottler, with various colleagues at differing times, has completed hundreds of interviews with therapists representing over twenty different theoretical models of orientation. From this extensive research an interesting conclusion about the influence of the theoretical models has been drawn by Kottler, (2010):

> '... many of these therapists don't even practice their identified theories any longer! They have moved onto other things… they have transcended technique to emphasise far more the human and relational features of their interactions with clients. In other words, they may no longer use their developed theory in pure form, but more than ever use their caring, compassion and other personal characteristics' (p.34).

Thereby, unlike Rønnestad and Skovholt, (2013), the body of research carried out over many years by Kottler and various colleagues, referred to above, appears to suggest that there are stages in a therapist's career where the theoretical models becomes less important. What Kottler suggests at this point, is that the therapist and the relational aspects of the therapeutic relationship becomes more of the overriding influence upon the psychotherapeutic work. The literature has many pieces of research that highlight the relationship as an effect on practice, this shall be explored more below. The literature that offers support to Kottler's suggestion that the theoretical models become less important to the experienced practitioner is not necessarily given a positive slant. Within the evidence-based therapy community, moving away from the theoretical model is seen as a negative thing. This phenomenon, commonly called 'therapist drift', is the process whereby a therapist ostensibly delivering an evidence-based therapy winds up doing something else instead. For Waller, (2009), this was not seen as a process that evolves and is replaced by the relational factors, but is a reason for C.B.T. not being effective.

These conclusions drawn by both Kottler, (2010), and Rønnestad and Skovholt, (2013), can be critiqued. Firstly, regarding Kottler's conclusion, it could be that the experienced therapist is so familiar with the application of the theoretical models that they are no longer conscious of their application to the therapy process, and their unconscious competence means they are applying them without consideration. Also the majority of Kottler's findings are predominantly based on interview questions and therapists self-reporting. It is worth considering that when participants are asked specific questions, it immediately encourages them to try to guess what the investigator wants to find out, otherwise known as researcher influence.

With regard to Rønnestad and Skovholt, (2013), the devising of their five stages and the influences to therapist development at each stage; these stages are devised by a series of six phases administered over five years. Phase 1

was the bringing together of a collection of their own previous research and their own observations via; classes, seminars, conferences and informal discussions. Phase 2 was individual interviews with therapists, which were transcribed. Phase 3, a senior research assistant listened to 75% of the interviews with the transcripts and listened for congruity. Phase 4 was a re-interview opportunity for 60% of the sample. Phase 5 was a construction of themes and phase 6 was a devising of the therapist developmental stages. Whilst this process may provide a wealth of data, the lack of uniformity in its collection, and at times, the absence of a rigorous process of analysis means that some of it could have been investigated and interpreted to produce the desired outcome. For example, the interview questionnaire held specific questions that were devised from the informal processes that Ronnestad and Skovholt had earlier been involved in, such as their own observations via; classes, seminars, conferences and informal discussions.

What may provide a more compelling piece of evidence would be a less contrived conclusion that the theoretical models are highly influential to psychotherapeutic practice. This could be gained by offering a sample of practitioners the opportunity to explore all of the influences upon their psychotherapeutic practice. If they were unprompted, and they identified the theoretical models as featuring highly in what influences their practice, then this would offer support to the literature emphasising the important influence of the models upon the therapist and the therapy process.

The Influence of the Client upon Psychotherapeutic Practice

Much of the empirical research suggests that it is the client who is primarily responsible for a lot of the activity. Bohart and Tallman, (1999), found that the influence of the client dictated the process of change. Asay and Lambert, (1992), estimated that around forty percent of therapeutic improvement is due to clients and the events that take place away from the therapy room. The humanists would say that the client is the centre of the

therapeutic process. ‘It is the client who knows what hurts, what directions to go, what problems are crucial, what experiences have been deeply buried’ (Rogers, 1961).

There is also a body of evidence that suggests that specific client factors have an influence on the process of the therapy, (Crits-Christoph, Baranackie, Kurcias, Carroll, Perry, Lubrosky, 1991). In further research specific client factors were explored, they included: motivation, (Orlinsky et al, 1994), the client’s hopes, (Glass, Arnkoff and Shapiro, 2001), the client’s psychosocial functioning, (Mohr and Beutler, 1990), the client’s ethnicity, (Clarkin and Levy, 2004) and the psychological mindedness of the client, (Piper, Joyce, McCallum and Azim, 1998). With regard to what leads to therapeutic change, the empirical research indicates that it is the client (Bohart and Tallman, 1999, Duncan, Miller and Sparks, 2004).

With a slightly different emphasis, Kottler, (2006), investigated the influence of the client on the individual therapist. Taking a different approach, Kottler and Carlson, (2006), asked therapists to speak of: ‘the client who changed them the most’. Despite not being able to recruit many therapists to the research, twenty-four experienced therapists did speak of the clients who had changed them. What was asked of the participants was: ‘tell us about a client who changed you and how this occurred’. Some of the participants spoke of a seminal case that had helped them to develop their practice. Others were far more focused on the personal, talking about how a client had taught them a personal life lesson, or touched them so much they themselves made life changing decisions. These insights gathered by Kottler and Carlson imply that what a therapist brings to, and takes away from the client encounter, is something that transgresses the boundary of the professional and the therapy room. As the examples given by these therapists were predominantly those of personal changes and effects, this raises an interesting reflection of how much clients change the therapist and in turn changes their practice.

The limitation of this particular study is that it fails to outline what effect these personally influential client experiences had upon the therapists actual practice interventions. Although Kottler, (2010), later expanded on this and wrote that it is clients that teach therapists to become better at what they do. However, this was an observational writing and lacked clarity in what specific ways these teachings influence a therapist's psychotherapeutic practice.

In a similar vein to Kottler, (2010), Rønnestad and Skovholt, (2013), also identified, in their five therapist phases, the importance of the client who was consistently reported as influencing the development of the therapist: "… that working directly with patients is the leading positive influence on their development" (p.279). Again the methodology used for gaining these concluding five phases has already been critiqued. However, as the major focus of any psychotherapist's career is the client, it would be impossible to dismiss the contribution of the client to a therapist's development.

Moving away from how the client influences the development of the therapist and more towards the aspect under scrutiny in this study, whether the client influences the choices made in when applying psychotherapeutic practice, here Scheel, Davis, and Henderson, (2013), seem relevant. They interviewed therapists and found that they would use the client's strengths to influence the psychotherapeutic processes. They found that:

> "Therapists reported using client strengths to broaden client perspectives and create hope and motivation, to create positive meanings through reframing and metaphors, to identify strengths through the interpersonal therapeutic process, to match client contexts through strengths, and to amplify strengths through encouragement and exception finding". (p.392).

In summary, a thorough investigation of the literature reveals that the client and their influence are found across many aspects of the therapy process and outcome. The recent key studies for reaffirming this have shown that the client can influence: the development of the therapist, both personally and professionally (Kottler and Carlson, 2006), the development of the skills of the therapist, (Rønnestad and Skovholt, 2013), the client's strengths influences the outcome and interpersonal development, (Scheel, Davis, and Henderson, 2013), and the client's needs are seen as central to the development of the therapeutic process, (Rogers, 1961).

There appears to be an absence of studies exploring how specifically the client influences the therapist, and the actual impact that influence has on the experienced practitioners psychotherapeutic intervention choices. In essence, how each of these highlighted influences actually manifest themselves in the therapeutic interventions of the therapy room, and how this would add an additional perspective, shining light on how the theory of client influence actually exists in the application of therapy.

The Influence of the Therapeutic Relationship upon Psychotherapeutic Practice

Another greatly acknowledged influence upon the psychotherapeutic process is the extensive literature supporting the influence of the therapeutic relationship. This refers to the 'quality and strength of the collaborative relationship between client and therapist' (Horvath and Bedi, 2002, p.41). The acknowledgement of its importance has been cited across the literature since the inception of psychological therapy, (Freud, 1913; Rogers, 1951; Winnicott, 1965; Kohut, 1977; Gelso and Carter, 1985; Dryden, 2007; Egan, 2010). Supported by a breadth of research that links the quality of the therapeutic relationship consistently with therapeutic outcome, (Keijsers, Schaap and Hoogduin, 2000; Orlinsky, Rønnestad and Willutzki, 2004; Norcross, 2011).

The humanists, led by Rogers, (1951), placed great emphasis on the therapeutic value of the relationship created by the therapist and client. Palmer and Woolfe, (2000), state:

"The quality of this contact and the capacity the client has to make contact is explored in the here and now encounter between therapist and client" (p.223).

For West, (2000), like other humanistic therapists, he believes the therapist is central to the therapy and it was awareness, both on the therapist and client's behalf, which produced change. To a large extent, each of the contemporary models of psychotherapy holds an association between therapeutic outcomes and the therapist-client relationship (Gelso, 2011).

By exploring what particular aspect of the therapeutic relationship provides the ingredient for effective work to be done, there have been many investigations. Lambert and Barley, (2001), reviewed the research findings gathered over many years exploring the aspects of the therapeutic relationship that can lead to successful outcome. They found that whilst there is variation in what these aspects are, their review confirmed that the primary curative component of therapy is the relationship, which then provides the context in which specific techniques exert their influence. Some of the techniques and their influence on the therapy relationship shall be explored further on.

By use of a different methodology, Arnd-Caddigan, (2012), offered a new way of considering the therapeutic relationship. Whilst closely studying one particular therapeutic process, she found that after an ambivalent start on the part of the client, there was a significantly improved outcome effect when the therapist 'internalised' the client; suggests that the therapist being able to closely approximate the client's likely contribution to an interaction, later improved the outcome. Her conclusion was that perhaps the therapeutic

process is better understood if one assumes that the alliance required is variable and varying with the same client at different points in the treatment.

One of the more succinct integrative summaries of how the therapeutic relationship influences psychotherapeutic intervention was concluded by Kahn, (1991):

> "At the moment of the existential encounter between therapist and client, the client's whole world is present. All of the client's significant past relationships, all their most basic hopes and fears, are there and are focused upon the therapist. If we can make it possible for them to become aware of their world coming to rest in us, and if we can be there, fully there, to receive their awareness and respond to it, the relationship cannot help but become therapeutic" (p.160).

Whichever of the theories the individual therapist chooses to align with, the acknowledgement of the role of the therapeutic relationship in influencing the process of the therapy is viewed as paramount. However, the majority of the research has investigated the correlation between the quality of the therapeutic relationship and the therapy outcome. The manner in which the therapeutic relationship specifically influences the intervention choices made by the therapist, is a complex deconstruction. Just some of the potential ways of how the therapeutic relationship could influence an experienced counselling psychologist's intervention choice, currently can only be surmised. Some specific examples of the relationship influencing practice choices, provided by a sample of experienced practitioners, would be an interesting contribution to the literature.

The Therapist's Influence upon Psychotherapeutic Practice

The notion that the therapist as an individual is important for psychotherapeutic process stems in part from the well-known and frequently cited finding of meta-analyses that therapy outcome appears to be less related

to the use of different therapy methods associated with established schools of therapy, and significantly related to differences between the individual psychotherapists providing the therapy (Benish, Imel, & Wampold, 2008; Blatt, Zuroff, Quinlan, & Pilkonis, 1996; Kim, Wampold, & Bolt, 2006). So in progressing with the investigation of what influences psychotherapeutic practice, this leads to the investigation of the therapist, from both the perspective of the personal and the professional. Writings by Goldfried, (2001), who focused on documenting therapist accounts of changes to their theoretical orientations, highlighted that it is the significant experiences, both in the personal and professional lives of the therapist that contributed to advancing their evolution of psychotherapeutic practice.

Yet, when exploring how the therapist influences practice, the literature tends to be divided across the influences of either: the therapist's professional life, or the influence of the therapist's personal life to their practice. This review shall aim to explore the literature pertaining to some of the major aspects of influence upon practice, gathered from both the professional and the personal aspects of a therapist's life.

The Influence of the Personal Aspects of the Therapist

The influence of the therapist's personality upon psychotherapeutic practice

Research indicates that clients consider their therapist's personalities as one of the most important factors in therapy, (Sloane, Staples, Whipple and Cristol, 1977). An abundance of the literature explores the personality traits commonly found in therapists. This promotes the thinking that a person that chooses to become a therapist would require a certain set of personality factors. Pope, (1996), listed 10 personality factors, elicited from experts that were deemed to be unlikely to change as a result of training. These personality factors were: acceptance, emotional stability, open mindedness, empathy, genuineness, flexibility, interest in people, confidence, sensitivity and fairness.

Pope's study claimed that these traits are essential and inherent, rather than learnt by the therapist. It would therefore be interesting to see whether practitioners see their personality as amongst their choices of tools of psychotherapeutic intervention.

However, there is little strong evidence to link specific therapist personality traits to an improved therapeutic outcome. Antonuccio, Lewinsohn and Steinmetz, (1982), did not find a significant correlation between a good therapy outcome and a wide range of therapist characteristics. In addition, Beutler et al, (2004), found no clear evidence that when matching the therapist and the client personality, had any more beneficial influence on the therapy process, than if they had opposite personalities.

Kottler, (2010), wrote that the practice of therapy is a: "… calling rather than a job or profession" (p. 43). He goes on to write that he sees therapists as having; a drive to understand the human condition and a need to make sense of life experiences and help others to do so. This line of thinking is supported by Gelso, (2009), who suggested that it is the personal qualities of the therapist that contribute to the therapeutic relationship, a factor previously outlined as essential to the therapeutic outcome.

This is also supported by the findings of Wheeler, (2000), who investigated what trainers deemed to be aspects that would contribute to a trainee counsellor being a good or bad practitioner. Amongst the top of the attributes for contributing to the trainee being predicted as a good counselor was whether they were personable. "It has confirmed that the personality of the counsellor is seen as the crucial discriminator between good and bad practitioners" (p.81).

Beyond exploring which of the personality traits is essential to a good therapist, one of the greatest debates across the psychotherapy literature is the degree to which therapists should bring their personality to the therapy room,

and the degree to which they adopt a stance based on learned techniques. A second debate is which personal aspects of the therapist are brought to the therapy room and used therapeutically. Rowan and Jacobs, (2002), suggest that the therapist uses three aspects of self: the instrumental, the authentic and the transpersonal self. The instrumental self would be the therapist's skills of applying therapeutic intervention; these are deemed as likely to be taught via training or supervision. The authentic self would be more concerned with aspects of the therapist such as; intuition, imagination, personhood, etc. Finally, the transpersonal, a term that refers to a phenomenon that exists in the therapy room that is beyond the personal. The transpersonal self-integrates the spiritual and transcendent aspects of the human experience. Thereby, Rowan and Jacobs, (2002), greatly acknowledge the important contribution of the authentic aspect, i.e. the personal aspect of the therapist.

Kottler, (2010), adds that he sees therapy affected by all the personal variables of the therapist and that: "Even with the best education, training, supervision, study and self-analysis, a therapist is hardly the anonymous, perfectly stable, all knowing and accepting creator that clients prefer to see" (p.46).

In summary, the personal and personality of the therapist are acknowledged as present in the therapy process. Conversely, despite the theoretical literature deeming the personality of the therapist as important to the therapy process, there has not been a great deal of investigation as to how the practitioner believes their personality influences their practice decisions. The research literature presents a convincing argument that: personality influences: the choices we make, the drive and choice to become a therapist, it influences whether you possess the skills associated with being a 'good' therapist, it influences therapeutic outcome, and that it exists in the therapy room in some format. However, the gap that exists in the literature is a picture of how therapists believe their personality plays a role when they are in the therapy room choosing particular therapeutic interventions.

The influence of the therapist's bodily responses upon psychotherapeutic practice

In every moment of a therapeutic conversation there is an enormous amount of information that is communicated non-verbally. The literature speaks about the body of the therapist being crucial in reflexive practices (Shotter, (2004), Csordas, (2002), Andersen, (1993). Elkaim, (1990), recommended an embracing of the body as part of the continuous 'self-referencing' on behalf of the therapist. For Elkaim, this 'referencing' was the heart of the therapy, providing the tools for the understanding and the therapeutic intervening.

The influence of the therapist's family environment upon psychotherapeutic practice

Much of the literature exploring the relevance of family environment and the influence upon the therapist is in the guise of it influencing an individual to choose to pursue a career in psychotherapy. Researchers have indicated that therapists are more likely than other professionals to come to their careers with a history of emotional pain and psychological distress. Elliott and Guy, (1993), found female psychotherapists reported a high prevalence of physical and sexual abuse, death of a family member, alcoholism and dysfunction in their families of origin than other female professionals. Murphy and Halgin, (1995), found that when compared to social psychologists, clinical psychologists were more likely to have experienced personal distress in their families of origin. Bager- Charleson, wrote that part of a therapist's reflections involves: "revisiting, re-examining and re-searching one's own motivations and strategies' encourages consideration of what we carry with us into our work 'in terms of our personal past, cultural values and belief" (2010, p. 142). It is worth noting that the majority of these findings were based on retrospective interviews with practitioners who are likely to assess their family experiences, post clinical training, differently to potentially those without such training.

Yet beyond motivations to work in psychotherapy being due to early emotional pain, there are other writings Kottler, (2010), suggesting that, on occasion, the initial training to be a therapist often takes place in early life and this can be through the original family environment. Kottler provides examples from therapist self- reporting, that as children they were the 'go-betweeners', family mediators and helpers. DiCaccavo, (2002), conducted a survey of trainee counselling psychologists and art students. They were offered questionnaires about their experiences of being parented. The survey showed that children of parents who had been prematurely placed into an adult-role, a phenomenon originally described by Boszormenyi-Nagy and Spark, (1973), as 'parentification', were as adults, more likely to seek out a helping-orientated career.

Previously, Kottler and Parr, (2000), wrote that a therapist's own personal family experiences and the professional dimensions of being a family therapist are inseparable:

> "… just as our own families, in the past and present, join us in every session we conduct. Until we are able to capitalise more fully on our personal experiences to enhance our professional effectiveness, we will continue to feel crippled by what we have lived through" (p.143).

A colloquial piece of evidence of the influence of the family environment on practitioners' psychotherapeutic practice was a recent article in the BACP monthly publication 'Therapy Today'. Sally Ingram, a practicing counsellor and Director of Durham University's counselling service, speaks in an article headed 'How I became a therapist'. Ingram makes reference to her childhood and family environment and how her parents influenced how she sees the world, which now influences her personal and psychotherapeutic practices: "I see now how they cultivated in me an enduring ethos of respect that continues to guide all my professional and personal interactions" (p.41).

To continue with how the therapist's original family environment influences actual psychotherapeutic practice, Fussell and Bonney, (1990), investigated the childhoods of psychotherapists and physicists. They offered the participants, who were psychotherapists and physicists, the opportunity to complete questionnaires relating to childhood. They found that the psychotherapists reported a comparatively high incidence of childhood trauma. Their study suggested that the experience and successful resolution of emotional pain enhances the therapist's empathic skills. Firstly, the experiencing of pain helps with empathy; secondly, resolution is essential to maintaining an appropriate distance to the client. The therapist can achieve this balance because they know that recovery is possible. In addition, early experience with ambiguity may help to develop another therapeutic skill, a tolerance for ambiguity, which can help therapists remain calm, which may in turn calm clients and help in the therapeutic progress.

More recently, Leiper and Casares, (2000), investigated the early experiences of 196 British clinical psychologists. They gathered the data via questionnaires asking about early loss and current clinical practice. The findings highlighted a relationship between the amount of early loss experienced and their current attachment style, their therapeutic orientation and experience of therapy.

The research appears to make an interesting and compelling conclusion. A therapist's original family environment not only influences the choosing of psychotherapy as a career, but it also influences the therapist's belief system and skills in the actual implementation of psychotherapeutic intervention. Leiper and Casares's study was specifically investigating therapist's experience of early loss. It therefore does not reveal whether an unprompted opportunity for British counselling psychologists would lead to them reporting that their original

family environment influences their therapy skills and therapeutic intervention choices.

The influence of the therapist's life events upon psychotherapeutic practice

As previously highlighted, it has been found that the family environment of the therapist can influence their choice and their skills in becoming and being a therapist. The literature also suggests that similarly a therapist's life events can also influence them choosing to become a therapist, Adams, (2014). Kottler, (2010), states there are generally several incidents that shape an individual's development and it will be one of these that will be the real reason why the person became a therapist.

A piece of research outlining which type of events would be influential to professional development was carried out by, (Skovholt and McCarthy, 1988). They explored, via 58 counsellors and what they deemed to be the 'critical incidents' in their development as a counsellor. 'Critical incidents' were events; "…that had a profound effect" (p.70) on their professional development. The predominant 'critical incidents' outlined were: particular client experiences, their own vulnerability, their own therapy, professional relationships, mentors, finding their niche, personal pain, letting go of over-responsibility, professional transitions and theoretical awakenings. So their findings revealed an assortment of both personal and professional events influenced a therapist's development.

In addition, Rønnestad and Orlinsky, (2005), wrote that some of the life events that can trigger change in a therapist's practice can be; critical, sudden, transforming or crisis led and can be experienced via personal and professional life. More recently, Trotter-Mathison, Koch, Sanger and Skovholt, (2010), gathered the narratives of 87 practitioners and explored the defining moments that they believe shaped their professional therapy lives. A 'defining moment'

was described as an encounter that produces a significant impact on the counsellor or therapist and is a vehicle for change. Many of the practitioners identified their own family and personal life experiences as, at times, being the greater defining influences upon their practice. Despite the content of these stories being based on a retrospective assessment, it is a substantial investigation and lends a weighty argument to a therapist's personal life events being influential to their professional practice.

Whilst these investigations provide some interesting information, they do emphasise the 'critical incident' or the 'defining moment' in the therapist's development. This excludes what may have been events and changes that were gradual and paced, but nonetheless, influential. These studies are predominantly interested in what influences a change in practice, rather than what influences the established intervention choices.

Kottler, (2010), adds that it does not necessarily have to be the major life events, but that also the more mundane personal experiences of the therapist are to be considered as influencing the content of their metaphors, statements, interventions and interpretations. "Much of what we say to clients is strongly influenced by what we have read and seen, whom we have encountered, and what we have done that very week" (p.65). In addition, Kottler, (2010), suggests that the intervention that the therapist may present at that very moment is who they are in that very moment, and this is ever changing: "My work in any given moment is the product of who I have become up to that very instant. As I change, so does the style of my therapy" (p.66).

As clients move through many challenges and developmental stages throughout their lives, so do therapists. These changes may not only occur prior to practising psychotherapy, but during their careers. As with the influence of the family environment, Kottler, (2010), theorises that life events go beyond influencing the person to choose psychotherapy as a profession, but they are

also relevant during psychotherapeutic intervention. He writes how a part of the therapist is contained in every client's story, which he suggests reminds us of our own unresolved issues and therefore influences the therapeutic processes.

Although Kottler is making many comments here that are worthy of consideration, some of these are predominantly based on his own self-observations of delivering psychotherapeutic intervention.

Adams, (2014), writes from both her personal experience and from a process of inquiry of how therapists believe their experience outside of the therapy room affects their work with clients. Her book explores some of the many intrusions that therapists may experience in their personal lives that are relevant to their professional lives. She speaks of the untroubled therapist being a myth and in her opening chapter writes: "The challenge is not to delude ourselves that we are able to leave our tensions at the door. Life happens, regardless of how conscientious or committed a therapist we might be" (p.3). She goes on to name just a few of the life events that she believes need to be acknowledged as having an influence on individual therapists and thereby their psychotherapeutic practice: having children, experiencing physical pain, depression, anxiety and loss.

In summary, the literature suggests that a therapist's life events may not only; influence their choice to become a therapist, their skills as a therapist, their choice in what type of therapist they will be, but also the on-going life events will influence their professional development and what takes place in the therapy room. It would be of great interest to investigate whether a sample of U.K. based counselling psychologist believe their own life events influence their practice choices and what type of life events lead to such an influence.

The influence of the therapist's well-being upon psychotherapeutic practice

Previous research indicates that when the change or life event has not been a positive one for the therapist, and especially if it results in their mental health being negatively affected, it is found to have an influence on their practice. According to some self-report studies by Kotller, (2010), and Adams, (2014), the well-being of the therapist can have a hugely significant influence upon the therapeutic process.

The older of the research tends to lean towards; if the therapist is 'suffering' then the therapeutic process will 'suffer'. The extent to which depressive symptoms can negatively impact professional functioning has been well documented: (Brown, 1991; Manning, 1995; Beutler, Machado, and Neufeldt, 1994; Porter, 1995; Sherman and Thelen, 1998). Guy, Poelstra, and Stark, (1989), conducted a survey of 749 practising psychologists in order to assess the impact of their personal distress on the quality of patient care (as assessed by the therapists themselves). A total of 74.3% of these therapists reported experiencing "personal distress" during the previous 3 years. Of those, 36.7% indicated that it had negatively affected the quality of their work, and 4.6% admitted that it had resulted in inadequate treatment for their patients. Unfortunately, his study does not allow for the remaining percentage to describe the effect the distress had on their therapeutic work if it was a positive one.

In other surveys and therapist's self-reports they identify experiencing such detrimental consequences as: the inability to maintain focus with clients, memory problems, fatigue, lack of self-esteem and lack of energy and motivation for therapeutic work. There is also some evidence that clients may lose self-confidence when working with therapists with low self-esteem (Wiggins and Giles, 1984). In addition to therapists with low self-esteem affecting the therapeutic outcome, therapists experiencing 'burnout' has also been found to have an effect on how they interact with clients. Maslach and Goldberg, (1998), defined burnout as: "… a problem that leaves once-enthusiastic professionals feeling drained, cynical, and ineffective". (p.63). Fine, (1980), described

therapists who have been practising a while and and as such studying the human condition too deeply, and for too long, experience a midlife crisis.

The more recent literature does begin to report the opposite phenomena, when the therapist is experiencing troubled times and having their well-being challenged, it can have a positive influence upon the therapy. Some reported positive effects on clinical work have included; increased identification, alliance, empathy, patience, faith/hope, appreciation, and reduced stigmatising of mental health difficulties (Cain, 2000). In an explorative study of 1000 therapists, it was found that therapists experiencing depression believed it did not have a detrimental effect on the therapy process, and they were willing to admit to their depression and seek personal therapy (Gilroy, Carroll, and Murra, 2002).

More recent research by Charlemagne-Odle, Harmon, and Maltby, 2014, also found a mixed reporting of both positive and negative effects of therapist distress. The research explored how clinical psychologists experience their own personal distress. They found that the participants identified several manifestations of their distress; one of these was that it had an impact on their clinical work. They identified a mixture of both negative and positive ways that this revealed itself in sessions: feeling more emotional, having more empathy with clients, feeling ineffective in sessions, less motivated or enjoying the escape or distraction of the client's difficulties. Once again, these findings need to be interpreted in the context of most of the data having been gathered via self-report studies of psychologists who were specifically asked to report on times when they were distressed.

Whilst research studies have consistently shown a mixed outcome of whether therapist well-being has a positive or negative influence on practice, a recent study takes a different approach there is a paucity of empirical data aimed at determining the point at which such impairment necessitates action. However, a recent study provides such empirical evidence, they explore when impairment to the therapist well-being is too much. Williams, Pomerantz,

Segrist, and Pettibone, (2010), showed psychologists working in private practice vignettes of practitioners with varying symptoms of depression or substance abuse. The findings revealed that psychologists judged that once psychological symptoms reach a certain point they would deem a therapist too impaired to practice psychotherapy. The study can be critiqued as it was based on feedback from fictitious vignettes, investigating only two kinds of therapist impairment. However, it raises an interesting point of reflection, especially as most of the judgment of 'fitness to practice' is self-assessed.

In summary, whilst there is a debate about whether the therapist's well-being is being challenged by their own life events, or by the existential confrontations they are faced in the therapy room, yet there is a consensus across the literature that therapist well-being has an influence on the psychotherapeutic processes. However, although the influence is acknowledged, there appears to be a difference of opinion in what manner, positively or negatively, the influence manifests in practice. This study aims to unravel whether experienced counselling psychologists believe their well-being has any effect on their practice, and if so whether it is a positive or negative effect. With particular reference to whether their well-being positively or negatively affects the psychotherapeutic choices they make when they are providing therapeutic intervention.

The influence of culture upon psychotherapeutic practice

According to Kleinman, (1988), psychology and psychotherapeutic practices are only appropriate for the western world's psychological problems. However, with the transient world population and the number of different cultures that both provide, and access psychological support, this limited view of psychotherapeutic intervention, cannot be merely accepted.

Multicultural issues in psychotherapy have been under the spotlight for some years. Consoli, (2008), researched the values of counsellors and what the implications of these would be when counselling clients from minority ethnic

groups. Their findings highlighted that when the counsellor's values were different from those of a client of a different ethnicity, these clients may find it difficult to work with them. However, when the counsellor's values were similar to those of the client, it could facilitate positive outcomes. They recommended that training programs should make a strong effort to foster awareness in trainees about their own and the profession's values and how these values may affect their work with clients from minority ethnic groups.

There has also been research that has suggested that an integrative model of intervention is better used with a client whom is culturally different to the therapist. Pedersen, (1985), suggested that in culturally differing therapy, the model should be client based, with the process of therapy being reformulated to fit the client. It therefore appears that in any discussions around what may influence the therapist's choice of interventions, a difference in culture between the therapist and the client, may have an influence on the chosen psychotherapeutic intervention.

Comas-Díaz, (2006) discussed how cross-cultural encounters within the therapy room are frequently rife with "missed empathetic opportunities." They include those moments when a client reports emotional issues and the clinician changes the topic without addressing or reflecting the client's feelings. Comas-Díaz contended that these missed empathetic opportunities are subtle, but occur more frequently when clinicians work with those different from themselves whether that is on the basis of; ethnicity, gender, sexual orientation, socioeconomic, ideological, and political differences. She also explored the role of culture within the therapeutic relationship and provided recommendations for addressing the cultural components of the client/therapist relationship to increase psychotherapy effectiveness. She especially suggested modification of the therapeutic relationship to the client's culture, special attention to understanding the client's voice, development of trust and credibility, and the promotion of cultural empathy.

Like many areas of influence upon therapeutic intervention, the cultural influence of the therapy appears to require further investigation. The emphasis in the majority of the literature lies in the importance of acknowledging culture in the therapy room; however it is not clear whether therapists are actually considering this aspect when they are providing psychotherapeutic intervention. A study that provides an insight into whether experienced therapists with an open opportunity to consider the influences on their practice choices, would identify cultural difference, or similarity, as an influence upon their practice choices.

The influence of religion and spirituality upon psychotherapeutic practice

Attention to the spiritual appears important when exploring the influences upon the therapeutic experience. West, (2000), described the phenomenon of when the therapist is attentive to the client, yet remaining aware of their own responses, as being akin to the spiritual practice of mindfulness. Others would add that therapists are spiritual healers as well as mental health experts (Faiver, O'Brien, and Ingersoll 2000; Miller, 1999). Again in support that therapy and the spiritual are inextricably linked was a survey by Bilgrave and Deluty, (1998). They took 237 U.S. clinical and counselling psychologists and found that 72% believed that their religious beliefs affected their practice and 62% believed their practice affected their religious beliefs. This survey appears to imply that the religious/spiritual beliefs of a therapist are going to have an influence on their psychotherapeutic choices.

The criticisms of this study are: that it is somewhat aged, the participants were based in America and the potential for the volunteers having an interest in the topic being investigated is probable. A current study with U.K. based practitioners, who are asked to explore all the influences upon their practice choices, may yield something different. If religion/spirituality is viewed as influential, it may also provide a more detailed picture of how this specific influence manifests in practice.

The Influence of the Professional Aspects of the Therapist

The influence of the therapist's professional experience and clinical skills upon psychotherapeutic practice

In 1950, Fiedler's classic study found that experienced therapists who were practising from different theoretical models had more similarities to each other than 'inexperienced' practitioners who were practising from the same theoretical stance. Fielder suggested that once therapists become more practiced, they advance toward a common conception of psychotherapy.

Fiedler's, (1950), study can be critiqued, it has been suggested that the questionnaire that was used could have influenced the findings. Yet, this suggestion that experience effects the boundaried application of the theoretical models raises an interesting point of focus. Upon reviewing the literature pertaining to influences on psychotherapeutic practice, the theme of the amount of experience the therapist possesses, presents itself in an assortment of guises.

Early reviews did not find any significant relationship between therapists' professional experience and client outcome, (Christensen and Jacobson, 1994; Shapiro and Shapiro, 1982). However, more recent studies have been able to disentangle which aspects of the therapist have positive effects on practice. Following many studies reviewing which of the therapist variables are most significant, whilst exploring therapist experience it was found: '… that what is relevant about experience may be general clinical contact rather than the development of specific competencies' (Beutler et al., 2004, p.240). Similarly, Orlinsky and Rønnestad, (2005), concluded that when therapists have been practising for longer, their clients will experience more healing. It is not clearly defined exactly how they gathered the information that the clients had experienced more healing, without this being based upon in-depth client feedback this conclusion that 'more healing' has taken place can be argued.

All of Rønnestad and Skovholt's, (2013), research was built around the assumption that the influences upon the therapist's development and practice changes over the lifespan of their psychotherapeutic career. As previously mentioned they investigated across the career stages and found that there are many influences such as: supervision, therapeutic models, personal life, personal therapy, clients, and that these influences shift in their importance across the five stages of therapist experience.

Also, the relevance of therapist experience emerges again in the literature when reviewing the influence of relational clinical skills upon practice, such as: repairing alliance ruptures, using transference and counter-transference interpretations, and using deliberate self-disclosure as a tool of therapeutic intervention.

Each of these shall be looked at in turn. The concept of 'alliance ruptures' has gained a great deal of focus in the field of psychotherapy. As previously outlined, the therapeutic alliance/relationship has been identified as one of the key ingredients to effective therapy. Therefore, '… a tension or breakdown in the collaborative relationship…' (Safran, Muran, Samstag and Stevens, 2002, p.:236), has the potential to detrimentally affect the therapy process. If a therapist's skill to identify and address such rupture is influenced by experience, as Orlinsky and Rønnestad's, (2005), research would suggest, the influence of experience is a significant one.

The clinical skill of using 'transference' as a therapeutic tool has its roots in the psychodynamic tradition. Transference interpretations can be described as those 'that help the patient to understand the link between their interactions with the therapist and the interactions they experience with others' (Connelly, Crits-Chritoph, Shapell, Barber, Luborsky and Shaffer, 1999, p.487).

A review of the literature reveals a mixed view of whether transference interpretations are enhancing to the therapeutic process. Piper et al., (1993),

found that a greater focus on transference is related to client drop-out. However, when therapists accurately interpret by use of the transference what clients seem to want from others, it leads to a more positive therapeutic outcome (Crits-Christoph, Cooper and Luborsky, 1988). In summary it appears low frequency, but accurate interpretations can have a positive influence.

As none of the literature appears to discuss how experienced counselling psychologists view transference as a therapeutic intervention choice over others, it would be a worthy addition to conclude whether experienced counselling psychologists view transference interpretations as influential upon their intervention choices.

The management of 'countertransference', again a psychodynamically rooted therapeutic intervention, is the management of 'all of the therapist's emotional reactions to clients that are based on therapist's unresolved conflicts' (Gelso and Hayes, 2002, p.267). A qualitative study of experienced therapists revealed that they identified this phenomenon occurring in 80% of sessions (Hayes, McCracken, McClanahan, Hill, Harp and Carozzoni, 1998).

Goldfried, Castonguay, Hayes, Drozd, Shapiro, (1997), suggested that the more skilled the therapist is in managing their countertransference, the less likely it is to affect the therapy. However, few studies have empirically examined this claim. The closest to such is Gelso, Latts, Gomez and Fassinger, (2002), who found that supervisors' ratings of the therapist abilities to manage countertransference gave better client outcome ratings.

In summary, if countertransference is so widely acknowledged as occurring, and if a lack of attention to it is so detrimental to the therapy process, there appears to be a gap in the literature exploring how much emphasis experienced counselling psychologists attribute it to influencing their psychotherapeutic intervention choices. Such information would prove a useful addition to training programmes and clinical supervision.

With regard to deliberate self-disclosure, this poses an interesting consideration of whether this is; a clinical skill, an authentic personal influence upon the psychotherapeutic interventions, or a combination of both. Some of the therapist self-disclosures in the therapy room are more that of a personality/individual nature, such as unavoidable self-disclosures around information like; choice of clothing, wedding ring, unconscious non-verbal gestures. Whilst a deliberate therapist self-disclosure would be when a therapist intentionally discloses a form of information that is personal to them, whether that is a factual statement, or an expression of an immediate feeling which they have decided to reveal.

In this particular instance, the interest is when the therapist makes a conscious therapeutic decision to deliberately disclose to the client some aspect of personal information, and therefore leaning toward this particular intervention being a therapeutic skill, which may be acquired via experience, rather than training. Throughout the literature there is a general consensus, particularly from the psychodynamic model that, the act of therapists engaging in deliberate self-disclosure should be generally deterred (Pope, Keith-Spiegel, and Tabachnick, 1988). There has also been the consistent debate about the ethical risk that is posed by therapist self-disclosure as it may increase the risk of harmful multiple relationships (Strasburger, Jorgenson, and Sutherland, 1992). However, more recent literature is beginning to acknowledge the regular occurrence and use of more experienced therapists choosing to deliberately self-disclose, and the debate is turning more towards how therapists can use self-disclosure most effectively as a therapeutic intervention.

When advising therapists about effective self-disclosure, Roberts, (2012), stated: “We need to keep asking ourselves the same crucial questions: in what ways might this disclosure be helpful to my clients” (p.36). Though therapists may come to different conclusions on whether or not to self-disclose, the literature advises therapists to weigh the positions up for themselves. Audet,

(2011), summarised: “Perhaps the greatest challenge facing therapists in this regard is providing disclosure that conveys some similarity to clients on a personal dimension while simultaneously differentiating them from the client on a professional dimension” (p. 98).

The literature is therefore claiming that deliberate therapist self-disclosure is regularly taking place and that the more recent trend is that therapists are more willing to openly acknowledge such therapeutic interventions. Yet it is interesting that there is a dearth of empirical data that actually reveals how much, and what are therapists disclosing when they are choosing self-disclosure as an intervention in the therapy room.

The amount of therapist experience is also highlighted as being relevant across the literature in that there is an over representation of the student, the trainee, or the newly qualified therapist. This could be due to gaining the time of an experienced practitioner for research can be more challenging, but it may also be that in the earlier stages of practice, the influences are easier to quantify.

Certain relational skills appear to be honed by the more experienced practitioner. Yet what may be suggested as missing is a clearer picture of whether the more experienced therapist’s sees these practiced relational skills such as, repairing alliance ruptures, using transference interpretations, managing counter-transference, using deliberate self-disclosure and the wealth of experience they have gathered, as being influential upon their psychotherapeutic practice.

The influence of the therapist’s training upon psychotherapeutic practice

The necessary attendance and successful completion of a professional training course is seen as a significant factor in the development of the counselling psychologist. The general educational route to gaining the

qualifications necessary to practice as a B.P.S. chartered counselling psychologist is a lengthy demanding one. With this level of demand and rigorous training, the expectation would be that most therapists would identify their training/qualifying course as having a hugely significant influence on their psychotherapeutic practice.

According to some of the literature the attendance of training increases the development of therapeutic skills (Lambert and Ogles, 1997). This offered support to Stein and Lambert's (1995), meta-analysis findings, where clients of therapists with more training did achieve better outcomes. However, there are contradictions in the literature, about which particular aspects of training courses actually have the greater influence on future practice and whether the influence of the training changes over the therapist's career. The main aspects of training that are identified in the literature as being most influential upon therapists are; peers, the personal growth aspect and as already discussed, knowledge of the theoretical models.

In terms of what type of training is most useful and influential upon practice, Beutler, Malik, Alimohamed, Harwood, Talebi, Noble and Wong, (2004), suggest that: 'training that is directed by specific, manualised concepts and tasks tends to produce enhanced results over non-specific and general training' (p.239). Yet there is other research that suggests that specific competence training only marginally increases therapist's abilities to practice in those ways (Crits-Christoph et al., 2006).

Rønnestad and Skovholt's, (2013), study found that across the developmental phases of the therapist, training continued to have a significant impact on the practitioner's development and practice. What also seems apparent in the research is that, the therapist's skillfulness and their credibility, which is often associated with having attended professional training, is associated with positive therapeutic outcome (Orlinsky et al., 2004). If training

appears important to the experienced practitioner it would be expected that they would identify its importance very readily.

The influence of peers in training upon psychotherapeutic practice

Some of the literature shows that the theoretical content and personal development experienced via a training course has the greatest influence on the trainee. Other research highlights the importance of the peers upon both the trainee and the qualified practitioner. Chui, Ziemer, Palma' and Hill, (2014), found that the participants (trainee therapists) generally reported that whilst training, they received expert guidance from clinical supervisors and their peers offered the opportunity for them to learn together. This finding is consistent with Linton and Hedstrom's, (2006), whose participants reported valuing feedback from supervisors, but also the alternative viewpoints offered by their peers. Also beyond training, Rønnestad and Skovholt, (2003), highlighted how newly qualified therapists would measure their work effectiveness using feedback from both supervisors and peers. Thus, although participants may obtain expert guidance from their supervisors, they may still be influenced by their peers' comments offered via informal conversations and group supervision settings.

It would therefore seem that the literature suggests that peers are a particularly significant source of support during the clinical training and in the early stages of post-qualification. The research does seem to neglect the exploration of how influential peers are to the experienced psychotherapeutic practitioner. This might be due to a lack of research in this area, or that peers are expected to become less important to the experienced practitioner.

The influence of the therapist's personal therapy upon psychotherapeutic practice

The personal growth aspect of attending a psychotherapeutic training course is identified in some of the literature as being a significant contributor to

influencing the therapist's subsequent practice, (Skovholt and Rønnestad, 1995).

One of the aspects of training that facilitates such personal growth is the attendance of personal therapy. At various times there have been considerations to relax the requirements for clinical mental health trainees to undergo personal therapy, (Orlinsky and Rønnestad, 2005). This consideration has potentially been due to the more cynical views of the aspect of personal therapy in training. Rizq, (2011), wrote that the British Psychological Society's (2001), training criteria of forty hours of personal therapy, may often be seen by trainees as a necessary hoop to jump through. Although the criteria is framed as being an opportunity to think about, engage with, and come to terms with damaged, or frightening parts of your trainee self, it is worth considering if whether this is actually achieved and thereby, does it truly prevent the qualified psychologist from allowing the vulnerable parts of themselves into the therapy room. Or indeed as some of the literature highlights, is that even remotely possible (Adams, 2014).

A small survey by Rothery, (1992), of Irish clinical and counselling psychologist's attitudes to personal development work, found that all the counselling psychology trainees identified personal growth work as essential. Similarly, Williams and Coyle, (1999), also reviewed a sample of chartered counselling psychologists. These participants identified that by attending personal therapy during their training they had gained three clear benefits: dealing with personal issues, dealing with training difficulties and most of all, learning about therapy. Byrne and Shufelt, (2014), found that although there was no clear consensus in how the personal therapy had benefitted trainees they concluded that, for most of the trainees it does yield some benefits.

Studies investigating the attendance of personal therapy beyond training does begin to grapple with how it influences practice. Around four out of five

psychotherapists have had, or are having their own psychotherapy, (Rønnestad and Ladany, 2006). Studies confirm the perception among mental health professionals, that personal therapy can help them to understand the intricacies of the client–therapist relationship and help them to become more reflective practitioners, (Grimmer and Tribe, 2001; Rizq and Target, 2008; Von Haenisch, 2011). Rizq and Target, (2008), investigated counselling psychologist's views of personal therapy. They concluded that:

> "… participants valued personal therapy as a vehicle for a genuine, intense relationship with the therapist, through which they were able to establish authentic emotional contact with themselves. This in turn helped them to establish a real relationship with their clients, and to acquire a sense of emotional and professional robustness in their clinical work" (p.20).

Yet, the research does not demonstrate a direct relationship between client outcomes and therapists' engagement with their own personal therapy, (Beutler, Malik, Alimohamed, Harwood, Talebi, Noble and Wong, 2004; Rønnestad and Ladany, 2006). In summary, the existing research suggests that the attendance of personal therapy in training yields something beneficial for the trainee. However, these studies fail to highlight in what way, if any, personal therapy during training influences their subsequent psychotherapeutic practice choices (Beutler et al., 2004; Norcross, 2005; Rønnestad and Ladany, 2006). In addition, whilst there is some attention given to the role personal therapy can play in the experienced therapist's practice, it tends to focus on how it may assist in establishing an understanding of themselves. A current study offering U.K. based counselling psychologists, who will have at the very least, attended personal therapy in training, an opportunity to reflect on whether they believe their personal therapy experiences influences their practice choices, will contribute to dealing with the over researched area of personal therapy and trainees or newly-qualified therapists.

The Influence of Clinical Supervision

Within U.K. psychotherapy there is an obligation for therapists to receive supervision (British Association for Counselling and Psychotherapy, 2007). There are several definitions of clinical supervision, but a reasonable description is that it is a structured, boundaried meeting of two therapists with the primary focus being the enhancement of one of the therapist's therapeutic encounters. This is expected to take place through the growth in competence of the supervisee, aided by the supervisor.

It seems the breadth of positive influence clinical supervision has is well documented. Watkins, (1997), discussed the importance of supervision in the development of a therapist's identity as well as providing a safe environment to learn and grow as a therapeutic practitioner. Research by Robiner and Schofield, (1990), suggested that supervision was, and continues to be, within the top five activities on which psychologists spend their time.

However, although the professional bodies, such as the B.A.C.P. demand that all psychotherapeutic practitioners engage in clinical supervision, and with more than two thirds of counselling psychologists providing clinical supervision (Fitzgerald and Osipow, 1986), some research suggests that its actual influence on practice may be questionable. A major review of 144 empirical studies of supervision concluded that there was a general absence of both conceptual and methodological rigour across the research, leaving the measuring and thereby the known effectiveness of clinical supervision in question, (Ellis, Ladany, Krengel, and Schult, 1996; Holloway and Gonzales-Doupe, 2002).

However, Milne, Pilkington, Gracie and James, (2003), via studying supervisory sessions and subsequent therapy sessions, observed, to a marked extent, themes from supervision being directly taken to therapy sessions. Thereby, concluding a direct influence of supervision to psychotherapeutic

practice. Despite the effect of the researcher observing potentially having contributed to the therapist being more mindful of supervision, it is an interesting outcome. In addition, a recent qualitative study found that therapists reported that supervision had a direct influence on their clinical practice; focus, congruence, confidence and safety (Vallance, 2005).

The older supervision research was restricted to examining novice rather than advanced therapists (Holloway and Hosford, 1983). With this limited focus being predominantly on trainees and newly qualified therapists, the more established therapists, who are likely to have different personal needs and professional interests, are not represented (Matarazzo and Patterson, 1986) and may respond differentially to supervision and the influence it has on their psychotherapeutic practice. The more recent research begins to provide more information about the actual influence supervision has on psychotherapeutic practice. With the debate of the real value of clinical supervision being an on-going one, the influence that it has upon therapists and their choice of psychotherapeutic interventions, remains unknown.

Given the complexity inherent in studying the influence of clinical supervision to practice, it may be more shrewd to explore what influence clinical supervision has had upon the moment a therapist makes a therapeutic choice in the therapy room. This study aims to gather data from experienced counselling psychologists, exploring what influences their psychotherapeutic interventions. The importance the discipline places on supervision, may lead one to expect an acknowledgment of clinical supervision and provide insight into how it influences their practice.

Summary of the professional influences

What appears to be indicated from the literature is that the professional development of the therapist, via the areas identified above; experience, training, peers, personal therapy, clinical supervision, are seen to have a varying effect on the therapist. Some of the research indicates that the most

significant difference in how much the; training, peers, personal therapy and clinical supervision influences the therapist, is dictated by whether they are trainees/newly qualified or experienced therapists. Whilst other research disputes, or struggles to prove, how these professional pursuits, offer any direct value to positive clinical practice.

Over the pursuit of proving their role in outcome measures, a 'working' picture, with examples of how these professional pursuits influence an experienced practitioner, who is proficient in what provides positive outcome, might be more revealing of their influence upon practice. It is the aim of this study to allow experienced practitioners the opportunity to reflect on both the personal and professional influences upon their practice choices.

The Influence of External Factors

The influence of the therapy setting

Across the literature, there are plenty of references to the relevance of the settings from which the therapist works. Walsh, Frankland, and Cross, (2004), acknowledged that counselling psychologists not only need to adapt to the needs of the client, but also the demands of the service provider. These providers include: the N.H.S., both mental health and general care settings, Employee Assistance Programmes, (McLeod, 2001), schools, (Cooper, 2013), private practice, occupational health departments, forensic settings, and child and family services.

The type of setting from which the therapy is provided, has often been seen as having an influence upon how the therapist may work with the client. It would seem that the more institutional settings remove an element of individual choice from the therapist via; a prescribed number of sessions, expected measurable outcomes, the choice of models of intervention. Repetitively across the literature, the aspect that is identified as allowing counselling psychologists to provide effective psychotherapeutic input, in many of the institutional settings,

is the provision of evidence-based psychological therapy, (Barkham and Baker, 2003). Which flies in the face of the literature supporting the therapeutic power of the individual client, and the individual therapeutic relationship (Roth and Fonagy, 2005). This throws up a confusing consideration for therapists working in this environment and provides interesting consideration when researching the influences upon psychotherapeutic choices. Whilst the therapeutic setting is well known to influence the theoretical model used, or the type of client seen, or the number of sessions allocated, whether the setting influences the moment-to-moment choices made by practitioners is an interesting consideration. This is something that may be revealed when practitioners are given the opportunity to explore all influences upon their practice.

The influence of the voluntary or involuntary client

If the client is coming to the therapy voluntarily, then they may have very different motivations and thereby have a different influence on the therapy, to that of a client who is attending the sessions involuntarily (King et al, 2005). Indeed, it appears that prescribed therapy may have an adverse effect on the therapy process. Both Lawrence, (2003) and later, Loewenberg and Krege, (2007), found this to be reported when interviewing clients who had been instructed to attend personal therapy as part of the requirements of gender re-assignment.

The voluntary or involuntary status of the client affecting the therapist's direct practice choices is not covered in the literature. Yet it is difficult to accept that this would not have an influence when it is intrinsically linked to; the motivation of the client, the 'power' of the therapist, the purpose of the therapy and the informal hopes of the practitioner. Were this identified as a conscious influence on practice choices it would provide a thought-provoking insight.

Critical Summary of the Literature

So far the literature pertaining to the potential factors that influence

psychotherapeutic practitioner's choices of intervention, consistently acknowledges three contributing factors: the theoretical model, the client and the therapeutic relationship. The more recent research exploring the one particular aspect of the therapeutic relationship – the therapist begins to highlight that not only the professional/skill aspects of the therapist has an influence on the choices and outcomes of psychotherapeutic interventions, but also the personal aspects, of which there are several. The personal factors range from the personal aspects of the therapist such as: personality, culture and spiritual beliefs, to the personal experiences of the therapist such as: their original family environment, life events and well-being. The literature also highlights the importance of the external factors to the therapy, which then influence the psychotherapeutic choices made in the therapy room.

So far, the literature contains several robust and influential investigations of the development of the therapist, yet there appears to be a gap in investigating how these transcend into directly influencing psychotherapeutic interventions. In addition, much of the literature is divided by investigations of either: the personal, or the professional aspects of the therapist, leaving a gap in the literature, with particular reference to investigating all aspects of influence on practice. There is also a need for more of a representation across the literature of counselling psychologists, particularly U.K. based counselling psychologists. The continued emphasis of the influencing factors upon trainee therapists, rather than experienced therapists, also leaves a gap in the knowledge base.

A further critique of the previous research is that lots of the key studies begin wanting to explore a particular aspect of influence on practice. However, there appears an absence of studies that allow the participants to explore all of the influences, personal and professional, upon their psychotherapeutic practice, and to both reflect on the current, but not exclude past considerations.

The methodologies for the studies may also be flawed. There are many outcomes based on self-reporting studies. Some of the aspects of the reliability of this style of data collection have already been highlighted. There are also extensive writings based on colloquial or the personal experiences and opinions of the writers. The issues around the presence of contradictions in such writings do negate some of their value.

Lastly, whilst across the literature, relating to all matters of therapy, there are many examples of client's life stories, presumably as the client's story is seen as being individual, special and unique to them, interestingly there are not many examples of the same for the individual counselling psychologist. Whilst the discipline of counselling psychology, quite rightly, reports the uniqueness of the client and the discipline, the uniqueness of the therapist appears somewhat neglected. The previous studies predominantly seem to want to present conclusions that are universal, rather than unique.

Initial Research Reflections

It is also worth mentioning that there is a personal interest in the subject under scrutiny. McLeod, (2002), clarifies this when he states: 'Presumably most researchers set up studies at least partially because the research makes some connection with dilemmas and questions arising from their own practice' (p.259).

Having attended a training course with a heavy emphasis on reflective practice, I had carried this style forward and this has an ongoing influence on my psychotherapeutic practice. Having been qualified for around five years, I began to reflect on how my practice had changed from when I was newly qualified. These reflections become more and more interesting to me, and when I informally spoke with experienced colleagues, their responses were interesting and revealing.

At this point of reflection, the seeds for this particular study were sown. It was coincidental that around this time I had read Bettelheim's (1976), 'The Uses of Enchantment: The Meaning and Importance of Fairy Tales': and had then incorporated the use of fairy tales in my psychotherapeutic practice. This had triggered further reading around the psychotherapeutic interventions that are not considered mainstream, some of which, such as deliberate self-disclosure, had been positively discouraged by some of my previous supervisors, seemed to now be featuring as a therapeutic choice.

I began to consider whether experienced practitioners might be secretive about how they take some therapeutic 'risks', using interventions that they were not taught on their training courses, or potentially use themselves more in the room than they used to do. I began to ask myself: Wouldn't it be interesting to find out if this is taking place? Wouldn't it be of interest to gain an insight into the usually unavailable processes of the therapy room?

Rationale for the Present Study

Norcross and Lambert, (2011), provide an overview of the field of research exploring the improvement of psychotherapy outcome and state that they encourage; "… the study of the patient, the therapist their relationship, the treatment method, and the context" (p.7).

So although the focus of this study is not to directly explore therapeutic outcomes, when exploring what influences the therapist's choice of psychotherapeutic interventions, the considerations seem to be similar. What the literature appears to indicate is what is of importance is the exploration of the whole of the individual therapist, without exclusion. It therefore appears vital to devise a study that is going to reduce the chance of elimination of any influencing factors from the investigation.

It is hoped that this study will fill the gap in the current literature. At present, there's plentiful literature exploring what improves therapy outcome, but not from the therapist perspective of what influences their specific psychotherapeutic interventions. The current study aims to provide an insight into what a small sample of experienced counselling psychologists identify as the greater influences on psychotherapeutic practice choices, without exclusion, or influence from the researcher. The choice of experienced practitioners was deliberate in trying to balance the previous research in this area, which is heavily weighted to trainees and newly qualified therapists.

The study will aim to enrich the current picture of what influences the psychotherapeutic choices for a sample of counselling psychologists, which may stimulate other counselling psychologists to explore more deeply the different aspects of themselves and their own influences when providing psychotherapy. In addition, empowering counselling psychologists to respond to the individual therapeutic requirements via an increasing range of interventions may also be gained by an exploration that yields the personal life stories of their peers.

This study aspires to explore what eight individual counselling psychologists report as influencing the choices they make when they are providing psychotherapeutic intervention, and to extend the knowledge of the broader factors that impact and interact with individual therapists, in particular, counselling psychologists and therefore the influences upon their individual psychotherapeutic interventions. It is hoped that by approaching the topic from a broad perspective, encouraging the practitioners to include any factors that they feel are relevant to their choices, it would provide a rich array of information. The study will also maintain a focus on the implication for counselling psychology practice, training, peer support and supervision. Thus providing the discipline of counselling psychology with a unique and worthwhile

piece of research with which to share its uniqueness with other relevant psychotherapy disciplines.

For me, I wanted to know these reflections and insights and I wanted to collect them from experienced practitioners, without restriction and without assumption. So a qualitative study of eight counselling psychologists speaking openly and without constriction, about what influences their psychotherapeutic practice, was irresistible not to conceive.

In summary, exploring what a sample of counselling psychologists are doing in their psychotherapeutic intervention and what they believe are the influences upon this seemed an exciting and potentially informative exploration for both myself, the participants, other practitioners and the reflexive-scientist element of the discipline of counselling psychology.

Research Question

What do a sample of counselling psychologists believe influences the choices they make when providing psychotherapeutic interventions?

In order to answer this question, a sample of counselling psychologists will be interviewed and a qualitative methodology – thematic analysis, will be used to analyse their responses. The findings will be presented and a discussion of what was learned alongside the strengths and limitations of the study, the implications for the practice of counselling psychology and suggestions for future investigations will conclude the study.

Chapter 2: Methodology

Overview

The focus of this chapter is to provide a detailed account of the process of the research. The chapter begins with identifying the research aims, followed by an outline of the epistemological position, from which the data is understood. The chosen research methodology is then explored and discussed, before describing the method of data collection used in this study and exploring the step-by-step process used to analyse the data. This is followed by an exploration of any ethical issues, concluding with an exploration of the reflexivity of the methodology and its potential short falls.

Research Aims

This study aims to explore what a sample of counselling psychologists would identify as influencing the choices they make during the process of implementing psychotherapeutic intervention. These influences would be identified via interview and inferring a link to how they make choices when delivering psychotherapeutic intervention. The data would be anlaysed by carrying out a thematic analysis of the individual interviews carried out with eight experienced counselling psychologists.

It was expected the findings from this study would add to the understanding of the range of psychotherapeutic interventions that counselling psychologists are providing and the breadth of influence that leads to such interventions. It was also hoped the findings will provide a snapshot of what is influencing a sample of counselling psychologists‘ practice, which may assist other practitioners in improving their confidence with the provision of less recognised interventions. Finally, the aim was to create a picture of a sample of counselling psychologists‘ personal journeys and what they see as the potential influences to their professional psychotherapeutic interventions.

Epistemological positioning

The aim of this study is to access the experiential world of the participants. It is assumed that their experiences and the social environment, within which they are created, are affected and shaped by a broader social context. It is with this in mind, that the approach to this study is positioned within social constructionism (see Burr, 1995). A social constructionist position essentially rejects the idea that an objective reality exists in the world. However, it seems that in order to construct this reality, the world in which we exist has a heavy influence and thereby gives each individual their meaning of the world. Crotty, (1998), captured this succinctly, suggesting that meaning arises through the individual's engagement with the world and arising from these interactions is a co-constructive process that is individual to each and every person. It is from this epistemological position that this study is constructed.

Choice of Methodology

Qualitative over Quantitative - A qualitative methodology

The largest body of work within the field of qualitative research in psychotherapy consists of studies exploring the experiences of therapy. These have been from both client and therapist perspectives. Therefore there was a lean towards a qualitative methodology. However, in order to decide on a qualitative over a quantitative methodology, it seemed important to reflect on several things. The first reflection was on what was the desired data. In this particular study, the intention was to gather some of the practice experiences of a small number of practicing counselling psychologists. Secondly, what would this data be used for? The conclusion being that the data would be explored, summarised, interpreted and reported. Thirdly, the aim was to allow the participants the freedom to identify their influences and convey this to me, the researcher, without constraints. Fourthly, as this exploration was arising from my own reflections on practice, I wanted to acknowledge the active role of the researcher across all aspects of the study. Finally, Bergin and Garfield, (2013), capture my motivation for the study and my hopes of what it would achieve:

“The appeal of qualitative research in the experience of therapy is that it offers participants a voice, and helps de-familiarize taken-for-granted practices in ways that allow clinicians to remain receptive and responsive to clients and trainees” (p.56).

Therefore, as qualitative methodologies aim to: produce a comprehensive description and explore a particular experience in detail, and therefore working well with a small number of participants, whilst acknowledging the role of the researcher, a qualitative methodology seemed be the most appropriate for this exploration.

A qualitative methodology

In order to investigate eight individual chartered counselling psychologists’ experiences and what they believe influences their choice of psychotherapeutic intervention, a qualitative research methodology was required. It was thought that this methodology was most likely to encourage the participants to fully explore their thoughts and feelings on this complex topic. Once again, in the spirit of encouraging the participants to fully express themselves with as little confinement as possible, one-to-one interviews, were chosen with as little participation from the interviewer as was possible. Therefore such a qualitative methodology needed to be participant led and, by the nature of the methodology needed to encourage the participant to describe their own experience of providing psychotherapeutic intervention and be able to make their own connections.

The qualitative methodology that facilitates the gathering of such data is a thematic one. Thematic analysis is a method for identifying, analysing, and reporting patterns i.e. themes, within the data. It organises and describes your data and then goes on to interpret the various aspects of the research topic (Boyatzis, 1998).

Thematic analysis is a methodology that fits very neatly with the research aims; to explore the world of the eight participants and to provide a rich thematic description of the data. Providing a rich overall description and summary that would be useful to the practice of counselling psychology. A thematic analysis also fits well with my epistemological position of social constructionism. This essentially is a rejection of the idea that an objective reality exists in the world, but rather that an individual's truth is created via their engagement with the world and arising from these interactions is a co-constructive process that is individual to each and every person.

Thematic Analysis in Psychology

Thematic analysis involves searching across a data set to find repeated patterns of meaning. It has some overlaps with other analytical methods and it has been described as a foundational method for qualitative analysis. Holloway & Todres, (2003, p.347) identified "thematizing meanings" as a generic skill required across qualitative analysis. However, Braun & Clarke (2006) maintain that thematic analysis is a method of analysis in its own right.

The methodology is a flexible tool, which provides a rich and detailed analysis for the most complex of data. A starting point when exploring thematic analysis is to consider what a theme is. "A theme captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set" (Braun & Clarke, 2006, p82).

Thematic Analysis for this study

Willig, (2008) states that qualitative research allows the researcher to tap into the perspectives and interpretations of participants facilitating the generation of new understandings. Thematic analysis is a method for identifying, analysing, and reporting patterns (themes) within data (Braun & Clarke, 2006). It is said to offer "an accessible and theoretically flexible

approach to analysing qualitative data… [and is] a useful and flexible approach to analysing qualitative research in … psychology" (Braun & Clarke, 2006, p. 77). Moreover, Boyatzis, (1998), suggests that thematic analysis not only reports data but interprets various aspects of the research topic. These aspects of thematic analysis mean that it has the potential to uncover and provide a: "rich and detailed yet complex account of data" (Braun & Clarke, 2006, p.78).

When considering thematic analysis, it seemed essential to uncover any of the potential flaws. One of the focal criticisms of thematic analysis is that when compared to a biographical methodology, which can obtain the consistencies and contradictions in an individual's account, the thematic can lose the sense of continuity of a participant's data. However for this particular study, it was decided that the biographical continuity of the individual data was not essential, as without it the identified influences to practice can still be extracted.

Considerations prior to collecting the data

Rich description or detailed account

Prior to collecting the data it's important to consider what the broader aims of this study were. With a thematic methodology there are two options: a rich description of the data set, or a detailed account of one particular aspect (Braun and Clarke, 2013). For this particular piece of research the aim was to gather a rich overall description of what a sample of counselling psychologists saw as influencing the choices they make during the process of implementing psychotherapeutic practice.

Inductive or theoretical deductive

A second consideration when using a method of thematic analysis, is that the themes that are gathered within the data can be identified in one of two primary ways: an inductive or 'bottom up' method, (Frith & Gleeson, 2004) or a theoretical deductive or 'top down' (Boyatzis, 1998). The inductive approach

requires the themes to be directly linked to the data and for them to be coded without trying to fit them into a pre-existing frame of coding. In order to explore what influences the choices counselling psychologists make when delivering psychotherapeutic intervention, an inductive approach was most appropriate.

Semantic/explicit or Latent/interpretative

Thirdly, there is a decision around the 'level' at which the themes are to be identified. This can be at a semantic/explicit level, or at a latent/interpretative level (Boyatzis, 1998). The semantic approach identifies the themes within the explicit meanings of the data, looking very little beyond what the participant has said. This is in contrast to the latent level which goes beyond the content of the data, exploring the underlying ideas and ideologies. For this particular study the semantic/explicit level of analysis of the identified themes would be the most appropriate. This process does not mean merely describing the data, but rather organizing the data to show patterns in content. The theorising of the significance of the patterns, their broader meanings and their interpretations (Patton, 1990), this is often done in relation to previous literature (Frith and Gleeson, 2004).

The primary source of data collection for the qualitative researcher is via interview. The aim of the interview in this particular study was to provide the participant with the best opportunity to fully explore all of the potential influences to their psychotherapeutic practice, free of influence or bias from the researcher.

Some of the qualitative literature advises the researcher to keep a log of the context of each interview, the setting, clarifications that were asked for, and any comments that were made by the participant pre or post recording. As a reflexive researcher, this was considered. However, it was decided that as the participants were likely to already be disclosing so much personal information, to note down further information external to the interview recording, felt

bordering on overly invasive. In addition, an interpretive tool such as a researcher's log also appeared out of keeping with the chosen semantic level of analysis. With this level of analysis of the contextual features it would be attempting to provide some level of analysis beyond what the participant had said during the interview.

In summary, when exploring what eight experienced counselling psychologists identify as influencing their psychotherapeutic choices, an interview appeared best placed. It is commonly reported that when the investigation has an experience-type question, where the participants have a personal interest, an interview yields the better data. The interview would be structured in such a way to capture the data without intrusion, or suggestion from the researcher. It is the expectation of the yield of 'rich' data, that leads to the process of a thematic analysis being the most likely to extract the data, gained via the interviews, in the most meaningful way.

Method of Data Collection

Recruitment - Criteria

Only chartered counselling psychologists who had been consistently engaged in clinical practice for a minimum of the previous six years were asked to respond to the recruitment advert. The reason for this was because the focus was on the professional and personal journeys of a sample of counselling psychologists that I believe could only be gained from an established practitioner. There was also the possibility that practitioners with less clinical experience may not have established a wide and varied set of interventions and have the confidence to discuss these in an interview setting. The minimum of six years post chartership, and consistently engaged in clinical practice, were the only criteria for interview inclusion.

Ethical Issues

Prior to the recruitment of the participants, ethical approval was obtained from City University. In addition, the British Psychological Society's 'Code of Ethics and Conduct' (British Psychological Society, 2009), the 'Ethical Principles for Conducting Research with Human Participants' (British Psychological Society, 2004) and Health and Care Professions Council Ethical Framework, (2007), were referred to and adhered to throughout the research process. These ethical considerations are referred to in more detail further in the chapter.

Advertising

Once the ethical board of City University had granted ethical approval, the recruitment process began. A recruitment advert was placed in the British Psychological Societies (B.P.S.) members' monthly magazine – The Psychologist. It was also posted via the City University student intranet (A). In addition ten counselling psychologists who fitted the criteria and were listed on the B.P.S. List of Chartered Psychologists were written to, either by post, or e-mail, using the recruitment letter shown in Appendix B. Accompanying the recruitment letter was also a participant information sheet (Appendix C).

The recruitment information detailed; the research, the participant's required level of qualification and clinical practice, the participant's required involvement and how to contact the interviewer. Those who expressed an interest were sent a participant information sheet (Appendix C) and consent form to read (Appendix D). The forms provided more information about the research, its purpose, their potential role and how their confidentiality would be protected.

As this investigation was likely to include personal opinions/information, consideration needed to be extended to the gathering of the data and the likelihood that personal material may be discussed during this process. Clandinin & Huber, (2010), support the position of the researcher being an

empathic listener, offering respect and a non-judgmental attitude that is applied across all aspects of the research material from interview, to analysis, through to the written piece. I therefore attended to this notion throughout the study, most importantly in my handling of the participant's information, (see more below) from the practical handling of such data, through to the analysis. I did so by being mindful of risks to confidentiality, attempting to accurately represent the participant's data.

Protection of Confidentiality

Firstly, there needed to be consideration as to the location of the interviews. It was important that the participant's would not be overheard by a third party. Secondly, the storage of the consent forms and the tapes and transcripts of the interviews would need to be stored securely and separately to any identifying information. This was decided as the participants would be writing their names on the consent forms and this could decrease the chance of them being matched to the interview tape/transcript. Once the interviews were transcribed, these were also kept in a locked cabinet.

Participant Well-Being

By the very nature of the subject of the study, it was possible that participants may have found the interviews and the conversation they had, aroused an emotional response. It was made clear to the participants that the interview could be terminated at any point, and each participant was given the opportunity at the end of the interview to discuss any concerns they may have, or any emotions they may be feeling. They were also advised, via a de-brief information sheet, that should emotional issues arise from the interview, they should speak with their clinical supervisor or trusted colleagues. However, the overall hope was that the sensitive handling of the interview process would leave the participants feeling they had gained an opportunity to gain further insight and validation.

For those willing to participate they made contact with the interviewer, via e-mail or telephone, to confirm their willingness to participate. The interviewer then discussed, either via telephone or e-mail, with the individual potential participant their preferences for time, date and place to conduct the interview.

Brief Profile of the Participants

Following the advertising process, nine counselling psychologists volunteered to participate in the study. All of the therapists met the criteria of a minimum of the previous six years practicing. All of the volunteers were female; they were all working in private practice with some of them working a smaller percentage of their working week in the N.H.S. Three of the participants had been qualified and practicing for over fifteen years, whilst six participants were nearing ten years qualified and had been in clinical practice throughout. The participants were located in differing areas across England and Wales.

Interview Settings

The interviews were carried out in a different location for each participant. Each of the participants were asked to choose their preferred date, time and location for the interview. The pilot study interview took place in my home. Four of the participants asked for the interview to take place in their homes. Two of these participants, had a room in their homes from which they provided private therapy sessions and this was the room that was used for the interviews. Whilst two of the participants suggested we conducted the interviews in their lounges. For one participant, arriving at her home had meant that prior to the interview; I met both her husband and children. One of the participants asked that the interview take place at City University where she was also studying. I facilitated a room being available and met with the participant at their chosen date and time. The room was not known to us, and had not been used by either of us in any other capacity. During the telephone conversations with two of the other participants, whilst discussing the logistics of setting a location for the interviews it became apparent that the preference of

the participant was that of a neutral setting and this was arranged. The choices of locations available on both occasions were limited; this was mostly due to needing a quiet area to conduct the interview where the tape-recording would not be negatively affected by other noise, and the geographical location being convenient for the participant. For both of these interviews, conference rooms in a hotel were chosen as being a setting that would cater best for all the necessary requirements. Finally, one of the participants requested that the interview took place at the clinic from which she provided private practice therapy sessions.

Pilot interview

Although I have previously interviewed and audio recorded individuals, I wanted to conduct a pilot interview. Firstly, my reasons for wanting to conduct a pilot study were more practical. I wanted to carry out a test of the audio-equipment and figure out: how to get the best sound possible and the better place for the audio-recorder to be positioned. Secondly, I wanted to practice my technique of interviewing and ensure that my one opening statement was enough to ensure the participants were confident enough to begin and continue to speak openly and honestly about the subject that was the focus of the study.

One of the volunteer participants was known to me. We had previously studied together for an MSc in Counselling Psychology therefore we already had an established relationship. The reasons for choosing this participant for the pilot study were a mixture of availability and the thought that should the interview not run smoothly, she would be likely to be understanding. Also the individual, whom was known to me, was the first person to volunteer to be interviewed, and in following the granting of ethics approval, her availability was immediate. It was therefore decided that although the potential was for some very meaningful data to be produced, it was also hoped that the familiarity would be useful in encouraging the participant to give honest feedback of what

had been the strengths and weaknesses of the interview experience. A pilot interview was carried out, the pilot question is below:

> **I am interested in where the therapist gains influence from when they are providing psychotherapeutic intervention. Please feel free to speak of both past and present.**

Throughout the pilot interview I became aware that the very open question that I had designed, which I had chosen so as not to influence the participant's focus, was a little too open ended and seemed to leave the participant uncertain where to begin her story. The opening statement was then extended, (Appendix E). This revised statement invites participants to share the full picture of what influences their psychotherapeutic practice and the re-wording encourages them to speak of both their 'personal and professional life'. The statement also aims to reduce concerns about judgment of their practice, as I did not want a 'textbook' explanation of the interventions that these participants were providing to clients.

In addition, during the pilot interview, without any participation from the interviewer, it seemed to lead to a 'drying up', or risk of a loss of the salient aspects of the participant's full influences to practice emerging fully during the interview. It was therefore decided that, at certain points in the interview, whilst maintaining as much coherence to the participant's description of their experiences, the interviewer would be able to clarify and encourage further exploration. It also provided the opportunity to clarify or encourage further exploration of certain topics.

Materials

The materials required for the interview were, an audio-recorder and recordable tapes, an interview schedule and a quiet room suitable for a confidential interview. The papers that are listed below were also used:

recruitment advert, (Appendix A); recruitment letter, (Appendix B); participant information sheet, (Appendix C); consent form, (Appendix D); interview schedule, (Appendix E); and debriefing information, (Appendix F).

Interviews

Prior to the commencement of the interview, the participants were once again presented with the information sheet (Appendix C) this had also previously been e-mailed to prospective participants. The participants were invited to ask any questions. They were then presented with a consent form to sign, confirming and reminding participants of the steps that would be taken to protect confidentiality and the limits of such. The interviews were audio recorded. Interviews ranged from fifty minutes to one and a half hours in length. There was not a time limit set for the participants, once they indicated to me that they had said as much as they wanted, they were thanked and the audio recorder was switched off. Participants were then given written debriefing information (Appendix F). The participants were all given a period of time in which to de-brief. This consisted of offering the participant the opportunity to speak about how they had found the experience and ask any questions. Participants were also reminded that any issues that may occur to them about the interview or research, they could contact me, details were given and more personal or clinical issues that may arise were encouraged to be discussed with their clinical supervisor or trusted colleagues. They were thanked again for their generous giving of their time and participation.

Method of Analysis

For this particular study, the interest lay with the identifying of the influences to psychotherapeutic practice that were presented by the participants. It was believed that in order to yield these, following Braun & Clarke's, (2006), process of thematic analysis would be likely to provide this outcome. In order for this study to reach the criteria for having been a good

process of thematic analysis, Braun and Clarke's, (2006), 15- point checklist was followed (See Appendix I).

Thematic Analysis

The steps that were followed for the thematic analysis were:

1) Transcription/Immersion
2) Initial Coding
3) Identifying Themes
4) Reviewing Themes
5) Defining and Naming Themes
6) Presenting the Themes

Stage 1 – Transcription

As with other qualitative research methods, the analysis of the data occurs throughout the research process, rather than separately after collection and during analysis of the data (Gehart, Tarragona, & Bava, 2007). Some researchers believe that the transcribing of interviews should be seen as "a key phase of data analysis within interpretive qualitative methodology" (Bird, 2005, p.227). Therefore I knew it was important to transcribe the interviews myself. I also considered when I should carry out the transcribing. The consideration being that I did not want to begin to gain some insight into the material and allow this to affect how I may interview any future participants. As the interviews were spread out over a six-month period of time, I therefore left all transcribing until after the last interview took place. I also saw this as further adhering to the inductive style of the research.

The transcription of the eight interviews took place over a period of approximately four months. Whilst transcribing the interviews, it was noted, that there were specific areas of influence upon practice that each participant appeared to refer to. The areas that repetitively presented themselves across the interviews were noted down on the transcripts and potential coding

schemes began to evolve. Later, during the thorough process of thematic analysis, these would contribute to the identifying of the coding across the data.

During the transcription of the interviews, the reporting of the data was that of a 'verbatim' account of all verbal comments, including for example, 'er', 'um', 'you know'. Some of the more identifying data such as names of individuals, university names and geographical locations were omitted or changed. Personal life events or departments in which participants may have worked could lead to some identification of the participant or a third party. However, some such information seemed so essential to the concluding data, as the study was about identifying what influences psychotherapeutic practice, which often included personal life events/experiences, it was decided that to remove all possible information that could lead to potential identification, as it could detract from the richness and meaning of the data. In order to address this, each completed transcript was sent to the relevant participant and if there was any material which they felt uncomfortable in its inclusion, it was omitted from the transcript. Only two of the participants asked for alterations and these were more of a grammatical request. It was explained that the transcriptions were verbatim and that it was unlikely that the grammar of the participants would be scrutinised. All of the participants were given pseudonyms.

Immersion

Once the transcription for each interview was completed, I embarked on an absolute immersion into the data. This involved the repeated reading of the transcripts. This was an active process, searching for patterns in the data and repetitively mentioned influences that could later become themes of the data findings.

In order to demonstrate how this process was rigorously followed for each part of the transcripts, below is an extract from a transcript where some of the influences are highlighted.

"I think my own experience would be that each of those approaches and many more are very valuable as individual approaches but also I believe that **none of them (theoretical models)** basically is foolproof or had 100% of the answers, so I think I found **through my training and also having qualified** and even up to date that I find **I kind of move in between different theories and approaches** depending on what the **client needs** and I find that the working alliance is obviously, **the therapeutic relationship, obviously is the most important thing** with the client. Then it is considering you know other elements **transference, person to person aspects, the transpersonal, what the client mentally needs and what is required at the time** and I think that sort of **underpins all my therapeutic work** and how that represents and manifests in a session is very much down to I think again **how many sessions I have with a client or the client needs, the relationship,** and that can be very, very different".

This extract demonstrates that the participant mentioned several potential aspects of influence upon her practice that could later contribute to the forming of the themes. These are: the theoretical models, ever changing approach, client needs, therapeutic relationship, transference, transpersonal, how many sessions available.

Stage 2 – Initial coding

Upon re-reading the transcripts many times, gives way to the generation of an initial set of notes written on the hard copies of the transcripts (see Appendix G). These notes identified the interesting points of the data, which began to answer the research question, for this particular study, these would be the repetitively mentioned influences to psychotherapeutic practice. During this stage, there was the application of codes to the data. The codes were given to any part of the data that seemed to be directly answering the phenomena under

scrutiny, i.e. identifying an influence upon the choices made in psychotherapeutic practice. Boyatzis, (1998), referred to this as: “the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon” (P.63).

This stage of the thematic analysis was done by systematically, working through each transcript and manually identifying the repeated patterns (themes) across the data. The process of coding is seen as all part of the analysis (Miles & Huberman, 1994), as you are organising the data into meaningful groups (Tuckett, 2005). The coding was carried out by writing the key word of the influence upon practice in the margin of the transcript (Appendix G). If the influence appeared set in a lengthy quote and without the context, the meaning would be lost, then all of the necessary data was underlined. A common criticism of coding is that the context is lost (Bryman, 2001).

The generation of the codes was ‘data driven’, this was important as other than the broad research question, I did not approach the interviews with specific questions in mind. The aim was to carry this approach through the research.

This coding was done for all of the transcripts. The short extract below shows an example of the initial coding of the data:

“I think that from my own life over the years, I evolve how my therapy work has evolved if you know what I mean. My life and things that have happened in my own life, um, and have been exposed to very much more, very much more vulnerable times and it’s been um, I guess, it’s been I suppose sometimes noticing that when a more vulnerable time has been sometimes the work feels, I don’t know, a bit more, it’s kind of a bit richer or something, I don’t know. I perhaps wondered what that’s about. Is it about parts of myself being less defended at those times. Like not so vulnerable that I shouldn’t really be

seeing anybody - I don't mean that sort of extra something, you know very traumatic that slices right across your life so that you really just have to stand back for a while, but times of different vulnerabilities, um, I think affect the work, my work, and I have had, I suppose, unusual weird things have happened that have been very - what's the word - felt very connected at times when maybe I didn't ever anticipate it".

Coded for:

1. Psychotherapeutic practice evolves over the years
2. Life events contribute to practice evolving
3. Life events cause therapist vulnerability
4. A vulnerable therapist produces a richer therapeutic connectivity
5. A vulnerable therapist is less defended
6. There is a limit to how much vulnerability can be tolerated whilst continuing to practice.

Stage 3 – Identifying Themes

Once all of the data has been coded and collated, it provides a long list of codes, which begin to form a picture of what the individual participants identified as the influences to the decisions they make when providing psychotherapeutic practice. The collating of the codes into potential themes, then allows for a thorough analysis of the codes, which begins to form the overall themes and the sub-themes. At this stage a theme has a central organising concept that tells the reader something meaningful about the content of the data (Braun & Clarke, 2013). It is important that only the themes that were answering the research question were selected here (Appendix H).

This process of analysis 'sets the stage' for beginning to think about how the codes might fit together to form themes, and how there might be potential relationships between the themes. For an initial thematic map of this early stage

of the identified themes, this can be seen in Figure 1 (page 224) referred to in the next chapter.

Stage 4 – Reviewing themes

Once the set of themes had been devised, the reviewing and refining of them was necessary. During this part of the process there were certain previously identified themes that did not hold as separate themes, and could neatly fit under other identified themes. In order to clarify which were the distinct themes, a review of the coded data was carried out. The review involved re-reading the extracts and thematic summary for each participant and deciding whether they provided a coherent pattern. If they fitted with the identified theme then they were left in. However, if the data did not coherently fit it was extracted and a new theme was devised.

Once this process had taken place, the themes adequately captured the data. They could then be summarised very clearly and gave an accurate representation of the data. The themes fitted together to tell an overall story about the data and gave an interesting springboard for consideration of the overall story they are now telling about the data. Braun and Clarke recommend once the researcher is happy that the themes fit the coded data adequately, then try and visually represent the themes to check their validity in relation to the data set. In other words, they recommend a consideration of whether the themes offer an accurate representation of the data set as a whole (Braun & Clarke, 2006).

All of the influences to practice that were identified by the participants can be captured under one of these seven identified themes. For the refined map of the themes this can be seen in Figure 2 (page 225) referred to in the next chapter.

Stage 5 – Defining and naming themes

At this stage, the thematic map of the data helps in the further defining and refining of each theme. Braun & Clarke, (2006), p.22, referred to this stage as the identifying of the 'essence' of each theme. By doing so, there is not just an overall picture of the data, but also there is an identifying of what each theme is about, and what aspect of the data each of the themes capture. This then allows the content of each theme to be summarised in a few clear and concise sentences. This alongside the thematic map, which can be seen in Figure 3 (page 226), referred to in the next chapter, provides a succinct summary of the data findings.

It is worth noting here, that whilst some of the themes were directly related to by the participants as being influential to them, others were merely discussed in the interview. I have at these points assumed, which are my own assumptions and do not reflect any form of absolute truth, that although the participant did not present a sentence directly connecting the event to influencing their psychotherapeutic practice, the mere fact they are discussing it, is taken that they see this theme as a significant influence upon their practice.

During the course of phase 6, the write up stage, the themes identified on this final map were used as the headers. Here the detail of **the themes and** their sub-themes are described with accompanying extracts of data to illustrate the data findings. This shall be presented in the next chapter.

Throughout the analysis of the data Braun and Clarke's the 15-point checklist for 'Good Thematic Analysis' was followed (appendix I).

Reflexivity

Reflecting on the process of carrying out a piece of qualitative research is part of executing good methodology (Willig, 2008). Once I had decided that I wanted to interview experienced counselling psychologists, I began to look forward to meeting them and gaining an insight into what was influencing their

practice decisions. I was faced each day of my clinical work with such choices and was thrilled that I was going to have the opportunity to discover what others were ‘calling on’ when making these decisions.

A continued level of researcher reflexivity was going to be essential across the study, especially as I was going to carry out the role of interviewer and was using a qualitative methodology, with potential for researcher bias within the process of data analysis. It is important to acknowledge the researcher's own personal processes as well as theoretical position and values since data coding cannot take place within an epistemological vacuum (Braun and Clarke, 2006). Throughout the study I reflected on the reality that I am a researcher who is also a practicing counselling psychologist. Whilst acknowledging that this may have allowed for the participants to feel that they may be offered a deeper level of understanding in the interviewing process, it may also have had a more negative effect on the participants. Therefore whether the effect was positive, negative and inter-changing, the reflection of the effect of my role on the interview process and gathering of the data will have been likely to influence the material that was obtained. The impact of my presence on the data is explored further in the chapter dedicated to the discussion of the research findings.

In addition it is also worth noting that, prior to transcription, I reflected on the “status of the text” (Willig, 2008). The study greets the ‘text’ as it stands, it is that participant’s perspective as they told it on that day, and it is therefore their truth co-constructed through their own lives and the world in which they move. At all stages of data collection and analysis, I am aware of both myself and the potential for interpretation of meaning to take place. As far as that which is within my conscious control at data collection, I ward against such and remain conscious throughout the process of analysis not to allow what I am hoping to find to influence this.

Chapter 3: The Results of the Thematic Analysis

Overview

A thematic methodology was used to analyse the data. Whilst reading the results it is worth considering that the findings are influenced by my part in the process of analysis and my own subjective perspective. The interview of the participants was a particularly enjoyable aspect of the study as it provided me with what I had personally and professionally craved at the point of conception of the study.

Prior to presenting the themes individually and in some detail, both an introduction to the participants and an overview of the findings will be presented.

Introducing the Individual Participants

Each of the participants seemed to find the interview experience an enjoyable one. They all seemed to speak openly and with reflection and consideration to what they wanted to convey in the interview. Following the interview, each of them reported having enjoyed the opportunity to consider this area of investigation. Some of the participants mentioned having not previously made connections with certain aspects of the data, and appeared to have found this useful and interesting to them, potentially both personally and professionally.

Below is an introduction to the eight individual counselling psychologists who participated in the study. The information is not intended to offer a character summary, but rather provide a context and a social, relational backdrop, from which the reader can consider the themes. I also wanted the study to provide other counselling psychologists with an insight into what colleagues were doing and an understanding of the potential reasons for doing such. It was therefore hoped that the brief introduction of the participants,

together with the thematic summary, would provide a rich insight. The participants are presented in the order their interviews were conducted.

Carol – Participant 1

Carol was born in Ireland and brought up in an area where family and community are important. [redacted]

Pauline – Participant 2

Pauline is a well-established practitioner; she began practicing in the 1980's. [redacted]

[redacted]

Catherine – Participant 3

Catherine is a woman who is moving towards the end of her working life. [redacted]

Georgina – Participant 4

Georgina's parents are Italian-Catholics; [redacted].

Helen - Participant 5

Helen began her interview by speaking about the sudden death of her father when she was a child and identified that this had sparked an OCD reaction in her. [redacted]

[redacted]

Annie – Participant 6

Annie began her interview discussing a time in her life when she had struggled with her own psychological well-being. [redacted]

Lucy - Participant 7

Lucy had completed a degree in psychology and then gone on to work in business and industry in London. [redacted]

[redacted]
[redacted].

Sonya - Participant 8

Sonya did not speak of her career prior to training in counselling psychology. [redacted]

Overview of the findings

Stage 6: Presenting the themes

Having transcribed the interviews, all of the data was coded; this was done by following the procedure outlined in the previous chapter. These codes then provided the picture from which the themes and sub-themes were constructed. To assist in making sense of these themes and how they fit together, a diagrammatical model was designed.

See Figure 1 (p.224) - A map of the initial themes

This initial map suggests how the themes might fit together. The central rectangle shows the core aim of the study, which is to identify the influences to psychotherapeutic practice choices. Coming from the central rectangle there are four circles, each of these represent an over-arching theme. The small squares are the sub-themes of these themes.

The circle on the top left-hand side has three boxes coming from it. These are the themes that were identified by every participant as consistently influencing their practice choices; the theoretical models, the client and the therapeutic relationship. Directly below this circle is another. This circle captures one of the sub-themes stemming from the over-arching theme of the ever-changing external influences upon practice choices, of which there are two; the therapy setting and logistics. On the right-hand side, the ever-changing influences continue to be captured by a further two themes. These are: the personal aspects of the therapist and the professional aspects of the therapist. From these two themes there are further sub-themes identified. Under the theme of the professional aspects of the therapist that influence practice choices are: clinical training and professional reading, work experiences, clinical supervision, time since qualified, and professional reading. Under the theme of personal aspects of the therapist that influence practice choices are the following sub-themes: personality, personal choice/opinions, life events, family

environment, health and well-being, instinct/intuition, lifespan stages, religious/spiritual beliefs, culture and philosophies and values. In between the circles representing the personal and professional aspects of the therapist, there is a double-ended arrow representing the sub-theme of the therapist's personal therapy. This was difficult to place as a definite sub-theme of either the personal or the professional aspects of the therapist as it falls into both sides of the therapist.

Following this stage of the analysis there is a further refining of the themes. This refining process is outlined in the previous chapter. The resulting refined data showed that all of the influences to practice that were identified by the participants, could be captured under one of seven themes. To assist in making sense of these refined themes and how they fit together, a diagrammatical model was designed.

See Figure 2 (p.225) – A map of the refined themes

The map shows that there remain two distinctive over-arching themes; the consistent theme and the ever-changing theme. Of the consistently influential over-arching theme there are three sub-themes; the theoretical model, the client and the therapeutic relationship. The influences that are ever-changing form an over-arching theme, of which there are four sub-themes; the personal aspects of the therapist, the professional aspects of the therapist, the personal experiences of the therapist and the external influences upon the therapy.

The final stage of analysis is the defining and naming of the themes. In the literature this is described as the 'essence' of each theme. For this study the core findings show there are two types of influences to practice choices, these are either; consistently present or ever-changing in their emphasis. From each of these two influences there are three sub-themes, the consistent influences to

psychotherapeutic practice choices are; the theoretical models, the client and the therapeutic relationship. The ever-changing influences to psychotherapeutic practice choices are, in order of the greatest to the least influential: the personal, followed by the professional aspects of the therapist and lastly the external therapy setting.

See Figure 3 (p.226) – A final thematic map

The Over-arching & Sub-themes

As previously mentioned, this study found that there are two 'over-arching themes' and from these, three sub-themes emerge. We shall firstly look, in more depth, at the three sub-themes of the consistent and enduring over-arching influences to psychotherapeutic practice choices.

A) The Influence of the Theoretical Models

All of the participants mentioned the psychotherapeutic models of intervention and some of them mentioned them several times during their interview. Carol described each individual psychotherapeutic model as being somewhat restricted as none of the models have: "100% of the answers". Carol reflected that at the time of training she had used the models in a purist sense and later had become more accustomed to using the different theoretical models in combination:

> Carol: "…**I think I have found through my training and also having qualified and even up to date,** that I find I kind of move in-between the different theories and approaches". Adding: "If one model….no space for the uniqueness of the individual".

It is worth highlighting that Carol speaks of the influence of the theoretical models as being throughout her practice, from her training to her current practice and whilst the theoretical model that she calls upon changes,

throughout her interview she refers to their influence of them as being ever-present in her psychotherapeutic practice.

Pauline had started practicing from a person-centered model, then early in her career was, “straddling” both person-centered and psychodynamic models. Pauline described keeping the cognitive “slightly aside” and whilst working in family therapy she had used a systemic model of psychotherapeutic intervention. Pauline said that she had always had her “eyes open” to different models and was open to adding to the “tool bag”.

Whilst interviewing, Pauline mentioned that at all stages the theoretical models had been influential, whilst training, the psychodynamic model had:

Pauline: “…made a tremendous amount of sense”.

However, she stated that she currently did not feel the need to be purist and described her current psychotherapeutic model as, “… I have become integrative”. As with Carol, Pauline speaks at length about the part the theoretical models play in her influencing her psychotherapeutic practice from training to the current time. Stating that the models are what a practitioner has to understand the person, she is therefore always adding to the tool bag:

Pauline: “… my eyes are always open to different models”.

Again, as with Carol implying that although the type of model is constantly changing the influence of the theoretical models has an enduring influence upon psychotherapeutic practice choices.

Catherine also described using an integrative model of psychotherapeutic intervention. She described how her preference for which of the theoretical models she predominantly used had changed over her years of

practice, however her reference to their importance and influence was peppered across her transcript.

Georgina stated that she was initially interested in the psychodynamic model of intervention and wanted to be purist, but found that her personality pulled her another way. Georgina described having continued practicing using the psychodynamic model until she finished her first counselling qualification (marriage guidance) and then began to integrate some of the other models. She felt the choice to integrate psychotherapeutic models was as much to do with her personality as the client group she was working with. She stated that prior to attending the counselling psychology training course, which was integrative; she had already started to integrate some of the models. Georgina went on to describe the influence of the theoretical models to be as present in her current practice as it was when she was training, however the current variety of the theoretical models that influence her are wider than when she was training.

Helen said she was initially led to C.B.T. by her interest in the symptoms of Obsessive-Compulsive Disorder – (O.C.D.), which is well-researched as responding best to cognitive-behavioural therapy (C.B.T.). However, she also has interests in psychoanalytic styles and since initial training has carried out further training, reading, and sought personal therapy with therapists working from differing theoretical models. Interestingly, whilst demonstrating a very current and long-standing deferment to theoretical models, Helen stated that models are only part of the story, adding the theoretical models are:

Helen: “… only as good as the therapist delivering them”.

Annie described having a strong affiliation with the Jungian model of intervention, however, added that she was not purist and rejects all the models in their purist form. Annie, like other participants, also believed that her choice to integrate the models had been a personal one. Annie added that all that she

has learnt about the models has been helpful, adding that for every therapy session, she takes all of her knowledge of each of the models into the therapy room with her.

Lucy reported that she was trained in Cognitive Behavioural Therapy (C.B.T.), psychodynamic and person-centered and she likes Cognitive Analytical Therapy (C.A.T.), relational, existential, narrative and systemic. Adding, that she finds person-centered interesting. Lucy identified her choice of theoretical model was what aided her to understand the client before her. Like the other participants, Lucy believes that her favouring of an integrative model of psychotherapeutic intervention is about the client need and herself as a person.

> Lucy: “They are good boundaries to have and use in my mind, but actually they’re just someone else’s theories...But by nature, I’m more of a magpie. I would never be purist in any form… I think my natural way is to take things from other areas…”

Lucy’s transcript supports the ever-present influence of the theoretical models and their influence upon her practice choices seem taken for granted.

Sonya stated that, historically, the psychotherapeutic models would have more heavily influenced her practice choices, but they remain influential in her current practice. She described having an interest in psychodynamic, object relations and systemic models of intervention. Sonya said her use of the psychotherapeutic models is of an integrative style. However, her liking of the systemic model was apparent and that this was based on an aspect of her personal view of the world. Adding that the systemic model was in-line with her own way of thinking. Therefore as others reported, Sonya described the models as ever-present influences to the choices made in her psychotherapeutic

practice. In addition, the choice of which of these models she refers to is influenced by her.

> Sonya: (theory) “it’s just ingrained and maybe it suits my eclectic way of being to have a tool in my tool bag and I draw it out”

In summary, every interviewee credited the theoretical models as influencing their choices of psychotherapeutic intervention. By what the participants mentioned, it can be deduced that all of them use an eclectic/integrative approach. Whilst ascribing some of their choice to work from a variety of models, as being responsive to client needs, training and work experiences, they also ascribed their choice, as being significantly due to their own personalities and personal interests. In addition, all of the participants spoke of the influence of the theoretical models as being enduring and consistent, spanning from their early training to their current practice choices.

B) The Influence of the Client

All of the participants mentioned how clients have a large influence upon their choice of interventions. They also identified a range of aspects of the client, which then influences their choice of psychotherapeutic intervention:

> Pauline: “Practice is influenced by who you have got sat in front of you in the room…”

> Annie: “…it depends what they are presenting with…”

> Catherine: “I tailor something to the client’s needs, no good me deciding what they need.”

Each of the participants, directly referred to the fact that each client’s needs are different, and therefore their practice choices need to be varied,

flexible and responsive to this. This is demonstrated below by quotes from Carol, Georgina and Sonya, describing the client's needs and the range of difference between clients as affecting her psychotherapeutic choices:

> Carol: "….things change, you know, the client comes with one issue and the real issue is something different, I think I it is being flexible to allow for that'.
>
> Georgina: "…clients don't just offer one thing, they come multi-dimensional".
>
> Lucy: "… go at their (client) pace".
>
> Sonya: "The core me is a changeable flexible one and I change and fit to that client".

All of the participants indicated that their approach to their psychotherapeutic practice is unique and heavily influenced by the individual client and that particular client's needs. Pauline, Sonya and Catherine identified that the focus of the psychotherapeutic work would be led by what the client identified as a priority. Annie identified the client's motivation, would have an effect on her psychotherapeutic choices.

Pauline added that how she may 'feel' with a client would have an influence upon the type of intervention she may deliver. Pauline also added that the style of thinking of the client would affect the psychotherapeutic model she may draw from:

> Pauline: "If the client is into thinking patterns, I can step over and be cognitive…"

In summary, the participants identified the client's needs as greatly influencing the intervention choices made in the delivery of the therapy. As well as what the client identifies as the priorities, the client's thinking style, their motivation, how the therapist "feels" with the client, the client's level of functioning and their strengths. Thus indisputably supporting the literature that the client is consistently influential to the experienced counselling psychologist's psychotherapeutic practice choices.

C) The Influence of the Therapeutic Relationship

All of the participants identified the therapeutic relationship as being hugely influential in the choices they make whilst providing therapeutic intervention. Below are the key quotes.

Carol: "… underpins all the work".

Pauline: "… integral part of the therapy".

Catherine: "The rapport with the client is very important, has to run under everything, then I think the methods and the clinical stuff comes in".

Georgina: "…beyond words...your unconscious' collide in the work and that's what makes the difference".

Helen: "It's a connection… the validity of those personal experiences…they make change, they make a difference, they matter".

Annie: "… developing the relationship is the first skill… then you use your knowledge and expertise to work creatively with that person".

Sonya:"… the therapeutic relationship is the centre of my work".

All of the participants spoke at length about how the therapeutic relationship can provide the basis for the therapeutic work to take place, and that it is a powerful precursor for therapeutic change and it is something that is co-created between themselves and the client. All of the participants made several references throughout their interviews to the therapeutic relationship and all of them professed this was a very important influence upon the choices they make in the therapy room.

As shown, all of the participants identified; the theoretical models, the client and the therapeutic relationship as being consistent and enduring influences to their choices made when providing psychotherapeutic intervention. These eight experienced counselling psychologists describe the nature of these three influences as being consistent and enduring across all stages of their practice experience.

The second 'over-arching theme' was the ever-changing influences to psychotherapeutic practice choices. The three sub-themes of this 'over-arching theme' are: the personal aspects of the therapist, the professional aspects of the therapist and the external setting. We shall begin with what was the most commonly referred to of these three influences to practice: the personal aspects of the therapist.

a) The Influence of the Personal Aspects of the Therapist

With regard to this as an influence upon psychotherapeutic practice choices, all of the participants referred to many aspects of themselves and their lives and how these influenced their choices of therapeutic intervention.

<u>Personal aspects</u> of the therapist that influence psychotherapeutic practice choices

The influence of the therapist's personality

At many differing points across the interviews, all of the participants made reference to their personality influencing several different aspects of their psychotherapeutic practice choices. Whilst there were references to their personalities influencing their choice to become a therapist, or playing a part in influencing their choice of theoretical model:

> Georgina: “Choosing the theoretical model is as much to do with my personality as it is the client group”.

Georgina also stated that the skills she applies during the provision of therapy are part of her personality:

> “… my default position is that you know people seem to seek me out and talk to me and I seem to be able to sit and listen and reframe with them…”

The participants also made reference to the type of client they chose to engage with as being dictated by their personality. **However, most importantly, the participants also made reference to their personality influencing their decisions made when providing therapy.** Carol described what she takes to the therapy room is:

> Carol: “… a combination of the personal attributes, personality, character of being a psychologist”.

> “Something about the personality and the presence of the psychologist being very important in the work.”

Sonya made direct reference to her personality traits, describing herself as impatient, non-conformist and straight-forward. She added that she believed

each of these aspects of her personality are present in the therapy room and the choices being made when she is providing psychotherapeutic intervention.

The participants also made reference to the relational aspects of their personalities as influencing their psychotherapeutic intervention. Some participants also identified how their personality traits are the therapeutic interventions that contribute to the healing of the client.

Lucy: “I’m very congruent, very genuine, very real…”

Sonya: in the room “it is me and it is how I see things and how I think”.

To continue with the personal aspects of the therapist, all of the participants made reference to how they saw their: life philosophies, values, personal choices, opinions, interests and intuition influencing their therapeutic intervention choices. Each of these sub-themes shall now be presented in more detail.

The influence of the therapist’s life philosophies/values

Carol stated that she thought all people are interlinked and that it is going through pain that leads to healing. Carol also stated that she held a strong sense of morality and right and wrong, with a belief in the provision of the N.H.S. and fair access to healthcare for all. Pauline, Georgina, Lucy, Annie and Sonya all shared the view of equal access and an equal life for everybody with everyone existing on one level.

Lucy: “… egality, equality, empowering people and they are probably my underlying philosophies”.

Pauline saw humans as existing in a series of systems, which have a constant effect upon them. Helen held the view that her goals and things she

would choose to put energy into would have to matter to her and match her value system.

Georgina stated that the vulnerability of the client does not deter her as she has a belief in the robustness of the human condition. In terms of her own journey through life Georgina stated that:

> Georgina: "… sometimes opportunity finds you rather than the other way around".

The effect of this belief on her practice choices seemed to be one of promoting optimism in her approach and a capacity to seize the opportunities that may arise in the therapy room.

The participant's life philosophies seemed influential not only in their own goals, but those they would encourage when engaged in psychotherapeutic practice. Such insights were:

> Carol: "… going through pain leads to healing".

> Lucy: "… no point planning to get goals that matter little at the end of the day".

> Annie: "… human beings need to be engaged in meaningful activity".

> Lucy: "… there but for the grace of God".

> Sonya: "… I do not have a pre-conceived hypothesis about someone".

Each of these philosophical approaches whether it be about life, clients, therapy or well-being, were seen to have an influence upon the choices these

counselling psychologists were making in the delivery of psychotherapeutic intervention.

The influence of the therapist's personal choices/interests/preferences

All of the participants spoke of their personal choices, interests and preferences and the influence of such on their psychotherapeutic practice. To begin with Carol, during her interview she mentioned,, several times, how her personal preferences were influential to her practice. She stated that one of her guides for choosing work is that it fits her on a personal level and that her choices and in that her provision of psychological therapy has to "feed" her on a personal level. Carol added that she had always "taken on" and done things that she has enjoyed and liked.

When speaking of choosing to be a psychotherapeutic practitioner, Pauline said that, despite the challenges to keep going with one to one client work, she had felt this type of work was meaningful to her and so she wanted to carry on and not let go of it. Pauline also spoke of her style of delivering intervention as having to make sense to her thus chooses a way of working that is "akin to her".

Catherine also used the word "enjoyed" when speaking of practice and she used this with particular reference to working with clients who have anxiety based problems. It is this type of work that Catherine predominantly undertakes, and she directly linked this as due to being the type of work she prefers(.), adding that she believes this 'enjoyment' to be apparent in her therapeutic approach. In a similar vein, Helen also described having a strong personal interest in O.C.D. and this had fed her desire to work with people who experience O.C.D. Helen also spoke of her natural personal preference in something logical and this influences her choices and her method of delivery of the therapy. So when looking at training and practice, Helen has chosen to work

in a way weighted towards evidence based practice and the psychotherapeutic model of Cognitive-Behavioural Therapy (C.B.T.).

Georgina also expressed having a real interest in people and how this had influenced her choice to practice counselling psychology: "… what people did and what made them tick". In addition, Georgina's own creative interest in art, led her to be interested in art therapy and influenced her desire to bring this to her psychotherapeutic practice and later in her career influenced not only her choice to work with children, but also influence how she provides this therapeutic intervention.

With regard to Annie, she described her interest in psychology as growing from her personal journey with her own issues and subsequently her own psychological therapy. Annie believes these experiences are with her each time she steps into the therapy room. She also added that her interests in other interventions, that enable psychological well-being, are also present in her practice decisions.

> Annie: "Sometimes enhancing people's sense of well-being is through them gaining skills, not through them doing therapy**".**

Lucy described her personal preferences in all aspects of life to have a direct influence upon her therapy practices. Similarly, Sonya spoke of her personal interest in tarot card reading and how this had influenced her to train in counselling psychology. Sonya had felt that her ability to read tarot cards was very similar to the skill or, "instinct", of a therapist and she had felt that the training and the discipline would give her a legitimate title from which she could merge her personal interest and a professional skill.

The influence of the therapist's opinion of psychology and psychological therapy

Not all of the participants referred to what they actually think of psychology and psychotherapeutic intervention. However of the ones who did, of whom there were six, because these opinions appear so influential, they seemed a valuable sub-theme in the personal aspects of the therapist and what influences therapeutic practice choices.

Carol defined psychology as a 'formalised' way of looking at the person, that psychology allows one to see the world through different eyes and that as a psychologist:

Carol: "We are exposed to a different type of life and death".

Pauline stated that in her early days as a therapist, she saw psychological therapy as feeling "real" to her, and at the time despite teaching psychology at a university, she had really wanted to combine the therapy side with the academic psychology and practice as a therapist. For Pauline, providing interpersonal therapy gives her something meaningful, "almost the privilege". Helen saw her provision of psychological therapy as being something useful she was giving to clients and something she has a skill in providing.

The opinions of the power of therapy provision when located in the N.H.S. weren't always positive ones. Annie held strong opinions about the concept of therapy, revealing that she had moved from a place where she thought everybody needs therapy, to believing that "therapy is over-rated", useful to only a small percentage of people. Annie saw the acquisition of skills as enhancing to the well-being of many clients. Her concern was that the provision of therapy is inward thinking. Her role in the decisions about the allocation and justification of psychology services seemed somewhat influential in this view.

Sonya stated that counselling psychology should be available in all areas of life. However, she felt that the profession itself almost prevented this:

> Sonya:"… before we can do that, we need to come out of our high towers".

Georgina described the discipline of counselling psychology as having a philosophical approach to the therapeutic work, therefore differing to the concept of a set of tools or interpretations. Whilst Lucy's opinion about the concept of therapy was that it is transitional and contextual.

> Lucy: "What we know from history is that things change, so our best attempts to define and analyse and look at therapy are simply people's views and they're all situated in who they were and where they were at the time".

Indeed, it appears relevant that the counselling psychologist reviews the provision of psychology and their own belief in its power to heal. Which then appears instrumental in not only influencing the practitioner's capacity to provide therapeutic intervention, but also to whom and how they do so.

The influence of the therapist's instinct/intuition

Not all of the participants referred to intuition in their interviews. However, of the five participants who did refer very directly to their instincts and intuition being an influence upon their choice of therapeutic interventions, they seemed to do so when considering several aspects of their intervention choices. Pauline identified early in her career that her choice to continue with the provision of psychotherapy was an intuitive one as in logistical terms it would have been easier to move away from it. In addition, Pauline refers to her instinct and how she feels with a client to guide her in her psychotherapeutic choices. Similarly, Georgina spoke of her psychotherapeutic interventions having an intuitive

content and being led by how it feels to her. Georgina also added that her choice of training course was directed by how it felt:

> Georgina: "… actually a lot of my life has been directed by a kind of intuitive feel".

Helen provided a succinct summary of the biggest influences to her practice:

> Helen: "My gut instinct is that it's my personal experiences because they matter to me more than something dry, theory driven, written on a piece of paper… I have a hunch, if it works, then good".

> Lucy: "I do very much listen to my gut".

Lucy went on to describe her practice as becoming both intuitive as well as "head led". Sonya referred to intuition in the context of her speaking of her history of tarot card reading. She stated the aspects she felt tarot card reading called upon, included:

> Sonya: "… intuition, deeper empathy, listening, observing…"

At the end of the list Sonya said: "tell me that's not counselling psychology"? Throughout the interview, Sonya also made several references to having the skills of instinct and intuition. She said: "I am very instinctive and intuitive…" However, with reference to referring to instinct in the therapy room and the practicing of psychotherapeutic intervention, Sonya seemed to believe it becomes more relevant as she becomes more and more experienced:

> Sonya: "… it becomes just ingrained, instinctive and natural and you can communicate it in that way and therefore clients don't necessarily feel therapised…"

From the remarks made and the series of references, it can be inferred, that these participants see intuition as an important aspect of what takes place in their practicing of counselling psychology. At times, the participants describe their intuition/instinct as being their greater guide, over other factors, in the therapeutic encounter. There is also the implication that this particular influence is one that is listened to more as the experience of the therapist establishes.

The influence of the therapist's culture

Two of the participants, Carol and Sonya, identified culture as having an influence upon their psychotherapeutic interventions. In both of these examples the participants were referring to their own cultural background influencing their psychotherapeutic choices and what influence their culture may have, in the form of a less conscious intervention, in the therapeutic room.

Carol referred to her Irish upbringing as influencing her to be caring of others and to offer help to the community in which she lived. During interview Carol identified this cultural aspect as influencing and beginning to equip her with the skills to be a counselling psychologist. Sonya spoke more of the influence of cultural background has on influencing both her conscious and unconscious psychotherapeutic interventions.

> Sonya: "… culture does in a way get in there… just your colour alone communicates something to the client in the room and it has meaning….. it says years of suffering, this person is going to understand me because they have been there… I weigh that up in the room…"

For Sonya, it appeared that she is aware of the influence that her ethnicity has on the psychotherapeutic work and she chooses her interventions according to how much of an effect she believes the ethnicity to be having in the therapy.

The influence of the therapist's religious/spiritual beliefs

Each of the participants made reference to their spirituality or religious beliefs. Carol mentioned that she was Catholic and was brought up with a strong Catholic influence. Carol said that as a counselling psychologist she thought the relevance to her practice was that she believes the philosophies of the main religions are similar.

Catherine appeared, during the interview, to feel uncomfortable with confirming that she had a religious belief system and this discomfort seemed to extend to the therapy room:

> Catherine: "I might have spiritual or religious beliefs, but I wouldn't dream of putting those out for the client".

Catherine was not alone with being cautious to declare having religious beliefs. Georgina added that she had felt in some arenas, for a psychologist to have a religious faith was seen as not being "rigorous enough". However Georgina stated that she felt there was very much an ethos of God in her work with clients, describing it as the most important influence upon her work:

> Georgina: "It's not sexy for a psychologist to have any kind of set of beliefs that surround; I'm going to say faith and God… I have been in some circles where it is not O.K. to be a psychologist with a faith".

Helen's emphasis was not organised religion, but the spiritual, believing there is a spiritual aspect to everyone, she described it as a "humanistic spirituality". She did make reference to how this spiritual belief may influence how she frames the therapeutic process:

> Helen: "… we are both (her and the client) on a human journey together".

Annie also made reference to how she does not belong to an organised religion, but sees that, for humans, there is currently a lack of “connectiveness” and “meaning in their lives” and made reference to how this is relevant in the therapy that she is providing. Similarly, Pauline also spoke of the ‘unusual’ things that can occur in the provision of therapy which when this takes place, it can strongly influence the level of connection with the client. Sonya also referred to spirituality and the human condition, highlighting that, toward the end of their work, many of the great theorists had come to the conclusion, that therapy is more about spirituality. Sonya stated that she believes the spiritual will influence the client that she psychotherapeutically works with:

> Sonya: “I believe you get the client that suits you, clients kind of oscillate to the right therapist”.

Lucy is engaged in the provision of therapy for those who are facing existential questions and are potentially facing death. In her practice her capacity to work with the existential is paramount and having had her own existential encounter is influential in how she manages this with clients in the therapy room.

In summary, of the participants who affiliated themselves with a denomination of organised religion, whilst they acknowledged that it potentially influences their psychotherapeutic practice, in particular the reflective process, they seemed to carry some discomfort with overtly acknowledging this both in and out of the therapy room. Of the participants who referred to their spiritual influence in less of an organised religious perspective, all referenced it as influencing how they view what is going on in the therapeutic encounter.

The influence of the therapist’s personal <u>experiences</u> that influence psychotherapeutic practice choices

The influence of the family environment

Five of the eight participant‘s spoke of the direct influence of their original family environment, firstly in influencing them choosing a career in psychotherapy and secondly, influencing the choices they make when they currently practice.

Carol believes that her original family environment influenced her choosing to qualify and more relevant to this study, it influences how she practices as a counselling psychologist. She spoke of the supportive nature of her family to others in the local community and the shared pursuit of caring professions across her family members. Carol holds the belief that her original family environment and her family’s beliefs about people, influences: her beliefs in her clients, her application of the transpersonal, her wider therapeutic approach and the decisions she makes in the provision of psychotherapeutic intervention:

> Carol: “My family are people orientated… friendly community… All my family members chose the caring professions…”

In addition to Carol, a further four participants, Helen, Georgina, Annie and Sonya, mentioned their family environment as influencing their pursuit of a career in psychotherapy and influencing the decisions they make in the delivery of psychotherapeutic practice. Below are some key extracts:

> Helen: “The loss of my dad at age 10 years… I have talked about dad’s death before, but not in terms of linking it with wanting to be a psychologist”.

> Georgina: “My family background probably had an influence and where I was positioned in the family as the eldest of four children, may have had an influence as to why I chose this profession”.

Annie: “… married when I was seventeen… by twenties a single-parent of three small children” triggered an interest in psychology.

Sonya: “If the question is what impacts me as a counselling psychologist, or what kind of things have influenced me in my practice and in my journey towards being a counselling psychologist, I have realised that as a result of this conversation, there is actually much more of my early childhood experiences than I would have imagined”.

These previously referred to five participants, also identified very particular aspects of their original family environment and how they see these as being an instrumental influence upon how they currently make psychotherapeutic practice choices. Carol thought that she had learnt from a young age that you help/support the people you have around, both in the family, as the eldest of six children and in the wider community, the emphasis being that you work to have a connection to the people you come into contact with.

In addition, to influencing her wanting to be a psychologist, Helen identified the death of her father when she was ten years old as contributing to her having symptoms of Obsessive-Compulsive Disorder - O.C.D. She believes this influenced her subsequent interest in delivering therapy to clients experiencing O.C.D. Helen also believes this experience of O.C.D. makes for a better level of understanding of the client and consequently providing a more refined psychotherapeutic intervention.

Helen: “… and they (clients) seem to be able to pick that up in me as well, and I get a lot of ‘gosh you are the first person who ever really got this”.

Helen added that her personal experience with O.C.D. led to her developing a logical approach to the management of these symptoms. She

believes this personal experience with O.C.D. and the personal appeal of the logic of C.B.T. influences her using this theoretical model in her current psychotherapeutic practice.

Georgina explained that she has a strong interest in the non-verbal aspects of psychotherapeutic intervention. She believes this interest is due to the relationship she had, as a child with her mother, which caused her to struggle with the pre-verbal stage in her own life. She went on to explain that, in her teenage years her mother had required her as the eldest child, to be her confidante and she had learnt to “listen well”. Georgina connected this to providing her with some of the essential skills for providing psychotherapy.

Annie referred to her original family environment and her difficult teenage years as having an effect on her views of people and their emotional needs. She spoke of falling pregnant at a young age, consequently learning early responsibility and caring for others, as now being influential upon her practice skills and beliefs. She spoke of her own mental health challenges at this time as influencing how she understands the human condition and her gauging of what is going to work with someone.

Whilst Sonya identified being fostered from a very young age led to her learning that she needed to work with difference, assess and read the situation quickly, understand it and respond appropriately to it. Sonya felt this was very much what she was doing when she was providing psychotherapeutic intervention.

> Sonya: “I have had to analyse situations and understand them. I have been doing it since day dot”.

In particular, Sonya thought that her lack of one role model, during her formative years, might also contribute to her not choosing one main model of psychotherapeutic intervention, but rather choosing an integrative model.

In summary, the aspects of the original family environment that influence practice choices are varied; a caring aspect family environment, the elder child, having a mother that needed support, loss, early responsibility and foster care were each identified. The influence upon practice was also varied; client group preference, listening skills, life philosophies, caring, assessing, working with difference, non-verbal expression, theoretical model preferences, connecting with people, understanding.

It is also worth mentioning that the three participants who did not speak of their original family environment, were chronologically older than the five participants who did mention their original family environment. In addition, two of these three participants had chosen counselling psychology later in their careers and all of the three participants, who hadn't spoken of their original family environment, did speak about more recent life events as having a significant impact on their psychotherapeutic practice. These shall be explored more below.

The influence of the therapist's life events & well-being

Beyond early original family environment experiences, all of the participants identified specific life events, and they all made reference to how they believe their own particular life events have been influential to their psychotherapeutic practice. Carol made a very clear statement identifying what is occurring in a therapist's own life has an influence upon how they may practice:

Carol: "What happens in personal life, affects professional practice".

Carol identified the recent illness and subsequent loss of her father, her young nephew needing chemotherapy and the end of a long-term intimate relationship, as all having an influential effect on her and her psychotherapeutic practice. Carol made several statements that illustrated how she saw her personal life affecting her professional psychotherapeutic practice. One of these was:

> Carol: “Going through things myself on a personal level actually improved my practice… When you are in the worst place yourself you do the best therapeutic work”.

Carol was not alone with these beliefs. Catherine believed that her own life events, particularly the difficult ones. Catherine described experiencing her understanding of clients as having “… widened and deepened” and in doing so this improved her psychotherapeutic practice:

> Catherine: “I think death and loss has helped me to understand something of what some clients who have had those experiences are going through”.

In addition to Carol and Catherine, both Georgina and Helen mentioned their own personal losses as being influential to their psychotherapeutic practice. Georgina referred to her recent loss of her aunt to cancer as being influential in her decision to change the type of client group with whom she worked. She also made reference to the demand of certain psychotherapeutic work interrupting her grieving, and this need to grieve had influenced her decision to alter her style of practice, referring more to play and art therapy in her choices of intervention.

In Georgina’s interview beyond the life events, she draws a connection of her own life stage (mid-life) as having an effect on her psychotherapeutic practice. Georgina believed that in addition to the loss of her aunt, her current

life stage as pre-menopausal, changed the way she practices. She expanded upon this by describing her existential awareness sharpening and in consequence this features more frequently in her practice reflections.

Regarding Helen, the life event she identified as influencing her practice was experienced in her original family environment, for Helen, this was as already discussed, the loss of her father when she was aged ten years.

Pauline made several references to having experienced vulnerable times in her life. She believes that during these times her psychotherapeutic interventions were different and she referred to when the vulnerability exists in her personal life, the influence upon her professional one is apparent. Pauline spoke of it influencing her therapeutic choices, which manifests in her giving more of herself to the therapeutic encounter and hence giving way to a richer experience:

> Pauline: “I think that as my own life over the years evolve how my therapeutic work has evolved… My life and things that have happened in my own life… I have been exposed to much more, very much more vulnerable times… when a more vulnerable time has been sometimes the work feels, I don’t know, a bit more, it’s kind of a bit richer or something… is it about parts of myself being less defended at those times? I don’t know… a stillness that can come with personal vulnerability… helps the process”.

It had been a particular life event that had triggered Lucy into training as a counselling psychologist. Whilst receiving treatment for breast cancer, she had accessed psychological support and having been through her own existential crisis she felt it was the right career for her. As a result Lucy works in a service supporting people with cancer, she believes she is a relational practitioner, who is not trying to be the expert but is trying to help the client

explore. Lucy states that she is genuinely trying to understand and support the client to be able to face the challenging 'stuff'.

Whilst all the participants made statements that implied that their own personal life events such as: experiencing loss, family illness, breast cancer, menopause, life challenges, responsibility, distress, had an influence upon their well-being and their practice, they all stated that they had enhanced their psychotherapeutic practice. This is captured by Sonya:

> Sonya: "… they (her life events) make me do this job in my own idiosyncratic way".

b) Professional Aspects of the Therapist that Influence Psychotherapeutic Practice

The influence of the therapist's personal therapy

With regard to the influence of the therapist attending her own personal therapy, it was challenging to decide whether this sub-theme was a personal aspect of the therapist or a professional aspect. In reality it straddles both the personal and professional and this is highlighted by its positioning of personal therapy on the 'initial thematic map' of Figure 2.

Four of the participants did not make any reference to their own personal therapy. However, it can be assumed by the requirements for B.P.S. Chartered status, all of the participants have engaged in their own personal therapy at least during their training. Of the four that did mention their personal therapy, there were mixed thoughts about it.

Helen reported having had therapy with a Jungian analyst, a Lacanian therapist and group therapy on her counselling psychology training and had attended a group therapy training course. Whilst Helen was not positive about all of her therapy experiences, she did report that she thought that attending

therapy had helped her both personally and positively influenced her psychotherapeutic practice:

Helen: “I worked through a lot of stuff.”

Helen added how it has helped in practice with: “… staying with clients… really important skills just being able to hold distress and being able to hold very uncomfortable feelings”.

In addition, the attending of personal therapy from a psychodynamic position had caused her to feel what she described as a power imbalance and this has influenced her to pay attention to this in her practice choices and to refer to evidence-based models in her provision of psychotherapeutic practice.

Annie mentioned having attended personal therapy when she was in her late twenties. She said that she had been “struggling” and was referred to a clinical psychologist. Annie framed this experience as facilitating her to gain more interest in the practice of psychology, we could interpret from her subsequent choice to go on and train as a counselling psychologist that her own personal therapy experience had been a positive one for her. Annie does not mention any further experiences of therapy, although her training route would have required such. Annie did not mention how her personal therapy influences her therapeutic choices.

With regard to Lucy, she mentioned having attended personal therapy on two separate occasions. Firstly, she had attended therapy for a year, following her experiencing breast cancer, then once again during her counselling psychology training when she had engaged in personal therapy. Lucy reported that she felt the therapy had been “massive” and that she “turned over a lot of stuff”.

Sonya spoke at length several times about her personal therapy experiences and her beliefs about its importance to her as a therapist. Sonya felt that her process of personal therapy had meant she had addressed a lot of her personal issues:

> Sonya: “You really need to get down and dirty with your own crap in order to allow you to work with clients, and I think yeah I’ve done that”.

Sonya stated that this process “allowed” her to work with clients. She added that it wasn’t necessary for the therapist to have resolved their “stuff”, but just to be prepared to look at it. Sonya had strong opinions about therapists needing to have engaged in personal therapy, asserting that therapists who had not engaged in personal therapy were expecting the client to participate in an activity or reach a state of awareness that they had not yet experienced.

> Sonya: “... I do think you need to have walked the walk”. Otherwise you expect...” the client to be open and exposed in a way that they have never been able to do”.

To summarise, the experience of attending personal therapy was one shared by all of the participants. However, only half of them acknowledged its influence upon their psychotherapeutic practice. Of those who did refer to it as an influence, they reported a mixture of things being gained by the process. The ability to be a better version of a practitioner, to deal with their own issues, to experience the process of being in therapy and consequently legitimise the expectation they have of their clients.

The influence of the therapist’s education, training and reading

All of the participants mentioned various aspects of their educational journey. Each participant spoke of the training course that led to them qualifying as chartered counselling psychologists and they all spoke of this training as

being influential upon their therapeutic practice. I shall provide a summary of the routes taken to acquire chartered counselling psychologist status and of their influence upon practice.

Carol had initially trained in general nursing, then gone on to train in counselling psychology, she had done so via the B.P.S. independent route attending a course convened by Petruska Clarkson. Carol ascribed Petruska as having a significant affect upon her training; attending clinical supervision with her further compounded this. For Carol the main influence that her clinical training has upon her current psychotherapeutic practice is the skill to integrate the different theoretical models. In addition, Carol identified the ability, to have placements during training with different client groups, currently influences her practice by enriching it and giving her confidence to apply different tools of intervention.

Both Pauline and Annie trained in several theoretical models and gained B.P.S. Chartership via the independent route. They both identified the attendance of courses, originating from a cross-section of theoretical models, led to them practicing from an eclectic/integrative model.

Georgina also described her training as equipping her to practice with an integrative theoretical model as her primary influence.

> Georgina: "… psychodynamic, C.B.T., humanistic and being able to integrate them very well".

The majority of the participants, Catherine, Georgina, Helen, Lucy and Sonya, trained via structured university integrative counselling psychology training courses. Catherine described having happy memories of her counselling psychology training, with a strong C.B.T. influence, which remains her predominant model of choice. Helen had followed a more traditional route of

an undergraduate psychology degree, counselling psychology training with a systemic, evidence-based emphasis. Again, Helen claimed it is the evidence-based models that influence her current psychotherapeutic practice, but this may have been her already comfortable influence upon her practice, with the training merely compounding such. Sonya, believed that her training has a significant impact upon her current practice and identified that training in a systemic model has been particularly influential upon her practice. Sonya spoke at length about the institution where she chose to study as it continues to influence both her practice and how she sees the therapist's own stuff as central to the therapeutic process.

In addition, throughout both Carol and Annie's interviews they make numerous mentions of their educational and training experiences. It could therefore be assumed that these were seen as relevant activities, which remain relevant influences upon their current practice choices.

With regard to reading, two of the participants, made reference to reading professional publications. Helen did not seem convinced that reading had a great influence upon her psychotherapeutic choices:

> Helen: "... read a hell of a lot of papers, but I can't think of any of those particularly having affected me".

However, holding an opposite view to Helen was Lucy who stated that reading had a very direct effect upon her psychotherapeutic interventions.

> Lucy: "… I was reading loads and loads and I'm still reading and finding my practice is existential…it's magpie, bits that I gleam from other people, that I've read somewhere…read things and absorb them, then it comes out (in practice) intuitively".

Whilst Carol did not directly make reference to material she had read, she did make the statement that you:

Carol: “... can’t unlearn something”.

It could be assumed by this that Carol sees all of her educative experiences as having an influence upon her psychotherapeutic intervention.

The influence of the therapist’s clinical supervision

All of the participants identified clinical supervision as influencing their practice. Carol made reference to supervision amongst the mix of other influential things she had received from Professor Petruska Clarkson:

> Carol: “…a combination of the training, of supervision, therapy and academia and she used to always say it was very hard to separate them”.

Pauline made reference to supervision in the context of her belief that it had influenced her choice of psychotherapeutic model. Pauline recalled that the supervision she attended, via one of her early counselling posts, was psychodynamic and therefore she described how this moved her practice into something much different to before; suggesting that Pauline saw supervision as having a substantial effect on her choice of psychotherapeutic practice, especially in her early days of practice.

Georgina made reference to supervision and several relevant aspects of this particular sub-theme. She referred to liking the supervisor she had in her early days of training and as this supervisor was psychodynamic, this influenced her own initial interest in the psychodynamic model. She also made reference to the supervisor having a strong faith and as Georgina, in other parts of the interview, makes reference to her own faith, we could deduce that

Georgina's mentioning of the supervisor having a faith, also provided Georgina with an additional aspect which she valued when reflecting on her clinical practice.

Helen also made reference to supervision she had received early in her practice experience. Helen spoke of a supervisor she had experienced when she was an assistant psychologist who she described as:

Helen: "… still in my head now when I practice".

Similarly, Lucy made a very definite reference to having had supervisors working from three different psychotherapeutic models, with each having a very direct influence on her:

Lucy: "… so three kinds of supervision. I use all of them and love it".

Sonya spoke of her experiences of supervision, but her thoughts on its influence upon her practice seemed mixed. Sonya stated that she had found supervision; "hit and miss". However she added that a supervisor had advised her to; "slow down" in her practice and she had found this useful. It therefore could be deduced that supervision has a direct influence upon Sonya's style of practice.

In summary, the overall sense of how clinical supervision was referred to by the participants was as a significant and relevant one, having a positive influence on their psychotherapeutic practice choices, especially in terms of choosing affiliations with theoretical models. Generally, the reference to clinical supervision seemed to identify its greater influence being located at the start of their career as a therapist, but remaining somewhat influential throughout.

The influence of the therapist's working experiences

All of the participants made reference to some aspect of their work experiences. These references were useful for helping to form the identity of the interviewee and are included in the: 'Introduction of the Participants' section at the beginning of this chapter. With specific reference to their psychotherapeutic intervention choices, the time qualified and as such the amount of work experience they had gained and the subsequent professional growth that had occurred, seemed to be of particular relevance to influencing their therapeutic intervention choices.

The influence of time qualified, professional experience & professional growth of the therapist

With the exception of Catherine, all of the participants identified a difference in their practice from being a newly qualified counselling psychologist and an experienced counselling psychologist. When interviewed, Carol had been qualified as a counselling psychologist for eight years. She stated that she saw some significant differences in the practice choices she currently makes, when compared to when she was first qualified. Carol reported that initially she would:

> Carol: "… do things by the book… when I started out… very much a right way and a wrong way".

Carol went on to say that she later realised that there were a lot of:

> Carol: "… grey areas" and that having now been qualified for a while she sees "things a lot differently".

With reference to what influences her practice changing since first qualifying; Carol stated that the change has been heavily influenced by clinical supervision. Carol identified that since qualifying she works very differently,

however the basic frame of the therapy remains consistent and is always a necessary for her.

Pauline had been one of the first people who gained the chartered counselling psychologist status; she had gained this via the independent route. Pauline identified one of the major differences between her early practice and her more established practice, is the confidence that you know what you are doing and the concept of more choice being available to her as she moved into her later career. She had described, at the time of qualifying, having to settle on one model and then later:

> Pauline: "… you are able to make choices". Pauline summarised her current practice as: "I know what I am doing when I do it".

She felt this ability was based on "unconscious competence", which she identified as being different to when she was practicing earlier in her counselling psychology career.

Helen also made references that seemed to show similar beliefs to Carol and Pauline. Helen's sense of early qualifying had been:

> Helen: "… you want to do things right and you want to do things by the book when you first qualify".

She added that in the early days of qualifying she would carry out psychometric testing with clients, but currently doesn't feel she has to measure or prove herself to anybody.

At the time of the interview, Georgina had been qualified as a counselling psychologist for seven years. When considering how she had practiced on initial qualification, Georgina made reference to supervision, highlighting that

she would follow what was advised in supervision. She described her more current practice as having:

> Georgina: "… a cognitive idea about what goes on as well as an intuitive idea".

At the time of the interview, Annie had been providing therapy for over two decades. She had also gained B.P.S. chartership via the independent route and during the route to chartership Annie described at times, feeling like she knew nothing. Whilst initially practicing Annie liked to refer to the psychotherapeutic models, but spoke of current practice being much more of a judgement:

> Annie: "It's kind of gauging it really, it's kind of knowing what's going to work with this person".

It is worth adding that unlike during the early days of qualification, Annie currently questions the legitimacy and worth of psychotherapy. This questioning appears somewhat fed by her position of witnessing the erosion of psychology across the N.H.S. and the need to find alternative approaches.

Lucy did not mention how long she has been qualified as a counselling psychologist. However, the criteria for participants inclusion was a minimum of six years post chartership, so we can be certain this was the minimum of Lucy's experience. Lucy was uncertain of what her practice was like in her early qualification days, she stated that:

> Lucy: "I'm not sure I ever did it by the book".

Lucy felt that being a therapist was something that had always come naturally to her and that she currently has to remind herself that it is a skill. The

biggest difference that Lucy identified as changing over the years since qualification is:

> Lucy: “I know I have become more comfortable in my practice”.

Similarly to Carol and Helen, Sonya spoke of an initial dependency on the training and theoretical models, but as experience develops this appears to wane and is replaced by something more natural.

> Sonya: “… for the first couple of years you are wedded to the theories and the approaches and all your lectures are in your head, but as you get older, your experience kind of builds… it ain’t about theories anymore, it ain’t about your lectures anymore, it becomes integrated into the person you are … I’m straight away here is my formulation…” She went on to say: “… suggests to me that the therapist, the counselling psychologist, has become so integrated into my personality, it is me and it is how I see things and how I think…”

Sonya described that what she is now doing in the therapy room as an, established counselling psychologist is:

> Sonya: “engrained, instinctive and natural”.

She added that as a counselling psychologist:

> Sonya: “… you can see that the integration of who I was then, (pre-training) has just continued and no matter what I am taught, or what I learn, it will be integrated into the framework at some point”.

A further demonstration of the “engrained” that she feels, was when Sonya spoke of her unconscious awareness of time during session:

Sonya: “I will stop talking within the fifty minutes, there is no clock around me, it just happens, you just know when fifty minutes is up”.

To summarise, there is a reporting from all but one of the eight participants, that the amount of experience they have acquired in the provision of psychotherapy, has an influence upon the choices they are making in the therapy room. The way this experience influences their practice appears to differ, but there is a united thinking that the models are referred to less and the intervention choices are based more on something intuitive, engrained and assessed.

The amount of experience also appears to influence the confidence the participants reported having when they are considering applying psychotherapeutic interventions that had not been especially encouraged during training. When considering the choice of self-disclosure as an intervention, all of the participants referred to it and all of them, at times, have chosen it as an intervention. Pauline stated that she saw therapist self-disclosure in the therapy room as being something she approached with caution and used it ‘sparingly’:

Pauline: “… still a bit of a no… it’s their story, not my story”.

Having experienced self-disclosure as a client, both Pauline and Helen had found it an intrusive therapeutic technique:

Pauline: “… it didn’t feel right”.

Helen: “… it should be about me and not you darling”.

Pauline, Helen and Catherine all made interesting references to now being more comfortable choosing deliberate self-disclosure as an intervention, than when they were first qualified.

> Helen: “If I’m asked directly… I’m not going to lie and I’m not going to be evasive… that reminds me of the power imbalance in the psychodynamic model”.
>
> Catherine: “… something very simple”.

During her interview, Annie was very specific about what she would choose to deliberately self-disclose to a client. Specifically mentioning that she would disclose, her beliefs around existential issues, as she would not want to infer having a shared belief system, when she didn’t actually share it. Like Annie, Lucy was also very specific about what she may choose to deliberately disclose to a client and the circumstances of such. Lucy’s biggest challenge, in the psychotherapeutic work with clients diagnosed with cancer, has been the non-disclosure of her own cancer experience. Lucy spoke of having been “rumbled” by clients and has then disclosed her own experiences, Lucy added this would be done with the caveat of: “I’m more interested in what has happened to you”.

Similarly, Lucy’s belief about choosing to self-disclose would be influenced by the want to preserve something real and congruent in the psychotherapeutic interventions. Sonya seemed to think that her fear of disclosing parts of herself to the client, made her reluctant, but would do so when she could see a therapeutic value.

In summary, participants made reference to having chosen deliberate self-disclosure as a therapeutic intervention. Interestingly, although they were not completely positive about it as a therapeutic choice, this did not mean they

completely excluded it from their practice. The suggestion being that they would choose self-disclosure with much reflection and when they considered that by not doing so it would have a detrimental effect upon the therapy process, they would be more likely to choose it. There was also an implication across the data that the participants had grown more comfortable with the concept of self-disclosure, as they had become more experienced practitioners.

c) External Influences to Psychotherapeutic Practice

The influence of the therapy setting

Most of the participants made some reference to their work environments as having an influence upon the therapeutic choices they make. Carol spoke of the constant thrust of work environments and climates changing and in order to fit to these settings, she felt her practice needs to:

> Carol: "… combine and shift".

This flexibility appears to have helped Carol to work in a variety of settings with a variety of client groups. Both Pauline and Catherine mentioned their concern that the therapy opportunities available in the N.H.S. may solely become C.B.T. focused. An alternative view was held by Helen who stated that the N.H.S. should not be providing non-evidence based therapy, which she felt is less likely to provide people with quick results. Annie spoke of something similar; she felt that in the N.H.S. there is only a "window of opportunity" and if there were five years with each client then more psychoanalytic work may be considered. She summarised, N.H.S. therapy as:

> Annie: "… trying to think of solutions and trying to work with the unworkable".

Georgina felt the current climate of the statutory sector was leading to an erosion of the value of counselling psychology. She added that compounding

this is the profession of counselling psychology is attracting people who want to work at a high standard in private practice, rather than be a part of a body of psychologists. Suggesting that counselling psychologists working in their own independent practice, will have an effect on the profession and by the nature of the client group it is available to, it will have an influence upon the interventions that are appropriate to use.

Lucy spoke of the general climate of her work being that of people who have suffered trauma, life-threatening illness or are imminently facing death. This particular therapeutic setting is by its very nature going to influence the range of interventions chosen by its therapists.

Sonya described having worked in environments that were located in areas of deprived socio-economic demographics. She stated that the requirement in such environments is not being a therapist with an armful of theory, but being a real person who can allow the client some non-judgmental space.

Carol and Annie, both identified the number of sessions they may have available to them with a particular client, will influence how they choose to work. In some therapy settings, this will be dictated by external forces and will directly influence the choices that are possible and thereby made in the provision of the therapy.

The influence of logistics

With regard to logistical influences, four of the participants mentioned logistics as playing some part in where they found themselves either: training or practicing counselling psychology. Pauline stated that having been tied to a university post, logistics had influenced her choice of course and later she had been, “guided by opportunity” rather than seeking out a client group. Sonya and Georgina also mentioned logistics as being relevant to the counselling

psychology MSc course they had attended. Georgina identified; “cheapest and closest”, as being relevant to her choosing the training institute. Whilst Sonya identified it as being the only course on which she had gained a place. Lucy had identified how a friend had linked her to a counselling psychologist who happened to be located not far from her and it was from there that she had discovered the discipline of counselling psychology had a training course nearby.

Although the participants didn’t overtly draw a connection between these logistical effects of their training and work choices, as having a direct effect on what influences their specific psychotherapeutic interventions, it would be fair to say that as they do see training, client groups and work settings as having an effect on their practice choices, logistics do seem like an influence upon practice choices.

This chapter has presented the results of the study. By following a process of thematic analysis, the data revealed that the influences upon these experienced therapist’s practice choices fall under two over-arching themes and five sub-themes:

1) Consistent influences - theoretical models, the client, therapeutic relationship.
2) Ever-changing influences - the therapist, the external therapy settings.

The detail of each of these themes and the implications of the above findings are discussed further in the following Discussion chapter.

Chapter 4 – Discussion

Overview

This chapter focuses on a discussion of the findings. The findings are discussed in relation to: the research question, the theoretical implications, the implications for the discipline of counselling psychology, the limitations of the study and ideas for future studies. The chapter ends with conclusions.

Considerations

Before discussing what the data revealed, it is important to place myself, the interviewer, in the context of the material. Bergin and Garfield, (2013), describe the qualitative researcher as a reporter who documents segments of everyday life, whilst also being an artist who is able to offer the audience a new way of seeing. It is this qualitative researcher role that was aimed for in this study. Whilst also acknowledging that me as the researcher will have created its own effect on the study.

There is great debate around qualitative research and its emphasis on the role and significance of researcher reflexivity (Etherington, 2004; Finlay and Gough, 2003). It is widely believed that the personal involvement of the researcher is likely to shape the data from collection to analysis. During this study, the participants engaged in an intimate exploration of their personal and professional experiences, with me as the interviewer who had a strong interest in the topic being explored.

“I am the audience to whom the respondent is presenting himself in a particular light” (Mishler, 1986, cited in H. Macallan, 2002, p.49). Acknowledging that the researcher will have affected what the participants included in their interview is referred to as ‘researcher effect’. This is a form of reactivity in which a researcher's cognitive bias creates a subconscious influence of the participant. A ‘reflexive’ process on behalf of the researcher is a way of working with this effect. Reflexivity urges us, ‘to explore the ways in which a

researcher's involvement with a particular study influences, acts upon and informs such research' (Nightingale and Cromby, 1999, p.228). A reflexive process has therefore been my starting point at each point of the research process: at the conception of this study, during the interview process, during the thematic analysis and the discussion there of.

The participants were aware that I am a counselling psychologist and had they looked at my website they could have seen that I work in private practice. Either way, they would not have been fully aware of my belief system, choice of theoretical model, personal circumstances etc., but it would be likely they would have made some assumptions about what type of person/therapist I might be. At the very least, participants were aware of the reason for the research and at which institution I was studying. They may have also considered what I hoped to uncover and could have made the assumption that I would want them to speak of certain influences upon their psychotherapeutic practice.

An example of how this effect may have existed in the interview process was that one of the participants had, like me, studied for her MSc at Roehampton. It was known by the participant that, at a different time, we had shared the same learning emphasis. The course tended to emphasise the reflective practitioner stance and valued the personal therapy experience of the training process. This participant could have speculated that I would possess a particular favouring for these aspects, and whilst being interviewed, they may have unconsciously drawn from this influence more than they would have done had they not had this knowledge of the interviewer.

Whatever the participant's knowledge/thoughts/opinions of me as the interviewer were, it would be likely that my subtle responses during interview would encourage the participant to emphasise certain topics. Although I was

aware of this potential and resisted overt encouragement, the reader should be aware of these potential effects whilst reading this research.

During the analysis of the data, there was a further point of reflection. The consideration of whether it is valid to draw the conclusion that because the participant chose to discuss a particular aspect of their personal or professional lives during the interview, does this mean they saw this as an influence upon their psychotherapeutic interventions? Not all of the participants directly referenced how the aspect they were discussing had influenced their psychotherapeutic practice. Therefore during the analysis there was a balance to strike. At times, in the very way they spoke of the topic, for example; at length or with passion, it seemed valid to conclude that they did see it as influential to their practice choices. However, at this point it is useful to contemplate Langdridge, (2007): "… we always have a view from somewhere" (p.136). This is a reference to the researcher's view of the research topic influencing how the data is received, interpreted and emphasised – 'researcher bias'.

If considering 'researcher bias', it is worth reminding the reader once more, that the choice of research is motivated by my interest in this particular area of psychotherapeutic practice. When I began to reflect on the influences upon my practice and what choices I made when providing one-to-one psychological intervention, I had been qualified as a chartered counselling psychologist for six years. I began to notice that I thought a lot less about the psychotherapeutic models of intervention, and the books I owned about psychotherapeutic models were referred to less and less. I also began to notice that whilst it was only occasional, I was much more prepared to use interventions that had not been taught during training. This was a significant shift from the days of training and early qualification when I would have vehemently adhered to the evidence based psychotherapeutic methods of intervention. As it was this particular aspect that had sparked my interest in the evolving nature of practice, it may have been during the interview stage, or

during the thematic analysis, that I may have been drawn to data that concurred with the reflections of my own practice.

With this in mind, I would also like to add a final point to reflect upon, this is a summary of the themes and sub-themes that are, in themselves, individual and ever-changing. As this research is approached from a social constructionist view, there is no one 'correct' version of reality and the reality of the interviewee is a co-constructive process that is individual to each and every person.

In summary, the discussion of the data is approached with the following considerations. Firstly, that the data gained from these counselling psychologists would be likely to have been affected by me as the interviewer. Secondly, what the participants included in their interview isn't to the exclusion of all other influences upon their psychotherapeutic practice choices. Thirdly, with the same individuals and all the same conditions, but (with) the interview taking place on a different day, week or month, it could have elicited a different emphasis in their data. Therefore what is stated is received as being in a state of constant evolution. Finally, my current motivations to carry out this study and any previous reflections are relevant and effect the interpretation of the data. It is in the context of what has been highlighted, that the findings can be discussed.

Discussion of the Findings

The findings in relation the research question.

The research question was interested in gaining a better understanding of what a sample of counseling psychologists would identify as influencing the choices they make during the process of implementing psychotherapeutic intervention.

The findings suggest that this sample of counseling psychologists all agreed that there are two 'over-arching themes'. The first contains influences

that are consistent and enduring influences upon their psychotherapeutic practice choices: the theoretical models, the client and the therapeutic relationship. The second 'over-arching theme' contains influences that are ever-changing and these fall under three sub-themes': the personal aspects of the therapist, the professional aspects of the therapist and the external influences on the therapy.

The findings in relation to the literature

As discussed in the Introduction chapter, there is a wealth of literature pertaining to the influences upon psychotherapeutic practice and the influences on a positive therapeutic outcome. Whilst this particular study was to specifically explore which aspects influence the psychotherapeutic intervention choices, a discussion of this study shows there is both difference and considerable overlap between these findings and those of previous studies. The following discussion will highlight the themes that both resonate, and differ to the existing literature.

Over-Arching Theme: Consistent Influences on Psychotherapeutic Practice Choices

A) Sub-Theme = Theoretical models

The APA definition of a theoretical model is: 'A theory of psychotherapy which acts as a roadmap for psychologists: It guides them through the process of understanding clients and their problems and developing solutions'.

Across the literature there is a great deal of debate about which of the theoretical models are the most effective, (Bergin and Lambert, 1978; Rachman and Wilson, 1980) and how much do they influence the therapist across the stages of their career development, (Rønnestad and Skovholt, 2013). In concordance with a great deal of the existing literature, this current study revealed that all of the participants identified the theoretical models of psychotherapy, as having an influence on their psychotherapeutic practice choices. Throughout their interviews, all of the participants made several

references to the influence the psychotherapeutic models have upon their practice. These reports do support Rønnestad and Skovholt, (2013), who investigated what aspects influence the development of the therapist across their professional lifespan. Their findings showed that across the career lifespan, the theoretical models influence the development of practice, including the career stage of the 'Experienced Professional Phase', who appeared most similar to the participants in this study.

The participants in this current study held several interesting views about the influence of the theoretical models. Firstly, all of the participants claimed to practice from eclectic/integrative theoretical models. The counselling psychology training courses tend to train in the three major therapeutic models: Cognitive-Behavioural Therapy, Humanistic and Psychodynamic. And the BPS, (2001), Division of counselling psychology statement of competences, states that minimum competency is being proficient in one model and cognizant of another. It could therefore be argued that for a counselling psychologist, an integrated/eclectic model would be an expected outcome. However, not all of the participants referred to their integrating of the theoretical models to be as a result of their professional experiences. Some identified their choice to integrate theoretical models as being due to how they personally see people, with differing needs and consequently requiring differing approaches. In addition, all of the participants gave acknowledgement to their; personality, personal interests and preferences, as influencing their choosing of integrative/eclectic theoretical models to influence their psychotherapeutic practice.

This poses another interesting reflection, that the choice of which theoretical model to draw from is influenced by the therapist's own already established pre-training, (as they would be aware that it is not training in a purist model) belief system and personality. This supports Marcus and Rosenberg, (1998), who very much drew an overt connection between a therapist's philosophies of life and their influence upon every aspect of practice. This

potentially positions a debate that it is the particular aspects of the theoretical models that resonate with the therapist, which then influences the choices they make when providing psychotherapy. To summarise, this indicates that the practitioner draws from the theoretical models that which works for them, rather than just what works for whom.

Two of the participants did suggest that the theory had, with experience, become less conscious in their minds, but used words to describe it such as ‘engrained’. Whilst one of the participants did suggest that with experience it is not the case that the theories are referred to any less than when training, but rather they are now unconsciously influencing her practice.

These remarks throw up a somewhat more complex consideration to Kottler’s, (2010), theory who concluded, that experienced practitioners don’t practice from their chosen models. Some of the participants did make reference to how the theoretical models seemed to be most influential to them during their training and early qualification, however they all referenced them as consistent influential frames of reference to their past and current practice choices. A further consideration might be that not only are the theoretical models unconsciously influencing, but potentially the therapist’s confidence in implementing psychotherapy has increased and this leaves them believing they need not rely so heavily on the theory.

B) Sub-Theme = Clients

Much of the empirical research would suggest that it is the client who is the primary factor for influencing change and certain client characteristics are what helps to contribute to the change. In this particular study all of the participants identified the individual client as having a significant influence upon their choices of psychotherapeutic practice, and because every client is different, their practice is altered to fit. The aspect of the client that influences their practice choices were described with some similarities and some variation

across the participants. The aspects of the client identified as being influential to the therapist's intervention choices, supports much of the literature, particularly that which explores the contributors to outcome. The particular client aspects that were referred to were: the client's needs, the client's identified hopes and priorities (Glass, Arnkoff and Shapiro, 2001), the issue they are presenting with, how the therapist "feels" with the client, the client's thinking style, their level of functioning (Mohr and Beutler, 1990), their psychological mindedness (Piper, Joyce, McCallum and Azim, 1998), and the client's motivation (Orlinsky et al, 1994).

The unanimous identifying of the client heavily influencing psychotherapeutic choices supports the previous writings from Rogers, (1961), and the humanist perspective. The data also offers support to the discipline of counselling psychology having the aspiration to have practitioners who are reflexive and responsive to the ever-changing client needs (Barlow, 1981, Long and Hollin, 1997). Whilst the focus of this particular study was not on therapist development, but rather influences upon practice choices, the data does still lend some support to Rønnestad and Skovholt's, (2013), conclusions. Their survey found that one of the most consistently and enduring influences on development, identified by the therapists across all five phases, was the client. The additional finding in this study is that the participants did not only highlight the client influencing their practice choices and professional development, but also the client influences them personally. Six of the participants stated that they personally gained from the client work, which then influences their future practice choices. A concept suggested by: Pachter, 1997; and Kottler and Carlson, 2006), who suggested the client teaches the therapist to be a therapist.

In summary, this study suggests that the client influences the choices made by the therapist in the therapy process and also has a broader influence

on the therapist, both personally and professionally. Later, I shall look at how these findings have implications for future study.

C) Sub-Theme = The Therapeutic Relationship

The therapeutic relationship has been repeatedly shown throughout the literature as the central feature to any psychotherapeutic encounter. In concurrence with the literature (Freud, 1913; Rogers, 1951; Winnicott, 1965; Kohut, 1977; Gelso and Carter, 1985; Kahn, 1991; West, 2000; Lambert and Barley, 2001; Rowan and Jacobs, 2002; Dryden, 2007; Egan, 2010), all of the participants identified the therapeutic relationship as being important and having a significant influence on the choices they make in the therapy room. The participants used phrases such as; 'underpins all the work', 'integral', 'central to the work', 'it's a connection', 'first rapport… then I think the methods', 'beyond words', 'basis for the therapeutic work', 'unique'. They seemed to be referring to the influence of what is created by the coming together of a particular client and themselves, a collaborative, joint relational outcome as being the cornerstone to the therapeutic work they then choose to implement.

The participant's comments also support the research identifying the greatest influence to a good therapeutic outcome is the authenticity and nurturing aspect of the therapeutic relationship (Yalom, 2002, Orlinsky, Rønnestad and Willutzki, 2004; Norcross, 2011). Their reference to the relationship was unrelenting in its influence upon practice choices, with the attendance to such being identified as a primary focus for the participants. It was the consensus that it is from this that the other therapeutic interventions develop.

Theoretical models, client and therapeutic relationship

To conclude, the over-arching theme of the consistent and enduring influences upon practice choices, were the influences on practice that were identified by all of the participants and importantly, identified as being ever-

present across their professional practice. These were: the theoretical models, the client and the therapeutic relationship.

These findings support the general consensus of the literature and the recent findings by, Moltu and Binder, (2014), who found that experienced therapists worked in difficult therapies, used the following techniques to obtain a therapeutic process: (1) tailoring the therapeutic frame to relational struggles, (2) using embodied empathy, and (3) creating meaning from the perspective of a theoretical model.

However, an additional finding in this study was that, with all clients, the participants named the therapeutic relationship as being primary to the following two enduring influences; the theory and the individual aspects of the client and that the creation of such is more of a collaborative venture.

Over-Arching Theme: Ever-Changing Influences on Psychotherapeutic Practice Choices

A) Sub-Theme = The Personal Aspects of the Therapist

The influence of the therapist's personality

The literature exploring the relevance of therapist's personality in psychotherapeutic provision has tended to focus on which personality factors are likely to yield a 'good' therapist: (Pope 1996; Wheeler, 2000; Gelso, 2009). Pope's, (1986), 10 personality factors: acceptance, emotional stability, open mindedness, empathy, genuineness, flexibility, interest in people, confidence, sensitivity and fairness. Interestingly, there were only two of Pope's personality factors that were referred to by the participants in this study: an interest in people and fairness.

More interestingly, this sample of counselling psychologists did refer to their personalities as influencing many aspects of their psychotherapeutic choices. The emphasis of the influence of their personalities was widespread,

not only in their calling to the profession of psychotherapy, but in their actual practice choices. Seven of the participants referred to their choice of theoretical model as being influenced by their personality. If we are to consider how Marcus and Rosenberg, (1998), saw therapist's values as underpinning their choosing of a particular theoretical model, this study offers support. However, the participants go further and identify their personalities as influencing; their choice of client group, their choices of which settings from which to work and how they connect with the client.

The themes extracted from the data gathered from these particular counselling psychologists would imply that their personality, personal preferences, interests and needs, in both the broader aspects of choice, across their provision of psychotherapy and the more day to day process of psychotherapeutic intervention, was a significant influencing factor to their practice and their choices.

The influence of the therapist's life philosophies/values

For decades there has been some acknowledgement across the literature that the values of the therapist are difficult to keep away from the therapy room: (Martini, 1978; Greenberg and Mitchell, 1983).

With the exception of one participant, the data for this sample of counselling psychologists was peppered with references to their philosophies and values. One of the most commonly mentioned being that of equality and fairness. Other belief systems were more generic but they included the strength of the human condition, the robustness of humans, the relevance of life's opportunities and the need for the activity that humans partake in to be meaningful to them. The conclusion would be that for these counselling psychologists, their core value system is linked to their psychotherapeutic provision. This appears to exist in their broader judgment of people and their capacity to overcome adversity.

Whilst identifying this particular influencing theme does not contribute a brand new finding to the literature. It does add to the picture that U.K. counselling psychologists are reflective and insightful of the contribution their personal values have upon their psychotherapeutic practice.

The influence of the therapist's instinct/intuition

Although when carrying out the initial review of the literature, instinct and intuition did not especially present itself as having been researched in the context of influences upon therapist's intervention choices, interestingly, half of the participants identified their intuition as having an influential effect upon their choices of psychotherapeutic intervention. In fact, it was such a reoccurring theme referred to so many times by these four participants, it seemed that further exploration was necessary.

Firstly, what is meant by intuition? It is generally agreed that intuition is based on automatic processes, which relies on assumptions, or knowledge structures, that are acquired by learning about humans. Intuitions are seen as processes that operate, at least partially, without consciousness and result in feelings, signals or interpretations. The data gathered from this sample of counselling psychologists implies that even with the heavy emphasis on evidence-based clinical work, in actual practice they believe they are combining their intuition with the evidence based clinical methods. Harding, 2004; Kleinmuntz, 1990; Welsh and Lyons, 2001, each reported that clinicians are uneasy with an exclusive focus on rational, evidence-based decision making and they all use their intuitions to some extent, in different stages of the clinical process (Garland, Kruse, and Aarons, 2003; Jeffrey and Stone Fish, 2011).

A recent paper by, Witteman, Spaanjaars, and Aarts, (2012), described what they thought intuition was when it is found in clinical practice. They summarised it as automatic responses that are based on knowledge acquired through significant, explicit learning from textbooks and from clinical practice.

What they found was that in actual practice, clinicians combine the empirical approach to their clients with the use of their professional intuitions. Schön, (1983), first wrote of this phenomena and coined the phrase 'reflective practitioner'. He was referring to how professionals think in action and gave the process a more rigorous positioning. What is suggested is that intuition it is a credible influence upon therapeutic intervention. Indeed this would be very much in line with what half of the participants in this study reported and they seemed comfortable with the phenomena influencing their practice choices.

The influence of the therapist's family environment

Five of the participants made reference to their original family environments as having an influence on: firstly, their choosing to pursue a career in psychological therapy and secondly, and potentially more relevant to this study, influencing their psychotherapeutic interventions.

The focus of much of the previous research has tended to focus on the connection between early distress and choosing a career in psychotherapy being attributed to wanting to 'fix' this; (Elliott and Guy, 1993; Murphy and Halgin, 1995; DiCaccavo, 2002; Bager and Charleson, 2010). Although in this study there was reference made to providing psychotherapy aiding their own healing: 'When you have done enough of the work you know you get healed and you don't have to do it anymore' it wasn't its only influence.

Overall the counselling psychologists in this study revealed that although they did see their early family experiences as influencing their choice to pursue a career in psychotherapy and gain some kind of resolve for themselves, what they reported was that these early experiences provided them with positive aspects to use in their psychotherapeutic intervention.

The participants credited their early family experiences as significantly influencing their psychotherapeutic interventions, by: aiding connection to others, aiding them to care, helping them to understand certain presentations of

distress, being responsible for another and learning to assess people quickly. This falls specifically in line with, Kottler, (2010), who believes that the skills with which to provide therapy are often learnt in the therapists' original family environment. One participant reported that the mental health needs of a parent and their own positioning in the family had taught her to be a 'good listener' and mediator. Another spoke of being the eldest sibling had prepared her for a caring profession, thereby supporting previous findings. Boszormenyi-Nagy and Spark, (1973), coined the phrase 'parentification', used to describe children who were prematurely placed in adult roles. DiCaccavo, (2002), surveyed the phenomena and found trainee counselling psychologists were more likely to have experienced such childhood experiences.

In addition, two participants spoke of early loss effecting how they choose to practice, whilst investigating clinical psychologists Leiper and Casares, (2000), had produced similar findings. The difference in their survey when compared to this study was that they had specifically asked about early loss experience, and the participants in this current study had without prompt, volunteered that it is a relevant influence upon their practice choices.

The three participants who did not mention their family environments were chronologically much older in age than the five who did and they had also come into the profession of psychotherapy later in their working life. This, omission of early family experiences could be because: this was not seen as relevant by the participant, later experiences have usurped them, or simply by accidental omission. This could be an aspect of influence that is worthy of further research across the career lifespan.

The influence of the therapist's life events and well-being

Beyond the early family experiences, all of the counselling psychologists in this study agreed that their personal lives impact their work with clients. The broad influence of the therapists' personal life events, are widely acknowledged,

in the literature, (Rønnestad, and Orlinsky, 2005; Skovholt and McCarthy, 1998; Trotter-Mathison, Koch, Sanger and Skovholt, 2010). However, the focus of these studies has tended to be on 'defining' moments that promote change in their professional development. The current study is interested in investigating all of the influences upon practice, they are not necessarily 'defining' or 'critical'.

The participants for this particular study all identified their own life events as having an impact on their psychotherapeutic practices. A quote that captures this; '… what happens in personal life affects professional practice', and across the interviews there were many similar phrases used. The participants spoke candidly about which life events had influenced their practice; loss and illness being the 'critical' ones, but also life stages, such as menopause and young family responsibilities were identified as having an influence upon practice choices. The conclusions of Trotter-Mathison, Koch, Sanger and Skovholt, (2010), that major life events effect practice are supported by this study, however, the less major events in life are also identified as influencing practice. Kottler's, (2010), self-reflections suggest this phenomena takes place within the therapist and therefore in the therapy room, even down to the very 'what' the therapist has encountered that very week.

In addition to identifying the type of life events that influenced their practice, the participants also spoke of how specifically their practice had been influenced by the events. The life-stage events were identified as improving insight and empathy with particular client groups, in particular if they were experiencing similar life stages. Also, all of the participants spoke about life events that that may not have been positive and at the time had affected their well-being. Interestingly, all of the participants saw the influence upon their practice as being a positive one. One of the comments supported the idea that the therapist's own challenges will allow them to be more understanding of the client's challenges, and this this will influence the positivity of the therapeutic outcome. Another participant observation was that when they are facing

challenges in their own life, their vulnerability provides something that helps the therapeutic process. Such findings are in opposition to some of the previous research findings. Guy et al, (1989); Williams et al, 2010, highlighted therapist distress as impairing fitness to practice. However, it does somewhat support, Charlemagne-Odle, Harmon, and Maltby, (2014), who found that when a therapist's well-being is challenged it can have both positive and negative influences upon practice.

A quote from Pauline appears to particularly capture something interesting:

"I think that as my own life over the years evolve how my therapeutic work has evolved… My life and things that have happened in my own life… I have been exposed to much more, very much more vulnerable times… when a more vulnerable time has been sometimes the work feels, I don't know, a bit more, it's kind of a bit richer".

In summary, like those people to whom a therapist provides therapeutic intervention, every therapist has a personal life and every therapist, at times, experiences challenges in their personal life. The challenging life experiences mentioned in this study were; loss, illness, menopause, responsibility and depression. Each of these were described as having an impact on their practice. Yet, the impact of these events were framed by the participants as positive influences. In essence, removing the concern about its existence and allowing them to connect more deeply with those they meet in the therapy room. A quote by Marie Adams (2014, p.139), captures this phenomena: "Empathy is a product of our shared histories and experiences, but anxiety is a current that keeps us apart from those we work with".

The influence of the therapist's culture

Although neither culture nor gender, are overly represented in the

sample for this study, there were some strong and interesting cultural comments made by the only non-white participant and an Irish participant.

The non-white participant discussed the influence of the colour of her skin when she is working with a client of a different skin colour. What she felt would be the assumption from the client, was that of an assumed suffering on her behalf. What she proposed is that this assumption will have an effect on the relational aspect of the therapy. The participant gave the example that her skin colour and the assumed suffering demonstrates an emotional robustness, therefore instantly providing the client with the reassurance that the therapist can relate to suffering.

With regard to the Irish participant, she referred to her culture experiences contributing to equipping her with the skill set to provide the essential psychotherapeutic interventions of empathy and citizenship. In addition, she referred to the cultural association that would be made by clients when they hear her Irish accent and this will affect their relational journey.

The importance of “cultural competence” (Sue, 1998), on behalf the therapist is just one aspect of delivering services that are culturally sensitive. Sue proposed that cultural competence is comprised of several characteristics or skills, including the therapist being able to recognise when and how cultural values or cultural group characteristics may be relevant to the client’s problems and also when to see the client as an individual. Interestingly, when cultural influence upon psychotherapeutic practice was discussed by the participants in this particular study it was in the context of the client’s assumptions about them as the therapist. The white participants did not refer to the cultural aspects of the client as having an influence on their practice choices.

The influence of the therapist’s religious/spiritual beliefs

There has been research that has linked the relevance of the therapists’ spiritual/religious beliefs and the potential influence to psychotherapeutic

interventions. Bilgrave and Deluty, (1998), surveyed psychologists and found that they saw their religious beliefs as influencing their psychotherapeutic practice and vice versa. However, the data in this study shows the participants have the opposite view, stating that they did not wish for the religious aspect of themselves to influence their practice.

Firstly, for the three participants who spoke of having a religious affiliation, it seemed to be an uncomfortable concept. They spoke of not overtly taking their religious beliefs to the therapy room, or discussing this with colleagues. With regards to the place of religion and its influence upon their psychotherapeutic practice, it seemed the participants made efforts for the two not to collide. The participants who claimed to have a religious affiliation said phrases such as; 'not rigorous', 'not sexy', 'not OK' and 'not relevant to share with a client'.

However, the concept of the spiritual seemed to be a more comfortable concept, with five of the participants directly linking it to influencing how they view what is going on in the therapeutic encounter, 'beyond words', 'connectiveness' and 'human journey'. This predominant view which also falls in line with West's, (2000), view, is that the therapeutic relationship is akin to a spiritual existence. This finding supports Rowan and Jacobs, (2000), view of the transpersonal aspect of the therapist influencing the therapeutic process. The transpersonal, is described as being beyond the personal, it is often held up as a person-centered perspective and is described as having a third level of empathy.

B) Professional Aspects of the Therapist that Influence Psychotherapeutic Practice

The influence of the therapist's personal therapy

Although the influence of the therapist's experience of personal therapy is listed under the professional aspects of the therapist, this is mostly because

during their professional training this sample of counselling psychologists will have engaged in a series of sessions of personal therapy. For some, this may have only been as part of their training requirements and for others this may have also been pre or post training. The British Psychological Society (B.P.S.) requires all chartered counselling psychologist to have engaged in personal therapy. However, other than the requirements, the reasons for students and qualified therapists seeking personal therapy and what they gain from it differs (Orlinsky and Rønnestad, 2005). Much of the literature is divided on therapist's engaging in personal therapy and whether it has a positive influence on practice (Beutler et al, 2004; Rønnestad and Ladany, 2006).

It is therefore interesting that of the eight participants only half of them made reference to their personal therapy. Of the four that did speak of their personal therapy experiences, not all of them were positive. However, two of the participants did make direct links to how their personal therapy had influenced their psychotherapeutic practice, These influences were: "staying with clients", "holding the distress", '"facing of their own stuff" It is these direct positive links gained from personal therapy that support the findings of, Rizq and Target, (2008). Their investigation of counselling psychologists also showed that they valued personal therapy and saw it as having a direct positive influence on their psychotherapeutic work.

The influence of the therapist's education/training

All of the participants made reference to their training experiences. This was somewhat expected as the opening 'interview statement' that was read to participants at the start of their interview, made reference to when they were first qualified, i.e. just finished training. The description of their training journey therefore must have seemed a sensible framework from which to begin their story. The influence of training to practice would support the findings of Rønnestad and Skovholt, (2013), who found that across the developmental

phases of the therapist, their training continued to have a significant impact on their development and practice.

With regards to reference to post training courses, several of the participants had attended significant training courses, which they seemed to have valued and by the comments such as ‘you can’t unlearn something’ and ‘very little is left at the doorstep’, it would seem those whom had engaged in further training saw them as having an influence on their psychotherapeutic practice.

The influence of the therapist’s clinical supervision

With the exception of one participant, all of the participants made reference to clinical supervision and the majority of these were of a positive nature. Much of the influential supervisory experiences that the participants described were of an historical nature, from early qualifying and training, however, this theme was presented in the context of their full interviews, as being something that they still believed currently influenced their psychotherapeutic practice. These findings support those of Robiner and Schofield, (1990), as being amongst the most common activities in which psychologists invest their time. In addition to providing supporting evidence to Watkins, (1997), who discusses the importance of supervision to the development an on-going growth of the therapist. Whilst these findings represent the thoughts of experienced practitioners, the majority of their references to the influence of supervision were focused on its influence being when they were training and acting as newly qualified practitioners. This merely adds to the literature the value of clinical supervision in early practice, but yields little definitive understanding of how the experienced therapist uses supervision to influence their practice decisions. The lack of detail about how the supervision influences the experienced practitioners practice is a theme across the literature. Milne et el., (2003), did find supervision did have a significant influence upon practice, however the methodology potentially effected this

finding. Whilst Vallance's, (2005), interviews and questionnaires found that qualified therapists, when directly asked about their supervision rated it highly and gave examples of how the influence manifested in congruence and confidence.

The influence of the therapist's professional experience and clinical skills

By interviewing many therapists at varying stages of their professional career, Rønnestad and Skovholt, (2013), were very definite in their writings, that there are stages within which therapists move along during their professional lives. According to their studies the experience and development of the therapist dictates the way they are practicing and the influences they refer to in order to develop their practice is dictate by the stage they exist in at that time.

With regard to the findings of this current study, with the exception of one of the participants, who didn't make reference to the changes in influence upon her practice since training, all of the participants had the belief that their practice was different now to when they had first qualified as a counselling psychologist. The differences that were identified as influencing their more established practice ranged from: doing things less 'by the book', 'unconscious competence', being less 'wedded' to the theories, 'follow my intuition more' and less 'guided' by supervision. This lends support to Fiedler's, (1950), study who suggested that the relevance of therapist experience was less reliance on the theoretical models influencing practice and more of a commonality of style of intervention across the theoretical models.

With regards to how these more experienced therapists felt about their practice also appears to have changed with their growing experience. The influence of such was less time spent on proving themselves via assessment tools of their psychotherapeutic work, and more time spent pursuing their clinical areas of interest.

A particularly interesting observation made by some of the participants was that now they were more established counselling psychologists, they saw some of the choices they made in the therapy room as not being influenced by their skill set. Rather they saw that their practice was just what they are: it is something ‘engrained’, ‘instinctive’, ‘authentic’, ‘natural’, ‘unconscious’, ‘feelings led’. In addition, one of the participants identified the continuation of any learning beyond the initial qualifying, all becomes integrated into the practice framework.

These findings support Rowan and Jacobs’, (2000), theory of the aspects of therapist that are taken to the therapy room: the instrumental (skills), the authentic (intuition, personhood) and the transpersonal (beyond the personal). It could be summarised that these experienced participants identified with the ‘authentic’ self. Yet this provides an interesting point to ponder, whilst the participants did heavily emphasise the aspects of themselves that are associated with the ‘authentic’ self as a tool of intervention, they did not speak overly positively about the influence of particular clinical skills that incorporate the therapists use of self. Whilst none of the participants spoke of managing the ‘transference’ or ‘counter-transference’, which according to previous research this would have been expected, (Crits-Christoph, Cooper and Luborsky, 1988; Hayes, McCracken, McClanahan, Hill, Harp and Carozzoni, 1998), they did refer to the influence of therapist self-disclosure and their opinions of this as an influential intervention tool.

Use of self as a clinical tool

The amount of experience seemed to influence the confidence the participants reported having when they are considering applying psychotherapeutic interventions that involve using themselves as the method of intervention. When considering such interventions, as instinct, intuition, authenticity, genuineness, and so on, the participant seemed confident of these influences upon their practice choices. However, when speaking of deliberate

therapist self-disclosure, the participants revealed interesting findings. All of the participants referred to it as an influence upon their practice and all of them, at times, have chosen it as an intervention. One of the more interesting aspects, that all of the participants whom referred to self-disclosure emphasised, was that deliberate self-disclosure was an intervention that they approached with caution. They used preambles and disclaimers such as; 'I use it sparingly', 'still a bit of a no'. This approach to self-disclosure was a cautionary line of Pope, Keith-Spiegel, and Tabachnick, (1988), who wrote that the act of therapist self-disclosure should be generally deterred.

All of the participants spoke of being aware not to take the focus from the client to themselves, adding that a disclosure would be swiftly moved on from in the guise of switching the attention back to the client. One of the main therapeutic uses for choosing deliberate self-disclosure was reported as being when it was judged that it would improve the connection between the therapist and the client. Audet, (2011), summarised that: "Perhaps the greatest challenge facing therapists in this regard is providing disclosure that conveys some similarity to clients on a personal dimension while simultaneously differentiating them from the client on a professional dimension" (p. 98).

Two of the participants did state that having gained more experience they were a little more comfortable choosing therapist self-disclosure as an intervention. This supports Bishop and Lane, (2001), who advised:

> "Novice practitioners ought not attempt the more difficult relational interventions until they have acquired experience and security in the basic tenets of psychoanalytic practice…Inexperience in knowing when and under what circumstances to attempt self-disclosure… have the potential to exacerbate enactments and entanglements for beginning therapists…"

Overall it would seem that if the participants were confident that they are able to judge that the intervention of self-disclosure is going to enhance the therapeutic process then they will be willing to implement it. This would be in accord with Roberts, (2012), who advised consistently reflecting on its helpfulness to the client. Therefore it would be useful to have on the agenda for: training courses, clinical supervision and peer conversation the complex, but possible task of refining the skill of the therapeutic use of therapist self-disclosure.

C) External Influence

The influence of the therapy setting

Another professional aspect that all of the participants identified as being of significant influence upon their psychotherapeutic practice choices was the work environment within which they are practising. The environments within which the participants practiced were not overly represented, but all of them were working in private practice and all of them had historically and some were currently, for a small amount of their working week, working in either the statutory sector, or a voluntary sector organisation.

One of the participants made reference to the changing climates and the need for practitioners to 'combine and shift' and adept to change. Whilst other participants made reference to the socio-economic environment within which they practice as influencing their choices of psychotherapeutic intervention. Others referred to the framework within which the psychotherapeutic work is taking place as being influential. To elaborate further, they were referring to the number of sessions that may be allocated, the pressures of funding, whether that was self-funded (the client), or third party funded (employer, private healthcare).

The emergent themes for these participants support the previous writings: (Corrie and Lane, 2011, Einhorn and Hogarth, 1981, Barlow, 1981,

Long and Hollin, 1997, and Walsh, Frankland and Cross, 2004), that the practitioner's choices are heavily influenced by the framework within which the psychotherapeutic work is taking place and that they need to evolve and respond effectively to both the client and service requirements.

The influence of logistics

Although it was half of the participants who made reference to logistics, they seemed mixed about whether they completely believed in the concept of logistics. One participant stated that her training institution had been the cheapest and the closest, but her choosing it had been because it had "felt right".

On reviewing the literature, logistics is not highlighted as an obvious influence upon psychotherapeutic practice choices. However, several of the participants identified logistics as influencing some of their psychotherapy decisions and subsequent practice preferences. These were in the guise of dictating their choice of setting within which to work, such as its geographical location. Others identified the logistical impact of which university granted them a training place, or which client group, within the N.H.S., had gained funding for a psychologist. In particular, several participants identified their early trainee placements and the logistics of such, having influenced their learning and early practice, which continues to have an influence on their current practice.

Summary of the key findings

The findings do support the wealth of literature that identifies the theoretical model, the client and the therapeutic relationship as having a significant influence upon psychotherapeutic practice. These aspects were referred to as influencing practice choices regardless of the stage of experience these experienced counselling psychologists are currently at, or were referring to.

Beyond these three influences, in this study, the personal aspects of the therapist are highlighted as being the next significant key influencing factors. The findings reveal that the aspects of the therapist that influence psychotherapeutic intervention choices are; their personality, personal preferences, their intuition, their original family environment, their life events, their own personal growth, their own culture, their religious affiliation and spirituality.

By the number of references made to the professional aspects of the therapist, being less than the personal aspects of the therapist, it is assumed that the professional influences were viewed as less influential upon the practice choices of this sample of experienced counselling psychologists. With regards to the professional influences on practice, all of the participants spoke of their training and work experiences as influencing their practice choices. Some added that their experiences of personal therapy and clinical supervision also have an influence upon their practice choices. However, the emphasis of these influences appear to be more located in; training and being a newly qualified practitioner.

Each of the participants made references to how the external influences to the therapy have an influence on their choices of intervention. These external influences were: the therapy setting, the number of sessions allocated, the funding source and the logistics of trainee placements and training institutions.

The thematic analysis suggest that the way in which the primary influences upon the counselling psychologist's psychotherapeutic practice, may change and shift at different points in their career. For example, Sonya identified that on first qualifying: "… for the first couple of years you are wedded to the theories". However, she then stated that with experience this changes: "… it becomes ingrained, instinctive and natural".

In addition, a second participant identified a change to her practice influence, which is gained with experience, and that is intuition. She reported that her practice was now more informed by a “cognitive idea” as well as having an, “intuitive idea”. Thereby offering direct support to the published findings of: Witteman, Spaanjaars, and Aarts, (**2012).**

Implications of the findings in this study

This is a small study that adds an additional insight to the qualitative literature attempting to answer the question posed. What are the aspects that have an influence upon the choices made, by the experienced counselling psychologist whilst providing psychotherapeutic intervention?

This study highlighted that along their career path, practitioners place emphasis upon three consistent influences the theoretical models, the client and the therapeutic relationship. The findings then proceed to provide a picture of the wide range of further influences upon psychotherapeutic intervention. Previous research has often focused on one, or a few aspects of influence, this study clearly shows this approach can be limiting to any further investigation.

This study, whilst acknowledging the significant influence of the client to the therapy process, it also draws attention to the lack of research from the vantage point of the client, both across the literature and in this study. Whilst the importance of the client to the therapy process is very definitely unanimously identified in this study, although it is not revealed how this influence takes place and the direct affect the client has upon the intervention choices.

Importantly, the study reveals that the personal aspects of the therapist are more influential to practice than either the professional aspects of the therapist, or the external influences to the therapy process. These personal aspects range from both the internal aspects of personality to the external

experiences, (life events) of the therapist. One of the more commonly referred to external personal experiences was that of the original family environment. Previous research has tended to focus on the influence the family environment has upon the practitioner's choosing of a career in psychotherapy. Whereas the findings show that this influence goes beyond this and exists in the interventions that are provided in the therapy room.

In addition, the participants in this study believe that when they are experiencing personal challenges, they are capable of providing rich and powerful therapeutic interventions.

Lastly, the study reveals that the amount of professional experience the therapist has does appear to influence which of the aspects has the greater influence upon therapeutic intervention. Whilst the three consistent influences continue to exist, the personal aspects of the therapist and how they use themselves as a therapeutic tool does seem to change as they become more experienced. The skill set appears less influential and the personal aspects viewed more so. The exception to the increased use of the personal in the therapy appeared to be expressed when the participants were consciously considering choosing deliberate therapist self-disclosure, which seemed to be as resisted in these experienced practitioners as it was in the newly qualified years.

Implication of the Findings in Relation to Counselling Psychology

The primary aim for a practising counselling psychologist engaged in psychotherapeutic intervention is to have a positive therapy outcome, which is generally an improved quality of life for their clients. It is with this in mind that this study is approached. One of the main aims of this study was to provide something that would be; informative, applicable and useful to the discipline and therapeutic delivery of counselling psychology.

It is also intended for the study to provide other practising counselling psychologists with an insight into what their peers are doing, in what is otherwise, a very private setting, the therapy room. By doing so this may allay fears, or provide inspiration, or material for reflection.

I also hoped it would encourage the Division of Counselling Psychology to ensure that even further acknowledgement is given to the profession of counselling psychology emphasising that the uniqueness of the discipline is the use of the therapist in the therapy, and all that may influence them in the personal and professional lives. In real terms, this may involve supporting trainees to be confident in providing not only the established psychotherapeutic models of intervention, but also to feel confident in bringing more of themselves to the list of psychotherapeutic influences and subsequent intervention.

As the study indicated these eight counselling psychologist attributed the personal aspects of themselves as a significant influence upon their psychotherapeutic interventions. Potentially counselling psychology training courses could extend this further in their training programmes and include the implicit acknowledgement of the personal, beyond the parameters of just personal therapy during training. By considering how psychological insight and recovery from life's challenges could be managed for the practising therapist, it would be introducing and giving permission for the practitioner to be allowed to acknowledge emotional turmoil and be more equipped to cope.

In addition, by training courses, clinical supervisors and peers acknowledging the therapist's well-being as a continued influence upon therapeutic intervention, it could assist counselling psychologists to feel less 'ashamed' of their emotional vulnerabilities, which are inevitably going to be encountered at different stages of their professional life.

An important aspect of the interview experience for the participant was that it seemed to serve to allow and encourage the opportunity to gain a deeper and greater understanding of the influences that may have previously influenced their psychotherapeutic practice, but that on a current reflection, may now be different. An interesting note being that four of the eight participants mentioned that they had found the opportunity to reflect on these particular themes had facilitated a further understanding of themselves and their past and present psychotherapeutic practice choices. This opportunity to reflect upon practice and its constant development could be an interesting addition to the practitioner supervisory process.

Clinical supervision, despite the literature and the governing bodies viewing this as one of the more important ways to develop professionally, it appears that it is not necessarily viewed as such by the therapists. Considering that a significant finding in this particular study was that the therapist's personal life and professional practice are significantly entwined, the focus of such could be an enhancing aspect of clinical supervision.

A component called 'mapping' personal and professional stories is used in some systemic training. This refers to how trainee therapists are offered the opportunity to explore the way their personal and professional stories affect their therapeutic work. "In practice a person's many life experiences and ideas may inform their action in different ways at different times…" (Hedges and Lang, 1993, p278). This would seem an enriching addition for counselling psychologists, in both their training and post-qualified, clinical supervision.

Personal Reflections

In concurrence with the finding that the therapist's personal life events influence practice, whilst writing up this study, I experienced a significant life event that influenced both my reflections on this study and my clinical practice. I became a parent for the first time.

The influence upon this study and the clinical work were extensive. During pregnancy the effect of such was discussed in supervision, generally in the context of how it was effecting work with particular clients and reflecting on the practical considerations of maternity leave and patient 'holding'. Cullington-Roberts, (2004), warns of the peril of not acknowledging the pregnant therapist in the therapeutic work and attendance to this enhanced the depth of the work with some clients. It also enhanced my skills as a therapist. I was able to truly empathise with the parent who was concerned about their child's well-being, or the mother who had experienced loss, or a traumatic birth. Furthermore, on becoming a parent the positive effect on my practice continues, from understanding the pressure on families to managing the schedule, to identifying with the unknown aspects of parenthood. Raskin, (1978), wrote of this balance between family life and clients, he reported the depth of intimacy and love he felt at home had made it easier to be human and authentic as a therapist. With regard to the study, this awareness of how the therapist's life events influences the intervention became my experience, and the reviewing of the literature and interviewing of the participants was running alongside it. Albeit the participants were unaware of my life event, it was interesting that despite all of them being female, none of them identified being a parent as influencing their practice.

Also, approaching the end of the writing of this portfolio provokes a similar reflection to that which prompted the start of this journey. My starting point had been a simplistic notion, that when compared to a trainee, or newly qualified counselling psychologist, an experienced practitioner would be using different influences upon their psychotherapeutic interventions. At the end of this study, I am realising that it is not just the journey from newly qualified, to established practitioner, which may influence a change of psychotherapeutic influence, but a myriad of other factors. And this myriad of influences is ever-evolving as is potentially the choices we make whilst engaged in psychotherapeutic intervention.

To continue with my reflections, my own and somewhat subjective impression of the participants was, they enjoyed the opportunity to speak about themselves reflecting on both the professional and personal aspects of their lives. This opportunity to reflect openly is a position seldom occupied by a counselling psychologist. The adherence to the boundaries of client confidentiality means that professional reflection is often restricted to the clinical supervisory experience, which tends to be mostly concentrated on client material. Whilst, the personal aspect of the counselling psychologist is habitually kept from being uttered in a professional capacity, it remains something that the practitioner has to reflect in isolation. During the interviews, the opportunity to reflect and speak openly on both aspects, in one arena, appeared to give way to much thinking and talking. Some of the participants also said that they had made interesting connections during the interview and had gained further personal and professional insights. The regular opportunity for this type of reflexivity, with a trusted peer, could be an interesting addition to clinical supervision.

Training programs might consider developing more formal models of examining the trainee therapist's implicit beliefs as well as creating methods to assess them. To some extent, it could be that the theories of psychotherapy interfere with the material that the majority of the literature places central to influencing psychotherapeutic intervention, which is the therapist. It might be helpful for counselling psychologists and trainees to examine their implicit beliefs and theories about forming relationships and therapeutic alliances.

In addition, some of the areas of conversation were those of which peers may not speak of openly. This seemed apparent when speaking of therapist self-disclosure, a subject that, on occasion, seemed to elicit some level of uncertainty and the implication that this was done without usual admission. Furthering the opening up of the discussion around deliberate therapist self-disclosure would be an interesting progression. In doing so it may encourage

other counselling psychologists to discuss this more in clinical supervision and with their other peers and professionals.

Evaluation of the Study

The methodology

Like all methods of analysis, the aim of a thematic analysis is to provide insights that answer the research question that was posed at the beginning of the process. In order to do so, Braun and Clarke, (2006), emphasised that thematic analysis needs to go beyond the surface level and generate an understanding of what is going on in the data. This moving below the surface of the data is done by applying a rigorous process of analysis that is detailed at each of the stages, with the researcher asking themselves several questions at every stage.

Braun and Clarke provide a 15-point checklist for the process of analysis of the data; they state the adherence to this provides a 'good thematic analysis'. In order, to demonstrate that this process has been followed, a 'paper trail' links the journey the raw data took from the transcript to the final discussion of the themes and sub-themes. This checklist is referred to in the methodology, it has been followed throughout the study and it can be found in the appendices. In order to offer further evidence of the quality and worth of the study, its process shall be explored further under the following headers.

Validity, Reliability and Generalisability

Qualitative methods are often undertaken using small, unrepresentative samples; this means that the external validity of the data is not usually as rigorous as that of quantitative data. However, the richer collection of data that qualitative studies such as this one allows for, means that the internal validity of the data is on the whole, better than that of quantitative data (Braun and Clarke, 2013).

As with all qualitative methodologies the validity criteria has to be applied differently to a quantitative methodology. Broadly, the definition of validity refers to the need for the piece of research to address what it claims to address (Goodman, 2008). Despite validity being somewhat problematic in qualitative studies, the issues can be addressed in a number of ways. Firstly, by the researcher not imposing their assumption in the participant. For this study this was done by offering an open-ended question, playing a minimal part in the interview and throughout the entire process engaging in reflexivity.

In order to acknowledge that validity is different in a qualitative study, the influence of the researcher has been acknowledged and embraced at every stage of this study. At interview, the researcher was acknowledged as having the potential to influence the answers that may be given. Despite the question being open-ended and the interviews being conducted with as little participation from the interviewer as was possible, the influence of the researcher/interviewer is acknowledged. Secondly, the researcher influences the coding and interpretation of the data. Consequently the findings from this study are influenced by my (the researcher's) part in the process of analysis and my own interpretation and subjective perspective. Again, during the process of the discussion of the findings, the researcher is acknowledged as bringing their own interpretation of the data.

With regard to the reliability, this refers to the possibility of generating the same results when the same measures are administered by different researchers to a different participant group (Yardley, 2008). This is problematic for qualitative methodologies as it acknowledges and relishes that the researcher influences the research process. Therefore the reliability of the qualitative study is measured for its trustworthiness in other ways.

The credibility of the data refers to the extent in which you can believe in the truth of the findings. For this particular study the participants were recruited

by self-selected and fitted the chosen criteria. The researcher went about the data collection and data analysis in a rigorous and ethical manner. Participants were not coerced, their consent was elicited and efforts were made for the interviewer not to influence the direction of the interview. The interviews were recorded and transcribed verbatim.

Dependability refers to the extent to which the coding of the data was undertaken reliably, and confirmability refers to the extent to which it is possible to conduct a formal audit of the study procedures. In terms of analysis, careful attention was paid to the guidelines for thematic analysis outlined by Braun and Clarke, (2006). In addition, care was taken only to elicit themes and sub-themes that were genuine and not imposed upon the data. Rigorous and systematic analysis of the data was performed by adhering to Braun and Clarke's, (2006) 15-point checklist for 'Good Thematic Analysis' (Appendix I).

Generalisabilty refers to the extent to which the results generated in one study can be applied to wider or different populations. Some argue that generalisability is not a meaningful goal for qualitative research (Johnson, 1997). Whereas, Sandelowski, (2004), argued that qualitative research results are generalisable, but not in the same way as quantitative results. In order for qualitative research to have any meaning it has to be acknowledged that they can yield data that is generalizable. As Yardley, (2008) states: "… there would be little point in doing research if every situation was totally unique, and the result in one study had no relevance to any other situation' (p.238).

In order to enhance the generalisability of this study, the Lincoln and Guba's, (1985), formulation has been followed. The key to enhancing the transferability of the study was to describe in great detail the context, the participants, the settings and the circumstances of the study. And as such handing the responsibility of the transferability to the reader to decide whether

their settings are enough like those of the original study to adequately transfer it.

In order to further address the issue with a qualitative methodology of generalisability, the aim of this study was not to provide findings that can be generalised to the wider population. Rather, this study would provide findings gained from a sample of counselling psychologists, which could be interesting and useful to the wider counselling psychology population.

On the basis that the data is likely to be trustworthy and that some of the results overlap with those of other studies, these findings demonstrate a degree of validity, reliability and generalisability.

Limitations of this Study

Possible areas of weakness in the study are the small number of participants interviewed. There were only eight counselling psychologists who participated in this study. This was mostly due to this being the number of willing participants. In order to increase the possibilities of recruiting a larger sample, I could have offered payment for their participation in the research. I could have also advertised more widely, all of the participants volunteered after reading a recruitment advert in either the B.P.S. monthly member's magazine - The Psychologist, or via a mail out through City University. In addition, I could have advertised on more than one occasion and maybe there would have been a further response on the second occasion.

Representativeness refers to the extent to which the results are representative of the population under scrutiny, For this particular study, the participant sample was all self-volunteering. It is possible that given that all participants volunteered to be interviewed that they were likely to be the ones that this particular area of study of interest to them. It is worth noting that the people who agreed to participate in this research could have had a vested

interest in the research topic or held strong views about it. It could be that this interest prompted them to participate in the study and this would add to the sample not being a truly representative one. It may also be that those counselling psychologists whom chose to participate in the study were already practitioners who are more reflective of their practice, and of their part they play in the facilitation and implementation of psychotherapeutic practice. If it were possible, it may be interesting to see what a sample of practitioners, who were not self-selecting, would report.

Also there were not any male counselling psychologists that responded or volunteered to participate in the study. Given the ongoing percentage imbalance of men and women working in the profession of counselling psychology and echoed across all branches of the psychological therapies, this was not entirely surprising. The British Psychological Society, (2004), raised concerns about the lack of diversity in the applied psychology workforce. In addition, Bradley, (2013), expressed concerns about the lack of men on counselling training courses that he was teaching on. This could lead to an interesting debate on the social, financial and historical reasons for the under representation of men in the delivery of psychotherapeutic intervention, however the limitations of this particular study would not allow for that. Needless to say that the general under representation of men in applied counselling psychology has certainly influenced the under representation of men in this study. In addition, there was also only one participant that identified herself as being from a minority ethnic group.

Once again, as with the lack of gender/cultural representation, leads to a lack of sample representation. Given that the data would be impossible to collect without consent from the participants, this would be difficult to influence. However, potential payment, or another incentive may have led to less altruistic, or subject interested participants.

It is for these reasons: sample size, the self-volunteering nature and issues of representativeness, that this study has some limitations to its findings. However, as these eight counselling psychologists do represent the greater significant proportion of the discipline, white and female, their opinions are valid and significant enough to provide material that is worthy of reflection, discussion and a springboard for future research. The study did not aim to provide a definitive list of influences, but rather it set out to build on the existing literature and by encouraging the participants to include any factor that they feel is a relevant influence, it would provide a rich array of information and promote the uniqueness of counselling psychology practitioners. From which counselling psychology training, clinical supervision and individual experienced counselling psychologists would have a springboard of reflection. Of course the aim of the study was not for the participants to represent all of the counselling psychologists in practice, but this sample because of its small size and because of its lack of gender and cultural representation, cannot be generalised.

Whilst limitations occur for all studies, it is worth noting that the issues identified earlier about the researcher's subjective perspective for this study can, in future studies, be overcome. Because of the nature of a doctoral study, the data was coded, the themes were identified and discussed by one person. This process allowed for consistency in the method, but failed to provide perspectives from a variety of people with differing biases. When using the thematic method for a future study, the coding of data could involve several individuals with themes being developed via discussions with other researchers and/or with the participants themselves.

As described, the viewing of the data through my lens, limits the study. In this particular study there was only my subjective analysis of the data. In addition, to the effect of the researcher bias, cannot ever be fully accounted for, whilst a minimal part played by the interviewer enables the participant to speak with as little intrusion as is possible.

Future Study

Building on this study

The participants were only offered the opportunity of one interview. However, it may have yielded more interesting data should there have been the opportunity of a second interview. The second interview may have captured any post-interview realisations that the participant experienced, or as mentioned earlier may have captured the phenomena of an ever-evolving set of influences upon psychotherapeutic practice. If the theory, that any interview is only the truth in that particular space in time, then this would be expected. It may also capture the ever-evolving nature of psychotherapeutic intervention. Also, more than one interview opportunity may have led to a deeper level of trust between interviewee an interviewer. This could have led to a potentially deeper level of candid reporting during their interview experience and thus providing a richer insight.

A second improvement to this study would be a second reader. The themes that developed during the course of the thematic analysis offered some insight into what these eight counselling psychologists saw as influences upon their psychotherapeutic practice, and with me as the researcher the themes that were extracted may have been somewhat effected by my interest in them. A second reader and process of analysis may provide an even richer data set to explore.

New Studies

In spite of an increased focus on therapy outcome and measuring its effectiveness, there appears very little definitive literature that truly captures the range of influences on therapy treatment choices and even less that actually captures which of these interventions are found the most therapeutic from a client perspective. Given that there appears so much more to learn and it appears necessary that further research focuses on what influences therapists in their psychotherapeutic intervention choices.

Brugha, Matthews, Morgan, Hill, Alonso and Jones, (2012), suggests that in order to generate a plausible qualitative meta-anlaysis around twelve studies on the specific topic are necessary. This would suggest that in order for findings to be taken more seriously and acted upon, a lot more replicable research needs to take place, with studies providing information about; sampling, validity and generalisability.

Building even more on the idea of a second opportunity of interview would be a longitudinal study. A study that would take place over a period of potentially a decade of psychotherapeutic practice would be highly likely to produce some interesting and rich data. The participants would be offered the periodic opportunity of interview where they would be encouraged to give only the same focus for their interviews. This could potentially capture the ever-evolving nature of the individual counselling psychologist's psychotherapeutic practice and the ever-changing influences upon such.

Qualitative studies are beginning to find their place in helping answer those questions alongside the larger quantitative studies (Dixon-Woods and Fitzpatrick, 2001). It is clear that more high quality, qualitative studies are needed to fill in the gaps left by quantitative studies to help us understand in more detail what influences are leading to treatment choices and which are having the greatest therapeutic impact. However, a future study may add even more valuable insights to the field of counselling psychology if it was to draw from a mixed methods research design. These studies could potentially offer a far richer set of findings. The findings based on quantitative standardised methods are seen as not telling the whole story as they focus on the subjective, localised and specific, rather than generating generalizable claims about objective reality. Therefore a mixed methods set of studies could add a significant insight to this important and interesting area of study. This could potentially measure therapeutic outcome and what influences experienced therapists practice.

To add an additional interesting angle and to maximise the relevance of the research exploring what influences therapists in their practice choices, would be to then gain an insight of how the clients experienced the interventions. These findings found that the client influences the therapist's decisions and has a personal effect on the therapist. Although across the literature in all areas of therapy there has been a great deal of research documenting the experiences of therapists, there has been little research using a collaborative, therapist and client perspective. Whist there is a great emphasis in maximizing outcomes, there seems a neglect of the client contribution to this picture. When looking at the small amount of research that has been conducted from the client perspective, (Rennie, 2002, Greaves, 2006, Mackrill, 2008), using qualitative methods that don't just rely on retrospective reporting yielded some insightful data about how the client saw the therapeutic alliance and how clients actively take control, or even manipulate the events of the interaction in the session in order to regulate the intensity, to change the focus of the interaction, and to contribute to the development of a good relationship with the therapist. By doing such research it could begin to link the complex picture of process by including the interplay of client, therapist, theory and technique.

Finally, Gabbay and le May, (2004), conducted a piece of in-depth research exploring the role of theory and research in shaping the clinical decisions of primary care doctors. This was an ethnographic study using standard methods of non-participant observation, semi-structured interviews, and documentary review. The data was collected over two years and analysed thematically. If this study was replicated with both counselling psychologist and client perspectives it would yield some essential contributions to the knowledge base of what influences the practice choices of counselling psychologists and which of these interventions are found to be the most therapeutic.

Final Reflections

Reflecting on the process of carrying out a piece of qualitative research

is part of executing good methodology (Willig, 2008). In terms of the analysis and write up, I found I very much enjoyed the process of discovering the themes and thinking about how they fit together.

In addition, exploring the potential for future study was inspiring and exciting, casting a light on the potential that counselling psychology research can bring to extending the knowledge of what takes place in the therapy room and what practice choices could improve therapeutic outcome. After all, it is increasing the chances of a successful therapeutic outcome that is the goal of every therapist.

Conclusion

The present study provides a detailed picture of eight counselling psychologist's experiences of being established practitioners and what they believe influences their choices of psychotherapeutic intervention. Although this picture is a small one, when compared to how many counselling psychologists are providing psychotherapeutic intervention, it can still offer a significant contribution to the bigger picture of the practice of counselling psychology. Chin, Hayward, and Drinnan, (2009), wrote that qualitative research should not be seen as a definitive account, but as a contribution to an emerging scene.

Yet there are still gaps in the understanding of the influences to psychotherapeutic practice choices. Further explorations of how the psychological processes described here impact the therapeutic process and even more detailed, deeper interviews with these counselling psychologists would be welcomed. By doing so there would be further examples of how individual counselling psychologists see their influences leading to specific interventions.

By using thematic analysis rich layers of information and an understanding of the influences on the psychotherapeutic practice of these eight counselling psychologists, from their perspectives, has been gained. This

data, whilst not claiming to provide a definitive list of influences, it does offer the reader an opportunity to reflect and discern from these themes and sub-themes some particular aspects with which to reflect on their own psychotherapeutic practice. It may also assist psychotherapeutic practitioners to understand further, the influences upon them both professionally and personally and how this transcends to their practice choices.

Applying a thematic research method in this detailed and time-consuming way revealed insights that could lay claim to a degree of generalisability. However, this analysis reflects the goal of the exploration, which was to be helpful to other therapists in thinking about and understanding their own experiences, and how they influence practice choices. It could be asked how one can learn from another therapist's opinion of what they see is taking place in the therapy room. According to Gabbard, (2000), most psychoanalytic evidence comes from clinical encounters and accessible material from case studies. He suggests how this process allows for learning that is via identification and is consequently beyond an intellectual level.

What is concluded from this current study is that which influences the counselling psychologist and their choice of psychotherapeutic intervention is the sum of all of the aspects of the therapy; the theory, the relationship, the client, the personal and professional aspects of the therapist and the external influences of the therapy setting.

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List of Appendices

Appendix A: Recruitment Letter

Where is the Therapist in the Therapy?

Dear

My name is Debbie Smith, I am a Chartered Counselling Psychologist. As part of the requirements of the Dpsych Top-Up Counselling Psychology course at City University - London, I am carrying out a piece of research.

The research aims to explore the therapist in their delivery of psychotherapeutic intervention with clients. I plan to investigate how therapists see their practice being influenced, both personally and professionally.

I'm looking to recruit Chartered Counselling Psychologists who are at least six years post qualified and have been practising with a consistent client case-load. If you were to participate, your participation would involve a one to one semi-structured interview, which would be tape-recorded. The structure of the interview would give you the opportunity to speak freely about this complex subject matter. The interview would be held at your convenience and in a location of your choosing.

At all times your confidentiality would be protected as much as possible. In the transcription of the interview, any information that could lead to you being identified would be changed. This piece of research is being supervised by Professor Carla Willig – [redacted] & Dr Jenny Hunt - [redacted]

For your information, please find attached the participant information sheet. This is an exciting area of investigation and I hope you share this interest. If you are interested in participating in this study, please contact me for further information.

Thank you for your interest.

Appendix B: Recruitment Advert

Where is the Therapist in the Therapy?

My name is Debbie Smith, I am a Chartered Counselling Psychologist. As part of the requirements of the Dpsych Top-Up Counselling Psychology course at City University - London, I am carrying out a piece of research.

The research aims to explore the therapist in their delivery of psychotherapeutic intervention with clients. I plan to investigate how therapists see their practice being influenced, both personally and professionally.

I'm looking to recruit Chartered Counselling Psychologists who are at least six years post qualified and have been practising with a consistent client case-load.

If you were to participate, your participation would involve a one to one semi-structured interview, which would be tape-recorded. The structure of the interview would give you the opportunity to speak freely about this complex subject matter. The interview would be held at your convenience and in a location of your choosing.

At all times your confidentiality would be protected as much as possible. In the transcription of the interview, any information that could lead to you being identified would be changed. This piece of research is being supervised by Professor Carla Willig – [redacted] & Dr Jenny Hunt - [redacted]

This is an exciting area of investigation and I hope you share this interest. If you are interested in participating in this study, please contact me for further information.

Thank you for your interest.

Debbie Smith

Tel: [redacted]

E-mail: [redacted]

Appendix C: Participant Information Sheet
Where is the Therapist in the Therapy?

My name is Debbie Smith, I am a Counselling Psychologist and I'm completing a Dpsych Top-Up Counselling Psychology course at City University, Northampton Square, London, EC1V 0HB. As part of the doctorate requirements, I am carrying out a piece of research. The name of my internal supervisor is, Professor Carla Willig - [redacted] and my external supervisor is, Dr Jenny Hunt - [redacted].

The research I am carrying out explores the therapist in their delivery of psychotherapeutic intervention with clients. I plan to investigate how therapists see their practice being influenced, both personally and professionally.

If you were to agree to take part, your participation would involve a one to one semi-structured interview. The interview would be tape-recorded. In order to allow you the freedom to speak freely about such a complex matter, the interview would not be time-limited, however, should you wish for a prescribed time allowance, this will be accommodated. The interview will be as relaxed as possible with the scheduling of and the location, arranged to your convenience.

At all times your confidentiality will be protected as much as is possible. In the transcription of your interview, you will not be identified and any information that may lead to you being identified, will be changed.

This is an exciting area of investigation and I hope you enjoy your participation.
Thank you for your time and interest.
Debbie Smith
[redacted]
E-mail: [redacted]

Appendix D: Participant Informed Consent Form

Where is the Therapist in the Therapy?

The researcher is Debbie Smith- Counselling Psychologist. The researcher is carrying out this investigation as part of the requirements of the Dpsych Top-Up Counselling Psychology course at City University, Northampton Square, London, EC1V 0HB. The name of the internal supervisor is, Professor Carla Willig – [redacted] and the external supervisor is, Dr Jenny Hunt – [redacted]

The researcher aims to explore the therapist in their delivery of psychotherapeutic intervention with clients. I plan to investigate how therapists see their practice being influenced, both personally and professionally.

The data will be collected via a one-to-one interview that will be tape-recorded and transcribed. The researcher and in some cases, possibly the supervisor and examiners of this research will be the only people who would hear the tape. The tapes will not bear an identifying label and will be kept in a locked cabinet, separate to your consent form and accessible only by the researcher. People interested in this area of research may read the transcript or extracts in the final report. All indentifying details will be removed from the transcript. The tapes will be deleted following this piece of research being passed by the examiners. A final copy of the research will be available on request.

The researcher has read and subscribes to the Ethical Frameworks of the BPS/BACP and will maintain confidentiality. However, it should be noted that confidentiality has limits, for this reason, please be aware of the information you are disclosing. Should you feel concerned about the limits to confidentiality, please mention this to the researcher. In accordance with the guidelines of the British Psychological Society, should you disclose anything involving a risk of harm to yourself or others, then the researcher will be obliged to report this to the relevant bodies.

By the nature of the research topic, it is possible, that you may discuss issues that lead to you reflecting on your practice. Should this occur, it is advised that you discuss this with your clinical supervisor.

You can withdraw from this investigation, or ask for the tape to be switched off at any time during the interview. You will be given a copy of this form and at the end of the interview, you will be given the opportunity to ask any questions of the researcher.

I endeavor, as much as is possible, to protect your confidentiality.
NAME: ……
SIGNATURE:……..
DATE:……..
CONTACT DETAILS:[redacted]

I have read the above information and I consent to participation on this piece of research.
NAME: (in capitals)…….
SIGNATURE:……..
DATE:……..
CONTACT DETAILS:……

Appendix E: Interview statement

As you will have read in the participant information sheet, this piece of research is to investigate the therapist in the therapy.

I am interested in exploring what influences the choices counselling psychologists make in their implementation of psychotherapy. Factors from both personal and professional life can be included.

During the interview, I will try to be as least intrusive to your story as is possible.

If you would like to begin by speaking a little about your style of practice and the influences to your interventions. Obviously, this is not about judging how you work with clients.

Appendix F: Participant De-briefing Information
Where is the Therapist in the Therapy?

Thank you for participating in this piece of research.

I would like to ensure that you are still willing for this recorded material to be used for research purposes as outlined in the Participant Information Sheet.

Do you have any questions regarding the interview or the research?

Should any concerns arise that you feel are related to this interview, which you wish to discuss with me, I will be available via the e –mail address and telephone number, which are written below.

If any issues arise from the topics covered in this interview, you are advised to speak with your clinical supervisor or trusted colleagues.

Once again, thank you for your time.

Debbie Smith
[redacted]
[redacted]

Internal Supervisor - Professor Carla Willig - [redacted]
External Supervisor - Dr Jenny Hunt - [redacted]

Themes

Theory Training

right in my research I found this theory and it was so interesting and it talked about the um phases of your training …

Interviewer: Oh ok.

New Qualified Models Important Training experience Intuitive?

Interviewee: you know for the first couple of years you are wedded to the theories and the approaches and all your lecturers are in your head but as you get older or your, your um experience kind of builds up post qualifying like eight years down the line, it aint about theories any more, it aint about your lectures any more, it becomes integrated into the person you are …

Interviewer: Oh ok.

Personality Unconscious skills?

Interviewee: so if that's the case, I don't know why is happens you can be at a bus stop and people just tell you their lives. Is it that I am functioning as a therapist all the time, you know I'm ludicrous. However people, I don't know why, feel safe enough to give me their stuff and I am always ready to receive it or give something back.

Interviewer: Yes, ok.

Personality

Interviewee: So that suggests to me that the therapist, the counselling psychologist has become so integrated into my personality.

Interviewer: It is you?

Values Intuition

Interviewee: It is me and it is how I see things and how I think, you know.

Interviewer: Yes.

Unconscious awareness Theoretical model

Interviewee: I am aware, I don't stop in that moment and think oh that's projection, that's that, it's so ingrained that you instinctively know and respond.

Instinct

Appendix I

Braun and Clarke's, (2006) 15-point checklist of Criteria for Good Thematic Analysis

Process	No	Criteria
Transcription	1	The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for 'accuracy'
Coding	2	Each data item has been given equal attention in the coding process
	3	Themes have not been generated from a few vivid examples (an anecdotal approach), but indeed the coding process has been thorough, inclusive and comprehensive
	4	All relevant extracts for all each theme have been collated
	5	Themes have been checked against each other and back to the original data set
	6	Themes are internally coherent, consistent, and distinctive
Analysis	7	Data have been analysed – interpreted, made sense of – rather than just paraphrased or described
	8	Analysis and data match each other – the extracts illustrate the analytic claims
	9	Analysis tells a convincing and well-organised story about the data and topic
	10	A good balance between analytic narrative and illustrative extracts is provided
Overall	11	Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly
Written Report	12	The assumptions about, and specific approach to, thematic analysis are clearly explicated
	13	There is a good fit between what you claim you do, and what you show you have done – i.e. described method and reported analysis are consistent
	14	The language and concepts used in the report are consistent with the epistemological position of the analysis
	15	The researcher is positioned as active in the research process; themes do not just 'emerge'

FIGURE 1

FIGURE 2

FIGURE 3

Part Four: Critical Literature Review
Therapeutically Beneficial Deliberate Therapist Self-Disclosure

THE OUTLINE OF THE CRITICAL REVIEW

Defining therapist self-disclosure

Deliberate therapist self-disclosure

The gain of critically reviewing this aspect of the literature

Critical review of the literature exploring the ‘whom, what, when, and how’ of deliberate therapist self-disclosure.

Critique of the methodologies

Summary

References

Defining Therapist Self-Disclosure

Psychotherapeutic intervention takes place on many levels. Attention to the appropriate boundaries and knowing were the client ends and the therapist begins is one of the foundations for contained therapeutic work. However, the literature also acknowledges that at the same time, there is the encouragement of authentic relating. Rowan and Jacobs (2002), wrote extensively about the therapist's use of self, within which they identified, three positions: the 'instrumental', the 'authentic' and the 'transpersonal'. Within the 'instrumental' the therapist engages with the client through techniques and sets aside self-reflection. Secondly, the 'authentic self', here there is less interest in the monitoring of therapist interference and the limiting effect of remaining merely with applying the technical skills i.e. the 'instrumental self' is acknowledged. Lastly the 'transpersonal' engages with what is passing between or beyond, attending to neither, therapist or client. With regard to this portfolio, the more relevant of the positions is the therapist's use of the 'authentic self'. This can involve several aspects; use of countertransference, use of projective identification, use of intuition, depth of empathy and the use of self-disclosure. The choosing here to focus particularly on therapist self-disclosure was due to the theme of the portfolio, exploration what is going on in the therapist when they choose certain interventions. Seemingly, self-disclosure is one of the more contentious psychotherapeutic techniques. Therefore, increasing the awareness of this intervention, may provide support to therapists who wish to use it with confidence.

At its most basic, therapist self-disclosure may be defined as the therapist revealing to the client personal rather than professional information. However, the literature implies that self-disclosure is more complicated than is captured by this basic summary.

In psychotherapeutic terms, the literature reveals there are four different types of therapist self-disclosures. Firstly, there is what is referred to as

deliberate therapist self-disclosure. This refers to when a therapist intentionally, whether it is via verbal or non-verbal communication, discloses some sort of information that is personal to them. Within the deliberate therapist self-disclosure literature there have been attempts to separate deliberate self-disclosure into two types. Firstly, self-disclosing statements, which according to Danish, D'Augelli, and Brock, (1976), are a "…statement of factual information on the part of the helper about himself or herself" (p.261). Secondly, there is what is referred to as self-involving communication. McCarthy and Betz, (1978), wrote that a self-involving communication "…requires the counsellor to express his or her immediate feelings about or reactions to the client" (p.255). These two types of deliberate self-disclosures have been described, respectively, as self-revealing and self-involving, (Knox, Hess, Petersen, and Hill, 1997). Throughout this review, unless specified, the term deliberate self-disclosure will be referring to both therapist self-revealing statements and immediate self-involving communication.

A second type of therapist self-disclosure is what is referred to as unavoidable self-disclosure. This covers a wide range of possibilities such as therapist gender, age, style of dress, pregnancy, wedding ring, place of work, decoration of therapy room and so on. It also covers therapist non-verbal cues such as spontaneous sounds or facial movements and body language. These disclosures begin when the client has their first occurrence that this individual (the therapist) exists in the world, whether the therapist is brought to the client's attention via, advert, website or recommendation, disclosure of information about the therapist is disclosed to the potential client. This type of disclosure then continues throughout the therapy, they are often seen as unavoidable and non-harming disclosures. Even for the therapist who strives to limit self-disclosure, "…every intention hides some things about the therapist, yet reveals something else" (Aron, 1991, p. 31).

The third type of therapist self-disclosure is that which is called accidental self-disclosure. These types of self-disclosures would be unplanned and likely to be unforeseen. An example would be a chance meeting outside of the therapy room when the therapist may be with their family or pursuing a particular hobby. Or, it can be in the guise of revealing personal information that was unintended, but it may also happen spontaneously either verbally or non-verbally (Knox et al. 1997).

Fourthly, there is self-disclosure that may occur via the client deliberately looking for information about the therapist. This has of course been made easier via the Internet and the information that is readily available to clients (Zur, Williams, Lehavot, and Knapp, 2009). These disclosures can often remain unknown by the therapist, but can still affect the therapeutic relationship.

Deliberate Therapist Self-Disclosure

Review of the literature

Being aware that these four types of therapist self-disclosure exist, leads to the conclusion that some type of therapist self-disclosure appears to be a phenomenon that occurs in every single therapeutic relationship. With regard to unavoidable, accidental and client-led disclosure, the therapist has little control over these, other than to try to be aware that they exist and to try to use them therapeutically. However, under the heading of the therapist choosing deliberate self-disclosure, whether that is self-revealing, or self-involving communication, this provides an interesting and emotive debate for therapists, clients and other health professionals.

The early therapists who followed the Freudian school of therapy were led by Freud's view that the therapists should not reveal anything to the client. Freud wrote that "The physician should be impenetrable to the patient, and like a mirror, reflect nothing but what is shown to him" (Petersen, 2002, p. 21). The ethicists, who see therapist self-disclosure as boundary crossing, further add to

this view, of the non-revealing role of the therapist.

However, in opposition to the purist psychodynamic therapists and the ethicists, some of the research shows, that therapists repetitively report that they are deliberately self-revealing or using self-involving communication with clients in the therapy room (Edwards and Murdock, 1994; Mathews, 1989). Pope, Keith-Spiegel, and Tabachnick, (1987), surveyed one thousand practising psychologists. The self-reporting survey reported that at least 90% of the respondents indicated that they engaged in self-disclosure behaviour, at least on rare occasions and saw this as not deviating from the therapeutic norm. This would indicate to the reader that deliberate therapist self-disclosure is taking place frequently and without guilt. This survey seemed like a good start to investigating deliberate self-disclosure, however due to it being concluded via therapist self-reporting and due to the stigma of such an intervention, it may have revealed a conservative reporting of self-disclosure. Koltko, (1989), criticised the survey for its vagueness, i.e. use of words such as “never, sometimes, rarely”, to measure frequency of occurrences. Secondly, in reference to its inappropriate interpretations of the findings, he wrote: “…there are few things that we can concretely say about professional behaviour on the basis of this study” (p.845). Thus again leaving therapists uncertain as to whether they are following the majority in their deliberate self-disclosure, or being a lone discloser, whom is potentially unprofessional and unethical.

In line with these conflicting messages, when interviewing participants for the research component of this portfolio, I found that some reported that during their training they remembered being encouraged to use self-disclosure as a tool of intervention. However, others recalled that during training both lecturers and supervisors, very much discouraged such intervention. The literature also suggests that for many practitioners during their training, therapist self-disclosure is either taboo or portrayed as a mistake (Pope et al., 1987). As such many therapists have either received contradictory, or little and no training on

the provision of therapist self-disclosure: (Beutler, Crago, and Arizmendi, 1986; Burkard, Knox, Groen, Perez, and Hess, 2006; Knox and Hill, 2003).

Furthermore, the topic of therapist self-disclosure appears to promote strong opinions from both other mental health professionals and clients. A feature on the BBC Radio 4 programme, “All in the Mind”, briefly discussed some research carried out with American clinical psychologists. The findings showed that 75% of the sample psychologists reported having cried whilst providing a therapy session. This research prompted a strong ridiculing disapproval from Professor Simon Wessely – Consultant Psychiatrist and due to such a strong response to the feature on BBC Radio 4, from both therapists and clients, the subject was revisited on the programme the following week. The presenter reported that of the 95 clients who had responded to the feature, two thirds had stated that it was O.K. for their therapists to cry. Yet, of those that didn’t hold this view, their views were strongly disapproving. This strong support or disapproval split also occurred across the sample of therapists who responded to the feature. Despite this being an informal investigation, it does seem to reflect the repetitive difference of opinion on therapists using self-disclosure as a therapeutic intervention.

In addition to Professor Simon Wessely, the psychiatric profession has previously urged therapists to reflect on this practice. In the American Journal of Psychiatry, Guthell and Gabbard, (1989), concluded: “When a therapist begins to indulge in even mild forms of self-disclosure, it is an indication for careful self-scrutiny regarding the motivations for departure from the usual therapeutic stance” (p. 238).

Therefore with contradictory literature, the historic position encouraging the avoidance of deliberate therapist self-disclosure, the addition of some of the training institutions offering differing messages to trainees, strong opinions within both mental health professionals and client arenas about whether

therapists should self-disclose and the ethical guidelines not wholly supporting this shift, it can leave therapists feeling uncertain, unethical, anxious and guilty about choosing deliberate self-disclosure. Knox and Hill, (2003), highlighted this therapist vulnerability when considering self-disclosure:

> "When they do disclose, clinicians may thus experience marked internal struggles about the appropriateness of their intervention, struggles that may be lessened by knowing the empirical research regarding the effects of therapist self-disclosure and the circumstances under which disclosure may and may not be an appropriate intervention" (p.529).

Yet, despite the contradictions, there does seem to be an overall shift in the literature towards the acknowledgment of the occurrence of therapists choosing self-disclosure, the focus therefore appears deliberate therapist self-disclosure. Gibson, (2012), wrote: "Now that most practitioners, researchers, and theorists are moving away from, "Should therapists disclose?'' and toward ''…what, when, and how should therapists disclose?" (p.295). It is therefore the literature exploring the, "what, when and how", which is the focus of this critical review.

Knox and Hill, (2003), had earlier highlighted the worth of therapist self-disclosure in enhancing the therapeutic relationship and facilitating gains in insight. They also provided a cautionary comment:

> "…therapist self-disclosure can be a helpful therapeutic skill. When used sparingly, when containing non-threatening and moderately intimate content, and when done in the service of the client…"(p.538).

To build on this shift in the literature, I hope that by reviewing this specific area of, "what, who, when and how" it will: firstly, assist therapists in feeling more able to confidently and skillfully consider the use of deliberate self-

revealing and self-involving communication, amongst their 'tools' of intervention. Secondly, it is hoped that it will promote ongoing reflection and discussion of this intervention amongst counselling psychologists and also the wider psychotherapeutic profession. Thirdly, I hope for those therapists whom are already using self-disclosure or/and self-involving communication as therapeutic tools, they will feel more able to be open and transparent about this without fear of negative judgment or being seen as a practitioner with lapsed boundaries.

On reviewing the literature exploring whether deliberate therapist self-disclosure is beneficial to the therapeutic process, some of it revealed that clients often reported they like therapist self-disclosure and find it helpful (Hill and Knox, 2002). Earlier, Knox, Hess, Petersen, and Hill, (1997), had explored client experiences of helpful therapist disclosure. This study showed that some clients perceived their disclosing therapist as more real, human or imperfect, which had an equalising effect on the relationship. However, this was not unanimous as one participant expressed concern about therapist disclosure blurring therapy boundaries and others remarked that it inappropriately removed focus from the client and appeared unprofessional. A later study by, Barrett and Berman, (2001), found that clients whose therapists had self-disclosed, reported liking their therapist more and having fewer symptoms of post-treatment distress. In addition, Knox and Hill, (2003), concluded that whilst assessing both the immediate and distal impact of therapist self-disclosure, clients found therapist self-disclosure to be beneficial. Clients felt that therapist self-disclosure allowed them to see their therapist as human, leading to a stronger therapeutic relationship.

More recently, Henretty and Levitt's, (2010), qualitative review of the quantitative literature researching verbal therapist self-disclosure found that across the studies, results point to therapist self-disclosure having no reliable effect on how clients perceived their therapists on the five qualities of trustworthiness, level of regard, empathy, congruence, and unconditionality.

However, their review provides the following summary as:

> "A review of the published quantitative studies exploring verbal therapist self-disclosure suggested that (a) self-disclosure (vs. nondisclosure) had a positive effect on clients; (b) clients had a stronger liking for, or attraction to, therapists that self-disclosed; (c) clients perceived therapists who self-disclosed as warmer; (d) clients self- disclosed more to therapists that self-disclosed; (e) clients had a more positive response to self-involving therapist disclosures (thoughts and feelings about the client) than to self-disclosing therapist self- disclosures (extra-therapy experiences)…" (p.69).

There is literature that appears to support that clients have found deliberate therapist self-disclosure to be therapeutically beneficial. However, across the literature there are also the clients who report not having benefitted from therapist self-disclosure and at times, found it very unhelpful to the therapeutic process. Also, via my own personal therapy experiences, there have been times when I have valued the disclosures from my therapist and at other times they have seemed, on their behalf, self-indulgent. Concluding that a client on some days may find deliberate therapist self-disclosure beneficial and others days not so, unfortunately the literature exploring the client perspective of therapist self-disclosure, does not appear to capture this potential grey area.

Which type of client - who

The next area of the literature to be reviewed is that which explores the options for therapists looking to provide deliberate self-disclosures. The literature cited above suggests that some clients are aware that therapist disclosure can influence boundaries in therapy and that they hold certain expectations around their therapist's ability to honour those boundaries. Bearing this in mind, knowing which type of client is most likely to benefit from deliberate therapist self-disclosure is invaluable to the therapist. Although, across the

literature there is not always agreement on who are the better client candidates for deliberate therapist self-disclosure, there does seem to be a consensus among the theoretical and empirical literature that some are better than others.

Numerous research findings conclude that therapists should consider using deliberate self-disclosure with clients with whom they have a strong alliance and/or positive relationship (Bishop and Lane, 2001, Gallucci, 2002, Myers and Hayes, 2006). Research also appears to point to deliberate therapist self–disclosure being resisted when working with clients whom already lack poor boundaries, or tend to focus on the needs of others (Epstein, 1994, Goldstein, 1994). In addition, the literature suggests that clients with a diagnosis of personality disorder or with a weak self-identity potentially do not seem to benefit from therapist self-disclosure.

The literature also suggests that deliberate therapist self-disclosure may be counter-indicatory when the therapists' struggles are similar to the client group. This was supported by Dilts, Clark, and Harmon, (1997), they found that when the therapist had shared having had/having the same struggles as the client, it may setup competition between therapist and client. However, Costin and Johnson, (2002), analysed, via therapist self-reports, therapists who were working with clients with an eating disorder diagnosis and listed the following benefits of therapists disclosing their own past eating disorders: increased trust and empathy, shame abatement, challenging patient narcissism and grandiosity, and avoiding getting stuck. However cited in a later paper by, Jacobs and Nye, (2010), Costin had later concluded that although she believes therapist self-disclosure is important and beneficial, clinicians must walk a fine line with each client between both novice and expert and that if they are unclear, therapists should err on the side of non-disclosure. Jacobs and Nye, (2010), added that clinicians must be cautious that they are not placing treatment expectations on their clients based on what they were able to accomplish or what they believed worked for them. Knox and Hill's, (2003),

analysis of the existing research-based literature had previously concluded that: “Therapist self-disclosures should therefore involve content that has been resolved” (p.538). Whilst seeming like a good therapeutic position, therapist’s, like everyone else, are not always able to accurately judge what they haven’t resolved of their own issues.

With regard to ethnicity findings, Wetzel and Wright-Buckley, (1988), found black clients paired with black therapists showed a preference for high therapist self-disclosure. Whilst black clients paired with white therapists, showed a preference for low therapist self-disclosure. In slight opposition to this, Henretty and Levitt’s, (2010), qualitative review of the quantitative literature researching verbal therapist self-disclosure suggested that the following variables did not affect, or were not affected by:

> “…therapist self-disclosure: therapists' education; clients' age; therapists' gender, clients' gender, and gender pairing; clients' expectation of therapist self-disclosure; clients' perception of therapists' trustworthiness, level of regard, empathy, congruence, and unconditionality; and clients' use of affective words” (p.69).

In summary, the literature exploring which type of client can benefit from therapist self-disclosure appears to discourage deliberate therapist self–disclosure when the client has issues with boundaries, when the client has a diagnosis of personality disorder, when historically or currently, the client and therapist share a similar issue and particularly where the therapist’s issue remains unresolved. It also appears that differences in gender and culture in the therapeutic relationship mean that the benefit of therapist self-disclosure can be variable. However, over the recent decade, the literature has provided research that shows that deliberate therapist self-disclosure with clients where there is a strong alliance and/or positive relationship, is found to be beneficial (Knox and Hill, 2003; Myers and Hayes, 2006;). Therefore the skill to judge who

is going to find self-disclosure therapeutically enhancing seems to be the first step, before judging what when and how to deliver this.

Other advice has been offered to therapists who are considering using deliberate self-disclosure in the therapy room. Peterson, (2002), suggested that therapists should consider the following questions:

> "Is my purpose in disclosing this information to benefit the client or to benefit myself? Will this particular client use this information in a way that is helpful? Will disclosing this information interfere with our therapeutic progress such as contaminating the client's therapeutic transference" (p.30)

Peterson also advised that as the opportunity for therapist self-disclosure can happen at any time during a session, therapists should give thought to the considerations, that she highlighted, prior to finding themselves in the position to self-disclose (Peterson, 2002).

So some of the literature offers advice to therapists looking for guidance on how often to deliver deliberate therapist self-disclosure. In addition, across the literature, therapists report having found self-disclosure beneficial when it is used across different points in time in the therapeutic relationship. Many therapists report that they disclose biographical information to new clients, such as their professional training, previous experience, and some demographic information (Henretty and Levitt, 2010; Knox and Hill, 2003). Whether clients have found such disclosures beneficial is unknown and whether they would have preferred less or more is also unreported.

What and when to disclose

When guiding therapists on what to offer when choosing deliberate self-disclosure, most studies found, via observational ratings, that low-disclosing

therapists and therapists using self-involving disclosure were generally rated as more expert than high-disclosing therapists or therapists disclosing personal information (McCarthy, 1979; McCarthy and Betz, 1978; Merluzzi, Banikiotes, and Missbach, 1978; Myers and Hayes, 2006).

Therapists also report that they use deliberate self-disclosure, in the guise of immediate experiences and self-involving communication, as a means to overcome an impasse or a rupture in the relationship (Sparks, 2009; Roberts, 2005). However there is a gap in the details of how; they might detect a rupture, use the self-disclosure and what results they have gained from doing so.

In support of these research findings, Watkins and Schneider's, (1989), review via observational ratings, of self-involving versus self-disclosing therapist statement. Suggests that observers, imagining being clients, viewed and respond, to self-involving over self-disclosing disclosure more favourably. Amongst the reasons cited for why self-involving disclosure receives comparatively more support than personal disclosure include, the gradual evolution over the past two decades towards a relational rather than intrapsychic focus in therapy and the fact that an increasing number of therapists in helping professions tend to emphasise relational factors in their approach (Farber, 2006; Zur, 2007).

In contradiction to the research favouring self-involving communication over self-revealing, Audet, (2011), using participant accounts as the method of data collection, found something different. This research provided a window into how therapist self-disclosure may affect the client experience. The results suggested that there are ways therapists can share personal information, self-revealing information, without transgressing boundaries or negatively altering their role. However, Audet fails to outline exactly how this may take place in the therapeutic encounter.

Guided by their own research findings Knox and Hill, (2003), wrote a list of

suggestions of how to provide effective and beneficial self-disclosure:

> "…infrequently and judiciously, use appropriate content in therapist self-disclosures, use appropriate levels of intimacy in therapist self-disclosures, fit the disclosure to the particular client's needs and preferences, have appropriate reasons for self-disclosing return the focus to the client after therapist self-disclosure, consider using disclosures of immediacy, consider using disclosures to facilitate termination, ask clients about their responses to therapist self-disclosure, self-disclose about issues that you have mostly resolved, rather than those with which you continue to struggle" (p.538).

Seemingly implicit in all of the findings is that therapist self-disclosure should be done wisely and prudently as a means to impart understanding and facilitate healing in the best possible way (Jacobs and Nye, 2010). Whether it's considering the: with whom, how, what or when of therapist self-disclosure, the literature appears to steadily highlight the need for careful consideration to be made by the therapist. The consideration in regard to the content, context, and timing of the self-disclosure is all in an attempt to combat potential risk of rupture to the therapeutic process. However, in an attempt to limit ruptures, Wells, (1994), identified an additional type of benefit of deliberate therapist self-disclosure. Wells wrote that when the therapist realises they have made an intervention that was inappropriate, insensitive or incorrect, the acknowledgement of such by the therapist can be a therapeutically beneficial therapist self-disclosure (cited in Peterson, 2002, p.21). Once again the contradictory nature of the literature, could leave the therapist feeling uncertain of which path to take.

However, it is worth highlighting that when this goal, outlined above, is not achieved, there can be risks, some of which are outlined in Audet's, (2011) article. According to Audet, therapists must be aware that self-disclosure could cause the client to see the therapist as less professional or less competent. It

could invite in social dynamics conducive to a friendship. Audet also warned that therapist self-disclosure can threaten boundaries or pre-existing client-therapist roles and the misuse of therapist self-disclosure could result in a mutation of the therapist's role and potential role reversal. At worst, clients may feel that their needs are not being met or that they have to care for the needs of the therapist (Audet, 2011). A somewhat unsettling cautionary note, especially for the newly qualified or trainee therapist.

Critique of the methodologies

Many of the studies from which the conclusions about deliberate therapist self-disclosure have been based, suffer from methodological limitations. Researchers have indeed used many different approaches to study therapist self-disclosure and its effects. As the research has been referred to in this review, the methodology has been identified. I shall now explore how these particular methods, when used to research this particular area, have their limitations.

The majority of the research done in the area of therapist self-disclosure has been done using quantitative methodologies. This can be in the guise of counting the number of perceived therapist self-disclosures and measuring whether these led to a better outcome. By counting self-disclosures and correlating this to a better outcome, it assumes that the number of therapist self-disclosures is correlated to treatment outcome. (Audet and Everall, 2003): "There is no compelling reason to believe that more disclosures should lead to better outcome. It may even be that therapist self-disclosure yields its positive effects because it occurs so infrequently" (Hill and Knox, 2001, p. 416). In support that the quantitative methodology may have its limitations in this area of investigation, Hill and Knox, (2002), carried out qualitative research and found that although clients generally rated therapist self-disclosures as helpful, there was not a consistent positive relationship between frequency of disclosure and

treatment outcome. Unfortunately, even within a positive investigation, it provides little guidance to the therapist.

Some of the studies mentioned here have used observer ratings of mock therapy sessions (Merluzzi et al. 1978; McCarthy and Betz, 1978; Watkins and Schneifer, 1989; Twohey, 2004;). Often, these consist of a contrived therapy session with a volunteer psychology student participating in a mock therapy interaction, followed by rating the therapist. Unfortunately, the limitations of such are identified in this quote, This does not:

> "…capture actual client internal experience of the dynamics of therapist self-disclosure in genuine therapy settings, nor does it give information about the perceived consequences.." (Knox, Petersen, and Hill,1997, p. 274).

As a method of gathering data the use of standardised videos of sample client-therapist sessions, with varying amounts of therapist self-disclosure, have their flaws. As outlined by Knox et al. (1997), the limitation with this method of data collection is that those watching, cannot know how the therapist self-disclosure felt to the client, or know anything of the context of this particular therapeutic relationship. In addition, therapy boundaries, roles and professional qualities are interdependent making it difficult to isolate the impact of therapist disclosure based on one sample session. This is a significant limitation of some of the studies, failing to account for the many variables that will have an effect on whether a therapist self-disclosing has a beneficial outcome to the therapy. The fact that, seldom will it be just the self-disclosure in isolation that will have had an effect, was identified in the literature decades ago. As Nillson, Strassberg, and Bannon, (1979) wrote: "Situational variables, such as content, timing and client expectation, are critical mediating variables determining the influence of counsellor disclosure, and relatively little is known of that influence" (p.403).

Regarding analogue studies, (Hill and Knox 2001; Nillson, Strassberg, and Bannon, (1979), they have considerable practical advantages and can provide heuristically useful information. Yet it has been argued that: “[they] are problematic because they are not ‘experience-near’ and thus have limited applicability to actual therapeutic situations. In essence, studies adhering to [these designs] decontextualise a situation in which context exerts a great degree of influence” (Farber, 2006, p. 147).

Other conclusions have been reached following a series of retrospective reporting. This consists of asking clients about their recent or previous experiences with therapist self-disclosure, and inquiring about their impressions of this self-disclosure and its impact on the therapeutic process, (Atkinson, Brady, and Casas, 1981; Beutler, Crago, and Arizmendi, 1986; Barrett and Berman, 2001; Hanson, 2005; Henretty and Levitt, 2010; Audet, 2011;). It has been argued that, due to the difficulty of appraising the impact of any single statement spoken weeks or months past on measurable client changes at therapy termination, distal outcome measures are not the best way to assess therapist self-disclosure (Knox and Hill, 2003). Distal effects of therapist self-disclosure are more difficult to establish, as it can be difficult to assess the impact on the outcome of treatment of a single statement given weeks or months ago.

In addition, some of the recommendations in the literature have been drawn from the outcomes of research carried out relying on therapist self-report of self-disclosure, (Pope, Tabachnick, and Keith-Spiegel, 1987; Anderson and Anderson, 1989; Costin and Johnson, 2002; Burkard, A., Knox, Groen, Perez, and Hess, 2006;). The obvious limitation of the case study approach is that it relies on a single perspective, and on the willingness and ability of the author to examine ‘‘positive’’ and ‘‘negative’’ disclosures and their motivations and outcomes. Even with the authors’ more complete descriptions and examples for

each guideline, the interpretations of these suggestions depend very much on the subjective judgment of the individual practitioner. In addition, as previously discussed, what is deemed ‘‘appropriate’’ for one setting, therapist, client or therapeutic moment, might be ‘‘inappropriate’’ in another.

In an attempt to overcome some of these methodological issues, a larger study by, Audet and Everall, (2010), interviewed clients and didn’t include questions specifically addressing boundaries and professional qualities, but rather emerged predominantly from questions about the therapeutic relationship before and after receiving disclosure. Although the interview process yielded rich descriptions of experiences related to boundaries and professionalism, it would be beneficial to conduct a qualitative study where clients are asked specifically about their thoughts and experiences of the impact therapist disclosure had on therapy boundaries and therapist professional qualities. Moreover, as with any study using self-report procedures, it should be noted that descriptions of experiences are based on the participants’ recollection of disclosure events. Although experiences shared may have been altered over time, they nevertheless reflect ways in which clients understand and appreciate the disclosure events at the time of their interview.

To summarise, the methodological limitations will always exist, due to the very nature of therapist self-disclosure, it will always be difficult to measure the effect/outcome a therapist self-disclosure has/had on the therapy. It is difficult to standardise anything about therapy and therapist self-disclosure appears almost impossible to standardise. In addition to the methodological limitations, some of the other challenges are that therapist self-disclosure is different for each therapist, since each therapist, is an individual, they have a unique constellation of possible disclosures. In addition, the impact and perception of this constellation of possible disclosures, will also change with each client.

In addition, to methodological issues and the difficulty in researching such a difficult to measure intervention as therapist self-disclosure, when reading the existing research, the definitions of therapist self-disclosure seem to vary across the studies. Unfortunately, it appears there is not a consensus of what is being investigated and this sets a limitation to what can be concluded from the literature. This lack of consensus and consequently lack of definitive outcome, means that therapists, supervisors and training courses are left not knowing whether what they deem to be therapist self-disclosure is what the research, that showed it to have a positive outcome, deemed to be therapist self-disclosure. Unfortunately this leaves the literature failing to reduce the uncertainty and anxiety, identified earlier, for therapists around the confident use of deliberate therapist self-disclosure.

Also the area of deliberate therapist self-disclosure, there has not yet been enough research done. So although most of the theoretical models have stated their position on the use of therapist self-disclosure, there is very little applicable research that has been undertaken that provides conclusive evidence as to with whom, how, when what, therapist self-disclosure should be used as a beneficial tool of intervention. An example of such is evident in the wealth of literature there is supporting the view that therapist disclosure of their sexuality to gay, lesbian, bisexual, transgender clients is beneficial to the client (see Lewes, 1988; Herlands, 2006). However, on investigation of research supporting these views in the literature, there appeared to be only Atkinson, Brady, and Casas, (1981), who directly investigated this issue and provided an empirical study supporting the view that such disclosure from the therapist was beneficial to the therapeutic process.

Summary

This review has attempted to explore the literature around one particular type of therapist disclosure, which is deliberate therapist self-disclosure. Throughout the literature, deliberate therapist self-disclosure, is identified in two

types, self-revealing and self-involving. The view of how the therapist themselves can be therapeutically beneficial to the client have changed greatly since Freud's original writings and as such the views on deliberate therapist self-disclosure have also evolved. Unilaterally, the literature points to the fact that deliberate therapist self-disclosures are taking place in the therapy room and much of the literature claims that this can be beneficial to the client.

With the focus moving from whether therapists 'should' self-disclose to how is therapist self-disclosure best delivered, the hope of this review of the literature was to provide therapists with an evidence based outline of how to provide the most beneficial deliberate self-disclosure. However, the literature is difficult to draw definite conclusions from and there are contradictions across all the areas of deliberate therapist self-disclosure. There is contradiction of which client group it works best with, differences in the findings as to whether self-revealing or self-involving disclosure provides more therapeutic benefit, there is also a difference of outcome on when to time therapist self-disclosure and how often to use it.

It is also worth noting that adding to the challenge of drawing conclusions from the literature is the reality that much of the writings are based on research with methodological limitations. In addition, the concept of therapist self-disclosure and its therapeutic benefit to the client, as with any therapeutic outcome, is extremely difficult to measure. It is also made even more difficult to confidently gain an overall consensus of the literature when there is not an agreement across the research of what exactly constitutes deliberate therapist self-disclosure. Finally, there has not yet been enough research done exploring the beneficial use of therapist self-disclosure. Consequently there is little applicable research that provides conclusive evidence as to how therapists can provide the most beneficial deliberate self-disclosure.

To summarise, the literature could be improved by further research. However, some themes seem to re-occur across the literature and are worth giving some validation. It would seem from the literature that the overall position is supportive of using well-considered, well judged, not too self-revealing therapist self-disclosure as one of the many helpful 'tools' of intervention. (Hanson, 2005; Knox and Hill, 2003). However, therapists could benefit from being aware that there are no risk-free therapist self-disclosures (Geller, 2003), and there is not yet, evidence based guidance on how to provide beneficial therapist self-disclosure. Therefore implicit in all of the findings is that therapist self-disclosure should be done wisely and prudently as a means to impart understanding and facilitate healing in the best possible way. Nevertheless, if therapists were offered guidance and an opportunity to discuss openly and without judgment, therapist self-disclosure on training courses, in supervision, in peer support groups, it may increase their chances of providing self-disclosure in an ethical, therapeutically beneficial and non-anxiety provoking manner.

Future researchers may want to consider following a similar methodology to Barrett and Berman, 2001, utilising naturalistic experiments, with real clients, real therapists, and real therapeutic relationships. Thus, in order to obtain a complete overall picture of therapist self-disclosure practices and their effects, researchers are compelled to rely on a range of techniques and sources and then potentially triangulate their findings. It also seems relevant to consistently re-consider Roberts, (2012):

"We need to keep asking ourselves the same crucial questions: in what ways might this disclosure be helpful to my clients" (p.36). Though therapists may come to different conclusions on whether or not to self-disclose, it is important for therapists to weigh the positions for themselves. Audet, (2011) summarised that:

"Perhaps the greatest challenge facing therapists in this regard is

providing disclosure that conveys some similarity to clients on a personal dimension while simultaneously differentiating them from the client on a professional dimension” (p. 98).

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