View from the Small Chair: Clients talk about their experiences of therapy

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Submitted in fulfilment of the requirements for the degree of: Professional Doctorate of Counselling Psychology

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May 2019

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THE FOLLOWING SECTIONS OF THIS THESIS HAVE BEEN REDACTED FOR CONFIDENTIALITY REASONS:

Acknowledgments

Firstly, I would like to thank both my supervisors, Dr Cross and Dr Corcoran for all their guidance and support, I am eternally grateful to them both and would not have been able to complete this project without them. I would also like to thank City University London for allowing me to complete my studies.

I would also like to express my deepest gratitude my husband who has had to put up with my constant indecisions about finishing this thesis throughout our married life. He has always supported me and encouraged me even when I was about to give up, thank you for believing in me. Lastly, I would like to thank two beautiful girls for putting up with mummy not being able to do various things with them such as watch them at their Taekwondo grading as she needed to finish her work.

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Abstract

Relatively little research has been carried out into experiences of clients in therapy and/or counselling. There is even less regarding the understandings of experiences perceived as negative by the clients of therapy. Consequently, the purpose of the present research was to examine the experiences of clients that have experienced dissatisfaction in their encounter of psychotherapy. This is done by investigating the experiences and conceptualisations of nine participants who self-reported as having had a negative experience of their treatment. A grounded theory is applied in the research process resulting in three categories (*client expectations*; *feeling unheard and* the *delicate dance of power*) and five subcategories (*safety within these four walls, alternative interpretations; same destination; view from the small chair and letting go*) that contributed to participants labelling their experience as negative. The implications of these findings towards the best practise are discussed.

Preface

Here I outline the three different components of this Doctoral Thesis Portfolio. The first part comprises of empirical research investigating clients' perceived negative experiences of counselling and psychotherapy and gaining an understanding through their experiences for best practise. The second part consists of a case study from my clinical practice in the NHS, which highlights the importance of listening to your clients and self-reflection as a therapist as these were themes that were present in the empirical research that was carried out. The third section is a critical literature review examining the importance of Personal therapy for trainee therapists as my interest in clients' experiences started as a trainee and inspired me to look further into the topic.

Part 1: The research

This section consists of an original piece of research aiming to explore in detail the perceived negative experience of clients who have had counselling and or psychotherapy. Traditionally, the perspective of therapists and researchers dominated the literature. Increasingly, there is recognition of the importance of examining the outcome from the perspective of the client. This has been, in part, due to recognition that not all-important areas for study can be adequately explored using quantitative research. Not all data comprises that which is reducible to measurable elements which can be studied within a positivist paradigm. The ability to use the client's own data,

through semi-structured interviews and qualitative analysis, has allowed researchers to champion the voice of the client.

The study utilised in-depth interview data, gathered from a sample of nine former clients who stated to have had a negative experience of therapy. The data was analysed using constructivist grounded theory (GT) which is a qualitative methodology underpinned by phenomenological and hermeneutic methodology. The research aims to understand what contributed to the participants of the study, labelling their experience negative and how as clinicians we can minimise the likelihood of our clients having negative experiences in the future. The analysis is presented and discussed in the light of the existent empirical literature and the implications for practice and further research.

Part 2: Professional practice

This section contains an example of therapeutic work in the form of a case study which illustrates professional practice of counselling psychology in action. The case study demonstrates my knowledge and practice of cognitive behavioural therapy as a psychologist working in the NHS and the benefits of having a counselling psychology training background. The case is conceptualised using the cognitive behavioural framework and interventions discussed. I chose this case study to highlight the importance of the therapeutic relationship, therapist flexibility and managing ruptures effectively as this was instrumental in a positive therapy outcome.

Part 3: Critical literature review.

This section presents a critical appraisal of the literature regarding personal therapy for trainee therapists. The British Psychological Society's Division of Counselling Psychology currently specifies a mandatory period of personal therapy for trainees. However, evidence for the role of personal therapy in developing practitioner competence is sparse. This review of the literature seeks to understand the different views on personal therapy from different modalities of therapy as well as the trainees.

Thematic connection for the portfolio

This portfolio comprises three related pieces of work in that they all highlight the complex nature of therapy from different perspectives namely, as a trainee, as a client and as a qualified therapist. It gives some insight in the complex dynamics of therapy that may influence how it is perceived by the recipient. The critical literature review focuses personal therapy for trainee clinicians, an area from which this projected originated from. As trainee counselling psychologist, I was required to have one-to-one personal therapy which I would describe my experience of as negative. This led me be curious about other trainees' experience of their personal therapy and in the wider context of clients' negative experience of therapy, thus aspiring to investigate this area further.

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PART ONE: DOCTORAL RESEARCH

View from the small chair: Clients talk about their experiences of therapy

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Chapter 1: Literature Review

1.1 Introduction

As counselling psychologists, we are applied practitioner-scientists and therefore the aim in carrying out research is to contribute both to the current practice and conceptual fields of counselling psychology and psychotherapy, by demonstrating not only what works in therapy but also by finding ways of improving the effectiveness of the psychotherapy we offer. Counselling psychology is an applied psychological science that is influenced not only by human science research but also by the principal psychotherapeutic traditions. "[It] draws upon and seeks to develop phenomenological models of practice and enquiry in addition to that of traditional scientific psychology [...] to develop models of practice and research which marry the scientific demand for rigorous empirical enquiry with a firm value base grounded in the primacy of the counselling or psychotherapeutic relationship" (British Psychological Society, 2005, p.1).

In recent years, researchers have been attempting to answer questions such as how can we enhance treatment effects and what works for whom? (e.g. Roth & Fonagy, 2005). Lists of potentially harmful treatments have been devised (Lilienfeld, 2007), changes to training strategies proposed (Castonguay, Boswell, Constantino, Goldfried, & Hill, 2010) and service-wide studies examining adverse effects of psychological therapies commissioned (Shepherd, Evans, Cobb, & Ghossain, 2012). However, the clients voice in research is often lost and, in most psychotherapies, regardless of theoretical

orientation, clients' experiences are seen both as an important source of information guiding the therapist's interventions and as an area in which it is important to achieve change. Understanding more about clients' experiences of therapy would enhance therapist ability to respond effectively and flexibly to the clients' needs. In short, the rationale underlying research on clients' experiences in therapy is that they can help us identify ingredients that are central to change and outcome and the moments in which those ingredients are most likely present. If they can be successfully captured and studied, we may learn more about how psychotherapy works, what the curative ingredients are, and how and by which processes they are mediated. This may in turn lead to clinically useful guidelines on how to practice psychotherapy in more effective ways.

This study attempts to make an original contribution to the research of counselling psychology by exploring not only clients' experiences but more specifically, experiences that client have labelled as negative. It hopes to equip psychotherapists with the necessary tools to enhance client experiences of therapy through better understanding of clients' experience of therapy from their perspective. There is a limited corpus of empirical studies in the field thus enabling the need to fill an evident gap in the literature.

1.2 Overview

The first attempt to examine clients' subjective views of therapy may be traced back to the 1950s when Rogers (1951) examined how clients in client-centered counselling experienced the therapeutic relationship by asking them to write accounts of their experiences after counselling. In this pioneering work, Rogers commented "how little this whole field has been explored" (p.130). Almost four decades later, in reviewing literature on the client's experience of counselling, McLeod (1990) similarly questioned why researchers have "shown so little interest in the ways that clients make sense of their involvement in counselling" (p.1). More recently, in a review of research on clients' experiences, Hodgetts and Wright (2007) also commented that "little attention is generally given to the clients' viewpoint of what happens in therapy" (p.158).

All of these authors pointed out that the dearth of interest in researching clients' experience may be due to traditional belief in the superiority of quantitative research methods developed for natural science. As a result, there may have been a perceived pressure on individuals to carry out research that follows the assumptions of natural science informed by positivism which is historically seen as the gold standard. In the positivistic view, subjective views of clients are seen as being not overt, thereby invalid and unreliable. Asking clients directly about their experience of counselling is thus problematic as it threatens the most fundamental assumptions traditionally held by the majority of scholars in the field. In this light, it is not surprising to see a considerable body of studies on the effectiveness of

psychotherapies, compared to a very small body of research that involves the clients experience of counselling.

This chapter will look at the early research available exploring clients' experiences of psychotherapy; popular methods of research using the clients experience namely studies looking at outcomes; helpful an unhelpful factors research; before looking more specifically at qualitative research that has utilised experiences of clients from a range of therapeutic approaches and lastly the few studies looking specifically at negative experiences of psychotherapy. The difference between therapist and client views of the psychotherapy encounter will also be considered as it is important to understand whether the both the therapist and consumer views are aligned as many studies are conducted from the therapist perspective. However firstly and perhaps most importantly first the rationale for asking clients about their experience is outlined.

1.3 Why ask the Clients?

To ask the clients directly about their experiences of psychotherapy gives the researcher detailed data on how patients interpret and use the therapist's actions, technique and interventions (Bohart & Wade, 2013; McLeod, 2013; Rennie, 2002). What clients perceived as helpful in alleviating their problems and in stimulating new ways of handling difficulties, might not be what clinicians expected. Thus, research from the clients' perspective can contribute to reducing the risk of clients deteriorating in therapies or of being harmed by therapy interventions. As a therapist,

adopting a client perspective on therapy is also interesting as a clinical version of triangulation in research (Malterud, 2014). When clients give honest feedback, clinicians get a unique chance to see whether their aims and interventions turned out and were understood the way they intended. This information is immensely helpful in two ways. First, by improving psychotherapy technique. Second, by improving therapist knowledge of how to inform patients of what psychotherapy is, and what could be expected of it, in ways that make sense to the client (Mohr, 1995).

From a psychodynamic perspective, the client perspective may be a chance to improve therapeutic interventions. For instance, the understanding of moments when patients “misunderstand” (Rennie, 2001) is important to improve the therapist’s ability to form a therapeutic alliance within psychotherapy. It could be argued that too much emphasis on the clients’ perspective would risk a loss of objectivity. Clients have an experience of the therapeutic process, but not necessarily the ability to describe the process explicitly enough to make a meaningful contribution to psychotherapy research. Clients with personality disorders might misinterpret therapist interventions, for instance. Psychotherapy researchers in the humanistic therapy tradition have met this scepticism by describing patients as co-creators of therapy, not passive receivers of therapy who respond or fail to do so (Bohart & Tallman, 2010; Bohart & Wade, 2013; Cooper & McLeod, 2007; Gordon, 2012; Levitt, Butler, & Hill, 2006; McLeod, 1990; Stiles, 2013).

In addition, as researchers, we are interested in the clients' perceptions of the therapists in their own right, independent of whether these describe an objective reality. These perceptions are what clients will base their actions on, and therefore important for therapists to consider.

Furthermore, a real-world reason for studying client perspectives is the societal shift towards increasing client power. There is a growing interest in consumers' opinions on services provided in all areas, and psychotherapy is no exception. Thus, services are forced to be interested in patient opinions and perspectives.

1.4 Early research involving clients experiences of psychotherapy

The interest in clients' experiences of psychotherapy as a valuable focus for research dates back to the early days of Rogerian psychotherapy and, more specifically, to Lipkin's (1948) study of 37 male clients in person-centered therapy who were asked to describe their experiences of what had brought them to therapy, the therapy itself, and the changes following it. Before that, research focusing on the qualitative aspects of the actual processes of change or the clients' subjective ways of understanding and relating to therapy was rare. When the first modern psychotherapeutic techniques were born at the turn of the twentieth century, descriptions of psychotherapy and the psychotherapy process were mainly presented and discussed in case reports. In these, all accounts of interactions, experiences, important events, and understanding were typically based solely on the therapist's expert perspective.

The development of learning-based and client-centered therapy approaches in the 1920s, 1930s and 1940s brought a greater emphasis than before on evaluating the effects of therapy. Cognitive and behavioural approaches developed rating scales and questionnaires that allowed a close monitoring of therapists' interventions and clients' response to treatment, and the research groups around Carl Rogers started to make audio-recordings of therapy sessions, which made the actual in-session interactions available for examination. However, most research on psychotherapy processes was still based on researchers' or non -participant experts' analyses of data from psychotherapies, which were seen as more objective and reliable than the participating clients' (or therapists') own reports and, thus, more suitable and trustworthy as empirical evidence.

In the 1950s and 1960s a research field focusing on clients' experiences started to evolve as part of the ongoing reaction against the dominating quantitative and experimental orientation in psychological research, which had focused mainly on measuring change. At about this time, the clients' perspective and an experiential perspective on the events of psychotherapy started to gain ground as important sources of information. Client and therapist versions of rating scales and questionnaires were developed, which allowed both the objective study of clients' and therapists' subjective experiences and comparisons of participants' and researchers'/observers' perspectives (see e.g. Orlinsky & Howard, 1967; Snyder, 1961; Strupp, Fox, & Lessler, 1969). There were also a number of pioneering studies in group therapy in which clients' and therapists' written reports on their perceptions

of important events were collected and classified into categories of therapeutic factors (see e.g. Berzon, Pious, & Farson, 1963; Bloch & Reibstein, 1980; Bloch, Reibstein, Crouch, Holroyd, & Themen, 1979). This area of research has grown substantially in recent years and encompasses a wide range of approaches to define, capture and analyse clients' experiences of important factors and processes in different types of therapy.

1.5 Process- Outcome research utilising client experiences

As stated above several research paradigms aim to capture clients' and/or therapists' experiences of important aspects of the therapy or the therapy process. One of the most common types of psychotherapy research, in general, is quantitative process-outcome studies in which participants' experiences of important aspects of the therapy process are collected and used to predict post-therapy outcome. However most of these studies use theory or therapist/researcher perspectives rather than client perspectives to identify which processes, events or tasks are important, and use structured rating scales, checklists or inventories to obtain the clients' experiences.

One of the variables most frequently studied in this way is probably the therapeutic alliance (see e.g. Horvath, Del Re, Flückiger, & Symonds, 2011; Martin, Garske, & Davis, 2000). Other examples are critical incidents or "key change events" that are identified and studied with the method task analysis (Greenberg, 2007), for instance problematic reactions (Rice & Greenberg, 1984), and alliance ruptures (Safran & Muran, 2003).

There are numerous studies of clients' experiences of therapy in which someone other than the client has defined which aspect of therapy or the therapy process is important, and in which the client's answers are restricted to the range of answers provided in the questionnaires or inventories constructed or selected by the researcher.

There is an abundance of findings from this type of process-outcome studies available in the literature, with different ways of identifying important aspects of the therapy process and with the experience measured from client, therapist and observer perspectives. Some of these results highlight the importance of the clients' experience for successful treatment. For example, it has been repeatedly demonstrated that in individual therapy, regardless of theoretical orientation, clients' ratings of the alliance (i.e. the collaboratively reached agreement between client and therapist regarding the tasks and goals of therapy, and the positive emotional bond between them) are better predictors of outcome than therapists' ratings (see e.g. Horvath et al., 2011). Research has also shown that clients' perceptions of therapist empathy and their experience of feeling understood by their therapists are related to positive outcome across theoretical orientations, treatment formats, and clients' level of severity (Elliott, Bohart, Watson, & Greenberg, 2011).

The strategy of correlating a measured process with treatment outcome, accounts for the majority of process–outcome studies, but this kind of research involves several methodological problems (Crits-Christoph et al., 2013; Elliott, 2010). The most obvious limitation with correlational process–

outcome research is that correlation does not necessarily imply causation. This limits the clinical usefulness of process–outcome findings and has contributed to process–outcome evidence being excluded from many reviews of psychotherapy research findings (e.g., DeRubeis, Brotman, & Gibbons, 2005) and from government guidelines on evidence-based practice (e.g., Kendall et al., 2011).

Furthermore, many researchers (e.g., Stiles & Shapiro, 1994) have argued that a persistent but unexamined and unhelpful medical model underlies many process–outcome studies. “drug metaphor” suggests that if a process component (e.g., interpretation, empathy, homework assignment) is an active ingredient of a successful psychotherapy, then administering a relatively higher level of it should yield a relatively more positive outcome, and levels of the process component and the outcome should be correlated across clients (Stiles & Shapiro, 1994). However, the expectation that a greater amount of any positive process variable should correlate more highly with outcome betrays an assumption of ballistic causality, meaning that it is assumed that the variable affects outcome irrespective of the emerging context within which it takes place. In reality, an effective therapist is likely to continuously modify the right dosage of the intervention in response to the client.

Another kind of causal gap occurs as a result of the interval between a given outcome measure, usually based on a symptom measure at the end of therapy, and the much more detailed level at which process is analysed.

Although process measures can range from whole sessions to elements of single utterances, they generally concern only a small proportion of the overall therapy (Elliott, 2010). For example, alliance might be sampled in say, Session 3, and then related to the measurement of therapy outcome, which may occur after a much longer sequence of sessions (e.g., after a course of 20 sessions). In this case, it becomes hard to know how representative the one sampled session is of the process that occurred in other treatment sessions (e.g., a rupture may have occurred in Session 3 that was subsequently resolved satisfactorily in Session 4). Not knowing whether the sampled unit of behaviour can be generalised to the processes that occurred in other units of behaviour or sessions makes it much harder to draw firm conclusions about causal links between process variables and outcome.

Another limitation of the use of correlations in process–outcome research is the risk of reverse causation. For example, the association of alliance with outcome has been questioned on methodological and empirical grounds. The fact that alliance is likely to increase as the client begins to feel better could imply that improved outcome leads to better alliance (DeRubeis et al., 2005). A recent review of 11 studies in which methodological steps have been taken to explore the sequential unfolding of alliance and symptom change has indicated that a positive alliance does indeed precede symptom change. A rather different but often overlooked limitation is that the perspective taken in process–outcome research (e.g., that of the client, the therapist, or an independent observer) leads to different results. It has now

been clearly established that significant differences exist between the views of therapists, clients, and trained observers regarding the same event (Altimir et al., 2010). It is known, for example, that empathy rated by the therapist, client, and external observer correlates only moderately. Moreover, the client and therapist demonstrate discrepancies in their alliance ratings, with their views of the alliance being only moderately correlated (r = .36; Tryon, Blackwell, & Hammel, 2007). This complicates comparability of many process– outcome results and questions the validity of the assumption that process factors operate in the same way across different perspectives. Yet many studies use only one or at best two perspectives on the variable of central interest to the study, and they often do not use the client's perspective.

1.6 Expectation and outcome research

Before entering therapy, people generally use whatever resources they have in overcoming problems; they may self-heal either through self-help books (den Boer, Wiersma and van den Bosch, 2004) or through talking to friends, family and colleagues (Tallman and Bohart, 2008). It is only when people are unable to overcome their difficulty or distress through these methods that they might turn to therapy for help, perhaps as an alternative to seeking medical assistance. However, not everyone who enters therapy comes with positive and realistic expectations.

Quantitative studies suggest that there are many different factors involved in clients' expectations of a successful outcome in therapy. One study of

therapists' perceptions not only found that clients held unrealistic positive or unrealistic negative expectations that impacted their therapy on different levels but the findings also indicated that clients do not have a clear realistic idea of how therapy works, what the therapist's role is and what is required from themselves as clients (Tinsley, Bowman and Barich, 1993). Awareness of what is required in the role of the client and what is expected from the therapist has thrown up differences with various groups. For example, New Zealand clients were unaware that therapy required them to be active participants in the discussion and collaboration of their treatment, expecting instead, to take a more passive role whilst conversely, American clients did expect to take an active role in their therapy (Deane, 1992).

In a similar vein, Asian American clients expected and preferred their therapists to be more directive and authoritative (Li and Kim, 2004). Thus, there are differences in cultural perceptions of what therapy is and how therapy works. Whilst findings suggest that a better outcome is achieved when therapists frame their approach to meet their client's expectations, it is also known that clients can be motivated and ready for change and yet hold low expectations that therapy can help them (Constantino, Arnkoff, Glass et al., 2011).

A meta-analysis of client expectancy studies found that client hopelessness is linked with negative outcome, although it is not clear what mechanisms are involved; conversely, that although there is an assumption that positive expectations are linked with successful outcome the findings do not strongly

support this. Constantino and colleagues (2011) suggested that there were too few existing studies to be able to reach a definite conclusion, although they found indications that those who expect a positive outcome are more likely to work collaboratively with their therapist, particularly if they feel that their goals are achievable, and that clients with higher expectations of active involvement in therapy seem to achieve greater changes in interpersonal functioning.

1.7 Helpful factors research

A different approach to capturing and studying clients' experiences of important aspects of therapy is to ask the clients what they found most important, helpful, or hindering in their therapy. This is also known as helpful factors research and consists of two main approaches: First, clients are asked post-therapy or after part of the therapy to describe what they found helpful, useful, important or hindering, or they can be asked to describe to what they attribute perceived changes over the course of therapy. This is done without necessarily specifying the distinct events within which the helpful factors occurred. Second, event-based approaches in which clients' are asked post-session to specify and describe the most helpful or important events that happened in the session and what made them helpful. In both approaches to helpful factors research described above, the clients' answers are usually qualitatively analysed and categorised into overviews of types of helpful factors, or into more detailed descriptions of specific types (or aspects) of factors or events, either by using more or less predetermined taxonomies or by defining, describing, labelling and categorising the data in

accordance with established qualitative research methods, mostly based on a realist epistemology.

There are several reviews on clients' experiences of helpful factors in therapy (e.g. Elliott & James, 1989; Greenberg, Elliott, & Lietaer, 1994; Howe, 1993; McLeod, 1990; Rennie, 2002; Timulak, 2007, 2010). Elliott and James (1989) found that the factors most frequently perceived as helpful by the clients could be divided into two broad categories: relationship/affective factors and task/problem solving factors. In the first category, the factors most often mentioned by the clients were facilitative therapist characteristics, the opportunity to self-express freely, and experiencing a supportive relationship with the therapist. In the second category, the helping factors most frequently mentioned by the clients were gaining insight/self-understanding and being encouraged by the therapist to practice skills and insights from therapy in everyday life.

Similar factors have been described in other reviews, for example, Howe (1993) remarks experiencing the therapist as warm, friendly, genuine, interested and accepting, and getting the opportunity to express experiences, to explore thoughts and feelings and make sense of them as benefits of therapy, which are frequently reported by clients.

Greenberg et al. (1994) organised the five most frequently described or strongly rated helpful aspects from 14 studies of helpful factors in person-centered experiential therapies and found types of helpful aspects that could

be organized into four groups: positive relational environment (e.g. empathy), client's therapeutic work (e.g. exploration), therapist facilitation of client's work (e.g. giving feedback, fostering exploration), and client changes or impacts (e.g. experiencing positive feelings, gaining insight/awareness).

Rennie (2002), who reviewed grounded theory studies on clients' experiences in humanistic therapy, found that clients experienced the therapist's guidance as helpful so long as it was in line with their hopes and expectations. Clients also experienced that they actively used the therapy sessions to work on themselves, but a lot of this reflective work was done covertly. Timulak (2007) conducted a qualitative meta-analysis of seven studies of client-identified impact of helpful events in a mixture of therapies. He found nine categories that replicated across studies. The most prevalent were awareness/insight/self-awareness and reassurance/support/safety, which occurred in all seven studies. Behaviour change/problem solution, exploring feelings/emotional experiencing and feeling understood occurred in more than half of the studies.

In summary, research on helpful factors has repeatedly found that the aspects and factors clients usually find helpful in therapy largely correspond to the concept of common factors, i.e. curative factors that are present in all or most psychotherapeutic methods, regardless of theoretical orientation. Common relational factors are the factors most often identified as helpful. However, there are also factors identified as helpful (or hindering) that would fall into the category of specific factors, i.e. curative factors identified as

specific for a particular type of psychotherapy. For example Gershefski, Arnkoff, Glass, and Elkin (1996) and Levy, Glass, Arnkoff, Gershevski, and Elkin (1996) found that although common aspects of treatment (e.g. the therapist's helpfulness) were most frequently reported in a group of clients treated for depression, some aspects that were considered treatment specific were also reported (e.g. focus on interpersonal problems in IPT, focus on negative cognitions in CBT) and these aspects were experienced as helpful by some clients and hindering by other clients.

1.8 Hindering factors research

Very few studies have examined clients' experiences of hindering/ unhelpful factors in therapy and those who do often discuss the difficulties associated with getting clients to disclose potentially negative or hindering experiences. Hindering factors are generally considered to be both under-reported and under-researched. Previous studies have found that clients are generally reluctant to talk about hindering experiences to their therapists (Farber, 2003; Levitt, 2002; Regan & Hill, 1992; Rhodes, Hill, Thompson, & Elliott, 1994).

Even though clients are aware of the finer aspects of the relationship with the therapist there are things concerning their experiences in therapy that they do not tell even if invited by the therapist to share experiences of dissatisfaction. Instead they may use silence in response to difficult aspects of the therapy experience (Levitt, 2002), and they sometimes adapt to the therapist to keep the relationship intact (Lietaer, 1992; Rennie, 2002). In

research interviews and questionnaires, clients seem slightly more willing to express hindering or unhelpful experiences (Dale, Allen, & Measor, 1998; McKenna & Todd, 1997) but they generally report fewer hindering than helpful factors (e.g. Levy et al., 1996), tend to give fewer comments to questions about unhelpful events and seem often to attribute the experienced difficulties to themselves (Lietaer, 1992).

In a study of helpful and non-helpful events in brief counselling interviews, Elliott (1985) developed taxonomy of non-helpful therapist responses. He found six types of events that clients experienced as non-helpful. Misperception events (where the clients felt misunderstood or inaccurately perceived) was the most common, followed by negative counsellor reactions (e.g. experiencing the counsellor as uninvolved or critical), unwanted responsibility (e.g. the counsellor failing to provide a desired response or pressuring the client to talk in session or take action outside therapy). Other non-helpful events were experiences of counselor repetition (e.g. dwelling on the obvious, going over old ground), misdirection events (e.g. counselor interrupting or interfering with the client's disclosure and exploration, and the client experiencing unwanted thoughts initiated by the counselor.

Lietaer (1992) reported similar results in an investigation of helpful and non-helpful processes in client-centered/experiential therapy. He found that the unhelpful experiences could be divided in two broad categories: The first category contained experiences related to the attitudes and interventions of the therapist, e.g. the therapist lacking warmth, involvement, or

understanding, the therapist being not enough or overly passive/active, or the therapist giving inadequate interpretations. The second category contained experiences related to the client's process, e.g. the client hindering the conversation, preventing the conversation from deepening, or avoiding to talk about certain issues. Lietaer (1992) also noted that, in the first category, it was difficult to separate aspects of the relational climate from the specific therapist interventions, which was not the case with helping processes. The non-helpful processes were mostly described as events in which relational attitudes and interventions were intertwined, so that e.g. badly timed or misdirected interventions may have caused the client to experience the therapist as lacking warmth and understanding.

Similar findings were reported in a recent study of seven dissatisfied patients' views of the therapeutic process and outcome (von Below & Werbart, 2012). Patients did not describe one single factor or incident as a starting point for their dissatisfaction and they did not distinguish between the therapist's intervention and what was perceived as flews in the therapist's personality. Instead, experiences of the therapeutic relationship, suppositions of the therapist as a person, and an unproductive therapy were linked together in the patients' experience of dissatisfaction. The finding that it can be difficult to separate relational aspects from technique aspects in some types of hindering factors links to other research findings highlighting the clients' preferences and expectations as important mediators of what is experienced as helpful or hindering. Gershefski el al. (1996) and Levy el al. (1996) found that in a group of clients treated for depression, although

common aspects of treatment (e.g. the therapist's helpfulness) were most frequently reported as helpful, some aspects that were considered treatment specific were also reported (e.g. focus on interpersonal problems in IPT, focus on negative cognitions in CBT) and these aspects were experienced as helpful by some clients and hindering by other clients. Experiences of particular modalities will be explored further in the next section.

1.9 Research with clients experience of different modalities

Studies which investigated clients' experiences of cognitive behavioural therapy (CBT) (Messari & Hallam, 2003; Donnellan, Murray, & Harrison, 2012; Pert, Jahoda, Kroese, Trower, Dagnan & Selkirk, 2013) found that all participants perceived talking about their problems with their trusted counsellors who understood them, treated them as an equal, and took their problems seriously, as key to their positive experience of CBT. For example, Messari and Hallam (2003) who used discourse analysis to explore a particular way of clients' talking about CBT reported that the participants positioned their counsellors as "healers" who helped them to feel better and "educators" who were active and directive in helping them to understand and accept their illness.

Pert et al. (2012) revealed that participants came to CBT with some hopes that are directly relevant to the problems that brought them to therapy. The subjective experiences of the outcome of CBT, as similarly described by participants in all three studies are: learning coping skills, gaining control of

their problems, being calm, developing more accepting attitudes, and gaining new perspectives about themselves and life in general.

Clarke, Rees, and Hardy (2004) explored five clients' experiences of cognitive therapy (CT). The study reported that the participants valued the feeling of being understood and they also found useful the specific components of CT, namely "thought diary" and "thought challenging" and they applied these models that they gained from the therapy in their lives out with the therapy. In terms of the impact, the participants felt that CT helped them to develop new perspectives: they felt more confident about themselves, more compassionate with themselves, and better able to let go of things over which they had little power.

Three studies that looked at clients' experiences of mindfulness-based cognitive therapy (MBCT), and they reported several shared findings (Fitzpatrick, Simpson, & Smith, 2010; Mason & Hargreaves, 2001; Williams, McManus, Muse, & Williams, 2011). Two studies reported that severe symptoms appeared to bring clients to MBCT and they came with a desire to have some life improvements; to get "a cure" and to find "a solution" (Mason & Hargreaves, 2001), and to try anything that might help them to cope with their symptoms (Williams et al., 2011). Mason and Hargreaves (2001) also suggested that participants' initial expectations of MBCT helped to determine their later experiences of MBCT; the intervention was evaluated according to their perception as to whether the perceived outcome met their expectations.

Another study by Williams et al. (2011) revealed that although most of their participants came to MBCT with expectations to experience change, some of them reported uncertainty and reservations about mindfulness (e.g., “it seemed a bit unscientific”, and “you sort of go in thinking you are going to sit there and chant with bells”).

Most participants in all three studies valued the group-based intervention of MBCT: they found sharing and hearing each other’s experiences in the group supportive and insightful. According to Fitzpatrick et al. (2010) and Williams et al. (2011), most of their participants perceived regular practice as key to their therapeutic gains. However, many participants in these two studies found the commitment to regular practice challenging. Not being able to commit to the practices, the participants felt that they missed opportunities to gain benefits from MBCT.

The participants reported the impact of mindfulness meditation in terms of discovery (Mason & Hargreaves, 2001), a shift from social avoidance due to Parkinson’s disease (which is caused by a fear of others’ reactions) to cope better with such reactions (Fitzpatrick et al., 2010), and “relaxation, “calmness”, and “inner peace (Williams et al., 2011).

More specifically, in Mason and Hargreaves’s (2001) study, although not all participants reported therapeutic gains, all of them who did reported gaining an insight into what caused their depression, being more sensitive to their emotions and thoughts, having some control over mind, being able better to

live in the present, and developing an accepting attitude. Fitzpatrick et al. (2010) similarly reported that many of their participants found mindfulness useful in breaking the circle of anxiety. They felt more empowered by being able to gain control over their stress and emotions, and this was thought to be the result of some development of an accepting attitude.

Williams et al. (2011) revealed that most of their participants felt that they had gained some helpful skills in coping with their anxiety, and they became more accepting of their health anxiety experiences. Some participants also felt that MBCT practices helped to enhance their awareness of their thoughts, bodily sensations, and emotions, and this increased awareness helped them to understand and break their HA circles. Moreover, all the participants in this study reported the shift in their outlook on their lives (e.g., having more positive views towards themselves and also being kinder to themselves when experiencing difficulties, seeing their difficulties as common rather than specific to themselves).

Bury, Raval, and Lyon (2007) used IPA to explore the experience of psychoanalysis from the perspectives of six young clients. The authors presented the themes chronologically, starting from the process of seeking help to the ending process of the therapy. The main findings indicated that the process of coming to the therapy was not straightforward and that it was shaped and influenced by the participants' recognition of the severity of their problems, their feelings of despair, and their expectations that the therapy would provide them with some help. Despite this, the participants also

expressed ambivalence about seeking help because they were afraid of being judged by others due to the perceived stigma and shame associated with having mental health issues. In the therapeutic process, the participants considered their counsellors as key in the therapeutic process. They placed a high value on being listened to, understood, and accepted by their counsellors. However, almost all the participants had a sense of powerlessness: they perceived their counsellors to be in a more powerful position which made them ambivalent about challenging the counsellors or even asking a question. It should be noted that this study did not report the impact of the therapy on these participants.

Another IPA study conducted by Hodgetts, Wright, and Gough (2007) explored five clients' experiences of dialectic behaviour therapy (DBT). The authors identified three themes chronologically: "Joining a DBT programme", "Experience of DBT", and "Evaluation of DBT". Entering therapy, the participants expressed feelings of despair and a desire to make some changes to their lives. In terms of the participants' experiences of DBT, they referred to particular DBT skills as useful, and they also considered the individual counsellors' qualities as significant in providing them support. Many participants also highlighted the importance of being self-healing agents: they believed that the extent to which DBT was effective varied according to the degree of their commitment to make use of what they gained from DBT. Evaluating DBT, all the participants reported change in terms of their increased ability to control their emotions.

Poulsen, Lunn, and Sandros (2010) explored psychodynamic psychotherapy from the perspectives of fourteen clients with bulimia nervosa (BN). Prior to the therapy, seven participants expected that their counsellors would teach them how to deal with their bulimic symptoms, but they experienced the counsellors as “passive, vague, silent, elusive, and too soft” (p. 474). However, the other five clients felt rather comfortable with their counsellors’ nondirective approach. The quality of the therapeutic relationship appeared to lie at the heart of the clients’ experience of the therapy. All the participants valued being listened to, accepted, and understood by their counsellors. They also valued the counsellors’ relational skills, such as the ability to clarify and make connections, the ability to ask good questions, and the counsellors’ encouragement of emotional expression. Seven participants perceived the impersonal characteristic of their counsellors as unhelpful. Following the therapy, all the participants reported change in terms of improvement of their understanding of bulimia nervosa and their bulimic symptoms.

In an ethnographic study, O'Connor, St. James, Meakes, and Pickering (1997) explored eight participants’ experiences of narrative therapy, aiming to reveal what the participants found helpful and/or unhelpful in narrative therapy. The findings suggested that the participant valued the feeling of being understood, accepted, and treated as the experts on their own family experiences. For the participants, these qualities of the therapeutic relationship enabled them to make some changes to their own problems.

However, some of the participants perceived the therapy as slow and this for them was unhelpful

Using grounded theory, Rayner, Thompson, and Walsh (2011) investigated nine clients' experiences of receiving cognitive analytic therapy (CAT) and found that the participants regarded the qualities of the therapeutic relationship as key: they valued talking to their counsellors whom they perceived as friendly, caring, truthful, reassuring, encouraging, personal, and sympathetic. As a result of CAT, most participants reported general positive changes within themselves: having a better understanding about their feelings which led them to doing things differently, being kinder to themselves, finding a relief, gaining new perspectives, developing self-confidence and self-esteem, and having a better relationship with others.

In summary, the published qualitative studies that explore clients' experiences of therapies are limited but provide evidence that all counselling approaches as reviewed, can generate some changes in clients. This accords with comprehensive reviews by Stiles, Shapiro, and Elliott (1986) and by Cooper (2008) that although there are differences both between and within the models of different therapeutic approaches, on average psychotherapies generate positive equivalent outcomes. This review suggests that clients across all forms of therapy place a high value on the quality of the counsellor-client relationship. It is not surprising that this relational aspect of counselling is generally termed in the counselling

literature as a non-specific factor (Lampert & Barley, 2001; Ward, Linvelle, & Rosen, 2007).

This is consistent with another extensive review of relational factors in therapy by Cooper (2008) who summarised that “the quality of the therapeutic relationship is closely associated with therapeutic outcomes, across both relationally orientated and non-relationally orientated therapies” (p. 125). Specific components of a particular approach (e.g., mindfulness meditation in MBCT and CAT tools in CAT) are also viewed as helpful. Moreover, several studies similarly indicated that clients came to therapies with hopes and expectations to make a difference to their lives. Although clients in many reviewed studies acknowledged counsellors’ personal qualities and skills as keys in facilitating the therapeutic change, they believed that such change depends largely on the degree to which they use what they gained from therapy for their own benefits. This echoes Bohart’s (2000) view that clients are self-healing agents “who operate on therapist input and modify it and use it to achieve their own ends” (p. 132).

These findings are broadly consistent with “common factors” that have been frequently identified in the counselling research. Hubble, Duncan, and Miller (1999) divided common factors across therapies into four main categories and gave each of them a percentage indicating its significance: a) Client/therapeutic factors: clients’ own strengths and abilities to heal themselves which is believed to account for 40% of the successful therapeutic outcome; b) Relationship factors: the quality of the therapeutic

relationship which is generated by, for example, counsellors' empathy, support, caring, and acceptance, accounting for 30% of outcome; c) Hope and expectancy: clients' beliefs in the potential positive outcome of the therapy, accounting for 15% of outcome; and d) Model/technique factors: the specific components within different therapeutic approaches and this accounts for the remaining 15% of the successful outcome. The authors of almost all the reviewed studies, except two (O'Connor et al., 1997; Pert et al., 2013), also explicitly commented on this issue and attributed such dominance to the little attention that the field has given to understanding psychotherapies from clients' own perspectives. These authors also highlighted the need for more exploratory studies, using qualitative research, within which it "allows for the discovery of phenomena without data reduction that may obscure meaningful distinctions" (Hodgetts, Wright, & Gough, 2007, p. 173). It is also noticeable that seven out of the twelve studies used IPA in their explorations. This suggests the particular relevance of IPA to an understanding of client's idiosyncratic views of their therapy.

Although the studies mentioned above have made good attempts to understand the experiences of therapies directly from clients' points of view, the findings presented in some studies were still largely descriptive and superficial, with participants' own words being heavily used without further exploration and explanation (Clarke, Rees, & Hardy, 2004; Hodgetts, Wright, & Gough, 2007; O'Connor et al., 1997). It is also noticeable that the research has very rarely examined the negative experiences of therapy, something

that the current study aspires to do. Two recent studies that have specifically looked at negative experiences of psychotherapy are outlined below.

1.10 Negative experiences in psychotherapy research

Crawford, M., Thana, L., Farquharson, L., Palmer, L., Hancock, E., Bassett, P., Parry, G. (2016) recently conducted a *real-world* survey of the negative experiences reported by clients. The audit examined clinical records and surveyed people in both primary and secondary care services and approximately 60% (220 services) of all eligible NHS services participated. Clients aged over 18 and receiving out-patient treatment for anxiety and/or depression were invited to complete an anonymous (online or paper) questionnaire. All of those who participated expressed whether they had experienced '*lasting bad effects from the treatment'*. The terms 'lasting' and 'bad effects' were left quite opaque.

Crawford and colleagues also assessed how various demographic and clinical factors were associated with the experience of lasting bad effects.

Below is a a summary of their findings:

- Most patients reported being referred at the right time, offered the right number of sessions and given sufficient information about treatment before it commenced
- Lower reporting of negative effects was associated with various pragmatic variables including whether patients were able to get to appointments without difficulty and whether they were scheduled at convenient times

- Patients aged over 65 (and especially those aged over 75) were less likely to report negative effects than younger patients
- The most striking findings, however, were the much higher rates of long-lasting negative effects of psychological therapy reported both by people from Black and Minority Ethnic groups (BME) and by non-heterosexuals (Lesbian, Gay and Bisexual: LGB).

The findings regarding BME and LGB groups are concerning. We know that LGB adults have a higher prevalence of poor mental health and lower wellbeing when compared to heterosexuals (Semlyen et al 2016) and the study suggests they are also at greater risk of long-term negative effects following psychotherapy. Similarly, it has been long-known that people from minority ethnic groups experience "persistent inequalities in both experiences and outcomes" in their contact with psychiatric services (Bhui et al 2015) and that UK clinical psychology services "…are failing to meet the psychological and clinical needs of people from minority ethnic groups" (Williams et al 2006). The result of the survey suggests that individuals already at increased risk of mental health problems may be more likely to report negative experiences resulting from psychotherapy. Further research with regards to race and ethnicity on client experiences of mental health are highlighted in the next section.

Scott & Young (2016) note that Crawford et al. (2016) do not account for how therapist characteristics contribute to the negative experiences of therapy. It is also worth noting that Crawford et al (2016) examined only

outpatients diagnosed with anxiety and/or depression. Future studies would need to look at rates of negative experience amongst those with more severe mental disorders. The study also assesses patients within the NHS and future work might explore the comparable figures in private practice.

Hardy, G.E., Bishop-Edwards, L., Chambers, E. et al. (2017) address one of the criticisms of Crawford et al's study in that they involved both patients and therapists. Patients were asked to reported on an unhelpful or harmful experience of therapy, and therapists on a therapy where they thought the patient they were working with had a poor or harmful experience. Their data comprised 185 patient and 304 therapist questionnaires, 20 patient and 20 therapist interviews. The thematic analysis highlighted that there was a Lack of fit between Patient needs, Therapist skills, and Service structures. They suggest that this could then result in Fault Lines, a tension between Safety and containment and Power and control. This tension led to Strain and Poor Engagement, which led to Consequences following the negative therapy experience.

Hardey et al (2017) concluded that patients require clear information, choice, involvement in decision-making, explicit contracting and clarity about sessions and progress. Opportunities for patient feedback should be the norm, where the therapist and service are vigilant for signs of deterioration and solutions considered. The findings of this study indicate the importance of providing patients with a supportive service structure that offers clear

information, choice and involvement in decision-making. Explicit contracting at the beginning of therapy and clarity about sessions and progress are also important in managing patient expectations throughout. However, it is also important to consider that the study includes an unselected sample therefore it is unclear how representative the sample was of patients and therapists who had negative experiences of therapy. The method of recruitment also meant the sample was heterogeneous regarding patient diagnosis, service type and context. Although the sample included both patient and therapists, patient-therapist dyads were not targeted, so no comparison of views of the same therapy was possible. Participants were asked to describe a therapy that had happened in the past, sometimes they reported events that had happened several years previously, and time and reflection will have changed their reporting of events.

1.11 Influence of race, ethnicity and sexuality on clients experiences of mental health treatment

Cultural competency on the part of mental health care providers has been mandated throughout mental health provisions, but it is unclear if cultural elements regarding race and ethnicity actually affect clients' experiences in treatment.

There is an abundance of research relating to the barriers faced by minority communities of accessing mental health services (for example, Gary 2005; Bhui et al., 2003; Kovandžić et al., 2011) but few empirical investigations of the effects of race and ethnicity elements on client satisfaction of

psychotherapy and perceived outcomes. Research in this area has mainly focused on racial matching (Karlsson, 2005). A meta-analysis of 10 studies found no significant difference between racially matched dyads versus unmatched dyads with regard to staying in treatment and overall functioning for African American and White clients (Shin,Camacho-Gonsalves, Levy, Allen, & Leff, 2005). Despite this, ethnic minority clients may view ethnically similar counsellors as more credible sources of help than White counsellors because they assume shared commonalities in culture or values, elements that may be important to minority mental health clients (Meyer, Zane, & Cho, 2011; Sue & Zane, 1987; Zane et al., 2005). It may also be that the counsellor's and client's racial worldviews (or racial identity stages) have a much stronger impact on the counselling process than race (Atkinson & Thompson, 1992). Ward (2005) found that racial match might be more important for individuals with a stronger Black identity.

Meyer and Zane (2013) in their study, demonstrate that issues surrounding race and ethnicity are important to ethnic minorities and that clients are less satisfied when such elements are not included in their care. They reported that when mental health clients felt like a cultural element was important in their care, but did not perceive it to be present, they were less satisfied with aspects of their treatment. However, it is important to note this was the case only for ethnic minority clients, not for White clients.

In addition, although racial match and provider knowledge of prejudices and discriminations was significantly related to aspects of the client service experience, neither was related to perceived treatment outcomes. These

results seem to corroborate those of other studies that concluded that cultural elements (e.g., racial match) might aid in treatment engagement and/or retention but play only minor roles in treatment outcomes (Beutler, Machado, & Neufeldt, 1994; Cabral & Smith, 2011).

The topic of matching client and counsellor sexual orientation has also received some attention with regards to the LGBT community, including a study by Bernstein (2000) that suggested that, presumably heterosexual, 36 psychotherapists can work successfully with lesbian and gay people and their families as long as they are accepting of their clients' sexuality and reasonably free of heterosexist bias and homophobic prejudice. The author highlighted the importance of disclosure, trust and collaborative meaning-making in creating a therapeutic relationship that is sensitive to the unique issues of lesbian and gay people, clinically effective, and ethically responsible.

A UK- based qualitative study of 14 gay men's experiences of psychotherapy and counselling found that, in contrast to most studies from the United States at the time, the overall experience of psychotherapy was considered helpful by the respondents, but that their experience of discussions around their sexuality was not and that they felt this area was not sufficiently explored (Mair & Izzard, 2001).

In a US-based qualitative study by Israel, Gorcheva, Burnes & Walther (2008), 42 LGBT individuals were interviewed about helpful and unhelpful

therapeutic situations. The study found that the participants did not necessarily focus on sexual orientation in their narratives and suggested that researchers expand their enquiry beyond just sexual orientation to broader therapeutic aspects. Also, given the different stages of identity formation and orientation identification, it was mentioned that psychotherapists need to take the fluidity of sexuality into account in practice. It was further highlighted that transgender issues appeared to be distinctly unique from LGB issues and required a special set of skills and knowledge to address. The authors felt that an understanding of LGBT clients' lives outside the therapeutic situation was important and that the effectiveness of psychotherapy could be increased by working with the larger LGBT community. This finding resonates with Nel's (2005) call for community-based organisational involvement in empowering LGBT communities.

A recent qualitative study among 16 self-identified lesbian, gay, bisexual and queer psychotherapy clients in the United States explored sexual orientation micro-aggressions. Taking a cue from race studies, the authors defined micro-aggressions as "communications of prejudice and discrimination expressed through seemingly meaningless and unharmful tactics" (Shelton & Delgado-Romero, 2011, p. 210).

Most of the participants experienced their more recent counselling as positive, useful and helpful. In some cases, previous experiences some years back were more negative and disaffirming. This might indicate that counsellors are more affirming today than before. Given that this is a

qualitative sample, the findings should be interpreted with care as several other studies have indicated more negative, discriminatory or negative experiences with healthcare providers (Graziano, 2005; Meyer, 2003; Rich, 2006; Wells, 2005; Wells & Polders, 2003). Israel et al. (2008) found that the most commonly described helpful situation was where counsellors were warm, trustworthy and caring, followed by counsellors being affirming in dealing with their clients' sexual orientation or gender identity.

Victor (2013) found that the majority of the participants' that reported negative experiences with a counsellor in his study, related to how the counsellor dealt with sexual orientation. Themes that emerged in his research included the counsellor viewing the participant's sexual orientation as abnormal; evidence of heterosexism and negative myths and stereotypes; viewing sexual orientation as an either/or dichotomy within which the participant had to "choose" or "decide" where they belonged; not dealing with the participant's internal homonegativity; not realising that LGB youth might face different challenges than heterosexual youth; a lack of comfort in meeting the counsellor in social contexts; and the counsellor viewing the participant only through their sexual orientation.

1.12 Client-therapist gap

As mentioned earlier in the chapter, there is some evidence to suggest that therapists have limited ability in predicting negative outcomes in therapy (Hannan et al., 2005).

Lambert (2007) asserts that to reduce negative effects in therapy, we must first be capable of predicting them. Preliminary findings underpinning this research observed that clinicians have limited abilities in predicting deterioration in clients. For example, Hannan et al. (2005) developed a set of laboratory tests to predict treatment failures, using various outcome measures and treatment predictors. Over three weeks, 26 (of 332) clients deteriorated. The tests correctly identified 20 (77%) of the 26 who deteriorated, whereas therapists only identified five, suggesting therapists require independent data to help them to identify clients that are likely to deteriorate.

Hatfield, Mccullough, Frantz, and Krieger (2010) used outcome measures to identify sessions in which client's symptoms significantly worsened to examine therapists' awareness of client deterioration. This was then compared with therapists' progress notes to examine whether the therapist had noted this deterioration. The results found that therapists detected deterioration in only 15 (21.4%) of the 70 cases where deterioration had been identified from outcome scores. The authors note the limitations with this design, for example it would be good clinical practice for therapists to record deterioration in progress notes, but this does not mean that it necessarily happened in every case.

Furthermore, research has consistently found discrepancies between client and practitioner perceptions (Hodgetts & Wright, 2007; Llewellyn, 1988), particularly when client views of therapy are negative (Below & Werbart,

2012). A number of studies identified that when therapists of clients who are deteriorating are interviewed, most attributed the deterioration to the client (e.g. Shepherd et al., 2012). Further to this, therapists were generally more satisfied with the therapy than their clients (Below & Werbart, 2012). This may stem in part from individuals, including health professionals, overestimating their capabilities (Tracey, Arroll, Barham, & Richmond, 1997; Woolliscroft, Tenhaken, Smith, & Calhoun, 1993). Therefore, when presented with information suggesting client deterioration, therapists tend to attribute this either to the client (Shepherd et al., 2012) or downplay the deterioration (Below & Werbart, 2012; Whipple & Lambert, 2011).

One study has also identified this discrepancy with clients who fail to respond to therapy. Coffman, Martell, Dimidjian, Gallop, and Hollon (2007), report on a subset of clients who describe 'extreme non-response' to cognitive therapy with regard to their self-reported depression. This self-evaluation of depression did not correspond with equivalent therapist ratings. The authors suggest that although this may be an anomalous result, it may equally be an outcome that the therapists did not detect, or alternatively the client may not have valued any improvement that had been made. Although this is a single study, when taken together with the literature on failure to detect deterioration, it becomes an area which warrants further attention.

Research has shown discrepancies between therapist and client evaluations. For example, previous quantitative research in the field of client experiences has highlighted that clients have different evaluations of

significant moments in therapy, as well as holding more accurate perceptions of their therapy than their therapists; but nonetheless greater emphasis was placed upon the judgement of therapists and external raters (Gurman, 1977; Tyron,Blackwell and Hammel, 2007b; Timulak, 2010). By privileging ‘expert’ opinion over clients’ views, therapists can be misled about what clients actually find important in therapy and what works for them.

It can be hard for clients to articulate dissatisfaction to their therapist (Levitt, 2002; Sells, Smith, & Moon, 1996). Instead, clients may take personal responsibility for difficulties experienced in therapy, blaming themselves rather than the ‘expert’ therapist (Dale, Allen, & Measor, 1998; Lietaer, 1992). The theme of destructive use of therapist power runs through many client accounts of experiences of having been harmed or damaged by therapy (Armsworth, 1990; Bates, 2006; Dale et al., 1998; Frenken & van Stolk, 1990). In a study of clients who had reported that their therapy had not been helpful, von Below and Werbart (2012) found that dissatisfaction was associated with two main factors. Clients believed that the therapy approach to which they had been exposed was not relevant to their needs. They also described their therapists as inattentive and nonresponsive. Taken together, these clients described themselves as having been emotionally and relationally abandoned. It was also notable that, at the same time, these clients acknowledged the existence of positive aspects of the therapy that they had received.

1.13 The Relevance of Research to Practice

Rowan (1992) suggested that those who are involved in research in psychotherapy have become remote from those who practise it, he goes on to state "It is difficult for the ordinary person to realize just how irrelevant most of the research actually is" (p.160). In a similar vein, Greenberg (1981) argued that often research in psychotherapy offers little to those practitioners with knowledge about what influences therapeutic outcomes being "disappointingly meagre". In the standard work on outcome research Garfield and Bergin (1986) offer a comprehensive review of current psychotherapy research.

Rowan (1992 pg.160), when discussing this work, suggests that the interesting thing about many of the studies described is that no clear results emerge at all. He concludes that the best controlled studies tell us virtually nothing about psychotherapy as ordinarily practised and suggests that we have to move to a new paradigm of research which does not even attempt to talk about variables, ".... but which talks instead about people, and to people and with people". In addition, if we believe that clients are instrumental in self-healing and experts in their own experiences, then we need to hear more clients' voices rather than rely on therapists to provide the only voice of what happens in therapy

Thankfully there is a developing professional awareness that psychotherapy research focusing on the perspectives of the consumer will provide relevant data which will increase our understanding of psychotherapy and its effects

(Mcleod, 1998; Howe, 1994; Barker & Baldwin, 1991). It supports the view of Rowan (1992) and Mahrer (1985) that our understanding is limited by our attempts to isolate and manipulate experimental variables, rather than be concerned with talking with people and exploring how they make sense of their experience. Such inquiry is seen as relevant to psychotherapy practitioners in that the clients' understanding of psychotherapy will influence how they interact and become involved in the therapeutic task.

Whilst there has been a slow trickle of qualitative research over the years, currently there are indications that this is advancing with more researchers developing different qualitative methods for researchers to follow and use in the field (e.g. Etherington, 2004; Charmaz, 2008; Smith, Flowers and Larkin, 2009). Accordingly, more qualitative studies are required in order to expand this research base and broaden our understanding about client experience. Although quantitative measures are useful for quantification across a large population sample, small-scale qualitative studies gather detailed accounts from individual clients themselves, supplying context, meanings and richness that cannot be obtained by using pre- defined and fixed-response questionnaires that by their nature can only be superficial. Studies using qualitative methodology bring complex analysed data to research that is equally important as quantitative outcome measures and is more relevant to clinical practice.

1.14 Aims and Objectives

The aim of this research study is to contribute to the understanding of factors that may lead clients to label their counselling experiences as negative. The qualitative research contained within this project hopes to add to the small number of studies previously conducted in the field of counselling psychology. It focuses on both research and clinical aspects of perceived negative client experiences during therapy, how clients make sense of such experiences, and the interpretations that can be discerned from participant accounts. In undertaking such research, we can begin to initiate discussions whereby outcomes of therapy can potentially be improved.

Chapter 2: Methodology

2.1 Overview

The chapter commences with a brief discussion of some of the key ontological, epistemological and methodological paradigms in real world research and the present project is positioned in relation to these. Once philosophical matters have been addressed, two main methodological categories used in social science research are outlined followed by the selection of the grounded theory methodology and implications of alternative approaches are considered.

2.2 Ontology and epistemology

A deep understanding and awareness of the predominant philosophical and theoretical beliefs and paradigms has been considered an essential prerequisite to conducting responsible and informed research, as the "researcher's theoretical orientation has implications for every decision made in the research process, including the choice of method" (Mertens, 2005; p. 7). This section will therefore aim to explain the reasons for the methodology selected in the present study.

2.2.1 The post-positivist paradigm

Ontology refers to the way one views and understands the social phenomena. For the post-positivist paradigm ontology is informed by realism and supports an objective, stable and independent of judgment view of reality (Cohen, Manion and Morrison, 2011). In this paradigm, knowledge is

seen as hard and objective and can be gained through direct experience and rigorous scientific procedures (Robson, 2011). The methodology that the researcher might therefore use in this paradigm is closely related to the natural sciences and tends to be primarily nomothetic and quantitative (i.e. experimental or quasi-experimental; Mertens, 2014).

2.2.2 The constructivist paradigm

While positivism has been traditionally described as 'the standard view of science', its fitness for all aspects of the social sciences has often been doubted (Robson, 2011). A body of criticism of the assumptions and methodology of the post-positivist paradigm and its application to real world research and human behaviour led to the formulation of the diametrically opposed paradigm of constructivism (Robson, 2011). The ontological beliefs of this paradigm are founded on nominalism, advocating against the universality of reality and for its subjective interpretation through each person's perception (Cohen, Manion and Morrison, 2011). Knowledge is perceived to be socially constructed and, in research, to be the outcome of the interaction between the researcher and the participants (Mertens, 2014).

This epistemological stance therefore requires the researcher to acknowledge their involvement in the research process and attempt to access and comprehend the participants' complex, multi-layered and actively constructed worlds as experienced and interpreted by them (Cohen, Manion and Morrison, 2011). Adherents of the constructivist paradigm are more likely to prefer idiographic and qualitative methodology in obtaining the

desired knowledge and understanding of the world (Cohen, Manion and Morrison, 2011).

2.2.3 The transformative paradigm

The transformative paradigm is concerned with power imbalances and aims to give control to marginalised groups of the population (Mertens, 2014). Political, cultural, economic and social implications in the under-research topic are placed in the epicentre of the research and the researcher's primary aim is to inform practice, bring change in favour of underrepresented groups and ultimately facilitate social justice (Cohen, Manion and Morrison, 2011). In this paradigm multiple realities are recognised as valid, but they are critically examined through their potential contribution in oppressive social systems and policies (Mertens, 2014). The discovery of knowledge is seen as an interactive process between the participants and the researcher and knowledge is examined within the social and historical influences it has been situated in (Mertens, 2014). The combination of qualitative and quantitative research methods is common in this paradigm (Mertens, 2014).

The next sections will detail quantitative and qualitative methodology.

2.3 Quantitative methodology

Quantitative research has its roots in the dominant positivist and post-positivist research paradigms (Rennie, 2002). Positivism posits that objective, immutable truths exist in the world, and that these can be apprehended through rigorous research methods; it is proposed that an unbiased researcher can attain the goal of discerning phenomena in the one

and only correct way (Willig, 2008).

Similarly, post-positivists postulate the existence of an objective reality; however, by contrast, it is argued that this reality cannot be perfectly apprehended because of the limits of the human researcher (Ponterotto, 2005). Further, post-positivism emphasises theory falsification (hypothetico-deductivism), in contrast to the positivist, theory verification approach (inductivism) (Lincoln and Guba, 2000). Karl Popper's (1969) primary criticism of inductivism was that no matter how often a given process was observed, e.g., a follows b, one could never be certain that the next observation would conform to the same pattern.

Post-positivism emphasises the derivation of hypotheses from extant theory, which are tested through observation or experiment (Willig, 2008). The aim is to falsify a theory's claims, rather than to verify them. Through this process, disingenuous claims can be identified which, in turn, moves the researcher closer to the actual truth (Willig, 2008).

Despite these differences positivism and post-positivism share significant common ground and, taken together, form the epistemological foundation of quantitative research (Ponterotto, 2005). Both paradigms emphasise prediction and the study of universal cause-effect linkages that can be generalised (Denzin & Lincoln, 2000), and view the role of the researcher as unbiased and detached (Willig, 2008). Therefore, quantitative studies generally use large-scale representative samples, carefully control empirical

variables, and analyse group means and variances through statistical test procedures (Ponterotto, 2005).

2.4 Qualitative methodology

Qualitative research as defined by Creswell (1994), is “an inquiry process of understanding a social or human problem, based on building a complex, holistic picture, formed with words, reporting detailed views of informants, and conducted on a natural setting” (pp. 1-2). Qualitative research uses a naturalistic approach that seeks to understand phenomena in context-specific settings. The fundamental belief of qualitative research according to Gay and Airasian (2003) is rooted in the perspective that meaning is derived from varying and differing viewpoints; thus, how people understand situations is contextual. Going further, because meaning is located on a continuum of time and space, the interpretation and/or experiences of people will ultimately change. Nonetheless, Gay and Airasian (2003) argue that no one perspective or contextual understanding of an experience is more factual. Hence, this substantiates the appropriateness of using a qualitative research method for this investigation as outlined below.

2.5 Qualitative methods in Counselling Psychology

Qualitative research and counselling psychology share a number of epistemological paradigms. Counselling psychology often emphasises de-pathologising clients’ presenting problems, and learning from clients about their difficulties, based on their idiosyncratic framework and background, through the intimacy of therapeutic relationship (McLeod, 2001b). Similarly,

the interpretivist-constructivist paradigm of qualitative research places emphasis on a relational process, within which the complexity and diversity of each client's subjective meanings and narratives can be explored (Morrow, 2007). The constructivist perspective acknowledges that there are multiple ways for people to experience and resolve problems (McLeod, 2001b). The idea of multiple ways of dealing with a specific phenomenon was thought to be of particular importance to the present enquiry when considering how clients and therapists experience therapy in different ways.

The methodological aspects of qualitative research, such as interviewing and case studies, are also well suited to the principles of counselling psychology, given their shared emphasis on the epistemological framework of subjective constructivism (McLeod, 2001b). Counselling psychology, as with the interpretivist-constructivist paradigm, is firmly rooted within the post-modernist philosophy (Woolfe et al., 2003).

2.5.1 Rationale for using qualitative research

The positivist nature of quantitative research was considered to be too reductionist to fully explore the contextual and interpersonal nature of 'client experiences. Qualitative research is considered to be valuable when examining areas which are characterised by intricacies and complexities, drawn by subjective experiences and internal representations of the world. The phenomenological framework of qualitative research holds that validity involves the process of intimacy. In qualitative research, data can be collected through in-depth and intimate contact with respondents (Charmaz,

2006): this can enable the researcher to establish trust with participants, which in turn can allow the exploration of intimate details of their experience. The in-depth contact with participants can also uncover new and previously undiscovered areas. In the context of the present research, the process of constructing meaning about clients' experience can generate valuable information which could otherwise be missed by standardised questionnaires. In this way, qualitative research can be complementary to quantitative findings by expanding these findings, as well as highlighting new areas for further examinations through quantitative enquiries.

The ontological positioning advocated by qualitative research is consistent with the researcher's understanding of the subjective experiences of therapy and the diversity and uniqueness of each individual. Qualitative research regards the role of the researcher as someone who actively engages with the data collection and analysis. Given the intimate nature of data collection, through a series of in-depth interviews, anticipated in this study, it was thought that a methodology which enabled the researcher to capture the reflective processes involved would be more suitable, and would also allow the researcher to pay close attention to the way in which he might affect his participants and how he might be affected by his participants.

2.5.2 Limitations of qualitative research

As with quantitative inquiry, there are limitations with qualitative research. One criticism which can be levelled at qualitative studies, such as those by Bedi (2006) and Manthei (2007), is that even though participants talked

about what they found helpful or unhelpful in their experience of therapy, it was not clear if these 'helpful factors' actually led to the improvement of their problems. This is due to the fact that in qualitative research the aim is to generate more in-depth understanding of participants' subjective experience, rather than using specific measures to examine the association between cause and effect. Thus, it is common practice to measure the effect of process in the improvement of outcome.

Qualitative research does not drive for generalisability and does not reveal much about frequency. It would be difficult, for example, to apply the results of this study to larger clinical populations. The aim of qualitative research is to provide sufficient information about the context and detailed information about the data, themes and analytical findings in order to allow the observer to make an informed decision about the level to which the findings can be transferred to other settings. Thus, it is the responsibility of the observer, rather than the researcher, to decide whether the findings are transferable or not (Golafshani, 2003).

Qualitative research analysis is also open to researcher's bias, and internal reliability is often problematic. This makes it difficult for the results to be replicated by another researcher. However, the process of ensuring rigour in qualitative research is designed to ensure transparency and transferability, rather than replicability.

2.6 Qualitative methods considered for the current study

Applied research in counselling psychology employs a variety of methods through which to explore the qualitative aspects of phenomena (Billington and Williams, 2017). Discourse Analysis was thought to be inappropriate in answering the research questions here due to its specific focus on discourse and the role of language in constructing reality (Langdridge, 2004). Its subsequent oversight of underlying procedures, like emotions, attributions, self-beliefs, self-awareness and other aspects of cognition and meta-cognition (Burr, 2003) was considered inappropriate for the purposes of this study.

Interpretative Phenomenological Analysis (IPA) supports a phenomenological epistemology, which considers perception to be intentional and individual experience to be unaffected of social processes and other influences (Langdridge, 2007). The purpose of phenomenological research tends to focus on describing the participants' experience but does not move forward to explaining it, therefore restricting the researcher's ability to understand the focus-area (Willig, 2013). For these reasons it seemed that IPA would not allow the exploration of the complexity of clients perceived negative experiences of psychotherapy to the fullest.

Thematic Analysis was also considered but was rejected on the basis of the criticisms that it has received for not being epistemologically rooted to a philosophical paradigm (Clarke, 2006). This has been seen as a limitation in enabling the researcher to go as far with their analysis as other

methodologies might allow them to by formulating complex and multi-faceted explanations of social-political issues (Joffe, 2012)

2.7 Rationale for using constructivist grounded theory

Grounded theory was initially conceptualised and remains to date as a suitable research method for the discovery or generation of new theory from data, as opposed to methods that aim to extend existing theories (Clarke, 2005). Subsequently, grounded theory has further been argued to be an appropriate research method for the exploration of a topic that is unknown and has seen limited research in the past (Holton, 2007). It is considered to be different than other qualitative methods in that it has the potential to go beyond exploring and describing to explaining complex phenomena in applied contexts that have not yet been captured fully by theory (Birks and Mills, 2015; Miller, 1995).

The purpose of the current study is to explore clients dissatisfactory experience of psychotherapy which is considered complex and, as noted, has received limited research to date. Grounded theory was therefore considered an appropriate methodology to address the aims of the study and explore clients experience. Grounded theory has also been claimed to be suitable for the development of social policy (Charmaz, 2012; Miller, 1995), which is in line with this study's hopes to contribute to future training guidelines for trainee therapists. Grounded theory, originating in sociological research, counts a variety of versions and models to date, three of which are

considered to be the most widely used (McCallin, 2004) and will be discussed here.

Grounded theory was initially conceptualised by Glaser and Strauss (1967) as an alternative to the then predominant quantitative research methods, aiming to allow an inductive generation of theory through systematic methodological strategies of analysis of gathered data (Birks and Mills, 2015).

This first version of grounded theory (also known as the ‘Glaserian’ or ‘classic’ grounded theory) is located within the post-positivist paradigm and claims for the ‘discovery’ or ‘emergence’ of data. The underlying idea is that, by following the methodological procedures systematically, the researcher will reveal the objective theory that is situated in the data, and the same theory will be revealed irrespectively of the person undertaking the analysis (Glaser and Holton, 2004). This idea has been viewed as contradictive and incompatible with the principles of qualitative research and the constructivist paradigm in particular, according to which there is no single reality and the researcher plays an active role in interacting with the data and constructing the results of their analysis (Bryant and Charmaz, 2007). In response to such criticisms, classic grounded theory is argued by its creator to form a unique methodological paradigm and indeed not to belong to quantitative or qualitative research methods (Glaser, 2002).

The third and final version of grounded theory discussed here is known as the ‘constructivist’ grounded theory and was developed as a response to the above models by Charmaz (2000). It might be argued that what is positioned at the core of this model is the acceptance of subjectivity and the acknowledgment of the active involvement of the researcher in what is seen as the construction and interpretation of data through dialectic processes with the participants and with the data (Charmaz, 2014). In other words, the researcher is not seen as an independent and objective observer, but rather as an intrinsic part of the constructed reality of the research process (Clarke, 2012).

As recommended by some authors (e.g. Cutcliffe, 2000), for the present study I decided to follow a single model of grounded theory instead of selectively using elements of various models. This aimed to strengthen the coherence of the study and contribute to its epistemological and methodological robustness. The present study employed the constructivist grounded theory method as it was considered to be compatible with the study’s constructivist epistemological paradigm and with qualitative research methods. By attempting to achieve methodological congruence it was hoped that the credibility and quality of this study would be strengthened (Birks and Mills, 2015). The less prescriptive and more flexible nature of constructivist grounded theory as opposed to the model developed by Strauss and Corbin (1990; 1998) was considered to be a strength in the inductive exploration of the topic under research**.**

2.8 Summary

This chapter discussed predominant epistemological paradigms in real world research and their implications for the research methodology. The discussion presented the rationale for a qualitative methodology within the constructivist paradigm, in line with the research aims. Alternative research methods were considered and constructivist grounded theory was adopted as the study's methodology in line with the authors ontological positioning. As such, it was assumed that the world is the sum of multitude of realities, influenced by political, social, economic, cultural and other beliefs, while subjective knowledge was seen as situated to the data and accessible through careful and systematic analysis (Mertens, 2005).

Chapter 3: Method

As noted earlier, the constructivist grounded theory model as outlined by Charmaz (2014) was followed throughout the stages of this research. This chapter will detail that procedure including recruitment of participants, interview and process of data analysis. This will be followed by a consideration of the issues of validity and reliability within qualitative research and how these concepts were addressed in the present study. Lastly the ethical consideration that were put in place will be outlined.

3.1 Selection of participants

Theoretical sampling

One of the strengths of GT is its rigorous sampling procedure. In GT, data analysis and collection is conducted simultaneously. The implication of this feature of GT is that the collection of new data is informed by perspectives formed during earlier analysis and is aimed at elaborating emerging theoretical categories. This process is referred to as theoretical sampling (Charmaz, 2006).

Theoretical sampling begins with selecting an initial sample, which is the researcher's starting point (Glaser, 1978; Charmaz, 2006). This initial sample will be selected based on its relevance to the research questions. Similarly, to purposive sampling, the researcher selects participants who are considered to be knowledgeable and can maximise the possibility of obtaining rich data (Coyne, 1997). In the present study, given that the initial

aim was not to enquire about any clinical sub-group, a pragmatic sampling approach was applied whereby clients who met the inclusion criteria and were willing to participate were interviewed. The individuality of each participant, such as their demographics and experience of therapy, was also regarded as a key factor, since in theoretical sampling variation amongst participants is considered to have the potential for elaborating emerging perspectives.

An essential feature of theoretical sampling is to look for gaps generated through constant comparison of the data. The aim is not to capture all possible variations of the area under study; rather it is to gain a deeper understanding of participants' responses (Glaser and Strauss, 1967). Once the collected data no longer develops new categories or refines existing categories, the data is said to be saturated and data collection is completed (Charmaz, 2006).

Rennie (1998) and Glaser (1992) have criticised Strauss and Corbin (1998) and argue that, in their highly structured version of GT, once conceptualisation is formulated the tendency is to verify this further during theoretical sampling. This can potentially result in researchers missing other important aspects of the research area. Thus, the saturation process is a highly contentious issue in GT. The difficulty, however, is that if researchers struggle to identify the suitable theoretical codes for their data, they can potentially be in a position of having to collect data indefinitely, as it can be very difficult to reach a stage where no new data emerges, without some

structure in place. Charmaz (2006) refers to an argument presented by Dey (1999), who has challenged the notion of saturation, and argues that in GT categories can be constructed based on partial data. Dey argues that it is difficult to produce evidence that proves properties of categories are saturated, and any such claim that it is reliant on researchers' conjecture.

Dey's critical take on 'saturation' was consistent with the researcher's constructivist ontological positioning, that reaching saturation, particularly in small research projects, was open to researchers' subjective interpretation, rather than an exhaustive process guided by systematic operational procedures. Dey offers 'theoretical sufficiency' as a more accurate alternative to saturation. Theoretical sufficiency occurs when data has been properly analysed and new data no longer adds anything new to the overall model or theoretical framework. Thus theoretical sufficiency does not mean 'categories and their properties and relations have been exhaustive' (Dey, 1999, pp. 116-117). Given the size of the present study it was thought that aiming for theoretical sufficiency was a more realistic target than saturation and data was collected accordingly.

3.2 Interview design

For the current research, an in-depth face-to-face interview was chosen. The decision to apply in-depth interviewing for the present research was informed by the chosen methodology. Charamz (2006) argues that in-depth interviewing permits in-depth exploration of a particular experience and thus it is a suitable method for GT and interpretive inquiry: they are open-ended

but directive, shaped but emergent, and paced yet flexible approaches (Charmaz, 2006). Moreover, Charmaz has stated that during in-depth interview, meaning and knowledge are co-constructed and made sense because the interviewers and the interviewees previous experiences and current interaction. This position is consistent with the present study's post-modernist paradigm.

There are three basic approaches to in-depth, which range from non-structured conversational interviewing to standardised and fully structured interviewing (Patton, 1987; Silverman, 2000). In the current study, an in-depth semi-structured method of interviewing was applied. In semi-structured interviews, a set of pre-designed questions are asked from all participants, but the interviewer has some flexibility around the order and the way with which the questions are asked and is able to ask more follow-up questions to gather more detailed information about specific areas.

The advantage of this approach is that it focuses participants' responses onto the research area through its systematic structure, while maintaining a conversational interaction and leaving room for researchers' flexibility and responsiveness. However, focusing participants' responses onto the area of study, while preserving room for flexibility and allowing space to generate, as oppose to force, data, can be a challenging task. Moreover, a possible disadvantage of this approach is that through the conversational nature of the interviews and inclusion of follow-up questions, the researcher may not maintain a consistent style of information gathering (Wengraft, 2001). Given

that the same six questions were asked from all participants, and most follow-up questions were influenced by previous data, it was thought that a sufficient level of consistency was preserved in all interviews. The questions were open-ended and non-directive, thus allowing room to pursue issues which were not previously anticipated.

The standardised and highly structured form of interviewing was rejected due to its inflexible nature. The guidelines set out by the constructivist version of GT (Charmaz, 2006) recommend researchers to generate knowledge inductively without pressuring or forcing data. It was believed that the restrictive and directive format of highly structured interviews can risk compromising these guidelines. The informal and conversational method of interviewing was also rejected, since the research question was designed to generate knowledge about specific parameters, namely clients dissatisfactory experience of therapy. This form of interviewing was also rejected due to its limited reliability. Moreover, from a pragmatic point of view this type of interviewing was ruled out due to the difficulty involved in analysing data collected through a highly unstructured interview.

3.3 Recruitment procedure

3.3.1 Advertisement

To recruit participants, an advertisement was placed in a local magazine - *Time Out (London)* (see Appendix) for a period of one month.

Time Out London was chosen as a place to advertise for participants with the aim to capture a range of people taking into consideration the diversity of

London. However, it is noted that the cost of the magazine may have influenced the recruitment of participants. That is, Time Out (London) was widely available to purchase in and around central London, primarily to capture London city workers and although this may capture a diverse population, the cost of the magazine would have excluded certain demographics. A future project may consider a form of advertisement that is more accessible to everyone.

3.3.2 Inclusion criteria

Participants were required to be:

(i) Aged 18 years or above;

(ii) Had previous negative experience/s of being in psychotherapy.

The rationale for the above was that the study was focusing on adults who had a negative experience of psychotherapy prior to participating in the study. By having a past negative experience, the aim was to ensure that the interview would cause minimal distress with the assumption that they have moved beyond the negative experience.

3.3.3 Sample

A total of nine participants responded to the advertisement in *Time Out* magazine London (n= 9, 1 male, 8 female). The age (age range: 21-58 years) of each participant was recorded along with the primary difficulty that led them to seek therapy review this sentence. The participants were all former clients who reported some form of negative experiences of counselling and/or psychotherapy. Participants were not asked about how

long ago they ended their encounter as it was supposed that having ended treatment would be sufficient for participants not to be distressed by their involvement in the study. Participants were able to withdraw from the study and they were able to access an independent psychologist if any distress was encountered. However, the length of time between the study and participants therapy may have had an effect on how much they could accurately recall.

Other demographic data was not gathered at this stage of the research such as ethnic background as it was felt that the focus of the project was to explore negative experiences of clients of psychotherapy and given the size of sample, any links that may have found may not have been generalisable. However, it is noted that this may have been useful information to consider as through a diverse sample the researcher can ascertain potential, interesting contrasts between groups (Charmaz, 2007), which may provide worthwhile avenues for future research (Glaser & Strauss, 1967).

It should be noted that participants reported a wide range of life issues such as depression, low self-esteem, existential issues, relationship issues as and loss of direction in life as well as requirement of a training course. None of these participants presented with active suicide ideation or reported that they had been diagnosed with an Axis II disorder (e.g., bipolar disorder; DSM-V). Participants had received therapy from private therapist; within the NHS or from university counsellors and from different modality of therapies such CBT and psychodynamic psychotherapy. The aim of interviewing

participants who had negative experience from various orientations was to increase the scope of the present study (Morse, 2007).

Table 3.1. Participant Demographics

Participant	Gender of participant	GP Referral	Gender of therapist	Significant event/ time	Occupation
Stacey	Female	Yes	Female	First year at university	Artist
Mandeep	Female	Yes	Female	Third year at university	Further Education in psychology
Ellie	Female	Yes	Female	Physical abuse	Administrator
Nick	Male	Yes	Female	Death of sibling and drug use	Hairdresser
Puja	Female	No	Male	Marital problems, young child	Teacher
Sally	Female	Yes	Female	Soon after second child	Trainee counselling psychologist
Mariah	Female	Yes	Female	Requirement of course/ loss of father	Trainee counselling psychologist
Jean	Female	No	Female	Feeling low, difficulties at work	Nurse
Nigella	Female	Yes	Female	Difficulties managing at work	Project manager

3.4 Interview procedure

Nine participants responded to the advertisement by e-mail and were sent an explanatory statement and consent form (see Appendix A). Those who chose to contribute to this study were asked to attend an interview or if they were not able to attend in person they were able to respond to the questions via e-mail.

The questions used in the interview were developed after the literature review and discussion in supervision, and were designed to explore clients' experience of therapy, and to open up more detailed discussions (See Appendix 1.8). As well as the original six questions which were asked from all participants, additional questions were added at various stages of data collection. These additional questions were designed to inquire about features of additional information gathered from preceding participants to provide a better understanding of the participants account.

Participants were given the option to have the interview video recorded (the video material was sought for use in a project that aimed to develop a teaching and learning resource under the auspices of City University London) and audio taped or just audio taped.

The interviewer proceeded by checking with each participant whether they had read the information sheet following which, a brief discussion took place to ensure that the participants understood the purpose of the study any questions they had point were addressed. Participants were then asked to

read and sign the consent forms (See Appendix A). They were also informed that they could withdraw from the interview at any time.

The video recorded interviews took place at an agreed venue and time that was suitable to all the parties involved. Participants were ensured that the video recorder was also bound by ethical guidelines regarding confidentiality. All participants were paid an attendance fee per hour and travel expenses. The funds came from the Department's Subject Payment budget which is managed by the Department Research Committee.

Participants who did not wish to be video recorded took part in interviews which were audio recorded; both video and audio interviews were later transcribed by the author and were stored securely in a locked cabinet and password protected computer.

The interviews lasted approximately 45 minutes. Five interviews were video recorded as well as audio recorded and two were audio recorded. Two participants e-mailed their contributions due to difficulties in arranging a suitable time for face to face interview. They were able to email further questions if the needed however neither of them took up this offer.

Transcripts have not been included in this report, however are available from the author upon request.

3.5 The interviews

Semi-structured interviewing appears to be a broadly used method of data gathering in qualitative research in psychology (Willig, 2013) and is often selected by grounded theory researchers (Birks and Mills, 2015). This popularity might be explained by its compatibility with various types of analysis, including grounded theory, and its flexible and adaptable nature (Robson, 2011). In the present study I took an intensive interviewing approach, which has been defined as “a gently-guided, one-sided conversation that explores research participants’ perspective on their personal experience with the research topic” (Charmaz, 2014; pp. 56).

For the semi-structured interviews an interview schedule was developed (Appendix 1.8). The interview schedule was used as a guide and, although many of the questions were asked to all participants, a flexible stance was maintained and additional prompts and clarifications were used or questions were skipped when it felt appropriate based on the participants’ accounts. This decision was informed by the flexibility encouraged by the approach of intensive interviewing, which “permits interviewers to discover discourses and to pursue ideas and issues immediately that emerge during the interview” (Charmaz, 2014, pp. 85).

Every effort was made to keep the questions open-ended and non-directive to allow the data to emerge. The key elements of intensive interviewing that were adhered to in this study are:

- In-depth exploration of participants’ experience and situations

- Reliance on open-ended questions
- Objective of obtaining detailed responses
- Emphasis on understanding the research participants' perspective, meanings and experience
- Practice of following up on unanticipated areas of inquiry, hints and implicit views and accounts of actions

Despite these attempts, the choice of the research and interview questions was still influenced by the researcher's prior training and experience as a therapist. Another researcher may not have considered different additional questions or may have approached the area from a different angle and different type of questioning.

Another challenge in the interviews for the present study was adapting to the varying style of clients. Some clients were very quiet and some probing. The problem with this, however, was the possibility of influencing participants into a set number of responses. Every effort was made to ask open-ended questions, and to only use information provided by them.

On the other hand, some clients talked continuously and found it difficult to focus on the questions. These participants seemed to find it difficult to separate their experience of being interviewed from that of being in therapy. It was also a challenge for the researcher to not fall into the role of a therapist, given her training in this field. However, in parts some interviews became a forum for some clients to reflect on a difficult time in their life.

Allowing them room for reflection was thought to strength the rapport with them, leading to exploration of key factors, which might not otherwise have been possible.

It is acknowledged that the different methods of recording interviews employed may have had an impact on the data, in that, the participants who agreed to be video recorded may have been more anxious than those who were only audio recorded. Although every effort was made to ensure that the participants felt comfortable during the experience to minimise this affect. It is also noted that the participants who emailed their response may have been able to tell their story more freely, as they did not have to see the interviewer and were not video or audio recorded. In addition, those that sent their responses via email may not have felt able to ask questions as easily and fluently as those that attended the interview, although this was an option they could have utilised. This may have been due to several reasons such as, the lack of natural flow of conversation as you would get in a face to face interview and participants may have preferred to complete process at the time of responding rather than awaiting a reply from the interviewer before completing their submission.

Face-to-face interviews allow the researcher to maximise the quality of the data and are often used to solicit information in projects that can be considered to be very sensitive (Lavrakas, 2008). They capture verbal and non-verbal ques such as body language, which can indicate a level of distress allowing the interviewer and participant to adapt the style, response

or questions accordingly to minimise any harm. Future projects would benefit from utilising face to face interviews solely for data collection especially given the nature of the topic under investigation.

3.6 Data Analysis

3.6.1 Initial coding

The first stage of the analysis for each interview was the stage that Charmaz (2014) names 'initial coding' and might be seen as the first strong expression of induction in the grounded theory analysis. Line-by-line coding of transcribed interviews is recommended for novice grounded theory researchers, as it has the potential to allow an in-depth, thorough and systematic analysis of the data while minimising the risk of overlooking ideas and concepts (Charmaz, 2014). I therefore opted for the method of line-by-line coding of each transcript (see Appendix B 1.1) for an excerpt of line-by-line initial coding).

The purpose here was to generate a wealth of codes based on what was suggested or implied by the data, with little preoccupation with the research questions and with an open mind. During this phase, I attempted to generate codes that were short, closely related to the data, and a level more abstract than the data, whilst avoiding concepts that were too abstract or theoretical. My aim was to move swiftly and spontaneously through the line-by-line coding process in order to allow my thinking to be fresh, critical, analytical and distanced from the participants' accounts (Charmaz, 2014). For example, when a line of data did not generate any codes at a first glance, I

made a note of it, proceeded through the data and returned back to the line at another time, with a clear mind. I also allowed myself the flexibility of renaming codes when needed, which aided my ability to work quickly with the data (Charmaz, 2014). The method of constant comparative analysis in grounded theory is fundamental and refers to ongoing comparisons among data, codes and categories (Tweed and Charmaz, 2012).

3.6.2 Focused coding and categorising

The second stage of coding I engaged in was that of focused coding. In each interview transcript, I filtered the initial codes and identified those that seemed to have a higher analytical value; those that appeared more frequently in the analysis; and those that were perceived to be more relevant to the research questions than other codes (Charmaz, 2014). The purpose here was to give some directions to the development of theoretical categories by synthesising and analysing large units of data in a more conceptual fashion. Appendix 2.3 demonstrates examples of open coding to focus coding.

Working in a flexible way and doing what was considered sensible, in the process of focused coding I sometimes kept the initial codes intact; sometimes collapsed several initial codes under one; and sometimes coded the initial codes as focused codes. The element of induction, inherent in constructivist grounded theory, was at this stage merged with elements of deduction and verification through the use of constant comparative analysis, aiding me in the generated analysis (Birks and Mills, 2015). This meant that I

had to move back and forth in the data and examine the application of focused codes to sets of data of the same or other interviews. Initial and focused coding was completed for each initial interview before I moved to the analysis of the next interview, following the order in which they were recorded. Through the process of constant comparative analysis, and as I was moving through the analysis of more interviews, some focused codes appeared to be a more accurate reflection of what was happening in the data, as they synthesised multiple layers of meaning and actions. Those focused codes that were judged to be of higher conceptual value were raised to categories. By using categories, the analysis was moved up a conceptual level (Charmaz, 2014).

3.6.3 Memoing

Memo writing, an informal form of taking notes, has been characterised as "the cornerstone of quality" in grounded theory (Birks and Mills, 2015; pp39). It is seen as vital in allowing the researcher to maintain their reflexivity, critical thinking and connectedness with the data and the story that is told since the beginning of the analysis and throughout until the writing of the study's draft (Glaser and Holton, 2004). In this way, the researcher is helped to move up at higher conceptual levels in the analysis until they have their body of theoretical categories (Clarke, 2005). Consequently, for this study, I recorded any thoughts and ideas that occurred to me in the form of written text, including complete or incomplete phrases and sentences; pictorial representations; and forms of diagrams. Throughout the analysis, I revisited the memos, developed new memos based on old ones, ordered them and

reordered them and used them until the theory had taken shape. Appendix B 1.2 presents a sample of some memos that relate to the codes.

3.6.4 Theoretical diagramming and clustering

Charmaz (2014; pp. 218) argues that “diagrams can enable you to see the relative power, scope and direction of the categories in your analysis as well as the connections among them”. Since early stages in data analysis, I used visual representations in an attempt to make sense of the codes and indicate their potential relationships. This started with accumulations of codes in the form of lists in single papers based on the underlying ideas (clustering). Later, the clusters were replaced by mind maps, in which a central code was linked to a number of other codes, with variations in the links among them (e.g. some of the codes were forming sub-groups, whereas others were only linked to the central code).

Through memoing and constant comparative analysis, the mind maps were converted into more refined diagrams that represented potential categories, their properties and concepts of direction, location and movement. Expanding, collapsing, removing, introducing and rearranging codes were ongoing and consecutive processes throughout the analysis. It needs to be noted that, although these visual representations were greatly helpful for my understanding of the evolution of the codes and promoted my thinking in the analysis, they did not replace the analysis (Charmaz, 2014). They were used as visual aids alongside written records kept through coding and memoing.

Appendix B 1.4 presents the development of the focused codes into conceptual categories that later generated the grounded theory of this study during the phases of the analysis.

3.7 Evaluation

In quantitative research, the aim of rigour is to attain validity and reliability, which means that the outcome is reflective of the population under examination and that another researcher can replicate the outcome with similar sample and design. Qualitative enquiry, on the other hand, acknowledges the influence of the researcher's interpretation and thus the process of rigour takes a different objective (Goldafshani, 2003). The reflexivity and transparency with which data collection and analysis is undertaken is imperative to ensure the credibility of the inquiry.

Yardley (2000) has discussed four ways of assessing qualitative research. These criteria are: sensitivity to the context, commitment and rigour, transparency and coherence, and impact and relevance. Yardley's proposition is one example from a number of different ways of assessing qualitative research (Greenhalgh and Taylor 1997; Silverman 2005) and was used to assess the quality of the present study.

3.7.1 Sensitivity to the context

In GT, sensitivity to the context is known as theoretical sensitivity, which refers to the personal knowledge and awareness of the researcher in relation to the research area. While theoretical sensitivity can improve the

researcher's reading of the research area, a more enhanced level of familiarity can influence the researcher's reading of the data. Thus, theoretical sensitivity also refers to the researcher's ability to separate his/her preconceptions from the data.

The researcher of the present study was a trainee counseling psychologist and was required to have personal therapy as part of her course requirement. This may have enhanced her ability to understand the clients' perspective better than a researcher who had never undergone any therapy themselves. On the other hand, this previous knowledge and experience may have influenced her view about factors that contributed to negative experiences and limited her awareness of other important and subtle issues in regard to the context. In line with the principles of GT, in the present study the researcher addressed the issues of theoretical sensitivity through constant comparisons of the data (Glaser and Strauss, 1967; Strauss and Corbin, 1990; Charmaz, 2006), theoretical sampling to inform the data collection process and memo writing. Memos were particularly helpful in ensuring that the researcher stayed aware of her own biases and perceptions, and in systematically assessing the relevance of her growing interpretations of the data.

Language also plays a key role in the process of data collection and analysis. Thus, throughout this research significant efforts were made to utilise the language of the participants, and interpretations of the language used were made based on participants' social and cultural context, while

acknowledging the influence of the researcher's subjective interpretation.

3.7.2 Commitment and rigor

Commitment refers to the continuous interest displayed by the researcher towards the topic of study, not just as a researcher but also as an involved member. Commitment also refers to the researcher's competence and skill in the method used (Yardley, 2000).

In terms of commitment, the researcher had experience of therapy as a client during training which allowed the researcher to have a first-hand experience of the topic under study. The researcher's training as a therapist included specialised modules on advancing skills such as empathic and attentive listening, paraphrasing, summarising and reflective probing. The author believes that these experiences have allowed her to have the competence and skill needed to apply the chosen method for the present study.

According to Yardley (2000) rigor involves the comprehensive completion of the data collection and analysis. In GT, this is undertaken by theoretical sampling and 'the process of saturation' and 'theoretical sufficiency' (Yardley, 2000). Chapter 3 outlines the sampling process in the present study in which the researcher felt theoretical sufficiency was upheld within the scope of the study.

3.7.3 Transparency and coherence

In qualitative research, particularly within the constructivist paradigm, the aim is to construct a version of the participants' experiential reality. The narrative process with which qualitative researchers make sense of their respondents' reality is an essential part of the research and often ensures the quality of that research. Thus, the data collection and analysis need to be transparently documented (Yardley, 2000).

In the present research, all aspects of the data collection and analysis, outside influences such as the researcher's previous training and philosophical influences, and possible practical constraints, were documented in the memos. In addition, the memos were aimed at demonstrating the researcher's reflexivity. This technique was designed to display examples of the transparent manner within which data was collected, constructed and built into the main categories and themes. (See appendix II, for samples of memo's)

The researcher used memos to reflect on her own views about the nature of therapy and tested her interpretations and hunches by collecting more data. For example, the researcher made careful notes about her own Cognitive Behavioural stance on transparency of the process during the initial assessment. This allowed her to be aware of her views against therapists not explaining to their clients the process of therapy in spite of clients' requests. In addition, various extracts from different interviews with participants were included in the analysis section, in order to demonstrate

evidence of the researcher's main categories. A systematic documentation of various stages of the coding procedure has been provided, along with a number of related appendices, to enable the reader to clearly see how the analysis was grounded in the data.

Moreover, the transparency of the present study was enhanced through the process of 'independent auditing' (Smith, 2001), whereby a separate independent researcher was asked to assess any possible bias and misrepresentation on the part of the researcher and verify the credibility of the findings. The independent researcher was a qualified and experienced research psychologist who had already obtained a doctorate in the field of psychology. She was asked to read through relevant transcripts of two interviews, along with the researcher's documented analysis of the data. The auditor verified that the focused codes were closely associated with participants' accounts. She also looked at the overarching categories and the way in which these were drawn from focused codes and verified that these were grounded in the data.

Coherence describes the link between the research question, the philosophical perspective applied, and the method of investigation and analysis undertaken (Yardley, 2000). In the present study, the application of a constructivist version of GT (Charmaz, 2006), was informed by the researcher's philosophical positioning, the nature of the research question and the existing paucity in the literature of negative experiences of therapy.

3.7.4 Impact and relevance

The quality of any research is inevitably shaped by its valued contribution to the wider world (Yardley, 2000). There is a dominant perception that qualitative research does not have the same impact on policy and practice as quantitative research, due to its lack of transparency of issues around validity and reliability. Thus, it is imperative for any qualitative research to clearly demonstrate the contribution it could potentially make which may not otherwise be addressed by quantitative research.

In addition to the scientific rigour of the research project, as a clinical and a researcher it was important to ensure the project was ethically robust. The ethical considerations will be outlined in the following section.

3.8 Ethical considerations

Ethical approval for the present study was gained by the Ethics Committee at the City University (Appendix 1.1). This entailed producing a detailed proposal including the advertisement to recruit participants, the explanatory statement, and consent forms, in adherence to the set guidelines. (See appendix A)

The proposal was evaluated by the research committee and approved with the revision that a snowballing sampling technique was not used, in order to minimise the chances of interviewing participants who had the same therapist.

The study adhered to the principles of Code of Research Conduct and Research Ethics that was published by City University. The British Psychological Society (BPS) Code of Human Research Ethics (2010) was also taken into consideration, with a particular focus on the areas below.

In addition, as clinician alongside my researcher role, the principles of respect, competence, responsibility and integrity highlighted by the BPS Code of Ethics and Conduct were adhered to at all times.

3.8.1 Respect for the autonomy and dignity of persons

The participants were shown respect throughout all the stages of the research. I attended to any questions or further comments the participants made prior to, during or after their involvement and shared any information that could support their decision making. The participants were given the right to withdraw at any point, as stated in the consent forms they signed (Appendix 1.5 & 1.6).

3.8.2 Scientific value

A research proposal was submitted to the university's Ethics Committee, as noted, which also involved a serious consideration of the project's scientific value and implications. The research project was scrutinised throughout the process mainly through supervision and informal discussions with peers and colleagues. Yardley's (2000) method of evaluating of qualitative research was also implemented.

3.8.3 Social responsibility

I maintained a reflective stance and considered the potential social implications of the study throughout its duration. The constructivist nature of the project aided to the respect of the participants' integrity and dignity. My reflective skills were supported by the use of a research diary, where decisions, dilemmas and ideas were recorded and discussed; informal discussions with other colleagues; and research supervisions. The reflective skills that are demanded for the profession of counselling psychology and the training to enter the profession contributed further in this area.

3.8.4 Maximising benefit and minimising harm

Former participants of psychotherapy were enlisted for this project with the aim that that they would no longer be involved in the perceived negative experience in order to minimise harm. It is suggested that the occurrence of potentially stressful situations was therefore minimised. However, participants may have agreed to participate in the study with the intention that they would be able to discuss their negative experience without becoming distressed yet when they started to speak about their experience, may have realised that it is more difficult than they originally thought. Although the researcher was not able to mitigate this possibility completely, a stricter inclusion criterion may have been applied. For example, only those with negative experiences that were more than 10 years ago were able to participate. This may have raised other difficulties such as how well participants can recall the event.

Participants in the study seemed to value the opportunity to be heard and gain a better understanding of their experience through talking. They were informed that should they experience any distress they were able to access further debrief/treatment if required. The interviewer, as a trainee counselling psychology was able to observe verbal and non-verbal cues for those that attended the interviews face to face and every effort was made to acknowledge and manage any distress that was noticed as soon as possible.

3.8.5 Valid Consent

Upon initial invitation to the research project, the participants were emailed a copy of the Information Sheet (Appendix 1.4), which outlined the details of the research and what this would mean in terms of their participation. Following that, I attended to any questions that arose. All of the participants who agreed to participate were emailed the consent forms (Appendix 1.5 & 1.6). On the interview date I also provided the participants with a hard copy of the information sheet before I received the consent forms, in order to refresh their memory and ensure that no areas were missed

3.8.6 Confidentiality

The participants' right to privacy was respected and all information was kept confidential. When excerpts from the interview transcripts are included in the main body of this paper or the appendices, any identifiable parts are removed or covered. An identification number was assigned to each participant for the data analysis. The audio recordings and transcripts of the

interviews have been stored in a secure location. Furthermore, a confidentiality clause was introduced, which ensured that the researcher would keep all information gained from the interviews private and confidential to ensure that the participants were able to be more honest and open in their answers given during the interview process, thus affecting the reliability of the study.

The participants were also made aware of the limitations of the confidentiality in that should the researcher learn about something illegal or illegal practices that emerged from the results of this study, they would be under obligation to report it to the relevant authority. Participants were made aware of this in the information sheet they were provided with.

3.8.7 Deception

The participants were fully informed about the nature and details of the research project and questions were explained fully to the researcher's knowledge. Upon reflection further consideration I could have been more explicit regarding the research being part of a doctoral thesis rather than a project to improve clinical practise, this may have had an impact on whether participants chose to be involved I the study.

3.8.8 Debriefing

The participants were given space for reflection at the end of each interview and the opportunity to raise concerns, ask questions or share any comments. The participants were encouraged to contact me again if any

issues occurred at any stage and were also able to request an independent debrief with the Qualified psychologist.

3.8.9 Further ethical considerations

The risk of creating a power imbalance through the research process, in which the researcher is considered to be privileged and in control, has been cautioned by many authors (Robson, 2011). In the current study I intended to facilitate an egalitarian relationship between myself and each participant and the steps I took towards that included (Birks and Mills, 2015):

- allowing some time for rapport building prior to the interview;
- maintaining a warm tone in my voice;
- communicating respect and unconditional positive regard;
- using the consultative skills of active listening, empathy, reflection, open body stance, open-ended questions, focusing and refocusing;
- allowing for laughter and jokes when initiated by the participants;
- maintaining a reflective stance and a high degree of self-awareness;
- refraining from setting arbitrary time limits and instead allowing the participants to finish their story at their own pace;
- working towards maintaining a balance between hearing the participants' full story without compromising the search for analytic properties;
- offering the participants the opportunity to ask any questions and share any reflections they had on the matters discussed at the end of each interview.

The above strategies and circumstances are considered to have been successful at meeting the purposes of creating an ethical and collaborative partnership between myself and the participants, consistent with constructivist grounded theory (Charmaz and Belgrave, 2012). However, unfortunately this was not possible to achieve for those who submitted their responses via email and may have had impacted the quality of data as discussed above.

3.9 Summary

A detailed account of the methodological procedures followed in data gathering and data analysis was presented to achieve transparency in the research process. Measures taken to enhance the quality of the present study were discussed and ethical considerations were explored in depth, in line with the expectations of a doctoral thesis and constructivist research. Now that methodological issues have been explored, Chapter 4 will present the outcomes of the analysis, including the focused codes and conceptual categories that led to the construction of the final grounded theory.

Chapter 4: Results

4.1 Overview

Nine former clients participated in this study. Their experiences of psychotherapy were analysed using grounded theory methodology and a theoretical model was developed from the data. Three categories (client expectations; feeling unheard and delicate dance of power) and five subcategories (safety in the room; same destination; view from the chair; alternative interpretations and letting go) were identified.

The model depicted in figure 4.1 also highlights the sequence of categories as it differentiates between the stages of the therapeutic journey, that is, the client may enter the room with preconceived expectations and beliefs about therapy such as therapy is about talking about your childhood. Clients may not be aware of the different modalities and may also have expectations about different components of therapy, for example, expectations about the therapist being an expert and therefore they will be able to cure them. If this expectation is not fulfilled it may lead directly to dissatisfaction or it may be that the client experiences several of the categories/subcategories which lead them to label their experience as negative

The model aims to illustrate the complex and intricate nature of the therapy and that there may be a number of different combinations of factors that may lead to an individual labelling their experience as negative. As exhibited by the model, dissatisfaction can occur at any stage of the therapeutic

encounter, that is, from entering treatment and consumers' expectations not being to the difficulties of leaving treatment.

Each of the categories and subcategories will be discussed in more details with examples given from participants of this study in the next section.

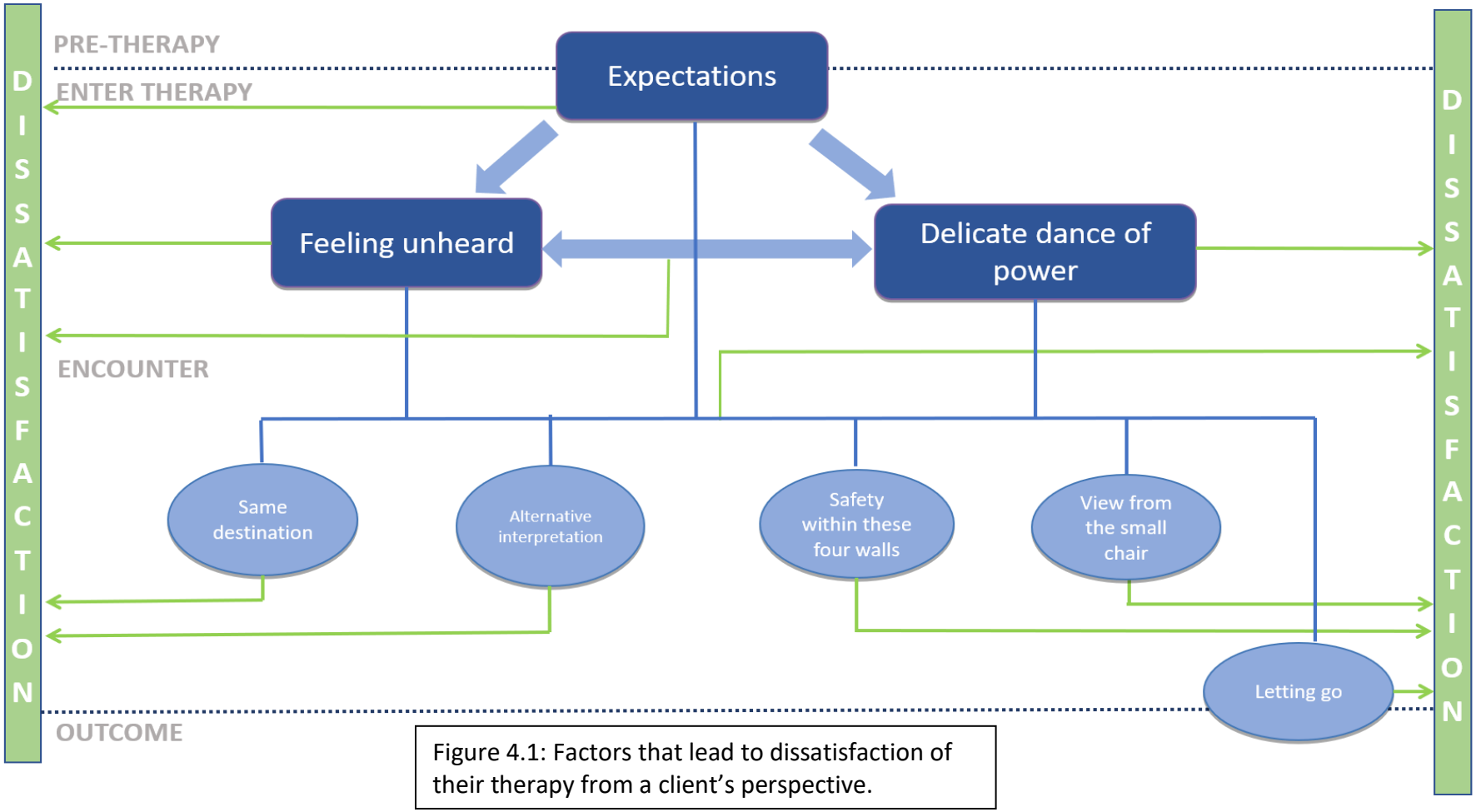

Figure 4.1: Factors that lead to dissatisfaction of their therapy from a client's perspective.

4.2 Client expectations

As can be seen from the model (figure 4. 1) one of the prominent categories that emerged from the participants recalling their negative experiences during the process of counselling and/or psychotherapy was that when they did not receive what they were hoping for from therapy they felt dissatisfied. This indicates that the participants come into therapy with some expectations that they may or may not be aware of and may have developed from a range of sources such as previous experiences of therapy and media. The main expectation that seemed to be consistent with a number of participants in this study was that of ‘being helped’. Although they may or may conscious that they are entering therapy with this expectation, it is evident that when these are not met participants in this study were left discontented with their treatment.

Clients may also not be aware that it there is a mutual understanding within a number of therapeutic approaches that the therapist will facilitate the client to enhance understanding of self and the contexts within which they express themselves interpersonally and experience themselves intra-personally. Advice giving, outside explicit psycho-education, was actively sought by a number of recipients of counselling and psychotherapy and appeared to be a common theme in client grievances related to their negative evaluation of therapy.

In the example below Ellie hopes that she will be given advice and guidance thus looking for solution to her problem rather than an understanding of how it may have developed

> *Ellie: "I…I think my expectations of it were…was that it was going to help me, that I was going to get the advice that I needed (…) I was expecting to be completely helped and given guidance and support…*"

Sally in the example below describes the ambivalence she experienced of not particularly wanting to be in therapy but at the same time wanting to be helped, possibly to be fixed by someone without having to be an active part of therapy and hence when this did not occur it may have led her to label her experience as negative.

> *Sally: "...you know I didn't want to be there particularly, I just wanted to be helped ..."*

Jean on the other hand is looking for the therapist to help her to understand her problems and then to be provided with an appropriate coping strategy to help her overcome the difficulties.

> *Jean: "Helping someone either recognise a problem and help them work through it, looking at things differently, helping someone coming to terms with something and to help the person to deal with it in the most appropriate way etc…"*

Nigella also describes a similar expectation of being helped or enabled to get better.

> *Nigella: "And here I was, with someone who I believe who could do this, finding that I wasn't being helped or enabled to find the door"*.

Some participants anticipated their therapist to be the 'experts' and hence being able to help them to solve their difficulties. Clients may not be aware that giving their therapist the role of being an 'expert', which the therapist may not be aware of and may not see themselves as, also effects the power dynamic in the therapeutic encounter as can be seen in the model and will be discussed in more detail later.

Stacey in the excerpt refers to her therapist as the 'expert 'and hopes that she will provide them with the solutions with their expert knowledge

> *Stacey: "This was a woman who was middle aged, very well respected and … was given to be the expert in eating disorders and addition so she was held up as being this… like that if anybody could help she would".*

Jean also postulates that because her therapist was recommended that she would be able to help her, possibly indicating that she does not necessary see herself as a key ingredient to getting better.

> *Jean: "The woman I went to was upon recommendation, so I thought she should be a credible counsellor…"*

4.3 Feeling unheard

Listening makes the person who is talking feel worthy, appreciated and respected. When we give someone all of our attention the speaker responds positively by interacting on a deeper level, perhaps by disclosing personal information or by becoming more relaxed. When a therapist pays attention to what the client is saying, they are encouraging the client to continue talking, as well as ensuring communication remains open and positive. When clients are not feeling heard or listened to it seems they make interpretations as to why this may be as shown in the example below. In addition, it is also closely associated with five subcategories identified in this study as shown in the model.

Jean reflected that whilst she was a new consumer of therapy, she was unsure as to what to expect from the process of therapy. However, she reported that she had a sense that her therapist was not interested in the material she was bringing to therapy and she goes on contribute her therapist not listening to labelling herself as being boring – i.e she made an

interpretation about the situation which could be linked to the sub-category of view from the little chair.

> *Jean: "As I had not been to a counsellor before I initially thought this was a bit odd but then thought nothing of it. As it persisted I felt like she was not particularly interested in what I had to say* (…) *It made me question if my needs were actually warranted or if I was just plain boring!"*

Mandeep in the example below explains that although she was explicitly telling her therapist that a significant part of her difficulties was not 'being heard', while at the same time she reported that she witnessed her therapist looking at the clock behind her rather than pursuing the role of 'actively listening' to the message she was trying to convey. Mandeep also makes an interpretation about the situation and goes on to state that she felt that she was not an interesting person as nobody wanted to listen to her:

> *Mandeep: "[I] used to spend most of the sessions … sitting there… in silence… I'd tell her about my week and what had upset me that week but never got much beyond that … urm… I would tell her that I was having problems because I didn't think anyone was listening to me whilst she was there looking at the clock behind me looking out the window… really not listening to me at all".*

In the following excerpt Stacey tells the interviewer that she felt ‘completely unheard’ and as a result concluded that she could not be helped which may also have led her to consider terminating treatment but also feeling as if she was not able to share and deeper issues with her therapist. This highlights that not listening to our clients has consequences for the therapeutic alliance and the outcome of therapy.

> *Stacey: “I had been completely unheard and … therefore I couldn’t think who might be able to help me”.*

4.4 Delicate dance of power

The power differential is the inherently greater power and influences that the helping professionals have, as compared to the people they help. Understanding both the value and the many impacts of the power differential is the core of ethical awareness. In the helping professions, the power differential can have great value, when it is used wisely and appropriately, it creates a safe, well-boundaried, professional context for growth and healing. However, it is just as easy to misuse this increased power by under-identifying with it. Thus, as therapist it is a necessity to understand and own our role power so that we can be conscious and informed. It is also important to note that in some instances the role power is amplified by the client expecting the therapist to be the ‘expert’.

In the following example, the participant referred to the therapist as the ‘big cheese therapist’ implying she felt that the therapist was the expert and thus giving him the role power (which he may not be aware of) and ended up making an assumption (view from the chair) that she must be wrong and thus feeling that she could not question what was happening in the therapy.

> *Sally: “I didn’t expect it because I thought it was something to do with me, I always thought I was inadequate (…) they are the big cheese therapist (…) who am I …you know…someone with two small children feeling kind of hopeless…this is me… I must always be wrong so…so I didn’t ever dare question it”.*

Nigella reiterates the role power that clients give to their therapist, in some way hoping that by being the ‘expert’ the therapist will be able to solve their difficulties. As a result of the assumption that her therapist ‘must know better’ she continues to remain in therapy even though she does not feel it is addressing her needs. This highlights the possible outcomes of the power that the therapist holds, which they may not be aware that of.

> *Nigella: “The awful thing is...what made me carry on was a total lack of self-esteem and the sense that she was the great qualified therapist and she must know better...”*

In the following example Ellie assumes that the therapist was the expert in the relationship and hence hoped that she would guide her in the right

direction with the supposition that they are heading to the same destination. Sally does not question her therapist as she believes her to be the expert and complies with her therapist's direction.

> *Ellie: "I allowed this woman (…) to occupy a position of total authority in my life… and I felt since she was the expert… she should almost know whether I should come twice a week… I remember saying I couldn't really afford twice a week and she said oh there are ways and means if…if you want to face what you need to face in therapy".*

Sally explains that she felt that her therapist misused her power in that she felt that like she had no choice but to attend therapy and when she did not attend for genuine reasons she was told she had chosen not to attend and was required to pay for the session. This may have been an inaccurate assumption made however from her perspective Sally felt 'abused'.

> *Sally: "There were abusive elements in that relationship because she used…her power…maybe not consciously but to try and keep me in that subservient, paying…arriving each week position".*

In the following example Sally suggests that her therapist not only used her role power to keep her coming to therapy but also made inaccurate assumptions (alternative interpretations) and was left feeling not heard.

Sally: "There was a big storm one week and it was really really bad and tubes were down and all that and… I couldn't go and she said no, you chose not to come to therapy and I said yes but…there was a really big storm and the tubes were down and she said …it was still your choice not to come so I think financially yeah maybe she did abuse me (…) even if I gave a week's notice, I always had to pay".

Sally goes on to highlight that following this encounter she now feels that the therapist should be equal in the relationship in order for therapy to be successful:

Sally: "...the important things in the room is equality, absolute equality even... even it if means disclosure...and then she feels that we're both equal...not that to me is the most vital thing because I always felt that there's this woman, sitting on a mountain top who knew everything, there was that psychiatrist sitting on a mountain top who knew everything, I wanted to dispel that in the room, its taking away mystique and taking away hierarchies is vital".

Mandeep felt that the fact that her therapist had chosen (consciously or unconsciously) the bigger, more comfortable chair and this symbolised to her that her therapist was more powerful in the room (view from the little chair) highlighting the importance of non-verbal communication within the therapeutic relationship.

Mandeep: "It was just little things, like… immediately as I saw her…just… I think it was the power of the relationship actually…because she had a big comfy leather chair and then sat me on this sort of urm…small chair in the corner so immediately I felt very small actually and very looked down upon by her"

Puja describes feeling like she does not have a voice in therapy due to the power differential and that as a result she was not able to defend herself. This may have been a difficulty she experiences in other aspects of her life and hence may have reinforced the belief that she has no say in matters.

Puja: "I disliked myself for never facing up to what had happened, never saying to the group…I didn't feel I had the power (…) I didn't have a voice, I couldn't speak up for myself"

Mariah explains that she felt that her vulnerability was taken advantage of by her therapist. This highlights the assumptions client may make about the intervention and the importance of demystifying the process of therapy as for example her therapist may have been helping her address the vulnerability she may have been feeling following her loss rather than taking advantage.

Mariah: "…I really felt she kind of took advantage if the fact that maybe I wasn't all there and not altogether…during that year you know when I was…been with my dad and stuff"

Mariah example also highlights the link between the delicate dance of power and safety within these four walls as the safety of the therapeutic space was likely to be compromised.

Nigella accurately elucidates that clients may allow their therapist to take control as they feel unable to due to the severity of their difficulties and hence giving responsibility to the therapist for making decisions with the client's wellbeing in mind.

Nigella: I was so low at that point that I would have agreed to anything

4.5 Safety within these four walls

In therapy, we aim to provide an emotionally caring/protective, facilitating space which respects and holds the client, and also contains emergent emotions and dynamics without being judged. The aim is to allow a client to express and explore feelings that may feel too shameful or painful to be shared with others; through this process the client learns to cope with those damaging, overwhelming, or potentially explosive emotions.

Participants in this study suggest that when there is not a safe facilitative space as a result of the power dynamic and/ or not being listened to, clients are left feeling judged or unable to express what they truly feel.

Nigella recalls that she felt his therapist did not show warmth and thus may have prevented him from explore in depths her difficulties

Nigella: "I do not ever remember her every smiling or showing and emotion of warmth or friendliness"

Puja described a situation which seems very unlikely to lend itself to her being able to share her difficulties as she was 'petrified' in the sessions she attended

Puja: "I spent most of time feeling like and I was chronologically the youngest…I became childlike and I was absolutely petrified…and I used to come out with my clothes actually wet from my armpits to my waist cause I was so frightened"

Mandeep recalls feeling 'judged' by her therapist and hence compromising the safe space of the therapeutic relationship. This rupture in the relationship may have lead Mandeep to feel that she is unable to share intimate details with her therapist as she may be judged.

Mandeep: "One thing in particular I remember her saying was she asked me what my doctors name was and urr I couldn't remember…it was after the end of the session and urr…and urm you know it seems funny that urr you can't remember the name of the person that helped you and I really felt that was…a completely judging statement…that she was judging me"

Part of creating a safe environment for clients is to adhere to maintaining professional boundaries. Participants in this study reported incidents when these boundaries may have been crossed and hence compromising the safety of the therapeutic space.

Puja recalls her therapist giving the group an update of his wife's state of health. It may be argued that this was not a necessary part of therapy and potentially could have had a negative impact on the group and the individuals within the group for example, not wanting the upset the therapist further and thus holding back on intimate details that they would have hoped to have been able to share.

> *Puja: Urm right from day one…we were almost waiting for her to die…(…) he would give us a run down on her state of health*

Puja then goes on to say that as well as awaiting the imminent death of the therapist wife that she felt that they were also being asked to support him through this time rather than address their difficulties that they had entered therapy to resolve/ understand.

> *Puja: "He was like…the sad parent who need the children to parent him…".*

Puja also refers to the therapist as a 'bully' and hence not providing an environment for clients to feel open and safe.

Puja: He was bullying (…) believed in school of hard knocks

Jean states that her therapist was not only falling asleep during her session but also told her that she drained her. This disclosure by the therapist is likely to have affected the relationship in that Jean may have refrained from revealing her deepest of emotions/ difficulties as not to burden her therapist anymore.

> *Jean: For someone going to talk to a professional about specific problem and finding that they (counsellor) was practically falling asleep was a little disheartening (…) The counsellor said that I drained her and she needed to have a cold shower after she saw me so she could carry on seeing clients"*

Jean goes on to tell the researcher that she felt initially felt extremely responsible for her therapist feeling drained and even changed her the time of her sessions so that she would not cause her further distress. Although eventually Jean does find evidence that it is not her that was causing her therapist to be tired but that her therapist was overbooking herself with clients.

4.6 Same destination

A shared goal is an important aspect of the therapeutic alliance as well the transparency of the process of achieving the agreed goal of treatment. In this

study participants remarked on the different paths that they seemed be on which could have been a result of the participants not communicating their goals to their therapist or the therapist directing therapy in a way which they feel will benefit the client without making it transparent this is what he/she aims to do.

In the following except, Nigella commented that her therapist expected her to be committed to the process without knowing what the therapeutic process actually was. This may suggest to clients that the process is mystical in some way and thus adding to the imbalance of power held by the therapist.

> *Nigella: "She didn't explain the process but went on at some length about my need to make a commitment to the therapeutic process".*

Mandeep reflected upon her experience as that even though she asked her therapist about the direction of therapy the process was never explained which may have left her feeling unheard and led her to feel as if her therapist was accusing of he of not engaging. This may have led to a rupture in the alliance and thus safety of the relationship may have been affected, ultimately it resulted in termination of the therapeutic journey.

> *Mandeep: "despite saying to her several times… I don't know where this therapy is going, I don't know what I'm receiving umm… she never explained it to me and in fact got rather urm… guarded – not the right word but urm…touchy about it… as if I was insulting her as a*

therapist… it went as far as she […] accusing me of not engaging in therapy so urm… after this went on for about six months I talked to my GP and got referred to someone else…"

Sally also states her dissatisfaction with therapy due to the lack of transparency about the therapy being provided and/ or the process of therapy. Although unlike Mandeep, Sally does not appear to have asked her therapist about the process.

Sally: "I didn't understand what was supposed to be happening in the therapy room...nothing was happening".

Nick describes how the therapist seemed to be looking for something that he felt was not there and not focusing on what he was there for which left him feeling frustrated.

Nick: "They basically constantly looking at your past…for this…this…you know, bad upbringing you had and this…this terrible painful existence that you had as a child or where somebody…your mother or father mistreated you… I couldn't find this bad thing that was supposed to have happened to me and …and urr (…) I think they found it…at times…quite frustrating"

Stacey also describes her therapist as focusing on an issue that she did not feel was a problem to her currently (feeling unheard) which prevented her

from moving forward. It may have been that her therapist had a genuine reason for pursing that particular avenue but without sharing this with her client it led to the client feeling stuck.

> *Stacey: "this particular psychologist started focusing on relationships urm... and again I thought oh my god, we're back on this one again urm... and really it wasn't my relationships I was interested in really I was more interested to sort out these irrational fears which still persisted... but she seemed to swing in roundabouts ... over there with the relationships and urm... we became... like in a qwog mine with that rather than progressing"*

4.7 Alternative Interpretations

A therapist interpretation is a technique that introduces the client to a new, theoretically based frame of reference. An interpretation goes beyond the explicit and observable client content and involves communicating an inferred component with the intention of adding new knowledge, understanding, or meaning.

In the current study participants commented on the accuracy of the interpretation and hence led to clients feeling dissatisfied. Participants may have also felt unheard by their therapist on the other hand the therapist may have felt that they were offering a new way of understanding the issue that

they were presenting. One of the observations of this subcategory was that it was often linked to another subcategory – letting go as can be seen below.

In the following example Sally reported that therapist interpreted her choice to end therapy as an avoidance strategy, and this left her not only questioning herself as a person but also whether embarking on the therapeutic journey was the correct thing to do or not.

> *Sally: "...when I tried to end therapy...she would...again and again I would say well I think I've had enough and she'd say...you really think that you've had enough...I wonder what it is that you're trying to avoid? This was her big thing, what are you trying to avoid and urm... and that was awful as well..."*

She then goes on to tell the interviewer that on another occasion when she when was unable to get childcare and thus took her child with her this was again interpreted as a form of avoidance.

> *Sally: "I took the baby with me and then he accused me again of not wanting to face anything in therapy because I was using the baby as a way of avoiding communication...at that time I just thought this is so bloody mean..."*

And in another session, her real fear of being attacked was attributed to being scared of coming to therapy.

Sally: "One day I said I was really scared by the journey and…she said…and what are you trying to avoid in therapy? And I said no, I'm scared by the journey because I think people are going to leap out at me from the behind the bush and she said I wonder what you might be scared of in coming here? I just thought fuck off bitch

Puja reflects on an interpretation made by her therapist that left her 'stunned' and leaving her not being able to comprehend the kinds of interpretations she was offered by her counsellor which may have increased the feeling of not being understood or being judged in some way.

Puja "...but right at the very end of he...he gave us...what I say a interpretation or...or thoughts about each of us as a person or just how he experienced us urm...and I can't remember what he said about my husband but certainly he turned to me and said...you could be a bitch but your voice belies you...and I remember feeling quite stunned..."

Nick explained that the therapists' inaccurate assumption that he was enjoying the silence allowed him to come to the realisation that he was not receiving what he wanted from therapy and that his therapists' assumption was incorrect, he did not want to spend the session on silence, he wanted to talk about his difficulties and find a way forward.

Nick: I just remember when I was lying there and I hadn't spoken probably for about half an hour into the session which was 40 mins and it was all very quiet and and the person turned to me and said…your enjoying this quiet moment aren't you? and I thought for 40 quid for 40 minutes I'm not! And you know what that was quite a big moment".

4.8 View from the small chair

This category encapsulates what sense participants make of what is going on in treatment, some of the client's interpretations of the situation were identified early in the category of when they felt that they were not being heard. It is important to remember as therapists we are not the only ones making sense of what is happening in the room, clients are also observing their therapist from the moment they meet to the moment they leave the building and possibly until they return to their next session. As mentioned earlier, being aware of our own non-verbal behaviour and how it may impact interactions with clients is central to improving our ability to establish rapport and maintaining a strong therapeutic alliance.

Mandeep in the expert below describes what she took away from the setting of the room.

Mandeep: "It was just little things, like… immediately as I saw her…just… I think it was the power of the relationship

actually…because she had a big comfy leather chair and then sat me on this sort of urm…small chair in the corner so immediately I felt very small actually and very looked down upon by her

And then went on to talk about how she felt about her therapist, accentuating the sensitive nature of clients that are coming into therapy and the importance of being aware of how we as therapist may come across to our clients.

Mandeep: "She didn't realise that she was portraying herself to be this person to be worshipped".

Sally also talks about the setting of the room as well as what she felt the therapist jewellery bared about her.

Sally: "Everything was terribly…the room was terribly neat…even though it was her own home…there was no feeling of living…in that room and she reflected that…"

Sally: "She had a string of pearls and she was totally and utterly together and I felt…like a wreck because…you know… sort of breast feeding mother…in relation to this I sat there thinking feel depressed and pissed off with life and yet she didn't seem to have any…sort of… empathy with this at all".

Nigella reports her impression of her therapist was a lasting one, possibly reflecting his needs, hopes and expectation at the time when entered therapy that her therapist would warm and nurturing. This expectation of her therapist was not met and how the therapist was experienced led Nigella not only to label her encounter as negative but also her symptoms of depression did not reduce.

> *Nigella: "…even now, many years later, was of a blank, featureless and cold person".*

Stacey explained that she was left with the feeling that her therapist was not taking her seriously which is unlikely to be the therapist intention and hence highlights the complex nature of clients that enter the room and how mindful therapist are required to be of what works for one client may not work for another

> Stacey: "*She knew I was studying fine art urm… and I guess way of putting me at my ease was to start there and ask me what I thought of my interior decor of her consulting room and she's planning to change its colour so what colour do I think her door should be and it was that kind of matter that urr…dismayed me quite a bit urm…because she really didn't take me seriously, I was just another first year student who didn't like being away from home…and she didn't really talk with me properly about what I was experiencing".*

Stacey surmised that she felt like she was a part of “a production line”, a metaphor she used to depict the feeling that she was just “another client” within the service which may have been contract to what she was hoping for the therapist, that is she may have been hoping to feel cared for and nurtured.

> *Stacey: “her manner was very urm… not unfriendly but I was very aware that I had a certain amount of time with her… you know once the door was closed and I was walking up the corridor and she be on to the next person… it was very much like being in a … in a production line”*

Nick concurs, he also describes the sense of ‘being another case’ and making the assumption that that his therapist only cares while he is in the room which may be difficult thought for a client to accept when they are knowingly or unknowingly looking for a particular kind of relationship. It may have been beneficial for Nick and his therapist to explore this further.

> *Nick: “…at the end of the day […] once you walk out the door they’re not taking responsibility for you whatsoever and you might be able to think well… you know… they care within that 45 minutes, but outside of that you know you’re just another case”.*

4.9 Letting go

As psychotherapists, we have numerous obligations to our clients that exist with the intent of ensuring that our clients' best interests are paramount in our thinking and resulting actions. As emphasised earlier, clients entrust their well-being to their psychotherapist, trusting that the psychotherapist will act with due consideration of the client's ongoing needs and best interests. This applies throughout therapy including the client's decision to leave therapy prematurely which may be for a number of reasons.

It is essential that the therapist listens and take on board the reasons the client is presenting for wanting to terminate the relationship and respond appropriately. It may be that the therapist feels that further treatment may be helpful and that the clients is terminating prematurely due to the sessions being too difficult for the client will not be helpful for the client however the client may not be aware of this rationale. Ultimately the client should always be given a choice.

In this study participants described being met with disapproval when they attempted to terminate therapy even when the reasons were aside from resistance to treatment from their perspective.

Sally as mentioned in the earlier category of alternative interpretations that she felt she was not heard and that her therapist made an assumption that she was avoiding something when she just wanted to finish therapy.

Sally: "When I tried to end therapy…she would…and again I would say well I think I've had enough and she'd say …you really think that you've had enough…I wonder what it is that you're trying to avoid (…) and that was awful as well, because I just wanted to finish…"

Nigella explains that she allowed the therapy to continue because he did not trust her own judgements and hence gave the therapist the role power to determine when therapy should be end.

Nigella: "Perhaps my sense of self-worth was so low at the time of seeing the counsellor that I didn't trust my judgement and felt that I could not take control of a bad situation that was making me worse"

Puja explained that she tried to end therapy more than once and her therapist made an assumption that she was terminating therapy because she was not able to manage difficult emotions. Although this may have genuinely been the case, the way in which the therapist presented this to her made her feel like a child being told off for not being grateful rather than enhance her understanding of her behaviours.

Puja: "twice I would come and say I don't think this is working for me, I… I think I should leave and I would say that to the group and…I remember that the therapist lectured me like a father and said that this is a very nice group, you are very lucky to have a place here, you should see it through…don't start something and when it throws out

problems which these groups are going to do …don't then say ohhh you know…I'm too frightened and I can't deal with this".

Nigella also spoke about trying to end treatment at some point as she could no longer afford to pay for it which resulted in her in feeling guilty, judged and weak.

Nigella: "About two months I told her I would have to stop as I was no longer working. I was honest and said I couldn't afford it. This followed her telling me that I was using money as an excuse not to 'get well' I disagreed at first but ending up feeling incredibly guilty and that I owed something. I felt judged and weak. It was horrendous and I carried on, the money adding to my worries"

4.10 Dissatisfaction

The aim of this study was to investigate what contributed to clients labelling their experience as negative. The main themes that emerged from the data are outlined above, however it was thought important to also include some of the excerpts that illustrate the overall dissatisfaction that the participants felt and the impact the experience has had for some of them.

Ellie was feeling angry with her therapist as she felt she was betrayed by her by not helping her explore the consequences of what may happen when she left her husband and as a result dropped out of treatment.

Ellie: "I stopped going to see that counsellor because I was angry that she never said this could happen…and I stopped going to see her as a result of that"

She also goes on to reflect that maybe her expectations where not realistic

Ellie: "No instructions like how to …how to deal with things…deal with situation at hand, we were looking at the past a lot and…and that sort of thing because I needed…like I wanted structure as to what the hell to do…but maybe my expectations of counselling weren't realistic".

Sally describes how she was left feeling worse than when she started.

Sally: What a terrible thing because ultimately it ended up making me feel worse, I went in not feeling great and ended up feeling totally and utterly inadequate…as if everything must have been fault because I couldn't even do therapy properly".

Therapists may argue that we sometimes need to feel worse in therapy before we feel better. In Sally's case, it may be that if her feelings were communicated to the therapist it could have been explored and worked through adequately however as this was not the case the client was left with feeling more inadequate than when she entered.

Nigella also designates his dissatisfaction to his wellbeing deteriorating

> *Nigella: "As well as the gloomy and rather unfriendly physical and emotional space on which therapy took pace, the key negative experience was that I did not get better, I think I got worse. (..) It failed to help me to define my low emotional state and thereby prolonged my experience of depression over more years than necessary".*

4.11 Summary

The results of the present study capture multiple components that contribute to perceived negative experiences during psychotherapy.

It was rare for participants to describe a single contributory factor that led to a negative experience. Participants journeys often began with their experiences not matching expectations; sometimes this started before they met with their therapist when the service provided little or no information or choice about what the service offered. If the lack of clarity about therapy continued, such as no clear assessment, agreed plan or focus, or clarity about sessions and progress, clients often found it hard to engage. Disclosure became problematic, particularly if they did not experience genuine concern or understanding by the therapist. Participants experienced sessions as unsafe, and at the extreme, as uncontained or unethical, leading to a poor relationship with the therapist. The importance of maintaining a good therapeutic relationship is recognised by all therapy approaches.

Participants in this study highlighted the consequences of not attending to relationship problems, as discussed by Bugatti and Boswell (2016), and of the incremental nature of factors potentially leading to negative experiences. This study only touches upon the complex interactions involved in clients labelling their experience as negative. Further research would be required to refine and fully understand the nature of possible routes leading to negative therapy experiences.

The implications as well the limitations of the current study be discussed in the following section and some reflection on future studies proposed.

Chapter 5: Discussion

5.1 Overview

In this section, the theoretical model that emerged from the analysis, will be explored with reference to the existing literature. Moreover, a critical evaluation of the present study will be undertaken, outlining its strengths and weaknesses. This will then be followed by suggestions for future research, and the implications for practice and training in counselling psychology. Finally, the researcher's overall reflective experience of conducting the present study will be briefly processed.

5.2 The emergent model in relation to the existing literature

As discussed in the literature review, there is limited research when it comes to factors that contribute to client dissatisfaction from client's perspective. One study that does look at dissatisfactions from the client's perspective was conducted by von Below and Webart (2012). They propose a model that suggests the experience of dissatisfaction is composed of many interacting factors combining into a vicious circle which is conceptualised as an experience of abandonment. The participants in their study did not describe one single factor or incident as a starting point for their dissatisfaction and they did not distinguish between the therapist's intervention and what was perceived as flaws in the therapist's personality. In the current study some of the participants did speak about how they perceived their therapist (view

from the small chair) and the impact that it had on their experience. Von Below & Webart's (2012) findings suggest that experiences of the therapeutic relationship, suppositions of the therapist as a person, and an unproductive therapy are factors that are involved in the clients experience of dissatisfaction. These factors were also indicated in the findings of this study, for example, when participants felt that their therapist was not working towards the same goals (same destination) and when participants did not feel safe in the encounter, this led to dissatisfaction. It is important to note that their sample was made up of young adults (19-25) who had undertaken psychoanalytical psychotherapy, one of the limitations of their study.

Crawford et al (2016) and Hardy et al (2017) have recently conducted studies that support the present study in that they both suggest that there are several factors that contribute to dissatisfaction and that it is difficult to sperate these factors as they impact in each other in some cases and not in others.

Gershefski el al. (1996) and Levy el al. (1996) support the above findings in their study in which they found that in a group of clients treated for depression, although common aspects of treatment (e.g. the therapist's helpfulness) were most frequently reported as helpful, some aspects that were considered treatment specific were also reported (e.g. focus on interpersonal problems in IPT, focus on negative cognitions in CBT) and these aspects were experienced as helpful by some clients and hindering by other clients.

Buckley, Karasu, & Charles, 1981; Elliott, 1985; Elliott & James, 1989; Grunebaum, 1986; Pope & Tabachnick, 1994) also noted that apposite themes have been reported by participants of psychotherapy: 1. The therapist might be perceived as distanced, cold, uninvolved, rigid, critical and lacking human attributes; 2. the therapist might be experienced as overinvolved, seductive, evoking undesirable feelings and thoughts, promoting an overheated relationship or perpetrating boundary violations highlighting the complex nature of the therapeutic encounter.

Lietaer (1992) reported comparable results in an investigation of helpful and non-helpful processes in client-centered/experiential therapy. He found that the unhelpful experiences could be divided in two broad categories: The first category contained experiences related to the attitudes and interventions of the therapist, e.g. the therapist lacking warmth, involvement, or understanding, the therapist being not enough or overly passive/active, or the therapist giving inadequate interpretations. The second category contained experiences related to the client's process, e.g. the client hindering the conversation, preventing the conversation from deepening, or avoiding talking about certain issues. Lietaer (1992) also noted that, in the first category, it was difficult to separate aspects of the relational climate from the specific therapist interventions, which was not the case with helping processes. The non-helpful processes were mostly described as events in which relational attitudes and interventions were intertwined, so that e.g. badly timed or misdirected interventions may have caused the client to

experience the therapist as lacking warmth and understanding which may have been the case in the current study.

Linden (2013) developed a useful checklist for assessing unwanted events and adverse treatment reactions; however, as Werbart, Andersson and Sandell (2014) pointed out, such definitions tend to locate the responsibility in the client or the treatment, without consideration of therapist effects (Kraus, Castonguay, Boswell, Nordberg, & Hayes, 2011; Saxon & Barkham, 2012) or complex interaction between these systems and with a wider context. Lambert (2011), for example, highlighted how obstacles to treatment delivery may contribute to treatment failure and negative client experiences.

Although research above compliments the current study, the theoretical model developed in this study is unique in that it looks solely at the experience from the perspective of clients that have labelled their experience as negative. Many of the above studies have considered therapists perspectives or have asked about unhelpful factors which may be closely linked to factors that lead to dissatisfaction but may not always be the case. The current study also identifies the role of the client in the perceived negative experience, for example, the role power a client may give to their therapist may lead to expectations not be met and hence a dissatisfactory experience. The model also differentiates between various stages of the encounter, namely the point at which the client enters, treatment itself and leaving therapy.

In line with research that suggests that being dissatisfied with psychotherapy is a multifaceted phenomenon (e.g.von Below & Webart 2012, Crawford et al (2016); Hardy et al. 2017), the model attempts to encapsulate the intricate factors involved in the clients labelling their experience as dissatisfactory. For example, when a client comes in with expectations that are not being met, they may continue with therapy, however, if they then experience not being listened to in addition to having their expectations not being met, they may go on to label they experience as dissatisfactory. Another example may be that although the client is aware of the therapy process and has realistic expectations of therapy, if they feel judged by their therapist this may again lead to dissatisfaction.

The theoretical model not only helps to bridge the gap in the available empirical research it has the potential to integrate the findings from various parts of the literature, including the findings from the 'common factors' research, which has aimed to place greater emphasis on issues around engagement and rapport (Lambert, 1992) as well as providing support for Lazarus' (2007) argument which asserted that Rogers' core conditions (2007) were necessary but not sufficient. Based on the findings of the present study, clients often look to therapists for guidance to help them overcome their specific problems, to create a space for self-exploration is sometimes not enough to resolve specific problems.

In the next section, the three main categories and the five subcategories, will be discussed in the light of the existing literature.

5.3 Main categories

5.3.1 Client expectations

One of the primary themes deduced from the data is that participants enter therapy with a number of expectations and although these may be a product of previous experience or other external modes such as the media. Participant's felt that therapy was unable to meet these expectations and they felt let down and although this may not have been the sole reason for them labelling their experience as negative, it was certainly a factor.

Expectations have been previously dubbed the "ignored common factor" in psychotherapy (Weinberger & Eig, 1999, p.357). However authors such as Michael Lambert (1992) estimate that client expectations contribute up to 15% of variance related to outcome, whilst others hypothesise that it may in fact be higher than this (Greenberg, Constantino, & Bruce, 2006). Callahan and colleagues (2009) examined the pre-treatment expectations of clients in a university psychology training clinic setting and found that client expectations were associated with 11% to 14% of the variance in premature termination. However, it is important to note that the clients expectations in the above study are general expectations for the effectiveness and duration of psychotherapy, which are held independent of consideration of specific therapeutic or psychotherapist factors.

Although the difference between expectation and preference was not deciphered in this study it is important to note the conceptual difference

between expectation and preference. Client expectations refer to the conditions a client thinks or expects will occur during the course of therapy (Dew & Bickman, 2005). Whereas client preferences refer to characteristics of the therapeutic encounter that are desired, valued, or wanted by the client (Arnkoff, Glass, & Shapiro, 2002). Clients can hold expectations and preferences related to their role as a client, the therapist's role, their clinical outcomes, and the processes of therapy (Dew & Bickman, 2005; Glass et al., 2001; Thompson & Sunol, 1995).

While research has indicated that client expectations and preferences are correlated, these constructs are distinct and can influence therapy differently (Tracey & Dundon, 1988). Prior research has found some age and gender differences for young people's expectations and preferences for therapy. Females have been found to be less likely to expect the therapist will like and accept them and were less likely to expect the therapist to self-disclose when compared with males.

Younger participants have been found to hold lower preferences to be motivated, open, and personally responsible in therapy and are more likely to expect the therapist to be directive when compared with older age groups (Watsford & Rickwood, 2012). All the participants except one in this study were female and four were under thirty, although the researcher has not specifically identified that each of these participants had expectations of guidance from their therapist it could have been something that could have been investigated.

As discussed in the literature review, much of the research has examined the effects of client expectations on important outcomes, such as clinical improvements, premature termination of therapy, service satisfaction, and therapeutic alliance (Dew & Bickman, 2005). Based predominantly on adult samples, the literature reveals a significant association between client expectations and clinical improvement; typically finding that more optimistic expectations are associated with improved mental health and well-being (Dew & Bickman, 2005; Glass et al., 2001; Thompson & Sunol, 1995).

Research exploring associations between role expectations and therapeutic alliance shows that more optimistic client expectations are related to higher client-rated therapeutic alliance (Al-Darmaki & Kivlighan, 1993). More positive client expectations have also been found to be associated with higher satisfaction with mental health therapy (Garland, Haine, & Lewczyk Boxmeyer, 2007). Associations with premature termination of therapy reveal that both extremely positive and extremely negative expectations (Nock & Kazdin, 2001) or generally pessimistic expectations (Shuman & Shapiro, 2002) are linked with higher attrition rates.

The present study highlights that when participants did not get what they were expecting to from therapy they labelled their experience as negative. This may have further negative impact in that it reinforced participants' beliefs about themselves such as being a failure that is that they had failed at therapy, although this was not specifically addressed in this study but could be an area for future research.

As highlighted by Hardy et al (2017), it seems that it is imperative that we are able to give clients a realistic understanding of what to expect if we are to prevent clients from evaluating their therapeutic experience as negative and would not only done at the beginning of therapy but throughout the process as client's expectations may change once treatment has commenced.

In discussing negative treatment effects, Boisvert (2010) poses the question 'is it time for a black box warning?' with regard to psychological therapies. It would be interesting to find out how many of the participants were informed about the potential risks of psychological therapy – when you have surgery for example physicians draw the patients attention all the potential complications and unintended consequences when asking for consent. The APA ethical guidelines ask therapists to gain informed consent, which includes informing clients of the anticipated course of therapy as well as potential risks (Boisvert, 2010). This may potentially temper some of the expectations clients may come with, or as Boisvert suggests, the warning could serve to cause harm in itself, causing some people to forgo therapy or misattribute increases in distress to therapy and drop out early.

5.3.2 Feeling Unheard

The second category that was identified was that of 'feeling unheard'. This was encountered by a number of the participants in the study. Rowan (1986) reports that listening is an intricate aspect of counselling, and regardless of our theoretical orientation, we are always needing to refer to the necessity of contacting the world as the client experiences it. Unless we can hear what

the client is saying, we cannot even begin to start any rationally defensible form of psychotherapy or counselling, which in this respect are the same (p. 83). Fromm-Reichmann's 1959 directive, "The psychotherapist must be able to listen," (as cited in Schuster, 1979, p. 71) is clear. Yet, as Schuster (1979) highlights, this goal is not only complex, but appears beyond the reach of many: Although this requirement appears to be extraordinarily easy to accomplish it continually slips through our fingers. We all seem to know how to listen, yet many of us (even trained psychotherapists) fail to listen correctly. (p. 71). Participants in this study provide evidence for the consequence of when clients perceive they are being listened to, that is, not only do they label their experience of therapy as negative but they may attribute the therapist not listening to beliefs they may already hold about themselves such as 'I am boring'.

Correlational research suggests that listening is experienced by many clients as one of the most facilitative aspects of therapy. When asked what helped them overcome their suicidal behaviour and thinking, for example, a sample of 35 previously suicidal clients gave 'being listened to' one of the highest ratings (Paulson and Worth, 2002). Similarly 'being a good listener is often rated as one of the most helpful therapist characteristics (Glass and Arnkoff, 2000) and in accordance Paulson et al. (2001) found that ' the counsellor not really listening' was rated as the most unhelpful or hindering thing a therapist could do out of eighty items. One reason why listening may be helpful in therapy is because it serves to deepen the therapeutic relationship. When asking about critical incidents that served to form or strengthen the

therapeutic alliance for instance, Bedi et al., (2005) found that active listening was the third most commonly cited type of experience.

Myers (2000) concurs that empathic listening represents a pivotal component in the relationships between these clients and therapists. In her study, she found that the therapists' careful listening, attendance to and remembrance of details, and non-judgmental acceptance were identified by clients as contributing to the empathic bonds that they shared with their therapists (Myers, 2000). These aspects were essential for their feeling cared for and safe. Although participants in this study were not directly asked about how safe they felt in the relationship, it is evident that not being listened to had an impact on the perception therapeutic alliance and for some participants may have left them feeling unsafe to share their fears/ difficulties/ emotions. As mentioned in the earlier literature review, Lietaer (1992) agrees that having one's experience directly focused on may have given the participant a sense that what she had to say was important and that the therapist was open to listening to her experience and hence feel valued, listened to, and understood.

In accordance with this study Myers (2000) surmises that whereas theoretical knowledge and therapeutic skill are essential, the essence of therapeutic work resides in the connection built between therapist and client. Therapists must meet each client, hear his or her story, and offer responses. Through this process of interacting and building a relationship, clients develop a sense of being acknowledged, heard, and understood. As

comforting as it might be for therapists to have a perfect model or recipe for empathic listening, the experience of being heard requires an interpersonal, relational context.

At the same time research into directivity and non-directivity suggests that listening alone can be experienced by some clients as frustrating, withholding or uncaring (Orlinsky et al., 1994)

5.3.3 Delicate dance of power

The third category to emerge from this study is that of Power. Power presents itself to the therapist in different and complex forms which is highlighted by participants. The study also emphasises that the power dynamic is a delicate dance between the therapist and the client in that for some participant attributed power to their therapist and wanted their therapist to be more powerful which is consist with findings of Douglas (1985) that clients attribute power to their therapists because of their expertise, position and verbal and interpersonal acumen. On the other hand, some participants felt that the relationship should be equal. Most therapists would agree that power dynamic is inherent in the therapeutic relationship and clients who enter the therapeutic relationship with an image of the therapist as being a powerful authority tended to do so in the early stages of the relationship.

This process has been observed by Mitchell (1997) who stated that clients often begin therapy by attributing vast authority to the therapist. This form of power dynamic appears synonymous with the concept of dependency which has been widely reported and discussed within the psychotherapy literature (Weiss, 2002). For the client to take up their role of dependency on the

therapist the therapist needs to play a complementary role. Both therapist and client are therefore mutually dependent on each other.

For Lacan (1964) this involved a transference relationship whereby the client attributes knowledge to the therapist. The therapist takes on great importance for the client. Jacoby (1984) believes that in this process clients project a lot of power onto the therapist. Paradoxically, once this power dynamic was established, participants reported that they felt relatively powerless to change it. As a result of this process, therapists reported that they were aware that their client held an image of them as being powerful and yet they experienced feelings of powerlessness. This highlights the interactive and multi-layered nature of power relations.

The participants' accounts in this study indicate that for the most part therapists are not consciously aware of their role power and that the power dynamics, as well as other factors, that were preventing the participants from feeling able to explore the negative effects of the role power in their relationship. This accentuates the importance of therapist's maintaining an ongoing attention as to how they use their power to set boundaries, define the rules of the relationship and manipulate the physical space as well as providing a safe space for clients to be able to discuss difficulties they may be experience in the relationship due to the power dynamics. In this study some participants alluded to their therapists as misusing their role power, for example, Mariah stated that her therapist overcharged her on more than one occasions and rather than apologises for the mistake used it to what the

client perceived as ridiculing her. Misuses of role power arise from the therapist exploiting the client for their self – interest (Salvin, 2001) and would be a breach of the ethical guidelines set by the British Psychological Society and other such governing.

The following section, the subcategories will be discussed with the literature available in mind.

5.4 Subcategories

5.4.1Safety within these four walls

Contracts of confidentiality and other general practices can help us create a safe therapeutic space but and involves empathising in a responsive way to the client, conveying that the therapy space is safe. Rhodes and colleagues (1994) emphasise that the findings in their study highlight the importance of ensuring the clients feeling safe in therapy. The study revealed that when clients did not feel safe they did not share dissatisfaction about their therapist. The results of their study highlights that ‘misunderstanding’ are a specific type of alliance ruptures that could lead to drop out and hence should be addressed appropriately.

One of the challenges clients face when attempting to resolve difficulties is confronting difficult emotions and talking about them which may have been the case in this study. Clients may over regulate and avoid disclosing them out of fear that they may be too overwhelmed hence the importance of

creating a safe space for them not to only disclose difficulties they may have with the therapist/ therapy but also experiences such as traumatic events that they would benefit from exploring (Rhodes et al., 1994).

It should also be recognised that what is safe for one person, may not be for another. For instance, some people will perceive a reassuring touching gesture as kind and compassionate, while others may find it invasive or disturbing. Thus the therapist is required to be attuned to the specific needs of the specific individual at any one time. Crossman (1966) refers to the 3 P's (Permission; Potency and protection) to create a safe space for clients in therapy as can be seen in Figure 3 which may be beneficial for therapist to keep in mind.

Figure 3: 3 P's (Crossman, 1966)

- **Permission** involves the therapist giving clients space to: feel their feelings, speak their truths, and be themselves: 'What do you want to have happen?' or 'What feels right to you?' or 'You have the power to think your way out of this and change but its your choice'.
- **Potency** – Potency refers to our (benign) power as therapists. Our interventions enable clients to feel that we know what we are doing, and why. Potency is also about becoming more powerful than the client's inhibiting, damaging *introjects* (i.e. internalised messages that come from family or society). For example, a client may feel that they are unable to speak openly because if they honestly express their anger they will be rejected or abandoned. Our role is to show we will not reject them, that we will give all necessary support against being abandoned. And for that to carry conviction, we must be perceived as having the power to grant that protection.
- **Protection** involves creating a confidential and boundaried space which keeps the client safe from harm. If the client needs to do some cathartic anger work, for example, we would ensure the room is set up so that neither therapist nor client can get hurt. If the client is afraid of revealing a shameful secret and being negatively judged, we need to communicate our *non-judgmental* acceptance and perhaps model some compassion.

5.4.2 Same destination

Therapeutic work needs to be collaborative requiring active engagement from both therapist and client, since research shows strong links between client-therapist goal consensus and successful outcome, as well as between collaboration and outcome (Tryon and Winograd, 2011). This study complements this research but also suggests that there is more depth to the process than just goal setting. Connected to the explicit processes of

negotiating aims and collaborating in the work together, there are implicit processes operating synchronically since clients need to be able to trust their therapist's skill in mapping this uncharted territory as well as in keeping them safe. For example, it is unlikely that Mandeep felt that her and her therapist were heading in the same direction, especially as her distress was increasing, the opposite of her hopes of therapy. This example also highlights the explicit and implicit nature of the collaborative engagement that is also depended upon the therapist's "responsiveness" to what was happening overtly and inter-subjectively in session (Stiles, Honos-Webb and Surko, 1998). The current study also illustrates that different clients want and need different things from their therapists and that collaboration and trust are also mutual processes of negotiation. Ellie, for example, needed to be able to trust that her therapist would guide her in the right direction and give her solutions to her relationship difficulties and Jean wanted to be helped by her therapist to find the way through her problem herself rather than being given direct advice.

When clients did not get what they wanted from their therapist or achieve their goals, they perceived their therapy to be negative. For example, Ellie wanted advice and reassurance rather than understand her difficulties at that particular time and Nigella neither gained the psychological knowledge nor connection that she desired, and Stacey felt disappointed at not reaching the heart of her problem. These examples accord with studies showing that different clients need or want different things at different times (Cooper and McLeod, 2007) and secondly, emphasises that a flexible integrated

therapeutic approach best meets these varying individual client needs and wants (Norcross, 2011). Taking into consideration the research and the results of the current findings it would be beneficial for both the therapist and client to be transparent about their goals for treatment not only at the beginning of therapy but throughout the process as the direction of treatment may change as therapy progresses.

5.4.3 Alternative interpretations

Transference and countertransference can contribute to positive therapeutic outcomes in non-analytic therapy as much as in analytic therapy. They can also contribute to negative outcomes and treatment failure as were evident from this study.

Poulsen et al (2010) report that the participants in their study valued the counsellors' relational skills, such as the ability to clarify and make connections, the ability to ask good questions, and the counsellors' encouragement of emotional expression. Judith Shaffer (2016) in her course 'Double Edged Swords: Improving Therapy Through Interpretation', defines the overarching responsibility of therapists to monitor their work as they diagnose and interpret transference and countertransference to their clients. She suggests that when therapists sensitively share their insights and invite corroboration or correction, which some of the clients in this study may have benefited from, clients can begin to realise that what is in fact transpiring in therapy is very similar, if not identical, to the unresolved conflicts at the heart of their problems and with this balanced, integrated insight, they can more

realistically resolve their conflicts They can heal themselves from within and change their relationships with others (Shaffer 2016). Crits-Christoph et al. (1998) state that more precise relational interpretations (both transference and otherwise) do tend to be related to better therapeutic outcomes as well as to a stronger therapeutic alliance (Crits-Christoph et al., 1993).

It seems the research suggests that a low frequency of accurate relational interpretations can be helpful (Piper et al., 1993). What is also clear from the research is that transference interpretations are most effective when embedded in the context of a strong therapeutic alliance and supportive interventions, and may be dangerous when the therapeutic alliance is not sufficiently formed, serving to further weaken and already tenuous bond (Bond et al., 1998). This may have been the case for some of the participants in this study for example Sally already had a difficult relationship with her therapist and the interpretation made by her therapist about her not wanting to be there may have weekend the alliance and ultimately led to feelings of dissatisfaction. She may have also evaluated her therapist as unsympathetic and hostile as found by various authors when therapist use extensive and early interpretations and confrontations (Crits-Cristoph & Connolly Gibbons, 2001; Hilsenroth & Cromer, 2007; Norcross & Wampold, 2011).

Shaffer (2016) delineates what therapists can do to make their interpretive work as effective as possible, namely, invite their clients to join in the interpretive process. Interpretations should be ‘invitations to clients to

collaborate in discerning the validity or invalidity of therapists' *observations*. Being tentative, they are "meant to be played with, kicked around, mulled over, and torn to pieces rather than regarded as official versions of the truth" (Bollas, 1983, 7)

5.4.4 View from the small chair

There is scare empirical research that's takes into account the appraisals the clients are making of their therapist. Butler & Strupp (1986), use a phenomenological/social constructivist perspective (Schutz, 1967; Collin, 1997) to argue that the therapeutic encounter is fundamentally an interpersonal one where therapist and client interact in an attempt to produce the conditions necessary for change. In doing so, clients actively interpret their therapists' actions within a social and historical context. The influence of these actions is governed by the meanings attributed to them by both clients and therapists, which may or may not correspond.

Similarly, Elliott & James (1989), in their review of clients' experiences in therapy, conclude that what is clear is that clients bring their own agenda to therapy. In contrast to the passive recipient of therapy implied by many models, clients bring their own hopes, aims and intentions to therapy and actively evaluate their therapists' actions in relation to these intentions (e.g. Elliott, 1986). The real relationship "begins to develop from the moment the therapist and client first meet. In addition to their verbal exchanges, the participants' nonverbal exchanges - such as voice tone, eye contact, and the affective experience of each toward the other - are also contributory." This

proposition is supported by neuroscientific evidence demonstrating that an ancestral social-neural system seems to be activated when people expect benefit from a ritualised healing experience, and that humans quickly make judgements about the trustworthiness of their doctor/therapist based on facial expressions and non-verbal behaviour (Benedetti, 2011).

From this study it seems clear that many of the participants were making judgements about their therapists throughout their interactions with their therapist. As this study did not involve the therapists it is difficult to say whether the therapist were aware of their verbal and non-verbal behaviours that they were being evaluated on, however it seems critical that therapist are aware their clients are often making judgements about what they say and don't say which may have any impact on their relationship. That is not to say that therapist should not, for example, wear pearls but more so to be attuned to the metacommunications and when needed to provide the client a safe space to be able to address these issues.

5.4.5 Letting go

Clients in this category felt that their therapists were reluctant to let them leave treatment and although this may have been for genuine reasons such as the therapist believing that this was a pivotal time in the treatment, the resistance to allow the participant to leave left many of the feeling frustrated and overall dissatisfied with their treatment.

There is very little research into why client terminate treatment from the clients' perspective, however in the few studies where clients with unplanned

endings have been actively followed up, three groups have been identified (Bados, Balaguer, & Saldana, 2007; Pekarik, 1983, 1992): those who were dissatisfied with therapy; those with practical difficulties preventing attendance; those who considered themselves improved, with the first group being the largest. The participants in this study would fall under the first two categories for example Nigella could no longer afford to attend the sessions and Ellie changed therapist due to dissatisfaction.

Interestingly, Hunsley et al. (1999), who examined the reasons for clients ending therapy from the perspective of both therapist and client, found that the reasons for ending given by both parties were rarely in concordance. In particular, it is clear that therapists are especially unlikely to attribute termination to problems with the therapy or client dissatisfaction with the therapist. Such reasons were, however, frequently cited by former clients as playing significant roles in the decision to terminate services.

The findings of this study concur that participants who do not view their therapist as being very helpful and interested in their person tended to want to leave treatment early. Negative processes" are an underestimated facet of therapeutic process and outcome, and one reason for this is our difficulty in dealing with interpersonal conflicts we ourselves are involved in (Binder & Strupp, 1997). Another possibility is that both patients and therapists might hope that the obstacles will be resolved if they continue a bit longer, thus believing that "more of the same", rather than "something else", is the solution

In addition, Guy and others have written about the personal challenges faced by those who work as therapists (Guy, 1987; Guy, Poelstra & Stark, 1989; Norcross & Guy, 1989). Guy (1987) points out that “many are drawn to a career in psychotherapy due to a hunger for closeness, intimacy, and meaningful attachment” (p. 86), adding that it is not uncommon, or necessarily undesirable, for a therapist to become attached to his or her clients. Therapists often care deeply for their clients, and are driven by a desire to understand and alleviate their suffering. It is also important to acknowledge that therapy is often a paid service, and that the departure of a client may also be a financial strain on therapists. Given these predisposing factors, it is reasonable to expect that therapists would feel troubled when their clients leave treatment early and maybe experienced as being reluctant to let their clients terminate treatment as was experience by some the clients in this study.

5.5 Summary

The findings of this study are in line with the limited research that has been conducted from the client’s standpoint. There is recognition that expectations; listening and power can have a negative impact on therapy if not managed appropriately by both the therapist and the client.

The literature also suggests that therapists should anticipate that their views of the therapeutic alliance and the therapeutic work are not necessarily shared by their clients. With this in mind therapists are encouraged to regularly seek clients' feedback concerning perceptions and expectations

regarding the relationship with the therapist, the work conducted and therapeutic progress. Swift & Callahan (2009) concur that the attentiveness to and acknowledgment of their own perspective on relevant problem(s) and therapeutic goals are valued by clients, and not always correctly identified by therapists. They should ensure that goals and therapeutic tasks are discussed together and mutually determined and remain vigilant for signs of tension in the relationship that could reflect a perceived lack of shared views, adjusting their responses accordingly.

To reduce the likelihood of the encounter being labelled negative it would be beneficial for therapists to explicitly address how the particular techniques or work strategies undertaken can be of help (e.g. foster improved self-understanding and new perspectives on problems) and are relevant to achieving desired changes. It appears important to ensure that clients view the therapeutic endeavour as empathic and that therapists' felt dedication to help the client is effectively conveyed to facilitate a sense of confidence and trust in the therapist and therapy.

We should also be mindful that, like medication, psychological therapies are something of a curate's egg. Parry et al (2016) point out *"it is becoming clear that psychological treatments cannot be at once psychoactive and harmless"*. One individual may experience both beneficial and harmful consequences in different areas of their life. Harms and benefits are no more mutually exclusive than they are with medication. The current lack of attention to harms resulting from psychological interventions means that patients are not

able to make informed decisions about treatment. The recognition of potential harms has been slow, but studies such as this provide crucial information about the experiences of patients.

5.6 Evaluating the research

Many methods of evaluating qualitative research have evolved, among them some incorporating parallel concepts to those used in quantitative research (Lincoln & Guba, 1985.) In the case of the current research, and in keeping with its epistemology, criteria designed specifically for qualitative research (Finlay, 2006 ; Elliott, Fischer & Rennie, 1999; Yardley, 2000; *NCSR,* 2003) have been referenced. As previously mentioned, Yardley's (2000) criteria emerge as relevant and appropriate and thus have been used to form the basis of the discussion which follows, together with additional comments illustrating where the research can be shown to meet the criteria of others.

5.6.1 Sensitivity to context

Good quality research, argues Yardley (2000), will show evidence of sensitivity to context: throughout the research process the researcher will engage with, and acknowledge, the context. In the current study, the theoretical context has been explored both in the literature review and in the discussion chapter, which has sought to situate the findings within that theoretical context, noting where the findings concur with, contest or extend concepts within that body of literature. Through this, it has been hoped to

reveal new ways to conceptualise clients' perceived negative experiences of counselling.

Yardley highlights the importance of exploring the impact of the researcher on the research. In the current study, this is done through attention to personal and methodological reflexivity. Sensitivity is also shown by adhering to strict ethical principles by such measures as those designed to protect anonymity and keep the data secure. Asking others to study the anonymised data, as has been done in the current study, also helps to show sensitivity to participants and their accounts and illustrates the researcher's efforts to get as close to participants' experience as possible (Yardley, 2000). Use of participant quotes provides direct evidence of the voice of the participant and lends credibility to interpretations.

Research as clinical work involves power relationships and privileged positioning. Yardley (2000) argued that although qualitative researchers in the field of therapy often claim to reject the medical model, with its inherent power inequalities, such researchers still essentially place themselves in the position of experts, commanding more power than their participants. I have attempted to address this through such measures as explanations of procedures so that consent to take part was fully informed and participants were aware of their rights, including that of withdrawing from the study at any stage.

5.6.2 Commitment and rigour

For Yardley, showing commitment and rigour involves demonstrating a prolonged engagement with the research topic. Yardley points out that the researcher's personal connection to the topic can evidence this, not just their role as researcher (Yardley, 2000, p.221). In my case, this would include the fact that I have had a negative experience in my personal therapy and that I am a practitioner who has worked with consumers of therapy who have had negative experiences.

Although the current study is small-scale, and despite the constraints imposed by time and other pressures, I have attempted to respect the spirit of rigour by adding value to my learning about GT via virtual and real-world groups and seminars, and by examining my work through Yardley's concepts. In addition I have sought guidance from peers, tutors and my supervisor when, for example, selecting questions and assessing the validity of my interpretations as well as when engaging the layered analysis and writing up.

5.6.3 Transparency and coherence

In research, transparency and coherence derive from explicating the research process in such detail that it is completely clear how the work has been conducted. Only on such a basis can an assessment be made that the findings fit well together throughout. My research diary notes and memos have helped me outline my procedures in detail and raise awareness of my own self in the data. Another aspect which helped with this my sharing

aspects of my analysis and procedural steps with a colleague who recently completed her PhD using GT. I have checked my work with my colleague to enhance the credibility of my findings, although I was conscious that findings are never concrete, never right or wrong.

When discussing coherence, Yardley refers to the quality of the research narrative and the need to establish that the research question is compatible with epistemology, method and analysis. For example, for a study like the current one, whose main objective is the exploration of the participants' lived experience, it would not be appropriate to triangulate data by including the views of experts: in my case, it would not have be appropriate to talk to the therapists my participants had been to, in an effort to validate their accounts. Sharing the analysis with tutors, peers and supervisors helped me in my efforts to establish a transparent and coherent account.

5.6.4 Impact and importance

For Yardley, impact and importance relate to the theoretical, practical and socio-cultural impact of the study. It can be difficult to demonstrate this for small-scale qualitative work, and it could be argued that the findings do not have to be widely relevant (Coyle 2007; Smith *et al.*, 2009). From a theoretical perspective, however, the current study may encourage researchers to build further on the empirical data from the clients lived experience. Coyle suggests that this kind of research can be viewed as a step towards building a bigger understanding of the area. In such cases, impact will be demonstrated through a series of research works over time

rather than from one small piece. In addition, as Smith *et al.* (2009) point out, knowledge about aspects of our shared humanity can be glimpsed from the analysis of one or more transcripts.

I would argue that the study, even if its findings are not generalizable, provides glimpses of our shared humanity (Smith *et al.,* 2009). Knowledge of such individual differences in experience helps us be more sensitive to factors in our practice that we may not routinely reflect upon. For example, I as a matter of course address expectations of therapy at the very first sessions and constantly review the sessions throughout the course of treatment.

5.7 Limitations and implications for future research

The present study has a number of limitations due to its design, sampling data collection, and analysis process, which can provide potential areas for exploration in future research.

To gain further insight into the concept of perceived negative experiences from former clients of therapy, clients were recruited by advertising in a popular magazine in London. This method of sampling has potential limitations in that there is likely to be a select audience would read this magazine, for example those that predominately live in or work in London. The cost of the magazine will have also had an influence on who participates in the study as mentioned previously. In future studies, a wider audience may

be captured to ensure that there is a better representation of clients of psychotherapy. This may be through a different means of recruitment, for example, the researcher may choose to use a magazine and or newspaper that free and is available more widely. Alternatively, the researcher may use social media, posters, leaflets as an alternative to a magazine/newspaper to capture a wider audience.

As part of the inclusion criteria, participants were required to be 18 years of age or older therefore, the main generalisations of the findings are potentially limited to this age group. It would be interesting for the study to be replicated with other samples of interest such as adolescents to investigate any difference in factors that contribute to client dissatisfaction. There are some studies that indicate difference in expectations, where younger participants have been found to hold lower preferences to be motivated, open, and personally responsible in therapy and are more likely to expect the therapist to be directive when compared with older age groups (Watsford & Rickwood, 2012)

Gender was also not specifically taken into consideration in the current study, there were 8 female participants and only one male participant in this study, thus it was not possible to obtain any clear differences between the two genders, given the vast and varied experiences that the participants had as a collective. A future study could focus upon the differences within male and female expectations of psychotherapy, and how these differences affect their experiences. Distinction was also not made between the negative

experiences had by the participants between male and female therapists, as this was also outside the realms of this study. However, it would be interesting to investigate whether the different client genders relate to the differences in therapist gender and subsequently effect their experience of therapy, that is, do female clients with male therapist experience dissatisfaction in therapy or is it mainly female clients with female therapist.

In addition, the current study was also limited in that the participants were predominately white British. This is an area which has been consistently neglected by the literature and it is possible that clients from different ethnic backgrounds and sexual orientations would have highlighted various factors as crucial in their experience. As suggested by Crawford and colleagues (2016) future research would benefit from including additional interviews with clients from ethnic minorities and the LGBT communities.

Another limitation identified is that the clients presented with various psychological difficulties that entailed different modalities of treatment, therefore, the response was also potentially different among the participants. Given that there is evidence to suggest that some treatments are more effective for some problems than others (i.e., Roth & Fonagy, 2005), future research could focus on collective perceived negative experiences of clients who have presented for similar difficulties whereby a similar treatment approach is offered to see if there are any differences in the outcomes and experiences overall.

There are some concerns about the time lapse between clients completing their counselling and being interviewed. Gaps in their memories regarding their counselling could have compromised the fullness and accuracy of the data obtained. This is a concern in such retrospective reporting and may have distorted the results in that they may have not appraised their experience as negative at the time but having processed the event and possibly comparing to another experience of therapy they may have subsequently appraised it as negative.

In addition, participants in this study were not asked if there were any positive outcomes of their experience, some authors argue that you are likely to feel worse before they get better in therapy and that, maybe those participants that terminated their treatment did not give the therapy enough of a chance and hence it was perceived as negative or that although they overall experience was dissatisfactory, there were some positive factors that have been discounted. Von Below et al. (2012) found that 2 participants in their study changed their view in a more positive direction than previously stated.

The sample size in the present study was of a moderate range for a qualitative study (Charmaz, 2006), but it is difficult to make any firm conclusion about the present findings given the small number of participants. However, in the present study the aspects of rigour and the completeness of the data collection and analysis were considered and the relevant requirements fulfilled. Efforts towards developing quantitative methods for

assessing different aspects of the theoretical model would be useful for future research. Through applying quantitative methods, a larger sample could be recruited to assess the validity of different aspects of the mode. Given that the present study did not produce a core category, future research would potentially be more fruitful if it remained mindful of the complex dynamic between the various factors. Mixed design studies could help to unravel some of these complexities.

The result may have been strengthened by inclusion of a more iterative approach in the design of the study and for future studies it would be important for the research to be able to go back to the participants and clarify certain statements that the participant may have made during the interview which the researcher may have not questioned at the time but may have benefited from being explored further if there was an opportunity to do so.

Given the fact that a more flexible version, in comparison to Strauss and Corbin (1998), of the GT was applied, it is possible that the researcher's influence may have reduced the transferability of the current finding. Another researcher with a similar clinical population could come to a different set of findings. Throughout the present study, concentrated effort was made to insure rigour and transparency. However the researcher could have analysed the result based on Strauss and Corbin, a more structured approach, and assessed whether or not similar findings would emerge.

Another methodological limitation of the study includes that the data was sourced by different means, that is participants of the study were able to choose whether they wanted the interview to be video recorded or audio recorded and in addition some participants also chose to email responses. Although all the participants were asked the same questions, their responses may have varied due to the method of recording as mentioned previously and may have affected comparability of the data. Future studies would only use one method of data collection as the advantages of face to face interview in picking up nuances that can provide a wealth of information cannot be taken in to account when participants respond online. For example their non-verbal cues may suggest that they did not understand the questions, the interviewer can then decide how to proceed.

5.8 Potential implications for the field of counselling psychology

The present research has a number of potential benefits for training and practice in counselling psychology which will be now be discussed.

In the case of counselling psychology training, this research has highlighted a number of factors and the dynamic interplay between them, which were considered to be highly influential in increasing the quality of clients' experience of therapy. This information can be potentially utilised in several useful ways, such as raising training organisations' and trainees' awareness of potential factors which can help to hinder or enhance their impact on clients. However the findings should not be limited to training programmes

although it would be notable to raise awareness from the outset, it is also important for professionals in any setting where they are working with people and there is a inherent power differential, to take on board the findings to highlight what may lead to a client labelling there experience as negative. For example, therapists may benefit form ensuring that expectations are addressed from the beginning of treatment and reviewed throughout the process in order to address any discrepancies.

In addition, being more aware that clients are also making sense of the encounter, possibly making judgements about the therapist based on non-verbal and meta-communications may be helpful to the therapeutic alliance. The data also suggests that transparency with regards to the process of therapy as well as demystifying the process may help clients by having realistic expectations about treatment and as a result reduce the likelihood of dissatisfaction

The findings propose that therapists would benefit from monitoring their way of working continually, and if necessary specifically adapt their approach to what best suits their client and their difficulties. It would be furtile to be working on behavioural activation if the client is depressed due to the loss of a loved one which they have not processed. In this instance, trainers could help trainees to adopt a responsive and flexible way of being with their clients, as extant client evidence indicates that poorly timed interventions and interpretations plus a rigid adherence to a technique or approach can impede

progress, cause ruptures and can leave the therapist feeling frustrated and self-critical (De Stefano,Mann-Feder and Gazzola, 2010).

Training and or supervision that helps practitioners to feel confident in these areas will assist them to relate more compassionately with ambivalent and resisting clients. The findings therefore complement the theories positing that the quality of the therapeutic relationship is paramount, and that therapeutic change appears to happen through the strength of the trust and the collaborative nature of the relationship as well as the flexibility of the therapist to adapt practice to individual requirements (Cooper and McLeod, 2007; Norcross, 2011). In psychotherapy research, increasing client motivation, involvement and reducing resistance and defence has been a continuing interest (Mahalik, 1994; Hill, 2005; Kelly and Yuan, 2009). When clients feel safe, with some control, and feel understood and trusted by their therapist, they feel more able to disclose difficult material, and even negative feelings about their therapy.

In addition, his research was focused on talking to clients of psychotherapy in order to provide their view and for this to be included in the development of practice guidelines. In this way, clients become co-creators of the interventions aimed at them which is a tenet of Community Psychology. The findings could be used to inform guidelines and competencies for various health care professionals and services with the view to improving client experiences including that of vulnerable groups in society.

The results could also speak to a number of professional body's and policy makers in order to ensure that clients are able to access treatment equally and without discrimination. For example, perinatal clients may need more flexibility in attending their sessions and making the therapy contract the same for different groups may contribute to clients negative experience of therapy.

The findings could also be applied beyond health professionals and be utilised other disciplines that are involved in improving individual relationships. For example, an occupational psychologist may inform managers about metacommunication and power dynamics that may lead to employee dissatisfaction and in turn reduced productivity.

5.9 Summary

In summary, this research project has provided an insight into an under represented group in therapy. It may be possible to take forward the ideas conceptualised in the model and apply what we know to be the experience of a small group, to a wider population, different client groups and therapeutic modalities. There is the potential for further qualitative and quantitative research to be undertaken to explore the proposed model.

Although these are ideas for future research, it is by no means an exhaustive list, what is clear from the results and consideration of the literature is that this is a stimulating area to which much previous literature is relevant. The

theoretical model proposes a starting point from which future research in this area can develop and hopefully begin to populate an under researched area of the literature.

Regarding the actual impact of my project, it has already influenced my practice. I have been more specific in my professional profile about the roles of client and therapist and what to expect in therapy as well as understanding the client's expectations and hopes, from the onset and throughout treatment. I am increasingly monitoring our relationship and ways of working so that it best meets clients' needs and wants as well as being more aware of the non-verbal communication and metacommunications that I may be presenting to the client and vice versa. For dissemination, I often discuss issues that have come up in this study with supervisee's in my workplace as well as with peers.

6.0 Conclusion

Our clinical work starts with our clients, their concerns and their well-being and we need feedback from our clients not only to maintain this commitment but also to hone our interventions and clinical practice based on their experiences. A test of a study's validity is whether it is plausible, useful and offers new ways of understanding (Yardley, 2000). I believe that my work can make a contribution to clinical practice and training by informing therapists, assessors, supervisors and tutors of what not to do in order to reduce the likelihood of clients labelling their experience as negative.

7.0 Reflexivity

[redacted]

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Appendices

Appendix A

1.1 Ethics Forms

Version 27/01/2017

Psychology Department Standard Ethics Application Form:
Undergraduate, Taught Masters and Professional Doctorate Students

This form should be completed in full. Please ensure you include the accompanying documentation listed in question 19.

Does your research involve any of the following? *For each item, please place a 'x' in the appropriate column*	**Yes**	**No**
Persons under the age of 18 *(If yes, please refer to the Working with Children guidelines and include a copy of your DBS)*		x
Vulnerable adults (e.g. with psychological difficulties) *(If yes, please include a copy of your DBS where applicable)*		x
Use of deception *(If yes, please refer to the Use of Deception guidelines)*		x
Questions about topics that are potentially very sensitive *(Such as participants' sexual behaviour, their legal or political behaviour, their experience of violence)*		x
Potential for "labelling" by the researcher or participant (e.g. "I am stupid")		x
Potential for psychological stress, anxiety, humiliation or pain		x
Questions about illegal activities		x
Invasive interventions that would not normally be encountered in everyday life (e.g. vigorous exercise, administration of drugs)		x
Potential for adverse impact on employment or social standing		x
The collection of human tissue, blood or other biological samples		x
Access to potentially sensitive data via a third party (e.g. employee data)		x
Access to personal records or confidential information		x
Anything else that means it has more than a minimal risk of physical or psychological harm, discomfort or stress to participants.		x

If you answered 'no' to all the above questions your application may be eligible for light touch review. You should send your application to your supervisor who will approve it and send it to a second reviewer. Once the second reviewer has approved your application they will submit it to psychology.ethics@city.ac.uk and you will be issued with an ethics approval code. You cannot start your research until you have received this code.

If you answered 'yes' to any of the questions, your application is NOT eligible for light touch review and will need to be reviewed at the next Psychology Department Research Ethics Committee meeting. You should send your application to your supervisor who will approve it and send it to psychology.ethics@city.ac.uk. The committee meetings take place on the first Wednesday of every month (with the exception of January and August). Your application should be submitted at least 2 weeks in advance of the meeting you would like it considered at. We aim to send you a response within 7 days. Note that you may be asked to revise and resubmit your application so should ensure you allow for sufficient time when scheduling your research. Once your application has been approved you will be issued with an ethics approval code. You cannot start your research until you have received this code.

Which of the following describes the main applicant? *Please place a 'x' in the appropriate space*	
Undergraduate student	
Taught postgraduate student	
Professional doctorate student	x
Research student	
Staff (applying for own research)	
Staff (applying for research conducted as part of a lab class)	

1. Name of applicant(s). (All supervisors should also be named as applicants.)

Lila Varsani

2. Email(s).

[redacted]

3. Project title.

When therapy hurts: Clients talk about their negative experiences in psychotherapy

4. Provide a lay summary of the background and aims of the research. (No more than 400 words.)

This project originally emerged as a result of my experience as a client of therapy during my training in counselling psychology. Meeting a therapist for the first time is especially anxiety provoking and for many people embarking on a course of therapy this may be a completely unfamiliar and strange experience, as it was for me. As such, many fears, ideas and expectations about the therapist and the therapeutic process may have been generated in my mind however none of them prepared me for the experience I endured. Reflecting on the overall experience after the sessions were complete, I felt as though I had no voice in the sessions, and was not actually listened to by the therapist. My views were discounted and I was unable to express what I truly thought on various subjects and experiences due to the inhibitive environment and yet I did not feel able to change and continued for the full forty sessions with my therapist. I knew that something was not right, that should not be feeling this way after each session and although I often wondered if was alone in my experience, I did not speak to anyone about it at the time. This experience has inspired me to investigate other people's experiences of counselling and psychotherapy, and to explore whether any current research exists regarding clients' negative experiences during therapy. This research study will aim to not only give clients a voice but also to learn, as a practitioner, from client experiences as to what can be done to optimise the clients' experience of therapy, and reduce the possibility of a client labelling their experience as negative.

5. Provide a summary of the design and methodology.

The researcher aims to interview former clients of psychotherapy who perceive their experience of therapy as negative. All participants will need to be 18 years of age or above. An advertisement will be placed in Time Out (London) for one month to recruit participants. The participants will be asked to respond to the advert and will be given more information about the study. If they wish to participate in the study they will be asked to attend an interview or respond by email following receipt of a signed consent form. An option will also be given for the client to be video recoded, information about the rationale will also be provided by the participant and consent will be obtained. The interviews will then be transcribed and analysed using a qualitative research methodology based on the constructivist strand of grounded theory (GT). Due to the exploratory nature of this research it is felt that a methodology which emphasises theory construction rather than verification is most appropriate given that there is very little research in the area currently. The overall aim is to develop a clearer understanding of the factors that contributed to clients labelling their experience of therapy as 'negative' and the knowledge gained will provide therapist with information that will help to reduce the likelihood of their clients labelling their experience as negative.

6. Provide details of all the methods of data collection you will employ (e.g., questionnaires, reaction times, skin conductance, audio-recorded interviews).

A semi structured interview will be conducted and audio recorded and for those who give consent to be video recorded will also be video recorded. The video recording will possibly used for a training video dependant on the results of the project. All participants will be informed if they are to be included in this video.
Participants who would like to take part but cannot attend will be given an opportunity to respond by email.

7. Is there any possibility of a participant disclosing any issues of concern during the course of the research? (e.g. emotional, psychological, health or educational.) Is there any possibility of the researcher identifying such issues? If so, please describe the procedures that are in place for the appropriate referral of the participant.

Participants will be asked not to disclose their therapists name however there is the possibility that the participant may disclose this information accidently, which may present an ethical dilemma, should the researcher learn about illegal practises.

Participants are to be made aware that the researcher is under ethical obligation to report it to the relevant authority if she learns of any illegal practises.

8. Details of participants (e.g. age, gender, exclusion/inclusion criteria). Please justify any exclusion criteria.

Former clients of therapy that are over 18 that have had a negative experience in psychotherapy.

9. How will participants be selected and recruited? Who will select and recruit participants?

An advertisement will be placed in Time Out (London) magazine inviting participants to contact the researcher.

10. Will participants receive any incentives for taking part? (Please provide details of these and justify their type and amount.)

A travel allowance of a maximum of £25 per person will be paid in addition to a fee of £20 per hour for participation. All potential participants will be eligible for reimbursement of travel costs on presentation at the interview site and provided with pro-rated payment for participation regardless of whether they complete interview or withdraw their consent to participate.

11. Will informed consent be obtained from all participants? If not, please provide a justification. (Note that a copy of your consent form should be included with your application, see question 19.)

Consent will be obtained in writing, with participants signing a consent to participation form

12. How will you brief and debrief participants? (Note that copies of your information sheet and debrief should be included with your application, see question 19.)

Participants will be given an explanatory statement to read before they attend the interview as well as verbal discussion about the project, participants will be invited to ask any questions for they commence the interview.
At the end of the interview they will also have an opportunity to debrief with the researcher who will answer any questions that may have come up for them.

13. Location of data collection. (Please describe exactly where data collection will take place.)

Interviews will take place at a mutually agreed venue that is suitable for example a room in the university or the participants home, where confidentiality can be maintained.

13a. Is any part of your research taking place outside England/Wales?		
No	x	
Yes		If 'yes', please describe how you have identified and complied with all local requirements concerning ethical approval and research governance.

13b. Is any part of your research taking place outside the University buildings?		
No		
Yes	x	If 'yes', please submit a risk assessment with your application or explain how you have addressed risks.

13c. Is any part of your research taking place within the University buildings?		
No	x	
Yes		If 'yes', please ensure you have familiarised yourself with relevant risk assessments available on Moodle.

14. What potential risks to the participants do you foresee, and how do you propose to deal with these risks? These should include both ethical and health and safety risks.

Participants may become distressed when talking about their experiences. If this was to occur participants will have the option to terminate the interview or have a debrief after the interview. If required participants will also be offered an extended debrief with Dr Jacqui Farrants a chartered psychologist with extensive experience in working with clients with trauma.

15. What potential risks to the researchers do you foresee, and how do you propose to deal with these risks? These should include both ethical and health and safety risks.

As mentioned above the researcher may be faced with an ethical dilemma if the participant was to disclose any illegal practises. Participants will be made aware before the interview that the researcher has an ethical obligation to report any illegal practises.

16. What methods will you use to ensure participants' confidentiality and anonymity? (Please note that consent forms should always be kept in a separate folder to data and should NOT include participant numbers.)

	Please place an 'X' in all appropriate spaces
Complete anonymity of participants (i.e. researchers will not meet, or know the identity of participants, as participants are a part of a random sample and are required to return responses with no form of personal identification.)	
Anonymised sample or data (i.e. an *irreversible* process whereby identifiers are removed from data and replaced by a code, with no record retained of how the code relates to the identifiers. It is then impossible to identify the individual to whom the sample of information relates.)	X
De-identified samples or data (i.e. a *reversible* process whereby identifiers are replaced by a code, to which the researcher retains the key, in a secure location.)	X
Participants being referred to by pseudonym in any publication arising from the research	X
Any other method of protecting the privacy of participants (e.g. use of direct quotes with specific permission only; use of real name with specific, written permission only.) ***Please provide further details below.***	

17. Which of the following methods of data storage will you employ?	
	Please place an 'X' in all appropriate spaces
Data will be kept in a locked filing cabinet	X
Data and identifiers will be kept in separate, locked filing cabinets	X
Access to computer files will be available by password only	X
Hard data storage at City University London	
Hard data storage at another site. *Please provide further details below.*	X
The data will be kept in a locked filing cabinet at the researchers home and on a password protected computer. The cabinet meets the BPS recommended standards for storing data.	

18. Who will have access to the data?	
	Please place an 'X' in the appropriate space
Only researchers named in this application form	X
People other than those named in this application form. *Please provide further details below of who will have access and for what purpose.*	

19. Attachments checklist. *Please ensure you have referred to the Psychology Department templates when producing these items. These can be found in the Research Ethics page on Moodle.

	Please place an 'X' in all appropriate spaces	
	Attached	**Not applicable**
***Text for study advertisement**	X	
***Participant information sheet**	X	
***Participant consent form**	X	

Questionnaires to be employed		
Debrief	x	
Copy of DBS		x
Risk assessment		
Others (please specify, e.g. topic guide for interview, confirmation letter from external organisation)	x	
The topic guide for interview.		

20. Information for insurance purposes.

(a) Please provide a brief abstract describing the project

Relatively little research has been carried out into experiences of clients in therapy and/or counselling. There is even less regarding the understandings of experiences perceived as negative by the clients of therapy. Consequently, the purpose of the present research is to examine the lived experiences of clients that have experienced dissatisfaction in their encounter of therapy. This will be done by investigating the experiences of participants who self-reported as having had a negative experience of their treatment. A grounded theory will be applied in the research process to develop an understanding of what contributed to participants labelling their experience as negative. The implications of these findings towards the best practise will be discussed.

Please place an 'X' in all appropriate spaces

(b) Does the research involve any of the following:	**Yes**	**No**
Children under the age of 5 years?		x
Clinical trials / intervention testing?		X
Over 500 participants?		x
(c) Are you specifically recruiting pregnant women?		x
(d) Excluding information collected via questionnaires (either paper based or online), is any part of the research taking place outside the UK?		x

If you have answered 'no' to all the above questions, please go to section 21.

If you have answered 'yes' to any of the above questions you will need to check that the university's insurance will cover your research. You should do this by submitting this application to insurance@city.ac.uk, before applying for ethics approval. Please initial below to confirm that you have done this.

I have received confirmation that this research will be covered by the university's insurance.

Name ..... Date.....

If you have answered 'no' to all the above questions, please go to section 21.

If you have answered 'yes' to any of the above questions you will need to check that the university's insurance will cover your research. You should do this by submitting this application to insurance@city.ac.uk, before applying for ethics approval. Please initial below to confirm that you have done this.

I have received confirmation that this research will be covered by the university's insurance.

Name ..... **Date**.....

21. Information for reporting purposes.

		Please place an 'X' in all appropriate spaces
(a) Does the research involve any of the following:	**Yes**	**No**
Persons under the age of 18 years?		X
Vulnerable adults?		X
Participant recruitment outside England and Wales?		X
(b) Has the research received external funding?		

22. Final checks. Before submitting your application, please confirm the following, noting that **your application may be returned to you without review** if the committee feels these requirements have not been met.

Please confirm each of the statements below by placing an 'X' in the appropriate space	
There are no discrepancies in the information contained in the different sections of the application form and in the materials for participants.	X
There is sufficient information regarding study procedures and materials to enable proper ethical review.	X
The application form and materials for participants have been checked for grammatical errors and clarity of expression.	X
The materials for participants have been checked for typos.	X

23. Declarations by applicant(s)		
Please confirm each of the statements below by placing an 'X' in the appropriate space		
I certify that to the best of my knowledge the information given above, together with accompanying information, is complete and correct.		x
I accept the responsibility for the conduct of the procedures set out in the attached application.		x
I have attempted to identify all risks related to the research that may arise in conducting the project.		x
I understand that no research work involving human participants or data can commence until ethical approval has been given.		x
	Signature (Please type name)	**Date**
Student(s)	**Lila Varsani**	
Supervisor	**Malcolm Cross**	

Reviewer Feedback Form

Name of reviewer(s).			
Email(s).			
Does this application require any revisions or further information?			
Please place an 'X' the appropriate space			
No Reviewer(s) should sign the application and return to psychology.ethics@city.ac.uk, cc'ing to the supervisor.		**Yes** Reviewer(s) should provide further details below and email directly to the student and supervisor.	
Revisions / further information required To be completed by the reviewer(s). PLEASE DO NOT DELETE ANY PREVIOUS COMMENTS.			
Date: Comments:			
Applicant response to reviewer comments To be completed by the applicant. Please address the points raised above and explain how you have done this in the space below. You should then email the entire application (including attachments), **with changes highlighted** directly back to the reviewer(s), cc'ing to your supervisor.			
Date: Response:			
Reviewer signature(s) To be completed upon FINAL approval of all materials.			

	Signature (Please type name)	**Date**
Supervisor		
Second reviewer		

Version 27/01/2017

Reviewer Feedback Form

Name of reviewer(s).
CARLA WILLIA
Email(s).
[redacted]
Does this application require any revisions or further information?
Please place an 'X' the appropriate space

No Reviewer(s) should sign the application and return to psychology.ethics@city.ac.uk, ccing to the supervisor.	X	**Yes** Reviewer(s) should provide further details below and email directly to the student and supervisor.	

Revisions / further information required
To be completed by the reviewer(s). PLEASE DO NOT DELETE ANY PREVIOUS COMMENTS.

Date:
Comments:

Applicant response to reviewer comments
To be completed by the applicant. Please address the points raised above and explain how you have done this in the space below. You should then email the entire application (including attachments), **with changes highlighted** directly back to the reviewer(s), ccing to your supervisor.

Date:
Response:

Reviewer signature(s)
To be completed upon FINAL approval of all materials. [redacted]

	Signature (Please type name)	**Date**
Supervisor	[redacted]	3 October 2017.
Second reviewer		

23. Declarations by applicant(s)		
Please confirm each of the statements below by placing an 'X' in the appropriate space		
I certify that to the best of my knowledge the information given above, together with accompanying information, is complete and correct.		x
I accept the responsibility for the conduct of the procedures set out in the attached application.		x
I have attempted to identify all risks related to the research that may arise in conducting the project.		x
I understand that **no** research work involving human participants or data can commence until ethical approval has been given.		x
	Signature (Please type name)	**Date**
Student(s)	**Lila Varsani**	
Supervisor	[redacted]	3 October 2017

1.2 Time Out Advertisement

Timeout Advertisement

Have you ever had negative experiences in counselling or psychotherapy? City University researchers are interested in your story. Please email [redacted] for more information on this very important project.

1.3 Email to Respondents

Dear _____

Thank you for your interest in our project. For you to decide whether you would like to participate we have provided more detailed information about the project and what would be required of you.

Please read the attached Explanatory Statement for participants.

If after reading the Explanatory Statement for participants, you decide not to volunteer for the study, you need do nothing more. We will not contact you again.

If you wish to participate you should complete the 6 questions at the end of this posting and reply via email.

1.4 Explanatory Statement

WHEN THERAPY HURTS: CLIENTS TALK ABOUT NEGATIVE EXPERIENCES IN PSYCHOTHERAPY.

The aim of this project is to improve counselling and psychotherapy practice by providing trainee counsellors with an understanding of what to avoid in their practice. While there are many professionally produced videos providing examples of 'best practice' in counselling and psychotherapy, there are no resources available that provide insight into what constitutes 'bad practice'. Through video recording of interviews with former clients of psychotherapy who report negative experiences, counselling psychology trainees will have the opportunity to learn what not to do, while gaining insight into impact of negative events in therapy from perspective of actual (former) clients.

Participants are being sought by advertising through institutions providing counselling training and Timeout magazine. Persons over the age of 18 who have had negative experiences in therapy are eligible to participate in this

research. All participants will be free to withdraw their consent to participate at any stage of the research process. If participants withdraw consent they will not be penalised or disadvantaged in any way.

For those volunteers who are selected to take part in the study a travel allowance of a maximum of £25 per person will be paid in addition to a fee of £20 per hour for participation. Those participants invited for interview will be eligible for reimbursement of travel costs on presentation at the interview site and provided with pro-rated payment for participation regardless of whether the complete interview or withdraw their consent to participate.

Following receipt of signed consent form from the prospective participants they will be invited to take part in an interview that will be video recorded.

Research assistants operating video recording equipment will be asked to provide written confirmation of their assurance to maintain participant confidentiality.

Participants will be interviewed for approximately 30 minutes, followed by 10 minutes debriefing.

Should participants experience distress as a consequence of discussing upsetting events they will be offered the opportunity to terminate the interview and referred to Dr Jacqui Farrants, a Chartered Counselling Psychologist, who has experience in working with clients who have experienced trauma. Dr Farrants will provide extended debriefing and referral for ongoing counselling if appropriate.

The records of interview will be stored in a locked filing cabinet in the Psychology Department of City University.

If you wish to complain about the study, you can phone 020 7040 8010 and speak to the Secretary to the Senate Research Ethics Committee and tell them the title of the project is: When therapy hurts: Clients talk about negative experiences in psychotherapy.

You could also write to the Secretary at the following address:

[redacted]
Email: [redacted]

1.5 Consent Form (video)

(To be completed prior to participation in the video interview)

WHEN THERAPY HURTS: CLIENTS TALK ABOUT NEGATIVE EXPERIENCES IN PSYCHOTHERAPY

I agree to take part in the above City University research project. I have had the project explained to me, and I have read the Explanatory Statement, which I may keep for my records. I understand that the interview will be video recorded and subsequently edited for use as a teaching resource.

I further understand that the interview will be transcribed (written out in words) and that the transcription (the written record of my interview) will not include any information that would allow someone reading the transcript to know that it was me. The transcriptions will be stored in a secure filing system and may be used for future research.

I appreciate that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalised or disadvantaged in any way.

Name:……..

Signature:.....

Date:.....

1.6 Consent Form (audio)

(To be completed prior to participation in the interview)

WHEN THERAPY HURTS: CLIENTS TALK ABOUT NEGATIVE EXPERIENCES IN PSYCHOTHERAPY

I agree to take part in the above City University research project. I have had the project explained to me, and I have read the Explanatory Statement, which I may keep for my records.
I further understand that the interview will be transcribed (written out in words) and that the transcription (the written record of my interview) will not include any information that would allow someone reading the transcript to know that it was me. The transcriptions will be stored in a secure filing system and may be used for future research.
I appreciate that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalised or disadvantaged in any way.

Name:……..

Signature:.....

Date:.....

1.7 Questions

Have you read and understood the information for participants?

What is your age?

What age were you when you encountered a negative experience in counselling or psychotherapy?

Briefly and in general terms describe what lead you to seek counselling?

Describe your negative experiences?

Would you be willing to discuss your experience on video? (Participants will be paid £20 per hour and up to £25 to cover travelling expenses – there may not be scope to include all willing participants in the final video project and the decision of the primary research Dr Malcolm Cross, will be final).

Please forward your reply to [redacted]

Thank you for your assistance with this very important project.

[redacted]

1.8 Interview Schedule

Can you confirm that you have read and understood the information for participants?

Can you tell me your age?

What age were you when you encountered a negative experience in counselling or psychotherapy?

Briefly and in general terms describe what led you to seek counselling?

Can you describe your negative experiences?

Is there anything else you would like to add?

Thank you for your participation

Appendix B

1.1 An illustration of line by line analysis

I would travel to her house…and I would find the silence…again… confusing and punitive… I didn't understand what was supposed to be happening in the therapy room…nothing was happening…and she…everything was terribly…the room was terribly, terribly neat…even though it was her own home…there was no feeling of living…in that room and she reflected that…she sort of sat all prim and proper and she was called (participants says therapists name) and remember her American accent…she had sort of string of pearls and she was totally and utterly together and I felt…like a wreck because… you know…sort of breast feeding mother… in relation to this I sat there thinking I feel depressed and pissed off with life and yet she didn't seem to have any…sort of…empathy with this at all…and I just found this endless sort of clean…rather bitchy approach made me feel worse about myself but I'd never dared say it and…and many occasions when I felt very put down, I mean one of them was because I…I used to walk from Southfield's station…and it was a long very creepy walk with lots of bushes and its dark because my appointments always at 8 o'clock and…one day I said I was really scared by the journey and…she said…and what are you trying to avoid in therapy? And I said no, I'm scared by the journey because I think people are going to leap out at me from behind the bush and she said I wonder what you might be scared of in coming here? I just thought fuck off, bitch…and I didn't expect it because I always thought it was something to do with me, I always thought I was inadequate, I always thought… but they are the great big cheese therapist and I felt this about the psychiatrist as well…wow psychiatrist…he must know everything and who am I…you know… someone with two small children feeling kind of hopeless…this is me... I must always be wrong so…so I didn't ever dare question it…I always assumed the process…was ok and that it was about her…you know that she…she was right and I was wrong therefore I must stay in this position, so however bad I felt…now moving on… what was so interesting was when I tried to end the therapy…she would…again and again I would say well I think I've had enough and she'd say…you really think that you've had enough… I wonder what it is that you're trying to avoid? This was her big thing, what are you trying to avoid and urm…and that was awful as well, because I…I just wanted to finish but… I couldn't because again I thought she somehow had this magic box of tricks that were going to help me…and now I look back and…actually I'm quite angry because I spent a huge amount of money on it because it turned out that the

1.2 Example of open codes with memos

Open codes	**Transcript**	**Memo's**
Client asked personal opinion about matter unrelated to client's presenting problem Dismay	she knew that I was studying fine art urm... and I guess way of putting me at my ease was to start there and ask me what I thought of the interior decor of her consulting room and she's planning to change it colour so what colour did I think her door should be and it was that kind matter urm... which dismayed me quite a bit urm.	Therapist asking irrelevant questions – participants makes sense of it by saying it may have been a way of putting her at ease but also feeling dismayed by the questions
Not taken seriously	because she really didn't take me seriously, I was just another... first year student who didn't like being away from home...	Here participant feels she is not being taken seriously because she is a first
Assumptions made by therapist	when I suggested that I hadn't, her response was that I should consider that I might actually be lesbian and... my problems were due to the fact that I wasn't having sex... and...	Suggestion made by therapist based on no evidence from participant
Despair Scared	I don't know if you can imagine what that can do to an 18 year old who is in despair and not really knowing what to do urm... but it scared me because...	Participant being scared by therapist comments
Expert Unheard	a) I didn't know what she was saying was true or not cause she's the expert and b) I had been completely unheard and... therefore I couldn't think who might be able to help me urm...I went to any adult that I thought might actually listen to me urm... that included somebody I think was... given to me as it were through the chaplaincy... she way kind of postural social worker and I saw her once a week and I had nice chats about what was going on urm...she was a nice lady and she gave nice advice but...	Participant spoke about not knowing whether she should believe the suggestion made by the therapist that her problem are dues to fact that she is not having sex especially as she was seen

	given the despair I was in and it was increasing... she didn't really make any difference	as the expert Not being heard and therefore feeling as though nobody was going to be able to help
Time	So I muddled along until urm...I went to another GP urm... we're talking about a span of about a year or so now urr… or even a couple of years	Very long time to before seeing a different GP
Dulled/ no feeling	and it wasn't particularly well thought through I think it was an emergency measure and so it kind of dulled everything urm... so I didn't feel despair, I didn't feel joy, I didn't feel anything urm	Effect of medication – no feeling
Consequence Trying to gain back control in trouble	but by then I was pretty severally anorexic…in bid to control something in my life and... urm... suffered pretty hefty consequences of, of being on the medication urm... so again feeling... that if this is the only help there is then... I'm in trouble.	Participant describes consequence of not receiving help she needed – she become anorexic
Religion	Urm...I guess... I mean it was a Methodist upbringing urr... and nothing was ever forced on me...I think... religion as I saw it was really about community, church community which was very supportive and it was really focused round my mother because she was the church going person urm... and I guess in terms of a port in a storm, that was my reason for going to the church first because that's were I had been supported in the past, not really knowing that the church couldn't deal with what was going on for me. But I didn't...I didn't have such a strong religious firmer about me that I felt abandoned by god or anything like that urm... so it was more the feeling of community, passion that drew me to the chaplaincy	Influence of religion – support from church

Background Gaining control	Urm at school I was very good at drawing and fortunately the school I went to was very arts orientated so... it was girls grammar school and of any of the girls showed particular skills they were really supportive to improve them so urrn...I ...I guess was help up as... as one of the stars at school, put into competitions and... generally people were impressed with something I could do urm...I never thought of myself as particularly academically bright but girls around me were applying to universities...I wasn't encouraged to do that but I thought well... if they can do it why shouldn't I... so all the applications went to... several universities around the country... got accepted by Newcastle and...I mean it just seemed logical for me to do fine art cause that's the only thing I could do really! Urm..but I think... because I was the first person from my family to go to university there was nobody to tell me what it might be like and... fine art at university is not like drawing and painting at school urm... and so from going um.. from concentrating on observation, watercolour type painting and winning competitions urm I was in a big studio with... a number of macho tutors whose urm... idea of a project initially for first years was to tell us to go out and activate space...now when just been painting quite happily that meant nothing... what it did do was have me think... oh my god that's scary... and that's fine art and what am I supposed to do with that so... there was a real gap between my idea about art and the universities urm... so I was a bit lost from the word go really urm... but to counter act that there was a life room and there were things that I could... in inverted commas happily get on with but I never really moved on from what I was doing at school because that was *safe* and I felt safe doing the observational stuff but it did occur to	Participant describes some personal history and possible reasons as to why she was where she was – becoming anorexic in a bid to gain some control over her life

	me that urm that...I got very frustrated just being able to make work about just what I can see rather than make work about the experience of seeing so my skills didn't allow me to... for example if I was working in front of a model it didn't allow me to describe how hot he was how bored she was how tired we all were, all I could do was paint what I saw so... I found that hard and... being in a studio on my own, having to think up my own degree urm... was very difficult too... so... given all that I became quite phobic about working so the whole notion of fine art became a great, scary mess... and my way of escaping was to take control by becoming anorexic and managing my body really	
Planted a seed	Urm... I think she... she planted a seed in my mind urm... I mean any thought of a sexual relationship at that point was just inconceivable urm... because not only did I not have any desire but I wouldn't have really known what to do with it if I had urm	Participant talk about therapist suggestions about her sexuality which she had never really though about
Abnormal	.. .and scared me really urm... so for her to say that...I was abnormal because I obviously should be having lots and lots of sex and I wasn't and it...I don't think I, I focused on which way I would swing as it were but urm... it just, it just made me think I'm...I'm abnormal and... ojbmv I've got to do something about it so... if anything there's, there's been a kind of pressure on me to be normal and.. and in terms of relationships generally, I think... given that urm... all these ideas of, of food and creativity and desire and all those kinds of need are together... and so for me any of these areas have been problematic because there... there always difficult areas for me to... deal with urm... so certainly sexual relationships have always been a problem because I cant approach	Made to feel like she was not normal because she was not having lots of sex

	them freely, if you see what I mean, they're always loaded urm... in someway.	
Communication/ language	Yes urm... I must have seen he over a period of a few months urm... and...I guess I call her the French psychologist because her, her... accent was very very strong urm... and bit of struggling to understand so I felt I was having to use very simple language to describe what were quite complex issues... but I, I think I... what had happened with the doctor right at the beginning was reinforced because this particular psychologist started focusing on relationships urm... and again I thought oh my god, we're back on this one again	Difficult to understand accent and having to use simple language to describe complex issues
Therapist agenda	urm... and really it wasn't my relationships I was interested in really I was more interested to sort out these irrational fears which still persisted... but she seemed to swing abouts... over there with the relationships and urm... we became... like in a qwog mine with that rather than progressing.	Therapist seemed to focus on relationships rather than what the participant wanted to focus on
Specific techniques Age of therapist	Like the urm... doctor I first encountered, this was a woman who was middle aged, very well respected and... was given to be the expert in eating disorders and addiction so she was held up as being this... light that if anybody could help she would urm... and her methods were very specific, she worked with urm... techniques that seemed to be very well homed, using lots of visualisation techniques... for example, well think of that packet of biscuits in the cupboard, you can see it in there and urm... imagine that its half empty, you don't	Participant taking note of therapist age Expert in eating disorders Using specific techniques

	have to eat the whole thing, that kind of thing urm	
Not taken person into account Therapist traits Manner	... which I guess works for a lot of people but it seemed to be this kind of like bolt on theory that was a... work for all kind of technique that again didn't seem to take into account... me urm... and she was quite school marmish in that like if I, if I'd reported that something hadn't particularly worked she'd was a bit put out by it urm... and her manner was very urm... not unfriendly	Participant did not feel that treatment was personalised to her needs Mannerism of therapist
Production line	but I was very aware that I had a certain amount of time with her... you know once that door was closed and was walking up the corridor and she'd be on to the next person so... it was very much like being in a... in a production line if youlike... urm I know...I know that's the way it works but urm... it was like she was... treating my problem rather than me and that was the key feeling that I was left with.	Participant describes therapy being a production line and that as a result the feels like she is not taken into account in the therapy just her problem
Too much about past	Urm...I think I've... I've spent a lot time informed by what happened to me, particularly at university urm... and thinking about that and trying to... still work out how I ended up the way I did... and the reasons for that, but along side that I tried to find alternative ways to managing people problems that didn't, necessarily end up way that... my problems did in or rather they were dealt with... so its been trying to readdress the balance I guess so... any information I could find or any different approach urm...particularly kind of looking at new wave of approaches which are more coaching and NLP and that kind of think.....looking forward rather than looking back to the past, they seem to be... more constructive approaches urm... and know I'm speaking personally but...I think every negative	Participant describes she would have benefited from looking forward and not concentrating on the past – was she aware of therapy she was receiving? Transparency?

	experience I've had has always been an attempt to analyse the past which has just kept me there, hasn't enabled me to move forward urm...	
Relationship Trust	and also the approaches that I endeavour to take with people I work with is less about theories and more about relating to them individuals urm... so that we can develop a, a trusting relationship which enables them to get to where they want to go. I never felt that I... I, I developed that trust, I was constantly having to work so hard to just...	Participant describes importance of building trusting relationship and relating to the individual rather than just the problem
Fit into boxes	What I do now is urm... lots of different things really urm... I'm still working in the creative sector in that having gone though being an artist and a... a curator and a art critique urm... and then a lecturer... I've got enough information about that to be able to offer artist who are trying to make their skills professional urm...I've got enough views of the fence if you like to be able to support them in their professional development so... that's one side of things... I would say that's... it's, its less to do with counselling, more to do with the, the coaching approach which, as I was explaining looks forward rather than back, so looking at where artists want to go with their skills and planning a strategy on how to get there urm... which often becomes a, a personal issue urm inevitably... but we don't dwell on the past urm... apart from that I'm a Samaritan and urm... done some training with relate... and I think that all that is a kind of bid to get a rounder picture of how to support people in the best way possible urm... and I guess what underpins all that is... is trying to move away from... theories which are well and good urm... I can see how necessary they are but when you actually dealing	Frustrating that people are put into boxes and treated as a result of the box they are in rather than as an individual

	with a person urm... it frustrates me that we're having constantly to fit into some boxes that	
Importance of relationship between therapist and client	What do you feel constitutes a positive experience? I think its... certainly, initially there has to be a positive relationship urm... and I, I guess it is the nature of, not necessarily just the NHS but private practice as well that, although you can to a certain extent choose who you are going to see...you...getting on with somebody is a very particular thing urm... and if the counsellor or the therapist... doesn't kind of prepared carefully for that urm... I think your setting yourself up for problems…	Importance of having a therapist that you can relate to
Person before problem Not listened to	I mean how, how that kind of preparation in terms of getting to know that person before getting to know their problem urm...happens, I'm not quite sure in the present structure how therapist and counsellors work or are trained to work urm... but I think the key to it is about looking at the person before the problem urm... and although counselling is supposed to be about listening, I actually think... given my own experience that...listening hadn't actually happened urm... there'd been prescribed something that has been... bolted on rather than looking at more individual approach ...and I...I don't know whether this is true but I suspect that the mass of counsellors are people who actually had problems, they know what its like to be sat on the other side of the room... that really does help to inform what comes out of their mouth.	Participant reiterates the importance of being treated as a person and not the problem and that therapist should listen to the client rather going with what they think fits with the problem. Benefits of personal therapy? Having been on the other side may give insight into how clients may feel

1.3 Example of open codes to focus codes

Interview transcript	**Open codes**	**Focused codes**
It was just little things, like… immediately as I saw her…just… I think it was the power of the relationship actually…because she had a big comfy leather chair and then sat me on this sort of urm…small chair in the corner so immediately I felt very small actually and very looked down upon by her	Power of the relationship Felt very small Looked down upon	Power dynamics Therapeutic alliance
One thing in particular I remember her saying was she asked me what my doctors name was and urr I couldn't remember…it was after the end of the session and urr…and urm you know it seems funny that urr you can't remember the name of the person that helped you and I really felt that was…a completely judging statement…that she was judging me	Completely Judged	Therapeutic alliance
…but that was the main problem, I don't know…I don't know what I was getting at all urm…used to spend most of the sessions…sitting there…in silence…I'd tell her about my week and what had upset me that week but never really got much beyond that	Don't know what I was getting No depth	Lack of transparency of the process

Focused codes	Examples
Expectation	…expected her to read it 3:154 …and that was why I was coming back to her to seek instructions what to do… 3:198 …my expectations of it were…was that it was going to help me, 3:41 …I thought I would be helped 3:111
Professionalism	…this man was in a very distressed state 5:298 …For someone going talk to a 'professional' about a specific problem and finding that they (the counsellor) was practically falling asleep was a little disheartening, 9:23 …she as older and she was…she threw her hands in the air and yelled 3:198
Training	I since learnt from the media that she was not formally trained 5:39 I soon realised that the people I was dealing with were…seemed to be trainees4:38
Power	…is that power relationship 2:192 abusive elements in that relationship because she used…her power 6:233
Expert	…she's the expert 1:45 …clean and great and a queen and looking down on me 6:172 she was the expert…6:195 this person to be worshipped, I don't know 2:139 she was the great qualified therapist 6:148
Judgmental	.. I felt judged 8:24 ..that she was judging me 2:66
Lack of Clarity	She didn't explain the process8:14 that clarity is hugely important...I want to take that away and give it to people…and equality 6:296
Lack of Feedback	I got little feedback from the therapist 8:18 she, she just threw it back on onto me7:37
Not listening	listening hadn't actually happened 1:240 really not listening to me at all! 2:71
Resistant to ending	I think I should leave and I would say that to the group and…I remember that the therapist lectured me like a father and said that this is a very nice group, you're very lucky to have a place here, you should see it through **5:99** and she was very resistant to me…stopping **6:161**
Disclosure	she went on to discuss the horses with my ex- because they had this thing in common3:257 …ask me what I thought of the interior décor of her consulting room1.33

Constant emphasis on past	had has always been an attempt to analyses the past which has just kept me there 1:199 they basically constantly looking at your past4: 144
Inaccurate interpretations	…she said I wonder what you might be scared of in coming here? 6:103 …then he accused me again of not wanting to face anything in therapy6:70 … she just looked for the symbolism of this 6:141 This followed her telling me that I was using the money as an excuse not to 'get well' 8:22 and he said… you could be a bitch but your voice belies you 5: 45
Burnout	the fact that this counsellor saw approximately 10 clients a day could have something to do with her falling asleep. 9:32 , I think he was in such a sad bereaved state urm 5:283
Taking advantage	I found there was a kind of found a discrepancy for about …5/6 sessions 7:57 then to make things worse…she even tried to overcharge me on the last session7:132 so I think financially yeah maybe she did abuse me 6:240
Rigidity	…her methods were very specific1:171 prescribed something that has been… bolted on rather than …looking at more individual approach 1:241 …treating my problem rather than me 1:184
Feeling	…I was angry 3:86 …I was mortified, I was so upset, 5:147 …frightened…and I was so frightened 5:90

1.4 Example of focused codes to categories

Focused codes	*Category*
Therapist as the expert	Delicate dance of power
Therapist being able to fix the client's problems	
Client being taken advantage of	
Lack of transparency of the process of therapy	
Therapist awareness of power	

1.5 Memos

Example of memos written during the analysis of the data

No voice in therapy
It seems from these first two interviews that there is injustice in the way these clients were managed by their therapists. I wonder what the rationale would be to be treating clients in this way? Surely as therapists we want our clients to feel better – I am left feeling angry. Some of the common themes that seem to come in both the interviews is that the client was not heard/ taken into account. It seems that the therapist had their own agenda and went with that rather than what they client was there for, the clients seem to have no voice – similar to my own therapist. Am I too close to the data? Another way to understand that the client has no voice in therapy would be to say that the client did not say what they felt and did not address the issues. This could be a result of them feeling to worried to confront their therapist or maybe they feel that they should not be questioning the therapist, that somehow the therapist has a magic way of making them better. A different perspective – no voice in therapy or not speaking up in therapy

Power
We know that power is inherent in the relationship between the therapist and the client but how do therapists manage the power dynamic – it seems that some therapist have not realised the effect of their power on their client - it is so important to be aware of the power dynamics playing in the room. Going through some of the transcripts again it seems may be the power is not only about the therapist and how they use it, some of the participants seem to have given power to their therapist by making them the 'expert'. I would not want my clients to

perceive me to be an 'expert' rather that I will help them to make sense of their distress and provide strategies to overcome their difficulties where appropriate. Although initially the thought that the therapists of the participants misused the inherent power in the relationship was an upsetting one, I believe that there is more to it than therapist misusing their power –essentially we would not have become therapist if we did not want to help people so how are we mistreating them or are we not -I will go back and see what the data brings up with this notion in mind.

Expectations

Expectations as a core category – can negative experiences be managed by addressing expectations right at the beginning/ throughout of therapy? Is that what the data is capturing? If Ellie was told that she would not get the advice she was looking but that x and y could be achieved therapy would that have reduced the likelihood of her labelling her experience as negative? As a CBT therapist, I am regularly reviewing how my clients is feeling about therapy but does not mean that my clients will be able to tell me and that may not just be about me as a clinician but about how confident the client is or the depth of their depression may lead them to dropout rather than address difficulties. It is really important to address expectation but it may be that even if these are addressed there are other elements in the relationship that may cause the client to label their experience as negative.

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PART TWO: PROFESSIONAL PRACTICE

CASE STUDY
The importance of feelings: A cognitive behavioural study of a client with anger problems

Lila Varsani

City University

Supervised by Dr Malcolm Cross & Dr Paula Corcoran

The Professional Practice Component of this thesis has been removed for confidentiality purposes.

It can be consulted by Psychology researchers on application at the Library of City, University of London.

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PART THREE: A LITERATURE REVIEW

Personal therapy for trainee therapists: should it be mandatory?

Lila Varsani

City University

Supervised by Dr Malcolm Cross & Dr Paula Corcoran

Literature review: Should personal therapy for trainees be mandatory?

1.1 Introduction

There is ongoing debate as to whether future and aspiring therapists should have personal therapy during their own professional training. A number of theorists (i.e., Wiseman & Shefler, 2001) have advocated the importance of personal therapy for upcoming therapists and agree that dealing with personal conflict of the self is indeed helpful for the trainees to become better acquainted with themselves. Malikiosi-Loizou (2013) asserted the importance of personal therapy in the training of mental health professionals began when Freud put forward the belief that personal therapy is the deepest and most non-negotiable part of clinical education (Freud 1937/1964). He stated that: "Where and how is the poor wretch to acquire the ideal qualification which he will need in this profession? The answer is in an analysis of himself, with which his preparation for his future activity begins" (p. 246). Freud also suggested that psychotherapists themselves should return periodically to their own therapy without the presence of shame.

Atkinson (2006) asserted that “work with the self” sheds some light on the characters and personalities of those who are fit and those who are unfit for the profession and provides trainees with expertise and skills that are necessary to exercise within the modalities of counselling and

psychotherapy. The latter premise argues for this aspect of training based on the belief that counsellors and counselling psychologists should have attained a significant level of psychological maturation, adjustment, and personal awareness in order to be able to help another person do the same (Norcross, 2005).

Despite this belief, however, empirical research has failed reliably to demonstrate that personal therapy has any useful or beneficial impact on the therapist or their professional work. The limited evidence supporting the practical benefits of personal therapy challenges traditional assumptions that it is central to the psychotherapist's training and practice. The majority of research looking at the impact of personal therapy on professional practice is quantitative.

The main areas of research, according to Macran and Shapiro (1998), include surveys of therapists' evaluations of their personal therapy, experimental studies that evaluate therapist responses in situations supposedly similar to therapy, and studies comparing client outcomes between groups of practitioners who have either had personal therapy or not. According to Grimmer (2005), most research has been conducted in America, and most of the studies suffer from significant methodological limitations. Personal therapy, for instance, is only one of a multitude of different factors that might affect therapist competence or in-session behaviour.

Quantitative research struggles accurately to differentiate between the various confounding and extraneous variables that can impinge upon findings. Accordingly, the research body has tended to produce inconsistent and, at times, contradictory evidence regarding the impact of personal therapy on the professional clinician. More recently, qualitative studies have provided detailed insight into practitioners' personal experiences of therapy. Although these studies cannot objectively ascertain the usefulness of personal therapy toward clinical practice, they can, according to Grimmer (2005), tell us what practitioners subjectively believe to have been helpful to their work.

Qualitative studies have revealed a complex relationship between personal therapy and the experiences of the practitioner, suggesting that personal therapy can be both a support and positive contributor to clinical work, but also a stressor and distraction, especially if undertaken during training (Kumari, 2011; Rake & Paley, 2009). The limited evidence supporting the usefulness of personal therapy challenges the belief that it should be included as part of psychotherapy training requirements. This topic is particularly pertinent to Counselling Psychology as it is the only British Psychological Society (BPS) division to require trainees to have a minimum of forty hours of personal therapy. According to Rizq and Target (2008), Counselling Psychology is committed to upholding the importance of subjective and intersubjective factors in therapeutic process, and also to developing a clear research base for counselling theory and practice.

Although personal therapy is an intuitively accepted part of the training, there is no clear evidence-base supporting its utility for the trainee. As Rizq and Target (2008) argue, it is currently unclear whether personal therapy fulfils the personal and professional development requirements laid out in Counselling Psychology training programmes. This has led many to question its inclusion as a mandatory training requirement in Counselling Psychology (Rizq & Target, 2008). This concern may be reflected by other training courses, particularly under the BACP, which removed mandatory personal therapy from its requirements for accreditation in 2005. It is essential, therefore, that further research be conducted in order to develop a clearer picture of the ways in which personal therapy impacts practitioners' professional development. This will ensure that the inclusion of personal therapy in training can be legitimately supported and will justify to the trainee that such a costly and demanding activity is necessary to their professional growth.

The aim of this paper is critically to review the literature appraising the rationale of personal therapy from the three main schools of counselling and psychotherapy. This will be followed by the empirical evidence available with regards to personal therapy for therapist and lastly the implications for the inclusion of mandatory personal therapy in training programmes will also be discussed.

1.2 Differing theoretical methods during personal therapy (in training)

Some modalities view personal therapy as an actual intervention to alleviate symptoms or difficulties (e.g. CBT), with others hold the belief that the primary role is to correct while others believe that its primary role is to correct the limitations and distortions dating back to their prior development of personality in attempts to promote their positive personal development (Orlinsky, Ronnestad, et al., 2005).

Person-centered, existential, psychodynamic, along with many other approaches support the conceptualisation that personal therapy should be an integral part of psychotherapy training, with each positioning offering various forms of exploration. The psychoanalytic approach, for example, is affirmative to the importance and the need for personal therapy of future mental health professionals; proponents of other theoretical approaches are less clear and vary in their positions concerning the value of personal therapy in the training of future therapists (Malikiosi-Loizos, 2013; Norcross & Guy, 2005). Below is a brief review of the stance held by the major theoretical approaches regarding this issue followed by a discussion of research findings with regards to personal therapy for professionals.

1.2.1 Personal therapy in psychodynamic training

From the early days of psychoanalysis, personal analysis was understood to be the essential process in an analyst's formation. In this influential text on

“Recommendations to physicians practicing psychoanalysis” Freud (1912) maintained that it is imperative for the analyst to go through the process of “psychoanalytic purification” and resolve one’s own unconscious complexes (while communicating this process to another), before being able to observe and work with such processes with their patients. Effectively this was the beginning of the tradition of the training analysis which, over the years became an institutionally integrated component of psychoanalytic training one of the three core components of training as an analyst, alongside academic seminars and the supervised clinical practice (Cabaniss & Bosworth, 2006; Jacobs, 2011; Balint, 1954).

Freud (1937) further maintained that ones’ training analysis is never fully complete while becoming an analyst came with the acceptance that analysis has no ending, and therefore there cannot be a pre-prescribed end to it, or a pre-set goal. As Leader (2006) clarifies, psychoanalytic training aims at a questioning towards the actual search for the goal, rather than a prescribed process of progression between training stages, after one has accumulated the necessary skills and knowledge. In his recommendations offered to practitioners, Freud (1912) made a further point to distinguish psychoanalysis as a research instrument producing scientific knowledge, and as a therapeutic practice, aiming to cure those in suffering. Through this distinction, the analyst is advised to abandon any theoretical attachments and claims of expertise and instead occupy the position of someone who does not know.

These early notions reflect the dual role of personal therapy within the psychodynamic model, to educate and to treat the neurotic candidates (Eisendorfer, 1959). The psychodynamic paradigm consists of many different theoretical schools (for example Freud, Klein, Jung, and Lacan) each introducing their own ideas with regards to the human condition and the therapeutic encounter. In general some distinct premises of the psychodynamic approaches include the acceptance of a distinction between conscious and unconscious processes, the identification of early experiences as formative for later patterns of relating with self and others, an interrogation of the function of language in shaping and uncovering experience, and a focus on symptoms as relational structures and manifestations of underlying intrapsychic conflicts (Greenson, 1967; Leader, 2006; Verhaeghe, 2008). The relationship with the analyst is central in psychoanalysis, as significant material is worked through by understanding transferential responses.

The majority of-if not all- psychoanalytic training programs nowadays require their trainees to be in training analysis for a year prior to the commencement of their studies, with training analysis continuing throughout the duration of their training usually for three to five sessions a week, requiring the investment of considerable emotional and financial resources on behalf of the trainees (Davies, 2009; Rizq, 2011). Due to the personally intense nature of psychoanalytic work, it has been argued that psychoanalysts practice a profession that places them at constant vulnerability and risk by staying with what patients find most disturbing, and personal analysis is therefore a

prerequisite for safe practice (Lasky, 2005). It is also interesting to note that analysts and psychoanalytic psychotherapists are potentially “trained from their weaknesses; all other professions build on their strengths” (Coltart, 1993, p.39), which further reflects the belief in the significance of training analysis, as well as its’ potentially paradoxical purposes.

Cabaniss and Bosworth (2006) critically summarise the relevant psychoanalytic literature and propose five main aims of training analysis: to analyse the novel therapist, equivalent to “honing the analytic instrument” (p.221); to educate the novel analyst in psychoanalytic technique through personal exposure; to provide support throughout the educational experience, address difficulties in learning and explore countertransference issues; to give the candidate an understanding of their own unconscious and develop empathy for their own patients; to foster a conviction about the efficacy of psychoanalysis as a valid treatment through working through ones’ personal complexes.

These authors clearly differentiate between the experience of training and non-training analysis (p 223) and even though they acknowledge that candidates are chosen based on their suitability as clients for psychoanalysis, they further challenge the notion that training analysis should resemble non-training analysis as much as possible. Despite the recognized status of training therapy in the training curriculum, there has been much debate and controversy over the issue of mandatory therapy within the psychoanalytic community (Kernberg, 2012,1996; Jacobs, 2011;

Frank, 2010; Cabaniss & Bosworth, 2006; Desmond, 2004; Fleming & Weiss, 1978; Balint, 1954; Nielsen, 1954). Many conflicting views regarding the need of the trainee analyst have been put forwards over the years (Fleming & Weiss, 1978; Gabbard & Ogden, 2009; Windholz, 1955; Wyatt, 1948), with some writers proposing that the aim of training analysis should be to make a patient out of the analyse and, or even aim to recruit mainly "neurotic" candidates (for example Nielsen, 1954).

In contrast, others have interpreted the positive influence of personal therapy on the psychotherapist's mental functioning through a suggestion that "healthier" or less disturbed therapists foster greater positive change in their patients (Garfield & Bergin, 1971a). Having said that, Lacan (1953) developed a controversial argument and consistently challenged the formalisation (p284) practices of the dominant training institutes of his time, warning against the possibility of analysts practicing a "psychology of knowledge", with training analysis fitting in with rather than disturbing this narrative.

More recently some of the problematic points over the purpose of training therapy include the lack of assessment of the needs of candidates for therapy, issues around the timing that candidates start therapy or whether there should be a pre-set duration time, considering potential dynamics of dependency towards the therapist to complete one's training (Jacobs, 2011). Further issues relate to concerns about anonymity, as trainees often belong

in the same professional circle as their training therapists, who are also often recommended by the training institute. This dynamic may have further implications for the experience of ones' analysis, potentially creating an agenda of issues to be avoided (Cabaniss & Bosworth, 2006; Davies, 2009; Fleming & Weiss, 1978). Even though training therapists have not been required to report back on the candidates' progress since the 1970s' (Frank, 2010), issues of power in training therapy are still greatly contested (Valentine, 1996), as pre-training therapy continues to be an entry requirement for most psychoanalytic trainings (Davies, 2009).

Frank (2010) and other contemporary writers further differentiate by emphasizing the need to stop treating training therapy as the "centerpiece" or the "core" component of the training (Balint, 1954), and opt for a more balanced view of the experience, acknowledging that different people (trainee-clients) will be affected in different ways. Furthermore, Kernberg (2012) strongly argues for the innovation of psychoanalytic education and proposes the abolishment of mandatory therapy as a necessary step towards constructive change. According to Kernberg, personal analysis should be kept completely separate from educational components, thus "operate against irresolvable transference idealisation" which places the training analysts as "superior psychoanalyst, expert supervisor, gifted seminar teacher, and wise administrator" (p.714).

1.2.2 Personal Therapy in thehumanistic approaches

Rogers (1967) saw the therapeutic relationship as initiated by the need for more congruent living by the client, which is met by a systematic approach of empathy, congruence, and unconditional positive regard on behalf of the counsellor. The therapist's use of self and self-knowledge are essential to offer the client the therapeutic conditions and the experience of a safe relationship, one that allows painful feelings to be acknowledged potentially for the first time (Gillon, 2007; Mearns & Cooper, 2005). Mearns and Cooper (2005) argue that self-awareness and self-acceptance is enormously helpful as it allows the counsellor to draw from the depths of her own relational experiences to connect with others. Despite the struggles that bring one to the therapist's doorstep, humanistic practitioners tend to view clients as autonomous and inherently driven towards self-actualisation (Mearns & Cooper, 2005; Mearns & Thorne, 2010; Rogers, 1967), rather than conflicted and divided by opposing desires, as in the case of psychoanalysis (Leader & Corfield, 2008; Verhaeghe, 2008).

Gillon (2007) also clarifies that person-centred and existential practitioners focus on understanding the client's lived experience, and they do not assume expertise through the use of interpretation, as in psychoanalysis, nor adopt the role of a "teacher" (p.182) which may underlie the practice of cognitive behavioural therapy. From a person-centred perspective, the therapists' work is to ensure that the therapeutic conditions are met sufficiently for positive

psychological growth to take place (Gillon, 2007; Mearns et al., 2013; Mearns, 1997).

In order to be able to facilitate these therapeutic conditions for one's clients, therapists are expected to devote considerable resources to developing an attitude of personal fearlessness and stillness (Mearns, 1997,p.94) required for working with clients at relational depth (Mearns & Cooper, 2005). The responsibility of the training programs is to ensure that their counsellors are exposed to a variety of relevant learning contexts that foster the process of personal development, through facilitating in-depth awareness and understanding of the self and encouraging experimentation with new ways of relating to self and others (Gillon, 2007; Mearns, 1997, 2003). The values and principles guiding humanistic training are reflected in Rogers (as cited in Gillon, 2007) statement that "no student can or should be trained to become a client-centred therapist" (p.168), as the qualities and attitudes required for such deep relational work cannot be reduced to measurable and learnt competencies but rather comprise of "personal qualities and attitudes that are considered unique, both in their acquisition and manifestation" (p.168).

Following this approach, Mearns (1997) suggested that often person-centred courses may resemble therapeutic communities. Many significant processes are thought to take place in a group context, such as experiential workshops, PPD groups, and the large group experience, which are integral components of person-centred, existential (Gillon, 2007; Mearns & Thorne, 2010), and

gestalt trainings (Philippson, 2013). Such experiences are considered to facilitate the trainee's self-awareness through expanding one's understanding of their relations with others, while the group setting can also be used to work through personal issues when appropriate. It has been argued that through experiential groups trainees have the chance to engage in a wider matrix of social relations and exchange feedback with many different people (Dryden, Mearns, & Thorne, 2000; Gillon, 2007; Mearns & Cooper, 2005), even though some experiences may not be suited for everyone (Gillon, 2007).

Personal therapy is recognised for its potential to provide the trainee with opportunities to learn about the self and therefore further develop as a counsellor, and it appears that even though it is not mandatory, humanistic practitioners tend to engage with psychotherapy and report to find it highly valuable to their practice (Elliot & Partyka, 2005). Mearns (2003) proposes that personal therapy may provide a helpful experience of being in a less powerful position, while Elliot and Partyka (2005) assert that personal growth is a consistent commitment within the practice of the humanistic therapeutic traditions, and conclude that most humanistic therapists would not "authentically ask a client to engage in a given therapeutic process unless he or she has also been through it" (p.39). Having said that, Gillon (2007) cites Brodley and Merry (1995) who discuss how some trainees may struggle with the emotional intensity of the large group experience and offer relevant recommendations for alternatives.

Many authors consider personal therapy to relate to matters of an intimate nature and the personal needs of the trainee, and therefore some would argue that it is insufficient to meet the diverse and wider demands for personal development work during training (Gillon, 2007; Mearns & Cooper, 2005; Mearns & Thorne, 2010; Mearns, 2003). Gillon (2007) further notes that as uniform and predetermined training might be problematic, a compulsory requirement to attend personal therapy would be seen as highly incongruent to the principles and values of person-centred and existential trainings, and notes the only humanistic practitioners who are expected to adhere to this practice are the Counselling Psychology trainees.

Personal therapy is not enough to meet the multifaceted and on-going demands of personal development work according to Mearns (2003), as the type of personal growth work undertaken during training aims to help the trainee counsellor gain a broader and deeper understanding of issues that may challenge one's practice.

Another alternative suggested by Mearns (2003) is that of "training therapy", distinct from personal therapy in its primarily educational focus to help the trainee resolve any difficulties with their personal development, and further facilitate the experimentation with the self. This type of training therapy aims to provide the trainee with experiential learning, help them develop empathy and capacity for genuineness and authenticity, and further support them

through the stress and vulnerabilities encountered during the training years (Elliot & Partyka, 2005; Rennie, 1998).

1.2.3 Cognitive-behavioural therapy and reflective practice

Cognitive-behavioural therapies (CBT) differentiate by the degree of their cognitive or behavioural focus, with more recent third wave CBT approaches further incorporating contextual elements and mindfulness meditation techniques (Beck, 1979; Hill, 2012; Padesky, 1994; Proeve, 2010). Despite their differences, all CBT approaches seem to accept that our thoughts, emotions, behaviours, and physiology continuously interact, and by changing our thoughts or the way we relate to our thoughts, we also bring about change to the other components of our experience. Consequently, it follows that psychological disturbance develops through distorted thinking patterns that may lead to maladaptive interpretations, occurring at different levels of cognition (automatic thoughts, core beliefs, schemata) (Bennett-Levy, McManus, Westling, & Fennell, 2009; Levy, 2010; Padesky, 1994). CBT developed as a disorder-specific approach (Moorey, 2010) and is widely recommended as a primary mode of treatment in mental health care settings, often alongside medication (www.nice.org.uk). Following this paradigm, the therapists' effectiveness seems primarily understood to depend on their technical skills and competencies (Mearns, 2004; Pilgrim, 2009).

Nevertheless Beck (as cited in Proeve, 2010) also saw therapists' warmth and empathy, and the core conditions previously suggested by Rogers

(1957), as highly potent ingredients, necessary to form facilitative relationships with the clients and invite them to engage in a process of “collaborative empiricism” (Beck as cited in Moorey, 2010, p.199). Moorey (2010) asserts that it is these qualities of the therapeutic alliance that enable the therapist to use “questioning and guided discovery to demonstrate that the beliefs are extreme or unhelpful” rather than merely “tell the patients their beliefs are unfounded” (p.199). The quality of the therapeutic relationship and therapist’s qualities are considered important components of cognitive-behavioural practice (Larsson & Sugg, 2013; Levy, 2010; Proeve, 2010; Sloan, 1999), however personal therapy or other kinds of personal development experiences do not have a very long history within the cognitive-behavioural therapies (Proeve, 2010; Laireiter & Willutzki, 2005; 2003).

Given the educative and disorder-specific focus of CBT (House & Loewenthal, 2002, 2008; Mearns, 2004; Moorey, 2010) and the lack of adequate research evidence regarding the contribution of personal therapy in clinical work, personal therapy was never recommended as a valid training requirement for trainees (Laireiter & Willutzki, 2005; Mcnamara, 1986; Parker, 2010). It has been noted that this difference in the training requirements of personal therapy could also express the cognitive - behavioral paradigm’s desire to differentiate from psychoanalysis, at least back in the early days of practice (Laireiter & Willutzki, 2005).

In general, an obligatory requirement of therapy would not be consistent with the application of CBT, which requires consistent engagement and motivation on behalf of the client; it is argued that personal therapy during training may be needed for some few trainees who face personal problems, as therapy can help them correct their personal problems and their dysfunctional personal and interpersonal style, but is not required by all (Laireiter & Willutzki, 2005). Issues around the self-development of the therapist have been explored in more recent years as they have been associated with more positive therapeutic outcomes (Binnie, 2012; Goldfried & Davila, 2005; Larsson & Sugg, 2013). Reflective practice is now considered an essential component of therapeutic work (Binnie, 2012; Levy, 2010). Activities like sensitivity work usually taking place in groups, as well as the self-application of cognitive-behavioural techniques have been suggested to enhance personal well-being and therapeutic skills (Bennett-Levy et al., 2009; Binnie, 2012; Laireiter & Willutzki, 2003, 2005).

Findings from empirical studies suggest that about fifty to sixty percent of CBT therapists engage in personal therapy, however it appears that it is highly unusual for CBT practitioners to undergo CBT therapy themselves (Laireiter & Willutzki, 2005; Norcross & Guy, 2005; Parker, 2010). It has been argued that personal experience of CBT therapy could be particularly beneficial for therapists who may gain a deeper sense of empathy towards their clients' difficulty to monitor their thoughts and challenge their behaviour, and further offer the novice therapists a conviction in the appropriateness of

the approach (Proeve, 2010). Proeve (2010) highlights that a notable exception is observed in the practice of mindfulness-based cognitive-behavioural therapy (MBCBT), an approach that has a “strong expectation” (p.153) that therapists participate in MBCBT groups throughout their training, while practitioners are also expected to practice what they preach and remain committed to their personal practice of meditation. Despite the focus of the cognitive-behavioural schools on technical expertise and the absence of any requirement for personal therapy, the importance of the therapeutic alliance (Sloan, 1999) and reflective practice in relation to successful therapeutic work is well supported by CBT practitioners (Laireiter & Willutzki, 2005; Levy, 2010; Strong, 2010). As Laireiter and Willutzki (2005) summarise, “self-reflection is no luxury but a necessary component of therapeutic practice. Accordingly, it may be regarded as a criterion of the quality of therapeutic practice in CBT.” (p.49).

1.3 Personal therapy and Counselling Psychology

As observed in the above sections, the approach towards personal therapy varies both between as well as within the different schools of psychotherapy. The role of personal therapy in Counselling Psychology training appears comparable to the institutionalised role of training therapy in the psychodynamic training curriculum, posing similar conflicts with regards to the ambiguous role of therapy to educate or to “heal”, and contested problems of confidentiality and anonymity. A significant difference between the two relates to the implications of training within an academic setting, as in

the case of Counselling Psychology, as opposed to a training institute (Parker, 2002; Strong et al., 2015), with further implications relating to the dynamics of statutory regulation (HCPC, 2015) which psychoanalytic organisations have strongly objected as antithetical to the principles of psychotherapeutic practice (Ingham, 2010; The Maresfield Report on the Regulation of Psychotherapy in the UK, 2009).

As mentioned earlier, the phenomenological and intersubjective focus of Counselling Psychology is strongly influenced by its humanistic value base. Similar to the Person-Centred approaches, Counselling Psychology rejects the dominance of models of pathology that reduce those who seek our support into their symptomatology (Larsson et al., 2012; Mearns, 2004; Middleton, 2015; Orlans & VanScoyoc, 2009), advocating instead for a holistic, phenomenological, and critical approach that values personal meaning. This is reflected through the emphasis of the humanistic approaches on the value of personal development and a focus on the therapist's personal qualities, which also informs the training curriculum of Counselling Psychology.

Finally, the cognitive behavioural approach shares considerable grounds with the practice of Counselling Psychology, given their mutually collaborative approach towards the client and the role of the practitioner as a facilitator of the client's process of self-development. Nevertheless, the gradual dominance of a diluted CBT model of therapy within the NHS therapy

services (Cotton, 2015; Pilgrim, 2009) and the development and expansion of standardized treatment protocols corresponding to categorical diagnosis with a clear political narrative (Cotton, 2015; Guy et al., 2012; Layard, 2005; Loewenthal, 2015) alongside the use of medicalised and restrictive language (Mair, 2015; Guy et al., 2012; Rizq et al., 2010; Rizq, 2009;Kendall & Cochrane, 2007) could pose challenges for trainee practitioners, whose experiences of training and personal therapy may be contradictory to models they encounter in practice.

Through reflecting on the epistemological differences of the main therapeutic approaches informing Counselling Psychology, and briefly evaluating the significant influence of the contexts in which trainees and qualified therapists practice, it appears that Counselling Psychologists are required to develop significant capacity to balance pluralism (p.613) from early on in their training, as Rizq (2006) poignantly reflects, while continuing to negotiate their multiple identities throughout their career, as Goldstein (2010) proposes. A commitment to personal development and reflective practice, and a systematic engagement with personal therapy present a distinct characteristic of Counselling Psychology. As shown throughout this section, this approach to practice is influenced by the discipline's allegiance with the humanistic, cognitive-behavioral and the psychodynamic schools respectively.

The following sections will explore the empirical evidence from quantitative studies relating to the characteristics of therapists as clients, common reasons for engaging with personal therapy, the arguments for and against the practice of training therapy, the influence of theory on practice and the documented impact on clinical outcomes, alongside relevant critical evaluations. Subsequently, the qualitative studies looking into the experiences of therapists as clients will be discussed in depth, with the focus on the experiences of Counselling Psychologists and Counselling Psychology trainees.

1.3.1 Quantitative studies

According to Ivey, (2014a) the complexity around mandatory personal therapy is largely generated by the tripartite role status of trainees, who are clients, therapists and students to the profession at the same time. In that sense it is possible to argue that trainees are a distinct client group.

Through their fifteen-year longitudinal study of nearly 5,000 psychotherapists, Orlinsky and Ronnestad (2005) reported that, regardless of career level and theoretical orientation, psychotherapists rank their own personal therapy as one of the most constructive influences on their current development, facilitating their personal and professional growth. The vast majority of studies suggest that personal therapy is thought to have a positive influence upon the personal and professional development of the practitioner, relating to interpersonal and intrapersonal factors. Perceived

benefits include increased sense of empathy and respect towards the clients, enhanced self-awareness, countertransference awareness, interpersonal skills, first-hand experience of therapy, working through personal conflicts, receiving support with interpersonal difficulties and aspects of training, and gaining conviction about therapy's effectiveness (Chaturvedi, 2013; Clark, 1986; Geller et al., 2005; Macaskill & Macaskill, 1992; Macran & Shapiro, 1998; Orlinsky, Schofield, Schroder, & Kazantzis, 2011; Pope & Tabachnick, 1994a; Wigg et al., 2011; MacDevitt, 1988).

Norcross, (2005) reflecting on 25 years of research, argues that personal therapy is "an emotionally vital, interpersonally dense, and professionally formative experience", central in the formation of psychotherapists, and warns against the primacy of technique-based trainings that quickly become "arid, disembodied, and decontextualized" (p.840). Therapists appear to generally favour personal therapy, despite also reporting various negative experiences, such as family and relationship conflicts, becoming 'too reflective', dual roles and concerns of confidentiality (Dearing, Maddux, & Tangney, 2005; Norman Macaskill & Macaskill, 1992; MacDevitt, 1988; Macran & Shapiro, 1998; Norcross et al., 1988; Williams, Coyle, & Lyons, 1999a).

It has been suggested that undertaking therapy early on in one's training may place the trainee in a vulnerable position, imposing additional emotional and financial strains during the demanding period of training, leaving them

preoccupied with their own personal issues and conflicts, thus potentially making them less able to engage effectively with clients (Pope, & Tabachnick, 1994; Buckley, Karasu, & Charles, 1981; Garfield & Bergin, 1971; Macaskill & Macaskill, 1992).

A UK survey conducted by Williams et al. (1999) exploring counselling psychology trainees' views on personal therapy suggests that trainees may use the learning experience of therapy better once personal issues have been dealt with. This study reports that the majority of the respondents (88%) favoured the personal therapy requirement during training, even though a percentage of the participants (38%) reported some negative effects as well (marital problems, emotional withdrawal, destructive acting out, and increased distress). Moreover, in a survey of Clinical and Counselling Psychology trainees, McEwan and Duncan (1993) further identified that despite the positive ratings, eighty-three percent of the participants saw at least one risk for harm through their therapy, which most often included issues with dual relationships and confidentiality within the trainees' therapy. Sixty-two percent of the sample reported not being assessed for their suitability to attend therapy at that point in their lives, while almost half of them were required to attend therapy by their training course, and many (49%) were not able to choose their therapist.

The critical review of relevant studies reveals a complex interplay between personal and professional needs and demands when considering the diverse

reasons for which therapists attend personal therapy (Deacon et al., 1999; Garfield & Bergin, 1971a; Geller et al., 2005; Macran & Shapiro, 1998; Orlinsky et al., 2011; Wigg et al., 2011). Pope and Tabachnick (1994b) found that psychologists go to therapy when confronted with personal difficulties, comparable to the general population, such as depression, suicidal thoughts, and harmful behaviours, such as drug and alcohol abuse, a finding which is replicated across studies (for e.g. Holzman et al., 1996; Norcross et al., 1988; Norcross, 2005).

The high prevalence of therapy has often been linked with the increased job-related stress of practicing as a therapist across different career levels (Darongkamas, Burton, & Cushway, 1994; Holzman et al., 1996; Macran & Shapiro, 1998). It has also been suggested that therapists may be driven to therapy by the same issues underlying one's choice to become a therapist, hence the wounded healer paradox (Hadjiosif, 2015; Orlinsky et al., 2011; Sussman, 2007; Dicaccavo, 2002), a narrative that remains influential in the selection of candidates for clinical/counselling trainings (Adams, 2014; Ivey & Partington, 2014).

Further evidence relating to the experience of personal therapy has been obtained from various studies exploring the increased concerns of trainees and qualified practitioners about issues of confidentiality and stigma within the community of therapists (Holzman et al., 1996; MacDevitt, 1988; McEwan & Duncan, 1993). Trotter (2006, as cited in Chaturvedi, 2013) has

suggested that clients may be both voluntary and involuntary, as their choice to attend therapy is partly due to compliance with external pressures; when applied to the case of trainee psychologists, this experience may fuel fears of being labelled as problematic for not attending (Chaturvedi, 2013), or feed into a culture of comply or risk not qualifying (Davies, 2009). Such concerns appear to influence therapist's help-seeking behaviours and use of personal therapy, especially during the time of one's training when issues of confidentiality may further relate with very real concerns about personal evaluation and professional progression (Davies, 2009; Dearing et al., 2005; Hadjiosif, 2015; Lasky, 2005; Tribe, 2015).

It is worth noting that relevant ethical dilemmas seem to impact both trainees who seek therapy and therapists offering mandatory therapy (Gabbard, 1995; King, 2011; Ivey, 2014). Theoretical influences and client outcomes Geller et al. (2005) reported that psychodynamically-oriented practitioners had the highest rates of personal therapy (82-94%), followed by those of humanistic orientation, while cognitive-behavioral therapists reported the lowest rates of attendance (44-66%). Furthermore, the majority of therapists, including those from cognitive-behavioural approaches, chose psychodynamically-oriented therapists for their personal therapy (Darongkamas, Burton, & Cushway, 1994; Guy, Stark, & Poelstra, 1988; Holzman et al., 1996; Macran & Shapiro, 1998; Norcross & Guy, 2005; Orlinsky et al., 2011; Williams et al., 1999a).

When considering the influence on client work, the length of therapy offered has been found to be comparable to the length of therapy received (Gold & Hilsenroth, 2009; Guy et al., 1988; Holzman et al., 1996), while a therapist's orientation appears to be the most influential factor in the choice of theoretical orientation by the trainee (Steiner, 1978).These figures appear consistent across studies (Guy et al., 1988; Holzman et al., 1996; MacDevitt, 1988; Macran & Shapiro, 1998; Orlinsky et al., 2011), and have been attributed to the strong theoretical influence of psychodynamic theories in the profession of psychotherapy (see Cabaniss & Bosworth, 2006; Lasky, 2005). Consistently across studies, therapists with experience of personal therapy are more likely to rate it as an integral and valuable influence to their practice when compared to those who have never attended (for example Norcross, Evans, & Schatz, 2008).

Authors such as Mace (2001) have proposed a clear preference of clients' for therapists with experience of personal therapy, however recent evidence from unpublished manuscripts disputes this with findings suggesting that clients do not show any preference with regards to therapists' personal therapy (Armour, 2008). In general, outcome studies have produced variable and inconclusive findings with regards to the relationship of personal therapy to clinical outcomes (Chaturvedi, 2013; Clark, 1986b; Norman Macaskill & Macaskill, 1992; Macran & Shapiro, 1998; Wigg et al., 2011). Macran and Shapiro (1998) reviewed nine published studies (including those previously reviewed by Greenberg and Staller (1981) and Macaskill (1988) concluding

that neither attendance in personal therapy nor length of therapy undertaken emerged as significant factors correlating with client outcomes. Wheeler (1991) found that length of time in personal therapy was negatively related with therapeutic alliance, a finding the author attributed to the encouragement of expression of negative transference by therapists who have attended long-term analysis.

In study conducted by Gold and Hilsenroth (2009), they found that personal therapy had no significant effect on therapeutic alliance, apart from therapist ratings of alliance variables; nevertheless, the study also documented a significant difference between client attendance rates, which were twice as long with therapists who had experience of personal therapy. Similarly, indirect evidence relating to the effect of personal therapy upon clients has been obtained through studies exploring therapist variables in general, indicating that personal therapy may contribute to the quality of the therapeutic alliance and secure attachment, therapist warmth and genuineness, and overall experience of a supportive relationship (Mikulincer, Shaver, & Berant, 2013; Rønnestad & Ladany, 2006; Høglend et al., 2011; Lane & Corrie, 2006; Norcross & Wampold, 2011; Stein & Lambert, 1995;). For example, in a recent study by Berghout and Zevalkink (2011) comparing therapist variables and client outcomes of psychoanalysis and psychodynamic psychotherapy, the researchers found that therapist's attendance and duration of personal therapy had no significant impact on clinical outcomes, however these researchers identified the attitudes of

therapists as more influential to treatment outcomes: a belief in the curative potential of kindness and a supportive manner of working with clients delivered significantly better results.

Sandell et al. (2006), drawing from data gathered for the Stockholm Outcome of Psychotherapy and Psychoanalysis Project (STOPPP), described a complex relationship between the length of a therapist's personal therapy and the impact on patient outcomes; the authors conclude that longer duration of personal therapy is negatively related to clinical outcomes in psychotherapy, but positively related to clinical outcomes of psychoanalysis.

As a possible interpretation of the findings, the authors refer to the modelling function of therapy and suggest that those who have undertaken a lengthy personal analysis are more likely to identify with their analyst's approach and attempt to apply inappropriately similar techniques and principles in brief work with clients. Concurrently, these authors recommend shorter training therapies as potentially better for the clients, however emphasise that their findings do not suggest that personal therapy is unnecessary or counterproductive, as it is hard to see "how therapists-to-be" would otherwise learn how a person might feel being a patient, how experienced therapists "do it", and how theoretical concepts manifest themselves" (p.314).

1.3.2 Critique on quantitative studies

Most studies suggest that personal therapy is perceived as both influential to one's practice and a much-needed support system for what is identified as a stressful profession. In addition, personal therapy is assumed to enhance therapist factors contributing to the therapeutic alliance, as it further prepares the therapist to provide the helpful therapeutic conditions they previously experienced in their own therapy. Nevertheless, the conclusions that can be drawn from traditional quantitative studies on the effects of personal therapy are limited and inconclusive in relation to both the role of therapy during training as well as its anticipated benefits for work with patients (Chaturvedi, 2013; Macran & Shapiro, 1998; Wigg et al., 2011). The majority of studies reviewed rely on the use of self-report methods and entail considerable methodological limitations, including low response rates and lack of control samples to limit within sample biases (Chaturvedi, 2013; Rizq, 2011; Wigg et al., 2011).

It is possible to assume that those with more positive experiences of therapy are more likely to participate in studies; it is also plausible that those who need therapy may well seek out therapy more often and with greater personal investment in the process, thus potentially being favorably predisposed to the outcome. Given that motivation and choice are considered essential client-initiated factors in therapy, the high ratings of personal therapy as a positive and integral experience of personal and professional development are hard to interpret in the absence of choice and

motivation to attend personal therapy, as in the case of mandatory personal therapy for trainees (Beutler, Machado, & Neufeldt, 1994; Chaturvedi, 2013).

As Chaturvedi (2013) points out, clients are significantly underrepresented in research on personal therapy, and outcome studies reveal variant and often inconclusive results. Some interesting findings include the association between the therapy experienced and the effects on therapy offered to clients, with relevant factors including the length of therapy, compatibility of theoretical models between personal therapy and clinical practice, as well as experience of helpful therapeutic conditions. Nevertheless, the question of "whether the evidence justifies the practice is related to the ongoing debate of what constitutes evidence in psychotherapeutic practice" (Chaturvedi, 2013, p. 455). The reliance on quantitative methods for psychotherapy research has been criticised by both researchers and practitioners as offering an impoverished and decontextualised description of the experience of personal therapy (for example Wigg et al., 2011; Macran et al., 1999; Wiseman & Shefler, 2001).

As Leader (2006) postulates, the relatively recent pressure to respond to external validation and "produce evidence- based research matching the standards and criteria of evidence-based medicine" (p.389) is incompatible with the theory and practices of psychotherapy. Focusing on enhancing critical dialogue and consummation of ideas within the therapeutic

community may be more meaningful, as well as giving voice to the different client groups affected (Leader, 2006; Loewenthal, 2015).

The attempt to bridge the gap between research and practice has given rise to the introduction of qualitative methods and greater emphasis on the participants' subjectivity in the exploration of the therapeutic encounter. Based on the review of quantitative studies, there is a need for deeper understanding of the multiple and complex effects of mandatory personal therapy for Counselling Psychology trainees; there also appears to be a necessity for greater clarity with regards to the differential impact of various therapeutic approaches on trainees as clients, as well as on subsequent clinical work (Rizq, 2010). This shift from questions of "whether therapy has an effect" to "how personal therapy is experienced" prioritises a focus on process over objective measures and outcomes and aims to capture a deeper understanding of the subjective individual experience through the use of qualitative methodologies.

Macran, Stiles and Smith (1999) conducted an IPA study with seven qualified therapists investigating how their current and past experiences of personal therapy were perceived to impact their personal development and clinical work. The findings were organised into three domains, describing aspects of intra ("orienting to the therapist"), inter ("orienting to the client"), and meta ("listening with the third ear") reflections on the functions and experience of personal therapy, which appear consistent with earlier studies as Wigg et al.

(2011) suggest in their recent review. Based on their conclusions these researchers proclaim that having the experience of “helpful conditions” in one’s personal therapy appears to foster the therapist’s perceived capacity to provide similar therapeutic experiences for their clients. Wigg et al. (2011) comment that the study’s lack of reliable testimonial validity may indicate that some of the participants may have disagreed with the outcome of the analysis; nonetheless the degree to which participant validation is relevant to IPA methodology is debatable (Smith, Flowers, & Larkin, 2009).

Wiseman and Shefler (2001) analysed the narratives of five experienced psychoanalytic psychotherapists with previous experience of long term personal therapy. The findings of this study identified personal therapy as an integral component in the participants’ training and ongoing professional development, relevant to their clinical work throughout their career. It is interesting that the study includes no evidence of any less favourable experiences, which may be attributed to the great investment of resources on behalf of the trainees/clients to undergo a long-term training analysis. Nevertheless, these findings show consistency with further evidence obtained from studies across cultures and therapeutic orientations. Amongst these studies is the IPA study by Oteiza (2010), interviewing ten Spanish psychotherapists, which resulted in six themes describing the positive influence of personal therapy for practitioner’s development. Similar findings were also replicated by Von Haenisch (2011) who used IPA to analyse thirty-minute interviews with a sample of six practicing UK counsellors. The study

appears to have a more descriptive than interpretive focus, and the author's previous relationship with the participants may have had some influence over the findings.

Rake and Paley (2009) conducted an IPA study with eight qualified NHS psychotherapists of various theoretical orientations working in the same service as one of the authors. These researchers identified three master themes: "I learnt how to do therapy" reflecting aspects of experiential learning that cannot be taught through academic modules, "I know myself much better" identifying the distressing yet helpful experience of personal therapy in appreciating what is bearable, and "a very dissolving process" which summarises participants' experiences of therapy as "inevitably destabilising", questioning the required length and time, and reflecting on potentially detrimental effects of the therapists' approach. The participants identified the mandatory requirement as having a potentially negative impact; nonetheless there was general agreement on the integral role of training therapy.

A larger scale study employing IPA methodology was conducted by Daw and Joseph (2007) in the UK, recruiting qualified therapists of various orientations. Consistent with previous studies, two-thirds of the sample had previous experience of personal therapy, citing personal growth and dealing with personal distress as the most common reasons for engaging in therapy, followed by experiential learning through being a client. The study identified the contribution of personal therapy through two broad categories, impact on

the person and impact on the professional, while according to theses researchers personal therapy was also considered an important aspect of self-care and personal development. This study suffered from low response rate (48 returned questionnaires out of 220) however which the authors interpreted as potential participation bias, where those with most favorable experiences of therapy might be most likely to participate in the study.

Similar comments can be made with regards to the findings of Bellows (2007) who interviewed twenty psychoanalytically-oriented psychotherapists (the sample included psychiatrists, psychologists, and social workers) about the influence of their personal therapy on their clinical practice and their views on its potential risks and benefits. The researcher concluded that therapists with more positive experiences were more likely to also internalise their therapist as a positive role model and identify personal therapy as highly influential to 36 their practice, informing their views of therapeutic process as promoting psychological change and “acceptance of the imperfectible self” (p.212). There is however concern regarding the clear hypothesis driving this study, which is generally incompatible with qualitative research methods.

Davies (2008, 2009) adopted an anthropological perspective in his study on the training of psychoanalytic psychotherapists in the UK. Within a period of two years, Davies conducted one hundred unstructured interviews with trainees and qualified practitioners, followed by two hundred questionnaires sent to members of the British Psychoanalytic Council. Davies'(2008, 2009)

thematic analysis produced three themes relating to training stages that seem to breed anxiety for trainees. The first theme, “Evaluative Apprehension and Fear”, relates to trainees’ anxiety and often pervasive fear of being judged as unsuitable for the profession of the therapist as a person, rather than as a practitioner. The findings suggest that the concept of suitability remains particularly vague, while these fears coincide and interact with significant financial and personal sacrifices that trainees experience as they undergo lengthy training analysis. The second theme, “Susceptibility Stemming from Clinical Stressors” relates to trainees’ concerns over their readiness and ability to work successfully with clients and the potential need for one’s clients to “get better” and not leave, and finally the theme ‘Pull and Thrill of Mastery’ describes the developing clinical confidence in one’s practice, and feelings of dependency upon the supervisors’ approval.

The themes of this study appear consistent with previous findings however, particularly mindful of the emotional and personal context around training, as Davies summarises, they further engage with a critical understanding of the commonly encountered institutional conditions experienced by trainees, which place them in a vulnerable position to conform to or adopt “institutionally sanctioned” clinical practices that subsequently shape their direction as therapists. The conclusions of Davies’ work include a detailed discussion of how pre-training therapy was experienced as a form of “covert vetting” of candidates, used to test ones’ suitability to progress, ensuring that all candidates who continue their training are positively predisposed to the

psychoanalytic paradigm. Nevertheless, Davies makes special note that only two candidates reported purely negative experiences of personal therapy and only a small minority reported “mild discontent”, which was attributed to failure of the therapist rather than the therapy. However, despite being a mandatory requirement, the vast majority of the candidates had initially entered analysis to address their own problems. While often their descriptions depict a conviction about the values and “redemptive nature” of therapy, they also express a feeling of gratitude towards the therapist and the process.

Relevant ethical dilemmas often experienced by those offering therapy to trainees were highlighted in King's (2011) thematic analysis of eight interviews with experienced psychodynamic therapists. According to this study, training therapists are confronted with clinical and personal dilemmas when treating trainees, involving the lack of motivation on behalf of trainees to be in therapy, who may feel they don’t need therapy, and are just “going through the motions”. The therapists identified conflicts of dual roles, often expressed through the trainees’ concern over confidentiality and being evaluated as “mad” , as well as the therapists’ “pull to act as a supervisor” in some instances. Therapists wanted training and therapy to be separate, yet they also recognised possible benefits of maintaining some form of communication in case fitness to practice issues arose. Moreover, therapists seemed to experience trainees as more challenging compared to lay clients

and suggest that considerable experience is needed to work with this client group.

1.3.4 Qualitative studies with trainee counselling psychologist

The majority of qualitative studies on the subject of training therapy have investigated the experiences of psychodynamic practitioners, which seem highly relevant to the field of Counselling Psychology. However, as explained in previous sections, there are also some differences in relation to the philosophical and epistemological positions adopted by the different disciplines.

The main qualitative studies looking at the experiences of personal therapy of Counselling Psychologists in the UK are discussed below. Grimmer and Tribe (2001) conducted a grounded theory study interviewing trainee and recently qualified Counselling Psychologists in the UK. Their findings suggest that Counselling Psychologists find personal therapy influential to their practice, facilitating the development of self-awareness and reflexivity through being in the client's role, and clarifying between the personal issues of the therapist and those of the client (countertransference).

Personal therapy also entails a process of professional socialisation, offering experiences of professional validation, modelling good and bad interventions and normalising the trainee's views regarding the person of the therapist.

These researchers proposed that the mandatory requirement was only initially affecting the participants' reluctance to engage with therapy, which seemed to relate with fears of being judged as unsuitable to practice if one's personal material becomes known. This however did not seem to have lasting effects on how trainees subsequently came to experience their therapy, while those with no previous experience of therapy showed greater change in their views about therapy as its importance for their professional development.

Personal therapy was perceived as a positive source of support during training, even though it also became a source of stress for some trainees. The researchers reported that unsuccessful treatment experiences were more often attributed to "therapist incompetence rather than inefficacy of therapy itself", similar to Davies'(2009) observations, and further commented on the potential "proselytizing" function of therapy as often expressed by new clients that "everyone should have therapy". Murphy (2005) also conducted a grounded theory analysis with UK trainee Counselling Psychologists and reproduced similar themes with Grimmer and Tribe (2001), reflecting the important role of personal therapy in enhancing personal and professional development. However, this study has also been criticised for failing to reach theoretical saturation (Turner, 2005), which is the recommended outcome of grounded theory analysis (Glaser & Strauss, 1967).

Qualitative studies offer a more detailed account of the meanings attributed to the experience of personal therapy, however the transferability of the findings is considered to be limited (Chamberlain, 2000; Chaturvedi, 2013; Wigg et al., 2011). As Chamberlain (2000) has argued, amongst others, qualitative studies tend to focus on "description at the expense of interpretation" (p.285) as they often fail to draw links between findings and theoretical models. In an attempt to respond to these limitations in the literature, Rizq and Target (2008a; 2008b) drew from the theory of metalisation (Fonagy & Target, 1997; Fonagy & Target, 1998) to offer a possible explanation of the psychological processes underlying the experiences of personal therapy.

These researchers used IPA methodology to analyse nine interviews with experienced Counselling Psychologists, with previous training in counselling and psychotherapy, working in both NHS and private settings. Their findings resulted in five themes identifying personal therapy as an 'arena for intense inner-self experiences',' defining self-other boundaries', providing a unique space for 'professional learning', and thus being 'integral to training' and further relating to self-reflexivity. Participants were in favour of the mandatory requirement for training therapy, nonetheless they also commented on the marked ambivalence regarding classifying the aims of personal therapy or evaluating its outcomes. This ambivalence was also linked with the participants' experiences of "pretend therapy" as a potential way of avoiding the intensity of their conflicting emotions. Through reviewing the data, these

authors suggested a possible parallel between of early parental attachment and the ability to be reflective in one's clinical work, mediated through "the power of being seen" by one's therapist, reflecting the importance of experiences of mentalisation within personal therapy. This link was further corroborated in subsequent studies where Rizq and Target (2010a, 2010b) combined data from the Adult Attachment Interview (AAI) with IPA interviews to investigate the relationship between attachment status and reflective function (RF).

According to their findings (Rizq & Target, 2010b), therapists were often assumed to fulfil parental roles; insecurely attached participants were more suspicious and cautious of mandatory therapy and would tend to attribute unsuccessful experiences of personal therapy to more global and general reasons rather than therapist inadequacy. All participants showed sensitivity to aspects of power and authority within their therapy, with low RF and insecurely attached participants presenting greater preoccupation with issues of power and control, hard to overcome and thus limiting their motivation to engage with their therapy on a deeper level. Another significant difference identified (Rizq & Target, 2010a) related to the modelling function of therapy: securely attached participants reflected an understanding of the self as a "wounded or fragile client", recognising vulnerability as shared with their clients, whereas those identified as insecurely attached and low RF focused primarily on the behavioural modelling of the therapist. Nevertheless, negative case analysis showed that high reflective function can also be

counterproductive to the therapists' development, as some individuals may become overly preoccupied with themselves and lose focus on the client's issues.

Wigg et al. (2011) points out, given the specialist sample recruited in the above study, the extent to which such findings could apply to less experienced populations, as for example trainees, is uncertain.

Moller, Timms and Alilovic (2009) recruited thirty-seven trainees for their study exploring the initial views of Counselling and Clinical Psychology trainees, and trainees in Counselling courses, about their personal therapy. These researchers employed data from two open ended questionnaires and adopted an inductive thematic analysis which resulted in two main themes: personal therapy helps me to be a better practitioner, through experiential learning, enhancing self-awareness and ensuring safe practice, and personal therapy costs me, addressing financial and emotional concerns of therapy. The authors commented on the similarity of answers obtained between the different trainee groups with regards to their ambivalence about the mandatory requirement of personal therapy. Nevertheless there are also marked differences between Counselling and Clinical Psychology trainees with regards to their views on cost, focus, and time of their personal therapy, which reflect the differences in the training costs and therapy requirements. Moller et al. (2009) suggest that the experiences claimed by trainees imply that there are personal issues to be dealt with. Nonetheless there seems to

be tension between the positions of “I don’t need therapy” and “everyone needs therapy”, as observed in earlier studies (Grimmer & Tribe, 2001; Rizq & Target, 2008).

A relatively recent study by Kumari (2011) used IPA methodology to explore the views of eight Counselling Psychology trainees at the Teesside University, about the mandatory requirement to attend personal therapy. The analysis produced four themes describing personal therapy as a unique opportunity for experiential learning and integral to one’s ongoing process of personal development, however also entailing additional stressors for the trainees, particularly relating to issues of time and money invested. The findings are consistent with previous studies and bear similar limitations with regard to the applicability of findings and concerns of emphasis on description rather than interpretation. In addition, even though the author mentions some general limitations in her discussion, there was a lack of acknowledgement regarding the degree to which the sampling process may have impacted the findings in particular ways. For example, given that all participants were recruited from two consecutive cohorts of a single training program where the researcher was also training, it can be argued that findings represent the common culture shared amongst trainees of the same program, and even more so between trainees of the same cohort.

As Smith et al. (2009) recommend for IPA studies, the sample must vary adequately so that there is space for different opinions and divergent

experiences to be expressed; in the study discussed there is no way of knowing the extent to which the experiences of the participants were too similar, for instance it is possible that they shared the same therapist or supervisors, apart from tutors, as often happens with trainees of the same training program, especially when studying in a smaller city.

In contrary to previous studies, Ivey and Waldeck (2014), who interviewed Clinical Psychology interns, emphasised a marked process of change in trainees' views and feelings towards their therapy: mandatory therapy was initially met with resistance, however once the trainees establish a "permeable boundary" between their training and their therapy, they became more able to utilise their therapy for personal issues and engage on a deeper level. These findings could be of further interest to the field of Counselling Psychology considering that many Counselling Psychology training programs require some form of communication with the trainee's personal therapist in order to ensure that the trainee is fit to practice. The authors further discussed emerging themes regarding the compatibility between theoretical training and model of personal therapy. This finding appears highly relevant to Counselling Psychology which holds a pluralistic view towards training and clinical practice, which may place trainees at conflict between what they are taught and what they experience in their own therapy.

Similar to previous studies, personal therapy was perceived to enhance professional skills, and potentially reduce trainees' expectations of support

from clinical supervisors. Themes indicating the disruptive impact of therapy upon the personal relationships of trainees were also explored. Therapy was assumed to bring about changes in intrapersonal and interpersonal relationships which participants ultimately came to describe as positive. The authors report that the study was conducted using participants from the researcher's training program, a factor which may have affected participant's willingness to share more openly their experiences. Nonetheless the researchers suggest that they made an effort to ensure the credibility of their study by engaging in systematic reflexivity about their own views and further validating their findings with the participants.

1.5 Summary

The above studies have increased our understanding of how personal therapy is experienced by practitioners as valuable and beneficial to their personal and professional development, with a closer look into the underlying processes revealing a complex and emotionally invested interaction between personal and professional spheres (for example Davies, 2009; Rizq & Target, 2010a). There is confirmation of the possible influences of the attitudes of training courses on participants, as there is also some discussion relating to stigma, experiences of evaluation, and issues of confidentiality for therapists in therapy, relating to much problematised topics of power and autonomy within the therapeutic endeavour (Atkinson, 2006; Desmond, 2004; Valentine, 1996) . Nevertheless published literature on the subject is scarce and inconclusive, indicating that the requirement of personal therapy

by many training organizations is still based primarily on sentiment and tradition, while the fact that psychotherapy is always a very private experience, makes an objective exploration of its' effects problematic (Chaturvedi, 2013).

The majority of qualitative studies since 2000 have focused on psychodynamic psychotherapy trainees or qualified and experienced practitioners, while studies recruiting Counselling Psychology trainees in the UK are limited (Grimmer & Tribe, 2001b; Kumari, 2011; Moller et al., 2009; Murphy, 2005), with only the one study adopting Interpretative Phenomenological Analysis (Kumari, 2011) which recruited from a single MSc program. Given the relevance of the considerable debate over the practice of mandatory therapy for Counselling Psychology trainees, the need for a deeper understanding of the experience for those immediately affected seems apparent. Some prominent issues surfacing include questions regarding the potential effect of the compulsory element for trainees, what would differentiate an authentic experience of therapy, as well as the effects of compatibility between theoretical model of training, approach to therapy and subsequent practice, as Rizq (2010) has also proposed.

1.6 The future of personal therapy in Counselling Psychology

To consider the future of personal therapy in Counselling Psychology, we must look at the changing contexts within our healthcare system, and the

challenges that we face. In the NHS today there is a focus on the delivery of manualised and empirically supported psychotherapeutic models, specifically tailored to treat various mental health problems. The treatment model is often seen as the most important and effective contributor to psychotherapeutic outcome, and the role and significance of the treating therapist can be overlooked and marginalised. Sprenkle and Blow (2004) state that the current focus in mental health care services leads to a view of therapy treatment as somehow removed from the person delivering it. Effective practice is evaluated through the therapist's command of specific therapeutic models, rather than their capacity for facilitating relational encounters.

It is interesting to consider whether the nature and focus of the healthcare system could have potentially important consequences for the place of personal therapy in training programmes, and as part of a therapist's continuing professional development. With such weight given to the importance of model-based competency, factors that contribute to personal development within the therapist may be evaluated as less important. If our current healthcare system does not recognise or value the personal contribution of the treating therapist, then the argument for the inclusion of personal therapy in training may eventually be downplayed or even rejected. Additionally, the current emphasis on delineating measurable components of psychotherapeutic phenomena favours the use of quantitative research methods and may limit further qualitative-based research investigating the

role of personal therapy. The current healthcare climate poses particular challenges to Counselling Psychology, which recognises the traditional medical model approach, but also keeps its roots strongly planted within the humanistic value base. The humanistic approach focuses on the importance of subjectivity and relational factors and upholds the therapist's self as a central component of psychotherapeutic change processes.

This view, very much contrasts with current healthcare focus which tends to, as mentioned earlier, deconstruct and marginalise the treating therapist, and uphold the importance of manualised treatment models. Incorporating both approaches could give Counselling Psychology a particular advantage; supplying a platform from which to disseminate the humanistic viewpoint within the wider world of healthcare. As Cooper (2009) comments Counselling Psychology must work to 'actualise' its humanistic value base. This could be achieved through the continued support of personal therapy as an important training requirement that contributes to Counselling Psychologists' personal and professional development. Such a stance may also help to 'keep alive' the view of the therapist as a significant contributor to psychotherapeutic processes within the wider healthcare service.

Counselling Psychology is also in a prime position to sustain a focus on qualitative research concerning personal therapy, and work towards delineating a clear evidence-based rationale to support its inclusion in training programmes.

1.7 Conclusion

There is a large and varied body of research investigating the impact of personal therapy on the therapist, but it has failed to reliably demonstrate that personal therapy positively contributes to the therapist's professional or personal development and clinical practice. Research has, on the whole, revealed mixed and contradictory findings. Studies also suffer from numerous methodological failings, for instance, small sample sizes, crude assessments of client outcomes and a lack of controls over extraneous variables.

Quantitative studies may not have the methodological sensitivity to delineate the complex interplay between different factors that may influence and contribute to the clinical efficacy of the treating therapist. Additionally, Norcross (2005) suggests that attempts to experimentally render the practitioner as a controlled variable are useless, as it is simply not possible to mask the personal and relational contribution of the therapist. Hence, the present body of quantitative research investigating the impact of personal therapy on the therapist, may be revealing only a simplified picture of what is, in reality, a highly complex and convoluted process.

Qualitative research studies, although fewer in number, have revealed more complex insights into the subjective experiences of therapists in relation to their personal therapy. An interesting finding relates to how personal therapy

can be experienced as having both positive and negative influences, particularly by those who are undertaking a training course.

As Kumari (2011) describes, personal therapy can be experienced as a detrimental influence on the trainee's ability to focus on their clients. Despite the potential difficulties associated with undertaking personal therapy alongside training, it cannot be ignored that the majority of therapists tend to report a positive experience of their personal therapy.

What is missing from the literature, at the present time, is the focus on the experience of trainees who undertake personal therapy. The current dearth of research specifically focusing on trainees means there can be no conclusive findings in this area, and researchers and practitioners remain divided. Before further research is completed it will not be possible to confidently ascertain that the professional and personal benefits of personal therapy legitimately support its mandatory use in training programmes.

A final consideration is the contextual factors surrounding the inclusion of personal therapy in our training programmes. The current healthcare focus on the efficacy of treatment models, as opposed to the therapeutic relationship, could challenge the perceived importance of personal therapy as a necessary training requirement. It is argued that Counselling Psychology must remain aware of the changing focus in our health care

system and work to both preserve and promulgate the humanistic values so central to the profession's identity. This involves continued support of personal therapy as an important component of practitioner training, and a renewed focus on qualitative research investigating personal therapy for trainee and professional alike.

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PART FOUR: PORTFOLIO CONCLUSION

This portfolio represents a professional journey that has taken me far longer than the three years of study denoted here. I have learnt to be able to relate in new ways to clients, and to use tools that are more sophisticated than therapeutic models from both the taught and practical components of the doctorate. For example, the use of my embodied perspective, as a therapist, and utilising intuition and felt sense (Gendlin 1978). I have learned, how to ensure that I am practicing from an evidence base that I understand and can critique, which is important for practitioners in order that we can engage in debates regarding commissioning, service provision, ethics and much more. I have also, through conducting a small scale research project, been given a deep insight into the complexities of conducting, as well as reading, research. I hope to utilise these skills in order to be able to carry out research and audit within clinical practice, and to critique the research underpinning my practice for the foreseeable future.