A client focused perspective of the effectiveness of Counselling for Depression.

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Appendices List

Abbreviations

BAC = British Association for Counselling

BABCP = British Association for Behavioural & Cognitive Psychotherapies

BACP = British Association for Counselling and Psychotherapy

BDI = Beck Depression Inventory

CAT= Cognitive Analytical Therapy

CBT= Cognitive Behavioural Therapy

CfD = Counselling for Depression

CPR = Change Process Research

DSM *V*= Diagnostic and Statistical Manual version V

EBP- Evidence-based practice

EFT= Emotion Focused Therapy

HAT = Helpful Aspects of Therapy form

HCPC = The Health and Care Professions Council

IAPT= Improving Access to Psychological Therapy

IPT = Interpersonal Psychotherapy

ITA = Institute of Transactional Analysis

MBCT = Mindfulness Based Cognitive Therapy

NRES = National Research Ethics Service

NICE= National Institute for Health and Care Excellence

PCT= Person Centered Therapy

RCT - Randomised Control Trial

SSRI = Selective Serotonin Reuptake Inhibitors

STPP= Short Term Psychodynamic Psychotherapy

UKCP = United Kingdom Council for Psychotherapy

As there is no clear demarcation between the terms counsellor and psychotherapist or counselling and psychotherapy, within this thesis these terms are used interchangeably.

Abstract

Estimates suggest 1 in 4 adults are diagnosed with a depressive episode at some point during their life; however, only one in four people with a diagnosis of depression in the UK receive any form of treatment. To address this, the Improving Access to Psychological Therapies (IAPT) program was established, ensuring people accessing NHS treatment had choice. Initially the only therapy commonly available was Cognitive Behavioural Therapy (CBT), raising concern regarding client choice and prompting the British Association of Counselling and Psychotherapy (BACP) to call for the development of a new evidence-based therapy called *"Counselling for Depression"* [CfD]. With regard to counselling, it is suggested that without knowing the client's view of their therapy there can be no effective evaluation of that therapy. In light of the above, the focus of this research is on the client's perceptions of CfD, the purpose of the study being two-fold; (1) to explore and evaluate CfD from the perspective of the client (2) to inform the counselling profession of what is taking place within this therapeutic approach as perceived by the client. This qualitative study, using Interpretative Phenomenological Analysis [IPA], focused on twelve clients' perceptions of CfD. Clients receiving CfD completed a Helpful Aspect of Therapy questionnaire after each counselling session and attended a semi-structured interview on completion of counselling. Findings identified four superordinate themes; a helpful process; Client's view of a counsellor; Gains; and Negative aspects. As no previous study has considered CfD in this way, this study gives voice to the client enabling them to convey their understanding of what they perceive is effective therapy. In addition, this study makes a significant original contribution both to the knowledge base regarding CfD and its effectiveness, and to the professional practice of counselling.

Chapter 1 Introduction

1:1 A Personal Starting Point

Whilst working as a Tribunal Advisor for the Citizen's Advice Bureau I became aware that I could manage the litigation and the advocacy, what I found difficult was coping with the emotional states that my clients presented as many of them were distressed at finding themselves in these difficult situations. To learn more about this I thought it would be helpful to explore counselling and in September 2000 I enrolled on the Certificate in Counselling at the University of Salford. I had thought it would just be a matter of tweaking my advice knowledge, but discovered I had to discard what I knew and start again. Thus began a love of understanding the emotional and the psychological makeup of human beings. Every page I turned brought revelations and I was fascinated by the individuality and idiosyncratic nature of people. I proceeded onto the Diploma in Counselling which drew upon the Person Centred approach, very different from advice work, but hugely illuminating in learning about what mattered to each client that I worked with. I went on to complete my Master of Science in Counselling Studies and was now deeply involved in both the practice of counselling and the supervision of other counsellors. As part of my continuous professional development I attended the National Anxiety Conference in 2006. The opening keynote paper was delivered by Professor Paul Salkovskis, who advised the 1000 counsellors sitting in the audience to "either retrain in Cognitive Behavioural Therapy (CBT) or leave the profession". This remark has stayed with me as an example of how erroneous a broad-based judgement can be, where individual need is overlooked when viewed through the narrow lens of schoolism.

My professional stance is based on working with the individuality of the client. My practice is client led and I would describe myself as working with a number of different models of counselling, integrating what is required into the therapy according to the need of my client. I no longer only use Person Centred counselling. If the client is telling me they need more direction then a different way of working is required. I will use CBT if it is appropriate to my client's needs and also Transactional Analysis and Brief Solution Focus Therapy to match the therapy to the client. Believing that matching the therapy to the client need is vital has been a very strong driver in leading me to this thesis. As will be seen later, the current zeitgeist within in the NHS is CBT and there is no matching of the therapy to client need (Centre for

Social Justice, 2012), hence I wanted to explore the effectiveness of a different approach from the client perspective.

The initial idea for the study was based on wanting to obtain evidence to challenge the monoculture of CBT in the NHS and show that counsellors working routinely in daily practice with their clients were getting good results despite using different therapeutic approaches. Ethical concerns that are discussed later in this report shaped the study into its present form, but the original idea of client need dictating the ways of working still holds.

Within this introductory chapter I will demonstrate how a new therapeutic approach was developed to widen the choice of therapy within the NHS, with the remainder of this Professional Doctorate thesis exploring the client's perceptions of this new therapy, namely Counselling for Depression [CfD]. CfD is described as a manualised form of psychological therapy specifically designed for counsellors working in the Improving Access to Psychological Therapies [IAPT] programme (Hill, et al., 2010). It is a form of Person-Centred/ Experiential [PCE] therapy that aims to help patients access and make sense of underlying feelings and draw on the new meanings which emerge to make positive changes in their lives. CfD focuses on the incongruence between how a person feels they actually are and how they feel they should be (Hill, 2011). This is in keeping with the Rogerian concept of the incongruence between the ideal self and the organismic self (1961). CfD differs from Person Centred therapy in that CfD is a brief therapy which, while taking a therapeutic stance from Person Centred therapy, also has aspects of Emotion Focused therapy (Sanders, 2013). Within CfD the person centred therapeutic conditions are established, but the emphasis is on collaboration and includes the negotiation of the client's therapeutic goals.

1:2 Overview

Initially this chapter explains the definition of counselling, its historical roots and its development into a profession. Consideration will be given to the debate regarding who can use the title of counsellor, how they practise and the difficulty in presenting a united front to manage challenges to the profession. Having established what counselling is and presented a discussion regarding related issues, there is then a consideration of depression, it's definition, history and prevalence in today's society. In light of depression being a recognised mental

illness (APA, 2012), the differences between the medical model and the common factors movement and the way in which each influences counselling are explored. Finally consideration will be given to the recent development of IAPT and the current concerns of the counselling profession which have led to the need for a different model of counselling such as CfD that can demonstrate evidence of its effectiveness acceptable to the National Institute for Health and Care Excellence [NICE].

1:3 Counselling as a profession.

According to the British Association for Counselling and Psychotherapy [BACP] "counselling and psychotherapy are umbrella terms that cover a range of talking therapies. They are delivered by trained practitioners who work with people over a short or long term to help them bring about effective change or enhance their wellbeing" (BACP, 2010a, para.1). However confusion still occurs in the assumptions made around the roles of both counsellor and psychotherapist. Psychological therapy has traditionally been viewed as a profession with therapists having specialised knowledge and skills to work autonomously, making decisions regarding treatment based on clinical judgement (Bower & Gilbody, 2010). This view is challenged by others who differentiate counselling from psychotherapy, not in their core activities of the relief of psychological distress, but in their historical roots (Dryden et al., 2000). Psychotherapy is described as aligning with a medical model, developed in response to mental illness, where the practitioner sees his/her self as a skilled professional and an expert in the treatment of mental disturbance (Dryden et al., 2000). However, the origins of counselling were in a voluntary capacity and stem from peer to peer support in the marriage guidance field. Counselling is described as being underpinned by educational and spiritual understandings of human dysfunction, growth and development (Dryden et al., 2000).

Counsellors initially were largely unpaid volunteers with a focus on the therapeutic relationship, the encounter in which client and therapist agree on the goals and tasks of therapy and the development of a therapeutic bond (Fluckiger et al., 2012). Volunteers in educational and spiritual organisations also took fundamental roles in the development of counselling. For example the Association for Student Counselling and the Association for Pastoral Care and Counselling joined the Standing Conference for the Advancement of

Counselling and thus became the founding divisions of the professional body the British Association of Counselling [BAC] (Dryden et al., 2000). On realising that it was representing not only counsellors but psychotherapists too, BAC changed its name in 2000 and became the British Association for Counselling and Psychotherapy (BACP, 2010b). BACP (2013a, para.1) state that they now have the "first psychological therapists' register to be accredited under a new scheme set up by the Department of Health and administered by an independent body, accountable to Parliament". This landmark event is significant in terms of its ability to provide the public with a means to check that they are receiving therapy from a suitably qualified and professionally accountable practitioner.

Although BACP includes both counsellors and psychotherapists, it is not the only professional body that therapists align themselves to. There are many others. Some are specific to particular models of therapy such as the British Association for Behavioural & Cognitive Psychotherapies (BABCP, 2013), or the Institute of Transactional Analysis (ITA, 2011) which governs the practice for Transactional Analysts in the UK. In addition there are other collective professional bodies such as The United Kingdom Council for Psychotherapy [UKCP]. The UKCP was established in 1993 and has more than 70 member organisations under its auspices. These organisations represent all the main traditions in the practice of psychotherapy. UKCP holds the national register of psychotherapists and its focus is mostly on psychotherapy, but recently it has allowed psychotherapeutic counsellors to join the organisation. UKCP (2013) states clearly that its members meet exacting standards and training requirements. Similarly, as with the other professional bodies, BACP (2013a) sees its role as being to set, promote and maintain standards for the profession. However, to date it is not compulsory to join a member organisation. Anyone, without any training, unregistered, and without affiliation to any professional association, currently may call themselves a counsellor or psychotherapist (Cooper, 1996; Talking Therapy, 2013). In 2009 there was an attempt to introduce statutory regulation of counselling and psychotherapy. This would have created a distinction between the two terms by stipulating roles. The Health and Care Professions Council [HCPC], who are a government funded body with the role of introducing a register of organisations in the health and social care field, drafted "Standards of proficiency for psychotherapists and counsellors" defining psychotherapists as able to recognise and work with severe mental disorder and understand methods of diagnosis of severe mental disorder, whilst counsellors were to focus on mental health and well-being and also obstacles to wellbeing and the facilitation of client development (HCPC, 2009, p.11).

The split was contested strongly and challenged on the grounds that the vast majority of standards were common for both counsellors and psychotherapists and further there was no evidence to show that the differentiated standards were an accurate reflection of practice (Alliance for Counselling & Psychotherapy, 2009). With the change of government in the 2010 election from Labour to a Coalition Government statutory regulation did not go ahead, however, the two largest professional bodies have since instigated their own voluntary registers. The BACP (2010b) do not distinguish between counselling and psychotherapy, whilst the UKCP (2013) acknowledge there is no commonly agreed definition, but suggest that the difference lies in the length and depth of training and in the quality of the therapeutic relationship. There is no consensus as to whether counselling and psychotherapy cover the same ground.

The professional bodies are focused on the professionalisation of counselling. This has encouraged a move towards accountability, but with that has come a prescriptive code and legalistic process which moves away from the autonomy of the original peer to peer practice (Dryden et al., 2000). There are concerns regarding counselling being regulated rigidly and apprehension that if accreditation is made obligatory then counselling may lose its capacity to value and validate life experience by placing precedence on academic qualifications (Bondi, 2004). BACP (2013b) acknowledge the difficulty of regulating precisely all the interacting variables involved in therapy, calling their code of practice a "framework ", suggesting it is a guideline rather than a dogmatic directive. However, accredited counsellors are asked to acquire and provide evidence of a definite level of training, gain technical knowledge, adhere to the ethical framework and meet the requirements for re-accreditation of practice, all of which incur costs. Whilst accreditation gives no guarantee of standards (Gabriel, 2009), it may exclude excellent practitioners who are unable to afford the high cost of training and membership and as a consequence become seen as lesser skilled or "unprofessional" because they do not hold the right credentials (Bondi, 2004). Undoubtedly this situation is brought about by the move of the professional bodies towards professionalisation thus changing the profession of counselling into something other than the peer to peer support it was in its original form. A person called a counsellor today is usually understood as working with their clients to achieve psychological and emotional wellbeing. Nevertheless, the term “counsellor” can remain vague and confusing because of its connections to fields outside of therapy, for example debt counselling, careers counselling or smoking cessation counselling (Haverkamp et al., 2011). Complicating matters further are different categories of people who

are not trained as professional counsellors, but who use counselling skills; social workers; nurses, teachers, preachers; peer helpers; support workers and informal helpers such as friends, family and work colleagues (Nelson-Jones, 2012). This has been further exacerbated by uncertainty stemming from the use of the seemingly interchangeable terms of counselling and psychotherapy (Dryden et al., 2000). It is hard to ascertain whether greater academic learning creates better practitioners or if life experiences are sufficient to develop the skills required for the role of counsellor and this question continues to form the basis of much debate (Paulson et al., 1999; Ahn & Wampold, 2001; Bambling & King, 2001).

1:4 Early Beginnings and the development of models of therapy

People throughout the ages have always needed psychological support, with stoical therapy and the skeptics' consideration of the challenge to dogmatic beliefs being an early example of this (Feltham, 1997). However, modern understanding suggests that psychological therapy was first formally conducted by Sigmund Freud in the early part of the twentieth century.

Freud believed that his patients' mental health problems had psychological causes. He believed early childhood experiences impacted on the individual's mental well being in adult life and through working with the unconscious mind he could help them resolve some of their inner conflicts (Storr, 1989). Although Freud was a medical doctor, a neurologist, he was content for psychoanalysis to be practiced by lay practitioners. In the United Kingdom this was often the case, in contrast to America where it was considered that it should remain within the medical domain (Strachey, 1959). Psychiatrists, at the time of the first world war, were commonly dealing with patients designated as insane (Tyson, 2004). Soldiers returning from the war with what was termed "shell shock", now recognised as post traumatic stress, were viewed by a government who did not want to appear unsympathetic to them by declaring them insane, so they were referred to the psychoanalysts rather than the psychiatrists (Tyson, 2004). The psychoanalytic school of therapy grew rapidly from the time of Freud, but alongside this, the behavioural model of therapy was developing. This was a different approach that, far from working with the unconscious, had its beliefs in behaviour modification and conditioning. Proponents such as Watson (1913) and Skinner (1938) adhered to the medical model much more closely using diagnosis, specific techniques and terming the therapy 'treatment'. This approach was later built upon and developed into CBT

by Aaron Beck (1976). However, it was Carl Rogers in the 1950s, (1951, 1989), working in a humanistic and what he termed a "client centred" way, who made a fundamental impression upon the field of counselling. His approach centres on helping a client to "self actualize" and to be empowered. Rogers' ideas challenge both the psychoanalytic and behavioural approaches as the person centred model places the humanity of the individual at the very core of therapy. Working with the client's subjective view, the lived experience of the individual is the key concept in much counselling work, but rather than focusing on the unconscious and issues in the past, as in the psychoanalytic approach, Person Centred counselling focuses on the here and now. Rogers categorically challenged the hierarchy of the medical model (discussed below) and the dispute between non medically trained counsellors and the medical model still causes tension today (UKCP, 2011).

Schools of therapeutic thought stem from four core modalities; Psychoanalytic / Psychodynamic; Humanistic (including Person Centred); Cognitive Behavioural and Integrative, although it has been identified that there are more than 400 different models of therapy where diversification has created new and adapted ways of therapeutic working (Cooper & McLeod, 2010). The BACP definition of counselling presents an all-encompassing and inclusive approach to the models of therapy (2010a). However, it is clear that not everyone agrees. The UKCP has an image described as a "cabal of trainings driven by vested self-interest" (Warnecke, 2011, p5). Further, promoters of specific models such as CBT (Salkovskis & Wolpert, 2012), who suggest their model works better than other models may confuse the public who are simply looking for a means of help (Bond & Tyrrell, 2002). The promoting of one model over another creates the opposite of a homogenous occupational community and leads to power struggles within the counselling profession. Moreover, the internal strife prevents the profession from offering a united front in the face of what could be viewed as challenges to counselling. For example, the NICE guidelines (NICE) (2009) focus on the use of CBT, narrowing the choice of therapy available within the NHS and excluding the models used by a large number of practising counsellors (Pearce et al., 2012a). Technological ways of working, which can actually eradicate the therapist with the use of computer programmes, also present a challenge to the profession. In addition to the NICE guidance (2009) and developments in technology, the stigma of talking therapy itself is also challenging. Vogel and Wade (2009) suggest that concern about the stigma associated with therapy is one of the main reasons people are reluctant or do not attend for therapy. Indeed, Dingfelder (2009) identified a fifth of returning soldiers from the wars in Afghanistan and

Iraq were struggling with post traumatic stress or depression but feared asking for support because of the stigma and shame they felt were associated with seeking therapy.

The picture above describes a profession that is not at ease with itself. Power struggles from within and challenges that are both historical and current create an uncertain future for the profession. Cooper (2011) makes a plea for research that delivers trustworthy evidence that will help to increase the prospects of the profession. This may help to challenge the external threat, but only the practitioners themselves can address the internal squabbling that undermines the profession.

1:5 Depression

Historically, Freud (Strachey 1957 p.243) described depression as "melancholia" but acknowledged even then that the "definition fluctuated". Emil Kraepelin, often described as the founder of modern scientific psychiatry, responded to a real need for diagnostic order in nineteenth-century psychiatry developing a definition of depression that described a mental disorder characterised by "retardation of thoughts, impaired attention, guilt and persecutory ideas, inhibited volition and the presence of anxious and depressive mood" (Trede et al., 2005, p.172). Currently the World Health Organisation (WHO) (2013) define depression as " a common mental disorder, characterized by sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, feelings of tiredness, and poor concentration". However, in the UK being diagnosed with, and treated for depression is dependent on the guidance set out in Diagnostic and Statistical Manual V [DSM V] (APA, 2013). To be diagnosed with a major depressive episode a person has to meet at least five of the following nine criteria; "feeling sad or depressed, anhedonia, decreased appetite or weight loss, sleeping more or less than normal, psychomotor agitation or retardation nearly every day, loss of energy, feelings of worthlessness or inappropriate guilt, inability to think or concentrate and suicidality". There is recognition that there is a difference between mild depression, feeling down and in low spirits, and major depression which can be life threatening; the latter having a high association with suicide (Reeves, 2010).

Depression is thought to have been around for thousands of years and there are many theories suggesting why it occurs from some elemental issues concerning earth, fire, water and air, or cycles of the moon, to more socio-cultural explanations such as personality, witchcraft, religious beliefs, sin, the devil, the supernatural or the struggle a person has with their conscience (Carr, 2007). Others see the causes of depression as genetic, a biochemical imbalance in the brain, psychosocial stressors, cognitive distortions, a lack of environmental and social rewards, social inequities, cultural influences, familial influences, dietary issues and a lack of physical exercise (Yapko, 2008). Kraepelin differentiated between depression that was exogenous, being caused by external events which were manifest, identifiable and measurable and endogenous causes stemming from within, being hypothetical and intangible (Lewis, 1971).

Although depression can occur for seemingly no reason, there can be a number of causal factors; life events such as being sacked, getting divorced, or physically or sexually assaulted, losses and bereavement, anger, childhood experiences, and also physical conditions and the side effects of medication (MIND, 2013a). MIND (2013a) also suggest that diet, drugs and alcohol may contribute to depression and/or that genes may play a part and the idea that depression may run in families. However, alongside the gene theory MIND (2013a) also identifies that behaviour and learned responses are passed on in families alongside the gene theory, reiterating the nature/nurture debate (Collins et al., 2000; Sherry, 2004). MIND (2013a, para.14) challenge the view that depression is caused by "changes in brain chemistry" highlighting the fact that the evidence for this is weak. For example, Lacasse and Leo (2005) contest the existence of a serotonin deficiency as there is no direct proof of this in any mental disorder. Davis (2013) corroborates this finding and notes that despite thousands of studies being undertaken there is no direct evidence that serotonin deficiency is responsible for depression. As there are no physical diagnostic tests available to identify depression there can be no absolute certainty as to a physiological cause of depression. Despite this lack of evidence, some doctors continue to tell patients that there is a chemical imbalance in the brain and this can be addressed by the use of anti-depressants. Nevertheless, depression alone accounts for seven per cent of the health burden within the NHS (MIND, 2013b) with an analysis from the NHS Quality Outcomes Framework (Ssentif, 2012) indicating that almost ten per cent of the population now suffers from depression with a cost to the NHS in the UK estimated to be £9 billion (Barrett et al., 2005).

1:6 Increase in diagnosis of depression

Undoubtedly there has been an increase in the diagnosis of depression (Leader, 2013). Worldwide it has been identified that more than 350 million people have depression (WHO, 2014). In the UK, in the 1950s, depression was formally diagnosed in 0.5% of the population, whereas in 2013, 1 in 4 adults will be diagnosed with a depressive episode (Leader, 2013). This is a large increase in diagnosis. A possible reason for the increase in the diagnosis of depression is perhaps due to pharmaceutical companies advertising their products and people then seeking help (Leader, 2013). Selective Serotonin Reuptake Inhibitors (SSRIs) are now among the best-selling drugs in medical practice and vast sums of money are spent on advertising them (Lacasse & Leo, 2005). However, a meta-analysis of published and unpublished drug trials found that the use of placebo duplicated about 80% of the antidepressant response (Kirsch, 2005). Therefore there is doubt as to the efficacy of these drugs per se, as well as the reliability of the evidence supporting the efficacy of the drugs. Criticisms have been levelled at the pharmaceutical industry regarding the lack of transparency within their clinical data and their hidden negative results (Forbes, 2014; Davis 2013). It has also been suggested that only a quarter of all published biomedical findings can be reproduced successfully (Loscalzo, 2012), yet in 2011 over 43 million prescriptions for anti-depressants were written in the UK alone (Pope, 2013).

The increase in the diagnosis of depression may also be due to more sophisticated diagnostic assessment methods (Angst, 2010), or possibly due to clinicians adhering to a clinical category in the DSM (Krueger & Eaton, 2010). The DSM is the "standard classification of mental disorders used by mental health professionals" (APA, 2014). This manual was first published in 1952 (APA, 2014) and guides practice both in the USA and UK although the UK also uses ICD-10 (WHO, 2014). The current version is the DSM V (APA, 2014). However, doubt is cast on the veracity of the categories in the DSM due to how decisions were taken on what to include in the manual (Davis, 2013). Decisions are taken by a group of American psychiatrists on whether to include a disorder or not from a consensus view. In other words, classification of a disorder depends on the opinion of a relatively small group of psychiatrists, who, if they are unable to agree "eventually decided by a vote" (Davis, 2013, p.30).

For some, namely those associated with the anti-psychiatry movement, mental illness is something of a misnomer. For example, Szasz (1974, p34) considered mental illness to be "metaphorical" and not in fact "a real illness" at all. Szasz criticised the way in which mental illness was viewed as separate from its social context and believed it was not possible to disconnect people from their "educational, economic, religious, social and political communities" (Szasz, 1974, p49). Szasz believed that what psychiatrists were working with was not mental illness but "personal, social and ethical problems in living" (1974, p262). Similarly Laing (1969) also challenged the idea of mental illness as a clinical entity and instead viewed the locus of the problem stemming from the environment in which the client was situated. He saw the client as a subject with their own understanding of their own world view, rather than objectified as a series of symptoms. However, these views have been overshadowed by the influence of the DSM (Krueger & Eaton, 2010) and the very act of naming and giving a label to a diagnosis makes it "actual" and therefore influences our beliefs about ourselves, regardless of questionable evidence to support the belief (Greenberg, 2013). Further, this is exacerbated by the demands by insurance companies for a specific diagnosis, requiring therapists to adhere to the categories in the DSM in order be remunerated for the work that they do (Decker, 2013).

Alongside the financial benefits of increased diagnosis of depression to drug companies, there is an identified change in the social understandings around sadness and distress (Mulder, 2008). Mulder (2008) suggests there are three assumptions in place. Firstly that there is a defined illness called depression. Secondly that it has increased and is very common and thirdly that it requires a medical solution. He suggests that lack of motivation, low mood, lack of energy, un-productivity and persistent unhappiness is viewed today as an illness whereas historically it was not seen as a health concern. Psychiatry sees depression separate from social conditions and places little emphasis on the socio-economic conditions that affect lives (Eaton et al., 2001). The increase in the diagnosis of depression could therefore be due to classification bias, financial incentives and socio-cultural acceptability as an illness.

1:7 The medical model

The medical model is the predominant Western approach to illness which locates the responsibility for symptoms on the biology of the individual rather than their psychology or

their environment (Sanders & Hill, 2014). Conversely it can also be seen as paternalistic, inhumane and reductionist (Shah & Mountain, 2007). It is a model that views illness in terms of causation and remediation as opposed to holistic or social models (Shah & Mountain, 2007). Within the medical model is the implicit understanding that the doctor or another practitioner will have the expertise to implement the necessary treatment. The doctor is seen as more powerful, but the patient is not powerless (Shah & Mountain 2007). One view is that the doctor can advise and treat, but the patient can choose to agree to the treatment and to act on the advice or not. This sees patients as active participants in the interaction. However, where patients hold beliefs about the power of the doctor, they are less likely to challenge the doctor's decisions (Braman & Gomez, 2003).

In counselling and psychotherapy a major reason for the dominance of the medical model, is the emergence of managed care where third parties such as insurance companies use the medical model and evidence based language (Bohart & Tallman, 2003). Therefore, in order that their clients can get their therapy provided, and their work is remunerated, psychotherapists and counsellors have to use the language of the medical model. Problems become pathologised and are talked of as "disorders" with therapists referring to treatments or interventions given to "patients", all of which places the therapist in the role of expert. Clients may come into therapy to create an opportunity for deep experiencing and personal meaning-making (Bohart et al., 1998), but the therapy environment may well be influenced by evidence-based practice guidance invoking the need for a diagnosis to be made in order to adhere to the correct NICE guidance (Clark et al 2009). Indeed the client's agenda is diluted even further when treatment decisions are influenced by treatment purchasers e.g., private health insurers who ask for certain treatments to be delivered (Fairfax, 2009). This moves the agenda even further away from the client and ignores an individual having their own unique set of difficulties and a particular history, as once they are given a diagnostic label it is then the label rather than the individual that is treated (Moncrieff, 2013). In light of this it is little wonder that patients are often left feeling that their concerns are forgotten and that they are little more than a disease being treated (Faulkner & Thomas, 2002).

There is a view that therapy is not a treatment, but rather a learning opportunity for the client who is an active participant in their own self-healing (Bohart, 2000b). In this scenario the therapist has to help to find ways to collaborate with the client to enable the development of a therapeutic alliance which facilitates them finding their own solutions. However, this goes

against the format of the medical model where the therapist is guided not by the client, but by the evidence base such as the NICE guidelines (2009) that instructs what should be done in session (Bohart, 2000b).

Since the 1950s there have been claims and counter-claims as to the effectiveness of psychotherapy (Eysenck, 1952, Strupp, 1963, Hunsley & Di Giulio, 2002, Cooper, 2008, Cuijpers, 2015). While people want to know if counselling works and whether it can help them to feel better, the answer to this question often remains elusive. This is because the outcome measures of counselling are subject to interpretation and judgements that may come from the counsellor, the referring doctor or referring agency or even from the outcome measure being used, yet, only the client can know what they are getting from their therapy, how useful it is for them and whether it meets their needs (Rogers, 1961). The understandings of a particular field, such as CBT, are only valid within the theoretical paradigms of that field and therefore there is a judgement in place that is external to the person who is the client (Gergen, 1996). There are ideological tensions between cost-effectiveness and objective evaluation and a conflict between the bio-medical cure orientated model and the non-judgemental core conditions that need to be in place to create the safe space a client needs in order to work through their concerns (House, 1999). Further, there is no evidence that as practitioners we are more expert than our clients in knowing what works for them, the "experts do not know best" (House & Totton, 2011, p.49). Nonetheless, Horvath (2013) still comes from the viewpoint of “We” need to decide what this therapy is for. “We”, being the experts, doctors, practitioners or researchers, but not the client themselves. It is not possible to choose therapeutic solutions outside of the person and their own individual context (Bohart, 1997). It is for the client to decide whether a specific therapy is effective for them, rather than assuming, as in the medical model, that expertise lies with the practitioner.

1:8 The common factors model

The recognition that many therapies have practices and ways of working that are not unique has been termed “Common Factors”. (Ahn & Wampold, 2001; Lambert & Ogles, 2013, p.151). The belief is that there are factors occurring in the therapy that are curative and responsible for psychotherapeutic benefit, but not specifically incorporated into the theory of change of any particular model of therapy. Wampold (2001, p.23) describes these factors as,

“common across approaches”, listing factors such as “insight, corrective experiences, opportunity to express emotions and acquisition of a sense of mastery”. These, along with the therapeutic relationship, the client’s emotional experiencing, exploration of their internal frame of reference, changing personal effectiveness and providing hope contribute greatly to positive outcome.

Grencavage and Norcross (1990, p.373) believe there are five areas of commonality: client characteristics, therapist qualities, change processes, treatment structures and relationship elements. They suggest that the most consensual commonalities were the development of a therapeutic alliance, the opportunity for catharsis, the acquisition and practice of new behaviours, clients' positive expectancies, beneficial therapist qualities, and the provision of a rationale as a change process.

It is suggested that the common factors model is beneficial as its focus is on the meanings it gives to procedures rather than their specific psychological effect (Wampold, 2001). Grunbaum (1981, p.164) proposed that characteristics of particular techniques are being dismissed as techniques and called “incidental”, but that actually a therapeutic process is at work.

Others consider that the debate between specific factors or common factors may well be spurious because it is impossible to separate out the technique from the myriad of ways of communicating and relating that take place in the context of the therapy (Watson, 2007). Ultimately, it has not yet been clearly identified what actually is taking place in therapy other than clients find the process helpful.

Common factors may be grouped into categories of support, learning and action, with all operating in many different therapies (Lambert and Ogles, 2013). However, during the last two decades attempts have been made to establish what percentage of various aspects of therapy account to positive therapy outcomes. Lambert (1992) identifies that whilst techniques may be responsible for 15% of a client’s improvement and expectancy may be responsible for 15% improvement, common factors may well account for 30% of the improvement with the remaining 40% being due to extra-therapeutic factors, such as client ego strength, social support and events that go on external to the therapy. Moreover, an analysis by Wampold, (2001) indicates that there is evidence to show that specific aspects of

therapy account for only 1% of variance in outcomes, meaning that non-specific factors are responsible for the remainder of improvement. Cuijpers et al. (2012) estimate extra-therapeutic factors are responsible for about one third of the improvement (33.3%), non-specific factors for approximately half (49.6%), and specific factors for the remaining 17.1%. There is remarkably little change between such findings in the last 20 years, 1992- 2012.

Orlinsky (2011, p.*xxii*) suggests, what works in therapy may not be about specific factors or common factors, but rather "therapeutic factors". These are the factors that contribute to effective change for clients and are present in all therapies with the recognition that some therapists are more responsive and some client are more receptive, but where the constant is a working therapeutic relationship within which the therapy is co-constructed by both participants. Wampold (2010, p.*xxii*) considers that the differences between the various positions are "fundamentally not reconcilable" and that the only essential question is "whether a psychological therapy is benefiting the particular patient being treated".

Despite such evidence, the research community still search to identify the ultimate factor responsible for bringing about therapeutic change. Indeed Cooper (2008) highlights that research tends to look upon diversity as random variance, whereas Kiesler (1966, p.117) identified an assumption of the "patient uniformity myth", that people with similar diagnoses need similar things. From a humanistic, Person Centred perspective, Rogers (1957) also challenges the uniformity myth. With a focus on the subjective and the individual, Rogers identified what he felt were the necessary and sufficient therapeutic conditions to bring about personal change. These conditions include; accurate empathy, unconditional positive regard and congruence.

For Rogers (1957) these conditions form the foundations of a working therapeutic relationship. The presence of these conditions will nurture a valuing process for the client with the aim of establishing the locus of evaluation within the person based in the immediacy of what is being experienced (Kirschenbaum & Land-Henderson, 1989). However, it has been challenged as to whether these therapeutic conditions are sufficient (Watson, 2007). Watson (2007) believes that if therapists are too accepting of a client, it may allow clients to avoid issues by diverting the therapy. For Watson (2007) and Bohart (2000b) the therapist may have to take a more active role in order to help the client use the therapy appropriately.

However, Watson (2007) acknowledges too much freedom versus too much structure is a difficult boundary to negotiate.

1:9 The development of IAPT

Depression and chronic anxiety have been cited as the biggest causes of misery in the UK with only one in four people suffering depression receiving any form of treatment (Layard, 2006). Further the total loss of output due to depression and chronic anxiety accounts for approximately £12 billion a year (Layard, 2006). NICE make recommendations on the commissioning and delivery of psychological interventions within the NHS. As a result of the prevalence rates, the availability of treatment and cost of depression in the UK, NICE guidelines were established in order to give people a choice of psychological therapy.
One initiative for giving people choice has been the IAPT program, introduced as a way of offering NHS patients "a realistic and routine first-line treatment" (IAPT, 2012, para.2). The service was piloted in two areas Newham and Doncaster, and in 2007-8 it was rolled out to 35 services nationally. By 2014 it is expected that the service will be available to 15 % of the population looking for treatment for depression and/or anxiety. It is difficult for people of low means to access therapy due to costs and availability, however, the IAPT programme has gone some way to ensure the NHS addresses issues regarding inequality of service provision (Pope, 2013).

The development of the service initially involved training at least 3,600 new psychological wellbeing practitioners to deliver the evidence-based psychological therapies recommended by NICE. However, since the inception of the training programme there was a dominance of CBT (NICE, 2009). IAPT uses a series of outcome measures known as "the minimum data set " to record the care provided to each client and to measure the client's progress. The implementation of these outcome measures was established as a way of being able to measure the performance of IAPT services. However it seems there are conflicting evaluations of the service. The IAPT (2013) three year report highlights a number of key successes including the 1 million plus people entering treatment, 680,000 completed treatment and recovery rates being consistently in excess of 45% and 65% significantly improved. Additionally, over 45,000 people came off sick pay and benefits, and nearly 4,000 new practitioners have been

trained. However, if the recovery rate is 45% questions need to be raised as to what happened to the other 55%. Further if one million people entered therapy and 680,000 completed their course of treatment, 320,000 people are unaccounted for. Others have scrutinised the IAPT figures and found them troubling. Sartori (2011) comments there are an estimated six million people in the UK with depression and anxiety, of 210,540 people who were referred to IAPT services only 123,975 actually received treatment. This is only just over 2% of the six million people who are suffering. In addition, for some people treatment has equated to just 2 sessions which is far fewer than recommended by the NICE guidelines of at least 6 sessions, while considerable variance between sites in recovery rates has also been reported (Gyani et al., 2011). Sadly, Lord Layard (2012) noted that in some areas IAPT services have stopped expanding and some have even been cut. This was not what was forecast when IAPT was initially established. A report from the British Psychoanalytic Council and UKCP (2015) states that waiting times, choice of therapies and quality of provision are all getting worse and cutbacks are resulting in 58% of clients with critical mental health needs being unable to get the help they need.

1:10 The Ascendancy of CBT

Although the Layard report (2006) recommended that people "have a choice of psychological therapy" CBT has become the dominant therapy as it was considered the most developed, having established a strong evidence base in hundreds of clinical trials (Layard,2006). CBT is recommended in the NICE guidelines for depression (NICE, 2009) due to the amount of research evidence available to support its efficacy (Butler et al., 2006). However, this has had the effect of reducing the choice of other psychological therapies available to clients via the IAPT programme. In contrast to other forms of counselling such as Person Centred therapy, CBT is delivered from a "manual" of practice, a framework which states what the therapist should do and ideally when with the aim of standardising treatment to everyone. This means of conducting therapy therefore lends itself to evaluation via randomised controlled trails, the "gold standard" of research evidence used by NICE and the NHS (Beutler & Forrester, 2014). In comparison, other forms of counselling such as Person Centred, Transactional Analysis and Psychodynamic are developed around each individual and therefore difficult to evaluate by means of randomised controlled trials and are thus not included as evidence-based forms of treatment within NICE guidelines (NICE, 2009).

The IAPT programme when initially introduced in 2008 promised to recognise psychological need and to inject the required funds to deliver therapy widely across the UK. However, what has occurred is a huge curtailment of services so that generally in the NHS, the only therapy commonly available is CBT (Platt, 2011). The introduction of IAPT and the privileging of CBT has impacted on existing counselling provision and counsellors, with services being replaced by CBT services that use newly trained psychological wellbeing practitioners (Perren & Robinson, 2010). This has lead to job losses for experienced counsellors, with vacancies not being filled when staff leave. Ballinger (2013) believes this is a threat to the existence of counselling in the NHS. BACP raised concerns regarding counsellor job losses and the lack of choice for clients accessing help from the NHS and responded to this challenge by supporting the development of a new evidence-based therapy called *"Counselling for Depression"* [CfD.] (Sanders & Hill, 2014).

1:11 Counselling for Depression (CfD)

CfD is the only humanistic therapy approach in the IAPT programme (Proctor, 2015). It is described by Sanders and Hill (2014, p.3) as a "new integrative counselling approach", being an integration of Person Centred counselling and Emotion-focused therapy. CfD focuses on working with the emotions underlying depression along with the intrapersonal processes, such as low self-esteem and excessive self-criticism, which often maintain depressed mood (Sanders, 2013). CfD is distinguished from traditional person centred practice as it emphasises collaboration and negotiation of client goals as well as counsellor instigated regular reviews of progress and client goals Sanders (2013). Also different from traditional person centred practice, the focus of CfD is on working briefly in that CfD is time limited and usually offered in contracts of up to 20 sessions (Pearce et al., 2012).

Sanders and Hill (2014) suggest that person centred therapists are best placed to offer CfD but point out that the concepts of evidence-based practice such as competence, manualisation, protocols, outcome and adherence measures may well be abhorrent to practitioners of humanistic theory. This is an acknowledgement of CfD being a new and different model of

counselling that may challenge the traditional concepts of person centred practice because of its attention to meeting the demands of evidence-based practice (Sanders & Hill, 2014).

The therapy model of CfD has been designed around a competence framework making it possible for it to be delivered from a manual. (Appendix 1) (Roth et al., 2009; Hill, 2010). The competence framework guides the therapist in how to implement the therapy based on descriptions of "best practice" derived from RCT research evidence supporting the efficacy of therapy (Sanders & Hill, 2014). A core premise of competence frameworks is that "the therapist needs background knowledge relevant to practice and can draw on and apply this knowledge in their therapeutic work" (Sanders & Hill, 2014, p.23). The idea that the therapist "applies" their knowledge in their work with their client places the therapist in the position of expert professional and is a very different stance to the Rogerian ideal of "timeless living in the experience", a unity of experiencing between client and counsellor which Rogers describes as "the height of personal subjectivity" (Rogers, 1961, p202).

The competencies are grouped into generic therapeutic competencies, basic CfD competencies, specific CfD competencies and meta-competencies (Hill, 2010). The following description of the competencies are taken from Sanders and Hill (2014, pp31 -36): Generic therapeutic competencies include; **Knowledge and understanding of mental health problems.** This equates to counsellors having knowledge of common mental health problems, particularly depression which is seen as vital for CfD counsellors. CfD Counsellors are required to have a detailed knowledge of the cluster of symptoms associated with the diagnosis of the disorder of depression. The medicalisation of CfD is evident in the choice of language referring to diagnosis of disorders and symptoms. **Knowledge of, and ability to operate within, professional and ethical guidelines,** the need to have practice underpinned by knowledge of national and local codes of practice is stressed and applying ethical principles to the therapeutic encounter is required. **Knowledge of a model of therapy and the ability to understand and employ the model in practice.** This refers to the in-depth knowledge of the model providing the rationale for the interventions used. However, it is recognised there is a need to be flexible according to client need and a balance is required between consistency and flexibility. **Ability to work with difference,** CfD counsellors are required to develop cultural competence that will underpin their work with clients from different backgrounds. There is a need to develop an appreciation of different lifestyles, beliefs and attitudes to foster culturally sensitive therapy. **Establishing and maintaining a**

therapeutic alliance, this is a key competence given that a good, working, therapeutic relationship is associated with positive therapy outcomes. This requires that the therapist can engage with the client, work empathically, and hold a range of emotions expressed by the client and build a safe environment where understanding can take place including a safe ending to the therapy. **Ability to undertake a generic assessment,** this is seen as a core competency for CfD counsellors. The aim is to understand the client's difficulties; giving consideration to the social situation, relationships, employment and any other matters that impact on the client. Inherent in the assessment is a consideration of risk along with personality factors that contribute to an evaluation of whether therapy is appropriate at this point and what the focus may be, or whether other therapeutic options need to be considered. **Ability to assess and manage risk of self-harm in clients presenting with depression,** this competency requires CfD counsellors to understand and manage the elevated levels of suicide and self-harm among depressed people. There is a need to develop plans to manage the level of risk whilst continuing to support the client's therapeutic progress. **Ability to use measures to guide therapy and to monitor outcomes,** the IAPT programme uses session by session outcome measures and CfD counsellors need to have a basic understanding of how the measures are constructed and how to interpret them. It is suggested that the benefits of integrating the outcome measures into routine practice in terms of obtaining feedback from clients and monitoring progress "should be appreciated by counsellors" (2014, p.33). **Ability to make use of supervision,** this is seen as providing support, guidance and professional development to the counsellor and is viewed as an important factor in the delivery of effective therapy. The ability to adapt practice in view of supervisory guidance is seen as essential.

Basic CfD competencies include; **Knowledge of the basic assumptions and principles of CfD,** the counsellor is required to have a thorough knowledge of 1) the philosophy and principles that inform the approach, 2) how the modality explains human development and psychological distress, the rationale for therapy and how this relates to therapeutic change,
3) the conceptualisation of depression by means of the principles and philosophy of the theories from which the model is drawn. An appreciation of these points supports the CfD counsellor's understanding of the client's problem and the factors that may be maintaining the depressed mood. **Ability to initiate therapeutic relationships,** explaining to the client the rationale for treatment is seen as a priority, both to support the principle of informed consent but also to help support the forming of a collaborative relationship. Also seen as a priority in

CfD is the ability to help the client develop a focus or aim for the therapy, but care must be taken that the development of a therapeutic aim does not detract from the forming of the therapeutic relationship. **Ability to maintain and develop therapeutic relationships,** fundamental in this area of competence are the three Rogerian core conditions of empathy, unconditional acceptance and authenticity. **Ability to conclude the therapeutic relationship, whilst** this is a time to review progress and look to the future it is acknowledged that the brief nature of CfD may for some client's conclude too soon. CfD counsellors are required to help facilitate any negative feelings that the client may have around endings and ensure as far as possible that the ending is associated with increased autonomy and self-awareness for the client rather than experienced negatively.

Specific CfD competencies refer to a set of more specific skills which may be relevant with particular clients in particular circumstances. Applying these skills is dependent on the CfD counsellor's clinical judgement and the client's preference in how they wish to work. The CfD approach is to work with emotions and emotional meanings with the emphasis on the client developing new meanings and understanding as a result of the focus on feelings. **The ability to help clients access and express emotions,** there is a need for an optimal level of emotional arousal in order for counselling to progress. Too little contact with feelings or conversely being overwhelmed by emotion may make therapeutic progress difficult. Therefore the CfD counsellor works to identify and explore with the client their habitual ways of managing their feelings which helps the client to contact underlying feelings and become aware of how they usually manage them. **Ability to help clients articulate emotions,** requires the CfD counsellor to help the client find appropriate language to describe how they feel, often using imagery or metaphor. The aim is to help the client to access the essence of their emotions and become aware of their significance. **Ability to help clients reflect on and develop emotional meanings,** following helping the client to put feelings into words, the role of the CfD counsellor now is to help the client in a process of reflection and the development of new perspectives. The counsellor supports the client in considering who they are and how they want to be. **Ability to help clients make sense of experiences that are confusing and distressing,** the CfD counsellor helps the client to make sense of situations where they may have over or under reacted or behaved out of character. These situations may cause stress or distress and the client may wish to re-visit them. Here the counsellor can help the client to create a richer narrative and to focus on the underlying feelings which did not surface at the time.

The meta-competencies domain is divided into two sections; general meta-competencies which apply to any therapist and counselling meta-competencies specific to CfD. **Generic meta-competences,** are high-order skills that any therapist practising any modality should possess, for example to adhere to a model of therapy, but be able to be flexible enough to meet a client's needs. To find a balance between these two aspects is the mark of a competent therapist. **Counselling meta-competencies;** these are the high-order skills relating specifically to the implementation of CfD. Although similar to the generic meta-competencies, they involve the ability to balance the different aspects of the competence model, for example, balancing a focus on a therapeutic task whilst maintaining a therapeutic relationship. Another example would be balancing a non-directive stance against the need to intervene with issues of risk. It is suggested this involves the need to talk reflectively with the client about the nature of communication in the therapeutic dyad and its impact. The focus is always to maintain the therapeutic relationship and to support the client making therapeutic progress.

CfD is a high intensity intervention "particularly appropriate for clients who experience persistent sub-threshold depressive symptoms or mild to moderate depression where 6 to 10 sessions are recommended over a period of 8 to 12 weeks. Where presentations are more severe up to 20 sessions of counselling are recommended" (Hill, 2011, p7). The language of diagnosis and the medical terminology that defines the model are very different from Rogerian person centred vocabulary. CfD training seeks to standardise counselling with depressed clients, aligning interventions with the evidence-base underpinning NICE guidelines (Hill, 2011), the implication being it is possible to assert what will be effective in counselling. There is recognition of a need for balance in the development of the competency framework (Sanders & Hill, 2014). If the guidelines are too simple then the potency of the therapy is diluted and the guidance becomes too general. If the guidelines are too detailed then the therapy can become mechanistic. However, there are critics who see this methodology as flawed and there are fears that counselling will move away from its roots and become directive (Chapman, 2012). Chapman (2012, p40) fears this means that therapists can no longer be trusted to use their own judgement and experience, he sees evidence-based practice as "pseudo-science masquerading as 'objective truth". This moves far away from Rogers' belief that the client is the expert on self and the inter-subjective relationship between counsellor and client in the here and now (1951).

However, there is a need to be pragmatic about the position of counselling and securing its place within the NHS (Pearce et al., 2012a). Therefore, during 2011, a total of 65 counsellors undertook training for CfD with the intention of meeting the competence requirements for the inclusion of this type of counselling in the IAPT program. At the time of writing this thesis, CfD is now being delivered within the IAPT programme. As there are no randomised controlled trails as yet completed on CfD its inclusion was orchestrated by developing the competence framework using therapy manuals from randomised controlled trials and exemplar texts which have impacted significantly on practice (IAPT, 2011). The therapeutic competences are closely aligned to the evidence-base and hence predictive of good outcomes for patients (IAPT, 2011). CfD is considered a NICE (IAPT, 2011) recommended psychological therapy and this has enabled counselling to be included within the NHS thus widening the choice for clients. As CfD has been designed around a competence framework, in essence this means it will be able to be standardised and therefore make the therapy suitable to be tested in a randomised control trial.

1:12 Consumer Perspectives

Since the Griffiths Report (DHSS, 1983) identified that the NHS was oriented to the needs of the service providers rather than the service users there has been numerous initiatives to change the status quo. Members of the public are now treated as "knowledgeable consumers of health care rather than just passive recipients" (Allen, 2000, p.183) and this is now embedded in Health Policy (Department of Health, 2007). However, while lay people using health care services wish to be seen as credible, it has been suggested that often lay credibility is challenged by hierarchies of evidence and positivist conceptions of knowledge (Thompson et al., 2012). Whilst acknowledging that the public may not be "experts" in a particular field, Kerr et al. (2007) suggest that what they can bring is a "normative" aspect that is potentially overlooked through a specific expert lens. Further, the public bring transferable expertise from their own fields of experience enabling a hybrid position with almost simultaneous claims to expertise and lay perspectives (Kerr et al., 2007). Rather than deferring to or challenging the expert position, what the public brings to research is partnership and dialogue that broadens the understanding and establishes commonality with other people (Kerr et al., 2007). For those working with people with mental health problems,

to understand the lived experience of their service users and to be able to make sense of that experience is seen as vital (Warne & McAndrew, 2010; McAndrew et al, 2014). Likewise and when specifically referring to counselling, it has been suggested that without knowing the client's view of their therapy there can be no effective evaluation of that therapy (Lambert, 2007).

1:13 The purpose of the study.

In light of the above factors the focus of this research study is on the client's perceptions of CfD, with the purpose of the study being two-fold. Firstly, the study explores and evaluates CfD from the perspective of the client. Secondly, the findings from the study will help to inform the counselling profession of what is taking place in this therapy as perceived by the client.

The aim of the study is to explore the client's experience of receiving CfD therapy. The objectives supporting the aim being:

To explore the client's views of helpful and unhelpful aspects of this therapy.

To discover what clients mean by "effective" therapy.

In undertaking this research study I will be able to make an original contribution to knowledge as this is the first study on the effectiveness of the CfD model. The study will generate an understanding of what is taking place from the viewpoint of the client experiencing this particular new form of therapy, CfD. Further, this study will provide a platform for valuing client perspectives, raising awareness of their views of CfD and providing insight into what clients consider is effective in terms of their mental wellbeing. In addition, findings from the study will provide guidance that will inform professional practice by obtaining client based evidence of what makes this model of therapy effective or not effective for them.

Much is assumed about what is effective therapy, based on an evidence-base derived from studies where variables are controlled. In contrast, this research will contribute client-based

evidence of what constitutes effective therapy from individuals entering therapy in normal everyday clinical practice. Having an understanding of the client view will provide significant information to counsellors, allowing insight into the experience of the other half of the counselling dyad. This new knowledge can help counsellors to adapt therapy to make it as meaningful as possible for their clients. Further, the knowledge this study generates will help to inform counselling provision by illuminating what is taking place in sessions thereby helping to guide decisions around what works in therapy by basing them on client-based evidence.

CfD is a newly developed model of therapy designed on evidence based principles but as discussed above it has not been tested as yet. In addition to evidence regarding its efficacy, in line with person centred principles, it is essential to understand the client's viewpoint (Bohart, 2000a; Lambert, 2007). Given that 1 in 4 adults will be diagnosed with a depressive episode (Leader, 2013), the need for effective therapy to help these people is clear. However, the limited choice of therapy within the NHS currently must be recognised and addressed in order that clients are able to access the therapy that best meets those needs. This study therefore aims to explore how CfD is being experienced by clients and whether they consider this approach effective in meeting their needs.

As no previous study has considered CfD from a client perspective this study is able to make original contributions both to the knowledge base regarding CfD counselling and its effectiveness and to the professional practice of counselling.

1:14 Reflections - Please follow the highlighted route

In this thesis I am presenting my reflective diary in sections relating to the material in the preceding chapter. I have framed the diary as a journey guided by the satellite navigation system in my car. It occurred to me while driving and thinking about the study that I am engaging in a journey. A journey of discovery. Unearthing personal learning of things I didn't know I didn't know and also gaining professional learning that helps to develop the profession and further our collective knowledge from the information gained in the study.

My sat nav usually does get me to my destination, but there have been journeys requiring U turns and occasional arrivals at unexpected destinations. So too with this study. There was always the intention to prize the client perspective, but I had no idea of the detours, road blocks, hold ups and tail backs that I would encounter and that would direct the study to an altogether different destination.

Initially the way forward had seemed so clear. This study was going to try to provide evidence that what I do as a counsellor on a daily basis works and that would challenge the NICE guidelines that express doubt over the evidence that counselling is effective. In the words of a meercat - simples! What has transpired has been anything but simple. I always knew this endeavour would create new learning for me, but I never realised how this would take place or that it would come from so many unexpected avenues. There have been many realisations on route - some absolutely delightful and some totally crushing.

For instance, it was astonishing to realise the different ways of writing that were required; an academic thesis for my supervisors, a lay summary for my participants, an accessible poster version for a conference, an attractive invitation to encourage counsellors, and then a translation of the work into an understandable explanation for those who asked me what I was working on. On the downside, it was heart-breaking to be turned away from one meeting of counsellors and told mockingly "the model doesn't exist".

This is a journey for me, and at times I have been lost and I have had to re-position. At the outset it never occurred to me that the way forward would be so convoluted. However, I am adopting the words of Calvin Coolidge - Nothing succeeds like persistence and my aim is to arrive at my destination, with my thesis complete having developed evidence that will help my profession move forward.

Chapter 2 Literature Review.

2:1 The purpose of the review.

The purpose of this literature review is to ensure a thorough understanding of the topic and its context, and to identify apparent gaps in the current knowledge that require further investigation (Brettle & Grant, 2003). While the nature of key ideas will be discussed, there is an awareness that the subjective position of the researcher will influence the articles chosen for inclusion, although care has been taken to be as impartial as possible in this regard. This review will offer a critique of the studies found relating to the research, providing a context for this study by highlighting how it fits into the current body of knowledge.

Following an explanation of the search strategy undertaken, this literature review begins with a consideration of the literature pertaining to counselling, in particular, studies written about the effectiveness of counselling and the factors that complicate the findings of counselling research. Following that, there is a discussion of the literature focusing on counselling depressed people followed by a review of the studies used to inform the NICE Guideline Development Group that approved models of therapy for depression for delivery in the NHS. Given that the focus of the research is on the client's perspective of CfD, there will then be a review of the body of literature that focuses on the client's perspective of counselling to ascertain where gaps in the literature exist and to identify the relevant place for this study.

2:2 Search Strategy

The searches were undertaken iteratively, at various stages within the Professional Doctorate process. There is a large body of research on the topic of depression over the period of time covered by this study. So, for the purposes of this literature review and to manage the volume of information, a previous paper prepared on Psychological Therapies for Depression for BACP (Brettle, 2012) was used as a starting point. This paper (Brettle, 2012) used systematic searches of a number of databases; Medline, Psychinfo, Cochrane Library and NHS evidence to provide a comprehensive and systematic overview of the effectiveness literature on this topic. As this study is considering a time frame since 1990 and continues past 2012 to current

day, other papers to illustrate additional points as needed were added to the review. This included papers collected during the taught programme and throughout the research process as described below.

To obtain an overview and ascertain the gaps in the field of counselling for depression from the perspective of clients, a series of systematic searches were undertaken. The databases searched were PsychInfo (psychological literature), Medline (biomedical information) and CINAHL (nursing and allied health). These data bases were chosen to give a range of perspectives and would be expected to reveal appropriate studies. Alerts that identified when new studies were published relevant to the search criteria were set up to track new material and emailed to the researcher. Additionally, the searches were re-run every 3 months from September 2012 for the duration of the study. In addition to the database search, reference lists of retrieved articles were scoured for further relevant articles and articles were also identified through the online resources Google Scholar, Psychotherapy Networker and Research Gate. As there were limited studies on the client perspective in relation to depression alone, studies of the client perspective of counselling more generally were also included.

As a member of several professional associations BACP, UKCP and CPC, professional journals linked to each organisation were automatically received by the researcher and searched on an ongoing basis. Alerts for new issues were also organized from other key journals in the field. These included: Psychotherapy; Psychology and Psychotherapy: Theory, Research and Practice; American Psychologist; Clinical Psychology and Psychotherapy; Journal of Theoretical and Philosophical Psychology. Also covered was grey literature such as conference abstracts /proceedings, and also government documents as well as theses via the ETHOS database.

The systematic searches on the client perspective were undertaken using the following terms as appropriate to each database. Free text and controlled vocabulary searching was used, and where possible the thesaurus was used to "explode "the terms in the hierarchy to incorporate the relevant narrower terms beneath; Psychotherapy/ or Psychotherapeutic Processes/ or Individual Psychotherapy/ or Counseling/ or Counselors/ or counselling.mp. Humanistic Psychotherapy/ or Brief Psychotherapy/ or Experiential Psychotherapy/ or Analytical Psychotherapy/ or Individual Psychotherapy/ or Psychodynamic Psychotherapy/ or

Expressive Psychotherapy/ or Supportive Psychotherapy/ or Adlerian Psychotherapy/ or psychotherapy.mp. or Integrative Psychotherapy/ or Psychotherapy/ or Eclectic Psychotherapy/ Client Centered Therapy/ or person centred counseling.mp. or "Rogers (Carl)"/ exp Cognitive Therapy/ or Cognitive Behavior Therapy/ or cognitive behavioural therapy/ client. or Clients/ Client Attitudes/ or Client Centered Therapy/ or client views. / client beliefs. / Perception/ or client perceptions in therapy. / Depressive Disorder./ depress$./ counselling for depression./ or Improving access to psychological therapies./ IAPT.

The Boolean operator 'and' was used to combine the different concepts (counselling, depression, client perspectives) in order to narrow the search to appropriate studies.

2:3 Database search results

Table 1: Database search Results

PsychInfo

Counselling (headings include all derivatives)	117563
Depression	108609
Client view	17710
Counselling and depression and client view	81

Medline

Counselling	72430
Depression	76188
Client view	2401
Counselling and depression and client view	3

CINAHL

Counselling	18228
Depression	62915
Client view	50
Counselling and depression and client view	0

Of the 84 studies that were found in the database searches on the client view of counselling and depression 52 were included in the thesis and 32 were excluded. Details of the studies and the reasons for exclusion are given in appendices 2 and 3).

2:4 Explicit inclusion and exclusion criteria

Both the searches for the effectiveness literature and those from the client perspective only considered articles written in English and covered the years from what was stated to be the start of the evidence based practice movement in "the early nineties" (Hall,2008, p.386), up to present day. However the following seminal studies are included because of the important contributions they have made to the subject being studied:

Rosenweig (1936) - Identification of the Dodo verdict.
Mayer and Timms (1970) - The first study to use interviews to enquire about clients experiences of counselling.
Luborsky (1975) - Reiteration of the Dodo verdict.
Smith & Glass (1977), Smith, Glass & Miller (1980) - First meta-analyses of counselling.
Llewelyn (1988) - First study to use the Helpful Aspects of Therapy (HAT) form. (Appendix 14).
Elliott & James (1989) - Meta-synthesis of 40 years of literature on the client experiences of psychotherapy.

To help sift, and manage the large volume of literature obtained from the searches, the following inclusion and exclusion criteria were also used to help determine what should be included in the review.

Table 2: Explicit inclusion and exclusion criteria

Inclusion Criteria	Exclusion Criteria
Counselling / Psychotherapy (interventions which accord with the BACP definition of talking therapies)	Children / "young people" (younger than 18) Counsellor view Families / Groups Other conditions – HIV / Alzheimer's etc.

Adult – 18 plus Qualitative studies Quantitative studies Service users /clients/patients 1990 - The start of the evidence-based practice movement. (Hall, 2008). Individuals (not couples) Depression Primary care or other day attendance services.	Inpatient treatment / care homes Drug/ other/ addiction Personality disorders Psychosis Eating disorders Imagery Pain Clergy / nurses etc (other professionals who may use counselling skills - but using interventions which do not accord with the BACP definition of talking therapies.) Trauma Internet interventions / minimal interventions / self help / exercise. Bibliotherapy. Animals used in therapy e.g. equine therapy Relapse prevention / Maintenance Costing exercises Diagnosis

As noted above the volume of literature relating to counselling and depression is vast. It was therefore decided to synthesise the literature according to themes which provided a context to the study and related to the study aims and objectives.

2:5 The effectiveness paradox of counselling.

Campbell et al. (2013, p.98) claim that "by any standard of effectiveness, psychotherapy works" and evidence for this is found in "thousands of individual studies and in hundreds of meta-analyses conducted over several decades". They highlight that a client receiving psychotherapy is better off than 79% of people who need psychotherapy, but who are not able to access it. However, the question of how psychotherapy works fuels a paradox between beliefs in the uniform efficiency of all models of psychotherapy versus particular therapeutic approaches (Wampold, 2001). One reason for this is most effects of psychological treatments

are caused by common, nonspecific factors and not by particular techniques (Cuijpers, 2008b). The finding that all therapies, despite their different practices and different philosophies, all achieve similar results has been consistently found in counselling research. Initially this was highlighted by Rosenzweig (1936) and is known in the counselling profession as the "Dodo bird verdict" after the Dodo bird in Lewis Carroll's Alice in Wonderland who, when asked to judge a chaotic race, said that "Everybody has won and all must have prizes"(1865/1993, p54). The Rosenweig (1936) finding was reiterated in 1975 with the caveat that any differential treatment effects may be due to the researcher's theoretical orientation (Luborsky et al., 1975). Contemporary research continues to consider that the researcher's belief in the superiority of a treatment is likely to influence the study outcomes in favour of the preferred treatment (Munder et al., 2013). Munder et al. (2013) found that when assessing for researcher allegiance in 30 meta-analyses, investigating the effects of any psychotherapy for any disorder or problem, there was a moderate effect size suggesting that differences in researcher allegiance can indeed threaten the validity of findings from comparative outcome studies.

The first meta-analysis on the effectiveness of counselling and psychotherapy, was undertaken by Smith and Glass (1977) and confirmed that counselling and psychotherapy are effective treatments, with subsequent reviews having drawn similar conclusions (Smith, Glass & Miller 1980; Wampold et al.,1997; Lambert & Ogles, 2004). A meta analysis undertaken by Elliot et al. (2004, p508) of 127 studies focusing on experiential psychotherapy, including person centred counselling, concludes that the psychotherapies are effective and moreover, "when different therapies are compared, all therapies are equivalent in their effectiveness". Also, Stiles et al. (2008), in a study comparing the outcomes of CBT, Person Centred therapy and Psychodynamic therapy, again concluded each of the therapies are effective and there is an equivalence of outcomes across the approaches. In a review spanning forty years and considering 400 randomised controlled trials Cuijpers (2015, p25) reports that "all therapies are equally effective in the treatment of depression", a conclusive finding that should lay to rest any doubts, but whether it will still remains to be seen.

However, criticisms are levelled at "equivalence" studies for missing results and drawing conclusions that are not warranted (Hunsley & Di Giulio, 2002). Further, the equivalence finding is challenged by those who consider evidence-based practice using specific techniques produces superior therapies (Clark et al., 2008; Salkovskis & Wolpert, 2012).

What is key here is the suggestion that "behavioural treatments are scientific and effective" (Wampold, 2013, p.21) and testing of the efficacy of different models of therapy is conducted by estimating the intervention effects under conditions of optimal control and standardization (Baker et al., 2008). This view however, is counter-challenged by those who suggest that "scientific truth is a social construction created by scientists" (Wampold, 2013, p.22) and others who comment that "it is illusory at best and deceptive at worst" to try and standardise an independent variable in therapy, as people are not identical and it is impossible to treat them the same in all respects bar one (Stiles, 2013, p.33-34).

Experiential non-directive therapies such as Person Centred counselling are seen as non-scientific and often downgraded by researchers who use this approach as the non-active ingredient in their study (Elliot et al., 2004). Cuijpers et al. (2012, p. 289) believe this is set up as an 'intent to fail' control and they suggest that this needs to change as their findings confirm that non-directive counselling is effective in itself and should be recognised as such. Elliot et al.(2004, p529) support this view and report that "time and time again non-experiential therapy researchers are surprised by the long term effectiveness of Client Centred therapy" suggesting that it is unwise to dismiss the healing power of the Rogerian model.

The "which therapy is best?" argument has been fiercely debated to the point where on occasions both sides will claim a study supports their case (Hunsley & Di Giulio, 2002; Duncan et al. 2004). Hunsley and Di Giulio (2002) claim a study by Shadish et al. (2000) confirms treatment effect sizes were larger for behavioural treatments. However, the same study is used by Duncan et al. (2004) to demonstrate equivalence between the therapies, maintaining that there is no difference in their effectiveness. The actual meta-analysis undertaken by Shadish et al. (2000) criticises the research methodology of studies where internal validity is based on randomisation and reducing attrition, suggesting that non randomised studies were more clinically representative of routine practice.

Since Rosenzweig (1936) first identified the equivalence paradox, none of the studies undertaken have been able to concretely define specific factors that make therapy effective. Timulak et al. (2010) highlight that there are different types of helpful significant events that occur with various frequencies within the myriad of different theoretical orientated therapies and also among therapists using the same therapeutic orientation. Whilst we do not yet know of the nuances that make therapy work, there is confirmation that counselling is effective

(Churchill et al., 2001; Wampold, 2002; Cooper, 2008; Elliott, 2013). Yet Cuijpers et al (2010a; 2011a) criticise psychotherapy research and comment that the effects for psychotherapy have been overestimated due to the poor quality of the studies considered in meta-analyses. Hence it would appear the debate continues and whilst this is so, it is vital to the very survival of counselling to strive to produce appropriate, carefully formulated research in order to confirm the value of counselling.

2:6 Difficulties in Counselling Research.

Since Strupp (1963) called for the profession to undertake research and produce evidence to support itself, it has become evident that such research is not easy to do (McLeod, 2003; Cooper, 2008). Some of the problems highlighted include: small sample sizes, lack of randomized studies, lack of control groups and heterogeneity between studies making comparisons difficult (Brettle, 2012). Often study findings in the field of counselling and psychotherapy are drawn from data that is imprecise (Cuijpers et al., 2010a). Methodological practices that clash with epistemologies are problematic. Randomised control trials objectify and attempt to confer generalisability to an individual, subjective area (Stiles, 2013). Stiles (2013, p.34) explains that clients in the same experimental condition of an outcome study each receive a "different individually tailored treatment" because of the way people respond to what is happening around them, meaning "what therapists do depends on what clients do" (2013, p.33). It is not possible to separate out one from the other. Further Stiles (2013, p.34) considers that treatment names do not confer standardisation believing that "treatments vary not just from study to study, but from therapist to therapist, from client to client, from session to session and from minute to minute". Therefore it is not possible to disentangle the effect of treatment types, therapist types and client types. Study designs that attempt to do this are aiming for a "mathematical ideal" which is not realistic in psychotherapy (Krause & Lutz, 2009, p.74). It is therefore very difficult to overcome the ambiguities presented by these entanglements making it difficult to say for certain what is taking place in psychotherapy. This situation is further complicated when research findings relating to psychotherapy are affected by bias introduced by researcher allegiance to a particular model (Cuijpers et al., 2012; Munder et al., 2013). In addition to the above, confusion arises in interpreting findings when the model practised is not defined. For example, Manne et al (2012), in an RCT comparing three interventions, refer to “supportive counselling”, but give no description of

what the therapist actually does. Likewise, Jakobsen et al. (2011) note the limitations of their systematic review comparing the effect of psychodynamic therapies versus 'treatment as usual' for major depressive disorder. The problem Jakobsen et al. (2011) identified was only three of the trials included used an intervention that was adequately defined. They state it is imperative that interventions are adequately defined otherwise it is unclear what kind of therapy participants are receiving.

Vague descriptions of what is taking place within intervention studies are also problematic when trying to assess the reliability of the analysis (Cuijpers et al., 2007b). In a meta-analysis of problem solving therapies for depression it was reported that the quality of the studies varied, they were very different from each other and the criteria had not been clearly defined (Cuijpers et al., 2007b). For example, only some participants met the criteria for major depression, some studies used intention-to-treat instead of completers-only analyses, and some studies involved the use of placebo medication and care-as-usual control groups but gave no details as to what they consisted of (Cuijpers et al., 2007b). It is not possible to derive clear understanding of what is being studied when the variables under study are so indistinct. The decision about whether or not the results of individual studies are similar enough to be combined in a meta-analysis is essential to the validity of the result (Cochrane Collaboration, 2002). However, what this would suggest is that estimates of treatment effects are added to assumptions regarding variables which are then taken as evidence of findings. Whilst the number of RCT studies now presents a large body of evidence, they offer very little in actual meaning (Storr, 2011).

Often much of the evidence is based on studies conducted outside the realm of primary care settings (Wolf & Hopko, 2008). This therefore will be different from routine daily clinical counselling practice where clients may present with co-morbid issues, long standing concerns and without the restrictions of the controls that randomisation dictates (Cooper, 2011). A study into guided self-help for anxiety and depression reported on the effectiveness of guided self-help at post treatment, but identified limited effectiveness with more clinically representative samples (Coull & Morris, 2011). Coull and Morris (2011) highlight that those studies reporting greater effectiveness tended to be of lower methodological quality and generally involved participants who were self-selected. They report that the evidence is therefore not conclusive and call for further rigorous research based on clinical populations

that examine longer-term outcomes. Commenting on the difficulties of obtaining definite results, Cuijpers et al. (2010b) state that in their meta-analysis the quality of the included studies was not optimal as only nine of the 38 (24%) studies met all quality criteria and further, the paucity of studies rendered some results inconclusive. Nonetheless, despite their misgivings, they still report that their findings show the intervention under study, which was Interpersonal Psychotherapy for depression, is effective.

There are other limitations too that confound results, for example Heatherington et al. (2012) using qualitative research explored the experiences of 76 adults receiving therapy for a range of conditions. The therapists were influenced by cognitive behavioural, psychodynamic and integrative or eclectic approaches, most clients had previous experience of therapy, but not all did. Of those who previously had therapy it ranged from 3 months to 3 years. Additionally some participants were paid and some were not. The range of variables here is considerable, demonstrating some of the difficulties encountered in counselling research as a whole.

Another example of the difficulties inherent in counselling research is a quantitative study comparing the effectiveness of cognitive-behavioural, person-centred and psychodynamic therapies in U.K. primary-care routine practice by Stiles et al. (2008). Although this study involved 5613 clients in 32 Primary Care services, assumptions and missing information reduce the value of the findings. Stiles et al. (2008) explain that all their participant groups began with equivalent outcome measurement scores and all improved. However, because the outcome measurement form cannot be generalised it fails to capture the subtlety of individual difference and the effect brought about by the environment in which the form is presented (Tomlinson, 2013). Tomlinson (2013, para.5) recalls a client telling him at the conclusion of therapy that "at the start he didn't know him or what would happen to the answers and therefore completed the measure by giving the answers he thought sounded right!" Further, concepts such as hope and self esteem are not readily quantifiable and are therefore missed by quantitative measuring instruments, but will affect how the form is completed (Lakeman, 2004). Lakeman (2004, p. 214) cautions that outcome measures have the potential to "shape reality" as they " hint at a uniformity, certainty and predictability" stating this is "simplistic" and fails to recognise the uniqueness of individual experience. Additionally, outcome measures fail to indicate recent onset of problem versus chronic longevity which can potentially make a difference to therapy outcomes. Moreover, Stiles et al. (2008) refer to problems with missing information due to forms not being completed and patients not

attending. From the identification of such difficulties it could be assumed that results may be compromised. Norcross and Lambert (2006) comment on the difficulties of obtaining absolute veracity in counselling research suggesting the human side of research, the complexities of psychotherapeutic working, the intricacies of each individual client working with the intricacies of each individual therapist, each with their individual backgrounds, their individual narratives and understandings, the organisational context, timing, and multiple influences all confound a definite result and this must be acknowledged. Although evidence - based practice demands outcome measurement and tailored treatment (Hall, 2008) it is perhaps wise to recognise as Einstein says, quoted in McKee (2004, para.3) "Not everything that counts can be counted; not everything that can be counted counts".

2:7 Psychological Therapy for Depression.

In the past 30 years there have been more than150 controlled and comparative studies that have examined the efficacy of psychological treatments of depression (Cuijpers, 2008a). The outcome of meta-analyses is generally that psychotherapy is effective and is superior to treatment as usual (Abbass et al., 2006; Bortolotti et al., 2008; Cuijpers et al.,2008b; Wolf & Hopko, 2008; Bell & D'Zurilla, 2009; Cuijpers, 2013a). Further, a meta-analysis of 7 studies involving over 700 people shows that psychological treatments can have an effect in preventing sub-threshold depression from developing into major depression (Cuijpers et al., 2007a).

Cuijpers et al. (2010a), in their meta-analysis of the effects of psychotherapy for adult depression, examined whether the quality of the studies was associated with the effect sizes and found that of the 115 studies that met their inclusion criteria only 11 studies met their criteria for quality - (participants met diagnostic criteria for a depressive disorder , $n \geq 50$, a treatment manual was used, the therapists were trained, treatment integrity was checked, intention-to-treat analyses were used, randomization was conducted by an independent party, and assessors of outcome were blinded). They therefore question the results of psychotherapy research and suggest that efficacy may be overestimated because of the inclusion in meta-analyses of low quality studies and suggest that in choosing what to review the question of quality often is not considered. However, despite this finding of overestimated efficacy, they still conclude that the effects of psychotherapy remain significant. Barkham et al., (2008) add

to this debate in their study that compared indices of treatment effects in RCT studies and practice-based studies of psychological therapy for depression and found that randomized trials showed a modest advantage over practice-based studies in the amount of pre–post improvement and further, that the size of the difference may be distorted depending on the method for the calculating degree of change. Once again, it is evident how researcher implemented practices influence the findings in a study regardless of the stated method used.

2:8 Different Models of Psychological Therapy for Depression

Many meta-analyses report the effectiveness of CBT and IPT and derivatives, such as mindfulness based CBT and guided self help (Feijo de Mello et al., 2005; Cuijpers et al., 2008b; Parikh et al., 2009; Chiesa & Serretti, 2011). A meta-analysis of 53 studies that compared CBT, nondirective supportive treatment, behavioural activation treatment, psychodynamic treatment, problem-solving therapy, interpersonal psychotherapy, and social skills training for depression, indicated there was no major difference in efficacy between the seven major psychotherapies but found that in CBT there was a significantly higher drop-out rate (Cuijpers et al. (2008b). However, the quality of the studies was not optimal and there were limited descriptions of the interventions making it difficult to know what was actually taking place. Parikh et al. (2009) in a Canadian study of systematic reviews of the literature consider that CBT and IPT are the only first-line treatment recommendations for acute major depressive disorder and remain highly recommended for maintenance. They suggest both computer-based and telephone-delivered psychotherapy, primarily studied with CBT and IPT, are useful second-line recommendations. Where feasible, combined antidepressant and CBT or IPT are recommended as first-line treatments for acute major depressive disorder. They comment that given the heterogeneity of treatment models, durations, and types of populations the studies only provide level 2 effectiveness however, this seems a criticism of comparators, rather than treatment. Feijo de Mello et al., (2005) in their meta-analysis of 13 studies reviewing the effectiveness of IPT report that it is more efficacious than CBT, possibly due to the correlation between depression and the social environment, specifically where IPT is working with the social mechanisms affecting depression. In their meta-analysis of 38 studies to integrate research on IPT, Cuijpers et al., (2010b, p.581) conclude "there is no doubt that IPT efficaciously treats depression" however, again they criticise the quality of the studies included, reporting only nine of 38 (24%) studies met all quality criteria, therefore

casting doubt on the findings. Chiesa and Serretti (2011) in a meta-analysis of 16 studies, identify that Mindfulness Based Cognitive Therapy in adjunct to usual care was significantly better than usual care alone for reducing major depression and helped reduce relapses. However, again they point to small sample sizes, non-randomized design of some studies and the absence of studies comparing MBCT to control groups that may affect validity of findings.

Driessen et al. (2010), in a meta-analysis of 23 studies involving 1365 individuals to assess the efficacy of Short Term Psychodynamic Psychotherapy [STPP] for depression and to identify treatment moderators, suggest that there is clear evidence that STPP is effective in the treatment of depression in adults. They report a significant reduction of depressive symptoms after STPP and these reductions were maintained at 3-month, 6-month and 1 year follow-up. Abbass et al. (2006) also support this view reporting that STPP treatments appear effective for a broad range of common mental disorders, with evidence of modest to moderate benefits that also include reductions in healthcare costs.
However, Jakobsen et al. (2011, p.7) in a study of six randomised controlled trials involving 648 individuals are more tentative, suggesting psychodynamic interventions "might" reduce depressive symptoms compared to treatment as usual. They are more hesitant perhaps due to the reported high risk of systematic errors (bias) and therefore cannot make definite conclusions.

2:9 Therapy and Duration

Cape et al (2010), in a meta analysis and meta-regression of 34 studies of treatment approaches for anxiety and depression in Primary Care involving 3962 patients, confirmed the effectiveness of three models of therapy: brief CBT, Counselling and Problem Solving Therapy for routine delivery of therapeutic intervention in primary care. They caution that effect sizes are low when compared to patients receiving these treatments over a longer duration and consider that for many patients brief treatments may not be sufficient. In a more recent study, Cuijpers et al. (2013b) suggest there is only a small association between the number of therapy sessions and improvement. They found instead that an increase from one to two sessions per week increased the effect size while keeping the total number of treatment sessions constant. They wonder if, rather than extending the length of therapy, it may be

advisable to concentrate more psychotherapy sessions within a brief time frame. Clarkin and Levy (2004) looking at the influence of variables on the effectiveness of psychotherapy, identify socioeconomic status influencing the length of stay in treatment, with lower educational background and low income being associated with a shorter stay in treatment.

2:10 Therapy and Age

There is no indication that age is a factor in determining effectiveness of psychological therapy for depression (Cuijpers et al., 2009). However, Cuijpers et al., (2009), point to their studies being undertaken with individuals with mild to moderate depression and that studies with those with severe depression were not included in their review. Likewise, Clarkin and Levy (2004) note that age does not seem to be an important factor in either therapy retention or treatment outcome, however they recognise that the elderly are more reluctant to seek psychological therapy than younger individuals.

2:11 Therapy and Antidepressants

Cuijpers et al. (2013a), in a meta-analysis of 67 studies with 5993 people considering the differences in effects between psychotherapy and antidepressant medication, found that pharmacotherapy was significantly more efficacious than psychotherapy in dysthymia, persistent mild depression, and pharmacotherapy was significantly more efficacious than non-directive counselling . However, psychotherapy was significantly more efficacious than pharmacotherapy in obsessive-compulsive disorder and psychotherapy was significantly more efficacious than pharmacotherapy with tricyclic antidepressants. However, the quality of the studies varied. Some studies used blinded assessors, some did not. Some had maintenance and booster sessions through a follow up period and some did not. The conclusions were summed up as "different kinds of antidepressants and psychotherapies have varying degrees of efficacy in treating depression and anxiety disorders", a finding which confirms that even current studies still struggle to specify clearly what works for whom and how in this field (Cuijpers et al., 2013a, p.146).

Wittink et al. (2010) identify that patients preferred counselling over medication and were uncomfortable with the side effects that came with medication. Patient preference is important given the finding that when people are offered a treatment that is congruent with their preference they are more likely to enter that treatment (Dwight-Johnson, 2001).

2:12 The evidence for Counselling for Depression (CfD)

NICE guidance sets the standards for the NHS for high quality healthcare and encourages healthy living (NICE, 2014). It has formulated guidelines for the provision of psychological therapy in the NHS and these guidelines recommend CBT for mild to moderate depression, along with IPT and Behavioural Activation (NICE, 2009). These guidelines also recommend counselling for people with persistent subthreshold depressive symptoms or mild to moderate depression if they have declined the other therapies and require the therapist to discuss with the person the uncertainty of the effectiveness of counselling and psychodynamic psychotherapy in treating depression. Currently NICE bases its decisions for which therapies for depression are available on the NHS on evidence from randomised control trials and systematic reviews. These approaches are considered the "gold standard" of research evidence (Beutler & Forrester, 2014). However the NICE guidelines do not take in to account other types of studies that provide evidence that shows that counselling is an efficacious intervention (Brettle, 2012). Whilst there are numerous RCT studies demonstrating the effectiveness of CBT (NICE, 2010), closer inspection reveals that often CBT is being contrasted with non-therapeutic interventions such as clinical management (Paykel et al., 1999; Scott et al.,2000; Bell & D'Zurilla, 2009); or G.P. care (Bortolotti et al.,2008); being on a waiting list (Cuijpers, 2007b); miscellaneous therapies, including relaxation and bibliotherapy (Gloaguen,1998); and psycho-educational techniques (Wolf & Hopko, 2008) rather than therapies that have an intended active therapeutic effect. However, in practice, CBT has become the recommended approach in the NICE (2009) guidelines for the vast majority of psychological problems, due to the volume of available experimental evidence, 46 studies, rather than a demonstrated superiority over alternative bona fide treatments (Stiles et al., 2006; NICE, 2010). In comparison the evidence base for the Humanistic Experiential Psychotherapies [HEP], which include Person Centred, Gestalt, Transactional Analysis and Emotion Focus Therapy among others, is much smaller. Indeed there were only

three studies related to counselling included in the previous guideline that were considered eligible for the review of evidence for the NICE guidelines in 2009 (NICE, 2010).

Despite Cooper (2008) identifying that there are hundreds of meta-analyses supporting the effectiveness of counselling, the significance of some studies was dismissed by the NICE Guideline Development Group (GDG) which considered which treatment to approve for the IAPT programme (NICE, 2009). For example, Stiles et al. (2006) was a non RCT study with 1309 patients, that compared CBT, Psychodynamic therapy and Person Centred Therapy in routine NHS settings using the CORE OM (an outcome measure) at the start and conclusion of therapy. They reported all the therapies showed an "averaged marked improvement and results were generally consistent with previous findings that theoretically different approaches tend to have equivalent outcomes" (2006, p.555). This study was excluded from the evidence review because there was no randomisation and no control group. Additionally, not all participants met the criteria for depression and there were other diagnoses rather than just depression included in the sample.

Another study that was excluded was undertaken by Marriott and Kellett (2009). This again was a non-RCT study comparing cognitive analytic therapy with person-centred and CBT. Findings report that CAT, PCT and CBT therapies delivered by the services appeared effective and equivalent, with the effect-sizes across the measures similar to those recorded in EBP trials. The study was excluded from guideline evidence review because it had no randomisation and no non-treatment group. Clients were allocated to a therapy according to the opinion of the screening therapist, as to what would be the most useful psychotherapy for the client to receive, but no information is given on how this decision was made. Further criticisms focused on the small sample size and that only 34% of participants had a diagnosis of depression.

Similarly in their RCT (n=464) Ward et al. (2000) compared the outcomes from groups of patients in non-directive therapy, CBT and usual G.P. care. The counsellors complied with a non-directive approach outlined in a manual that was developed based on the work of Rogers. The CBT therapists complied with a problem formulation and staged intervention approach outlined in clinician and patient manuals. All the therapists agreed to one hour of supervision for every six hours of patient contact time. Patients were offered 6 sessions up to a maximum of 12 on a weekly basis. General practitioners treated patients in their group according to

their usual practice. Participants were assessed at referral and at four and 12 months post-intervention. Participants were randomised between three study arms, those randomised to either psychological therapy or G.P. care and those who chose their treatment. Therapists were requested to tape sessions, but equipment malfunction and problems with client consent meant only 69% of therapists submitted tapes and two recordings of non-directive counselling from two therapists were rated as atypical which does cast doubt on the therapy being delivered. However, results report that both therapy groups improved significantly more rapidly than the usual care group in the first four months, while at eight months follow up the usual care group made up the difference. While the researchers paid a great deal of attention to the design of the study, the GDG excluded it as only 62 % of the sample met the diagnostic criteria for depression. Results from the sub-group of 62% were re-submitted for consideration as it showed a significant improvement for patients and this sub-group analysis was included in the GDG analysis for the NICE 2009 guidelines. Along with Ward et al., (2000), five other studies were included for review in the guidelines: Greenberg and Watson, (1998); Bedi et al., (2000); Simpson, et al., (2003); Watson, et al., (2003); Goldman, et al., (2006).

Greenberg and Watson (1998) compared the effectiveness of process-experiential psychotherapy (later called Emotion Focus Therapy [EFT]) with one of its components, person-centred psychotherapy, in the treatment of (n=34) adults suffering from major depression who were randomly assigned to either treatment. The experiential treatment consisted of the client-centred conditions, plus the use of specific process-directive gestalt and experiential interventions at client markers indicating particular cognitive-affective problems. The primary aim of the study was to see if the addition of the EFT interventions would be helpful or not, with a secondary aim to test the efficacy of PCT itself. The outcome was both groups improved significantly after treatment on all measures, with large pre-post treatment effect sizes and the EFT group reported superior effects at mid-treatment with regard to depression and at termination of therapy on the total level of symptoms, self esteem, and reduction of interpersonal problems. Whilst the EFT group seemed to improve more quickly, there was no difference between the groups at 6 month follow-up. There was no control group as such "therapists were used as their own controls" (1998, p.213) and each therapist had two clients in each treatment condition. Separating out the impact of the intervention from the qualities of the therapist relationship must be open to question and is difficult to assess. However, the finding was that both approaches were effective in the

reduction of self-reported depression scores. This evidence was considered by the GDG, but they urged caution in the interpretation of the findings as the sample size was small and there was no none-treatment control group.

In their study Bedi et al. (2000), compared the effectiveness of counselling and anti-depressants in an RCT that also had a patient preference arm. They report 103 patients participated in the randomised arm and 220 in the patient preference arm. They had hoped for 1600 participants, but could not achieve those numbers. They state it became apparent that when patients had a choice, the majority chose counselling over anti-depressants. Those patients who chose anti-depressants had a more severe depressive illness as rated by their G.P., although the researchers do claim that the baseline for both randomised and preference groups were similar which seems contrary to their stated summary of baseline values which shows 10% with a severe depressive illness as rated by their G.P choosing anti-depressants whereas only 4% with the same baseline diagnosis chose counselling. The aim in the study was to deliver a treatment as it might be delivered routinely in a primary care setting, but, the researchers report that some of the counsellors were more highly experienced than one might expect in a primary care setting so there is doubt cast as to whether it may be called "routine". There was a protocol for the drug treatment - but G.P.'s did not have to follow it and the counselling was not standardised. Counsellors could use whatever approach they considered best with their depressed clients, the number of sessions however, was fixed at 6. Patients were predominantly women with generally a diagnosis of moderate depression. The researchers describe the eight week follow-up took place at a median of 10 weeks - i.e. 2 weeks later and by this time the depression had resolved for 69 % of participants and there was no difference across the groups irrespective of how the patients had been allocated to them. The researchers expressed surprise that being able to have a preference had made no difference and suggest that as patients were only given a choice after they had refused randomisation this may have impacted upon their findings. To have a free choice at the outset may give a different result. However, yet again there is the Dodo bird finding that highlights the equivalence in the comparison of efficacy of different treatments. Bedi et al., (2000) found the two treatments, counselling and antidepressants, were equally effective at eight weeks. However, the GDG said the study was inconclusive because it had an element of client choice rather than being completely randomised and there was considerable difference in the base-line severity between the arms of the study.

Simpson et al., (2003) carried out a RCT study (n=145) comparing psychodynamic counselling in primary care with routine G.P. treatment. The focus of the study was on patients who had been depressed for six months or more. The results demonstrate only "very limited evidence of improved outcomes in those referred to counselling" (2003, p.229). However, there are discrepancies in the report. It is stated that at "the 6 and 12 month follow-up, there were no significant differences between the experimental and control groups on any of the outcome measures. However, there were significantly fewer cases on the Beck Depression Inventory (BDI) (Beck et al., 1961) in the experimental group than in the controls at 12 months" (2003, p.237). This would seem to suggest an important difference. Further, there were a higher number of more severely depressed patients allocated to the experimental group and this may account for the lack of improvement in this group. Also reported was "higher proportions of the initially mild and moderately depressed patients improved in the experimental group than the controls and were classified as 'non-cases " (2003, p.237). Given these points it is a harsh judgement to say there is only very limited evidence of improved outcome in the light of these findings.

In their RCT study (n=66) Watson et al., (2003) examined the differential effectiveness of CBT and process– experiential therapy [PET] in the treatment of major depression. In this study all clients were diagnosed with major depression. This again was a study that took great care in the design, maximising adherence to the model, trying to eliminate researcher allegiance and presenting a clear description of what was taking place in the study. Watson et al., (2003) report that clients overall, independent of treatment group, improved significantly on all the outcome measures at the end of treatment and believe that the results of this study demonstrate the efficacy of both PET and CBT in treating major depression. Further, although outcomes were generally equivalent for the two treatments, there was a significantly greater decrease in clients' self-reports of their interpersonal problems in those accessing PET. The GDG criticised this study because of its sample size and concluded that evidence from it was inconclusive about the effectiveness of the two interventions.

Goldman et al., (2006) replicates the earlier Greenberg and Watson (1998) study and also compared Person Centred Counselling with Emotion Focused Therapy [EFT]. They describe the therapy "builds on the client-centred relational framework by adding the use of particular process-guiding interventions to resolve particular types of emotional processing difficulties thought to underlie depressive symptoms" (2006, p.537). It is a more directive process than

PCC as it will both follow the client and also take the lead when needed. This study again has the therapists being their own control, ostensibly controlling for the therapist's personality and manner, which have been shown to be factors affecting outcome (Lambert & Bergin, 1994). However, it is acknowledged that it still does not counter bias and "it is possible that the therapists in the EFT condition could have communicated a stronger belief in that therapy" over the PCT and vice versa (2006, p.546). Nevertheless, this study reports that there was no difference in the proportion of people who recovered from depression in each treatment and that both treatments are effective in reducing symptoms, increasing interpersonal functioning, and increasing self-esteem, but improvement on symptomatology was superior in the EFT condition. Again the GDG urged caution in the interpretation of the findings as the sample size was small and there was no none-treatment control group.

Despite their caution however, the overall finding of the GDG was that there is evidence to support the effectiveness of counselling (IAPT, 2009). Apart from the Simpson et al., (2003) study, the evidence that supports the inclusion of counselling in the NICE depression guideline is generally RCT's of Person Centred Counselling or EFT (Sanders &Hill, 2014). However, it is only included for mild to moderate depression regardless of the fact that four of the studies: Greenberg & Watson, (1998); Simpson, et al., (2003); Watson, et al., (2003); Goldman, et al., (2006) were conducted on populations diagnosed with major depression.

Most recently the effectiveness of counselling is confirmed by a new meta-analysis (Elliott et al., 2013) that reviewed 200 outcome studies of Humanistic, Experiential and Person Centred therapies (HEP). It included 27 studies focussing on depression, comprising 1287 patients. Elliott et al., (2013) concluded that the HEP therapies are effective and findings show large pre/post client change, demonstrating that clients are able to use the therapy to bring about change. Also, once again the findings demonstrate that HEP therapies are statistically and clinically equivalent in effectiveness to other therapies.

2:13 The client perspective.

Much of counselling research is usually focused on outcome studies, therapist qualities and examining common factors, which are universal across therapies (Gordon, 2000). A great

deal of counselling research is viewed as testing theory, often from a scientific psychological perspective, using more quantitative methods (Gordon 2000). These methods are limited in the insights they can provide, because of the natural science paradigm limiting their understanding of the meanings of the therapeutic situation (Gordon, 2000). Emphasis has been given as to how far removed research is from practice and that precision is actually seen as being opposed to relevance (Rowan, 1992). For some it is the client who implements the change process and therefore it is highly relevant to consider what is taking place from their perspective (Rodgers, 2002). Indeed Clarkin and Levy (2004) believe that it is vital to further our understanding of the clients who seek psychotherapy, but note that often research looks elsewhere.

The earliest studies based on client experience were conducted in the late 1940's (Rogers, 1951). These involved clients writing accounts of their counselling when their therapy concluded or keeping journals for the duration of their therapy. The first study to use interviews to enquire about clients' experiences of counselling was undertaken by Mayer and Timms (1970), who interviewed 61 clients, mostly working-class women, to distinguish those who were satisfied with the help they had received and those who were not. However, four decades on, while most counsellors are still not informed by any psychotherapeutic research (Polkinghorne, 1999), in particular research from the client's perspective is even less well known (Manthei, 2005). Further, the literature indicates there are gaps where the client's view needs to be heard (Lambert (2007). Duncan and Miller (2000, p.170) complain that "the client has been woefully left out of the therapeutic process". The lack of client perspective within the body of knowledge is significant as the client's role is pivotal. It has been identified that client factors, strengths and supportive elements account for 40% of the outcome variance (Hubble et al., 1999). Furthermore, if factors such as hope and expectancy are added, and if it can be said that the client contributes as much to the therapeutic relationship as the counsellor, then it may be as Cooper states, "as much as 75% or more of the change in psychotherapy is due to client factors" (2008, p.60). This idea that the client is an active change agent who makes significant contributions to the change process is supported by Bohart (2000b) and challenges the common view that it is the therapist characteristics and actions that largely determine therapy outcome (Miller et al., 2008). Further, although many models and much research see the client as a passive recipient of therapy, in actuality the client attends therapy with their own agenda, hopes, expectations, aims and intentions (Macran, 1999). Similarly, therapy and therapist are evaluated by the

client with emphasis being placed as to how the therapy fits for them. Paulson et al., (2001, p.58) consider that the client holds "privileged access to certain aspects of counselling and they are often overlooked in counselling research". Without this knowledge it is impossible to know what is actually taking place in the counselling session.

2:14 Research on the Client View

The client perspective is the most direct source of information about what takes place in the therapy experience (Elliott & James, 1989). In their meta-synthesis of 40 years of literature on the client perspective they suggest the client may be "the only accurate source of information about the meaning and value of therapy" (Elliott & James, 1989, p445). They identify nine domains of client experience that appear in the empirical literature. Of these five domains pertain to clients' expertise of their own psychological processes during therapy: intentions, feelings, style of self-relatedness, style of relating to therapist, and central concerns. Two domains refer to clients' experiences of the action and person of their therapists, therapists' intentions and characteristics and 2 domains concern clients' experiences of change in therapy, therapeutic impacts and helpful aspects of therapy. However, in order to obtain as much information as possible, they also report a blurring of the client and researcher perspectives and highlight that it is possible that relying on indirect, observer measures of client experience gives no guarantee that these correspond to actual client experiences and further limitations may occur when relying on instruments and content coding schemes developed to measure what researchers, not clients-think are important client experiences (Elliott & James, 1989).

Hodgetts and Wright (2007) agree with Elliott and James (1989) that we cannot fully understand how psychotherapy facilitates change without asking clients about their experiences. In their research, Hodgetts and Wright (2007) do not say how many papers are reviewed or the rationale for choosing them other than they are related to client perspectives. However, a range of studies are discussed where clients' views and experiences of different therapies, or where the individual components within a therapy, are the primary sources of data. In their survey Hodgetts and Wright (2007) report the client's perception has proven to be a rich and useful source of information which is still overlooked and they identify five core issues: helpful aspects of therapy; therapist advice and problem solving; client's

understandings / expectations of approach; reflexive aspect; e.g. self-disclosure, and processes developed from bottom up enquiry. They consider that results reaffirm the findings that clients who experience their therapist as personable, caring and competent will have a more favourable outcome.

2:15 Why the client's view is not considered:

The predominant goal of psychotherapy and counselling is change. However change is often discussed in the research literature without it being defined and different models of therapy have different ideas on how change occurs and what changes take place (Carey et al., 2007). Although the client is identified as the active change agent (Bohart & Tallman, 2003), the client's role in defining change is under-estimated or ignored, with priority given to the therapist view or even to the researcher's analysis.

Although Elliott and James (1989, p.445) view the client as "the only accurate source of information about the meaning and value of therapy" they then go on to report that clients are not perfect sources of information. They suggest that clients may not recall events in therapy or will limit or distort the information they share with the researcher. They imply that external influences or pre-existing beliefs may bias client reports and that further, a lack of vocabulary or idiosyncratic understanding reduce the reliability of their input. Although Elliot & James (1989) acknowledge that the client perspective is the most direct source of information about their therapeutic experiences they maintain that the best use of client perspective data is to augment data from other sources or to assess the validity of therapist and observer ratings.

It is possible the greatest reason that client views are not included is due to "researchers' methodological or theoretical shortcomings" (Hodgetts & Wright, 2007, p.158). Beliefs firstly about the necessity for "pure" quantitative research and secondly unchallenged doctrines regarding non-contamination of the therapeutic setting have become obstacles to obtaining the clients' viewpoint (Hodgetts & Wright, 2007). However, Hodgetts and Wright (2007) in their article discussing a range of studies that explore the role that clients play in research, also cite clients being unable to make accurate judgements, being unaware of therapy usefulness, being biased, struggling with recall and unable to articulate as possible

barriers to their involvement. This identification judges the client contribution as lacking credibility and intimates that the therapist's viewpoint is more knowledgeable, meaningful, better informed and of more use. This view reinforces that of McLeod (2001) who suggests research on client experience is of limited value as clients are not aware of significant therapeutic processes. Some consider that this is a return to Freudian concepts, whereby clients are thought to be largely unaware of the processes causing their problems and therefore there is little point in asking their opinion about how their therapy is progressing (Macran et al., 1999). Others identify that clients are not seen as active thinkers who can generate their own solutions in tandem with the therapists, instead they are seen as passive or dysfunctional (Bohart & Tallman, 2003).

However, it is argued that for evidential, political and conceptual reasons it is important for psychotherapy researchers to consider clients' perspectives (Macran et al., 1999). More recently emphasis has been placed on seeking the views of those who use services, reflecting the socio-political change whereby the focus is on listening to people's needs and views (DOH, 2007). In terms of real world research, to fully understand the effects of psychotherapy and the outcome of its functional and social impact on clients' lives it should be evaluated through the perspective of the client as psychotherapeutic techniques have no meaning apart from those attributed to them by the participants (Macran et al., 1999). Further, Heatherington et al., (2012, p184) reiterated "clients do have opinions on their therapy and can verbalise them" and make sense of the changes brought about by their therapy.

2:16 Differences between therapist and client reports of therapy:

Norcross and Lambert (2006,) warn against researchers being "therapist centric". It has been noted that the client's view of the therapist and the therapy is very different from the therapist's view (Metcalf & Thomas, 1994). In their qualitative study exploring client and therapist perceptions of solution focused brief therapy, Metcalf and Thomas (1994) note that clients attribute success to the therapist, but the therapists perceive themselves in a more passive, observing role. Evidence shows it is not sufficient to accept the counsellor view of what takes place in therapy as it has been repeatedly found that there are differences between the client and therapist views even when considering the same session (Llewelyn, 1988;

Paulson et al, 2001; Manthei, 2007; Bachelor, 2011). According to McLeod (2001), counsellors familiar with the therapy process are likely to report from an "insider" perspective, clients however, will have their own experience of the process, and this may well challenge the assumptions of the therapist and also of the theoretical basis of the model of counselling being used. Llewelyn (1988), in a study that explored 40 therapist-client pairs asked participants to record their views concerning the helpful and unhelpful events after each session of psychological therapy. The study identified how clients' and therapists' perceptions of what takes place in therapy differ. Llewelyn (1988) feels it is necessary to consider the views of both clients and therapists for a full appreciation of the change process. However, the study gives little evidence of how therapist and client views are related, whether it matters and how this might or might not impact on outcome.

Bachelor (2011) performed exploratory factor analyses on three measures of the therapeutic relationship in a study that explored clients' and therapists' views of the relationship, exploring similarities, differences and any connection to therapy outcome. The study identified that clients are more concerned with the helpfulness aspects of the therapeutic relationship and a common view of goals and tasks, whereas their therapists attributed greater importance to client contributions to the therapy. Bachelor (2011) suggests that therapists do not take for granted that they see things in the same way as their clients do and advises therapists to invite their clients to contribute their views on their therapy, introducing the idea of team work.

Paulson et al (2001) suggest the client contribution is valuable particularly as it does often differ from the therapist. Hearing the client perspective plays an important role in challenging therapist' assumptions that they know what the client is experiencing (Elliott & James, 1989). It is only the client who can say what the experience is like for them and therefore it is misleading to make inferences about the meaning of the psychotherapeutic experience of another individual (Macran,1999). It is therefore erroneous that so much weight is given to the therapist side of the dyad when there are two people involved in the activity, the client and their problems being pivotal to the therapeutic encounter. Mohr (1995) notes that negative outcomes are seldom reported, raising the issue of the profession feeling daunted by the possibility of the client's negative perception of therapy and therefore shies away from asking.

2:17 Change process research

Research on the client experience is studied in different ways (Gordon, 2000; Elliot, 2008). Change process research (CPR) is the study of the processes by which change occurs in psychotherapy (Elliott, 2010). It examines, identifies, describes, explains and looks at predicting the effects of the processes that bring about therapeutic change (Elliott, 2010). Its aim is to establish the existence of a causal relationship between therapy and client change.
The process- outcome paradigm of using in-therapy process variables to predict outcome is one of the most common forms of CPR counselling research. This type of research has focused most often on the therapeutic relationship (Bachelor, 1995; Fitzpatrick et al., 2009; Bachelor, 2011; Oliveira et al., 2012; Bedi & Duff, 2014).

2:18 Studies exploring the client view of the therapeutic relationship

Table 3: Studies exploring the client view of the therapeutic relationship

Study	Location	Methodology	Points	Findings
Bachelor, A. (1995). Client's perception of the therapeutic alliance: A qualitative analysis. *Journal of Counseling Psychology, 42*, (3), 323-337.	Canada	Phenomenological study exploring clients' perceptions of the therapeutic relationship	Some of the characteristics differed in definition. For example, attentive listening for some meant the therapist was caring and for others it meant they were involved and committed to participate with the tasks of therapy.	Clients were categorized into three groups: nurturing, insight-oriented, and collaborative. Each category represented a focus of indicated characteristics, which were summarized as: 1) therapist (16 variables, e.g. non judgemental, attentive listener, understanding, competent, facilitative attitude); 2) client (10

				variables, e.g. trusts therapist, discloses self, explores self, expression of emotion); 3) mutual (7 variables, e.g. choice of goals and means, authenticity, exploratory activities); 4) climate (5 variables, e.g. trusting, professional, friendly, equal); 5) effects achieved (4: self understanding, change in attitudes and behavior, well being.
Fitzpatrick, M. R., Janzen, J., Chamodraka, M., Gamberg, S. & Blake, E. (2009). Client relationship incidents in early therapy: Doorways to collaborative engagement. *Psychotherapy Research, 19*, 654–665. doi:10.1080/10503300902878235	Canada	The purpose of this Consensual Qualitative Research study was to elaborate how (15) clients understand the development of the alliance and to highlight aspects of the process particular to depressed clients	The interviews were conducted after the third session of therapy and may be different from alliance maintenance processes that are typical of more developed relationships in later treatment.	Participants were able to identify the importance of their own activity (disclosing and working with therapist input) as their collaboration in the incidents. Clients reported their therapists facilitating new thoughts or actions, providing

		working with experienced therapists. Fifteen participants described critical incidents in early therapy that influenced how they understood their working relationships with therapists.	Recognition that different approaches to coding that are inevitable when different teams conduct qualitative analyses.	support, communicating understanding, and remaining nonjudgmental.
Bachelor, A. (2011). Clients' and therapists' views of the therapeutic alliance: similarities, differences and relationship to therapy outcome. *Clinical Psychology and Psychotherapy. 20*(2), pp 118-135.	Canada	This study investigated, first, the components of the alliance that are relevant to the therapy participants; second, their relationship to post-therapy outcome; and third, the relationships between participants' alliance constructs. Exploratory factor analyses were performed on clients' (n = 176)	Factors suggested that despite similarities, the therapy partners' views of the alliance differ in important ways. Compared with therapists, clients appear to place greater emphasis on helpfulness, joint participation in the work of therapy and negative signs of the alliance.	Results suggested that clients view the alliance in terms of six basic components (Collaborative Work Relationship, Productive Work, Active Commitment, Bond, Non-disagreement on Goals/Tasks and Confident Progress) five of which were found to predict client-rated and/or therapist-rated post-therapy outcome. Results for therapists suggested four basic components

		and therapists' (n = 133 observations).		(Collaborative Work Relationship, Therapist Confidence & Dedication, Client Commitment & Confidence, Client Working Ability), of which three predicted post-therapy outcome.
Oliveira, A., Sousa, D. & Pires, A.P. (2012). Significant events in existential psychotherapy: the client's perspective. *Existential Analysis 23*(2), 288-304.	Portugal	Three ex-clients were interviewed about significant events occurring within existential therapy. Data was analysed through a descriptive phenomenological method.	Some interviews took place 2 years after the conclusion of therapy. Interviews were only 30 minutes long which is short for a phenomenological study.	All participants identify a powerful therapist, an authentic alliance, a non-judgemental environment, validation of subjectivity and a cooperative approach. Two participants also identify therapist disclosure and reflection/experiential restructuring events.
Bedi, R. P. & Duff, C.T. (2014). Client as expert: A Delphi poll of clients' subjective experience of therapeutic alliance formation variables, *Counselling Psychology Quarterly, 27*, (1), 1-18. doi: 10.1080/09515070.2013.857295	USA	36 clients participated in a three-round-modified Delphi poll in which the subjective importance of 74 client-derived, common alliance	This study only addresses the actual process of therapeutic alliance formation indirectly. What is offered is an account of client subjective	Variables related to validation and asking about parts of the client's life other than the presenting concern were considered as most important by at least one-third of the

		formation variables was rated using a six-point scale. This study gives a rank-ordered representation of the elements believed by the participants to be most helpful for an alliance formation.	experience of variables related to counselling and psychotherapy that seem to the participants in this study to be associated with establishing a solid "working relationship" with their mental health professional.	sample. Validation is characterized by counsellor behaviours such as validating client experience, normalizing client experience, identifying and reflecting back feelings, paraphrasing what clients say, making encouraging comments, asking about non-problematic areas of clients' lives, agreeing with clients and making positive comments about client.

2:19 What clients consider to be helpful to them in therapy.

Significant events research is another form of CPR that looks at client-identified important moments in the therapy process where within-session events are delineated and classified into types, either helpful or hindering. One such was undertaken by Llewelyn (1988), the first study to use the HAT form (Appendix 14). This was a mixed methods study of the specific therapeutic ingredients as identified by therapy participants. The study was "oriented towards discovery" rather than testing hypotheses (1988, p.223). Participants identified four helpful therapeutic ingredients; insight, reassurance/relief, problem solution and personal contact. Differences in perception were found between clients who most often felt that reassurance / relief were most important and therapists who most frequently report "insight" as being most

important. Results are also compounded when it is considered that both client and therapists in session saw it differently and then afterwards coders put their interpretation on it, possibly rendering results that are quite different from what originally took place.

Elliott & James (1989) report clients' helpful experiences of therapy as follows:

Task/Problem-Solving
gaining self-understanding, insight, guidance, self-awareness, learning to take responsibility, facing reality
Interpersonal/Affective
unburdening, expression, reassurance, confidence, relief, feeling understood, instillation of hope
Treatment-Related Changes
increased self-esteem, symptom relief, improvement in interpersonal relationships, greater sense of mastery.

Elliott and James (1989) also found aspects such as facilitative therapist characteristics, permitting client self-expression, experiencing a supportive relationship and also the therapist encouraging practice outside of a session were reported by clients as being helpful to them. This study was an amalgamation of results from a range of disparate studies - factor analysis from questionnaires, qualitative analyses of free descriptions of therapy, content analyses of free descriptions of therapy, quantitative data on most frequently or strongly endorsed questionnaire items and definitions of observer-perspective process measures of client experience. Elliott and James (1989) acknowledge it is a representative review rather than an exhaustive one, however it is not clear how examples were chosen or the process that guided the choice. Further, there was a blurring of client and researcher perspectives. This blurring took the form of (a) relying on indirect, observer measures of client experience when there is no guarantee that these correspond to actual client experiences; and (b) relying on instruments and content coding schemes developed to measure what researchers - not clients - think are important client experiences.

In a review of four qualitative papers of consumers evaluating their mental health treatment Glass and Arnkoff (2000) identified clients found the most helpful element to be a therapist who listens and shows understanding. Clients also valued a collaborative relationship where

the therapist sees beyond a diagnosis to the whole person. Interventions used/issues addressed and helpful experiences outside of the mental health system were also seen as helpful. Specific interventions were not identified; rather, clients referred to the value of therapists' ability to deal with difficult and strong emotions while showing a willingness to explore and provide comfort.

Timulak (2007) conducted a meta-synthesis of findings from seven qualitative studies focusing on client-identified impacts of helpful significant events which are analysed with application of meta-analytical procedures that are described as resulting in a rigorous secondary analysis of primary qualitative findings. This was not an attempt to measure effect sizes as in a quantitative meta-analysis, but a qualitative analysis that was used to obtain a detailed description of a phenomenon and to identify central features or core categories of the studied phenomenon. The aim of the meta-synthesis was to identify core categories of client-identified impact of helpful events in psychotherapy across several studies with the key question being what kinds of impacts do clients identify as being helpful? Timulak (2007) identified nine core categories of helpful events: (a) awareness/insight/self-understanding; (b) behavioural change/problem solution; (c) empowerment; (d) relief; (e) exploring feelings/emotional experiencing; (f) feeling understood; (g)client involvement; (h) reassurance/support/safety; and (i) personal contact and reported that similar processes and impacts were found across different therapeutic approaches. No single finding in any of the primary studies seemed to contradict other findings in the primary studies, however, categorising the findings is somewhat artificial because some categories were hard to allocate only to only one meta-category.

2.20 Summary of Helpful Events:

The studies discussed outline factors that clients generally find helpful in their therapies. Most research in this area is conducted via single qualitative studies. Meta-syntheses are rarer giving a different overview. Clients may be interviewed either at the end of therapy or part-way through, or with the use of a post session questionnaire such as the HAT form.

The evidence indicates that clients consider that a therapist who listens and shows understanding is viewed as most helpful. Clients value a healing relationship where they are seen as a whole person. Also being with a therapist who can "hold" difficult emotions whilst

being supportive is key. Client value being able to unburden themselves, gaining self-understanding, insight, self-awareness, facing reality and learning to take responsibility for their problems. They see counselling as a place to gain reassurance, confidence, relief and hope. Further gains are in increased self-esteem, symptom relief, improvement in interpersonal relationships and a greater sense of mastery. Since the Elliott and James (1989) meta-synthesis up to current day studies such as Bedi and Duff (2014), findings repeatedly point to clients needing to establish a working relationship with their mental health professional and this relationship is identified by clients as a key factor in terms of helping them meet their needs. Similarly, empathy is reported as one of the most consistently reported predictors of satisfactory therapy outcome. However the findings are to be viewed with caution in that there is a danger that clients may make errors in attributing benefit to their therapy when in fact the result is due to other extra-therapy events, or clients may simply be unable to assess or express what has taken place. Additionally, poor interviewing technique or weak analysis may affect results.

2:21 What clients consider to be unhelpful to them in therapy:

Whilst many clients report substantial improvements resulting from their therapy (Elliot et al., 2013) not every client has a positive experience and some find their therapy has not been helpful to them. However, there is much less research completed on hindering aspects of therapy than on what is helpful (Henkelman & Paulson, 2006). It has been identified that often clients are reluctant to criticise their therapy or report to their therapist what they feel are hindering experiences (Paulson et al., 2001; Henkelman & Paulson, 2006; von Below & Werbart 2012). This is possibly due to the deference a client may feel for their therapist and a fear that being negative towards their therapist may harm their therapy (Rennie, 1994). Therefore it is pertinent to recognise that even whilst all may seem well in the therapy, it may be that certain aspects are not being addressed (Paulson et al., 2001).

In a recent Grounded Theory study exploring the views of seven clients who were dissatisfied with their psychotherapy, therapists were described as passive and indifferent (von Below & Werbart 2012). Although the authors stated they used "Grounded Theory", there are deviations from the methodology in that the interview strategy was constructed in advance and there was no continuous sampling to deepen the categories. The findings they report are

that dissatisfied patients lacked confidence in their relationship with their therapist describing them in negative terms and concluding that they lacked direction.

It has also been reported that therapists have been found to be distanced, cold, uninvolved, rigid, and critical, or conversely over-involved, seductive, evoking undesirable feelings and thoughts, promoting an overheated relationship, or perpetrating boundary violations (Elliot &James, 1989; Pope & Tabachnick, 1994). Indeed it has long been found that a poor therapeutic alliance and a critical and judgemental therapist are experienced as being most unhelpful (Glass & Arnkoff, 2000). In their summary of mental health treatment Glass and Arnkoff (2000) discuss that other unhelpful events included therapists' superiority and making assumptions, as well as showing a lack of respect to the client. The therapist's reluctance to explore difficult areas, e.g., abuse, or to communicate disbelief about the client's experiences also hindered therapy. It was also suggested that being viewed as a "mental health patient" was de-personalising and that the medical view took priority over the client's opinions and wishes (Glass & Arnkoff, 2000). Although, the majority of the papers they analysed were relating to in-patient situations, the finding common to all the work they reviewed was that hindering aspects of therapy either stemmed from problems with therapist attitudes or difficulties in the therapeutic relationship. This identification is further confirmed by Mohr (1995) who considers that a lack of empathy, underestimation of the severity of the patient's problems, negative counter transference, poor therapist technique, high concentrations of transference interpretations, and disagreement with the patient about the therapy process all have been associated with negative outcome.

In a case study of six people engaged in person centred therapy with the aim of identifying narrative processes occurring during moments in therapy perceived by the client as either helpful or hindering, Grafanaki and McLeod (1999) report that unhelpful aspects are usually connected with negatively perceived events, where the therapist is felt to misunderstand or be detached or judgemental. They suggest that the way in which clients experience events in therapy primarily depends on how they are received by the therapist. The therapist reaction will open up or shut down a client's exploration. However, clients in this study were asked to generate a total of 18 helpful and 18 hindering events, a process that may well direct the client to follow the researcher's agenda and perhaps to find answers to satisfy the researcher, rather than reflect their actual experience.

Paulson et al. (2001, p.56) used Concept Mapping to "spatially represent unknown latent relationships amongst variables" in a study exploring clients hindering experiences in counselling. They asked two open ended questions 1) What was unhelpful about your therapy? and 2) What would have made your counselling more helpful? Results from 28 participants identified concerns about vulnerability, lack of commitment and motivation, uncertain expectations, lack of connection, barriers to feeling understood, structure of counselling, negative counsellor behaviour, insufficient counsellor direction and a lack of responsiveness. There were two data gathering sessions. Initially eight clients were interviewed and then a second sample pool of 20 clients sorted and rated the initial eight clients' responses. Three themes emerged from this process that were felt to hinder the counselling experience: client factors; structural and external barriers; and counsellor variables. There was no explanation given in the paper as to why this methodology was chosen and the potential for data to be missed seems great. What they describe is the second sample of participants analyse the first sample's responses and this is then mapped by the researchers. In considering how the research methodology impacts on the findings, it would seem an extraordinarily complicated way to obtain results that has real potential to obfuscate findings and a missed opportunity to ask the second sample participants about their own views, rather than just their interpretation of the initial eight interviewees.

2:22 Summary of unhelpful events:

Research on hindering experiences in therapy is difficult and more complex than studying helpful events and the body of research in this area is much smaller. The evidence presented here indicates that clients are deferential to their therapists and therefore are often reluctant to criticise them. However, findings suggest that clients are dissatisfied when the therapeutic relationship is less than satisfactory and their therapists are perceived as cold and dispassionate. Feeling judged and criticised by their therapist is viewed by clients as the most unhelpful aspect of therapy. Likewise, being seen as a "diagnosis" instead of as a person and a lack of empathy, lack of respect shown to the client, high concentrations of transference interpretations, and disagreement with the patient about the therapy process as well as boundary violations all contribute to unhelpful perceptions of the therapy experience.

What emerges is an identification that often the therapist is unaware their client is not feeling helped and the client is reluctant to raise the issue. This creates an environment where things are left unsaid and therefore unaddressed. As counselling is a relational activity anything that undermines the relationship should be addressed and to enable the client to say what is not being said will be key in promoting the development of a therapeutic relationship.

2:23 Sequential process design:

The micro-analytic research of sequences of client and therapist in-session behaviours, called the sequential process design, is another form of CPR. There are examples such as studies that explore events in the client's moment to moment experiences in session (Henretty et al., 2008), or client's perceptions of change over the period of therapy (Berg, et al., 2008). Other studies use hypotheses around therapeutic processes such as gender (Farber & Pattee 2008). Studies may focus on the minutiae of the session with narrative analysis of the spoken word (Levitt & Piazza-Bonin, 2011), or look at a specific situation in the session (Israel et al, 2008), or reflections over all the therapy (Feifel & Eells, 1964)). Data may be collected through interview or questionnaire, prior to sessions (Lambert, 2007), or during, for example via tape-assisted Interpersonal Process Recall (Elliot, 1986), or before, during and post session (Stiles et al., 2008). Each method provides different aspects of data from global overviews of a whole treatment to the specificity, immediacy and richness from the intricacies of within session events.

In summary, the process-outcome design of research is the most used design of CPR with the therapeutic relationship being the aspect most studied (Elliott, 2010). The two most common perceived helpful aspects of therapy were facilitative therapist characteristics and client self-expression, but experiencing a supportive therapeutic relationship ,achieving insight, and the therapist encouraging extra-therapy practice were also reported to be helpful as well (Bachelor, 1995; Gutheit, 2000; Elliott, 2008; Gostas et al., 2012; Heatherington et al, 2012). Conversely, a poor therapeutic alliance and a critical and judgemental therapist were seen as being most unhelpful (Elliot &James, 1989; Pope & Tabachnick, 1994; Glass & Arnkoff, 2000; von Below & Werbart 2012).

2:24 Client characteristics:

While every client is unique, the multifarious characteristics of the client have the potential to influence the therapeutic encounter and subsequent research (Clarkin & Levy, 2004). External variables such as social support, finance and education, or intimate aspects such as intelligence, characteristics that are fixed such as gender or ethnicity and psychological characteristics, numerous personality traits and attitudes will all impact on the therapy relationship (Leibert, 2005). A history of sexual abuse will have an impact on the success of the therapy as will the degree and duration of impairment and a client's motivation to engage in the therapy (Bukh et al., 2013). Further, Clarkin and Levy (2004) see the client's quality of relating in interpersonal relationships as an important factor as is the nature of the client's attachment style, both of which will impact the therapeutic alliance. Eames and Roth (2000) also comment that clients who had security in attachments were able to have a good alliance with their therapist. However, for clients who were anxious or avoidant in their attachments, engaging in therapy was much harder for them. Both Eames and Roth (2000) and Clarkin and Levy (2004) acknowledge the results they base their summaries on are not always consistent. Indeed, this is not surprising given the individual and subjective nature of the issues being discussed. Anderson (1998) attempts a taxonomy of personality constructs and acknowledges that the definitions may be too broad or general. However, fundamentally the attempt is flawed when considered in terms of numerous confounding variables and all of the characteristics that will interact with the similarly limitless variables of the therapist, which in response, will likewise interact with the client's making a myriad of responses each of which is individual and each of which is unique.

2:25 User Involvement in Research

User involvement has become a central component of NHS policy (Telford et al., 2002). Yet despite the best of intentions it does not carry into practice and its implementation is patchy. Possibly this is due to a lack of information, financial and time constraints, concerns over representativeness, and a resistance to the idea of users as experts (Tait & Lester, 2005). However there is a belief that user involvement is a worthwhile activity with a range of practical and ethical benefits, even if changes to practices need to be made and challenges to professional territory overcome (Davies & Maguire, 2014). The importance of inclusion, autonomy and independence is central to empowering an individual's direct capacity and

opportunity to initiate change (Beresford. 2002). It has been argued that patient knowledge is a form of evidence and politically user views and experience are key sources of evidence for policy and practice development (Consumers in NHS Research, 2000; Involve, 2014).

2:26 Summary.

This literature review has described the struggle counselling has had to represent itself in research that is acceptable to those who approve psychological therapy for the NHS. The difficulty of obtaining high quality research in a field beset with the variables of human beings is evident and compromises the trust that can be placed in that research. The drive to obtain evidence of best practice to guide counsellors in their work with clients is laudable and is reflected in the increase in research since the Layard report in 2006. However, the dissemblance between the factions that hold differing philosophies between randomised controlled trials and the qualitative focus on subjective life experience maintains an ongoing tension in the profession, with each highlighting the limitations of the other. This review of the literature has highlighted the effectiveness paradox of counselling and the difficulties of carrying out research in this field. It has outlined the research on psychological therapy for depression and underscored the increase in people suffering with depression necessitating the formation of the IAPT programme set up to meet their needs. The review has identified how the need for a new model of therapy, CfD, was developed to counter the threat of losing counselling in the NHS. This review has also outlined the body of literature pertaining to the client view of counselling and explored why there is a gap in this corpus. To date, there is no research on the effectiveness of the model of CfD, neither is there any research on this model from the client perspective. The review has identified how this study of the clients' view of CfD will add to the knowledge base in this area, but crucially this study will also add vital knowledge about CfD that is timely and necessary in a field that had not been covered before.

2:27 Reflections - Traffic Jam

At the time of writing this Literature Review I was also seeking ethical approval for this study. Gordon (2000) describes many of the reasons why the client's view is looked at less

often than other areas of counselling in research, but I found there are other aspects that also deter and discourage the pursuance of this type of research. I can add to his list my own frustrating experience of going through the NHS ethical approval process, struggling with the content of the form, the differing guidance, the technology and the exasperations pertaining to that, the reluctance of other counsellors to support the study, and the problems in the research design that whilst protecting the therapeutic relationship caused huge difficulties in recruitment. I sent emails and made phone calls to other professionals that went unanswered. I spent hours trying to find IAPT services that had adopted the model when not all services had. I attended distant meetings where the room was full of developers and trainers of CfD but no practitioners, all of which made the recruitment of participants hard. Then the lack of information from counsellors regarding participant numbers kept me unsure of what was happening and created a tension for me between wanting to know where things were up to and not irritating the counsellors with frequent calls. I felt uncomfortable having to chase for information all the time. Only one counsellor provided updates, while with the others I felt very much out of sight and out of mind. Similarly, keeping up to date with where clients were in their therapy duration and timing their interview appropriately was very difficult because I was so remote from the process. I have had to be persistent in chasing for answers. It does not come easily to me to push forward my own agenda but this has been necessary to facilitate the completion of the study. Once I met the clients, I have to say that was the easiest and most delightful part of the whole process. However, reaching them was like climbing Everest in roller skates.

Chapter 3 Methodology

3:1 Overview of Methodology

Traditionally research is divided into two paradigms; empirical, analytical quantitative research and qualitative research which is founded on a holistic world view that is based on there being no single reality (Moser, 1999). Quantitative and qualitative paradigms have different philosophic premises, purposes and epistemological roots (Morse, 1994). Theoretical frameworks are grounded in an underlying philosophy that can guide practice based on assumptions and values that are explicit (Cody, 2013). The epistemological stance helps to explain how we believe we know what we know. There is a distinction between objectivist/positivist (quantitative) research and constructionist/subjectivist (qualitative) research and this will now be considered.

3:2 Positivism and Post-positivism

Comte (1788-1857) is often seen as the founder of positivism (Butts & Rich, 2011). Others believe the concept has been around much longer and was found in the writings of Francis Bacon (1561-1626) centuries earlier (Crotty, 1998). The stance of positivism offers ideas of clear, value-free, accurate knowledge of the world (Crotty, 1998). It is an authoritative view with a belief in the validity and generalisability of findings based on properties that can be measured or counted. Positivism claims to be "scientific" research because it is not arrived at speculatively, but instead is grounded firmly on what is *posited* - as in the word "given" which in Latin is "datum" or as plural, data. (Crotty, 1998). Positive science holds the belief that it is possible to identify reality with certainty and looks to scientifically establish facts based on observation, experiment and comparison, where objects in the world have meaning prior to, and independently of, any consciousness (Crotty, 1998).

A challenge to the precision of positivism came with the development of post-positivism. This position is one of probability rather than certainty (Crotty, 1998). Post-positivism does not limit knowledge only to that which can be empirically verified and argues that reality can only ever be approximated (Denzin & Lincoln, 2000). A key difference between the two stances is that positivism stresses theory verification whereas post-positivism is concerned with theory falsification (Ponterotto, 2005). A common goal of the two stances is to

emphasise the cause and effect links of phenomena that can be studied and measured, with both positions requiring the researcher to be objective and detached from the material under study (Ponterotto, 2005). The frameworks of positivism and post-positivism underpin quantitative research.

3:3 Post-Modernism

Even the attenuated form of post-positivism however, is rejected by proponents of the post-modernist position, where post-positivism is viewed as a "kind of science that silences too many voices" (Denzin & Lincoln, 2000, p10). According to post-modernists there is a need to capture important aspects of existence such as individual beliefs, cultural and social contexts, power differentials, issues of gender, class and economic influences, all of which need to be explored through using an approach that can question what is taken-for-granted. Post-modernism is grounded in Constructivism /Interpretivism in which a relativist position holds that there are multiple realities; all of which are valid (Ponterotto, 2005). It takes a view that findings are versions of external reality (Bryman, 2008). Crucially, this stance acknowledges that reality is constructed by the research participant and that the researcher is involved and will impact upon the interaction and subsequently the research (Ponterotto, 2005). The interaction between researcher and participant is central to meaning making with the belief that they both co-construct the findings of the study from their joint interactions (Ponterotto, 2005). It is a position that recognises uniqueness and diversity. A position that acknowledges reality is different for everyone and will change over time and that what we know has meaning only in specific contexts and situations (Ross, 2004). Here the emphasis is on hermeneutics, narrative traditions, discourse, critical social theory and feminism (Butts &Rich, 2011). Post modernism is a pluralist approach and out of this grew non-empirical modes of inquiry, qualitative methodologies that could give a mechanism to the researcher to gain greater understandings of unique realities.

Differences between qualitative and quantitative research are identified as follows (Guba and Lincoln, 1994, p.105):

- Quantitative research does not account for context. It is based on deliberately chosen sets of variables with random selection and experimental controls and deliberately

excludes all other variables which may have an effect on the outcome. Qualitative methods encompass specific contextual knowledge.

- Quantitative methods exclude meaning and purpose. Qualitative research accepts that human behaviour cannot be understood without an appreciation of the meaning and purpose inherent in every person.
- Quantitative methods align themselves to the etic theory of an outsider uninvolved and distant from his studied objects. Qualitative methods uncover emic or insider views.

The data gained from each method also differs. For example quantitative data is data in numeric form whereas qualitative data is usually collected in the form of language or text, offering descriptive life experiences gained directly from those who have experienced the topic being researched (Taylor et al., 1995).

Qualitative research has been described as a situated activity that locates the observer in the world (Denzin & Lincoln, 2000). Table 4 presents a guide to the development of qualitative research showing the development in the understanding of social complexities, but also highlighting the difficulty of characterising qualitative research.

3:4 Development of Qualitative Research. (Denzin & Lincoln, 2005)

Table 4: Development of Qualitative Research

Period	**Phase**	**Stage of research development**
Early twentieth century	The traditional period	Studies looking at life through a positivist lens.
Post second world war - 1970	Modernist phase	Studies begin to be more rigorous and are still tending towards the positivist, but less so than the traditional period.
1970-1986	Blurred Genres	This period sees a great

		variety of epistemological and ontological approaches explored as the base for qualitative studies. Still with a tending towards positivism, but now with the introduction of interpretative ways of working and the understanding that researchers interpret their participants interpretations.
Mid 1980's onward	Crisis of Representation	Here, researchers become aware that their writings reflect only one way of representing reality. There is recognition of the limit in the scientific authority of research. Following on from this the next periods are referred to as a "Triple Crisis" - of representation, legitimation and praxis. An understanding forms that it is not possible for the researcher to fully capture lived experience and that the link between experience and text is problematic.
Mid 1990's	Postmodern period of experimental ethnographic writing	An awareness of different ways of representing research participants - often referred to as "the other". The concept of

		the aloof observer is abandoned.
1995-2000	Post-experimental enquiry	This period sees the emergence of the Alta Mira Press publishing new forms of qualitative writing. Pushing boundaries and developing new ways of expressing experience.
2000-2004	The methodologically contested present	Typically this period sees much debate about how qualitative research should be conducted and sees the publication of two new journals *Qualitative Inquiry* and *Qualitative Research.* There is criticism of the quality of qualitative research studies causing tension and the need to rethink strategies.
2005 -	The fractured future	This period sees a reassertion of the values of traditional science and a challenge against qualitative research.

The categories above are arbitrary and there is overlap and much debate around what takes place and when (Cooper & White, 2012). However, ways of working from the historical periods do not just stop; they continue and are used alongside newer ways. What is evident is that there is a multiplicity of ways that research can be performed, represented and interpreted.

3:5 Worldview

Researchers in all research adopt a worldview that guides their inquiries (Cresswell, 1998). Ontological issues are concerned with the nature of reality and being, and inform a certain way of understanding phenomena (Crotty, 1998). Whether the social world is fashioned by people or whether it has an existence that is independent of them remains an ongoing debate. Positivists consider that there is one true reality that can be discovered and is identifiable and measurable, a position known as naive realism (Ponterotto, 2005). Post positivists also consider there is one true reality, but they believe it is not possible to truly capture and measure it, a position known as critical realism (Ponterotto, 2005). Counter to this is the Constructivist / Interpretivist position, believing there are multiple realities known as the relativist stance. Sartre (1943, p.17) suggests that the "ontological foundation of knowledge is subjectivity". This very much fits with the premise of Person Centred counselling and CfD, that the client is the expert in their own life trajectory (Rogers, 1980).

Epistemology considers what it means to know and the acquisition, creation, categorisation and dissemination of knowledge and the relationship between the knower, the research participant, and the one-who-wants to know, in this instance the researcher (Ponterotto, 2005; Butts & Rich, 2011). Knowledge has a relationship to the knower (Ceci, 2000). In positivism the participant and researcher are deemed to be independent of each other and there is no influence or bias on the material stemming from the researcher; it is a position of objectivism where findings are considered to be true (Ponterotto, 2005). In contrast, Post-positivism does acknowledge the researcher does have some influence on the process, but still maintains an objective stance, with the participant and researcher still being deemed to be independent of each other (Ponterotto, 2005). The Constructivist/Interpretivist stance is subjective. It considers that reality is socially constructed and the researcher and participant may well be changed by their interaction and dialogue, they are not independent of each other.

3:6 Paradigms for Counselling

Research in the field of psychology and counselling historically has been based on positivist and post-positivist paradigms which some suggest has limited advances in the field

(Ponterotto, 2005). By taking broader perspectives and adopting other research methodologies it is thought that the profession would be better placed to build on its professional knowledge and advance its impact on society (McLeod, 2001).

Given the many different models and beliefs inherent in the numerous therapies available, fitting counselling and psychotherapy into a paradigm is not easy (McLeod, 2003). For some psychology, counselling and psychotherapy could be considered at a 'pre-paradigmatic stage' being not yet mature enough to formulate theories in the way that science can (McLeod, 2003). Popper (1962) proffered the idea that science progresses through a series of 'conjectures and refutations'. Theories are tested in an effort to refute them. However, McLeod (2003) points out, it is most unlikely that any theory of therapy would be refuted due to research evidence, because people are not objects to be manipulated experimentally. Difficulties arise in quantitative methodology with the attempt to control variables as no two people are identical and it is not possible to treat them identically (Stiles, 2013). Where research methods categorise clients too rigidly, all clinical meaning becomes lost (Marzillier, 2004). This finding may well influence the lack of interest that many counsellors have in research (Kernberg, 2011). Where research is seen as generalising rather than specific and where it is seen to be influenced by the researcher's agenda and bias rather than being founded on clinical practice, then counsellors will look elsewhere to inform their practice (Cooper, 2008). Given that therapists need to attune to an individual's experience and that doing so enhances the process of engagement it is important that in both therapy and research individuality is acknowledged and respected (Kilkku et al., 2003). It seems vital that not only does the method have to be fitting in addressing the research question, it also has to engage the readers and deliver findings that are of interest and materially apposite to the counsellors who will be reading it.

As a counsellor and as a researcher there was a need to reflect in depth on the methodological choices that I needed to make. Working as a counsellor with the subjective, world views of clients, epistemologically I struggled to believe there can be a wholly objective reality and that from a positivist paradigm, by using particular methods of enquiry, an absolute and certain truth can be revealed regarding an individual person. Working in a quantitative way would not be appropriate in this study due to a lack of conviction on my part that truly meaningful information relating to counselling could be produced by manipulating and controlling variables. I found it difficult when working with individual perceptions to accept

an ontology professing that laws are fixed and that generalisations that can apply to all can be employed. It was not appropriate to take a nomothetic approach, as this study is not about universal laws or generalisability. Johnson (2003) suggests that truth can be seen as objective and subjective; objective as dispassionate, theoretical, empirical, rational and scientific, subjective as personal and passionate. In light of the above, the approach taken in this study is what Hansen (2004) describes as anti-essentialist. This considers that there is an acknowledgement of the co-existence of multiple realities, and therefore not one absolute truth. With this in mind this study will attempt to keep as close as possible to the participants' realities, the descriptions of clients' experiences, or as Giorgi (1997, p. 236) suggests, *"The totality of lived experiences that belong to a single person"*. In view of this I decided to take a qualitative approach in my study. Qualitative research explores "what it is like to be" in the given context of the topic being studied, with emphasis on the meanings people attribute to their experiences. This approach to research considers how people understand experience and interpret their world (Mason, 1996). Qualitative methods seek to embrace and explore the complexities of human experience by recognising each individual has multiple realities which they construct separately in order to make sense of situations at a given time (Denzin & Lincoln, 2000).

3:7 Approaches to Qualitative Research

How we think the social world is constructed influences what we think we can know about it, but in research the methods we use to look at it shapes what we can see (Mason, 2002). Thus, there is not one approach to qualitative research, but many different strategies with different data sources and different methods for exploring life, generating theory or describing the behaviour of a cultural group (Cresswell, 1998). Table 5 below outlines different methods.

Table 5: Approaches to Qualitative Research

Approach	**Focus**	**Method**	**Data Source**	**Not Considered because .....**
Ethnographic Approaches	Patterns of behaviour, customs and way of life.	Firsthand experience / observational methods / immersion in a	The cultural / natural setting. Participant observation, stories, rituals,	1. I am not looking to describe a culture. 2. Ethical concerns

		setting.	artefacts.	regarding affecting the therapeutic alliance would make observational methods problematic.
Grounded Theory	To generate theory.	Studying how people respond to a phenomenon and developing a theoretical proposition.	Theories are grounded in data from the field. Actions and interactions and the processes of participants. Interviews / questionnaires / journals/ diaries.	1. I am not looking to generate a theory. 2. The focus of this study is on individual participant experience and is not pertinent to developing a theoretical proposition.
Feminist Approaches	Gender as a basic organising principle shaping the condition of people's lives.	Creation of collaborative and non-exploitive relationships that place the researcher in the study - avoiding objectification.	Interviews / questionnaires / journals/ diaries	1. The client perspective of counselling is key to this study. It is acknowledged that there may be an effect on this perspective from gender based experiences,

				however that effect is not the focus of this study. 2. Neither is the deliberate promotion of empowerment a key issue in this study, although the egalitarian prizing of the client is held as sacrosanct.
Conversation analysis / Discourse analysis	Analysis of social interaction. Through the activity of talk.	Studies the way people produce social interaction. Often by observing naturally occurring talk.	Emphasis on text and talk. Close scrutiny of dialogue.	This study is not looking to gain systematic insight into the ways in which people interact or to represent the sequential organization of talk.
Case Study	In depth exploration of a "case" - which may be of one individual or of many, but rich in context and with	Situates the case within its setting. Particular and contextual.	Extensive data collection: observations, interviews, documents, audio/visual materials.	This study could have been a case study. However, the need to obtain wider sources of information from the counsellors, case notes, GP's and other

	multiple sources of information.			contributors, would have weakened the voice of the client. It was felt the client voice needed to be heard unfettered by external opinion.
Phenomenological Approaches	Meaning of the lived experience of a phenomena or concept	Looks for the "essence" of, perceptions, reasonings, meanings and individual understandings.	Interviews / questionnaires / journals/ diaries.	This study could have taken a purely phenomenological approach. However, given the political climate in which this research is conducted it was felt necessary to add the hermeneutic approach as a basis for interpretation and analysis as this acknowledges the findings as more than purely descriptive.

3:8 My Personal Philosophy for Undertaking this Study

One of the prompts for this study was the realisation of unwelcome external interference on ways of working in counselling that have been imposed by the demands of evidence-based practice. As the study design progressed, it became evident that the same process was at work epistemologically where external views were attempting to instruct ways of methodologically structuring the study: As though the "method" was the protocol which leads to results and therefore following the right steps would lead to the "right" answer. This pressure stemmed from The NICE guidelines (2009) for the inclusion of therapy in the NHS which were based on randomised control trial methodology [RCT]. This is their preferred 'gold standard' methodology used to good effect on precise interventions in medical research (Beutler & Forrester, 2014). However, RCT's are not thought a good method for use when researching counselling as it is argued that RCTs present a skewed version of therapeutic reality as they study counselling in a "pure" form that is not representative of daily clinical practice (Storr, 2011). Although Cooper (2011) acknowledges that quantitative research distils human experience into a set of numbers and despite him arguing that RCT's could be seen as the *"antithesis of counselling values and practices"*, Cooper advocates for RCT's to develop the evidence base for counselling (2011, p.11). Cooper (2011) believes that policy makers have no interest in qualitative methodologies and there is no waning of the current emphasis for RCT's. Further, he comments that in all likelihood qualitative studies of counselling are only ever going to be seen as supplementary, not as an alternative to the RCT. Others too argue that subjective qualitative accounts are viewed as inferior (Johnson, 2003), while Lambert (2007) describes her struggle to get her qualitative study of client views accepted by her ethics committee because it was not thought to be "scientific enough". The current position of counselling in the NHS is predicated on evidence -based practice (Hall, 2008), but there is a hierarchy ranking the evidence where RCT evidence is held as the pinnacle and non-RCT studies are seen as lesser (McLeod, 2011).

The plea by Cooper (2011) to conduct more RCT studies came at a time when the design for this study was under consideration. I have struggled to place this study ontologically, to frame the exploration of the therapy journeys of my participants. Certainly, their experiences were never going to be viewed from a positivist perspective as discussed earlier, but it was hard to adopt a solitary lens that honours both my participants' world view and my own

reticence to conform to set theories. Perhaps it is due to my counselling training and an awareness of the need for an internal locus of evaluation guided by the self. Staying with therapy for a moment, Carere-Comes (2014) describes theory driven approaches to therapy versus process driven modalities and suggests that process oriented therapies, whilst not theoretically neutral, utilise empirically supported theories only when it is required by the process; in other words letting the process dictate the theories used. Consequently ontologically in this study my view is rather than making the study fit with an established ontology, I have tried to find an ontological lens that fits with the process of the study. My own stance is to take nothing for granted. I believe that often all that can be known is that we do not know and it is through the experiencing that things become known. Therefore I struggle with certain ontological theories that present with confidence that things are a certain way. I am not comfortable with the constructionist understanding that meaning is co-created between parties, and certainly would not hold with the notion of "all knowledge and therefore all meaningful reality is jointly constructed" (Crotty, 1998, p.41). I would rather follow Sartre's (1996, p.44) thinking that "we ourselves decide our being" and agree with Pinker's (2002) view that our knowledge is based on our experiences.

In order to bring to light the client perspective the study needed to be able to take an idiographic approach, focusing on the individual's perception of their experience. This study therefore was designed to stay close to the client's perceptions and protect them from external influences that would manipulate their meanings. Sartre (1996, p31) believed *"man cannot pass beyond human subjectivity."* For me this point was hugely important because it highlighted that there was no need to bend and mould the project to fit the outlines of others. Instead, there was a realisation that what was needed was to use the philosophy I used every day.

Kierkegaard (1992, p.189) argued that *"subjectivity is truth"* and *"truth is subjectivity"*. This is not a use of the word truth in the positivist sense, as in one true truth that can be discovered and apprehended if the correct method of seeking it out is used. Here, I would suggest, the word truth is used as an individual's description of a way of conveying the experiencing of being; of what is believed by an individual "*conscious of being conscious of something"* (Sartre, 1984, p.23). This is not about knowledge, but absolutely about being and the experience that comes from being is then known to that individual in their own way and that specific knowledge is their subjective truth. What a client brings to counselling is *"A truth*

rather than the truth" (Rowan, 2013, p.21). Minton (2000, p.27) suggests this is the "truth that is true for me". This is the material therapeutically worked with in counselling and is the material that will form the basis of the analysis of the participant views in this study because it is based on their experiences.

Schwandt (2000) suggests qualitative inquiry can transform the theory that guides it and my belief is that we transform our lives as we live them. Accordingly, this study has to be understood as delivering ideographic representations of phenomenological, existential, individualism rather than constraining it into an existing framework of other people's ideas.

Taking this as the initial standpoint, I must then acknowledge the influence that I bring to bear upon my participants' own expert view of their selves, with my interpretation of their views. This then does become a co-constructed piece of work and I cannot deny my influence upon my participants' material despite wishing to deliver their views as unimpeded as can possibly be. Therefore I have used both Interpretivist and Constructionist stances to inform this study, but it is with the acknowledgment that my interpretation of my participants' views is only one way of delivering their experiences to meet the needs of the study. I consider my view has no authority and I have no intention to change or manipulate the words of the participants. I have tried to stay as close as possible to their meaning and I understand and accept they may have meant something very different to that which I have interpreted.

3:9 Approach

To achieve the above, this study will use Interpretative Phenomenological Analysis [IPA]. It is a qualitative methodology which brings together phenomenological description, insightful interpretation and an ideographic approach that aims to explore the experiences of participants from within their socio-cultural and relational contexts (Smith et al., 2009). Within this methodology, phenomenology is used as both an interpretive theory, developing new or fuller meanings that call into question what is taken for granted (Crotty, 1998), whilst at the same time it is also a study of experiencing individuals. It will not be used as the phenomenology of the "first person exercise" in a Husserlian stance (Crotty, 1998, p.8), but instead the emphasis is on the exploration of the topic via clients' personal experiences and their subjective understandings of their therapy experience (Finlay, 2009).

3:10 Theoretical Foundations of IPA

Husserl was interested in how someone may come to understand their own experience with a depth and rigour so they could identify the *essential* qualities of that experience (Husserl, 1927; Smith et al., 2009). In doing this the 'essential' would transcend the particular and that could help others understand a given experience. He believed that experience perceived by human consciousness should be an object of scientific study, believing it was possible to identify features of lived experience that are common to all people having had that experience (Lopez & Willis, 2004). These are known as 'universal essences' or eidetic structures. Husserl considered these to represent the true nature of the phenomena being studied, an objective consideration of reality, removed from context (Lopez & Willis, 2004). Husserl considered it was necessary to "go back to the things themselves", meaning the essential elements of consciousness, a focus on each and every particular thing in its own right (Moran, 2002). Husserl believed it is necessary to step outside of the everyday 'natural attitude' and instead direct the gaze inwards with 'a phenomenological attitude' towards our perception of an object (Shinebourne, 2011). Husserl cautions not to take for granted the experience of the world. He argues that the relationship between perception and its objects is not passive (Gubrium & Holstein, 2000). What is experienced in the consciousness of the individual is key, with a relationship existing between the process occurring in consciousness and the object of attention. So consciousness is always consciousness of something / seeing is the seeing of something / judging is the judging of something (Smith et al., 2009). Husserl believed we should not look at things with pre-existing understanding, instead assumptions, prejudices and theories should be suspended or placed under an "epoche", meaning to cease, with the aim to *"expose the transcendental structures of consciousness itself"* (Moran, 2002, p.16). This process is also known as 'bracketing'. Husserl believed it was possible to do this. His aim was *"to purify consciousness of all intrusion from objective actualities"*(Moran, 2002, p.78). Moustakas (1994) comments on the difficulty of achieving this state, but others consider it is not at all possible to achieve, in particular Heidegger, a student of Husserl who rejected Husserl's ideas and developed his own approach (Reiners, 2012).

Heidegger's approach starts the hermeneutic and existential emphases in phenomenological philosophy (Smith et al., 2009). Whilst Husserl was concerned with "what do we know as persons", Heidegger's focus was on studying being in the world rather than knowing the

world (Reiners, 2012). This is a different approach. Whilst Husserl focused on the descriptive, transcendental, abstract, individual psychological process, Heidegger is concerned with the ontological question of existence itself (Smith et al., 2009). Heidegger sees a human being not as a spectator looking at the world, but as an agent involved practically with their environment, influenced by the world in which they live (Overgaard & Zahavi, 2009). His approach is not independent of context. He sees a human being as an "inherently social being who already operates with a pre-theoretical grasp of the already existing structures that make possible particular modes of Being" (Wheeler, 2013, Chapter 2, para. 2.1). In other words, the distinctive *mode* of Being realised by human beings (Wheeler, 2013). It is a reflexive awareness of self-hood that also recognises the existence of others and acknowledges there can be no detachment from a pre-existing world of people, objects, language and culture (Smith et al., 2009). However, Heidegger dismisses culturally derived meanings as coming from the "they, the one, the anyone" a concept he calls "*das man"* , instead he uses the word *"Dasein"* to mean "living a way of life that incorporates an understanding of being" (Crotty, 1998, p.97).

Heidegger considers that our understanding of the everyday world is derived from our interpretation of it, and he questions the possibility of knowledge other than from an interpretive stance, grounding it in the "lived world" into which we are "thrown" (Reuther, 2013). In this instance thrown equates to having no choice. Many aspects, genetic make- up, gender, race, culture and indeed being born, are imposed on us and we have to make something of what we are given (Adams, 2013). Heidegger believes that interpretation must be based on assumptions that come from *"fore-having, fore-sight and fore-conception"* (Heidegger, 1962, p.192). He implies we therefore cannot bracket off our assumptions as Husserl proposed (1927) because there is a presumption of prior understanding. Further, Heidegger believed that presuppositions are valuable guides to inquiry and considered it was not possible to not know or to suspend the understandings that lead a researcher to study a topic in the first place (Lopez & Willis, 2004). However, Heidegger indicated that the meanings that come from the researcher's interpretations are not the researcher's alone, but are a blend of meanings from both researcher and participant (Lopez & Willis, 2004). Meanings must reflect the realities of the participant, but there is not one true meaning from an interpretive study because of the interaction of both researcher and participant. As a researcher decisions had to be taken on ways of working and beliefs identified that would guide ways of working. I did not feel I could suspend my knowledge of counselling and the

political situation that was driving this study. Therefore a Husserlian approach that negated all my prior knowledge about counselling, the theories I held and the experiences I have had was not feasible. The course of study I have undertaken demands the application of expertise based directly on the practice setting (Lee, 2009). The Heideggarian interpretive approach is useful in examining contextual features of experience that have direct relevance to practice (Lopez & Willis, 2004).

3:11 The existential view

The ideographic aspect of IPA makes a commitment to the detailed examination of the particular experiences of an individual (Smith et al., 2009). The Person Centred counselling tradition was founded by Carl Rogers (1951), his view being that the client is the expert with regard to self. He is guided in his belief by the words of Kierkegaard "to be that self which one truly is" (Rogers, 1961, p166; Kierkegaard, 1941, p.19). This principle guides my every day counselling work and it will also guide the intentions in this study. However, it is well established that our experiences can be influenced by others (Spinelli, 2007). While the power of the other can be influential, we are responsible for our own attitude and what we make of ourselves (Sartre, 1996; Frankl, 2006). We are always in the process of becoming, rather than something pre-defined waiting to be discovered (Sartre, 1996). Existentially, the search for meaning and what it means to be a human being cannot be taught it is something that every person must discover for themselves (Rogers, 1961). It is suggested that all that can be known about the world can only come from our own particular point of view or our experiencing of it (Merleau-Ponty, 1962).

3:11:1 Other influences

This study will be informed by phenomenological, hermeneutic and existential approaches that consider the meaning of experiences for clients taking part in CfD. These approaches will guide what will be studied i.e. the clients' views of their experience of receiving CfD and how the study will be conducted i.e. in ways that seek to interfere as little as possible with the phenomenon under study. The approach, will facilitate gaining a "rich description of the lifeworld/lived experience" of the participants, and requires the researcher to adopt an open attitude refraining from importing external frameworks and setting aside judgements about the 'realness' of the phenomenon (Finlay, 2009, p.2). It must be acknowledged however, that

research, as in therapy, has an interpretive aspect and therefore it is not possible to be assumption free or to move beyond the influence of experience on understanding. The challenge is to recognise that in undertaking the study the researcher may not be aware of all their preconceptions and to address this, use could be made of the hermeneutic circle (Smith et al., 2009). The hermeneutic circle requires repeated movement to and from the whole to the part and an intense engagement with the material. Close attention paid to the participant helps to intensify the understandings of both parties and helps to separate out one from the other (Smith et al., 2009). In this instance the researcher repeatedly moves from the *'whole',* the researcher's ongoing life and worldview, to the *'part',* the encounter with the participant in the study. However, it should be acknowledged that a double hermeneutic will be taking place whereby the researcher is making sense of the participant's making sense of a situation (Smith et al., 2009).

3:12 Limitations of the method

IPA can be said to be a relatively new model that is still being developed and refined and as such is not supported by a large corpus of work built over years (Larkin, et al., 2011). However, because it is new this may generate opportunities for "creativity and freedom" (Willig, 2001, p.69). The method of IPA has been described as having "essential simplicity, paradoxical complexity and methodological rigour" (Biggerstaff & Thompson, 2008, p.2). When undertaking this study I found I agreed with Brocki and Wearden (2006), that the method of analysis described by Smith et al. (2009) was easily comprehendible and gave straightforward guidelines, but some have suggested that the method is unclear and allows too much flexibility (Giorgi, 2011).

Willig (2001) queries the phenomenological underpinnings of IPA. There is an argument that IPA is concerned with cognition in that it seeks to understand what a participant thinks or believes about a given topic (Smith, 1996). This would not fit with the underlying principles of phenomenology which aims to understand lived experience (Willig, 2001). Further, it is at odds with the phenomenological stance of capturing the way in which the world presents itself to the individual in an unmediated sense (Willig, 2013). However, Larkin et al. (2011, p.318) argue that IPA can illuminate the importance of situating embodied personal experience in the context of meaning, relationships and the lived world. Willig (2013, p.96)

suggests that a more differentiated conceptualisation of "cognition" would be helpful and acknowledges that the "use of the word "cognition" in phenomenology requires further exploration". Giorgi (2011, p.205) comments that specifying terms precisely in phenomenology is difficult and that "any step beyond a superficial association of terms becomes problematic". Smith (2010, p.188) argues that IPA is not a "prescriptive methodology" but is there to be adapted by researchers who are concerned with how research participants make sense of their experiences. This study is concerned with how the participants made sense of their CfD experiences. The researcher has been guided by the framework set out by Smith et al. (2009), and has been able to refer to the experiencing of CfD counselling related by the participants and how they consider the meaning and nature of reality for them. This has been used as a guide in the analysis, both in order to stay close to the participants' voices while allowing ‘‘an interpretative account to be offered of what it means for the participant to have such concerns within their particular context"(Larkin et al., 2006, p.113).

A common misconception about IPA is that it is a "simply descriptive" methodology (Larkin et al. 2006, p.102). However, while Larkin et al. (2006) point out that IPA is praised for its accessibility, flexibility and applicability, Callary et al. (2015) explain there is a need to recognise that "IPA extends simple description and makes sense of participants’ lived experiences by developing an interpretative analysis of the description in relation to social, cultural, and theoretical contexts". Smith et al (2009) argue that an IPA study always has a clearly declared phenomenological emphasis on the experiential concerns of the participants and recognises that access to that experience is only ever partial and is always complex. However, they summarise that both the phenomenological and hermeneutical aspects are key in an IPA study and that "without the phenomenology there would be nothing to interpret and without the hermeneutics the phenomenon would not be seen. (Smith et al., 2009, p.37)

IPA occupies a mid point on a continuum between experiential approaches such as descriptive phenomenology and discursive approaches such as discourse analysis (Shinebourne, 2011). IPA has been described as being similar to grounded theory, but differs in that in IPA the focus is on personal experiences, whereas grounded theory focuses on social processes (Willig, 2001). Described as both phenomenological and interpretative, the success of IPA as a method is dependent on participants to recall and articulate their experiences

adequately and by the researcher's ability to reflect and analyse (Brocki & Wearden, 2006). It is suggested that all phenomenology is a form of interpretation and as such is dependent on language, as participants try to convey their experiences to the researcher through language (Willig, 2008). Willig (2008) suggests that language does not just convey experience, but adds meanings that are inherent in the very words themselves. For example, that interview transcripts say more about "the way in which an individual talks about a particular experience in a particular context, rather than about the experience itself" (Willig, 2008, p.67). As this study was the first study to explore the effectiveness of CfD from the perspective of the client, the aim was to deliver to the counselling profession the clearest conveyance of the participants' views rather than looking at the discourses inherent in their words. By using reflection and clarifying during the discussion in the interview the researcher tried to ascertain a clear meaning from what the participant talked about but it is accepted that there are many ways of describing things and language will have constituted meanings that shaped the participants' responses. Language was taken into account in the analysis, but only as part of the analysis along with descriptive and conceptual comments. (Please see appendix 6). It is accepted that analysis of the discourses within the participants' language in this research study would be grounds for another study in its own right.

Willig (2008) questions the applicability of phenomenological methods if used with those participants who may not be able to articulate their experiences. It may not be possible to capture the intensity of the experience if the language skills of the participants are unable to convey the richness of what took place, or furthermore if the researcher's skills are lacking in the data collection and analysis. In this study, I used listening and reflecting skills to encourage the participants to describe their experiences as fully as possible. Time and space was allowed in the interview for participants to think back over what had taken place and bring it to the forefront of their memories. Time was given to the participants to clarify, check and to mull over things as thoughts surfaced. Afterwards, working on the analytic process, although the guidelines were followed and this added a structure and a mentoring aspect to the conduct of the research, it was still necessary to learn the complex skills to work with the data and engage fully in the intellectual, emotional and practical application of the analysis.

Given the gap in the literature about the client perspective it seemed vital to place the client at the centre of this study and to privilege their experiences. Quantitative methods were

discounted because I did not wish to control or place limits on the presentation of the client's material. There is an acknowledgment that this study is not seeking to assert objective, reliable, generalisability in its findings. The aim that guides this study is one of trustworthiness and credibility in facilitating the promotion of client experience to enable wider understanding of being in receipt of a specific therapeutic process. In taking this stance, this study considers that it is misleading to make assumptions or to generalise about how clients perceive their therapy experiences and therefore ways of enabling their subjective meanings to come to the fore were chosen. As this study needs to concentrate on conveying the clearest presentation of the client experience an IPA approach was considered appropriate.

3:13 Ethics

BACP advise that counsellors should base their practice on well founded evidence and consider that evidence from research is a major source of guidance (Bond, 2004). The Ethical Guidelines for Research focus on both protecting the public and on creating ethically conscientious practitioners (Bond, 2004). With this in mind approval was sought and granted from both the College of Health and Social Care Ethics Panel and the NHS National Research Ethics Service (NRES). The University process required me to complete the Ethical Approval Form and a Risk Assessment Summary. The NHS process was considerably more onerous, taking almost a year, and even following NRES approval, subsequently each IAPT service required its own Research and Development department approval and in each case these were sought and granted (Ethics panel approval letters are shown in Appendices 4-9).

Working as a counsellor on a daily basis I am familiar working with issues of confidentiality. Therefore I understood the importance of prioritising my handling of this concern. I took great care to work with the counsellors who were recruiting for me, in keeping the client's data confidential by arranging for them to hand out sealed packs that would enable the clients to keep their data private and separate from their counsellors. Also, I am experienced in working with risk issues and much thought was given in how to minimise risk to my participants, both in the planning stage of the research and also in the active data gathering stages. In the HAT form data and in the interview itself there was a monitoring and a listening for indications of risk. Participants were advised, prior to engaging in the research,

should anything be disclosed about harming themselves or anyone else, confidentiality would be broken at this point. Further, the participant would be given a sheet with information on where they can obtain further support should they require it.

Participants were fully informed about the research procedure and asked to give their informed consent to participate. This included the researcher explaining to potential participants the possibility of painful material emerging and the resources that were available to them to seek support should they need this. I believe my understanding and skills as a counsellor would be helpful in the immediate situation, whilst acknowledging that I am not their counsellor, but in a research role and therefore longer term support should be sought elsewhere. Care was also taken to ensure participants understood that this was a research project, not a continuance of therapy. It was also explained that there would be no therapeutic intent on the part of the researcher during their participation in this study. Further, participants were told they would be free to withdraw from the study at any time without fear of reprisal. It was also explained that if they did decide to withdraw their data would be destroyed and not form any part of the research if that was their wish.

Interviews were conducted at a mutually convenient time with much thought being given to location and practicality. Participants were invited to identify a location that they found convenient e.g. home or G.P. surgery, or they could opt to attend for interview at any of my three clinics. The clinics provide a private space, they are sufficiently safe and secure as they are used for counselling work and have the approval of Employee Assistance Programme directors. If participants preferred, the interviews were carried out in their own homes. In one IAPT service all the interviews took place in the clinic. In the other IAPT service all the interviews took place in the participant's homes. In keeping with the university “lone worker policy” where participants opted to be interviewed in their own home, their details were left in a sealed envelope in a locked cabinet in my clinical supervisor’s office. My clinical supervisor was informed of the appointment time of each interview and I arranged to contact my supervisor to advise them when the interview was over and I had returned safely. It was agreed that the envelope would only be opened if I have not made contact with my supervisor for 30 minutes after the end of the advised interview time. This risk procedure was approved by both the university ethics committee and the NHS National Research Ethics Service however, it was never necessary to implement it.

Permission was sought from participants for the interviews to be audio taped and then transcribed verbatim. Participants were asked to choose a pseudonym to maintain their anonymity if that was their wish. Only the researcher would be aware of the connection between the participant's own name and the pseudonym chosen. There was only one record of the link between pseudonym and proper name and this was kept in a book locked in a drawer in the researcher's office. Only the researcher had the key to the drawer. The book will be destroyed on completion of the study. All identifying data was removed as soon as was practicable and tapes will be destroyed on completion of the study. In the text the counsellors are referred to as "counsellor" again to preserve anonymity.

3:14 Participants

Clients who are participating in the new program of CfD were invited to take part in the study (Appendix 10). In an IPA study the requirement is that the sample is relatively homogeneous (Smith et al., 2009). Therefore a purposive sample was used for the study as this allowed the researcher to intentionally select participants who have experienced the phenomenon under investigation, that being CfD (Parahoo, 1987). No limits were placed on gender or ethnicity, however recruitment was limited to English speaking adults (18 years and above), as the needs of children and young people bring differing perspectives that would be more suited to a study of their own, and there were insufficient resources for translators within the confines of this doctoral study. CfD is a new model of therapy therefore the sample is limited to the clients of trained CfD therapists who will have experience of using this particular model of therapy. Equality to be involved was maintained as all clients who met the inclusion criteria were invited to participate in the study.

The number of participants can vary considerably in qualitative research. IPA studies benefit from a focus on quality of data not quantity of participants (Smith et al., 2009). It is understood that it is important to gain sound qualitative insights and to be wary of a large number of interviews that yield data too superficial to be of use (Becker, 2012). However, it is vital to ensure the amount of interviews support the conclusions derived from the data and not to surmise what cannot be supported by the data. It is also acknowledged that it is difficult to make all of the sampling decisions ahead of time (Adler & Adler, 2012).

However, it is suggested that for a Professional Doctorate IPA project between four and ten interviews can be a reasonable sample size (Smith et al., 2009).

My aim for this study was to sample until the clearest picture possible was achieved of the client's perspectives of their experiences. To achieve this I needed to get a balance between getting as clear a picture as possible from as many participants as I could and ensuring interviews were as in-depth as is realistically obtainable with the time and costs available. Therefore, the aim was to ask 12 - 15 participants to complete the HAT forms (Llewelyn, 1988) (Appendix 14) which act as an aide memoire for the clients regarding events in their therapy and also provide prompts for discussion in interview. Then from this pool of clients, I intended to invite between 6 and 10 people to come for interview (Cresswell, 1998). From my experience of previous research I have found it difficult to get large numbers of people to participate and therefore the 6-10 people was a conservative estimate, but fits what has been identified as an appropriate sample when using IPA (Smith et al., 2009).

With regard to their counselling sessions, keeping the interference in the therapeutic alliance to a minimum was an important factor. The desire was to enable the clients to have as routine an experience of counselling as possible so this study stayed very much in the background. Video or audio taping of sessions was considered so that the counsellors' adherence to the model could be checked, but it was then ruled out because it would have brought a different dimension into the client's sessions and ultimately to the research.

Regarding adherence to the model this was covered in a number of ways. Initially, calls were made to IAPT services to ascertain if they delivered CfD in their practice. If this was the case, invariably I was directed to speak to the practice manager who again was asked to confirm that CfD was one of the services they offered. Following on from this I was usually put in touch with the manager of the Counselling Service who again confirmed that CfD was being practiced. My specific request to the counselling manager was for counsellors who had completed and passed the CfD training which meant a few trainees had to be turned down for the study. Counsellors who agreed to recruit participants for me were briefed on the need to adhere to the model and they confirmed this is what they would do. After sessions were completed I again checked with the counsellors that the participants had received CfD and the counsellors confirmed this. Lastly, in the interviews and the analysis it became clear by virtue

of the comments that the participants made, that it was CfD that they had experienced. (Please see Chapter 4 and also Appendix 19 example: Caledonian: C205).

Exploratory enquiries were made to a number of IAPT services to ascertain their requirements and the practical arrangements that would need to be in place to enable their participation in the study. Two IAPT services participated in the study. In both services two counsellors recruited their clients. All four counsellors had completed and passed their training courses in CfD and all confirmed they practised the model. The counsellors were asked if they would be willing to invite their clients to participate. Discussions took place with IAPT services regarding distributing the study information to new clients when they attend for screening. Following that, the CfD counsellors reminded clients about the study when they did their contracting and care plans at the start of therapy. The counsellors were provided with a supply of "invitation to participate" letters (Appendix 10), "participant information sheets" (Appendix 11) and consent forms (Appendices 12 / 13) which they handed out to their clients before therapy began. Clients were asked to respond directly to the researcher to minimise any interference with the therapeutic relationship between counsellor and client.

3:14:1 Participant Information

Table 6: Participant Information.

Participant	Information	HAT	Interview
Agnes (f)	8 sessions attended. Age 50. Occupation: not working due to ill health.	Yes Completed 8 HAT forms.	Yes
Joanne (f)	10 sessions attended. Age 32. Occupation: teacher, but currently on maternity leave.	No (Tidied up and threw them away)	Yes
Gillian (f)	12 sessions attended. Age: 51 Occupation: Unemployed	No (Said she had handed them in to the practice - but no one could find them)	Yes
Sandra (f)	10 Sessions attended. Age: 52 Occupation: Housewife.	No (Said she posted them back, but I never received them).	Yes
Sarah (f)	20 sessions attended Age: 60 Occupation: Retired.	No (Didn't complete them.)	Yes
Steve. (m)	12 sessions attended. Age: 42 Occupation: Computer engineer.	Yes. Completed 8 HAT forms.	Yes
Isabel (f)	15 sessions attended. Age: 41 Occupation: Unemployed	Yes Completed 15 HAT forms	Yes

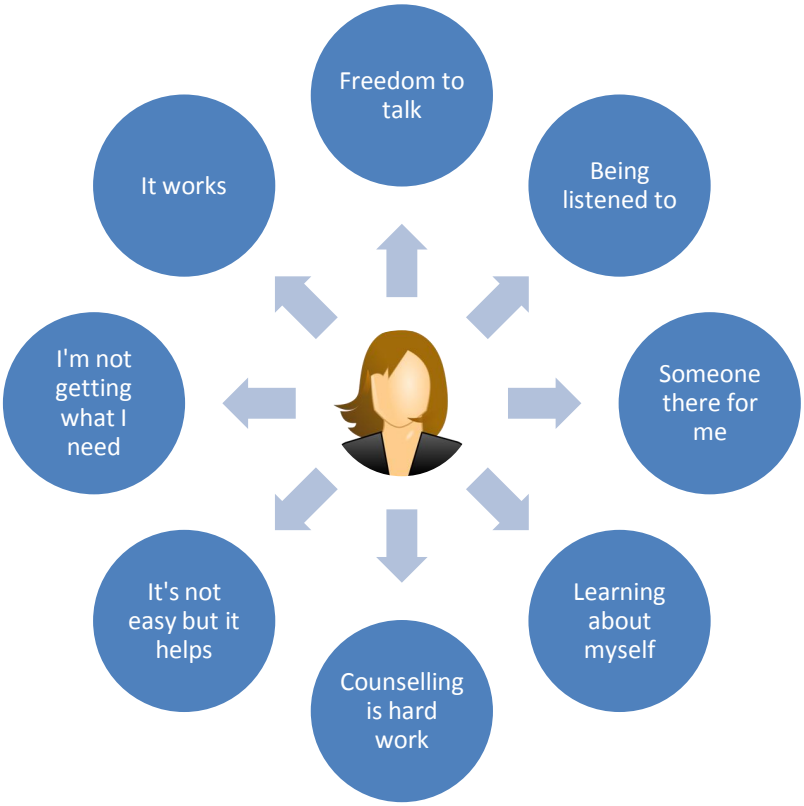
Henry (m)	8 sessions attended Age. 56 Occupation: Postman	Yes Completed 1 HAT form	Yes.
Lorraine (f)	12 sessions attended Age: 60 Occupation: Trade union representative.	Yes Completed 10 HAT forms	Yes
Caledonian (f)	12 sessions attended Age: 62 Occupation: Unemployed	No (couldn't find them).	Yes
Olivia (f)	11 sessions attended	Yes Completed 9 HAT forms	No
Lily (f)	5 sessions attended	Yes Complete 4 HAT forms	No

3:14:2 Participant Introductions

What follows is an introduction to the participants, there is a summary of their background and an overview of their reflections on their CfD experience. The themes they refer to in their interview are displayed in the diagrams below their introduction.

Agnes

Agnes is 50 years old and is not working due to ill health. Agnes says all she wants to do is be able to talk to someone. For Agnes the main concern was the lack of time available for her to talk through her concerns. Initially she had CBT that she believed did not meet her needs because it was too *"text-booky"*, so she had been on a waiting list for CfD. Agnes describes her irritation with the first two sessions being taken up with administration matters, form filling and the counsellor explaining about the therapy. Agnes's wish was for space to talk to someone who is non-judgemental and who would allow her the time to work things out. The sessions were limited in number and Agnes expressed her concern about opening up her problems and not having sufficient time to work through them before the sessions ended. There is a noticeable difference between her HAT form data which is overwhelmingly positive and the negative reflections that Agnes gave in her interview that were about the limited number of sessions and running out of time in the session to talk things through. Nevertheless, although Agnes was not able to identify what makes the therapy work she describes it as "amazing" and says she would certainly recommend it to others.



Joanne

Joanne is 32 years old and is a teacher currently on maternity leave. She reports coming into counselling following the ending of a violent relationship. Her view of counselling is it is hard work, but empowering. Joanne identified that it is "hard to look at yourself," but that her counselling had lead to her looking at the reasons why things happen, how she feels about herself, gaining control over what happens in her life and looking at why she made the choices she made. Joanne referred to a point in the counselling that almost lead to the termination of the counselling relationship. This was due to the counsellor breaching client confidentiality believing there was a risk of harm at home from Joanne's ex-partner. Joanne described feeling betrayed by her counsellor whom she had turned to for help, but who she viewed at this point as "grassing her up". When reflecting on this Joanne talked of understanding why her counsellor acted as she did and she feels it was the strength of the counselling relationship that enabled her to continue with her therapy. Joanne reports that her therapy was helpful and believes in the ten weeks of counselling that she has come a long way. Joanne stated she would recommend the counselling and feels that it has been effective for her.

Gillian

Gillian is 52 years old and describes herself as unemployed. She told me her GP recommended counselling to help her with her anxiety and depression. Initially Gillian was reluctant to go to counselling fearing that people would "think she was mad". However, whilst it was strange to be talking to a stranger, Gillian reports she began to open up to her counsellor and it became a place where she was able to talk freely about things that she had not been able to tell anyone else. An important factor for Gillian was that she would not be judged. Also important was being listened to and feeling her counsellor was able to put her at her ease. Gillian scores her therapy "10 out of 10". For her this therapy worked and she said she would recommend it to others. Further, she reports there was nothing that was unhelpful about her therapy.

Sandra

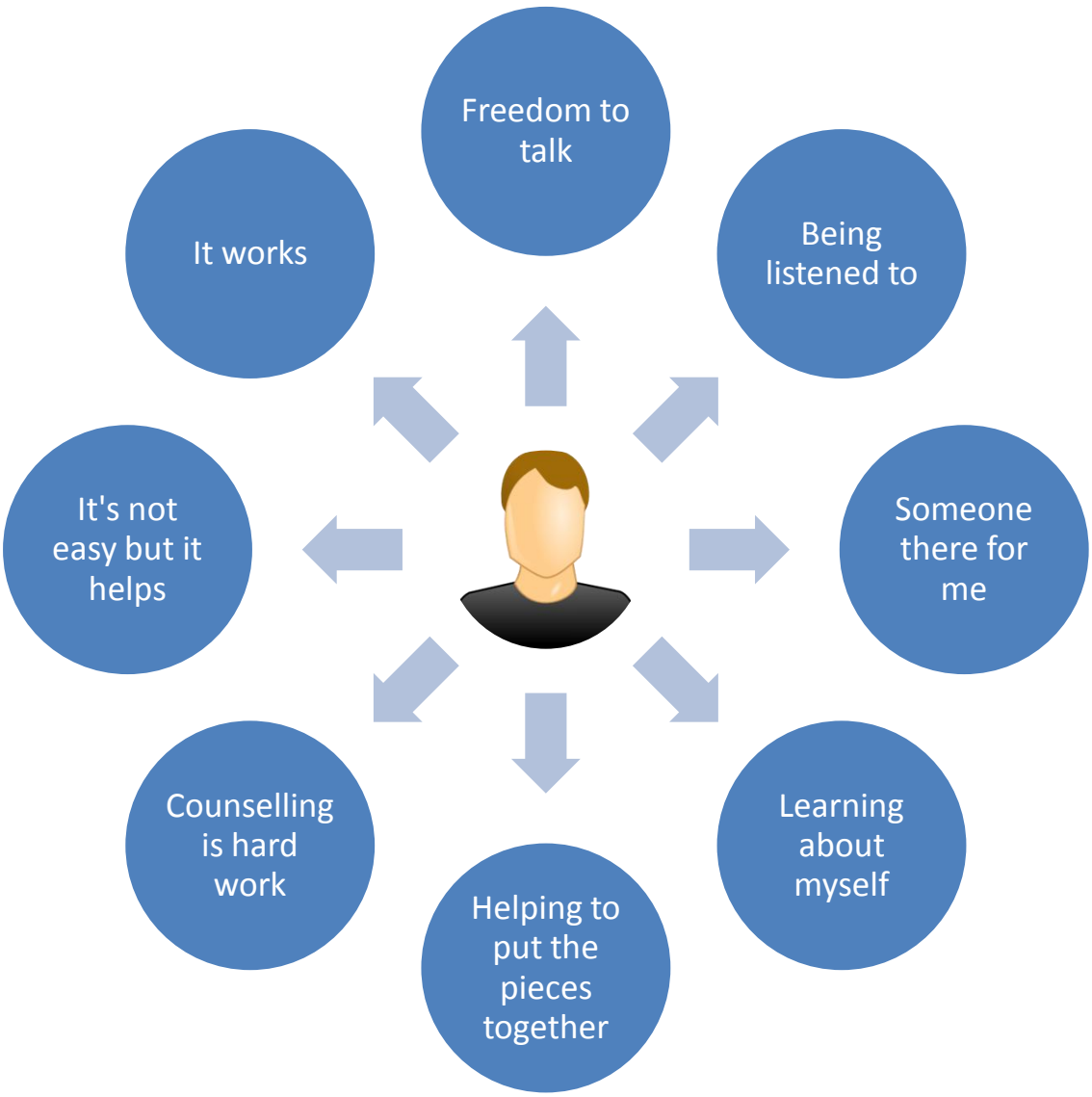
Sandra is a 53 year old housewife who reports coming into counselling as she was feeling very stressed and "quite down". Sandra was a student on a Person -Centred counselling course and she was viewing her counselling experience with her therapist both as a client and as a student of counselling. This was apparent through her use of counselling terminology throughout the interview. Sandra recognised her counsellor "was present" and "genuine" and she showed an understanding of the counselling relationship. However, Sandra still found it un-nerving to go into counselling where there were still a lot of unknowns - not knowing the counsellor not knowing how it would be, not knowing if she was going to get on with the person or what would come of it. Reflecting on her counselling experience Sandra viewed it as a learning experience, learning about herself and having to face things she did not want to face. She felt counselling had been a "very positive experience" and that it "had really helped her". Sandra reported "big changes" and "feeling stronger" with an exclamation of "oh wow" on realising what was going on and what had happened.

Sarah

Sarah is a 60 year old lady who is a retired school teacher. She attended counselling for 20 sessions. Sarah stated she had entered counselling because of a series of concurrent and historical stresses that culminate in an overload of emotional distress. Sarah described her counselling experience as amazing and her counsellor as a fantastic listener. Sarah told me she feels "really joyous" about her counselling experience as she feels so different as a result of it and so much has changed for her. Alongside this Sarah states that her counselling experience was excruciatingly difficult. Seemingly whilst being a very helpful process where Sarah has learnt to view things differently, it had also been very hard and distressing work. Sarah did not report anything unhelpful within the counselling itself, her negative feedback centred on finding it difficult waiting for her session in the waiting room and that the stairs up to the counselling room were hard to manage.

Steve

Steve is a 43 year old computer engineer who attended for 12 sessions of counselling. He explained he had gone for counselling following the break-up of his marriage. He described how it was important for him to be able to have one person with whom he felt safe enough to talk through his concerns and they would be able to respond to him and help him to make sense of things. He reports having friends, but not wishing to show his vulnerable side to them, whereas with the counsellor he could cry if he needed to and he felt safe in telling her about his difficulties. Steve identified that the counselling provided a place where he could explore his emotions. Steve described his counsellor as a "sounding block", explaining that she did not direct him or tell him what to do, but instead she helped him to" join his own dots" and find his own answers.



Isabel

Isabel is 41 years old and is unemployed. She sought counselling because she was struggling to come to terms with the break-up of her marriage. Describing herself as someone who always "puts a front on" with people she is close to, Isabel talked of it being a relief to have a space with her counsellor where she can just be herself and talk about the things she wanted to talk about without having to consider the feelings of the person she is talking to. She describes her counsellor as being impartial, remaining calm and being willing to listen. These are qualities that Isabel feels she does not get from the people around her at home. Isabel stated that her counselling has helped her to realise it is "ok to have emotions" and that feeling angry is appropriate and does not have to be hidden away as something shameful. She described how she found the counselling process disturbing and tough, but despite this she felt it was "brilliant" and "immensely helpful". Isabel talked of self exploration and coming to accept herself. Isabel feels the counselling has worked for her and she now sees things more positively. Isabel said she would have preferred the sessions to be more spaced out as attending on a weekly basis did not give her sufficient time to process and reflect on the work undertaken during the session and she would have preferred them to be held every two weeks.

Lorraine

Lorraine is a 60 year old trade union organiser who attended for 20 sessions of counselling to explore her current low mood and feelings of uncertainty. For Lorraine it was important for her to work with a female counsellor of similar age. Lorraine was very clear she could not work with a man and she wanted a form of counselling where she could talk and share in a relationship with a counsellor who could understand her life experiences. Lorraine reports her counselling experience as "life changing" and would "certainly recommend it to others". However, Lorraine did describe a session where the service agenda came to the fore and threatened the therapeutic relationship to a point where it could have terminated. Lorraine felt very strongly that her counsellor was being directed by service policy to report a historic issue recalled by Lorraine during one of her counselling sessions. Lorraine described resenting this because this matter was not what she had come into counselling to discuss. Fortunately, the therapeutic relationship was strong enough to withstand the challenge and the therapy continued to a positive conclusion. Lorraine described gaining a real awareness of how her approach to her family and friends was negatively affecting the quality of her life. She also described how through the counselling she became empowered to make changes that were helpful in relieving the perceived pressures that she felt under. Lorraine explained to me that she believed she had gained a real understanding of what she needs to do differently in future.

Henry

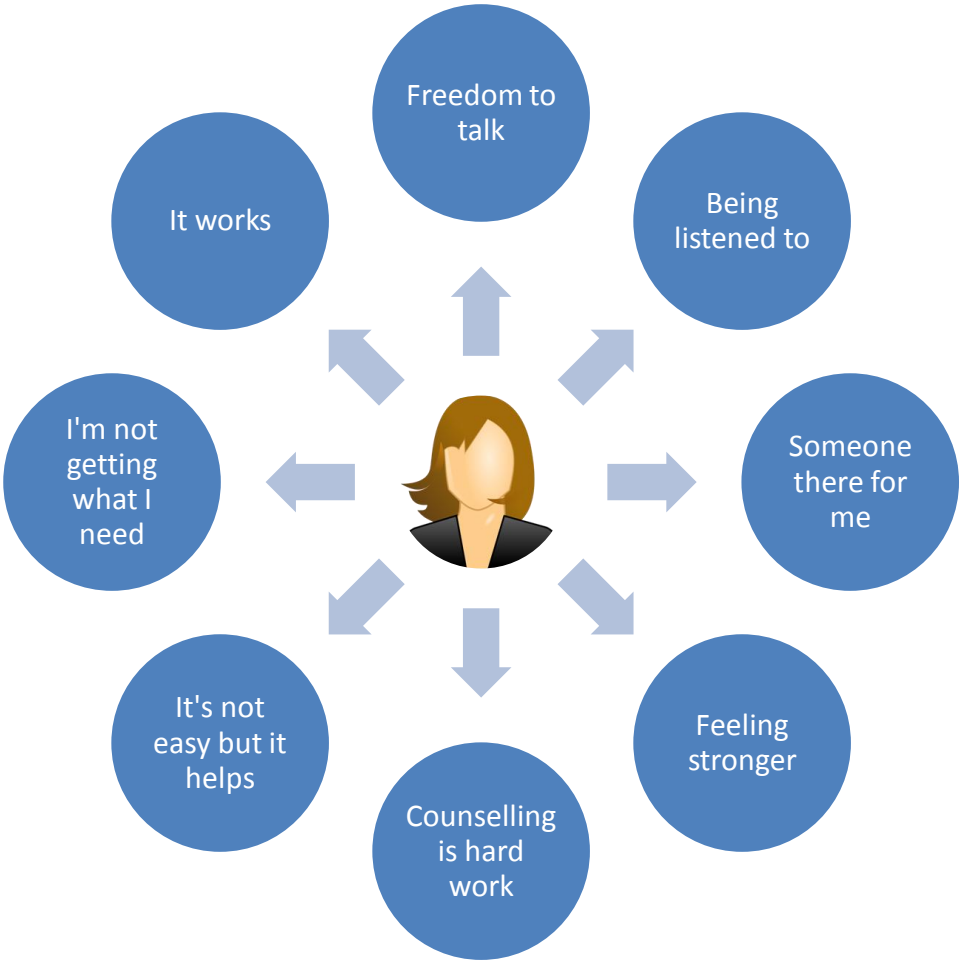
Henry is a 57 year old postman who attended counselling for 8 sessions. He told me he had come into counselling following the death of his wife and his family's reaction to his subsequent new relationship. Henry identified that counselling provided him with a unique place to be able to talk freely about his distress and isolation from his family who have shown their disapproval of his moving on with his life. Henry, in describing his counsellor suggested he had found someone who listened without judging him and without dismissing him as he talked. Henry explained how it had been hard to say some of the things he had discussed, but there was a delight in being able to have a place to say them out loud and he showed a clear appreciation of his counsellor's attention and listening skills. Henry saw his counselling as akin to "taking a lid off a bottle and allowing everything to pour out". Henry rated his counselling as helping him 110% and reported nothing unhelpful about his counselling.

Caledonian

Caledonian is 62 years old and describes herself as unemployed. She attended for 12 sessions of counselling following a referral from her G.P. because she was feeling depressed and anxious. Caledonian was distressed at times throughout the interview particularly where the material touched on her self concept and self esteem. It became apparent that it was a major achievement for her to be sat talking to me as prior to her counselling she would have not been able to face talking to someone unknown to her. What also became clear was that Caledonian's understanding of mental health support was based on what she described as "the terrifying treatment that her son had undergone as a result of his schizophrenia". Caledonian had thought that she needed to be guarded when talking to her counsellor or she too would end up in a "straight jacket". It was a "brilliant surprise" for her to find she could trust her counsellor and be able to tell her things she had told no-one else. This provided Caledonian with a unique space to feel supported and working with her counsellor she had been able to question herself and to think about things differently. Caledonian described the end of her counselling and the loss of contact with her counsellor as being “deeply felt” and “a huge loss of a precious resource.” However, the learning that has come from her counselling continues in terms of being able to attend this interview, a realisation that she can think about things differently, an improved relationship with her sister and a realisation that she has something to give. Caledonian suggested that she found her counselling to be very helpful and she would recommend it to others. She reported that there was nothing unhelpful about her counselling.

Olivia

Olivia did not attend for interview as she completed her counselling after the ten interview places had been filled. She attended for 11 sessions of counselling and submitted nine HAT forms. It is from the material on the HAT forms that her experience of counselling is compiled. Olivia described how she was able to talk freely without embarrassment and she felt her counsellor was interested in her and did not judge her. The sessions were not easy for her and she reported feeling tearful at times. Olivia noted how she could talk to her counsellor about things that she could not say to anyone else and she felt the sessions provided a safe space for her to talk things through. She identified that her counsellor would pick up on things which would then be opened out into a discussion. However, Olivia felt that because the sessions were limited in number, she had to skim over things and "could not look in depth at matters because there was not enough time". Overall, Olivia felt the sessions were helpful, describing it as feeling like a "weight was lifting from her shoulders".



Lily

Lily did not attend for interview as she also completed her counselling after the ten interview places had been filled. She attended for five sessions of counselling and submitted four HAT forms. It is from the material on the HAT forms that her counselling experience is compiled. Lily described her counselling as providing her with support and she was glad of having a space where she could talk freely about herself and how she was feeling. Further, she expressed that having someone unbiased to talk to who was outside of her usual circle of close friends and family helped her to talk about her problems. Lily reported that because of the shortness of time in the first session she could not elaborate on how she was feeling. However, she makes no mention of this in the subsequent sessions and reports that as a result of her counselling she gained an understanding about her situation and it also increased her confidence to the point where Lily felt strong enough to go forwards without further sessions.

3:15 Consent

The study was introduced to the participants via "Invitation to participate" letter (Appendix 10). The participants were given a written statement of the research aims, procedures and information about any potential risks, all contained in a participant information sheet (Appendix 11). The counsellors had the details of the study explained to them and so they were in a position to answer any questions initially raised by potential participants. However, participants were encouraged by the counsellors to contact the researcher directly with any questions they may have had. A dedicated email address and telephone number were arranged solely for this purpose. Once a person had made an informed choice to participate they were given a consent form to sign (Appendices 12/13). Consent needed to be given in writing. If the participant was not literate then the forms could be read to them by the researcher and the participant's own mark would be acceptable on the consent form.

According to the BACP Ethical guidelines for Researching Counselling and Psychotherapy (2004), best practice is to review consent at key stages, therefore consent to participate was checked at each of the following stages:

1. Initially when participants first entered therapy.
2. The sending back of the completed HAT forms was taken as the participant's consent to proceed with the research at that stage.
3. Contacting the counsellor to arrange the interview at the end was accompanied by a check of consent that the participants were content for the interviews to be audio taped, transcribed verbatim and their quotes reported in my thesis and any subsequent presentations or publications.

All participants received information about the name and address of an independent person with whom they may consult, or to whom they may complain, regarding any concerns arising from their involvement in the research study (Appendix 11).

3:16 Data Protection issues

The transcribed data was stored both electronically on a secure computer in a locked office, where only the researcher has access and the data analysis, in written form, was also kept secure in a locked drawer in a locked office. Both electronic and written data were kept in

accordance with the Data Protection Act 1998. The tape data will also be destroyed on completion of the study.

After completion of the study, the data will be kept in line with the Data Protection Act 1998. The data has been anonymous and stored securely until being disposed of appropriately as per the University of Salford Data Protection policy. Participants were assured that the collection, storage and use of data gathered will only be used for the purpose for which the participant's consent has been given. There will be no un-authorised access, use or disclosure. The ethical responsibilities of trustworthiness in counselling and psychotherapy, is central to me as a practitioner and as a researcher in this field of work. The only exception to this confidential trust is if the participant discloses risk to self or to others or criminal activities. At this point, it would be necessary to breech confidentiality. However, an attempt to seek the participant's permission to do this would be sought wherever possible.

3:17 Data Collection

Data was collected via questionnaires and interviews. In order to obtain as in-depth perspective as possible, but without intruding on their therapy, clients consenting to participate in the study were invited to complete the HAT form (Llewelyn, 1988) (Appendix 14) immediately after the end of each therapy session, while the material was still fresh in their minds. It is not possible to say how or when the participating clients completed the forms as the researcher was not present with them. However, participants were requested to post the forms in a pre-paid envelope straight back to the researcher so as not to interfere with the therapeutic alliance. The form asks the client to describe in their words what was helpful or not helpful about the session. The form captures a range of information such as processes, effects and context from the client's perspective. There was no expectation that participants will respond to similar questions in a similar way. This study was not looking to generalise opinion or reproduce answers and this is a well respected form that has been used often (Llewelyn, 1988; Castonguay et al., 2010; Elliot, 2010). The purpose of using the HAT data was to obtain the client's views at the time of their therapy. Evidence suggests that clients struggle to recall events in therapy precisely and therefore the rationale for using the HAT form was to obtain the clearest, current perspective on each session (Elliot et al., 2001). The immediate capture of events by using the HAT helps to reduce the loss of data through

passage of time or memory lapses and the forms were used as an aide memoire in the interview when therapy had ended. In the format provided to me ((Version 3.2; 05/2008. R. Elliot, personal communication, 19 May 2012) the HAT form contained one Likert scale which is a quantitative rating scale. It asks the client to quantify how helpful a particular event in their session was by using a nine point scale from *extremely hindering to extremely helpful*. Although Elliot (2010) suggests that the quantitative rating scales on the HAT form provide a means of comparing significant events from different sessions, this method is not compatible with the IPA approach taken in this study and for this reason the Likert scale was removed. A question was added to the form: What do you think makes therapy effective? This was done to gather the participants' views on effective therapy close to the events taking place on a session by session basis.

The use of both the HAT forms and interview data was gathered in the interest of gaining multiple aspects of the phenomenon under study. It is an attempt to maximise the data gained from the participants, to enhance the understanding of what has taken place and to minimise data loss due to time passing since the therapy experience.

The HAT form (Llewelyn, 1988) (Appendix 14) asks "Of the events which occurred in this session which one do you feel was the most important or helpful for you personally? (By event we mean something that happened in the session. It might be something you said or did, or something your therapist or counsellor said or did.)". This wording could be said to bias the participant completing the form with the suggestion that indeed there was something helpful in the session and therefore their answer must find something that was helpful. However, there is a countering question on the HAT form that asks "Did anything happen during the session which might have been hindering? This enables the participant to comment on unhelpful aspects and gives them a chance to report other views, enabling a wider reflection on what had taken place in session.

As a counsellor in practice the researcher recognises that her belief is that counselling works and is helpful. The researcher is also aware that she is uncomfortable with the positivist absolutes of evidence-based practice where outcome measures are viewed as delivering truth without consideration for validity (Proctor, 2015). Therefore, holding awareness of both these views helped the researcher to approach the study with a curiosity that encouraged a more neutralising stance as CfD is described as an evidence-based therapy which a priori is felt to

be "troublesome" for humanistic theory (Sanders & Hill, 2014, p.4). There could be no taking for granted that this model of counselling would work because its principles were very different to the researcher's own learning and beliefs. Awareness of both these different views became a guide in the conduct of the study that helped to mitigate potential bias. Whilst acknowledging that bias can never be ruled out, this stance helped to uncover assumptions which were then examined against the emerging insights as the study progressed.

At the end of their episode of counselling, clients contacted the researcher to arrange and attend an in-depth, semi-structured interview (Appendix 15). In an IPA study the semi-structured interview is considered the most appropriate means to obtain rich and detailed accounts from the participants (Broadbent, 2013). This format facilitates the empathic exploration of the client's experience of therapy. This protocol encourages an inductive, bottom up, standpoint that can collect a wide range of perspectives which are client initiated rather than researcher lead.

3:18 A consideration of therapy distinct from research

For therapists undertaking research it is acknowledged it can be difficult to retain the boundary between therapy and research (McLeod, 2003). Just as qualitative research seeks to illuminate the meanings people hold about aspects of their lives so does therapy (McLeod, 2003), thus creating a tension between therapy and research where potentially boundaries may become blurred (Warne & McAndrew, 2010). The similarities between the therapeutic interview and the research interview require the researcher to be mindful of the focus of the research rather than engaging in the pursuit of personal "client" issues that may manifest as a distraction from the research topic (West, 2002). When undertaking this research it was vital that in my role as researcher I remained cognisant of the differences between therapeutic endeavour and the research process (Dickson-Swift et al., 2006). In essence I had to recognise that in therapy it is the client's agenda that is followed and that the therapist responds accordingly, whereas in the research process it is the research agenda that is prominent (Sherwood, 2001). First and foremost I needed to be aware of not taking on a dual role of both therapist and researcher with my participants, but rather to acknowledge myself as researcher. The motivation and goals of the research activity stemming from me rather than my "client" have to be acknowledged. Indeed it is the research questions that lead the

agenda and the information gathered must be appropriate to answer those questions. Likewise, although a choice of responses and the need to choose the appropriate response is recognised, this can create a dilemma for a researcher between maximising the production of data for the study, whilst at the same time trying to avoid causing undue distress to the participant (Hart & Crawford-Wright, 1999).

Similarities and differences between therapy and research are contrasted in the diagrams below:

3:19 Differences between therapy and research

Table 7: Differences between therapy and research

Therapy	**Research**
Client lead agenda	Researcher lead agenda
Confidential	Anonymous
Conjoint working of interpretations in the session	Researcher interpretation after encounter
Purpose - well-being of the client	Purpose - to collect data and disseminate new knowledge

3:20 Similarities between therapy and research

Table 8: Similarities between therapy and research

Therapy and Research
The need to create a safe space to work through possibly sensitive issues.
Sufficient skills to create an environment where the client/participant can talk as openly as possible.
A collective practice - each encounter building on the one before.
Takes an explorative stance - an openness to inquiry.
Guided by ethical frameworks that hold as central the safety of the client/participant.

3:21 Reflections on Therapy and Research

Table 9: Reflections on therapy and research

In therapy what is discussed remains confidential (other than the normal exceptions of disclosure of risk). Further, the meanings that emerge are personal to the client.
In research the intention is that the material will be read by a wider audience and participants will be made aware of this.
In research the intention is to deliver new knowledge to a wider audience for dissemination and discussion.

There is not the time in a research study for the material to be worked through and processed in the way it would in a therapeutic contract.

In therapy there is an absolute need to separate out what belongs to the client and their frame of reference and what material stems from the therapist's own frame of reference. In research adopting an IPA approach it is a requirement to interpret and therefore the researcher will imprint the client's material with their own interpretation stemming from their own understandings (Smith et al., 2009).

There is external support available to the participant as I am not their therapist and there is external support available for me as researcher in the form of both my university supervisors and my clinical supervisor.

Research is not intended to be a therapeutic endeavour, although there is evidence that taking part in research is itself potentially therapeutic (Lakeman et al., 2013).

Strategies for managing the boundary between therapy and research include letting the participant set the pace, managing silences instead of staying with them, finding ways to arrange for the participant to take "time out", letting the participant turn off the audio recording, or even making a cup of tea. Ultimately the researcher has no control over whether the research encounter is therapeutic. However, therapy may be viewed as working with vulnerable adults whereas, it is suggested research involves collecting data from autonomous people (Lakeman et al., 2013). In this study the approach taken was to regard the participants with the greatest respect and deference for granting me their time. I was mindful of their autonomy in consenting to take part in the study, completing consent and HAT forms, agreeing to be interviewed, making themselves available at the agreed time and being willing to share their experiences with me. However, in the interviews I was also mindful of their presence and their manner and I was attentive to the nuances in their speech and body language throughout, but especially where sensitive material was being discussed. At these points I checked with my participants whether they wished to continue, asked if they needed anything and an offer was made to stop the tape. This offer was never taken up and participants continued to talk to me, sometimes through tears, but clearly signalling they wished to continue and telling me that they did not wish me to stop the interview. Draucker, et al. (2009) suggest that most participants tolerate research on sensitive topics well and that most participants find benefit in participating in research on sensitive topics. However, Lakeman et al. (2013) point out that research can bring a focus onto painful experiences and in this case, as per the research protocol, the participant would be given a sheet with information on where they can obtain further support should they require it. I viewed the participants as both autonomous individuals and as potentially vulnerable people and my aim was to have continuous awareness of both aspects as a researcher attempting to answer my research questions whilst at the same time being sensitive to my participants' needs.

3:22 Analysis

The researcher transcribed the interviews herself. It helped to maintain confidentiality, but it also helped the researcher to become immersed in the data by becoming familiar with the data in detail. An example of the analysis showing a transcript with initial noting, HAT form

analysis and development of emergent themes is given for client Agnes in Appendices 14/15/16. An example of quotes that support the themes is given in Appendix 19.

In an area that is under-researched and where participants' views are not known, it is recommended to provide a rich thematic description of the entire data set (Braun & Clarke, 2006). Both the data from the HAT forms and the interview data was analysed following the steps outlined in Smith et al. (2009), to look for emergent patterns (See below). The steps indicate that there will be a discovery of convergence and divergence and also commonality and nuance. Data was identified and combined into data sets, with individual data items in that set and precise data extracts referring to specific parts of text to help to identify emerging themes. Superordinate themes evolved from the emerging subordinate themes and highlighted the key aspects of the participants' experiences. Summary tables of superordinate and subordinate themes were created. To ensure the themes stem from the data, repeated reading of the transcripts helped the process of entering the participant's world (Smith et al., 2009).

The HAT data was used to obtain the client's views at the time of their therapy. The rationale for using the HAT form was to try to obtain as clear and current perspective on the session as possible, while minimising the research impact on the therapeutic relationship. Data collected via the HAT questionnaire was analysed using IPA steps to develop its own story, but it was also used as a prompt for those clients who agreed to be interviewed. Unfortunately, the completion rate of these forms was poor. Of the ten participants interviewed, only five completed their HAT forms. The other participants said they could not find them, had thrown them out or had handed them back to the counsellor who had no record of this. Of those participants that had the HAT forms available at interview they were a valuable aide memoir. It is regrettable however that many were missing.

In an IPA approach the analysis follows a set of processes moving from the particular to the shared and from the descriptive to the interpretative (Smith et al., 2009). The steps of an IPA analysis and used for the purpose of this study are as follows (Smith et al., 2009):

Reading and re-reading: becoming immersed in the original data, listening to the audio recordings and imagining the voice of the participant. This was important as the tone of voice and expression added meaning and depth to an audible, but disembodied discussion. Strong

and powerful first impressions were captured in a note-book to store them and to stop them interfering with the thoroughness needed to work slowly and deeply at this initial stage of becoming familiar with the data. The researcher did indeed read and re-read the transcripts and in each reading deeper understandings emerged which were captured in notes and later used to inform the analysis.

Initial noting: (Appendix 16) This needs to be detailed, but is also time consuming. It needs to explore the content and the language used, keeping an open mind and noting anything of interest in the transcript. This helps to understand the specific ways in which the participant talks, understands and thinks about an issue. This is a deep engagement with the text, much more than a superficial skimming, and one that stays close to the participant's explicit meaning. The aim here is to produce a detailed set of notes and comments on the data to be taken forward and used in the next step. Three types of exploratory comments are highlighted; *descriptive comments* describing the content of the talk in the transcript; *linguistic comments* focusing on the specific use of language by the participant; *conceptual comments* on a more interrogative level. Once these comments are identified there then needs to be a consideration of the links and connections between them. Additionally, there needs to be a seeking out of similarities, differences, contradictions and paradoxes. A contemplation of what each phrase and word means for me and an attempt to work out what each means to the participant albeit at this stage, provisionally. The search for these exploratory comments involved again re-reading the texts, but now with a focus on observing different aspects, particularly participants' descriptions of the phenomenon, linguistic features and then developing the interpretative, conceptual comments which again deepened the understanding of what had been said. The notes were made in different coloured fonts to highlight the different aspects considered: Descriptive comments in pink, linguistic in black, conceptual in green and questions that the researcher needed to ponder on were in blue. An example of this is given in Appendix 16.

Developing emergent themes: (Appendix 18) This stages moves to working primarily with the initial notes and away from the transcripts. This stage entails a re-organisation of the data which fragments the participant's experiences, but is a part of the hermeneutic circle, where the data becomes a set of parts to be reintegrated at the end of the analysis. This step is about the ‘I’ in IPA, being the interpretation. This places the researcher as collaborator with the participant in the co-formation of the results of the analysis. The main task is to identify what

was important in the initial notes and to turn them into themes which both capture the psychological essence of the work with enough particularity to be grounded and enough abstraction to be conceptual. This is now a combination of the participant's words and the researcher's interpretation with the aim of capturing and reflecting an understanding. I found this step difficult particularly with regard to fragmenting the data and developing the themes. For me, there was a security in the transcript as a whole as it depicted the participant's reflections on their experience and the realisation I was expected to overlay their perceptions with my own felt a massive responsibility to do justice to the participant's words. Moving to working with my own notes brought a real pressure to ensure that my interpretation was appropriate and honoured my participant's perspective whilst delivering a credible account of what they said. The notes were read and again re-read a number of times and each possible theme noted against the phrase from the original transcript which enabled it to be checked for meaning against the original. Explanatory points and queries were noted in a third column to be reflected on and to help develop the themes.

Searching for connections across emergent themes The next step involves a mapping of how the themes fit together. This is determined by the research questions and Smith et al. (2014, p.96) suggest that it is a drawing together of the "most interesting and important aspects of the participant's account". Not all themes are incorporated. In this study it was the research questions that determined the forming of themes. So for instance one participant described an experience with a previous counsellor several years ago which was unhelpful for her because she felt judged and she had explained to me that she felt this was because her counsellor came from a different culture. This particular piece of data was not included in a theme because it did not relate to CfD. It is not that the participant's comments are deemed irrelevant and indeed her comment may prompt other studies looking at culture or judgements, but in this instance I decided to discard this particular aspect as it was not pertinent to the purpose of this study. In mapping how the themes fit together clusters of related themes are formed and a super-ordinate theme is developed. This is annotated with the page or line within the transcript from where it derived and illustrates, with key words, from the participant where it originated (Appendix 18).

Moving to the next case. Usually an IPA study involves more than one participant, and therefore requires the above process to be repeated for each person, treating each transcript as unique in order to do justice to their individuality. This follows the IPA commitment to being

idiographic. There is a recognition that the emerging knowledge from the initial analysis cannot be "not known", but adherence to the above steps allows new themes to emerge with every case. Post it notes were used to capture the themes from each participant. Each participant had their own colour or shape of post it note, which while enabling the themes to be grouped and sorted also allowed each participant to keep their own identity within the group (Appendices 18/19/20).

Looking for patterns across cases. This considers which themes are most compelling and the connections in the themes across cases. The researcher is required to check if themes in individual cases are shared across cases. For this research the post it notes were stuck onto large sheets of paper and grouped according to each theme. The arrangements of the post it notes were lived with for a number of months. This allowed the themes to be considered and often prompted rearrangements of the post it notes, considering the patterns and what felt appropriate according to the interpretation within the analysis, driven by the research questions. (Appendix 20).

An IPA analysis moves from the parts to the whole. A close reading of the individual data, informed by all of the cases, brings the participants' material to the whole. No external frameworks are imported to explain the data, instead the analysis keeps close to the text of the transcript and is verified by what is said in the individual data and in the larger corpus of unfolding analysis.

It may be questioned as to whether it is possible to obtain full understanding, with some believing that there can never be a wholly correct interpretation of a subjective account (Schwandt, 2000). However, in keeping with an IPA approach, the intention is for the researcher to try as much as possible to suspend bias and prejudgements and enable the subjective meanings of the participants to foreground the study. The aim of the research is to deliver credible and convincing findings, but it is understood that the knowledge produced is co-created by both participant and researcher. It will be the participant's interpretation of their experience and the researcher's interpretation of the participant's account that will be presented in this thesis.

The participant data was analysed according to the steps described earlier. A document was created in Microsoft Word that placed either the transcribed verbatim interview or a scanned

picture of the HAT form in the centre of three columns. To the left of the text was a column for initial comments on descriptive, linguistic and then conceptual interpretations of the data. The column on the right would be used for themes as they emerged. Table 9 gives an example from the interview with Caledonian.

Table 10: Example of interview data analysis

Descriptive Comments - describe content Linguistic Comments - use of language

Conceptual Comments - Interpretive Questions

Initial Comments	Transcript	Themes
This is magic? It's strange because the mechanics are unknown, but the result is good. Friend is offering to help, - talk to me instead - but dismissing the counselling as ridiculous Would she be "stupid" if she came to counselling? - What will they think of me if I go to counselling? They'll judge me negatively "bloody counselling" condemned as ridiculous - emphasis with swearing This lady has friends but is not confiding in them - but is confiding in the counsellor - she knows/ they don't. I won't give them the chance to judge me?? Don't think badly of me Mental health problems + being treated = medical terminology This counsellor has been so good for me. She should be rewarded for doing so well. "People like her" - not people like me ??? People like me can't be helped, it's a waste of time??	34. I: Ah-ha, so she couldn't give you a magic pill and yet something was going on and you were feeling better? 35.P: Yes. In actual fact one of my friends said 'bloody counselling, don't be stupid that's ridiculous, talk to me if you need to somebody'. 36.I: Right so she dismissed it? 37.P: In actual fact there is not one of my friends know how I am, none of them know I am actually having mental health problems, that I am being treated for anxiety and depression, none of them know because she was the first person I spoke to and I thought well if that is the reaction I am just not going to tell them. 38.I: Yes 39. P: So I mean The counsellor, I mean I just, somebody should give her a halo, I think people like her are amazing and I went in totally believing it was going to be a	I don't know how it works, but it's great - Stigma - the importance of not being judged - the importance of not being judged It works Surprise that it works?

"a halo" this counsellor is an angel ? Someone so good. A real accolade . I didn't think it would, but it has worked for me.	complete waste of time. 40.I: So really going in quite doubtful, quite negative about it? 41.P: Yes, yes	

This process is akin to "free textual analysis (Smith & Osborn, 2007). The material was read and re-read and the columns populated with my thoughts and reactions to my reading. Initially these were thoughts on the content, the descriptions that the client was relating. A second reading focused on the linguistic aspects and was supplemented by checking the interview scripts with the audio recording to hear tonal variations and emphasis on certain words. Subsequent readings developed the conceptual ideas, a more interpretative stance, but still based on the client's words. With the second and subsequent transcripts there was an awareness of holding more knowledge each time. Every participant added their experience to the bank of knowledge and this had to be both suspended to allow a clear reading of the new transcript and at the same time acknowledged when sets of material corresponded or when they diverged. This was achieved by multiple readings of the texts and standing back from the data to obtain an overview of the material. This was then checked against initial understandings and then against the analysed data of other participants. Emergent themes were written on post it notes, a different colour for each participant, and grouped together (Appendices 18-20). These were then sorted and shifted into related themes, but it was still possible to identify who had said what because of the colour of the post it notes. This created a paper trail and from this sorting it was possible to create superordinate themes, following their development from the subordinate themes and the individual participant ideas that supported them. These themes derive from the words of the participant interpreted by the researcher. Guiding the interpretation was the double hermeneutic of how is the participant making sense of their experience and how was I making sense of their making sense.

However, the idea of themes passively emerging from the data denies the role and influence of the researcher. Data must be filtered though the researcher's understandings, interpretations, constructions and experiences. There was no attempt to link the themes to any existing framework, but there must be acknowledgement that researcher beliefs, experiences, culture and bias cannot be eradicated (Hollway & Jefferson, 2000). These researcher influences were suspended as much as possible, in order to allow the themes to be data driven rather than have meanings imposed upon them. The impact of this became evident in writing

up the Discussion chapter when relating the findings back to the research objectives - these initially being:

To explore the client's experience of receiving CfD therapy.

To explore the client's views of helpful and unhelpful aspects of this therapy.

To discover what clients mean by "effective" therapy.

The themes of helpful and unhelpful aspects of the therapy answered the second research objective. The third research objective was answered by the responses to a specific interview question - "what do you feel makes therapy effective?" However, it became apparent after the analysis process that the first objective which was "To explore the client's experience of receiving CfD therapy" was reflected and expressed within the other two objectives and henceforth the first objective of the study was actually the aim of the project and not an objective itself. This realisation emerged from the analysis which then shaped the framework for the rest of the study itself.

My focus was on looking to identify what matters to the participant in terms of events, relationships, concepts and processes. It included what the experiences mean for the participant and what their stance is in relation to them. I also looked for patterns and inconsistencies, images and metaphors.

My interpretation was developed from the text in order to achieve credibility and authenticity Again the use of the hermeneutic circle enabled me to tie the whole of the interview to the fragmented parts of data, which were reconstructed through the researcher's interpretation into a new whole. Examples of the hermeneutic circle in use are given in the Analysis section.

In order to add depth to the interpretation and as a checking process the anonymised transcripts were sent to my university supervisors for their interpretation. These were then discussed to see where the analyses converged or differed. I also discussed my findings within an IPA study group and additionally, I put my findings forward for peer review with two counselling colleagues. One reviewed them solely from a counselling perspective and the

other counsellor was a PhD student also using IPA for her own study who considered the material from a counselling perspective, but also with an eye on the methodology. All the feedback has informed the Findings chapter.

The aim of reviewing my findings with others was not to check for validity and reliability as in quantitative research, but instead the purpose was to ensure the credibility of the analysis (Osborn & Smith, 1998). There is debate around the criteria for assessing the quality of qualitative research, and a balance is needed between over-adherence to prescriptive checklists and sampling strategies or over-reliance on self reports and verbal representations of the world (Power, 2001). Yardley (2000) specifies four principles to assess the quality of qualitative research; sensitivity to context, commitment and rigour, transparency and coherence and lastly, impact and importance.

Sensitivity to context

In this thesis adherence to this principle is achieved through awareness of both theoretical and academic contexts. Awareness of the context of current literature and the political situation of the profession, but also an awareness of the need to choose a methodology that will allow close engagement with the ideographic perspectives of the participants in the study. Although the claims in this study are presented as possible readings of the data, they are based on numerous verbatim extracts that both support the argument and give the participants a voice in the study. The extracts also allow the reader to check the interpretations being made.

Commitment and rigour

This refers to expectations of thoroughness across the study (Yardley, 2000). The sample in this study was appropriate in that all participants were clients receiving CfD counselling from counsellors trained and qualified in the model of CfD. The researcher, herself as a counsellor was very used to meeting people in interview situations, with skills to manage the process and a clear focus on the topic. Training was undertaken on IPA and the analysis was conducted thoroughly and systematically with a clear trail of how this was achieved. This was a comprehensive analysis based on prolonged engagement with the topic.

Transparency and coherence

In this thesis the stages of the research process are clearly described. The contradictions and ambiguities that emerged from the analysis are laid out clearly, with all relevant aspects

disclosed and the reflections of the researcher are presented as they relate to each chapter. Yardley (2000) suggests that coherence relates to the fit between the research question and the underlying assumptions of the approach being used. The process followed in this study is consistent with the principles of IPA and is demonstrated by both the phenomenological and the hermeneutic aspects being apparent in the Findings and Discussion chapters.

Impact and importance

Yardley (2000) infers that the real test of a piece of research is whether it tells the audience something interesting and important. There is a clear aspiration for this study to deliver findings that will make an impact and convey important participant views to the counselling profession. From this comes a commitment to disseminate the findings to professional settings; journal publications and conferences, to gain as wide an audience and make as strong an impact as possible.

3:23 The Professional Doctorate

Lee (2009, p.6) considers that the Professional Doctorate is associated with *"the acquisition of knowledge and research skills to further advance or enhance professional practice"*. It became evident whilst progressing on the research journey that I was acquiring and developing a number of skills. Initially it was purely about learning to study; to read with a purpose and to learn to challenge and critique the text. However, as I progressed other skills were developed and realised. The proposal that was designed entailed the need to obtain both university ethical approval and approval from the National Research Ethics Service (NRES). At the outset I had no idea that this would be such a mammoth undertaking. It was a long and laborious task that challenged my confidence many times.

The ethical approval process for this study actually took almost a year. However this process reinforced the determination to succeed and honed a persistence that has been useful in other domains, for example getting past telephone gatekeepers to access the managers I needed to speak to in order to gain access to the NHS services, following up on emails that had not

elicited a reply and generally learning to navigate unfamiliar situations that have to be negotiated in order to bring the study to fruition.

3:24 Research Difficulties

When working as a counsellor in daily practice ideally there should always be an adherence to the BACP ethical framework (BACP, 2004). It becomes part of the counsellor's way of working and its guidance permeates all aspects of a professional attitude. According to BACP (2013c), practitioners are required to seek to enhance the quality, effectiveness and safety of their practice on well-founded evidence. BACP believe that research is a major contributor in helping practitioners to do this. However, only 4% of counsellors ranked research as the most useful source of information on how to practice (Cooper, 2008). Instead it has been established that they prefer to refer to existing knowledge, prior experience and/ or make reference to the accumulated knowledge of their profession (Bower, 2010). However, Bower (2010) also highlights the need counsellors' have for wanting to know "how" their counselling works, whereas much of the research to date has focused on "whether" it works. One reason cited for the reticence of counsellors to engage with research may be due to the insistence that best evidence must come from certain types of information, derived from certain types of research methods (Bower, 2010).

The design of research studies are often a cause of concern for some counsellors. For example some counsellors would dispute the validity of quantitative research in terms of how representative it is of routine practice because of the control over variables (House, 2011, Van Oojjen, 2011) , or whether the study maintains the authenticity of practice when therapists are coached and given extra supervision (Duncan et al., 2004).

Not only are counsellors reluctant to engage with reading or implementing research, but few counsellor training courses actually have a comprehensive research element (Horton & Varma, 1997). A search of the literature in the databases sees the same names occurring repeatedly, usually attached to university research departments and often working in teams (Elliot et al., 2001; Cuijpers et al., 2007a; Stiles, 2008; Hill, 2012).

Personally, as a lone researcher it feels a lonely place to be most of the time. The loneliness comes as a result of being the only counsellor in the cohort of nurses and social workers in my years at university and lonely as a researcher when with my counselling colleagues, who are not imbued with the same passion to follow this course to the end. In addition, I also struggle with competing demands at home to get the time and peace to concentrate amidst the need to meet family requirements. It has been necessary to stay focused on the end goal of completing the research and to frequently bolster the determination to succeed. The challenges to success are considerable. It is difficult to keep focused when it is necessary to keep breaking away from the writing. Costs too are significant, not only of the academic course fees, but in research training, books, stationery and in the providing of participant materials and postage.

Designing a counselling study poses particular problems. In order to challenge the NICE (2009) guidelines that referred to the evidence for counselling being uncertain, this study was originally designed to be a retrospective account of personal practice. Looking at the ways of working with clients and seeing with whom best results were achieved as per the study of Paul Clements (1994). He did a documentary analysis of his casework and reported the results. What I found when I began exploring the requirements for my study was that due to data protection restrictions, the gatekeepers at the Employee Assistance Programs that referred clients to me would not give permission to use session notes for research, neither would they permit any research work with current clients. Private clients were an available source, yet difficulties were encountered. Pistrang and Barker (2010, p84) advise against working with a therapist's own clients on *"ethical grounds"* as combining the roles of therapist and researcher could be considered a conflict of interest. Further, they believe that a client being asked to participate in their therapist's research could compromise their ability to consent freely, as they may fear negative consequences if their refusal disappoints their therapist and if being asked about the quality of their therapy, integrity may also be difficult. However, there are differing views on this. In a personal communication, Professor J.C. Norcross advises *"Asking one's clients/patients what they find useful or helpful in psychotherapy is a common and evidence-based practice"*. He suggests that providing there is an informed consent procedure in place then it is part of good practice. (Professor J.C. Norcross, personal communication, 26th August 20011). A contrary view however was expressed by Professor M. Cooper who advised that there may be *"a blurring of roles to be*

both researcher and therapist, and it does raise issues about how much clients can really tell you about what is going on for them" (Professor M. Cooper, personal communication, 6th August 2011). With all this information in mind, the study was changed to considering the client views of other counsellors. However, this was met with refusal after refusal as colleagues declined to be involved with any research. They cited worries about damage to the therapeutic relationship and concerns about a third party involvement in the normal counselling dyad. There was also a sense of apprehension about being judged. The fear of being criticised is a strong influence that prevents participation in research and this was found in early counselling research (Meyer &Timms, 1970) and is still current today (Bergold & Thomas, 2013).

It was clear from the literature search that there are far fewer studies from the client perspective than studies about what the therapist thinks, and in light of this it was clear it was the client view that this study needed to focus on. It was around this time that Pearce et al (2012a) introduced CfD as a model of counselling for use within the IAPT programme and it was clear that to consider this new model from the clients' perspective would be a significant and valuable piece of research that would have the potential to inform practice. Information on what was taking place in the therapy would give useful information both to other potential clients thinking about having CfD counselling and professionals delivering it (Henkelman & Paulson, 2006; Manthei, 2007). A key point would be that therapists would gain evidence of how their therapy was being experienced and this evidence could be fed-back to policymakers and funders.

3:25 Reflections - Perform a U turn where possible

This became a very different study from the one envisioned at the outset. Due to the participants now being the clients of NHS counsellors, rather than my own or my peers' clients, access to these clients was through the portal of the counsellors in G.P. practices. For me as a researcher, this felt distant as I felt far removed from the participants. I felt a real loss of power and control as there was a dependency on others to recruit to the study and I had doubts as to whether it would actually happen. It felt like there were "five stages of hoping":

1. Hoping to find the IAPT services that had adopted CfD.

2. Hoping to find the Counsellors in those Trusts who were trained in CfD.

3. Hoping to obtain the agreement of the Counsellors who practised CfD to ask their clients to participate.

4. Hoping to obtain the agreement of the clients to participate.

5. Hoping that the clients will follow the study protocol.

Further, there were also worries about the change in the power balance from counsellor to researcher, should any interviews take place. As a practicing counsellor the counselling sessions are interviews that take place on a daily basis, but the agenda for the counselling "interview" is the client's. In my role as a researcher the agenda is driven by the research questions and this changes the power balance. In counselling the client attends usually with the intention of gaining "something" to make their situation better. It could be said "they want something from me". However, in undertaking research this changes to "I want something from them". The dynamic of the relationship has changed and they are attending at the researcher's invitation, a situation not initiated by the client. This is a reversal of roles and for me was new and uncomfortable. The new situation needed managing to facilitate a new way of working so that as the researcher I could enable the participant to relate their experience and perceptions to satisfy the needs of the study.

Chapter 4 Analysis of Findings.

4:1 Introduction

This Chapter reports on the findings from seven sets of HAT forms and ten transcribed interviews from the twelve participants, ten female and two male, who had received CfD and agreed to take part in this study. Ten participants were interviewed, eight females and two males. Five of those interviewed had completed HAT forms. Two participants completed HAT forms only and were not invited for interview as per the research protocol. Participants were recruited from two NHS Trusts and the CfD sessions were delivered by four female counsellors. (Please note that all participant quotes are given in italics).

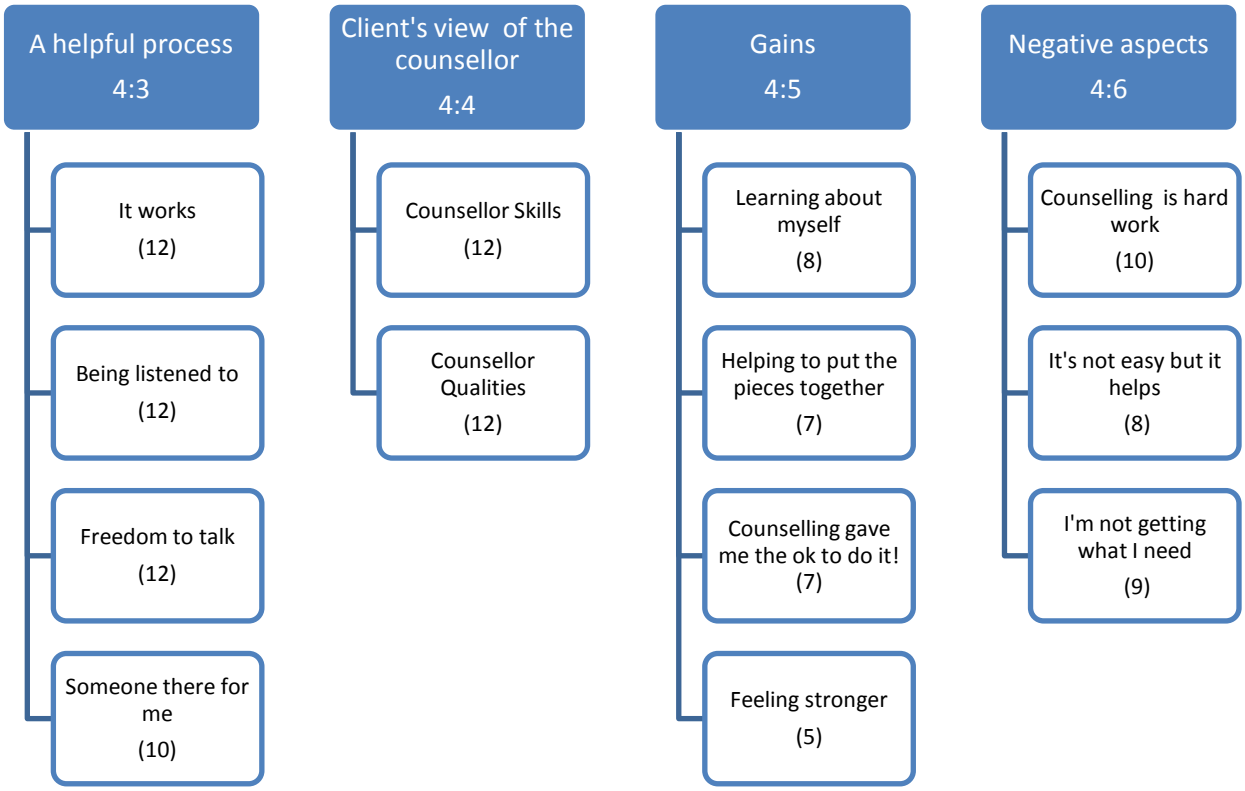
This section presents the key emergent themes from the 12 participants' data (Shown below in table 10). There is a detailed findings analysis of four superordinate themes: A helpful process; Client's view of the Counsellor; Gains; and Negative aspects. The superordinate themes evolved from the analytical steps of IPA (Smith et al., 2009) detailed in Chapter 3. The analysis in this study accords with the parameters of IPA as the themes across the group of participants are illustrated with particular example quotes from the individual participants (Smith et al., 2009). Checking the recurrence of themes is important as connections are made within and across cases whilst care is taken to maintain the distinctiveness of individuality. For a theme to be deemed recurrent "it must be present in at least a third to a half of all participant interviews" (Smith et al., 2009, p.107). There are a number of themes common to all participants. However it is clear that there are differences too. The commonalities and divergences are discussed, with the analysis being shaped by the Research Aim and Objectives for the study, these being:

To explore the client’s experience of receiving CfD therapy.

To explore the client’s views of helpful and unhelpful aspects of this therapy.

To discover what clients mean by “effective” therapy.

Table 11: Superordinate themes supported by subordinate themes



4:2 Reflections on the analysis of the themes

The interpretative nature of the analysis is influenced by my personal and professional knowledge and experience. I have kept a reflective journal throughout this process and it brings a subjective lens to the analysis which I have used both to gain understanding of the texts, but also to try and highlight my frame of reference as being different to the frame of reference of my participants. After reading a HAT form or attending an interview, I would note my thoughts, reflections and emotional responses on the material. For example during her interview Sarah had described how she felt "*really joyous*" about her counselling because

she "*felt so different now*". When reflecting on her comment for me, as one human being to another, there was a rejoicing with her that she had found such positive change. For me as a counsellor, there was a sense of satisfaction at a job well done and praise for the CfD counsellor for working so well. For me as a researcher, I had to acknowledge these two viewpoints, but then set them aside as best I could in order to bring the focus onto the aims of the study and the research questions and how this material related to that. I was aware of the potential to bias the research findings should I foreground the positives regarding CfD and I had to be careful not to collude with Sarah's joy; only to deliver her experience of CfD. Likewise my feelings of praise for the counsellor had to be set aside, so as not to influence the findings. This process of reflecting on my frame of reference has informed the analysis.

As a result of my clinical practise, professional development and research training I am used to working reflexively and being self aware. My hope was this way of working would help to limit the impact of my bias on the analysis. I kept returning to the participants' words also as a way of limiting my bias. Further, by developing the analysis through using the hermeneutic circle, where the whole text informs the meaning of a part and the part illuminates the meaning of the whole text, meaning is derived from my understanding and subsequent interpretation of the participants' words but it is guided and shaped by the whole text and informed further by the single text in its place within the whole body of all the participants' data collected. For example, Olivia states

"The counsellor was listening to my story, which was my life".
(Olivia: HAT/3)

This is one line written on a HAT form, yet the preciousness of having the counsellor there, someone who will listen and who will bear witness to a client's testimony, is replicated by all 12 participants. In my own words, all of the participants described how "it is helpful to have someone to listen to me" this being found in all texts for all participants across the corpus of the data.

4:3 Superordinate Theme One: A helpful process

It works 4:3:1	**Being listened to** 4:3:2	**Freedom to talk** 4:3:3	**Someone there for me** 4:3:4
Agnes *Joanne* *Sandra* *Gillian* *Sarah* *Steve* *Isabel* *Henry* *Lorraine* *Caledonian* *Olivia* *Lily*	*Agnes* *Joanne* *Sandra* *Gillian* *Sarah* *Steve* *Isabel* *Henry* *Lorraine* *Caledonian* *Olivia* *Lily*	*Agnes* *Joanne* *Sandra* *Gillian* *Sarah* *Steve* *Isabel* *Henry* *Lorraine* *Caledonian* *Olivia* *Lily*	*Agnes Joanne* *Sandra* *Sarah* *Steve* *Isabel* *Henry* *Lorraine* *Caledonian* *Olivia*

The first theme 'A helpful process' reflects the participants' opinion that their counselling was a positive and beneficial experience. Reflecting on their experiences of their counselling, the view of all the participants was this process of counselling was helpful for them and they felt better at the end of it than when they started. They specifically referred to aspects that they considered had made it helpful such as having someone to listen to them, being able to talk things through, talking to someone outside of their normal circle of family and friends, and not being judged. All of the participants identified that having a safe space and the freedom to say whatever they wanted to say was important. Moreover, participants spoke of their surprise that counselling worked for them having been sceptical initially about whether it would work. None of the participants could determine exactly how the process worked, but they described it as an amazing experience; using superlatives in their vocabulary to depict a brilliant and magical experience that was effective for them.

This superordinate theme of ‘a helpful process’ can be depicted in the following four subordinate themes.

4:3:1 It works

All the participants said their counselling had worked for them. There was full consensus that they felt better at the end of their counselling than before they went. While there is not a uniform description, help is discerned across practical, emotional, physical and educational realms. For some it relates to getting on with their lives and not needing further support, as Lily describes *"Being able to face life and not need any further counselling for the time being"* (HAT/4). For Sarah connecting with her counsellor and being touched by her authenticity and ability to hold her uncomfortable feelings made crying acceptable and facilitated the opportunity to deal with emotions in a safe way:

"You know it was just so brilliant. It just worked. You know it really worked for me. So, you know, the right counsellor. Someone who wasn't fazed by my tears because I cried for 19 of the 20 sessions. Um, somebody who wasn't fazed by anything I was going to say. Who wasn't fazed by my uncomfortableness. Which was massive. Um. So, you know, it just, it just kind of worked."
(Sarah: 102.)

Steve judges the success of his counselling by a measurement of his increased activity. He described how much of a mess his house had become before he started his counselling, judging the effectiveness of his therapy by the tidiness of his home now:

"I would rate it really very high, I mean for me to be sat in here now looking at this and I can see work surfaces and I can see the floor, I say it was 100% personally."
(Steve: 202.)

The clarity and understanding he gained during his counselling has now been put into action through changes in his behaviour and he is pleased with the results. Likewise, Joanne recognised how the counselling had helped her to make changes in how she approached relationships. For Joanne, she has learnt to do things differently and the repetition of "really" in her transcript emphasised that the counselling truly did work for her.

"It really helped me to understand that, accept it and move on from it and make different choices now, so really, really useful"
(Joanne: 215.)

Joanne is able to break the pattern of repeating what she does thereby gaining greater control of her life and being able to engage in what works for her.

Many of the participants were surprised that their counselling had worked for them. Initially they were uncertain of both the process to be helpful and themselves in being able to make use of it. They discussed how astonished they were that counselling was effective for them and that they gained a great deal from it. Isabel explains *"I never thought it would work and I was surprised at how effective this therapy is"*.
(Isabel: HAT/6)

It would appear that Isobel was predicting failure ahead of time, but on reflection in comparing what she first thought, with what actually transpired she is surprised at the good results and she recognises this is a successful outcome for her despite initial misgivings.

In every interview participants were asked how they thought their counselling had brought about the results they had experienced. The actual mechanism responsible for improvement could not be defined. However, what was recognised was that it was not possible to identify what made it work, only that it had worked and for them it was a positive experience. Agnes summarises:

"It just seemed amazing that you come away and think Oh god that's better out than in. But it always struck me that how the hell did that happen? Do you know what I mean? How did that happen?"
(Agnes: 18 -20)

Agnes identifies she feels better as a result of her counselling, but queries how it came about and cannot explain how it had happened. Sarah was also unable to articulate how the counselling worked, however, she did acknowledge the process of change was over time. The consensus of the participants is ‘counselling has worked for me but I don't know how it has worked’.

"It was just such a gradual process of change within the sessions, you know, the development through the 20 weeks. I used to joke that she had a magic wand because it felt like that

sometimes, that, you know, that I could just bring it and talk about it, so it became easier for me to talk". (Sarah: 158)

Similar comments to those identified above can be found in all of the transcripts, highlighting that all participants agree that the counselling they have experienced has been helpful. While individually what they each gained from the experience differs, at the conclusion of their sessions they all report the process had worked for them. This is the case despite some being sceptical initially. It was not possible for participants to identify the mechanism by which the process worked, but the language they use to describe the process is very powerful *"brilliant" "amazing" "magic"* giving a sense of a remarkably beneficial process with positive results.

4:3:2 Being listened to

All of the participants value being listened to. Within the transcripts there is a sense of the counsellor listening with understanding. This is described as a purposeful listening to ascertain clients' emotions and the personal meanings that they are discussing in their sessions. The counsellor not pathologising, the absence of someone else's agenda, being uninterrupted and clearly paid attention to, was recognised by the participants as positive aspects of their counselling experience. Knowing that the counsellor was focusing on them, as an individual, facilitated communication and helped to underpin the relationship between client and counsellor. As Isabel comments:

"*The way she was listening to me, she listened very attentively to everything and she would paraphrase it afterwards and things, so I do feel that she heard exactly what I said and was trying to help me "*(Isabel: 8)

The agenda here is the client's and the counsellor who is actively listening is perceived as being helpful and part of a helpful process. Within the process no pressure, no advice, no direction is given by the counsellor. The focus is on the client's frame of reference with accurate listening demonstrating that the counsellor is a person who is supportive and the client recognises she/he is being heard and being attended to.

Listening was not seen as a passive process, but one that is active and dynamic. For Lorraine it was an activity that highlights material to work with. Lorraine stated:

"She was picking up on things, we would discuss that and I could see that actually she was listening."
(Lorraine: 68.)

Listening builds the therapeutic relationship, it also identifies the work to be done, and it helps in other ways too. Agnes reports the benefits she gets from being listened to: *"It is talking to someone who listens. I feel such a release when I leave. Almost lighter".*
(Agnes: HAT/6)

For Agnes there is a "letting go" of weighty concerns that can be abandoned in the process of talking things through and being heard. A connection with the counsellor is generated that facilitates the client being able to share their story with another person and receive their attention in return. It offers a sense of being valued and is felt to be gratifying. Olivia describes the preciousness of being listened to when she says: *"The counsellor was listening to my story, which was my life".*
(Olivia: HAT/3)

Within Olivia's description is a sense of confiding something that is cherished, not being dismissed, but being received with great respect. The value of being listened to was hugely important to the participants in this study. It is highlighted here as a prized undertaking, demonstrating the counsellor's dedicated focus on the client.

4:3:3 Freedom to talk

This theme was referred to by all participants. Having a safe space to say whatever they needed to say. The idea of different boundaries in the counselling space, where confidentiality was upheld, meant that internal worlds could be revealed and communicating openly was felt to be cathartic in itself. It was summed up by Caledonian who stated: *"It was brilliant having someone to talk to*" (Caledonian: 23). Participants referred to struggling to say what they needed to say to people around them because they did not want to be a burden or they feared hurting the people they loved. They did not have these fears with their counsellor. Isabel explains

You know just talk about anything and everything, it has been very free flowing with me, I am surprised how well it has gone, you know, how comfortable and natural. Whereas with say family or friends, I am always very conscious of what I am saying and I don't want to upset them, am I burdening them and I don't want to be unhappy and talk about my problems to them, I want to be positive and jolly, so in a lot of ways it is that front you put on. With the counsellor you can let all that side down and talk about anything you feel you need to.
(Isabel: 24)

Inherent in this is allowing the self to be and not suppressing it to meet the needs of others. Henry recognises the unique space that counselling provided for him when he states: *"Some of the sessions it really did hurt to say things that I had suddenly remembered were going on, but it was the sort of thing that 'great I can say it, I can actually say it."*
(Henry: 119)

The contrast between the burden of hurt he has kept within and the relief he felt at being able to say it out loud to his counsellor emphasises the importance of having a place to be able to say what he wants to say. This was not an everyday experience for Henry and his counselling gave him the space to talk, an opportunity he needed. Lily also refers to the solace she gets from talking and again the sense for her too of a special place, different from the norm when she suggests: *"Being able to talk and explain about how a person feels and being able to find comfort at last for a few minutes".*
(Lily; HAT/3).

The sense of being "held" by the counsellor and being soothed in that holding reflects the enabling that the therapeutic relationship engenders. The *"for a few minutes"* highlights how briefly this respite lasts, only for the duration of the session and it recognises the difference between the freedom to talk in counselling compared to the rest of her life.

Within this theme is an intrinsic link to the counsellor being seen as a stranger; someone outside of close family and friends, someone with no connections to anyone in the client's life and therefore someone who will not gossip or leak details of what is said to them. There is a fear of being judged if they were to disclose to someone close and that they may be then viewed negatively or it would lead to them being treated differently. As Agnes describes:

"You know you are the person at the bus stop that people can tell everything. You don't know them, you are not going to see them again, well please don't let me see them again" (laughing).
(Agnes: 381- 383.)

The metaphor of the bus stop and telling your personal story to someone who is unknown to you and who you are never likely to meet again is telling. It personifies the counsellor as a safe person to talk to because they do not know the client or anyone associated with them, and what is told to them will stay secure. Nothing can leak. Gillian sums this up when she says:

"It was a stranger and I knew she didn't really know my family or people that I knew. She didn't know anybody that I knew and she couldn't discuss me to other people. There were no connections".
(Gillian: 181-185.)

An important finding was the fear of negative judgement. Rather than the fear of criticism closing therapeutic relationships down, the counsellor's non-judgemental attitude opened up a safe space where clients felt free to say whatever they wished to say, because it demonstrates they can be trusted. The counsellor's acceptance of the client and his/her story promotes a comfortableness within the counselling dyad. However, the creation of an environment to talk openly is not always evident initially as Caledonian comments:

"Because as I say the things going back to when I was a very little girl that I have never spoken to anybody about and it took a few weeks before I opened up about some of the things, but it was like once I started talking it was like opening flood gates and I just thought God I could talk to this woman about anything, and she is not going to sit here and judge me, she is not going to make me feel bad, it was excellent".
(Caledonian: 117-119)

The opportunity of having space, time and permission to talk freely facilitated by the counsellor appeared to offer these participants something unavailable to them elsewhere. This opportunity was very much appreciated and seen as helpful by the participants. There is a reassurance for them that comes from knowing the counsellor will not be troubled or upset by

what the client talks about within the therapeutic relationship. Counselling is a place to say the unsayable without fear of consequences.

4:3:4 Someone there for me

This theme describes the strong sense of the counsellor as "someone supporting me". It has positive connotations, viewing the counsellor as helping and assisting, but also unconditionally caring about the client's wellbeing. The counsellor "sees" the client and reflects the hidden material beneath the words. The client in the counselling relationship allows their self to be visible to the counsellor and the unconditional positive regard that supports the relationship permits the feedback from the counsellor to be appreciated. Such feedback accurately pinpoints key issues that the client had not considered, but then recognises and can then work with. However, the core conditions of empathy, unconditional positive regard and congruence and a good working therapeutic alliance between counsellor and client needs to be in place to facilitate collaboration and consensus on the tasks of the therapy. Some of the conditions noted above and the importance of both parties working in the relationship is evident in the descriptions of what is taking place in session as Isabel reflects on their collaboration:

"The counsellor showed me the path I need to take. Although I know I've tried to find it myself during the counselling sessions. The support of the counsellor and her empathy regarding my feelings has helped me. Her positive responses are helping me be less negative and concentrate on the things I can change".
(Isabel: HAT/8)

There is a meaningful connectedness that supports their work together and encourages a clearer perspective on what can change. Isabel perceives the therapist's empathy, compassion and support as helpful. For Caledonian it is her counsellor taking a special role, being on her side that is important:

"It sounds a bit like kids in the playground, she is on my side but I don't know how else to describe it, it was just all of a sudden I had somebody taking my side".
(Caledonian: 225.)

This describes a unique occurrence fulfilling a need for the client. The counsellor is seen as a support, someone there "for me" when no one else is. Likewise, an appreciation of not being alone is also explicated by Sarah:

"Just being able to articulate and that person being able to hold it for you and be with you in it. It just felt so supportive I think. It felt supportive and that you know, with someone just there for you. For that bit of you, at that time".
(Sarah: 366)

The sense of being recognised and validated appeared to be valued by the participants. It is evident that the counsellor fills a role for the client that is not filled elsewhere and this is determined by the quality and strength of the therapeutic relationship. The work of therapy is facilitated by this relationship and clients feel held and supported within it.

4:4 Superordinate theme two: Client's view of the counsellor

Counsellor Qualities 4:4:1	**Counsellor Skills** 4:4:2
Agnes *Joanne* *Sandra* *Gillian* *Sarah* *Steve* *Isabel* *Henry* *Lorraine* *Caledonian* *Olivia* *Lily*	*Agnes* *Joanne* *Sandra* *Gillian* *Sarah* *Steve* *Isabel* *Henry* *Lorraine* *Caledonian* *Olivia* *Lily*

The second superordinate theme relates to the participants' perceptions of their counsellor. It differentiates between the personal attributes of the counsellor and the skills that participants consider their counsellor was using.

4:4:1 Counsellor Qualities

The general perception that participants had about their counsellor was that they thought she was a lovely person whose aim was to help them. Participants identified personal qualities that they felt their counsellor possessed enabling her to be the kind of person that they felt comfortable working with. As Steve describes:

"I picked up her as a very nice person really, you know, she was very nice, very presentable, easy to talk to"
(Steve: 40)

The counsellor's ability to put them at ease, remain calm, offer understanding and be trustworthy were captured in Isabel's reflection:

"She is a very nice lady, you know I did really really enjoy talking to Xxxxxx as time went on, I felt more and more comfortable in her company and I did off-load a lot, I left nothing unturned"
(Isabel: 46)

The counsellor appeared to offer Isabel a soothing and supporting environment. The sensing by the client of the counsellor being a person they can feel comfortable with enables and empowers them to open up. The emphasis on '*really really'* and '*more and more'* illustrates how much this relationship was valued and how deeply engaged the client was able to become in the work, stemming from the connection with the counsellor that facilitated the "offloading".

Participants described a commitment from their counsellor that helps to form a bond within which the work can take place. They see her as a consistent and containing support with whom they can feel safe. Sarah reflected:

"She did anything to make me feel comfortable. And to make me feel comfortable in terms of confidentiality, and being non-judgemental. So those things she would return to, if I needed her to, she would constantly return to those."
(Sarah: 102)

It would appear there is an emotional connectedness between counsellor and client, where the counsellor empathically senses the need of the client and meets that need resulting in the work being able to continue and develop more deeply. There is an inherent patience on the part of the counsellor, she is seen as constant and reliable with a willingness to stay with the client's subjective needs, rather than a counsellor set agenda.

4:4:2: Counsellor Skills

Participants reported the work they did with their counsellor could not have been done on their own. The counsellor was picking up on things that were out of the participants' awareness and her reflecting brought it to their attention. Further, participants describe their counsellor taking a special role for them, performing a task for them, becoming someone in their life, unlike anyone else. As Sandra states:

"But things I hadn't picked up on myself, that kind of really nitty gritty hitting the hammer on the head. 'Oh yeah I do that, that's a pattern that I do'. Yeah, that's something, I repeated that I didn't realise I was repeating, a negative thought process, you know, how I felt about myself and challenging that as I say, that was a big part that, you know, I don't think I could have done that on my own, even if I had of been sat on my own room, forever on my own, because I wasn't aware of it".
(Sandra: 266.)

For Sandra a realisation takes place that "this is what I do" which creates an opportunity to consider other ways of being and learn from this. Participants' identify it is due to the counsellor's input that this realisation takes place and that enables and empowers them to make changes. Agnes also refers to this saying: *"Counsellor sort of made points - do you think?..... I thought oh my God yeah".*
(Agnes: 28.)

Some participants viewed the counsellor as an expert using her skills to achieve a helpful purpose. A "she knows better than me" description of an interaction where the client feels the counsellor is being skilful in order to help her is described by Sandra:

"I was working through things for myself, but without having, erm, Xxxxxx there to do the reflecting and to, you know, to be the person she was and to be able to pinpoint and to challenge things. I wouldn't have been able, I don't think I could have done it, it is not like I could have done it on my own."
(Sandra: 260)

There is a regard to the counsellor's skills in the repetition of "*I wouldn't have been able, I don't think I could have done it, it is not like I could have done it on my own."* This is an appreciation of the value added by the counsellor's input, but that is not to say that the counsellor actually manifested the persona of expert and this is recognised when Sandra points out *, I felt very much an equal relationship, which was really nice"* (Sandra : 228).

Conversely there was also a more collaborative stance where the counselling was seen as team work, both parties being engaged in the work, Lorraine identifies:

"I think it was just this picking up on things that Xxxxxx had the ability to pick up on the things that I was obviously thinking was really important or was affecting my mood, and then having that discussion and me accepting then, by what I am saying, actually why am I doing that?"
(Lorraine: 202)

In the talking and thinking, the work of therapy is taking place between counsellor and client, where the counsellor is facilitating the client to consider inner processes and to confront, explore and work through them, but the participant sees herself picking up on the counsellor's points and processing the work herself. There is here an equitable attribution of power in the relationship between both counsellor and client that is demonstrated in the reflections of the participant. For Lorraine this equated to working with the counsellor, but seeing herself as very much an equal partner in the work.

4:5 Superordinate theme three: Gains

Learning about myself 4:5:1	**Helping to put the pieces together** 4:5:2	**Counselling gave me the ok to do it** 4:5:3	**Feeling stronger** 4:5:4
Agnes *Joanne* *Sandra* *Sarah* *Steve* *Isabel* *Lorraine* *Caledonian*	*Agnes* *Sandra* *Steve* *Isabel* *Henry* *Lorraine* *Caledonian*	*Joanne* *Sarah* *Gillian* *Isabel* *Lorraine* *Caledonian* *Lily*	*Sandra* *Gillian* *Lorraine* *Caledonian* *Olivia*

All of the participants reported gaining something helpful from their counselling. Often cited gains were realisation, acceptance and understanding with a number of them also noting they had developed greater self awareness too. Participants described how their feelings had altered over the duration of sessions and they identified those changes as including feeling worthwhile, valuing themselves and gaining the power to make things different for themselves. Counselling was felt to be a learning process that resulted in making helpful changes.

4:5:1 Learning about myself

Many of the participants felt that a major gain had been in attaining learning that highlighted aspects of themselves they had been unaware of. In looking at underlying issues the counselling revealed different perspectives that helped the participants to change their perceptions about the way things are. As Agnes describes:

"I understand that all the negative things that have happened since childhood have made me the person I am today. I have to let go of the "nasty" stuff and take on board all the positives in my life. It was an "eye-opener" to realise there are actually quite a lot of positives".
(Agnes: HAT/8)

Counselling brings a challenge to the status quo which leads clients to question long held beliefs about themselves, bringing previously hidden concepts to the fore which influence attitudes and behaviours. It challenges the external definitions that limit self worth and prompts a shift in the locus of evaluation so that the self can be valued and work towards self actualisation. This was identified by Caledonian:

"I have spent my whole life, there wasn't any doubt I mean I just knew that I was a waste of space, that's why people didn't bother with me. But the counsellor has made me question that about myself and she has made me aware that I am a worthwhile person".
(Caledonian: 237-239)

Through the counselling process long held "labels" are disputed and self-fulfilling prophesies can be challenged to allow the real self to emerge.

It was clear that participants viewed their counselling experience as a learning process. They refer to acquiring learning about themselves and believed that the counsellor was helping them to transform the way they viewed themselves. They discover how the self has been shaped by others and how the counselling enabled their own views, thoughts, opinions and feelings about themselves to surface. Sandra states this plainly:

"It was a learning process, definitely, a learning process. A learning about myself and someone enabling me to do that".
(Sandra: 392)

Sarah too recognises the learning that has taken place for her. Learning which validates and empowers self acceptance and which allows her to change the self concept she has held for so long:

"Allowing myself to be me. So recognising myself for who I am. Learning to like myself. Learning that I'm valued, that I am of value".
(Sarah: 272)
There is an acceptance and valuing of the self. A trusting of the internal locus of evaluation and a shift in the conditions of worth that are no longer dependent on the opinion of others.

4:5:2 Helping to put the pieces together

Participants identified that their counselling had helped them to make sense of events and given a clearer understanding of their lives. They see the counselling as a process that facilitates their gaining insight and acceptance. Sandra explains:

" I can see kind of, I feel like I have pieced it together and I can see what I have been, how I have got to where I am and how I can change that and what obviously I need to accept that maybe I didn't want to accept before".
(Sandra: 56)

The counselling created a safe place where the client can accept their responsibilities. It enables the acknowledgment of the need to make changes which then supports those changes being made. Steve discusses how working with his counsellor has helped him to make connections that have clarified what was taking place. Things start to make sense and his understanding grows.

"Obviously you pin these things up and then the counsellor can remind you of the other things that are linked with it sort of thing, so it can help you put these links together".
(Steve: 284.)

The counselling brings into awareness elements to be explored, building like a jigsaw from the pieces that already existed to create a greater understanding. Counselling can connect separate parts but it can also uncover causes that fracture the pieces as Lorraine comments:

"To be able to discover the many ways in which my mind is being pulled. The extra pressures I am trying to decipher."
(Lorraine: HAT/4)

Piecing together gives an idea of fixing something that has broken thereby revealing a new whole. There is a sense of progression taking place moving from the past into a new future with new understanding.

4:5:3 Counselling gave me the ok to do it.

The participants were positive that their counseling had empowered them to behave in a different way. Often this related to doing something that had never been done before. The counselling promoted a change in the self concept that fostered a confidence that said "it's ok for me to do this". This change was felt at all stages of the process, from facilitating actual talking in the sessions to a changed world view that impacted on responses to events even after counselling had ended. Participants appreciated the role of the counsellor in creating these new experiences, conveying "permission to do this" being generated from a facilitative relationship that motivated and supported the client. Sarah reiterates such an experience:

"I think she enabled me to talk about myself. I think she made it ok for me to talk about myself, which was something I had never done."
(Sarah: 112.)

Helping Sarah to talk was fundamental for the mechanism of counselling as "talking therapy" to take place, but it also challenges a deep set way of being and brings about a new world view in which "talking about myself" is no longer proscribed and is now permitted. Isabel felt the counselling gave her permission to have feelings as she explains:

"She made me realise as well that it is ok to be certain things, you know it is ok to be angry, it is ok to feel hurt, it is ok to behave a certain way after certain situations."
(Isabel: 52)

For Isabel the learning has involved knowing it is human to have feelings. The counselling confirmed the validity of her feelings in relation to circumstances, creating an openness to experience that allows Isabel to trust her own judgement of how she truly feels. Other participants reflected on how the counselling has empowered them to behave differently. Gillian identifies that she now responds completely differently to people. She is no longer depressed by what others say, instead she can choose an alternative response, one that works for her and she relates how things no longer bother her:

"Whereas before I would have just like listened to what she had to say, but then it like it depressed me when people were telling me things and I used to think 'Oh God', where now I just, I will be truthful, it just goes over me head now."
(Gillian: 77)

Realising it is fine to do things differently brings a freedom and removes the restraints that keep life fixed in a way that does not work. Lily comments that she is now *"able to face life and not need any further counselling for the time being."* (Lilly: HAT/ 4). This was a successful experience that enables Lily to move on with her life and get her needs met.

4:5:4 Feeling stronger

A number of participants identified their counselling had resulted in them gaining strength in themselves. Through gaining inner strength the self concept of worthlessness becomes challenged and is replaced by feelings of being a worthwhile person with value. Caledonian summarises:

"I think she has made me feel that actually it is worthwhile being here and I have something to give."
(Caledonian: 49.)

Inherent in this statement is the sense of growing self worth that Caledonian identifies as stemming from her counselling. Although it is arguable that rather than saying this is something" I have done", and thereby taking the praise for herself, Caledonian is attributing the result to her counsellor "*she has made me feel"* which lays the power with the counsellor to "make her feel". In the interview Caledonian recognises the work is not complete and reports that she has been referred to the psychological medical team for further support. However, despite the early stage of the work she is already recognising changes taking place and states:

"I know I am still at the beginning of what is going to be a really long journey, but through the counselling I am sort of starting to find strength to get forward a wee bit with it".
(Caledonian: 93)

Caledonian is recognising there is still work to do, but the strength gained so far can help the work to progress further. Other participants recognised they too are feeling stronger. Lorraine reports she felt *"That I was turning a corner. That I was stronger in mind and body"*. (Lorraine: HAT/11). There is a positivity being described that she was now moving forward in the right direction. Likewise Gillian reflects:

"Yes I am a stronger person and you think like the 12 sessions erm, I didn't think I would feel like this but I can see a difference in myself."
(Gillian: 83)
Despite doubts initially that she could make changes in the short space of twelve sessions, Gillian is reporting that she knows she has changed. There is a shift in her self concept and a movement towards self actualisation.

4:6: Superordinate theme four: Negative aspects

Counselling is hard work 4:6:1	**It's not easy, but it helps** 4:6:2	**I'm not getting what I need** 4:6:3
Agnes *Joanne* *Sandra* *Gillian* *Sarah* *Steve* *Isabel* *Lorraine* *Caledonian* *Olivia*	*Agnes* *Sandra* *Gillian* *Sarah* *Steve* *Isabel* *Lorraine* *Caledonian*	*Agnes* *Joanne* *Sandra* *Gillian* *Sarah* *Isabel* *Lorraine* *Olivia* *Lily*

There were negative aspects of the counselling experience identified by participants, but they did not specifically refer to CfD, they could relate to any model of psychological therapy. Actually struggling with the work of the counselling, being in touch with deep emotions and having the focus on themselves were all aspects of the counselling that the participants found difficult. However, as hard as it was, they still attended and put themselves in this difficult environment, because they identified they were getting positive results from the experience

and the benefits outweighed the disadvantages. The time limitation caused problems for a number of the participants. A fear of opening up the work and not having time to contain it or address it was seen as a negative factor that impacted on the level of work they felt they could safely do within the given time constraints. Further, participants report feeing aggrieved when the agenda in the sessions was taken over by service procedures or policies that did not meet their needs.

4:6:1: Counselling is hard work

For many of the participants going to counselling and participating in the sessions was hard work, draining and upsetting. They described being scared to open up and then becoming distressed about the material discussed. Being in an arena where the focus was on having to talk about themselves was alien and uncomfortable, partly because this was not the norm and partly because of the depth to which the conversations would go. This was not an everyday chat. As Isabel acknowledges:

"I found every week was too gruelling, I use that word but it was too hard on me because I did feel quite worn out with it as well, you know going through that really deep, deep emotional stuff."
(Isabel: 114.)

The level of distress is considerable as Steve comments:

"I sometimes came out and it was where I had to put my dark glasses on because I had been crying that much."
(Steve: 130.)

Feelings surface in a facilitative counselling environment. Within such an environment there does not have to be a lid placed on the feelings to keep them contained and so they flood out. Whilst this encounter with feelings can be experienced as overwhelming it does put the client in touch with what is going on for them and helps them to understand their world from their point of view, which may have been hidden up to now. As Sandra reflects:

"I felt a couple of times I was uncomfortable with something, but in actual fact what I realised that was, was things about me that I really didn't want to face."
(Sandra: 372.)

4:6:2: It's not easy but it helps

Although attending counselling was hard, participants voiced the sense that it was worthwhile because they were getting something positive from the experience. They would put themselves through the distress and the anguish of looking at difficult feelings, because the rewards of emotional relief ameliorated the discomfort felt in the process. Sarah summarises:

"I found it very, very difficult to start talking about myself. I found it very difficult being in a one-to-one where the focus was on me. Um, but I mean, you know it was just so brilliant, it just worked. You know it really worked for me."
(Sarah: 102)

As hard as it is to talk about themselves, the participants appreciate that doing so is cathartic. Even when it is hard to go, participants have still pushed themselves to attend, believing that they will benefit. Gillian explains:

"I still have good days and bad days but like I mean I have gone there on bad days and I have just thought, I can't be doing with this, but then when I have come out and I have like spoke to her and everything, I felt a bit of light at the end of the tunnel."
(Gillian: 39)

It is evident that even when the inclination is "I don't want to go" clients do push themselves to attend their sessions because the sense is that this is a supportive and helpful endeavour. Caledonian recognises the improvement derived from her counselling:

"After a few weeks I felt brilliant, this has been strange because although The counsellor can't give me a magic pill and make everything better, inside, each week I felt a bit calmer because I had got something else out."
(Caledonian: 33)

4:6:3: I'm not getting what I need

For a lot of the participants the restriction placed on the number of sessions available was a concern, with doubts about being able to complete the work in the time available provoking anxiety. The feeling was they should be able to decide themselves how many sessions were appropriate and they should have as many sessions as they felt they needed. Agnes felt this very strongly:

"The time restraints and that is, how can somebody open up and lay it all out bare then somebody comes we have got to wind it up. It was too, you know, too, too short a time definitely, too short a time."
(Agnes: 257-265)

She is not alone in expressing such concerns. Lily feels she was cut short and did not have time to say all that she wished to. *"Because of time I was not able to elaborate on how this left me feeling."* (Lilly: HAT/1) and Olivia too feels that more time is needed:

"Just being limited to a handful of sessions, some of which were form filling and "getting to know you" was not enough. I had been skimming over events and not getting any depth of discussion, leaving out vital facts, having always been aware of time limitations."
(Olivia: HAT/7)

There are feelings of being rushed and pushed due to insufficient time. The decision to apply a limit to the number of sessions, whether due to protocol, funding or because of demand for the service, exerts power through improper provision denying participants what they feel they need. Counselling aims to empower clients to meet their own needs, but this is made more difficult when the mechanism that should empower is itself denying clients the means to do it because of insufficient provision.

Participants were keenly aware when events in session did not follow their agenda. They referred to irritation when administration took up vital time in their session. In relation to concerns about the limited number of sessions, when the time available was then taken up

with form filling and explanations about the service, the frustration was evident. At these times they felt their space was being eroded. As Agnes explains:

"Actually the first two sessions were about her explaining to me how the service was, what kind of therapy she practices. It was kind of her stuff. It's sort of wasted. Hang on, you're in my two weeks here. Do you know what I mean? I've only got twelve weeks and you've just wasted two flippin' weeks there."
(Agnes: A192/195/197.)

Also, concerns were raised about breaches in confidentiality of the material discussed. Counselling was seen as a safe space to be able to talk freely, but it became apparent there were consequences ensuing from sharing information that were both unwanted and alarming. Joanne was extremely upset when her counsellor perceived a risk to her baby from the baby's Father and informed social services. Joanne felt let down and her anger is clear when she says:

"I did feel really kind of, a bit angry about at the time. It kind of put me off the counselling a bit, I was in two minds about going back. I was thinking 'oh you know, I have come here for help and I am trying to sort myself out and you know you have kind of grassed me up' sort of thing."
(Joanne: 25)

In the statement above there appears to be a parallel process taking place; whereas in her home life Joanne was being let down by those she trusted, here in the counselling relationship a similar betrayal is taking place. The effect was such that this breach could have resulted in a break-down of the therapeutic relationship. The counsellor / service agenda took precedence over the client's wishes and events took place that she did not initiate. Instead of empowering, in this instance the service disempowered her and the feeling of disappointment is clear.

There were also preferences expressed about the spacing of sessions to give time for the work to be processed. Isabel comments

"Sometimes for me I think that the sessions were a bit too near together because I felt I got the most out of it processing things through, so perhaps it was every two weeks I would have a little while to think things through and I would think things through because as the sessions went on, the more sessions I have had, I realise some of them I wasn't handling very well, I was repeating myself and going over and over things and not making the most of the session, but I found that if I had a 2 week gap I was processing things and discovering things you know that had been said and done during that session and working through them a lot better."
(Isabel: 110)

All of the above comments stem from a wish to be allowed to "do things my way" but clients are prevented in doing this by structures put in place to "manage a service". The need to meet the person, achieve meaningful rapport and therapeutic depth becomes lost in the need to manage the service, with clients recognising other factors take priority over their wishes which may echo the very events that have brought them into counselling.

4:7 Effective Therapy

The current political climate is demanding the counselling profession prove its effectiveness, therefore the second objective of this study was to discover what clients mean by "effective" therapy. As discussed earlier in the Literature Review, research studies are held as exemplars of good practice to be disseminated for the good of all people with a particular diagnosis. However, this takes no account of individual, subjective need because the majority of studies are quantitative and often evidence is generalised from RCT studies which is considered inappropriate (Devisch & Murray, 2009; Chapman, 2012). What follows below are the participants' answers to the specific question "What do you think makes therapy effective? (Appendix 24). The answers have been analysed following the steps of IPA as described in chapter 3 (Smith et al, 2009) and are grouped in accordance with the themes above, but this is a deliberate presentation of the findings in the participants' words in order to convey as closely as possible the participants' views on what they themselves consider made their therapy effective. The intention here is for the counselling profession to hear from the clients, rather than researchers or policy makers regarding what makes therapy effective.

BEING LISTENED TO

Someone to listen to me

- Being able to speak to someone just there to listen.
- Support, someone prepared to listen.
- Listening and highlighting the things I have said. This shows me the counsellor is attentively taking in what I'm saying.
- For someone to spend the time to listen.

FREEDOM TO TALK

- Knowing I have help at hand and someone who is not biased or too close to the situation.
- Being able to talk and explain about how a person feels. and being able to find comfort at last for a few minutes
- Not being judged.
- Being able to really express how you feel.
- The counselling allows you the space to talk and think and then you can take that away and use it in a positive, productive way. . I mean she didn't really say or come up with any practical things, it was just literally just talking about it and me thinking.
- To be able to be in a space where you can be honest.
- You can talk about things that you bottle up and would never tell anyone else. You don't want to hurt or upset the people you love by telling them you are so unhappy and are having morbid thoughts.
- Being able to talk without being judged.
- Being able to talk frankly.
- Being able to talk to someone not involved in the situation
- Being able to talk things through.
- Being able to discuss matters and examine my feelings more closely.
- Being able to talk about how I was feeling.
- Being able to talk to someone who listens.
- Something where you feel comfortable enough to talk about yourself.

LEARNING ABOUT MYSELF

- I think the fact that it makes me question myself

- Not relying on others but helping you to rely on yourself.
- Getting more and more control of me.
- Change the negativity I'm left with.
- Like a guidebook showing you where to go.
- A learning process.
- Learning ways to manage your life and get over experiences.
- Gaining tools to help you back to the positive side of things.
- Digging deep and peeling back the layers underneath to find out some reasons why we are the way we are.
- Helpful tools and ways to change the way we think.
- The sense that you re-evaluate your thoughts and put them into boxes of what is really important.
- The counsellor made me look deep into my life and thoughts. It enabled me to take stock and to let my family know I need to be supported too. I know that it is going to be life changing.
- Looking at why I've made the choice I've made.
- Looking at why it has happened.
- Making sense of the confusion and conflict.
- More helpful to focus on the way I did what I did.
- More helpful to focus on feelings.
- Looks at why you accept stuff happening.
- Focus on behaviour patterns.
- Looking at the reasons why things happen.
- The main thing is that you can come away with a focus. So the fact that each week we pretty much spoke about ‘A’ particular thing, then you know, I would go back and reflect on that and what kind of changes can I make.
- How you feel about yourself.
- A place where you learn about yourself.
- Learn new skills to manage life.
- To recognise things in yourself so you can move on and not slip back into old patterns of thinking.

FEELING STRONGER

- Identifying the strength in yourself.
- Gain control of what happens in my life.

COUNSELLOR QUALITIES

- Trusting the counsellor and talking
- Connection with the counsellor

COUNSELLOR SKILLS

- Providing core conditions
- To look at problems in more depth.
- To really focus on what is important.
- The counsellor showing the client that only you can make the changes.
- Being able to go to somebody else about who you are and how you are, and the realisation of being able to move forward
- Confirming what I need to do
- Counsellor exploration of the situation helped to make sense of it.

COUNSELLING IS HARD WORK

- I realise I didn't like what I was hearing from my counsellor. I needed to hear this because I am making changes.

ANOMALIES

- Being able to discuss all your problems with one person
- Seeing the same person for that continuous period of time.
- It's progressive - moving at your own pace.
- Something that has a good end result.
- It's encouraging.
- It's amazing.
- Comfortable environment.

The answers given by the participants describe effective therapy as having a safe space to talk things through and to a lesser extent being listened to. They also report the effectiveness of

their counselling in terms of what they have gained from the process, primarily in terms of learning about themselves, and secondly in terms of feeling stronger. Whilst there is recognition of counsellor input, there is also a sense of collaboration, the client and counsellor working together to make the changes that are helpful for the clients themselves.

What comes across is an absence of techniques or strategies and what feels clearly evident is the client is not being directed but instead is supported to move in a positive direction which would accord with the principles of person centred therapy. Participants refer to effective therapy being like a guidebook, learning new skills, and gaining tools, confirming a sense of doing something different and making changes. This is not a static process, but a description of positive movement taking place.

The findings outlined here revealed the varied perceptions of the participants' experiences of their CfD therapy. In the discussion chapter that follows, the data from the participants are considered in relation to existing literature.

4:8 Reflections - Which way to go?

This chapter of all the chapters took the longest time to develop and write. Recognising that punctuating the transcription can change the meaning of a participant's words gave me power to manipulate meaning that I did not want. I would go back and forth between my knowledge and experience and the participants' words to ensure their meaning was as uncontaminated as possible by what I knew and what I could not have known. The weight of responsibility to represent the participants' views was immense and phrases were written and re-written many times to try and do justice to the participants' narratives.

As the analysis progressed I recognised there was a decision to be made over which quotes to include and the power to shape the research according to which quotes were picked. Hours at the computer tempted me at times to skim over paragraphs, but then the duty to the participants to represent their experiences would pull me back as I needed to show respect to their contributions. This would make me slow down and submerge myself again in their words so I could take from them their clearest meaning.

Not having the client present during the analysis was both freeing and constraining. Freeing because it meant there was an openness to explore the data without the restriction of the client correcting the interpretation, but also constraining because there was no way of going back to check that the understanding of their meaning had been accurately captured. This was felt particularly strongly in the analysis of the HAT forms for Olivia and Lily. There were themes which had emerged from the interviews of the other participants which did not appear in their forms and I had only a limited view of their counselling, particularly as Lily had only returned four forms. I am left wondering what material would have come out of an interview with them and how that might have increased my knowledge of their CfD experiences.

Likewise I am sad that having planned the study with such care, trying not to intrude on the therapy, I have actually hampered myself in not being able to ensure the HAT forms were all completed. I have ended up missing out on data that a differently designed consent form could have enabled me to access the participants more easily. If I had requested the participant contact details on the consent form initially and asked for permission to contact them, I would not have been so distant from my participants and this might have helped completion rates. However, there is the satisfaction that the study has enabled the participants to have their therapy routinely with little interference from the study and their experiences will reflect this.

For me, the clients are always the priority, but even more so now after hearing their views, they have become ambassadors showing the way that counselling should be done. The realisation must be that this is how these particular clients see counselling should be done, but it has been a hugely refreshing process to hear from the people who matter, rather than the usual professional perspective that advises counselling be done in other ways.

Working out the themes was truly illuminating. I thought I had a good understanding of what the participants meant during the interviews with them and this developed further during the process of transcribing. However, the real enlightenment came when manoeuvring and sifting through the emerging themes. Meanings jumped out as the categories were manipulated and realisation dawned that "this is what they mean" and "this is how it is for them". The learning from clients in this study for me as a counsellor has been huge and I consider that these findings challenge the current beliefs in the way things are done within the counselling arena.

Chapter 5 Discussion

5:1 Introduction

The outcome of this research has been a rich, detailed description and interpretative analysis that reveals the twelve participants' views of their experiences as a client receiving CfD. The findings in Chapter 4 present their thoughts, feelings, attitudes and reflections of their experiences and these will now be discussed in detail. As no such research has been carried out previously on this model of counselling this study presents the first findings on the effectiveness of CfD and on how these clients viewed this process. (In this chapter, as before, participant quotes are written in italics).

In this chapter section 5:2 will respond to the aim of the research which was to explore the client's experience of receiving CfD therapy. There is a detailed discussion of their experiences based on the superordinate and subordinate themes which were presented in Chapter 4 and will now be considered in relation to existing literature. In Sections 5:3 and 5:4 the first and second objectives of the research, encompassing an exploration of the client's views of helpful and unhelpful aspects of this therapy and discovering what clients mean by "effective" therapy, respectively will be discussed. Such discussions will centre on the participants' experiences based on the superordinate and subordinate themes and considered in relation to the existing literature. Further, the material presented here is linked to the CfD competencies described in the Introduction chapter. In Section 5:5 I will offer a summary of the above discussions and Section 5:6 will present the limitations of the study.

In this chapter the results are placed within a wider context. There is a dialogue between the findings and the existing literature, but it is important to acknowledge that whilst attending as closely as possible to the world of the participants, the subjective interpretations of the researcher will impact on what is presented in the thesis. Whilst the aim was to get as close as possible to the participants' view of their personal world it is acknowledged that it is not possible to access it directly or completely (Smith, 2007). The researcher is both a professional counsellor with views on the profession and its practice and a student researcher negotiating the boundary between phenomenology and interpretation. It is the counsellor and the researcher who has decided what material to include and how to frame it and those decisions will shape this discussion.

5:2 Exploring the client's experience of receiving CfD therapy

The findings in this study indicate that for all the participants their CfD counselling was a positive experience that they regarded as beneficial. They are saying "*This works for me"*. The participants recognised in their sessions they could work at their own pace on material that was important for them. That no advice was given by the counsellor and no-one was telling them what to do was seen as constructive, supporting a feeling that this was "*me time"* which sustains the concept that it is the client's self-healing capacities that make therapy work (Rogers 1957, Bohart, 2000b). Participants refer to the process of counselling as "*amazing"* and *"magical*" but they cannot identify the precise mechanism by which the "*great"* results came about. They know they obtained relief, but could not articulate how it happened. The CfD approach is summed up as "an ability to offer a therapeutic relationship that facilitates experiential exploration within a relational context" (Sanders & Hill, 2014, p.193). The participants' descriptions do fit with seeing the CfD therapeutic stance as primarily relational where mechanistic practices are avoided and a balance is struck between non-directive responding and therapeutic interventions. The participants' comments suggest that their counsellors were competently implementing the CfD counselling meta-competencies into their practice, creating an environment where helpful changes can take place (Sanders & Hill, 2014). The findings show the framework has been able to balance providing the counsellors with clear guidance on evidence-based best practice, but it has not become so prescriptive that counselling becomes mechanistic and loses its core values.

The participants recognised they have been able to express their emotions, gain insight and achieve an increased sense of self confidence by working with their counsellor in a therapeutic relationship offering what Rogers (1957) would call the necessary and sufficient therapeutic conditions to bring about personality change. These are Basic CfD competencies requiring the CfD counsellor to have "the ability to maintain and develop the therapeutic relationships" (Sanders & Hill, 2014, p.34). The core conditions include; accurate empathy, unconditional positive regard and congruence. Participants referred to the emotional connectedness they had with their counsellors. Sarah for example recognised the constancy her counsellor offered her and that her counsellor is following her in the work, letting her take the lead rather than the counsellor imposing her own agenda on the sessions. This is

evident in Sarah's statement *"her knowing when to wait and when to help me"*. Here Sarah's counsellor demonstrates her adherence to the Basic CfD competency of "Knowledge of the basic assumptions and principles of CfD" (Sanders & Hill, 2014, p.33), and working within the CfD counselling meta-competency of balancing the therapeutic relationship with the therapeutic tasks.

CfD is described as primarily a relational approach (Sanders & Hill, 2014). The therapeutic relationship is the most researched aspect of the non-specific common factors that contribute to all therapy (Weinberger, 2014). Research does show that where the quality of the relationship is good then the impact on the outcome of the counselling is positive (Martin et al. 2000; Hodgetts & Wright, 2007; Horvath, 2011; Crits-Christoph et al., 2014) and the findings in this study concur with that. The person centred approach prioritises the quality of the relationship between counsellor and client (Mearns & Thorne, 1999) and the clients' reflections in this study confirm that their CfD counsellor maintained that approach in keeping with the Basic CfD Competencies (Sanders & Hill, 2014). The findings show that the participants' perception of their counsellor's acceptance of them also fosters their trust in the counsellor and importantly encourages their own trust in themselves. This is a description of the counsellor putting her trust in the capacity of the client to work towards fostering the actualising tendency which is a movement towards autonomy and away from external control (Rogers, 1961). Working in a non-directive way where there is no intention to bring about specific changes in clients, is consistent with respecting the right to self-determination (Grant, 2014). This approach helps a client move towards becoming more truly themselves, what Rogers (1961, p205) believes to be "the essence of therapy". The findings in this study demonstrate that CfD counsellors are able to convey this "essence" demonstrating "the ability to experience and to communicate a fundamentally accepting attitude to clients" which is inherent within the Basic CfD Competencies (Sanders & Hill, 2014, p. 202).

Participants voiced different ideas on how they wanted to work with their counsellors. Some talked of wanting to hand the work over to their counsellor, wanting her to ask questions or take charge. For example Sarah stated "*I think I tried always to sort of hand the lead over to her. I'd of been much more comfortable if she had just asked me questions and I'd have provided the answers"*. However, there are clear differences in that some clients prefer to lead the sessions themselves and clearly know the issues they wish to focus on, a finding which concurs with previous studies (Gallagher et al., 2005; Simonsen & Cooper, 2015). For

example, Steve in comparison stated: *"It is the getting it out in them sessions you just join the dots yourself to a degree and I think that is the whole point, you have got to really be able to join the dots yourself".* Such contrasting views highlight the individual nature of counselling and the important contribution of qualitative research in guiding clinical practice. In this study some participants describe how hard it was to do the work in the session where having to look within themselves was really difficult. They describe not knowing how to do this and struggling with the discomfort of focusing on painful aspects of their lives as Isabel describes *"I found every week was too gruelling, I use that word but it was too hard on me because I did feel quite worn out with it as well, you know going through that really deep, deep emotional stuff".*

This contrasts with other participants in this study and other studies where clients report it is really helpful to undertake this scrutiny and they gain much from the process (Simonsen & Cooper, 2015). Focusing on painful aspects demonstrates Specific CfD Competencies in action such as the "ability to help clients articulate emotions", "ability to help clients reflect on and develop emotional meanings" and the "ability to help clients make sense of experiences that are confusing and distressing" (Sanders & Hill, 2014, p.35).

For some participants, their counselling was viewed as collaborative team work and the experiencing of a supportive therapeutic relationship enabled them to achieve self-understanding and move in positive directions (Omylinska-Thurston & Cooper, 2014). The development of mutuality in the counselling relationship is central to the counselling process and from this develops a shared understanding which has been identified as reducing defensiveness (Mearns & Thorne, 1999). Further, mutuality enables and facilitates the client's self acceptance derived from an empowering and empathic connection with the counsellor (Hilsenroth & Cromer, 2007). A facilitative therapist and a supporting therapeutic alliance are commonly seen as helpful aspects of therapy (Elliott, 2008). Whilst traditional person centred practice would view collaboration occurring only if the client wished it, CfD views collaboration as a key approach and moves away from the traditional stance (Sanders & Hill, 2014). Participants in this study felt that collaboration was helpful to them, for example as Lorraine stated "*Obviously you pin these things up and then the counsellor can remind you of the other things that are linked with it sort of thing, so it can help you put these links together".* This process highlights the use of Specific CfD Competencies in encouraging the

client "to develop new ways of understanding the situation and their responses to it" (Sanders & Hill, 2014, p.204).

The participants report individual ways of working within their counselling. For some it was a consideration of "what is going on for me" placing themselves centrally in the work and working towards self actualisation (Rogers, 1961). Others placed themselves outside of the work looking in on it, distancing themselves from too much pain, a tentative acceptance of what is being offered, but wary of the depth of the work facing them. This difference may be due to a client's readiness to make changes; they may take what they need from an episode of counselling and re-enter therapy later on when they feel more ready to undertake the work involved (Norcross, 2012). Others are able to consider their life history and the learning that comes from this, and how they could use this to make changes in their life. In their individual ways all the participants in this study were finding their own way to find their "self" and CfD was supporting and aiding them in this journey. Wampold (2012) sees clients in counselling as not being passive recipients of treatment, but instead actively processing the meanings of their discussions and taking a stance on the situation based on the conditions of worth that they hold and the roles they attribute to themselves. Certainly the therapeutic stance of CfD would concur with that view. CfD counsellors are encouraged to hold the therapeutic conditions with deep convictions as attitudes not as skills and to see them as the "very fabric of the therapeutic relationship" used to create relational moments together with the client's own wisdom (Sanders & Hill, 2014, p.134).

For some participants; Caledonian, Joanne, Isabel, Gillian, Sandra and Sarah, the tendency was to place the counsellor in a position of power in accordance with Rennie (1994), where clients defer to their counsellors. Here participants refer to their ideas of their counsellors being special people as Caledonian for example states "*I think people like her are amazing"*. "People like her" (the counsellor) being different from "people like me" (Caledonian). Whether this is to do with clients' low self esteem and a feeling of "not being worthwhile" is uncertain, but this finding fits with the Rogerian theory of a client coming into counselling in an incongruent state meeting with a therapist who is congruent and genuine and able to convey that to the client (Rogers, 1961). Sanders and Hill (2014, p.139) point out that being congruent and genuine, transparent and open is a requirement for the CfD therapist "in order to be effective and therapeutic" and is inherent in the Basic CfD Competencies.

Individuality is also reflected by the participants reporting their counselling working for them in different ways. For example Steve describes his counselling has worked for him because it has changed what he does; he can now get his house tidy, whereas for Sarah it is changes in how she feels that means her counselling has worked for her and for Isabel and Joanne, it is learning to do things differently. What is being reported here are individual responses to what is ostensibly the same process; CfD derived from a competency framework. This framework is intended to standardise practice, yet it has clearly managed to meet the participants' varying requirements. The participants are confirming the "patient uniformity myth" (Kiesler, 1966, p.110) in that they are working within the process differently and are all taking something different from their counselling, yet CfD is meeting their needs as Rogers (1957) believed they needed to be met. Participants report that they felt heard and attended to, they are being "prized" with unconditional positive regard by a therapist who is authentic and present with them. This gives a clear indication that the Basic CfD competencies are being delivered in accordance with the philosophy and principles that inform the CfD approach. Further, participants report struggling with painful emotions and working with their CfD counsellors to make sense of those emotions demonstrating the use of the Specific CfD Competencies helping clients to access and express their emotions. Moreover, the participants are describing that their counselling was allowing their self to "be" and they were not having to suppress that self to meet the needs of others. Their locus of evaluation was changing from being external in seeking the approval of others, to becoming internal with a growing confidence in themselves and they talked of now feeling "*worthwhile"*. In describing their CfD experiences the participants convey the premise that the core conditions are being perceived by the client as Rogers intended (1957) and the manualisation of counselling has not changed this as some feared it would do (Chapman, 2012).

The individual different ways of working within sessions and the differences in what the participants have gained from their counselling in this study adds weight to the theory that the client is the active agent of change in therapy (Bohart, 2000b; Duncan et al, 2004). The relationship with the self is influenced by the relationship with the counsellor, but the client's self-awareness and personal agency will impact on how the sessions are used and what may come from them (Rennie, 2001). These findings show that the participants shaped their counselling to meet their priorities and took from it what was helpful for them and significantly this differed according to what each participant felt is useful for them.

Within this study participants talked of their counselling as a precious achievement, sometimes undertaken with apprehension and uncertainty initially, but one that culminated in "*brilliant*" and "*amazing*" results. Whereas counselling professionals may talk of the quality of the therapeutic alliance these participants refer to "*magic*" and "*mystery*" in their discussions of the process; a very different worldview to the objectivity of evidence-based practice. Yet these participants are providing evidence based on their actual experiences of the phenomenon of CfD. In the hierarchy of evidence the qualitative views of 12 participants will not be heard against the gold standard of RCT's (Beutler & Forrester, 2014), yet there are growing numbers of qualitative studies that are all indicating that clients find it helpful when their therapy involves the skilled listening of their counsellor, a safe space to talk and express themselves, a counsellor who is neutral and independent, an emotional connectedness to the counsellor and a flexibility within the sessions to meet their individual needs (Elliott & James, 1989; Gallagher et al., 2005; Omylinska-Thurston & Cooper, 2014; Simonsen & Cooper, 2015).

What is clearly demonstrated in this study is that counselling is inherently unpredictable. It works in different ways for different participants and what they take from it differs too. It is complex and difficult to specify beforehand as the proponents of evidence-based practice would wish (Scott, 2010). The practice of counselling cannot be mechanistically scientific, but instead involves counsellor and client responding to each other in a dynamic relationship between both counsellor and client and involving the variables inherent in each human being. This is because what counsellors do depends on what clients do (Stiles, 2013). In the culture of evidence-based practice where the notion of evidence itself is essentially taken as unproblematic (Bohart & House, 2008) these findings confirm the need for the dialogue to continue to promote ways of working in counselling that meet the clients' needs. That CfD is able to do this, despite its evidence-based competency framework, is a testament to its design and to its ability to maintain the focus of its work on meeting client needs and in creating the conditions for this to take place.

Significantly none of the participants referred to the "model" or used its name CfD as they did when referring to CBT. They called their counselling "counselling". Whether this is due to the newness of the model and the lack of media coverage when compared to CBT, or because of the generic components of the name is uncertain. Or perhaps clients are not concerned about the name of the therapy as long as it helps them (Ahn & Wampold, 2001;

Lambert, 2007). It remains to be seen whether the anonymity of the model impacts on service provision, but there is a danger of CfD being rendered invisible because it is subsumed into a melee of indistinguishable counselling terminology. This would be a shame as these findings show CfD to be an effective model of counselling in its own right.

5:3 Exploring the client's views of helpful and unhelpful aspects of CfD

This section will highlight areas in each of the super-ordinate themes of the client views of what was helpful or unhelpful within their therapy and the findings are discussed in relation to the existing literature and linked to the CfD Competency Framework.

5:3:1 Being listened to

One of the clearest findings in this study was that all the participants said that having a counsellor who listened to them was really helpful. Glass and Arnkoff (2000) identified clients found the most helpful element of therapy to be a therapist who listens and shows understanding and there are numerous studies that echo this (Bachelor, A., 1995; Duncan & Miller, 2000; Clarke et al., 2004; Fitzpatrick et al., 2009; Gostas et al., 2012; Jones et al., 2015). Being listened to conveys the idea that the therapist is paying attention to the client and the client knows they are being heard. Not only does listening enable the counsellor to make accurate reflections back to the client, but it also conveys an important validation for the client "I am worth listening to" a powerful message for many of those who seek counselling (Fitzpatrick et al., 2009). Validating a person's worthiness demonstrates the counsellor's interest in the client and the importance of what the client is saying (Israel et al., 2008). The Basic CfD competencies are shown here, in particular "Knowledge of the person centred theories of human growth and development and origins of psychological distress" (Sanders & Hill, 2014, p.201). Additionally, the CfD metacompetencies are also in place enabling a balance between the therapeutic relationship and the therapeutic task (Sanders & Hill, 2014). The participants in this study highlighted how their counsellors listening to them was helpful to them in establishing and clarifying what they are actually thinking and the meanings they are giving to situations (Gostas et al., 2012). From such clarification different ways of understanding what is happening can emerge and subsequently can help to bring about changes (Lambert, 2007). The importance of allowing the client to be heard without the therapist intruding with their own values and assumptions comes across strongly in this study

and brings a challenge to more directive ways of working. The findings in this study highlight that positive change is achieved as a result of being listened to and this echoes previous research (Gallagher et al., 2005; Lambert, 2007; Simonsen & Cooper, 2005).

For participants intrinsic in their counsellor listening was the idea that their counsellor cared. This also confirms the conveyance of the basic CfD competencies in the nurturing of the therapeutic relationship. The counsellor showing care, encouragement, and support through attentive listening is confirmed by other studies (Levitt et al., 2006; Gostas at al., 2012). Additionally the converse is also shown where not being listened too is perceived by clients as unhelpful (Manthei, 2007). It is pertinent to state that none of the participants in this study identified their counsellors not listening to them.

5:3:2 Freedom to talk

Another major finding from the data was how their counselling provided the participants with a much needed space to talk. This was expressed as a freedom to talk. Their counselling sessions were felt to be a safe space to say whatever they wanted to say without having to take into consideration the feelings of the counsellor. Clients value being able to unburden themselves by being able to tell their story (Marzillier, 2004). The participants in this study found relief in being able to express themselves, viewing this as a real benefit that came from talking openly to their counsellor who may be the only person they have ever spoken to about certain issues. Elliott (2008) confirms that one of the most helpful aspects of therapy is client self-expression and the findings in this study demonstrate delivery of the specific CfD competencies of the ability to help clients access and express emotions, the ability to help clients articulate emotions, the ability to help clients reflect on and develop emotional meanings and lastly, the ability to help clients make sense of experiences that are confusing and distressing. The aim of the specific CfD competencies being to help clients to process their emotional experience and expand their self-awareness (Sanders &Hill, 2014, p. 35). The experience of freedom and relief comes from being able to talk openly and not having to censor anything to shield the recipient from material that may upset them (Lambert, 2007). Friends and family are seen as either too biased and partial or alternatively unable to cope with what the client wants to discuss (Omylinska-Thurston & Cooper, 2014). In their CfD sessions the lack of censorship enabled clients to articulate deeper, hidden feelings that "*have been buried for years*". Self-understanding that comes from exploring feelings and meaning

making constructed by talking helps us to assess what we think and clarify understanding (Lambert, 2007; Timulak et al., 2010). Further, images of reality, regarding self, and our relations with others, can be reviewed by talking things through and subsequently helps us to make sense of what is happening within our life (Marson, 2008). Facilitating self-expression and helping a client to self-disclose is considered to be an immensely helpful feature of counselling (Paulson et al., 1999).

A significant aspect of this theme was that it was helpful to talk to the counsellor because she was a stranger. Talking to a stranger, someone outside of close friends and family, someone with no connections, was felt to be freeing by the participants because there was no chance of anything leaking out to anyone who knew them so there could be no gossiping about them. This supported the idea of confidentiality and made talking about their difficulties easier. Agnes portrays her counsellor as the *"person at the bus stop that you can say everything to"* implying the underlying idea that "I can talk freely here because I will never have to see you again", so any embarrassment or uncomfortable feelings are more manageable with the view that the counsellor is not part of their ongoing social circle. Therefore the purpose assigned to the counsellor is the person with whom talking about important personal issues is appropriate and counselling sessions are the place to be able to do it. The concept of counsellor anonymity is supported by other studies (Kadam et al., 2001; Rogers, 2002; Simonsen & Cooper, 2015). A neutral counsellor is viewed as unbiased and impartial and this aids client self-disclosure (Paulson et al., 1999; Glass & Arnkoff, 2000; Gallagher et al., 2005). Further, Rogers (2002) identifies that because the counsellor does not know the client, the client takes the view that there are no expectations from the counsellor that they should "be" a certain way, which leaves them free to "be themselves". This certainly fits with Rogers (1961) idea that the locus of evaluation lies within the person themselves.

Not being judged by their counsellor was clearly important to the majority of the participants. The counsellor's acceptance of the client was crucial in allowing the work to open up. Initially participants voiced fears of being disapproved of and being viewed negatively. Such circumstances would have resulted in closing the work down because of a fear of criticism, but participants were delighted to find this was not the case. This is demonstrated clearly by Gillian who states *"I felt as though like she wasn't judging, because I kept saying to her 'I bet you think I am off me head don't you?' and she went 'No, no', she was really nice and it did help, it did help."* Being accepting and non-judgemental contributes to the idea of a

counsellor being with their client in a human to human encounter, which is seen as being the very opposite of objectifying or pathologising (Oliveira et al. 2012). Conveying a non-judgemental attitude is seen as significantly improving the therapeutic alliance with clients (Hilsenroth & Cromer, 2007). Further, in this environment of acceptance and unconditional positive regard, therapeutic movement is more likely to take place (Mearns & Thorne, 1999).

In any relationship where the aim is for one person to help another there is a power imbalance (Lambert, 2007). Caledonian initially believed her counsellor was immensely powerful with the authority to have her put in a straight jacket if she said the wrong thing, causing her to enter counselling fearful and guarded. It might be expected that clients who present with high anxiety to be in more distress at the outset of therapy, yet where clients can form a good working relationship with their counsellor they are expected to have a better response in their counselling (Sauer et al., 2010). Caledonian confirms her engagement in the process and how she has come to trust her counsellor when she says *" Once I started talking it was like opening flood gates and I just thought God I could talk to this woman about anything, and she is not going to sit here and judge me, she is not going to make me feel bad, it was excellent"*. The client, having a sense of being able to trust the counsellor, comes across clearly and with this in place the therapeutic relationship is reinforced (Oliveira et al., 2012). Where a client knows they are in a supportive relationship with their counsellor, who accepts them and will not judge them it is seen as a helpful factor in enabling the personal connectedness that is key in encouraging the self acceptance which is at the heart of counselling (Hilsenroth & Cromer, 2007). Pertinently, the participants' descriptions of feeling accepted and not judged by their counsellor and to feel that their counsellor is a person that they can feel safe to talk to highlights the delivery of the basic CfD competencies and in particular, the ability to experience and communicate a fundamentally accepting attitude to clients (Sanders & Hill, 2014).

5:3:3 Someone there for me

As discussed earlier a prerequisite for counselling is a healing therapeutic relationship (Gostas et al., 2012). Essential within this is the counsellor as a person who displays a keen interest in the client and in the issues they are grappling with. Clearly, facilitative therapist characteristics and a supportive therapeutic relationship are perceived as helpful aspects of therapy (Elliott, 2008). Participants in this study saw their counsellor's contribution as uniquely helpful in a worldview that considers no-one else is able to do this for them,

Caledonian comments "*All of a sudden I had somebody taking my side"*. The counsellor is viewed as distinct from other people in the participant's life and is seen as being there as a support for the client, as Sarah explained. "*It just felt so supportive I think. It felt supportive and that you know, with someone just there for you. For that bit of you, at that time"*. Participants described the sense of support that came from their counsellor as being immensely helpful and recognise the counsellor being emotionally present with them through her ability to focus on their issues. Pertinent here are the basic CfD competencies of the ability to initiate therapeutic relationships and the ability to maintain and develop therapeutic relationships with their fundamental foundation in the Rogerian core conditions of empathy, unconditional positive regard and congruence (Rogers, 1957). Based on Maslow's hierarchy of needs (Maslow, 1943), Huitt (2007) discusses the need to have relationships with significant others and to be valued and esteemed in their eyes. Maslow (1943, p381) suggests that absent relationships with meaningful others cause "maladjustment and more severe psychopathology" believing that having relationships and meeting the need to belong is a basic need that human beings will always search to fulfil. For some of the participants the struggle to meet this need and the lack of relationships were the reason for attending counselling in the first place and from this stems a lack of self esteem and conditions of worth that will be the focus of the work in the counselling sessions. Wiggins et al. (2012) consider this work takes place within the therapeutic relationship, but that the relationship itself can be transformative. Where the client can experience themselves as being able to relate to another in the therapeutic relationship, the client can then proceed to relating to others in their life (Mearns & Thorne, 1999).

5:3:4: Counsellor qualities

The way the participants viewed their counsellor seems to fall into two different categories. Participants reported an awareness of the counsellor's skills which they believed were learnt and used as part of professional practice. These included displays of professional learning and specific helpful abilities. This aspect is discussed further under the heading below of Counsellor skills. This section on counsellor qualities covers aspects of the counsellor which participants described as innate attributes that are more to do with the counsellor as a person and her subjective reactions. Characteristics, such as impartiality, remaining calm, patience, being a constant, always the same, being lovely, a nice person, making the client feel comfortable, and having a connectedness were all cited as important attributes. The overall

feeling gained from the participants was one of their counsellor taking an interest in them and caring about them, believing she was the right person for them to work with. These innate attributes are inherent within both generic and basic CfD competencies reflecting the ability of the counsellor to both engage with the client and also work according to the philosophy of the approach (Sanders & Hill, 2014). This connection between client and counsellor is a key factor in building a therapeutic relationship (Bachelor, 2011), and importantly the strength of the therapeutic relationship influences the outcome of the therapy (Owen et al., 2010). Mearns and Thorne (1999) reiterate that the counsellor's being is of fundamental importance in the creation of therapeutic conditions. Therefore the counsellor as a person and how she relates to the client is a vital factor influencing the outcome of the therapy.

Participants talked of being able to trust their counsellor, feeling safe in the environment she created and safe in the perception that she can offer containment and stay grounded no matter what emotion the client brought into the room. "*So, you know, the right counsellor. Someone who wasn't fazed by my tears because I cried for 19 of the 20 sessions. Um, somebody who wasn't fazed by anything I was going to say. Who wasn't fazed by my uncomfortableness, which was massive."* Knowing that the counsellor remains constant and reliable brings reassurance that it is safe to work at this emotional depth (Mearns & Cooper, 2005). This description conveys a real sense of engagement in the therapeutic process. It is only by the client and counsellor working together in the therapeutic relationship that this can be achieved.

5:3:5: Counsellor skills

Participants identified their counsellors were using skills in their sessions such as reflecting, querying and challenging. Indeed, the participants in this study saw their counsellors' skills as intrinsically helpful, for example Isabel comments on her counsellor *"Just her skills really, just amazing"*. The participants placed their counsellors in the position of an expert who was being skilful in order to help them (Gallagher et al, 2005). The counsellor was seen as using her skill in developing the work, picking up on things and being able to focus on what mattered to the participant. This lead to the participants feeling her input made a difference. The participants felt understood and described how their counsellor had been able to highlight material out of their awareness, and convey a sense of purpose in the sessions, this was not simply chatting, there was work to do. Further, the counsellor's ability to hold and

work with the client's deeply felt emotions was appreciated by the participants, leading them to gain new understanding as a result of the counsellor's skill. This accords with both the specific and meta-competencies of CfD requiring the counsellor to be skilled in accepting and staying close to the client's frame of reference whilst at the same time alert for pointers which are relevant to the client's presenting problem (Sanders & Hill, 2014). The interaction between the personal characteristics of the counsellor and advanced therapeutic skills show promising links that impact on outcome (Castonguay, 2011). However, it is not possible to control for variables such as the counsellor or their contribution in sessions despite evidence-based practice attempting to eliminate individual variables in randomised controlled trials by standardising practice (Norcross & Lambert, 2011). Whilst Rogers (1957) would not consider the core conditions as specific skills, believing that the manifestation of empathy, unconditional positive regard and congruence were a part of him and his way of being, currently the manualisation of counselling has specified that these are relational attitudes that therapists must adhere to (Sanders & Hill, 2014). Rogers (1961) considers that scientific ground rules must be agreed in order for the findings of science to be adopted. The evidence-based climate in the counselling profession is agreeing to view the core conditions as treatment protocols, but this moves away from the subjective experiencing at its base. That the participants viewed their counsellors as skilled is perhaps dependent on a number of factors not least of which is often the low level of self-esteem with which a client enters counselling and the expectation that they will be working with a skilled professional who has the ability to help them (Rennie, 1994). It is noted that clients who expect their therapist to be competent and capable have a more satisfactory experience of therapy. This is not necessarily dependent on counsellor expertise, but on a facilitating environment and their own client involvement in the process. (Anderson et al., 2013; Frankl et al., 2014). It could be said that a skilled therapist creates the facilitating environment that encourages a client to feel able to become involved in the counselling work; certainly the participants in this study believe that to be the case. Sandra reflects this in her comment *"I felt we worked well together"*. In CfD the "modus operandi" of the relationship is collaboration, both counsellor and client working together on the therapeutic task (Sanders & Hill, 2014, p.139). Sandra explains this further *"it helped me to put the pieces together but never in such a way as it didn't, you know she wasn't leading to that, you know, it was always open for me to do the piecing. I pieced everything together,* but *the counsellor was really helping me focus on what it was"*. Sandra's comment fits with the features of collaboration in CfD where there is an "acknowledgment that the client knows what is best for them and has the ability to manage their own healing process",

whilst at the same time there is an "acknowledgment that the counsellor has a set of understandings, skills and offerings that are intended to help clients locate and engage with their ability to self heal". The establishment of a collaborative therapeutic relationship differentiates CfD from traditional person-centred counselling. It would be usual in person centred counselling for collaboration only to take place at the request of the client. In CfD collaboration is an integral part of the model, used as part of the process of creating a threat-free relationship where the counsellor can be trusted to "make therapeutic offers" yet leave the client in control of the process (Sanders & Hill, 2014, p.140).

5:3:6: Gains

For many of the participants learning about themselves was the major gain from their counselling. This enabled them to gain understanding about why they did what they did and whether it was helpful to them or not. Further, the insight gained brought realisations of self worth and challenged sometimes years of assumptions that they were not worthwhile. For example Sarah identifies *"Allowing myself to be me. So recognising myself for who I am. Learning to like myself. Learning that I'm valued, that I am of value".* This realisation challenges repressive conditions of worth such as I only have value if I meet the expectations of others (Mearns & Thorne, 1999). The idea of counselling facilitating new thoughts and actions is consistent with previous research that identifies clients gaining a new awareness about themselves and fundamental acceptance of, and comfort with, gradual self-change (Gallegos, 2005; Fitzpatrick et al.,2009; Owen et al., 2010). This concept is also consistent with the Basic CfD competencies in particular those relating to "knowledge of person centred theories of human growth and development of psychological distress" (Sanders & Hill, 2014, p.201).

The participants identified that their counselling helped them to gain new understanding of their problems. This finding links to the Specific CfD competency of "Ability to help clients make sense of experiences that are confusing and distressing" (Sanders & Hill, 2014, p.35). Participants recognised that their CfD counselling had helped to facilitate insight, put things in context and create new meaning about distressing situations. This was experienced by the participants as gaining greater understanding and clarification of issues. The findings in this study echo Bachelor (2011, p.124) who stated clients reported "improved understanding and

new perspectives on problems" resulting from their counselling. Further, participants in this study also identified that their counselling helped them to accept things that were not possible to change. Timulak et al., (2010) confirm that therapy can help clients to work through and resolve problematic events, but it also may mean helping a client to accept things that cannot be resolved.

Participants in this study described how their counselling empowered them to make changes for themselves. This took a number of forms; from being able to look at themselves differently, actually being able to talk about themselves, facing up to things in their lives, forming strategies to approach situations, believing in themselves and last, but not least, that it is permissible to feel things and that having emotions is a human response to events. These findings link to both the Basic CfD competency of "knowledge of the person centred conditions for, and goals of therapeutic change" and the Specific CfD competency that encourages the client to "develop new ways of understanding the situation and their responses to it" (Sanders & Hill, 2014, pp.201-4). Participants describe taking from their counselling a permission to make changes as Lorraine comments, "*I think the counsellor allowed me to have permission to do lots of things that I should have done a long time ago"*. The findings in this study are consistent with Timulak and Elliott (2003) who report five types of empowerment events; poignant, emergent, decisional, empowerment, and accomplishment. They also report clients' accounts of empowerment during sessions; gaining inner strength, pride in self, self-confidence, energy flow, liberation, enthusiasm, and encouragement (Timulak & Elliott, 2003). The counsellor and the client work on consolidating insight and empowerment emerges through a combination of counsellor empathic reflection and/or collaborative interpretation added to the client's quest for self-understanding (Timulak & McElvaney, 2013). The empowerment may arise out of a conceptual linking between the past and present, or emotional experience-based awareness. These realisations lead to an understanding of a need that is not fulfilled which then moves the client to actions which seek to meet those needs.

Participants in this study reported quality life improvements stemming from the idea that they were feeling stronger as a result of their counselling. Sandra recognises *"I mean I just feel so, so much more, much more strength within myself that I didn't feel I had before, you know, and I really do feel that now"*. This finding is consistent with the fundamental principles of person centred therapy which promotes the client's agency (Mearns et al., 2013). This

finding also links to the Basic CfD competencies of "knowledge of the philosophy and principles that inform the therapeutic approach and knowledge of the person centred conditions for, and goals of therapeutic change" (Sanders & Hill, 2014, p.201), The recognition of feeling stronger by the participant reflects their emerging autonomy and clearly indentifies their release from oppressive conditions of worth. It presents a challenge to the negative self concept that has developed from internalising the values of significant others and instead a more positive self concept becomes defined by the client themselves (Smith et al., 2012). This aspect is key in terms of the non-directiveness of a person centred counsellor's approach, guided by the belief in the actualising tendency. This states that when environmental and social factors are optimal then the tendency is for a human being to proactively grow, develop, and move toward autonomous functioning (Joseph & Murphy, 2013). Crucially, it is a biological tendency inherent within human beings and this tendency is facilitated in counselling by the counsellor's respect for the self determination of the client. This finding is linked to the Specific CfD competency "Ability to help clients reflect on and develop emotional meanings" (Sanders & Hill, 2014, p.203). Sanders and Hill (2014, p.203) point out that inherent within this competency is helping clients to explore their "implicit central assumptions about self, others and the world" and to adapt these assumptions in the light of experience, also exploring alternative ways in which they experience themselves and others.

5:3:7: Additional Factors

It is evident that clients are active participants rather than passive recipients of interventions during sessions (Wampold, 2012). Further it is said that clients interpret what occurs in their counselling sessions and those interpretations impact on the outcome (Mackrill, 2009). Mackrill (2009) discusses different approaches to client agency from stages of change similar to those identified in Changeology (Norcross, 2012). Changeology suggests client agency varies at different stages of the change process and may account for why Lily was able to conclude her counselling after five sessions, whereas other participants made use of the full twenty sessions. Readiness to change may impact the results achieved in counselling.

It seems the participants in this study take a view that sees their counselling as occurring in their sessions and being the product of their counsellor working with them to achieve helpful results. However, there may be extra therapeutic factors that impact on these results and these

should be taken into account. Duncan et al. (2010) suggest that clients enter counselling with varying degrees of motivation and varying amounts of resources and believe that client extra-therapeutic factors are estimated to contribute 40% to change. Sprenkle and Blow (2004) suggest it is not only the events that take place in the counselling session that impact on the results of the session: social support networks, socio-economic status and life events will also influence outcome and awareness of this is pertinent to the results of this study.

5:3:8: Unhelpful Aspects

There were far fewer responses that related to unhelpful aspects and significantly, none of the responses related specifically to CfD. The responses could be applied to any model of psychological therapy. Significantly, although unhelpful aspects were highlighted, not one of the participants reported they felt their therapists did not understand them or had not listened (Glass & Arnkoff, 2000), or were critical and unresponsive (von Below & Werbart, 2012). Likewise, the participants' experiences of counselling are not in keeping with the findings of Lilienfeld (2007), whose participants suggested their counselling had made them feel worse and had harmful effects. It is not possible to say for sure that there are no unhelpful aspects regarding CfD. It may that the sample in this study was too small, or possibly the participants just did not wish to voice anything unhelpful out of respect for their counsellors or that they were trying to please the researcher (Rennie, 1994; Elliott, 2008). Further, participants were aware that the researcher was also a counsellor and this too may have impacted on their responses.

5:3:9: Counselling is hard work

Feeling scared to open up, being in a completely new situation and going back over years of hidden feelings contributed to the belief that counselling was hard work. Participants reflected they had never been in a situation like this before and most of them voiced that they struggled with it. There was a fear of being told what to do by someone who would give them advice. This belief was dispelled early on, but the unease took longer to disperse and the reverse became apparent which then brought its own discomfort. Clients sought advice from their counsellor, but realised it was not forthcoming and soon became aware that part of the work of counselling was to look within for their own answers. This reflects the working of

the Rogerian model (Rogers, 1961). Rogers (1961, p205) acknowledges how frightening it is to consider "becoming something different" and he feels this is the "essence of therapy". Specific CfD Competencies refer to working with the deeper emotions, helping clients to reflect on them and to make sense of distressing situations. That the participants recognise this process occurring confirms the counsellors' adherence to the competency framework (Hill, 2010). This would indicate that the framework has not changed counselling as some feared it would by allowing evidenced-based ways of working to dictate practice (Devisch & Murray 2009; Chapman, 2012). Significantly, it also challenges the idea of non-directive counselling as an "intent to fail" condition (Cuijpers et al., 2012). The idea that nothing is happening is clearly disputed. What is happening is both powerful and difficult to tolerate, but ultimately that is what can happen in a good, working, therapeutically effective model of counselling.

5:3:10: It's not easy but it helps

Participants in this study report that attending for their counselling is hard, draining, exhausting, uncomfortable, nerve wracking and disturbing. The findings here concur with earlier studies (Berg et al., 2008; Timulak et al., 2010). However, participants say they kept going to sessions because they believed they were getting something positive from the experience. It is characterised as much more than just going to talk. It is recognised as being about learning, working and progressing. Participants discussed how difficult it was to talk about themselves and to face things they had avoided facing for years. However, similar situations are viewed differently. Being tearful was viewed as overwhelming by Steve who described having to wear dark glasses to hide his crying, but seen as a release of tension by Agnes who felt relief finally have a "*proper crying session"*. McManus et al. (2010) describe such experiences as an emotional roller coaster; highs from the achievements and improvements, but lows from the anxiety of undergoing the process.

5:3:11: I'm not getting what I need

For half of the participants the limited number of sessions was problematic. A need to have more sessions to enable them to open up their work to sufficient depth and have time to contain it and work through it was desired. The feeling was sessions should continue until

they themselves were ready to end, rather than have a preset number of sessions authorised as this was felt to curtail the work. Also for some the actual time in session and the frequency of sessions was an aspect they would have preferred to change. This limitation has been found earlier (Glass and Arnkoff, 2000; Barkham et al., 2006; von Below & Werbart, 2012). McManus et al (2010) identify that having time to consolidate gains is an important aspect of counselling, while Cape et al (2010) caution that results are poorer for time limited therapies in primary care compared with therapies of longer duration and that for many patients brief treatments may not be sufficient. There was a variance in the number of sessions allocated to the participants, ranging from six to twenty. The external imposition of a time limit on sessions is at odds with a Person Centred perspective where the client is held as expert on self (Rogers, 1951). The participants are identifying "this is not right for me" and their needs are not being met due to funding shortages and evidence-based practice (Layard, 2012; Tomlinson, 2013). In their review considering the parity of esteem between mental and physical illness BACP report that "half of patients who complete therapy feel that the number of sessions received is insufficient" (2014, p.7). Gyani et al., (2011) highlighted clients were not getting sufficient sessions in the IAPT programme and this is confirmed by the participants in this study. This study identifies practice-based evidence that needs to be heard. Five of the participants reported attending a course of CBT before they were referred on to CfD. Four participants reported being given an onward referral to "psychotherapy" as they called it when their CfD sessions had ended. Two participants describe a therapy journey moving from CBT, to CfD to psychotherapy. It raises the question as to would this journey be necessary if they could stay longer in one therapy and work though their concerns till they felt ready to conclude. This question is pertinent given the "abundance of research" showing that all bona fide therapies are effective (Lambert, 2013b, p.43). The shortcomings of IAPT fit with what Mearns and Thorne (2000, p41) refer to as the "politics of appearances" where it is seen to be important to be "doing something", but what is done is much less than what is needed. There is a dilemma in whether to bring more therapy to more people regardless of it meeting their needs, or to more effectively help fewer people.

Other aspects that were viewed negatively relate in the first instance to time being taken up in session with outcome measures to complete and administrative issues. Considered in the context of the issue of time limited sessions and the participants' feelings that there is insufficient time to get the work done, this was an important issue. When time is used for material other than the client's agenda, the frustration felt by participants that their time is

being eaten up by matters that the counsellor has introduced was palpable. Participants suggested it was an encroachment on their counselling time that is already scarce and highlights the difference in priorities between the socio-cultural needs of the client in wanting to talk and work on their agenda and the biomedical zeitgeist of evidence-based practice (Kadam et al., 2001) where the outcome measure has a louder voice than the client.

Secondly, participants voiced their dismay when there was a threat to their confidentiality. As identified earlier, participants viewed their counselling sessions as a safe space to talk. This safety was shattered for two of the participants when against their wishes their counsellor wanted to report issues the participants had disclosed to outside agencies because of a perceived risk. Whilst confidentiality is viewed as a fundamental ethical and legal obligation owed by counsellors to their clients, it is not absolute and there are exceptions to this (Bond & Mitchels, 2014). What seems contentious is whether counsellors are breaching their clients' confidentiality because of actual risk that requires active management, or whether this is adherence to service agendas for the purpose of limiting liability. Where outside agencies had investigated, no action was taken, but the damage to the therapeutic relationship was such that the participants felt they may not have returned to their counselling. They did return, and the relationship was strong enough to continue, but the breach could have caused a potential termination in therapy and the consequences of this must be weighed against the perceived need to break confidentiality.

5:4 What do clients mean by effective therapy

Although all the participants had come into counselling with a diagnosis of depression all the participants brought their own issues and perspectives on those issues. It is evident from the findings reported earlier that what took place in their CfD sessions aligns with Stiles et al. (2008) in that no two participants had identical experiences in their counselling sessions and arising out of this are different meanings of what effective therapy meant for each person. For this reason it is crucial to understand the participants' view of what they feel is effective counselling for them, as they each revealed a meaningful evaluation of the effectiveness of CfD from their own experience and it is not possible to obtain this data without their input (Lambert, 2007). The client perspective brings another lens to the debate regarding what

makes therapy effective. It is not an objective scientific lens, but it is based on experience and in that sense it is indisputable.

The participants consider that effective therapy comes out of a trusting relationship with their counsellor, where they have a good connection and can focus on problems in depth. This comes about as a result of feeling supported by their counsellor who attentively listens to them and gives accurate feedback on points that then brings them into the client's awareness. These findings concur with previous studies (Horvath, 2011; Crits-Christoph et al., 2014; Omylinska-Thurston & Cooper, 2014). To really focus on what was important to the client was seen as enabling the realisation of what needed to change which could then be explored. As found previously, working with a counsellor who accepted them was seen as a vital component of effective therapy (Hilsenroth & Cromer, 2007; Oliveira et al. 2012). Feeling judged was viewed as a factor that would inhibit them, making a client close down rather than open up. The participants felt the effectiveness of their therapy was promoted by being in a space where they could be honest and this was facilitated by the acceptance of the counsellor, but also because she was a stranger to them therefore they could say what they needed to say and not fear the consequences.

Participants saw their counsellor as crucial to the achievement of effective therapy. Her responses and personality impacted on the therapy and the participants recognised and appreciated this. They saw her responses as "*peeling back the layers"* so the work could move to deeper levels. Further, there was a strong sense that the deepening of the work was dependent on the counsellor being there. Participants felt they could not have done this on their own without their counsellor. Her reflections were felt to help make sense of the confusion and conflict, and help them to understand why things happened and to move forward.

5:4:1: Definition of effective counselling from the client's perspective

Given the current political climate where the counselling profession is required to demonstrate its effectiveness based on evidence from RCT studies (Cooper, 2011), the aim in this study was to present an alternative view by obtaining evidence from clients themselves of what they found effective in their counselling for them. This informs the counselling profession and policy makers of a different perspective about what matters to the client in a

counselling session. Participants in this study answered the specific question "What do you think makes therapy effective"? (Appendix 24). Their answers were analysed and from this analysis originated a definition of effective counselling based on their CfD experiences. The word definition is used here as a statement that explains what the participants consider is meaningful to them in creating an experience of counselling that is effective in meeting their needs. This is a definition that takes into account the participants' different ways of working within sessions and the different gains that each took from their counselling. The competency framework of CfD suggests the components of effective therapy for the counsellors, the definition derived from the participants in this study offers a view from the other side of the dyad.

5:4:2: Study derived client definition of effective counselling

Effective counselling is defined by clients as having a skilled, accepting counsellor to attentively listen to them in a safe environment where they can feel free to talk about their situation and how they feel about it. Clients consider that effective therapy is a learning process where they can find out the reasons for why they are the way they are, learn new skills to manage their difficulties, which helps them to feel stronger and to gain some control over their lives.

5:5 Agendas

The twelve participants in this study cannot advocate that CfD works for everyone, but having received CfD, each participant is clearly saying their counselling has worked for them. To find the support that works for them is every client's agenda when they come in for counselling. That the development of CfD was not greeted with unanimous welcome indicates other agendas. Conflicts over professional identity, territory, power and access to resources all stem from the question of who defines the practice of counselling (Addis & Cardemil, 2006). It is clear there are many external others that now objectively encroach on the subjective endeavour of counselling and there are many competing agendas. My agenda from the outset of this project has been to undertake and complete this thesis and produce meaningful results that can positively impact on the profession of counselling. However, it was the pressure coming from other agendas that impelled the undertaking in the first place. Following the Layard report (2006) IAPT has the laudable aim of increasing access to psychological therapy for people suffering from depression and anxiety, but it is constrained

by economic agendas resulting in people in need of psychological therapy not getting the therapy they need (BPC & UKCP, 2015). IAPT is also underpinned with a hidden agenda of getting people back to work and off welfare benefits (House et al., 2011). The idea for this study was triggered initially by the threat to the existence of counselling in the NHS (Pearce et al., 2012a). CfD was developed with the agenda of maintaining counselling in the NHS, where counsellors want to keep their jobs and use their skills to reach people suffering with depression and help to ease their emotional pain (Sanders & Hill, 2014). The agenda of the NICE guidelines is to determine which treatments should be approved, but the way this is done is not agenda free (NICE, 2009). Hierarchies of evidence have established CBT as the preferred approach regardless of what clients themselves may choose. The importance of meeting client need matters more than ever not only due to wishing to honour the participants who shared their lives with me and allowed me to witness their stories, but vitally for the countless other would be clients who perhaps cannot say at present "counselling worked for me". The participants in this study had a positive experience in their counselling, but this is not always so due to the professional climate where evidence-based practice has other people deciding what works for clients. There is an argument that the basis for person-centered therapy lies in the ethic of "*respecting the right of self determination of others*" (Grant, 2004, p.158). Between self-determination and evidence-based practice lies a debate involving epistemological positions and world views, but there is an ethical component too which begs the question who has the right to say what is right for another?

That the client should set the agenda in a counselling session is to me self evident; according to Kierkegaard (1941, p18) *"to be that self which one truly is"*, and Sartre (1996, p.30) *"man is what he makes of himself"* with Rogers (1980, p.49) believing that " *the individual has within himself or herself vast resources for self-understanding, for altering his or her self-concept, attitudes and self-directed behaviour"*. However, these principles remain unheeded in the purview of evidence-based practice which sets the standard for what should be practised in counselling in the NHS. Clients are saying clearly what they want, but they are being overruled and presented with a limited choice that often does not meet their needs (BPC & UKCP, 2015). The profession needs to listen to the clients. In every sense this is true; in sessions absolutely, but in matters of policy too. The profession needs to hear what clients are saying and respond in a way that meets their needs.

5:6 Summary

The aim of this research was to explore the client's experience of receiving CfD. The first objective was to explore the client's views of helpful and unhelpful aspects of CfD. The findings reported here echo much of the existing research findings on counselling in that participants reported their counselling was effective for them and it was helpful to have a skilled counsellor who listened to them and provided a safe space to express themselves in a supportive relationship where they were not judged. These are not new findings about counselling per se, but they are innovative findings in relation to CfD. Further, this research adds an additional dimension to the body of counselling research in that these are the first findings on the effectiveness of this new model of counselling. Significantly, because they are wholly stemming from the perspective of the client, these findings contribute to the growing corpus of knowledge about what clients want and find helpful from their counselling.

This research has identified individual differences in how the participants wanted to work with their counsellors, some were happy to take the lead in sessions and some found this hugely difficult, but ultimately worthwhile. The findings also show individual ways of working within counselling. Some of the participants immerse themselves deeply in the work, others work more tentatively, apprehensive about facing aspects of themselves, and there are others who hold back, fearing that deeper working cannot be contained within the time available. Additionally, the participants reported their counselling working for them in different ways, empowering them to make changes that are practical, psychological as well as emotional. What this highlights is the individual and idiosyncratic needs of clients are being met by a model of counselling based on a framework that aims to standardise practice.

There were fears that the competency framework would change counselling from its non-directive stance due to the framework directing ways of working, however, the findings in this study indicate this is not the case. What these findings reveal is that there is in CfD a confirmation of the core values of counselling that have been reported in numerous studies over the years and these values are present and active in this manualised therapy.

The second objective of the research was to discover what clients mean by "effective" therapy. The purpose of this objective was to provide guidance that will inform professional

practice with client based evidence of what makes this model of therapy effective or not effective for them. From the participants' reports on their CfD experiences in this study it has been possible to create a definition of what these participants feel makes therapy effective for them. This finding is crucial as it is currently the only definition of what clients consider to be effective therapy based on their experience of CfD. Moreover, it stands as a challenge to the medical model of evidence-based practice, as what is presented here is practice-based evidence that shines a light on what is effective from the very people who have been through the experience. As a result of the above discussion key issues for recommendations for future professional practice will be proposed in the final chapter of this thesis.

5:7 Limitations

This thesis has a number of limitations. Due to the newness of CfD the recruitment pool was very small, both for counsellors delivering CfD and for clients receiving it. In both of the research sites all of the counsellors were female and there were no ethnic minority counsellors or clients. Participants were not randomly recruited, the participants were recruited for the study by the counsellors working with them. This may have had an impact on who was asked to participate and whether they agreed. It must be presumed that the therapists used their own criteria in selecting their clients and that the clients were interested in the project. It has been identified that people participate for many different reasons in a research study, considering the costs and benefits to themselves and to others (Bourne & Robson, 2013). It could be argued that this form of selection on the part of therapists and the clients themselves may have created bias which might have impacted on the findings (Mitchell & Jolley, 2013).

That the researcher is a counsellor in clinical practice may have impacted on the interviews. Knowing I was a counsellor might have made participants wary of what they told me, but conversely my counselling skills may have helped to form a working relationship that put participants at ease and facilitated their interview. It is also possible that a counsellor's trained ear and keenly tuned response may have had the researcher closing some material down for fear of opening up issues that were more suitable for a counselling session than a research interview. This was done in the interests of risk management, but could possibly have lost material that would have been useful to the study had the conversation continued.

This study is retrospective in nature and dependent on participant recollections and what they are prepared to report. Participants reflecting on what could be considered an emotional experience may find it hard to put into words. There may be aspects of the experience they do not wish to talk about, or do not have the language to convey, and events may be forgotten, misremembered or altered (Riach, 2009). Participants may be playing the part of interview respondent which may colour their view in terms of what they feel they "should" be saying. They may make attributional errors where they wish to reflect their counsellor in a good light, or want to please the researcher (Elliott, 2008). The HAT forms were intended to act as an aide memoir however, the design of the study made it problematic to ensure the forms were completed as the researcher was distant from the participants and many forms were thrown away or simply not completed which made them less valuable than was hoped at the outset.

5:8 Reflections - Park up for a moment

Pulling all the threads together in this discussion shed beams of light over all the aspects of this project. It reinforced the initial reasons for undertaking the doctorate in the first place in wanting to address the challenge to my daily work coming from others who were pushing different theoretical allegiances. In writing the discussion chapter I began to see how the picture built around the different theories. My participants words amplified my learning and brought to life what before had been dry procedural commentaries found in the research papers I had read. I could now relate what my participants were saying to these commentaries in a way I could not have conceived prior to undertaking this study.

My reflections on this journey are based on several audit trails. The research diary full of jottings made at every conceivable hour of day and night as thoughts came to me and had to be captured, but also from the hugely useful walls of post it notes laden with the themes of the study. Every time I walked past them they prompted ideas and more reflections. If one note fell off it forced me to consider where it needed to be reattached and whether the fit was right. Keeping the participants on their own individual coloured post its kept their identity

and allowed their voice to speak through in both the findings and the discussion chapters and it helped to ground the argument on what mattered to them because I could visualise the participant and the context of the comment.

The research demanded that I set aside my hunches and I did do this as best I could. I viewed the analysis as a new canvas to be revealed. I was eager to see what would be shown, and tried to start from a dispassionate and detached stance. It was so exciting though to hear the participants' view and it was hard to stay detached. It was with delight that as with peeling an onion, layer after layer of revelation uncovered meanings relating to how clients feel about their sessions. These meanings depicted what they experienced and it was a privilege to have a window into this world.

Chapter 6 Conclusion

6:1 Introduction

This final chapter draws together the conclusions from the research process and the subsequent analysis. This chapter looks at how the aim of the research has been met and presents the unique contribution to knowledge made by the research. As this study is undertaken as part of a Professional Doctorate there is a necessary requirement for the research to *"further advance or enhance professional practice"* (Lee, 2009, p.7), therefore there will be a consideration of how this study can inform practitioners and the practice of counselling. Additionally, recommendations for further research are identified.

6:2 The research aim

The overall aim of this thesis was to explore the client's experience of receiving CfD, with the objectives being to explore the client's views of helpful and unhelpful aspects of this therapy and to discover what clients mean by "effective" therapy. The research aim was met by exploring via interview the views of ten participants who had been clients receiving CfD, five of whom had also completed HAT forms and two further participants who completed HAT forms only. Their experiences were analysed using IPA, a qualitative research methodology that focuses on how people make sense of their life experiences (Smith et al., 2009). The analysis provided rich detailed descriptions which gave deep insights into the participants' experience of CfD, covering both how it felt for them to be in the counselling process and what they achieved as a result of attending. These findings contribute to research knowledge by providing insight into the new model of counselling, CfD, and they present the counselling profession with the opportunity to gain understanding of what is taking place in CfD sessions from those who are experiencing it.

6:3 Overview

At the outset the background and context which prompted the study were introduced. The necessity to increase the support for people suffering with depression and anxiety was highlighted and the IAPT service that was created to address this need was discussed (Layard, 2006). However, laudable as IAPT is, it was argued that the dominance of CBT in the NHS was narrowing the choice of psychological therapy available to clients and resulting in experienced counsellors losing jobs (Perren & Robinson, 2010). It was explained why CfD was developed as a pragmatic solution to address this situation (Pearce et al., 2012a), even though doubts were expressed that counselling was losing its way (Chapman, 2012). With members of the public now treated as "knowledgeable consumers of health care (Allen, 2000) the importance of obtaining the client view of CfD was clear, as without knowing the client's view of their therapy there can be no effective evaluation of that therapy (Lambert, 2007).

The literature review contextualised this study further. It provided a thorough understanding of the topic and identified where this study fitted against the existing research. The review highlighted the effectiveness paradox of counselling and the ongoing debate between the common factors approach (Wampold, 2001), based on Rosenweig (1936), and those who consider specific factors make counselling more effective (Hunsley & Di Giulio, 2002; Clark et al., 2008; Salkovskis & Wolpert, 2012). Further, the review discussed the difficulties of carrying out research on counselling and the impasse currently where RCT evidence is held as gold standard, but is felt by many to be an inappropriate methodology for a subjective endeavour such as counselling (Krause & Lutz, 2009; Storr, 2011; Stiles, 2013). The review highlighted what was felt to be helpful and unhelpful in counselling and also identified that much research in counselling is focused on outcome studies or from the therapists' perspective. The review underscored that by comparison, research from the client's perspective is lacking and identified there is a definite gap in the research corpus from the client's side of the dyad. This study makes a significant contribution towards addressing that gap and adds to the body of knowledge regarding the client's perspective of CfD and what is effective for them.

The methodological approach needed to meet the aim and objectives of the research was described. A discussion regarding research paradigms was followed by a detailed explanation

of why the qualitative methodology of IPA was adopted to access the insight of individual, subjective perceptions of experience (Smith et al., 2009). A purposeful sample of clients who had experienced CfD and a small number of ten interviews allowed an intense interpretative analysis of this homogenous group. The research design of post session questionnaires and semi-structured interviews had the aim of maximising data capture whilst minimising any interference in the therapeutic relationship. The complexities of the boundaries between therapy and research were considered as were the ethical challenges of designing a counselling research study.

The findings that were presented and discussed in relation to the existing research provide a reflective engagement with the participants' data and offer insights into their experiences of CfD. Whilst all the material presented here was subject to researcher interpretation, the findings are credible. The process of working throughout the study from conception through analysis to conclusion has a full audit trail of paperwork, all of which can be confirmed and which is the foundation of the trustworthiness of this research.

Out of the analysis emerged four superordinate themes and thirteen subordinate themes.
CfD was found to be a helpful process. Being listened to, having the freedom to talk and having the counsellor there in a supportive relationship all contributed to the confirmation that CfD worked. The counsellor's role was seen in two ways; "qualities" described innate attributes that supported the view "she is the right person for me to work with". Secondly, the counsellor was felt to be using "skills" to develop the work. Participants credited the counsellor's input with making a difference to work that they could not do on their own. There were clear gains that came from the CfD experience; learning about self, clarifying matters, gaining insights and understanding and being able to make helpful changes. The counselling process was experienced as empowering and helped clients to feel stronger. CfD was described in superlatives as: "*amazing", "brilliant", "magical"*. However, the precise means that brought about changes could not be identified and the description of the process of counselling echoes the common factors approach (Wampold, 2001) in that general processes were identified, rather than specific techniques.

There were no unhelpful aspects of CfD specifically reported, however, there were negative factors identified that could be inherent within any model of therapy. Being in the process of

therapy was felt to be hard work. There was unease and discomfort that was hard to tolerate, looking inward was difficult and the process of change was frightening to contemplate. Form filling, administrative issues and breaches of confidentiality also caused concern.

This study has reported on the experiences of a homogenous group of clients - in that they are all presenting with depression and they all received the same standardised therapy, CfD. Yet it would be wrong to assume equivalence in their experiencing. There are differences in the experiences of both the counselling process and the gains derived from that process. What the divergence highlights is that CfD is helping each client to meet their needs in their own way. This is a key aspect of person centred therapy. It is not possible to describe these experiences as uniform and therefore we cannot assume it will be the same for everyone. What is clear however, is that all of the participants in this study, despite their distinct individualism, all confirm that their counselling has worked for them.

That a client is able to go into counselling and work with a counsellor who enables them to get their needs met is the ideal. Certain participants in this study were able to do just that. However, for others even though they report the counselling as helpful, the time limitations restricted the depth of the work causing them either to pull back leaving some work undone, or because there was insufficient time to complete the work it necessitated an onward referral to another service. This is less than ideal.

Given the current climate of evidence-based practice in the profession, where the decision of what is effective therapy rests with NICE (NICE, 2009), it was crucial to understand the clients' view of what they feel is effective counselling for them. Participants answered a specific question of "What do you feel makes therapy effective?" and their answers give a clear definition of what is important to them and what they need their counselling to deliver:

Client derived definition of effective counselling

Effective counselling is defined by clients as having a skilled, accepting counsellor to attentively listen to them in a safe environment where they can feel free to talk about their situation and how they feel about it. Clients consider that effective therapy is a learning process where they can find out the reasons for why they are the way they are, learn new

skills to manage their difficulties, which helps them to feel stronger and to gain some control over their lives.

6:3 Unique contribution to knowledge

At the outset of this project the unique contribution to knowledge from this research was intended to be two-fold but with the development of the client derived definition of effective counselling this study has increased its unique contribution to counselling knowledge by delivering three significant objectives.

This is the first research study on the effectiveness of CfD and as such makes a substantial contribution to counselling knowledge in that it breaks new ground in delivering to the counselling profession a picture of what is being experienced in this new model of counselling. The findings provide the profession with insight into a model of counselling deliberately designed to be evidence-based, the significance of which has ramifications that affect the future of counselling in the NHS. The profession can be reassured from the findings in this study that participants are saying clearly that they find CfD effective in meeting their needs.

Secondly, this study explores the client's experience of CfD. This study delivers to the counselling profession a clear view of what is taking place in this therapy from the perspective of the client. In addition, this study also brings the much needed standpoint of the clients' views to the attention of policy makers with a clear message that their experiences of CfD have been helpful to them. This study challenges the assumptions of evidence-based research that asserts what is helpful for clients in counselling and offers instead a counter view of practice-based evidence from those who have directly experienced CfD.

The third significant contribution arising from this study is a client derived definition of effective counselling based on their experience of CfD. This is the first time this has been achieved. This definition acts as a guide and a reminder to the profession of why we do what we do and how clients would like us to do it.

6:4 Recommendations for practice

This research has established that the participants found their experience of CfD to be helpful for them and they consider their counselling to be beneficial and effective. There are clear implications for the profession arising from this. The findings from this study indicate that the CfD competency framework which provides clear guidance to counsellors both facilitates their adherence to a standardised way of working and enables them to meet individual client needs. The findings from this study offer reassurance to the counselling profession that counselling is not losing its core values and they can regard CfD as a constructive bridge between prizing the subjective needs of their clients and the demand for evidence-based practice.

As CfD can be said to be a bona fide evidence based therapy which is effectively able to meet the needs of individuals it is vital that more counsellors complete the training in the model, qualify and go on to deliver CfD in IAPT services. Equally important, more IAPT services need to adopt CfD and this will widen the choice of therapies available to clients. This was a key objective of the Layard report (2006) that up to now IAPT has struggled to meet (Pearce et al., 2012a).

The findings from this study highlight there are aspects of the counselling experience that participants felt were problematic. Time limited sessions were felt to curtail matters or there was not enough time to finish the work. There is evidence that half of clients seen in IAPT services feel the number of sessions is insufficient (BACP, 2014) and it is recognised that results are poorer for time limited therapies (Cape et al., 2010). It would be ideal if the number of sessions were determined by need and progress towards recovery.

6:5 Further Research

The rich results and clear theme development emerging from this thesis highlight the value of using qualitative research methods that enable the participants' views to come to the fore. It would be useful for many more studies to ask their participants the question "what do you think makes counselling effective?" Further studies can build a body of knowledge that

eventually can challenge the mass of positivist research with practice-based evidence from those speaking about their own experiences of counselling.

There is a growing body of research that is gathering evidence of what clients find helpful and unhelpful in counselling and psychotherapy and this corpus of knowledge needs to be furthered in order to address the lack of research in this area. Research from the client's perspective needs to be undertaken across the spectrum of modalities and with different populations and different concerns to increase the professions' understanding of what is useful to clients in their counselling.

There is further work to do certainly in exploring all aspects of CfD. There is an RCT ongoing to test the efficacy of CfD (Barkham, 2013). This is the PRaCTICED Trial: a fully-powered pragmatic RCT of CfD versus CBT currently being conducted by the University of Sheffield within the Sheffield IAPT service. From the clients' perspective the comparisons and interpretations offered in this thesis should be considered as a point of departure to be built on with further research. As more counsellors are trained in CfD and more services adopt the model, more research can be undertaken with more clients. This can only be helpful in building professional knowledge identifying what clients' need from their counselling.

Certainly there is further work to do with regards to disseminating the findings of this study to appropriate professional organisations, conferences and journal articles.

6:6 In conclusion

This study has met its aim. A clear picture has emerged of the participants' CfD experiences. The findings in this study show that clients value the core concepts of counselling and this echoes many of the existing findings in counselling research. The findings from this research reaffirm that the core values of counselling are being delivered, even though CfD is an amalgamation of two therapy models, and is built around a competency framework that is intended to standardise the practice of counselling. The participants in this study are saying "this counselling is helpful for me, I like it and it effectively meets my needs".

6:7 Reviewing the journey.

This thesis has not just been a process of learning how to do research, it is an undertaking that has challenged me repeatedly on many levels. On a personal level I have become more proactive and more determined to achieve my own ends. I have learned to be more critical and less accepting of other views. I have certainly learned persistence. Undertaking this study has also resulted in huge professional learning in being presented clearly with what clients want from their therapy. It is a message that comes across loud and clear and has kept me grounded, when reading the journals and hearing expert opinions have tempted me in more abstract directions. To meet my clients "where they are" in a psychological sense reminds me never to forget my client's individuality and it is a humbling reminder that often in session neither of us know the answer and therefore the only answer is to trust the process, designed by Rogers and refined by CfD.

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Willig, C. (2013). *Introducing qualitative research in psychology*. (3rd ed.). Maidenhead: Open University Press

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World Health Organisation. (2014). Depression is a common illness and people suffering from depression need support and treatment. Retrieved 17 March, 2015, from http://www.who.int/mediacentre/news/notes/2012/mental_health_day_20121009/en/

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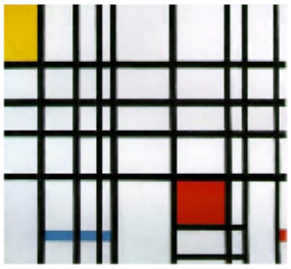
Appendix 1: Counselling for Depression Competences



The competences required to deliver effective Counselling for Depression (CfD)

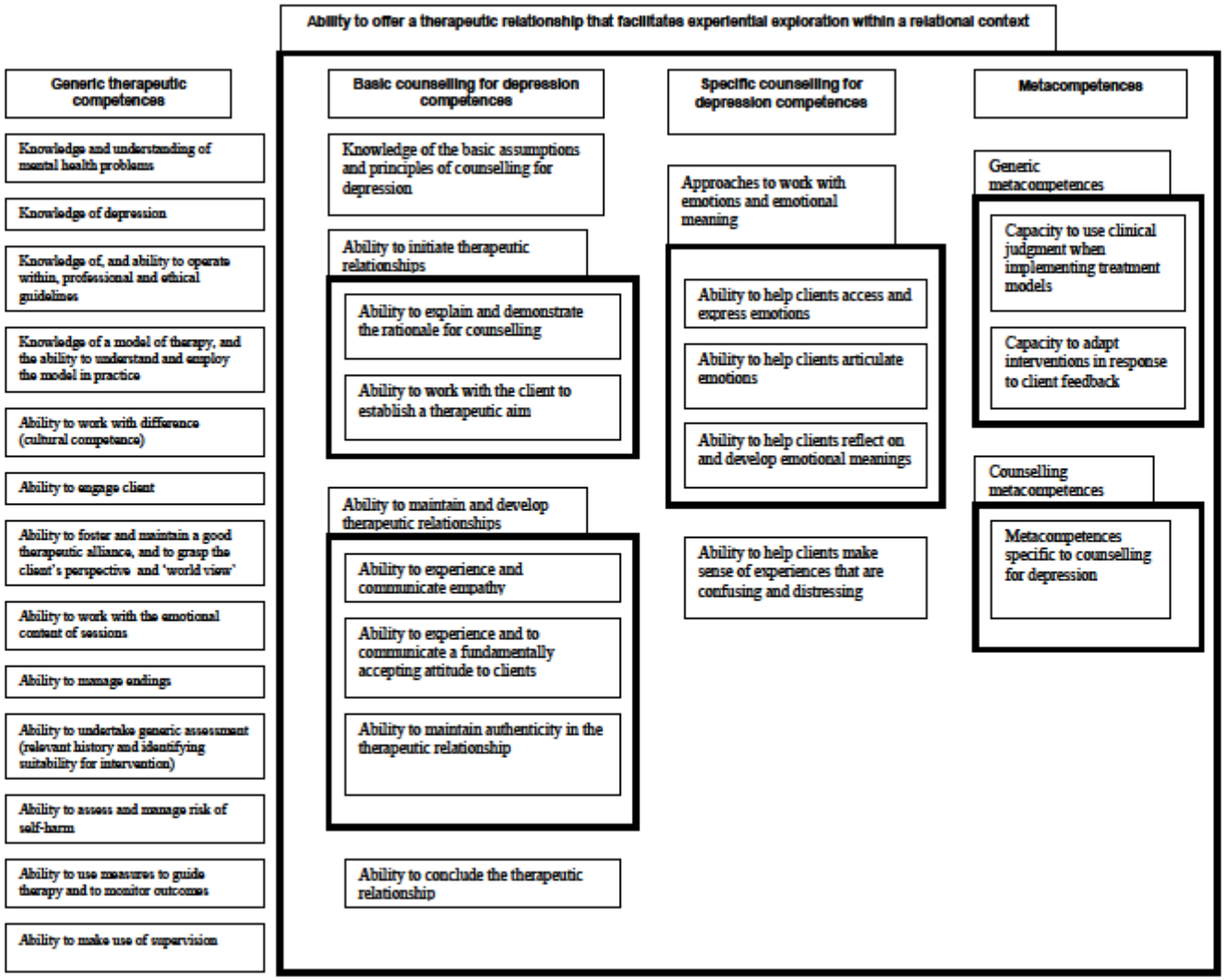
Andy Hill

British Association for Counselling and Psychotherapy

This document represents a guide to the competences required to deliver Counselling for Depression (CfD). By design it is based on the document for commissioners and clinicians published as part of the Humanistic Psychological Therapies competence framework (authored by Roth, Hill and Pilling, and available on the CORE website).

The full listing of the competences associated with CfD, and the Humanistic Psychological Therapies competences which underpin this approach, can be downloaded at:

www.ucl.ac.uk/CORE


Ability to offer a therapeutic relationship that facilitates experiential exploration within a relational context
Generic therapeutic competences
Knowledge and understanding of mental health problems
Knowledge of depression
Knowledge of, and ability to operate within, professional and ethical guidelines
Knowledge of a model of therapy, and the ability to understand and employ the model in practice
Ability to work with difference (cultural competence)
Ability to engage client
Ability to foster and maintain a good therapeutic alliance, and to grasp the client's perspective and 'world view'
Ability to work with the emotional content of sessions
Ability to manage endings
Ability to undertake generic assessment (relevant history and identifying suitability for intervention)
Ability to assess and manage risk of self-harm
Ability to use measures to guide therapy and to monitor outcomes
Ability to make use of supervision
Basic counselling for depression competences
Knowledge of the basic assumptions and principles of counselling for depression
Ability to initiate therapeutic relationships
Ability to explain and demonstrate the rationale for counselling
Ability to work with the client to establish a therapeutic aim
Ability to maintain and develop therapeutic relationships
Ability to experience and communicate empathy
Ability to experience and to communicate a fundamentally accepting attitude to clients
Ability to maintain authenticity in the therapeutic relationship
Ability to conclude the therapeutic relationship
Specific counselling for depression competences
Approaches to work with emotions and emotional meaning
Ability to help clients access and express emotions
Ability to help clients articulate emotions
Ability to help clients reflect on and develop emotional meanings
Ability to help clients make sense of experiences that are confusing and distressing
Metacompetences
Generic metacompetences
Capacity to use clinical judgment when implementing treatment models
Capacity to adapt interventions in response to client feedback
Counselling metacompetences
Metacompetences specific to counselling for depression

Appendix 2: Database search results on clients views of counselling for depression.

Of 84 studies found - the following 52 studies are included in the thesis.

1. Abbass A. A., Hancock J.T., Henderson, J. & Kisely, S.R. (2006). Short-term psychodynamic psychotherapies for common mental disorders. *Cochrane Database of Systematic Reviews, 4.* doi: 10.1002/14651858.CD004687.pub3
2. Allen, D. (2000). "I'll tell you what suits me best if you don't mind me saying": "lay participation" in health care. *Nursing Inquiry, 7,* 182-190.
3. Bachelor, A. (1995). Client's perception of the therapeutic alliance: A qualitative analysis. *Journal of Counseling Psychology, 42*, (3), 323-337.
4. Bachelor, A. (2011). Clients' and therapists' views of the therapeutic alliance: similarities, differences and relationship to therapy outcome. *Clinical Psychology and Psychotherapy. 20*(2), pp 118-135.
5. Barg, F. K., Mavandadi, S., Givens, J.L., Knott, K., Zubritsky, C. & Oslin, D.W. (2010). When late life depression improves: what do older patients say about their treatment ? *The American Journal of Geriatric Psychiatry, 18*(7), 596-605.
6. Berg, C., Raminani, S., Greer, J., Harwood, M. & Safren, S. (2008). Participants' perspectives on cognitive-behavioural therapy for adherence and depression in HIV. *Psychotherapy Research, 18* (3), 271-280.
7. Carey, T.A., Carey, M., Stalker, K., Mullan, R.J., Murray, L.K. & Spratt. B. (2007). Psychological change from the inside looking out: a qualitative investigation. *Counselling and Psychotherapy Research, 7* (3), 178-187.
8. Castonguay, L.G., Boswell, J.F., Zack, S.E., Baker, S., Boutselis, M.A., Chiswick, N. R., ... Holtforth, M. G. (2010). Helpful and hindering events in psychotherapy: a practice research network study. *Psychotherapy Theory, Research, Practice, Training, 47*, (3), 327-344.
9. Clarke, H., Rees, A. & Hardy, G. (2004). The big idea: client perspectives of change processes in cognitive therapy. *Psychology and Psychotherapy: Theory, Research and Practice, 77*, 67-89.
10. Duncan, B. L. & Miller S.D. (2000). The client's theory of change: consulting the client in the integrative process. *Journal of Psychotherapy Integration, 10*(2), 169-187.
11. Eames, V. & Roth, A. (2000). Patient attachment orientation and the early working alliance - a study of patient and therapist reports of alliance quality and ruptures. *Psychotherapy Research, 10*(4), 421-434.
12. Elliott, R. (1985). Helpful and non-helpful events in brief counseling
13. interviews: an empirical taxonomy. *Journal of Counseling Psychology, 32* (3), 307-322.
14. Elliot, R. & James, E. (1989). Varieties of client experience in psychotherapy: an analysis of the literature. *Clinical Psychology Review, 9* (4), 443-467.
15. Elliott, R., Slatick, E. & Urman, M. (2001). Qualitative Change Process Research on Psychotherapy: Alternative Strategies. In J. Frommer and D.L. Rennie (Eds.), *Qualitative psychotherapy research: methods and methodology.* (pp. 69-111). Lengerich, Germany: Pabst Science Publishers
16. Elliot, M. & Williams, D. (2003). The client experience of counselling and psychotherapy. *Counselling Psychology Review, 18* (1), 34-38.

17. Feifel, H. & Eells, J. (1964). Patients and therapists assess the same psychotherapy. *Consulting Psychology, 27,* 310-318.
18. Fitzpatrick, M. R., Janzen, J., Chamodraka, M., Gamberg, S. & Blake, E. (2009). Client relationship incidents in early therapy: Doorways to collaborative engagement. *Psychotherapy Research, 19,* 654–665. doi:10.1080/10503300902878235
19. Fluckiger, C., Del Re, A.C., Wampold, B.E., Znoj, H., Caspar, F. & Jorg, U. (2012). Valuing clients' perspective and the effects on the therapeutic alliance: a randomised controlled study of an adjunctive instruction. *Journal of Counseling Psychology,59* (1), 18-26.
20. Glass, C. R. & Arnkoff, D. B. (2000). Consumers' perspectives on helpful and hindering factors in mental health treatment. *Journal of Clinical Psychology,56* (11),1467-1480.
21. Goedde, C. (2000). A qualitative study of the client's perspective of discussing spiritual and religious issues in therapy. Unpublished Doctor of Psychology, Psy.D. Clinical Dissertation, Alliant University: United States
22. Gostas, M.W., Wiberg, B., Neander, K. & Kjekkin, L. (2012). 'Hard Work' in a new context: clients' experiences of psychotherapy. *Qualitative Social Work,0*(00), 1-18. doi: : 10.1177/1473325011431649
23. Grafanaki, S. & McLeod, J. (1999). Narrative processes in the
24. construction of helpful and hindering events in experiential psychotherapy. *Psychotherapy Research, 9*(3), 289-303.
25. Gutheit, K. (2000). The internal experience of the patient in the psychotherapeutic relationship. Unpublished Doctor of Philosophy, Clinical Psychology, The Union Institute, United States.
26. Heatherington, L., Constantino, M.J., Friedlander, M.L., Angus, L.E. & Messer, S.B. (2012). Clients' perspectives on corrective experiences in psychotherapy. Castonguay, L.G. & Hill, C.E. (Eds.). (2012). *Transformation in psychotherapy: corrective experiences across cognitive behavioural, humanistic, and psychodynamic approaches.* (pp. 161-190). Washington, DC: American Psychological Association.
27. Henkelman, J & Paulson, B. (2006). The client as expert: researching
28. hindering experiences in counselling. *Counselling Psychology Quarterly, 19*(2), 139-150.
29. Henretty, J.R., Levitt, H.M. & Mathews, S.S. (2008). Clients' experiences of moments of sadness in psychotherapy: a grounded theory analysis. *Psychotherapy Research, 18(3),* 243-255. doi: 10.1080/10503300701765831.
30. Hodgetts, A. & Wright, J. (2007). Researching clients' experiences: a review of qualitative studies. *Clinical Psychology & Psychotherapy 14*(3), 157-163.
31. Hook, A., & Andrews, B. (2005). The relationship of non-disclosure in therapy to shame and depression. *The British Journal of Clinical Psychology /The British Psychological Society, 44*(Pt 3), 425-438
32. Israel., Gorcheva, R., Burnes, T.R. & Walther, W.A. (2008). Helpful and unhelpful therapy experiences of LGBT clients. *Psychotherapy Research, 18(3),*294-305. doi: 10.1080/10503300701506920.
33. Lambert, P. (2007). Client perspectives on counselling: before, during and after. *Counselling and Psychotherapy Research, 7*(2), 106-113.
34. Levitt, H., Butler, M. & Hill, T. (2006). What clients find helpful in psychotherapy: developing principles for facilitating moment-to-moment c. change. *Journal of Counseling Psychology, 53,* (3), 314. doi: 10.1037/0022-0167.53.3.314

35. Levitt, H.M. & Piazza-Bonin, E. (2011). Therapists' and clients' significant experiences underlying psychotherapy discourse. *Psychotherapy Research, 21(1),*70-85. Doi: 10.1080/10503307.2010.518634.
36. Lilliengren, P. & Werbart, A. (2005). A model of therapeutic action grounded in the patient's view of curative and hindering factors in psychoanalytic psychotherapy. *Psychotherapy: Theory, Research, Practice, 42*,(3), 324–339. doi: 10.1037/0033-3204.42.3.324
37. Llewelyn, S.P. (1988). Psychological therapy as viewed by clients and therapists. *British Journal of Clinical Psychology, 27,* 223-237.
38. Manne, S. L., Kashy, D. A., Rubin, S., Hernandez, E., & Bergman, C. (2012). Therapist and patient perceptions of alliance and progress in psychological therapy for women diagnosed with gynaecological cancers. *Journal of Consulting & Clinical Psychology, 80*(5), 800-810.
39. Manthei, R.J. (2005). What can clients tell us about seeking counselling and their experiences of it. *International Journal for the Advancement of Counselling, 27* (4), 541-555.
40. Manthei, R.J. (2007). Clients talk about their experiences of the process of counselling. *Counselling Psychology Quarterly, 20* (1), 1-26.
41. Metcalf, L. & Thomas, F. (1994). Client and therapist perceptions of solution focused brief therapy: a qualitative analysis. *Journal of Family Psychotherapy, 5*(4), 49–66.
42. Oliveira, A., Sousa, D. & Pires, A.P. (2012). Significant events in existential
43. psychotherapy: the client's perspective. *Existential Analysis 23*(2), 288-304.
44. Paulson, B. L., Truscott, D. & Stuart, J. (1999). Clients' perceptions of helpful experiences in counselling. *Journal of Counselling Psychology, 46,* 317–324.
45. Paulson, B.L., Everall, R.D. & Stuart, J. (2001). Client perceptions of hindering experiences in counselling. *Counselling and Psychotherapy Research, 1* (1), 53-61.
46. Perren, S., Godfrey, M. & Rowland, N. (2009). The long term effects of counselling: the process and mechanisms that contribute to ongoing change from a user perspective. *Counselling and Therapy Research, 9* (4), 241-249.
47. Rennie, D. L. (1994). Clients' deference in psychotherapy. *Journal of Counseling Psychology,41*(4), 427-437.
48. Rodgers, B. J. (2002) An investigation into the client at the heart of therapy. *Counselling and Psychotherapy Research, 2(3),* 185–193.
49. Sherwood, T. (2001). Client experience in psychotherapy : what heals and what harms? *Indo-Pacific Journal of Phenomenology, 1*, (2), 1-16.
50. Timulak, L. (2007). Identifying core categories of client-identified impact of helpful events in psychotherapy: a qualitative meta-analysis. *Psychotherapy Research, 17*(3), 305-314.
51. Timulak, L., Belicova, A.& Miler, M. (2010). Client identified significant events in a successful therapy case: the link between significant events and outcome. *Counselling Psychology Quarterly, 23* (4), 371-386.
52. von Belowa, C. & Werbart, A. (2012).Dissatisfied psychotherapy patients: A tentative conceptual model grounded in the participants' view. *Psychoanalytic Psychotherapy, 26* (3), 211-229.

Appendix 3: Database search results on clients views of counselling for depression.

Of 84 studies found - the following 32 studies were excluded in the thesis for the reasons listed below.

Study	Reason for exclusion
Cahill, J., Paley, G. & Hardy, G. (2013).What do patients find helpful in psychotherapy? Implications for the therapeutic relationship in mental health nursing. *Journal of Psychiatric & Mental Health Nursing. 20*(9):782-9. doi.org/10.1111/jpm.12	Mental health nurses and clinical psychologists - not counsellors.
Wilhelm, K., Wedgwood, L., Malhi, G., Mitchell, P., Austin, M., Kotze, B., Niven, H. & Parker, G. (2005). Great expectations: Factors influencing patients expectations and doctors recommendations at a Mood Disorders Unit. *Journal of Affective Disorders. Vol.88*(2), 187-192. doi.org/10.1016/j.jad.	Study focus is on the expectations of clients with diagnoses of major depression - not about their views of the actual counselling they received.
Pollock, K. & Grime, J. (2003).GPs' perspectives on managing time in consultations with patients suffering from depression: A qualitative study. *Family Practice, 20*(3), 262-269. doi.org/10.1093/fampra	Study explores views on counselling and depression but from GP perspective.
Nabeel, A., Abdulkareem, A., Abdulhakeem, A., Salah, A. & Heba, M. (2008). Depressed patients' preferences for education about medications by pharmacists in Kuwait. *Patient Education and Counseling,72*(1), 94-101. doi.org/10.1016/j.pec.2008.01.027	Depressed patient views - but looking at how pharmacists interventions affected patients' medical knowledge.
Davy, B., Keizer, I., Croquette, P., Bertschy, G., Ferrero, F., Gex-Fabry, M. & Bondolfi, G. (2009). Patient satisfaction with psychiatric outpatient care in Geneva: A survey in different treatment settings. *Schweizer Archive fur Neurologie und Psychiatrie, 160*(6), 240-245.	Client views - but of psychiatric outpatient care.
Sharpley, C. F., Bitsika, V., & Christie, D. R. H. (2009). Helping prostate cancer patients understand the causes of anxiety and depression: Comparing cancer-caused vs patient response events. *Journal of Men's Health, 6(4),*345-353. doi:10.1016/j.jomh.2009.08.193.	Depressed client views - but looking at lifestyle changes - and clients had anxiety diagnoses too.

Kyriakopoulos, A. (2011). How individuals with self-reported anxiety and depression experienced a combination of individual counselling with an adventurous outdoor experience: A qualitative evaluation. *Counselling & Psychotherapy Research, 11(2),*120-128. doi.org/10.1080/147331	Client views of counselling but combined individual therapy with an adventurous outdoor experience.
Hansson, M., Chotai, J. & Bodlund, O. (2012). What made me feel better? Patients' own explanations for the improvement of their depression. *Nordic Journal of Psychiatry, 66(4),* 290-296. doi.org/10.3109/080394	Depressed client views of group counselling.
Prins, M.A., Verhaak, P. F. M., van der Meer, K., Penninx, B.W. J. H. & Bensing, J. M. (2009). Primary care patients with anxiety and depression: Need for care from the patient's perspective. J*ournal of Affective Disorders, 119(1-3),* 163-171. doi.org/10.1016/j.jad.2009.03.019	Aim of the study was to determine the specific perceived need for care in primary care patients with anxiety and depression.
Hallam, R., Ashton, P., Sherbourne, K. & Gailey, L. (2006). Acquired profound hearing loss: mental health and other characteristics of a large sample. *International Journal of Audiology, 45*(12), Dec 2006, pp. 715-723. doi.org/10.1080/149920...	This study was a survey that investigated the mental health and other characteristics of people with acquired profound hearing loss.
Fitopoulos, L. (2005). Counsellor awareness of client-identified helpful events and its association to the psychotherapeutic process in process-experiential therapy with depressed clients. *Dissertation Abstracts International: Section B: The Sciences and Engineering, 66*(1-B), 549.	The focus in this study was on counsellor awareness of client identified helpful events.
Matthias.F., Kuns, M. & Schmitz, N. (1999). What happens with an advice to begin psychotherapy after psychotherapeutic counselling in a psychosomatic CL-Unit? *Zeitschrift fur Psychosomatische Medizin und Psychotherapie, 45*(2), 95-112.	Examined the effect of advice to begin psychotherapy.
Newbold, A., Hardy, G. & Byng, R. (2013). Staff and patient experience of improving access to psychological therapy group interventions for anxiety and depression. *Journal of Mental Health, 22*(5), 456-64. doi.org/10.3109/096382	The study investigates how patients and staff experience group-based therapy.
Shankland, J. & Dagnan, D. (2015). IAPT practitioners' experiences of providing therapy to people with intellectual disabilities. *Advances in Mental Health and Intellectual Disabilities. 9*(4), 206-214.	Study looks at practitioner views.

doi.org/10.1108/AMHID	
Wu, S. M., Brothers, B. M., Farrar, W. & Andersen, B. L. (2014). Individual counselling is the preferred treatment for depression in breast cancer survivors *Journal of Psychosocial Oncology. 32*(6),. 637-646. doi.org/10.1080/073473	Study investigated treatment preferences between individual counselling, antidepressants and support groups for patients with breast cancer.
Hepner, K.A., Hunter, S. B., Paddock, S.M., Zhou, A. J. & Watkins, K. E. (2011). Training addiction counsellors to implement CBT for depression. *Administration and Policy in Mental Health and Mental Health Services Research, 38*(4), 313-323. doi.org/10.1007/s10488	Clients were in substance abuse treatment programs.
Givens, J. L., Houston, T. K., Van Voorhees, B.W., Ford, D. E. & Cooper, L.A. (2007). Ethnicity and preferences for depression treatment. *General Hospital Psychiatry, 29*(3), 182-191. doi.org/10.1016/j.genh	Study described describe ethnic differences in attitudes toward depression.
Wall, T. N. & Hayes, J. A. (2000). Depressed clients' attributions of responsibility for the causes of and solutions to their problems. *Journal of Counseling & Development, 78*(1), 81-86. doi.org/10.1002/j.1556	Study looked at clients attributions about responsibility of the cause of their problems.
Rusch, A. J. (1997). Differential effects of rhetorical question and declarative statement counselling styles. *Dissertation Abstracts International: Section B: The Sciences and Engineering. 58*(6-B), 3327.	Study explored whether a rhetorical questioning style of counselling would result in greater cognitive elaboration than a declarative statement style of counselling..
Walter, M. I. & Handelsman, M. M. (1996). Informed consent for mental health counseling: effects of information specificity on clients' ratings of counsellors. *Journal of Mental Health Counseling, 18*(3), 253-262.	Study looked at how initial perceptions are influenced by the amount of specific information conveyed to clients via an informed consent procedure and the effects of depression on recall on perceptions.
Meier-Swickard, D. F. (1993). Comparison of group counseling for divorced single mothers. *Dissertation Abstracts International, 54*(4-B), 2213.	Group counselling.
Claiborne, C. D. & Dowd, E. T. (1985). Attributional interpretations in counseling: content versus discrepancy. *Journal of Counseling Psychology, 32*(2), 188-196.	Study prior to inclusion date of 1990
Stone, H. W. (1984). Theology and pastoral counseling : A client's viewpoint. *Pastoral Psychology, 32*(4), 251-261.	Study prior to inclusion date of 1990
Lossnitzer, N., Herzog, W., Schultz, J. H., Taeger, T., Frankenstein, L.& Wild, B. (2015). A patient-centered perspective of	Study focus was on specific needs of patients with chronic heart failure who must cope with depression.

treating depressive symptoms in chronic heart failure: What do patients prefer? *Patient Education and Counseling, 98*(6), 783-787. doi.org/10.1016/j.pec.	
Manne, S.L., Kashy, D.A., Rubin. S., Hernandez .E. & Bergman. C. (2012). Therapist and patient perceptions of alliance and progress in psychological therapy for women diagnosed with gynaecological cancers. *Journal of Consulting & Clinical Psychology, 80*(5),800-10.	Study aim was to understand both therapist and patient perspectives on alliance and session progress for women in treatment for gynaecological cancer.
Knowles, S.E., Toms, G., Sanders, C., Bee, P., Lovell, K., Rennick-Egglestone, S., ... Bower, P. (2014). Qualitative meta-synthesis of user experience of computerised therapy for depression and anxiety. *Public Library of Science ONE. 9*(1), ArtID e84323.	Internet intervention.
Ziolkowska, J. (2014). Time and the psychiatric interview: The negotiation of temporal criteria of the depressive disorder. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine. 18*(2),163-178. doi.org/10.1177/136345	Doctors views in psychiatric hospitals.
Holtforth, M. G., Wyss, T., Schulte, D., Trachsel, M. & Michalak, J. (2009). Some like it specific: The difference between treatment goals of anxious and depressed patients. *Psychology and Psychotherapy: Theory, Research and Practice, 82*(3), 279-290.	Specifically looked at the difference in the treatment goal themes between anxiety and depressed patients.
Storey, J. E. (1997). Psychotherapy with HIV/AIDS' patients: A preliminary study comparing the experiences and outcomes of inner-city patients with their urban counterparts. *Dissertation Abstracts International Section A: Humanities and Social Sciences, 58*(1-A), 0294.	Study focus was on psychodynamic psychotherapy with HIV positive patients
Meier, P. & Donmall, M.C. (2006). Differences in client and therapist views of the working alliance in drug treatment. *Journal of Substance Use, 11*(1), 73-80. doi.org/10.1080/146598	Study focus was on exploring the extent to which, in drug treatment, clients and counsellors agree in their perceptions of their alliance.
Pixton, S. (2006). Experiencing gay affirmative therapy: An exploration of clients' views of what is helpful. *Counselling & Psychotherapy Research, 3*(3), 211-215. doi.org/10.1080/147331	Study focus was on gay affirmative therapy.
Levy, S., Jack, N., Bradley, D., Morison, M. & Swanston, M. (2003). Perspectives on	Study focus was on attitudes to telecare.

telecare: The client view. *Journal of Telemedicine and Telecare, 9*(3), 156-160. doi.org/10.1258/135763	
Lothian, J. & Read, J. (2002). Asking about abuse during mental health assessments: clients' views and experiences. *New Zealand Journal of Psychology, 31*(2),. 98-103.	Study explores whether abuse is asked about at assessment.

Appendix 4: University of Salford Ethics Approval Letter

Research, Innovation and Academic Engagement Ethical Approval Panel
College of Health & Social Care
AD 101 Allerton Building
University of Salford
M6 6PU
T +44(0)161 295 7016
r.shuttleworth@salford.ac.uk
ww.salford.ac.uk/

27 June 2013

Dear Stacey,

RE: ETHICS APPLICATION HSCR13/14 – A client focused perspective of the effectiveness of Counselling for Depression (CfD)

Following your responses to the Panel's queries, based on the information you provided, I am pleased to inform you that application HSCR13/14 has now been approved.
If there are any changes to the project and/ or its methodology, please inform the Panel as soon as possible.

Yours sincerely,

Rachel Shuttleworth

Appendix 5: National Research Ethics Service - Conditions Met Approval Letter

National Research Ethics Service
NRES Committee North West –Greater Manchester West
3rd Floor
Barlow House
4 Minshull Street
Manchester
M1 3DZ
Telephone: 0161 625 7434 i

02 October 2013
Mrs Stacey Goldman
Professional Talking Therapies Ltd
30 Church Lane
Whitefield
Manchester
M45 7NF

Dear Mrs Goldman

Study title:	**A client focused perspective of the effectiveness of Counselling for Depression (CfD).**
REC reference:	**13/NW/0595**
IRAS project ID:	**126616**

Thank you for your email of 18 September 2013. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 10 September 2013

Documents received

The documents received were as follows: *Document*	*Version*	*Date*
Participant Consent Form	2	15 September 2013
Participant Information Sheet	3	15 September 2013

Approved documents

The final list of approved documentation for the study is therefore as follows: *Document*	*Version*	*Date*
Covering Letter	Email	13 August 2013
Evidence of insurance or indemnity	UMAL	11 July 2013
Interview Schedules/Topic Guides	2	25 May 2013

Investigator CV		Goldman	
Letter from Sponsor	Email - Rees/MHSC		08 March 2013
Letter of invitation to participant	1		21 February 2013
Other: CV Academic Supervisor		Brettle	
Participant Consent Form	2		15 September 2013
Participant Information Sheet	3		15 September

Protocol	2	25 May 2013
Questionnaire: Helpful Aspects of Therapy	3.2	01 May 2013
REC application	3.5	30 July 2013

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

13/NW/0595 **Please quote this number on all correspondence**

Anna Bannister
REC Manager

E-mail: nrescommittee.northwest-gmwest@nhs.net

Copy to:

Prof Tony Warne,
Mr. David Rees, Psychological Services Care Group within Manchester Mental Health and Social Care Trust

Appendix 6: National Research Ethics Service - Minor Amendment Approval Letter

Health Research Authority

National Research Ethics Service

NRES Committee North West – Greater Manchester West
3rd Floor
Barlow House
4 Minshull Street
Manchester
M1 3DZ
Telephone: 0161 625 7434

19 March 2014
Mrs Stacey Goldman
Student
Professional Talking Therapies Ltd
30 Church Lane
Whitefield
Manchester
M45 7NF
Dear Mrs Goldman

Study title:	**A client focused perspective of the effectiveness of Counselling for Depression (CfD).**
REC reference:	**13/NW/0595**
Amendment number:	**1**
Amendment date:	**04 March 2014**
IRAS project ID:	**126616**

Thank you for your letter of 04 March 2014, notifying the Committee of the above amendment.
The Committee does not consider this to be a "substantial amendment" as defined in the Standard Operating Procedures for Research Ethics Committees. The amendment does not therefore require an ethical opinion from the Committee and may be implemented immediately, provided that it does not affect the approval for the research given by the R&D office for the relevant NHS care organisation.
Documents received

Notification of a Minor Amendment	1	04 March 2014
Participant Consent Form	3	11 February 2014

Statement of compliance
The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

13/NW/0595: Please quote this number on all correspondence

Yours sincerely,

Anna Bannister
REC Manager

E-mail: nrescommittee.northwest-gmwest@nhs.net *Copy to:*

Mr. David Rees, Psychological Services Care Group within Manchester Mental Health and Social Care Trust
Prof Tony Warne

Appendix 7: Manchester Trust Approval Letter

MANCHESTER CITY COUNCIL

Manchester Mental Health NHS
and Social Care Trust

Standardised Process for Electronic Approval of Research

Research & Innovation Office
Manchester Mental Health & Social Care Trust
Room N.3.FC027
3rd Floor
Rawnsley Building
Manchester Royal Infirmary
Hathersage Road
Manchester
M13 9WL
t 0161 276 3311

4th October 2013

Mrs Stacey Goldman
Professional Talking Therapies Ltd
30 Church Lane
Whitefield
Manchester
M45 7NF

Information for ID Badge if required:
Research Project Ref No: 1257
Expiry Date: 30/09/2015
You must take this letter with you.

Dear *Stacey,*

Re: Research Governance Decision Letter

SPEAR/Trust Project Reference: 1257
Project Title : A client focused perspective of the effectiveness of Counselling for Depression (CfD).
REC No. : 13/NW/0595
Protocol: v.2 25/05/2013

Further to your request for research governance approval, we are pleased to inform you that this Trust has approved the study. Please note when contacting the R&I office about your study you must always provide the project reference numbers provided above.

Trust R&I approval covers all locations within the Trust, however, you should ensure you have liaised with and obtained the agreement of individual service/ward managers before commencing your research. This letter also gives NHS permission, on behalf of Rotherham Doncaster and South Humber NHS Foundation Trust, to undertake the protocol specified research activities within the Early Intervention Service.

Please take the time to read the attached 'Information for Researchers – Conditions of Research Governance Approval' leaflet, which give the conditions that apply when research governance approval has been granted. Please contact the R&I Office should you require any further information. You may need this letter as proof of your approval.

We would like to point out that hosting research studies incurs costs for the Trust

Together we are better

Appendix 8: Devon Trust Approval Letter

Devon Partnership NHS
NHS Trust

Research and Development
Wonford House Hospital
Dryden Road
Exeter EX2 5AF
Sarahlaidler@nhs.net
Tel: 01392 674 112

Mrs Stacey Goldman
Professional Talking Therapies Ltd
30 Church Lane
Whitefield
Manchester
M45 7NF

8 April 2014

Dear Stacey

Re: Trust Approval for Devon Partnership Trust

Study: A client focused perspective of the effectiveness of Counselling for Depression (CfD)
Chief Investigator: Mrs Stacey Goldman
Sponsor: The University of Salford
References: DPT 0278
MREC: 13/NW/0595

NHS permission for the above research has been granted on the basis described in the application form, protocol and supporting documentation. The documents reviewed were:

Approved documents

Document	Version	Date	Date of ethics letter
Protocol	2	25/05/2013	02/10/2013
Letter of Invitation to Participant	1	21/02/2013	02/10/2013
Participant Consent Form	3	11/02/2014	19/03/2014
Participant Information Sheet	3	15/09/2013	02/10/2013
Interview Schedules/Topic Guides	2	25/05/2013	02/10/2013
Questionnaire: Helpful Aspects of	3.2	01/05/2013	02/10/2013

Therapy			
REC Application	3.5	30/07/2013	02/10/2013
Evidence of insurance/indemnity	UMAL	11/07/2013	02/10/2013
Investigator CV	Goldman		02/10/2013
Other: CV Academic Supervisor	Brettle		02/10/2013
NRES Approval Letter			02/10/2013
NRES Approval Letter – Minor Amendment			19/03/2014

Permission is granted on the understanding that the study is conducted in accordance with the Research Governance Framework, ICH GCP (if applicable), and NHS Trust policies and procedures available at http://rdeweb.exe.nhs.uk/default.asp?a=2&m=0

Permission is only granted for the activities for which a favourable opinion has been given by the REC (and which have been authorised by the MHRA).

You are reminded that you must report to the R&D office any **adverse event or serious incident,** whether or not you feel it is serious. This requirement is in addition to informing the Chairman of the Research Ethics Committee which approved the study. The research sponsor or the Chief Investigator, or the local Principal Investigator at a research site, may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety. The R&D Department should be notified that such measures have been taken. The notification should also include the reasons why the measures were taken and the plan for further action. The R&D Department should be notified within the same time frame of notifying the REC and any other regulatory bodies.

All amendments (including changes to the local research team) need to be submitted in accordance with guidance in IRAS. These changes must also be reported to the R&D Department. Likewise any change to the status of a project must also be reported to the R&D Department.

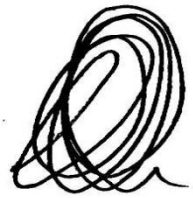
Please note that the NHS organisation is required to monitor research to ensure compliance with the Research Governance Framework and other legal and regulatory requirements. This is achieved by random audit of research and requests for study related data. You are also required to submit to the R&D office a **final outcome report** on completion of your study, and to provide interim reports on progress as requested. Should **publications** arise, please send copies to the R&D office, Wonford House for inclusion in the study's R&D file and the Trust's research publications library.

I would also like to remind you of the responsibilities of anyone who conducts research within the NHS, which are:

1. The Data Protection Act requires that you follow the eight principles of 'good information handling' as summarised in the guide for staff.
2. You must be aware of, and comply with Health and Safety standards in relation to your research
3. You must also be aware of NHS Indemnity Arrangements; summary details can be found in Appendix 1.

With best wishes for a successful study.

Yours sincerely



Dr. Peter Aitken
Directorate of Research and Development.

cc: Tobit Emmens, R&D, DPT

Appendix 1

RESEARCH IN THE NHS: INDEMNITY ARRANGEMENTS

• NHS indemnity covers clinical negligence. It does not cover indemnity for any other liability such as product liability or employers' liability.
• NHS indemnity is Government policy: it is not a statutory obligation.
• NHS indemnity covers negligent harm to patients and volunteers.
• NHS indemnity means that NHS organisations forgo the right to recover costs and damages from their staff in respect of liabilities arising out of clinical negligence (except where that involves criminal or wilfully negligent behaviour).
• Research is a core NHS activity. It is therefore treated in the same way as any other NHS activity in relation to potential liabilities for clinical negligence.
• For all NHS research activity, whether commercial or non-commercial, liability for clinical negligence on the part of NHS staff lies with the health-care professional's NHS or honorary NHS employer.
• Being a research sponsor does not increase potential liability. However, the sponsorship agreement should clarify where liability lies.
• *Where appropriate,* honorary contracts may be used for those involved in research. They provide the opportunity under the NHS organisation's vicarious liability to define the legal arrangements for non-NHS personnel undertaking research.
• An honorary contract extends an NHS employer's responsibilities, but not beyond its existing legal duty of quality and its common-law duty of care.

Appendix 9: Rochdale Trust Approval Letter

Research and Development Department

Pennine Care NHS
NHS Foundation Trust

Research & Development Department
Trust Headquarters
225 Old Street
Ashton-under-Lyne
OL6 7SR
Tel: 0161 716 3086

Email: researchdevelopment.penninecare@nhs.net

Date: 25th October 2013

Mrs Stacey Goldman
Professional Talking Therapies Ltd
30 Church Lane
Whitefield
Manchester
M45 7NF

Dear Mrs Goldman

Research and Development approval letter
Re: Study title: A client focused perspective of the effectiveness of Counselling for Depression (CfD)
Pennine Care reference: 13-A-12-A REC reference: 13/NW/0595 IRAS project ID: 126616 CSP reference: N/A

Thank you for submitting your research project for consideration by the Research and Development (R&D) Department. The project was reviewed by the R&D Panel in line with the 'Research Governance Framework for Health and Social Care' and in regards to its impact on resources for the Trust and its suitability within our research portfolio.

We have also verified the relevant documentation and approvals from all necessary regulatory agencies. These may include, but are not limited to, the National Research Ethics Service (NRES), the Medicines and Healthcare products Regulatory Agency (MHRA), and the Administration of Radioactive Substances Advisory Committee (ARSAC).

On this basis, we are now able to grant approval for your project at Pennine Care NHS Foundation Trust, subject to the terms and conditions listed below.

- The currently approved protocol is **Version 2 dated 25th May 2013** and the approved documents, including the Participant Information Sheet and Informed Consent Form, are those listed in the Research Ethics Committee's favourable opinion letters for this project dated **2nd October 2013**. These must be the only versions in use.
- In the event of any amendment (substantial or minor) to the protocol or documentation, approval must be sought from the necessary regulatory agencies. Approval for the amendment must also be obtained from the Research and Development Department before implementation.
- Any significant deviation from the approved protocol or documentation must be notified to the R&D Department as soon as the issue is discovered.
- The Chief Investigator, local Principal Investigator and all other researchers working on the project must abide by and adhere to their specific responsibilities as detailed in the 'Research Governance Framework for Health and Social Care'. They must also meet all UK statutory requirements, with particular significance, where applicable, to: the 'Data Protection Act 1998', 'The Medicines for Human Use (Clinical Trials) Regulations 2004', the 'Mental Health Act 2007', the 'Human Tissue Act 2004' and all subsequent amendments to these.
- The only researchers approved to perform the research activities for this project at any Pennine Care site or involving any staff, service users or other persons under our duty of care are those listed on the SSI form and/or delegation log for Pennine Care.

continued on page 2...

continued from page 1...

- All personnel listed on the SSI form and/or delegation log for Pennine Care must undertake and provide evidence of Good Clinical Practice (GCP) training at least once every two years.
- Recruitment figures for Pennine Care participants in relation to this project must be sent to the R&D Department on a minimum of a six monthly basis.
- If applicable, the Sponsor or Chief Investigator must notify the R&D Department of any Serious Adverse Events (SAEs) that occur during the conduct of the trial.
- The R&D Department must be notified about any suspension and upon completion of the project, and must be sent a copy of any final report and/or findings.
- Pennine Care reserves the right to suspend or terminate approval for this project with immediate effect if any of these conditions are breached or in any other circumstances it deems necessary.
- Any further project specific conditions as detailed below:

  _____
  _____
  _____
- The Sponsor's Representative, Chief Investigator and Principal Investigator or Local Collaborator as proof of their agreement to the terms and conditions described above must countersign this letter.

Thank you again for submitting your project to Pennine Care. We wish you good luck with recruitment and with the progress of your project. If you need any further assistance, then please feel free to contact the R&D Department via the contact details at the top of this letter.

Research Approval Granted:
Study title: A client focuses perspective of the effectiveness of Counselling for Depression (CfD)
Pennine Care reference: 13-A-12-A REC reference: 13/NW/0595 IRAS project ID: 126616 CSP reference: N/A

Name: Reagan Blyth **Signature:** _____
Role: Associate Director of Quality Assurance and Research, Pennine Care NHS Foundation Trust

We, the undersigned, hereby agree to all of the terms and conditions as specified by the approval letter above.

Name:	_____	**Signature:**	_____
Date:	_____	**Role:**	Sponsor's Representative
Name:	_____	**Signature:**	_____
Date:	_____	**Role:**	Chief Investigator
Name:	_____	**Signature:**	_____
Date:	_____	**Role:**	Principal Investigator/Local Collaborator*

*delete as applicable

Please return one original signed copy of this letter to the R&D Department immediately and retain the other copy for your own project file.

Appendix 10: Invitation to participate

School of Nursing, Midwifery & Social Work
University of Salford
Salford, Greater Manchester
M6 6UP United Kingdom
Tel: 0796 244 3000
E-mail: talkingtherapies2013@hotmail.co.uk

Invitation to participate in research study

My name is Stacey Goldman and I am a student at the University of Salford. I am undertaking a research project to find out about your views of the effectiveness of your counselling. If you would like to consider participating in the study you will be asked to fill in a short questionnaire after each counselling session and then there is a possibility of being invited to attend for an interview after all your counselling has finished. If you decide to take part in the research all the information you give will be anonymised.

Enclosed with this letter is an information leaflet that gives you more details about the study and what you will be asked to do if you want to take part. Please read the leaflet and if you feel that you would like to participate in the research, please contact me on the phone number or e-mail addresses that are at the top of this letter. Once you make contact please ask as many questions as you want and I will attempt to answer them before you decide to participate.

If you decide to participate in the study then the information you give to the researcher will be kept confidential and, if you agree to have an audio-taped interview the researcher will call you by a different name of your choice and will make sure you do not say anything that would reveal your identity during the session. The only time the researcher would have to tell someone else who you are is if you tell the researcher about anything that is likely to indicate that you or others may be at risk of harm.
If you are interested, please contact me via phone or e-mail

Your help would be greatly appreciated

Yours sincerely

Stacey Goldman

V2 (15.9.13)

Appendix 11 : Participant information sheet

Participant Information Sheet

Title: A Client focused perspective of Counselling for Depression.

INVITING YOU TO HELP US

I am trying to find out about whether your counselling works for you. As you are attending Counselling for Depression I would like to invite you to participate in the study. Before deciding if you would like to help or not, please take time to read the rest of this leaflet and if you wish discuss taking part with others

WHAT IS THIS STUDY ABOUT?

- It is about gathering client views of whether they feel their counselling works for them.
- It will involve completing a questionnaire after each counselling session and possibly attending an interview when all your sessions have finished. Due to the time available to complete this study, not everyone who completes the questionnaires will be able to be interviewed. Up to ten people will be invited to interview.

WHAT IS THIS STUDY HOPING TO DO?

- To gather client views of their counselling.
- To explore whether clients feel their therapy is effective for them.
- To establish what was helpful or un-helpful about their counselling.
- To use the findings to inform and improve future services.

DO I HAVE TO TAKE PART

- No you do not have to take part. If you decide that this is not for you it will not affect the care you receive in any way.

BEFORE PARTICIPATING IN THE RESEARCH

- This leaflet explains what you will be expected to do if you decide to participate in the research. Once you have read the information (this leaflet) there will be opportunity for you to contact the researcher to ask questions about the research.
- If you are happy to participate, you and the researcher can arrange how you receive your questionnaires and how you will contact the researcher to arrange your interview when your counselling has ended.
- Any care that you are receiving will not be affected in any way should you not wish to participate.

WHAT WILL HAPPEN DURING THE RESEARCH?

- Before participating you will be asked to sign a consent form. If you wish, the form will be explained to you so that you are clear about what you are agreeing to do.
- Part 1 - Questionnaires: Once you have given written consent the researcher will explain how you will receive your questionnaires and how to return them using a pre-paid envelope. After each session you will complete a questionnaire about your views of the treatment in that particular session. This will take approximately 5-10 minutes.
- Part 2 - Interviews; Please note that due to the time available it is not possible to interview all participants. Only ten participants will be invited to attend for an interview. If you have indicated on your consent form that you are willing to be interviewed, then as people finish their counselling they will be invited to attend for an interview, up to a maximum of ten people. If are coming to an interview you can bring all the questionnaires with you to the interview to give to the researcher. If you are only completing the questionnaires, you can post them back to the researcher in the prepaid envelope that you will have received.
- If you are selected to attend for an interview when your sessions have finished, the researcher will arrange to interview you at a place of your convenience. If you indicated on the consent form a willingness to be interviewed but you were not selected – the researcher will write and let you know that you will not be interviewed.
- During the interview the researcher will be careful not to use your real name (an agreed name prior to the interview starting can be used if you prefer) or the names of people or places that might identify you.
- The interview will last approximately one hour (this is the usual standard time for interview, however it maybe a little shorter or longer to meet your needs) and what is said will remain confidential between you and the researcher, unless you indicate that you or others may be at risk of harm which the researcher is duty bound to report.
- With your permission the interview will be audio taped.
- At the end of the interview the audiotape will be turned off and there will be some time for you to talk, if you feel the need, about any aspects of the interview you found upsetting or difficult. This information will not be included in the research.
- You will be free to terminate the interview at any time. If you do decide to no longer participate in the research the information you have given will be destroyed and not used in the research.

WHAT HAPPENS AFTER THE QUESTIONNAIRES AND INTERVIEWS

- The researcher is hoping to get your views on your counselling experience.
- Once the data is collected it will be analysed by the researcher.
- Once this work is complete the researcher will write a report and all information in the report will be anonymised.

CONFIDENTIALITY

- Anything you say will remain confidential between you and the researcher, but if you do tell the researcher anything that indicates that you or others may be at risk of harm the researcher is duty bound to report it to the appropriate authorities.

WHAT ARE THE BENEFITS OF PARTICPATING IN THE RESEARCH

- By sharing your experience of your counselling you help others to get an idea of what is useful about this kind of counselling, how it helped you and whether they might benefit also. Further, hearing from clients about their counselling experience helps

therapists to get an idea of what works or doesn't work and this is useful to help develop the counselling and to help to improve it.

WHAT ARE THE DRAWBACKS TO PARTICIPATING IN THE RESEARCH

- Talking about your experiences might be distressing. If this occurs at any point in the interview or at the end of the interview the researcher will turn off the tape recorder and provide an opportunity if you feel the need to talk about any aspects of the interview that you found distressing. This will not form part of the research.
- If you feel that you would like further help the researcher will be able to direct you to appropriate services that you can choose to contact.

PERMISSIONS AND REVIEW

Permission has been given to conduct this study by Manchester Mental Health and Social Care Trust. It has been reviewed by the researcher's supervision team at Salford University. It is conducted under the ethical approval of Salford University and the NHS Ethical Committees.

Please note although your counselling will be conducted within the NHS, the researcher is not an NHS employee.

MAKING A COMPLAINT:
If you wish to make a complaint about the research you can contact:

Supervisor details:
Dr. Alison Brettle
University of Salford.
School of Nursing, Midwifery & Social Work. University of Salford.
Greater Manchester M6 6UP.

WHAT NEXT?

- Take the information leaflet and think about participation, contact details are written at the bottom of this sheet if you want more information.
- If you are unsure talk to someone you trust and feel will be able to help you make a decision as to whether or not you should participate.

Researcher's name: Stacey Goldman
Phone number: 0796 244 3000
E-mail : talkingtherapies2013@hotmail.co.uk

Thank you for taking time to read this leaflet. V3 (15.9.2013)

Appendix 12: Consent form - amended

Consent Form

Project Title: A Client focused perspective of Counselling for Depression.

Please tick the appropriate boxes	**Yes**	**No**
Taking Part		
I have read the information sheet and I have been verbally informed about the above research and I understand what I am being asked to do.	☐	☐
I have been given the opportunity to ask questions about the project, and all questions have been satisfactory answered.	☐	☐
I understand that relevant sections of any of my medical notes and data collected during the study, may be looked at by responsible individuals from Salford University, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.	☐	☐
I agree to participate in part 1 only that is I agree to my completed questionnaires being used for the research.	☐	☐
I agree to participate in part 2 of the study which will include taking part in an interview as well as returning my completed questionnaires.	☐	☐
I agree that my interview will be audio recorded and then transcribed.	☐	☐
I agree that the researcher can use my anonymised direct quotations in the finished report and any associated works that may be presented and/or published.	☐	☐
I understand that my taking part is voluntary; I can withdraw from the study at any time and I do not have to give any reasons for why I no longer want to take part, and that my withdrawal will not affect any aspect of my care.	☐	☐
If I do decide to withdraw I understand that the information I have given will not be used in the research.	☐	☐
Use of the information I provide for this project only		
I understand that my personal details will be kept confidential	☐	☐
I understand that my words may be anonymously quoted in the researchers thesis, publications, and other research outputs.	☐	☐

_____ _____ _____

Name of participant [printed] Signature Date

Telephone: .... Email .....

_____ _____ _____

Researcher [printed] Signature Date

Appendix 3: version 3. 11.2.2014

Appendix 13: Consent form - original

Project Title: A Client focused perspective of Counselling for Depression.

Please tick the appropriate boxes **Ye**

Taking Part

I have read the information sheet and I have been verbally informed about the above research and I understand what I am being asked to do. ☐

I have been given the opportunity to ask questions about the project, and all questions have been satisfactory answered. ☐

I understand that relevant sections of any of my medical notes and data collected during the study, may be looked at by responsible individuals from Salford University, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records. ☐

I agree to participate in part 1 only that is I agree to my completed questionnaires being used for the research. ☐

I agree to participate in part 2 of the study which will include taking part in an interview as well as returning my completed questionnaires. ☐

I agree that my interview will be audio recorded and then transcribed. ☐

I agree that the researcher can use my anonymised direct quotations in the finished report and any associated works that may be presented and/or published. ☐

I understand that my taking part is voluntary; I can withdraw from the study at any time and I do not have to give any reasons for why I no longer want to take part, and that my withdrawal will not affect any aspect of my care. ☐

If I do decide to withdraw I understand that the information I have given will not be used in the research ☐

Use of the information I provide for this project only

I understand that my personal details will be kept confidential ☐

I understand that my words may be anonymously quoted in the researchers thesis, publications, and other research outputs. ☐

_____ _____ _____

Name of participant [printed] Signature Date

_____ _____

Researcher [printed] Signature Date

Appendix 3: version 2. 15.9.2013

Appendix 14: HAT form

HELPFUL ASPECTS OF THERAPY FORM (H.A.T.)
(Version 3.2; 05/2008)

Therapist _____ Client ID ___A1_____

Date _____ Session _____

1. Of the events which occurred in this session, which one do you feel was the most **important** or **helpful** for you personally? (By "event" we mean something that happened in the session. It might be something you said or did, or something your therapist or counsellor said or did.)

2. Please describe what made this event important/helpful and what you got out of it.

3. About where in the session did this event occur?

4. About how long did the event last?

5. Did anything else particularly **helpful** happen during this session? **YES** **NO**

Please describe the event briefly:

6. Did anything happen during the session which might have been **hindering**? **YES** **NO**

Please describe this event briefly:

7. What do you think makes therapy effective ?

Appendix 15: Interview Guide

A Client focused perspective of Counselling for Depression.

Interview Guide

1. **Can you please confirm what counselling you have just had?**
2. **Can you tell me what your counselling was like for you?**
3. **Please describe anything that stood out for you as helpful in your counselling?**
4. **Please describe anything that stood out for you as un-helpful in your counselling?**
5. **What do you feel makes counselling effective?**
6. **How effective would you say your counselling was for you ?**
7. **Has your counselling now ended ?**
8. **And how do you feel about that ?**
9. **How many sessions did you attend for?**
10. **Did you miss any sessions?**
11. **Would you recommend this counselling to someone else?**
12. **Is there anything I've not asked that you would like to tell me about?**

Please note this is a framework of the kinds of questions that will be explored in the interview.

V2 (25.5.13)

Appendix 16: Agnes Transcript

Client concerns - Agnes	Interview - Agnes
Descriptive Comments - describe content **Linguistic Comments - use of language** **Conceptual Comments - Interpretive Questions** I do need to speak to someone. Not like a text book. No jargon. I just want to talk. It's the talking that's important - not the jargon. Let me talk. There's admin they have to go through but I just want to talk. This won't work if I can't talk. Once the admin was out of the way then it was really great. It was great once the therapy actually started - but not the pre-amble. I'd lost that person to talk to. What I wanted from the therapy was to have a person to talk to. The same use of the work amazing to describe the therapy (as Sarah.)	1. I: Ok, so, over to you. How was this therapy experience for you? 2. P: I actually quite enjoyed it. Um, I was a bit of apprehensive at the start because I'd been through a CBT course, um, last year, which I wasn't overly impressed with because it was just a bit too jargony for me, do you know what I mean? It was like text book. So I thought I'll give this counselling a go, because I do need to speak to somebody 3. I: Yeah st admit when I first met the counsellor, it was a bit and I thought ooh here we go, but she had to go h all the, I suppose that they have to do it. 5. I: Aha 6. P Do you know what I mean? That they have to go through you know, who they are, what kind of therapy they're doing. I was just, I was sat there thinking oof I just want to talk. Do you know what I mean, this is not going to work. But I thought I have to give it a go. But once we started, got that sort of preamble out of the way. Got started , this is like, this our therapy session, it was great and we really clicked and it really gelled and it was really nice. I think it helped me because my best friend that I'd known since I was 18, we went to uni together. She moved to France a couple of years ago. She'd lived very close by, so I'd lost that somebody to talk to about a lot of things, do you know what I mean ? 7. I: Yes 8. P: So that's what I wanted out of the therapy, somebody to, that you can't talk to your husband about because half the time it's about him. Or you can't talk to your family because half the time it's about, do you know what I mean? 9. I: Sure 10. P: Somebody that's a bit more, not that I could talk to my friend about all the things, but just that person out of the family 11. I: That person to share with 12. P: Yeah, to share with. I think once we got started in the sessions, you know getting away from all that initial hoo-ha, it really settled down. I was amazed at how... Sometimes I was sat in the waiting room I thought what am I going to talk about today? I don't think there's, this might have

Not knowing what to talk about, but finding it all pouring out in the session. Realisation - this is what is going on for me. Learning about myself out of the therapy. The therapy enables realisations and understanding about what is going on for the client. I don't know how it happens but we always managed to get to the problem. Not knowing how it happens. Confirmation of what matters, rising volume and emphasis in the voice. Amazing that it feels better after the session. Again the use of the word amazing Questioning how did that happen. Surprise at the topics talked about. Questioning - counsellor's skill ? Knowing I felt better after the session. It was great. It was great - but how did that happen? It's not fixed the problems but it's highlighted to me where the issues come from. It's not fixed things but I have gained knowledge from the process. Usually keep things in a box - but the sessions were a place to let them out. The sessions were a place to explore things usually kept hidden and to allow the emotions out. The counsellor would make points. I got a lot out of it.	to be the last session, I can't think what I'm going to talk about. I got in there brrrrrrrrr 13. I: It all came out (laughing) 14. P: (laughing) brrrrr oh god! And I thought, it really struck me, do you know what I mean, it's in there 15. I: Yes 16. P: I didn't realise it's festering in there. And it was just when I sat down, I don't how we got into it, but we always managed to get to whatever the problem was. Do you know, she was very, I don't whether she did it? Or whether, how she did it ? Or 17. I: But it always got to where it mattered 18. P: It got to where it mattered. And you could always tell because that's when the tears started . Oh my god, this is obviously upsetting me because this is obviously what the problem is because the tears would just, I'm getting teary just thinking about some of the things but it just seemed amazing that and you come away and think Oh god that's better out than in, do you know what I mean 19. I: Sure 20. P: But it always struck me that how the hell did that happen? Do you know what I mean ? How did that happen? 21. I: I was kind of wondering about that? 22. P: I didn't think I was going to be talking about that, or, I just didn't think, do you know what I mean, but that's where it went to and I don't know whether it was the counsellor's skill, a mixture of everything, but when I came away from the sessions I was a bit lighter on my feet and you know, it's great. 23. I: Sure, sure 24. P: I can't really say that maybe, it didn't fix things, do you know what I mean? I can't say that, it's not fixed the problems. I'm not any sort of, the depression, the reasons are still there. But it's highlighted to me where. I think deep down I've always, I know where the issues all come from. I think everybody does. But you sort of put them in a box, 25. I: Aha, 26. P: because you can't deal with it every day and then so in those sessions it came out of the box 27. I: Yeah 28. P: and that's where all the emotions sort of come out, then you leave, you put it back in the box. But you've brought it out, you play with it, you've thought about it, you've analysed it a bit more, the counsellor sort of made sort of points - do you think? I thought oh my God yeah, do you know

Gained understanding from the counsellor responses. A lot came out of it - it was worthwhile.	what I mean? I got a lot out of it. 29. I: I'm really hearing this, yeah 30. P: But I can't honestly say that I'm fixed, do you know what I mean and that my depression's gone. Those issues are still there. The problem with it is that you know it's a finite number of weeks.
T hasn't completely done the job - because it is a finite number of weeks. The problem is it is not open ended.	31. I: Yes 32. P: And as it was getting towards, to be truthful, as we were getting towards the end, that's when it was all, you were just really
Trying to describe the problem but no clear description at this point. The ends of the phrases are not complete.	33. I: As you were getting towards the end of the sessions that's when you were in the thick of the work?
It is not stipulated specifically but the strong feeling is of closing down because insufficient time to completely work through the issues. There is not enough time to safely work through what I need.	34. P: That's when you were, you thought, and you knew you only had maybe a couple more, so you sort of, I don't know, it might have just been me backed up a bit, because I knew, well we're not gonna be, I could bring this all out of the woods and this is my last week, or something, do you know what I mean? And I didn't want, so you're sort of, not intentionally, but you're sort of mentally sort of backed off because you wanted it to, I said to the counsellor, I could come and see you every week, every fortnight, whatever, once a month
I could keep seeing the counsellor indefinitely. Really wanting much longer time to work through things. It's too limited. Stated clearly.	35. I: Yes 36. P: Because that's what I need 37. I: So something about the time limited 38. P: It's too limited
You think you've got ages at the start but it takes half of that to get to the issue. There's not enough time to work through it all.	39. I: Factor, yeah 40. P: You think at the beginning, oh twelve, ten sessions whatever, twelve, oh that's ages, well we won't, but honestly, it takes half of that before you really get to what is 41. I: Yeah. To unpack it all
You are building the work over the weeks - but when you're close to getting there you realise time is running out. Scared of letting it all out because there's nowhere to go with it. The work closes down because there is not enough time to work through it. Wanting enough time to work through it all. Really wanting more time. Not to have time pressures -" we've got as much time as it takes". The time limitation is not helpful.	42. P: Do you know what I mean? You're sort of, every, different, each week it's like you're picking a different area. But then as the weeks go on, you're actually, it's actually leading you to where the issues all arise from, but, but, you're getting there, you know, you've only got, oh I've only got a few more weeks, and you're sort of getting a bit scared, not scared, but, I was apprehensive that I'm going to bring this all out and I've got nowhere to go with it. Because I'm coming towards the end. I could have done with another, her saying you know, we've got another 6 weeks, or we've got another, oh don't worry, we've got as many weeks as it takes 43. I: Time to work it through 44. P: Yeah. I think that, where you're limited, that's

Problems are not time limited. It shouldn't be time limited because problems are not time limited.	where it falls down because your problems aren't limited to ten weeks. Do you know what I mean ? 45. I: Sure 46. P: But I can understand the demand on the system. The fact, you know, you've got to give everybody a chance, but it's only when you get in to the counselling that you realise how much you actually do need it
Understanding others need the service too - but the point is I need it.	47. I: Yes, yes
I need this therapy for me. It's me that needs the help. I need this help, but I can't get all the help I need because the time is too short. The time limitation hampers the work, because what's the point of going into things more deeply when the work has to then stop.	48. P: And you sort of think I don't care about the rest, it's me, it's me, I want to sort out, I want to be sorted out 49. I: Sure. I need this help 50. P: Yeah, I need this help. But I've only got a few more weeks so what's the point of digging it all out because ? 51. I: So the fact that it is time limited really closes down the work? 52. P: It does. For me it felt like that and you knew it was time limited from week one. Do you know what I mean?
At the start you think you've loads of time. Working towards what matters.	53. I: Yeah 54. P: But at that time you think oh god, that's, oh yeah, we'll be done and dusted 55. I: Yeah, the feeling is loads of time
The skill is bringing it out, (whose skill - therapist, therapy, client ??) but you panic because there's not enough time to work through something so huge. Out of all the talk comes the real issues and it is a skill to enable this to happen. Then you have to pack it away because the sessions are stopping and it is too big to be contained in the time available. I got a massive amount of benefit from the weeks I had. It was really a huge benefit to me.	56. P: Yeah, loads of time, but like I say, you're sort of faffing around, not faffing, every week you're dealing with something, but it's only as you get through towards the middle onwards that you're really heading towards what's really, you know, that's the skill of it, you know, it's bringing it out, and then for me you're backing off a bit because you're thinking oh my god, you're panicking because you think I don't have enough time to, you know, I want to talk, this is something that's huge and it needs more than the next three sessions or, do you know what I mean, so you're sort of, which is a shame, but it's not to say that I didn't get massive amount of benefit off the weeks I had 57. I: Mmm
I'm left with all my issues and nowhere to sort them out It's opened stuff up, but not enough time to sort it out. It's back to what I was.	58. P: Because I did, you know what I mean? I came away, but it has slightly opened the old wounds and the old can of worms and I've nowhere to go with it, do you know what I mean 59. I: It's stirred stuff up 60. P: It's back to what I was. It's stirred things up and I'm back in the same position that I was before I went, do you know what I mean? Only before I put them all to the back 61. I: Aha 62. P: But they're festering. So 'bout. They're out there

I'm in the same position as before I started. Before I started I could pout stuff to the back of my mind - now it's in my thoughts more. I used to move stuff to the back of my mind - but it's bouncing back in my head now because I have nowhere to go with it (L.66). Counselling stirred up the issues and moved them more into awareness, but there wasn't time to work through the issues and get them settled. Didn't use the full allocation of sessions because one or two more wasn't enough. Fear of getting in too deep meant pulling back now because there wasn't enough time. **The issues of time was a major downfall of the system.** But the sessions you do have work well. Reiteration of need. I needed it, it was good, but it hasn't fixed things because there wasn't enough sessions.	now 63. I: They're not quite so in the back as they were 64. P: They're a bit, they're more in my thoughts now. I do think, I mean a lot of my issues led back to the parents, my mum, you know, the relationship with my mum. And what, and she was having us, I don't know if I actually did say anything, but she left my dad and she took the young, us younger ones, us 3 and left 4 children behind with my real dad. And I went through my life and she told me that my stepfather was my real father. And she would have sworn on her deathbed, in fact she did die, sort of left swearing it. So all that is back out in my thoughts. Whereas, I'd sort of, oh for god's sake I actually just have to let it go. Because she's dead now. Everybody's dead now that's you know, my father, stepfather, her. I've got to let it go. But it's bouncing back in my head again, do you know what I mean? 65. I: Yes 66. P: So I have nowhere to go with it now because I did actually, I could have gone on for a couple more sessions. I think I didn't go through the full whack of sessions but that was me because I thought I need more than whatever, the one or two whatever that I needed 67. I: There might have been one or two more, yeah 68. P: Might as well back up now, because otherwise I'm going to get in too deep with that and I've not got enough time to sort of go though it and analyse it, do you know what I mean? 69. I: Absolutely 70. P: So I think that whole issue of being the time was a, it was a major downfall of the counselling system, but it's not to say that in the time that you do have it doesn't work very well 71. I: Sure 72. P: And you do need it 73. I: That actually having gone through what you went through there's a sense of feeling light, there's something really good that's come out of it for you 74. P: Yeah 75. I: But it hasn't fixed the issue 76. P: It's not fixed. No, no 77. I: In fact instead of it kind of being at the back of things it is now perhaps moving around a little more for you, but that is a consequence of actually having to pack it back away, because you knew it was going to come to an end? 78. P: Yeah, yeah. I know it been coming to an end. I mean I know that that whole thing is where my, a

I would like to have done the deeper work I think ... or maybe not ? Questioning the thoughts? Is this a reflection triggered by the research interview? I'm left with all of this now to deal with myself. Abandoned ? I'm on my own now to deal with this. (Mother didn't meet needs - truth / Therapy didn't meet needs - time. If this was therapy then the material could be explored but not in a research interview.) I didn't want to feel worse* So I left it before it got to that point. Client keeping safe by ending before she got in too deep as a result of knowing the sessions were to end before she could complete the work. Reflecting on what she has come through and what is responsible for how she feels. Questioning what is responsible for the improvement. Questioning - would it be different if the counselling was at a different time of year ?	lot of my problems arise from and I would of maybe liked to have, I would have liked to have sort of gone more deeper into it. I mean whether it's just me blaming something and that's the something, do you know what I mean, that I'm blaming? Is it really that or is it other things ? Or 79. I: There's question marks? 80. P: There's question marks which if we had a lot more time you could have gone down those paths, do you know what I mean ? Which would have been interesting. But there just wasn't in the time, do you know, I didn't want to go down those roads, but to just, oh god, that's, we've done our 12 weeks or whatever, oh right, oh right, I've got to go deal with this myself now 81. I: I've laid it all out 82. P: I've laid it all out 83. I: There wasn't the time to work it through and I'm left with it 84. P: And you think what do I do with that. I feel worse now and I didn't want to feel worse. I think that's probably a good point. I didn't want to come away, because I 'd opened all that out and not dealt with it and not talked about it and then you think I feel worse, oh god, this isn't what was supposed to happen, do you know what I mean ? 85. I: Sure 86. P: So I left it at a point, where I didn't go down too deeply and I did feel a bit brighter. I always said to her, I don't know whether it's because the sun is shining, or I've come through the winter, you know the winter is miserable as sin for me. So the sun is shining, the spring is coming, I've lost a bit of weight, I've got a hernia. Oh can you believe it? It's just one more thing. But it's been a turning point in that I've lost over a half a stone. So it's been a lot of issues which would make me mentally feel, or is combined with the counselling, do you know what I mean ? 87. I: Yes 88. P: Is it just the counselling? Is it a mixture of all of the above? That's something. If I had the counselling through the winter it might have been a completely different, do you know what I mean 89. I: Mmm 90. P:For me in my depression, the winters are bad. and literally, when the clocks change, when the sun starts it's like, there was like a weight lifting anyway 91. I: Aha 92. P: Do you know what I mean ? 93. I: Yes. Everything seems brighter

I feel better anyway when I move towards the summertime. The counselling helps you to get through things. The counselling is helpful. I could do with more sessions. I need more sessions what I've had is not enough. I know a lot of people need it - but it should be there for me - I need it. The service should meet my needs. Sufficient time to look in depth. Enough time to do the job properly.	94. P: Yeah, All I can see now is that I've got to go through the winter, you know what I mean. My life is always around winter so, and 95. winter's are hard, but I'm hoping you know like, things that you deal with in the couns.., you know it helps you to get through the things 96. I: Mmm 97. P: Do you know what I mean. I could do with another 12 week course 98. I: Yes that would be welcome. 99. P: It would 100. I: Sure, sure 101. P: You know that's just the nature. I mean I understand that it's oversubscribed and its, but it just seems, there shouldn't be a time limit. It should be, do you know, from my point of view, it should be as long as I need it 102. I: Yes, yeah. You want to get the job done 103. P: Yeah 104. I: What do you think actually would get the job done ? 105. P: It's a hard one. Whether it's just a case of having the time to really look in depth at all those issues. But it, it, I don't even think it's a case of looking cos I've looked at those issues before, but I need to get closure on them, do you know what I mean? And I think that's, that's the problem. I mean, I could talk to death about all the things I think is wrong, but it's turning them around and saying well, ok that happened, but you've got to let it go 106. I: Something about acceptance? 107. P: It's accepting it 108. I: And in the therapy, what I think I hear you say is the time I that I had was really useful, but not enough of it. This isn't fixed for me, so I guess the question that is coming up for me is actually what do you need to help you fix this ? 109. P: (sighs). I don't know. Can it be fixed? 110. I: Can it be fixed? 111. P: Can it be fixed? Maybe fixed is not the right word because I don't think it can be fixed. I think it is the closure 112. I: Aha 113. P: Acceptance, closure, they're better words because I don't think it can be fixed because there's too much gone under the bridge and that 114. I: Aha 115. P: Do you know what I mean. There's too much damage has been done. But it's forgiveness. I need to forgive my Mother and stop blaming her do you

I'm having to do the work on my own now. Because the counselling didn't get me to point where I'd got what I needed, I have to do it myself now. Things could have been different - realisation / reflection Working on things after therapy had ended. The work doesn't stop just because therapy ends - it continues afterwards. The counselling brought things out and they are still out in my head. The counselling brought things out but there wasn't time to finish working through it.	know what I mean ? I used to think ooh, how could she do that? How could she do what she did ? And. But as a Mother and a wife myself, I can, as I've got older, I have in a sense, sort of understood, do you know what I mean that marriages are not always great I mean, and kids can, I mean I don't think, it wasn't us that was the problem, it was her marriage that was the problem. And as an adult, as a married woman, I can see that marriages don't always last. Do you know what I mean ? But what she did, was completely the wrong way of going about it. It was a turning point and I need to sort of go back to that turning point and look and analyse, well, do you know, if we didn't do this, if she didn't do this and we went this way, and I'd have stayed and went that way life might not have been any better that what it 116. I: Mmm 117. P: Do you know what I mean ? And that's the path that I sort of need to look at. Because I can look and see where my siblings that were left behind, where they are. We're from Northern Ireland there's a lot of, it was a very Protestant family and I mean very Protestant 118. I: Aha 119. P: And I would have been in the depth of that and I wouldn't be the person I am now if I'd have been left in that environment. 120. I: Mmm 121. P: I mean I married a Catholic. Oh my god that went down like a lead balloon over there, do you know what I mean. So, my life, I've got to accept that you know, that actually my life could be better now for what she did. Now this is something I would have liked maybe to analyse more with the counsellor, but because it's all out in my head, I'm analysing it myself 122. I: Sure, sure 123. P: Do you know what I mean? So if that's a good thing that came out of it, I'm analysing it. It's bubbling about, and I think, well do you know, if I had been left behind life could have been hell 124. I: Aha, These are reflections now coming after the therapy, 125. P: After the therapy 126. I: That you are working on in your own time 127. P: In my own, it's like homework, taking it away. 128. I:Yeah, yeah 129. P: All these things that have been brought out of the box are still out of the box and they're getting... You know ooh, I think what brought it to a head

	was cos during the time I was seeing the counsellor, my brother that lives in Canada, his stepson died just a few months ago. 130. I: Oh I'm sorry to hear that 131. P: His wife died last year, of his stepson. So he's in Canada alone now. That's what brought the whole thing, when I got chatting with the counsellor was because he was left behind. He's only three years older than me, but then there's a gap between him and my elder brothers and my sister. Do you know what I mean? So he was only at school. The rest were like, left school, working 132. I: Aha 133. P: He was at school, we were at Primary, he was at High school, so quite a few years. Now he, has his own issues, and I think that's what brought it all out because he says he remembers the day well that Mum left. He says it was a normal day, he went to school and came back and we were all gone. 134. I: Aha, 135. P: And he turned into an alcoholic. He's got ... he left completely and went to Canada and he's been a drinker all that time. You know he's got major health problems and I thought now is that, his health, is that because of the situation? Like me we've all been damaged, 136. I: Aha 137. P: in our own ways from the situation. But because his stepson died it just brought that, sort of, my god, she damaged him and now he's there on his own 138. I: There are consequences for all of you. 139. P: There are consequences for all of us in our own different ways. So what makes me feel that I'm more affected by it? Do you know what I mean? And the other thing that came out of it all is like my sister, the three of us, my sister who was only a year older than me and my brother who's younger than me, well my sister that's older than me, she's, her birthday is April too, and I'm next April, that she's his half-sister 140. I: Aha 141. P: You know, I've sort of switched that off in my head for ever. For ever. I've never thought about it. It's bubbling in there now because she is my step-father's daughter, which turns my Mother into a right old cow because she had her with him and then had me and my younger brother with my real Father. Do you know what I mean? And it's like, it went back for years because I was like 8 whenever

	she left, so this had been going on for years and it's just a mess and a muddle. And I can't, it's hard for me to forgive her. And that's, it is an area we sort of were getting towards three quarters of the way through our sessions it was coming back to that we were getting ... and I don't know whether it's that I was scared to open up about it too much, but I did open up about it. Do you know what I mean? We did get started talking, because it always upset me, but I could have done with a lot more time
	142. I: I'm really hearing this
3/4 of the way through the sessions were we coming to work on this issue. I don't know if I was scared to talk about it? But I did talk about it and it always upset me, but I needed more time to spend on it.	143. P: To talk about it, um
	144. I: What you had, I think I'm hearing you say, was good,
	145. P: Was good
	146. I: But actually not enough
	147. P: But not enough
	148. I: You'd really have welcomed more
Although I was frightened I was talking about what mattered, but I really needed more time to talk it through.	149. P: You know we could have stopped talking about everything else before and just gone straight into that. That's the way it should have gone, but that's not the way it goes, because there's other things that you know, we talked about. There's other, loads of things
	150. I: You sift and you sort and you hone it down
We should have really started with the major issue, but there's loads of other things too.	151. P: And you hone it down. Um, but like I say it's all out there at the minute. And it's all, like a cloud, you know, it's up there and I keep looking up at it and I'm trying to sort of deal with it now but it's out there and I'm trying to make sense of it. I just want to get to the stage where I just want to say right, oh god, there's nothing I can do about it, just let it go. And you know, that's hopefully where the counselling is helping me to sort of think like that
We should have worked immediately on the most important thing, but there's so many things to talk about as well.	152. I: Sure, sure. If you had to design a counselling service from scratch. For you, what are the criteria, if you like, of effective counselling?
It's like a cloud above me and I'm trying to work through it.	153. P: Well it's like I say, when I first went I almost was put off by the first session
It's still hanging over me, but I'm trying to work though it and maybe the counselling is helping me to sort it out.	154. I: So that is absolutely is stuff that isn't effective counselling
	155. P: Oh god ! Do you know what I mean ? I consider myself an intell.... I've got a degree. I'm not stupid, but that's not what I want to hear, do you know what I mean ? It's just, it was, I understand that they have to do it, but it's sort of, it's like a bit of a turn off. I might have gone away and thought no I'm not going back (laughing)
	156. I: Potentially you could have not returned?
Almost put off by the first session.	157. P: I could have not returned because I didn't get the sense of that closeness, you know, that the

It's not what I want to hear. **The client does not want to hear about the procedural and theoretical aspects of the counselling.** I could have not gone back. The first session. was very off putting. I didn't feel close to the counsellor or feel she was a good listener because it was "too text-bookie". **The procedures prevented the relationship growing.** As with the CBT - pre-prepared speech - this is how to do it. This is not meaningful for the client- it's not her stuff - it's the counsellor's procedures. The first 2 sessions were just pre-amble stuff and I might have not gone back - but the 3rd sessions was so different. The first 2 sessions didn't meet client's needs - but a recognition of change in the 3rd session - this was an "eye-opener - "**because we talked".** This description of the "text-book script feels surprising - more expected with CBT - but CfD is supposed to be a relational model and there's no sense of the relationship in place in the first two sessions - is this because the service procedures are getting in the way or is this actually the model? The counsellor explained what kind of therapist she was but I can't remember what she said. **I don't care about what kind of counsellor you are I just to talk to someone.** **The explanatory stuff was not even remembered by client and didn't mean anything to her.**	counsellor was a good listener, do you know what I mean ? Because it was too text-bookie. Do you know what I mean ? It's like when I did the CBT. It's like, you could have almost had a text-book when she was speaking - this is what I need to say, this is what you, oh, I need to do 158. I: Like a script almost 159. P: Yeah, it was, you don't need that, I think even from week 1, I mean, it was like a session went into the next session, all that pre-amble stuff. It was literally the third session before we fully got into counselling. so I think that first and second session I might have just said sod this, I'm not going back, but it was like an eye-opener when I went for my third session and then 160. I: So what was so different? 161. P: Because we talked, we'd got rid of all that stuff. I mean she told me what kind of therapist she was. I thought for the life of me, I can't remember what the hell she said 162. I: The title didn't mean anything 163. P: Didn't mean anything to me 164. I: No, no 165. P: I can't, honestly, she said whatever it was and I thought phft, gone. I don't care what kind of counsellor you are, I just want to talk to somebody. It reminded me of an experience, that I thought this was what it was going to be, because way back, before I even knew what I wanted to do, obviously because of my problem, I actually dabbled with being a psychiatric nurse. I did actually apply 166. I: Aha 167. P: And I was out for the day with, um, we went straight into the community the first session. I was out with this psychiatrist, um, and we went to visit this man, in his house, and this man had lost his wife. He was an older gentleman and he was just so upset. And he just wanted to talk. That psychiatrist was not interested. That was not what he was there for and he literally just fobbed, this, and off he went. And I thought, that man wanted to do, and it put me off the whole thing, because I thought this isn't what I thought this was about. I thought, you know I wanted him to sit down. This man wanted to talk 168. I: Yes, you could see that 169. P: And that's what I wanted to do. So when it was just all this babble about the kind of service it is and you know, and this is the kind of counsellor I am, and you know, we need to, I thought, oh god, all I want to do from week 1

	170. I: From the off 171. P: Is talk 172. I: Yeah 173. P: Do you know what I mean ? What do I want to... so I just, I don't know ... I didn't... I don't understand why it has to be done ? Why it took so long?
All I want to do is talk. All the explanations are "babble".	174. I: Mmm 175. P: Why you can't just go straight ....I don't know. There's obviously reasons, you know, they must prepare the courses with the .. Are you getting bored ?(addressed to the dog on her knee)
	176. I: Aww 177. P: They must prepare the whole course structure, you know we have to do this. Then we've got to have a, at the end we have to have a whole review thing of what we've talked about. And to be fair for the person, the client, err me, I don't give a toss about that. I want every week to be...., so I don't think
I don't need all the "babble". I don't understand why they need to do all this babble.	178. I: What's the end of that sentence, I want every week to be about 179. P: ME (laughs) 180. I: Yeah 181. P: And I think we did actually, I said that to her, I said what I'm getting out of this time with you, I said this is me time, I mean I'm in this house it's me time all bloody day. But there's no distractions. There's no .... in this house, I can feel myself getting upset, so I know that this is an issue 182. I: Sure, and if you need to stop at any point do let me know
I don't "give a toss" about the course structure - I want every week to be about ME. I need the sessions to be about ME. Nothing else matters. The sessions provide "me time". The sessions provide "me time". I got "me time" from the sessions. The sessions provided something I wasn't getting anywhere else. To have the "me time" affected by service procedures was really unwelcome. Client knows what she wants from her sessions - but the	183. P: I know that having time that's out of the house, out of where my problems are, that's me time. And that's what I got from the sessions 184. I: Yes, Yeah 185. P: So to start talking about you know, like we can do a review, next week we can do a mid-week, a mids review and I thought... I suppose they have to see whether it's worked, but sometimes I would think, how am I supposed to answer this ? Do you know, what does she want to hear? I was trying to think what does she want to hear ? 186. I: What was the question? 187. P: It was like - what are you getting out of this ? 188. I: Aha 189. P: Do you feel that, I can't quite remember what exactly the question is. But sometimes, I can remember the feeling of sitting there thinking how am I supposed to answer this without offending or upsetting or .. Do you know what I mean ? You

protocol and policy of the service imposes its own agenda which doesn't fit for client. Not knowing how to answer the counsellor's question - considering what is the answer the counsellor wants to hear. The service agenda creates a situation where the client is trying to please the counsellor. I don't know how to answer this - will I upset or offend you. I want to be the perfect client and tell you "I'm getting loads"- but actually you're checking is getting in the way of my doing the work. Counsellor's agenda gets in the way of client's agenda - the counsellor trying to satisfy the Service requirements gets in the way of the client doing the counselling work. The counsellor's agenda was wasting my time - my precious counselling time. I only have 12 weeks and you're wasting them with your stuff. It's not an hour that you get. You don't get your whole hour. Do not look at your bloody watch. The counsellor's focus on time highlighted how short the time was. Don't be obvious in managing the time - because it emphasises time is	sort of want to be the perfect client ... you know, the perfect ..yes, yes I'm getting loads. And I was, but do you know what I mean ? But I don't want to be stopped 190. I: I think what I'm hearing is you're saying to me, actually, truly, what I wanted was me time. Time for me to talk to somebody out there about what is going on for me 191. P: Yeah 192. I: And actually the first two sessions were about her explaining to me how the service was, what kind of therapy she practices. It was kind of her stuff 193. P: Yeah, 194. I: Not talking about me 195. P: It's sort of wasted. Hang on, you're in my two weeks here. Do you know what I mean ? I've only got twelve weeks and you've just wasted 196. I: And they're precious, yeah 197. P: Two flippin' weeks there 198. I: Mmm 199. P: Do you know, that was like, to be fair, twenty minutes. I think cos, oh you say it's an hour, but it's not an hour, it's like, she did look at her watch. So it's like... oh right... I mean I ... She could have done with a clock behind me so she didn't have to look at her watch. Do you know what I mean ? But that was a point, if you wanted to say anything, do not look at your bloody watch because that immediately, oh god, time's getting short. I can't go down that road because that's going to take... I mean I was trying to look at my own watch. Well what time is it ? Do you know what I mean ? Because it was only like, there was a wind-down sort of time, because she wants to have time to do whatever she has to do before the next person she sees. So she doesn't run over, it's a finite ... 200. I: So the sessions need managing time wise, 201. P: But not so obvious 202. I:But the actual physical looking at the watch 203. P: Obviously looking at the watch was a bit of a put off because you knew , oh is it already that, that sort of, but I did, I thought, it's only sort of like, we've got another ten minutes. You know, it was sort of emphasising in your head, we've only got ten minutes, so I'd better not go down that road. Do you know what I mean ? Because that's going to take longer than ten minutes, so you maybe waffled a wee bit. I mean it's coming out now with the negatives, whereas before I was a bit glowing wasn't I? But there were negatives like this

running out and it makes me hold back because I know we have to finish. Shortness of time limits the depth of work, because the client pulls back in preparation for the session ending. I'm talking about the negatives now compared with the positives before. Acknowledging there's a difference in the perception- where previously it was all positive now there's a discussion of the negatives. Is this due to time passing? The interview situation ? Why was it not reflected in the HATs? Counsellor's focus on time distracted client from her work and made her stop short of going deeper into the work, knowing the session was shortly to end. Someone else might not be bothered by this. Client pulls back from the criticism - downgrading the importance of her noticing the limitations of the time. But then picks up the theme again. You don't get your full hour. Both number of sessions and length of sessions is too short. A full hour should be what you get. It takes time to get to the nitty gritty.	obviously 204. I: Mmm 205. P: I mean I think if I was her, I would invest in a little clock and put it (gestures behind me), it's easier just to flick your eyes 206. I: So you can monitor it without actually distracting 207. P: Because it was distracting. That's the word. It was a distraction. Um, cos it just then made you aware that time is short here 208. I: And there's a sense it closed things down 209. P: And you've got to wind it up, do you know what I mean ? Because you haven't got time to go down that path so you're sort of... you know... which is a shame. But it is a point, but like I say, I don't want to say, it's not a massive point. It's just that I noticed that. Somebody else might not have. 210. I: But this feels really important and again there's a sense of it focusing on time. Not just about the number of sessions 211. P: Actually, the length of the sessions as well 212. I: The length of the sessions, yeah 213. P: You thought, oh I get an hour's counselling, you don't. You literally don't. It's 40 minutes because that last is a bit of a wind ... it's not even 40 minutes because you are winding down 214. I: Yes 215. P: Literally you're 45 minutes and then you're out of the door because she's got whatever she's got to do and then get the next person in. So it's not an hour and I don't think 45 minutes is enough really. But I can understand 216. I: What would be enough, do you think ? 217. P: Well, I think a full hour would be. You think you're getting a full hour. That's what you should get. But it's, you know so .. 218. I: Because I think what I'm hearing you say is the last ten minutes can't be used as fully as a middle ten minutes 219. P: No, no. That it's a sort of .... I mean but sometimes, and that's what, it's like I said with the whole, that it was three quarters of the way through the block of sessions, you could almost say it's almost three quarters of the way through the individual session that you were getting to the nitty gritty 220. I: Mmm 221. P: And then suddenly she looks at her watch and I think oh shit. Do you know what I mean ? So it's like three quarters of the way through the whole block you were coming to the issues that were

You can't get to the point straight away. Counsellor looks at her watch and I know we're going to have to stop. I get stopped in my tracks and prevented from doing the work because of the shortness of time. Is it due to the counsellor's way of working ? Being too cautious and then running out of time just when the important work is starting? Questioning the counsellor's way of working that creates this situation where the work is closed down due to the time limit. You put the work away - but next week start somewhere else. There's not a continuation where you left off - you start next week somewhere else - but then get round to it again. There's no flexibility with the time.	really important, but also in each session, it was three quarters of the way, that was you know really ... Now whether it was just that's the way it felt because the way she works, she's building it up so that it is by then that you start everything comes out. Do you know what I mean ? She's been pussy-footing around and it's literally, but then it's come to whatever the real bug-bind is for that day, and oh, but we haven't got really time 222. I: Yes 223. P: We're running a bit short of time here. You know, and ohh, ok. Do you know what I mean ? So, how long do you need I don't know 224. I: Digging down and searching for something and peeling away the layers and uncovering and uncovering. You're just within sight of it, and then you've got to start covering and packing it all away again 225. P: You've got to put it away. and when you come back next week it's not where you start off 226. I: You're somewhere else next week 227. P: You're somewhere else next week. But then three quarters of the way through you are getting back to that, you know what I mean, it's, it's how long is enough of a session? I don't know. Do you know what I mean, there is days there that I thought that I could talk for a lot longer, I think every day I could have talked for a lot longer, but you are conscious that you don't have, or haven't got that time to talk, so... 228. I: So this sounds like you were really engaged in the process involved, every day I could have talked a lot longer. 229. P: Yes 230. I: There was a real kind of commitment to the process but because of the management of the time structure.... 231. P: Humm 232. I: Actually that is what ...? 233. P: Yes you have got your slot and you have got to fit in that slot that's, and there is no leeway, I can understand that because if you are sitting waiting out, you don't want, ergh, I have many of time I have been sat waiting for, you know it is part of life, but obviously for this service time management is a big thing, do you know what I mean? You know, you give and then you see your next client, you know, dead on 10 o'clock or whatever time she would call me in kind of thing, so I never expected that because where else do you get called in at the time of your appointment –

	NOWHERE – do you know what I mean? 234. I: She was absolutely on time 235. P: Yes, on time, because, mind you bearing in mind I was the first client but there was a time I was later on in the day, I thought 'oh my' but I wasn't, no dead on. 236. I: The time of your appointment was the time you went in 237. P: Called in, and that's the ONLY place that's, it happened actually with the CBT woman as well, so obviously it is the way it is done now, it is all structured, you have got your start time and that's it. 238. I: Your start time starts on time but your ending time also ends on time. 239. P: time, yes. There is no running over because oh it might just, cos, I imagine it must be frustrating for her because she, you know, she said 'I really, I really you know would have liked to'. I thought 'yes but really should have and could have, there are you know'
Other places keep me waiting - but here I was always in on time. "Dead" on time. Recognition that NOWHERE else does this happen.	240. I: This is the time we have got so we have got to finish 241. P: It ain't going to happen is it [unclear over talking 0.34.13]
	242. I: Yes
Always on time. Always on time.	243. P: And like you say when you come back the next time that's passed and you can't rush straight back into that, you are sort of, phhh, you just can't do that, so you sort of go, you know, wherever it takes and then you know you are heading back to that and again you are coming to the end of the time so it, so each week yes I did talk, I did, we talked about other things and things and stuff like that, but yes, I think the whole process of that whole thing, you've caught it on the head, it's time restriction.
Acknowledgement that this is way it's done. The timing is structured - start and ending.	
There's no running over. Hearing the counsellor say "I would have liked to" (meaning continue) - but client feels " really should have and could have" - but didn't. Knowing the session time isn't flexible. The extension of the session time was not going to happen despite what the counsellor said.	244. I: Yes, yes 245. P: Erm and now looking back on it it really does stand out, it is all based on a set amount of, you are given a set amount of time and nowhere else do I, I mean whenever I was, I can't remember how long, but I have been in counselling before and I have really forgot to mention it to the counsellor as much, I did bring it up cos, but when I was at University/College I went to see the student counsellor there and I loved that man I still not, I would love to meet him again because he was what I considered to be a coun... he was just completely different, I mean he was amazing...
I would talk but again you are coming	246. I: What are you thinking of there when you say 'he

to the end of the time. A sense of frustration - again running out of time. Repeatedly, up against time. There's only a set amount of time. Time is fixed - I'm stuck with a limited amount of time. I saw another counsellor- completely different - amazing. There's a different way to be a counsellor that is "amazing". A counsellor from the get go gets straight down to business. A proper counsellor gets straight on with the work - no messing about. He set the standards by which I measure other counsellors. He absolutely did it right.	was what I considered....' 247. P: He, he's, he's, he's a counsellor, I could go in there and from the get go straight down to business, now we are going back a long time. I am sure I have got rosy glasses when I think about it, but Dave Stott was his name and I would love to meet him again because, it, this my friend that went to France, a lot of my issues where about her, [laughs], she was going to see him too so he was getting me and then he was getting her and he never ever, never.... 248. I: No he held those values yes 249. P:No, no, and I knew that he is getting it from me and it was like he was probably like a parent of you know, the two siblings, you know, he is getting it from her and he is getting it from me. But he was, now he is what I hold up other counsellors and other counselling services against that's, to me that's... 250. I: So what are you thinking of there? 251. P: I don't know whether it was just because I was younger erm... 252. I: What was it he did? 253. P: Actually it was, he was when I first brought up about my mother, I mean the whole, apart from my friend, the whole of my sessions were the issues with my mother and that family, all my problems, because that affected me way back even then, it affected my relationships with boys, it was just all encompassing because she would never admit that my step-father was not my real father. Now we worked through that, I mean and you know there was tears, there was buckets of tears and just, and you know we found, when I graduated I just went 'they are coming over' and he said 'well why don't you ask them, just tell, ask...' so he built me up when they sat in front of me to straight, tell me straight. 254. I: Ah-ah, really empowered you to do that? 255. P: Really empowered me and br,br, br, br, br and I sat then down and I asked them and they still bloody lied, she still said that 'no, no he is your real father, this is....' I have got blood tests and that's what really pisses me off, I have got blood tests that show he is not my father [laughs] 256. I: You have got the evidence? 257. P: She gave me the blood tests, she's got her own iss... she had her own issues, she gave me those blood tests that said that he was not my real father but he could have been my sister's, so even knowing all that and I asked her 'Mum please be

	honest, please is...' and she still said 'no he's...' you know, and I went back to see Dave and then he sort of had to bring me back down, he said 'Agnes you are just never going to get her to admit it'. So that was when I did put it sort of back in the box, but it is always, it festers, festers, festers do you know what I mean, but she is dead now so I have to sort of let it go but when I look back at those sessions I can't recall them being time limit, they probably were, I don't know, they probably were, but I didn't feel it, whereas I felt it at these sessions. I felt it at that CBT course as well. The time restraints and that is, how can somebody open up and lay it all out bare then somebody comes we have got to wind it up, do you know what I mean? 258. I: Yes 259. P: It is ama... I mean it is, that is something they really do need to look at and only as an observer looking back at it now that I think that did make me hold back. 260. I: That feels hugely important. 261. P: It does and I think if they were trying to look at ways of improving it, I don't know how they can improve it, if they give me an hour and a half would an hour and a half be enough? I don't know, do you know what I mean? 262. I: Yes 263. P: But definitely 40 sort of minutes isn't enough. 264. I: It doesn't feel sufficient. 265. P: Do you know what I mean, that's like you can talk to somebody at the bus stop for 40 minutes but to actually open up and to try and go in deep and bring out pain and hurt and get it all out there and then, because when I cry I go like a belisha beacon so I was like, it was always getting to the end of the session and I thought 'oh Christ I have got to walk out of here and go to the car and people are going to think I have been told I am dying', do you know what I mean it is just, it was too, you know, too, too short a time definitely, too short a time. 266. I: Yes, I really hear this, yes, yes. 267. P: Too short a time, and I think that is one major area where they need to sort of look at it, but then there is so many people... 268. I: Sure 269. P: But is it better to have, see a lot of people and give them a short time of say, I mean I waited a long time for the, you know... 270. I: How long did you wait? 271. P: Phhhgg, I can't remember exactly, I have got
I wasn't aware of the time then - but I am very aware of it in these sessions. How can someone open up then have to close down because you're running out of time. This needs to be addressed because It did make me hold back. Time did affect the usefulness of the sessions and if they want to improve the service they should look at increasing the length of the time available - but how much time is enough?	

40 minutes just isn't enough to go to where the pain is. I have to walk out when I've been crying and people will see me and think I've been told something awful. I have to face people after I've been crying and they'll see I've been upset and there isn't time to compose myself and feel ok to out there. But lots of people need this service. Querying use of resources - is it better to see a lot of people for a short time - or see fewer, but work longer ? I've waited and waited - but I will get my time to talk. Then to find it is still restricted is not right. **It' s not fair to have to wait and then still not to get what you need. (275)** (Mother didn't meet needs - (truth), therapy didn't meet needs (time), does this compound the feeling - I can't get my needs met ?). The job was not done. Questioning the purpose - is it to get you thinking about it yourself - Which **I** would say it is - but the feeling of the	fibromyalgia, I am very forgetful and things that should stick in my mind don't stick in my mind. Things that I wished didn't stick in my mind stick in there for bloody ever, but do you know what I mean, little things like that, looking back I can't remember exactly how long, but I was on a waiting list. 272. I: You knew you were waiting. 273. P: So I was waiting, I waited and waited, I want to wait until so that when you do get seen, we are going to be the time... 274. I: And do the work yes. 275. P: To be waiting, waiting and then to be seen and you are still, it is still restricted, that just doesn't seem right do you know what I mean. If you are going to wait you might as well wait another month or two and then have as long as you need 276. I: Yes, yes 277. P: Rather than waiting and still be restric... you know what is the point of that, I don't...? 278. I: What I think I am hearing you saying is that 'I want the time to get the job done'. 279. P: The job was not done, but like we have said earlier, it is in my head and I am sort of, whether that is part of what they do and what the whole purpose is is to get you thinking about it yourself, I don't know, but I have been thinking about it myself before I had the coun... do you know what I mean, so? 280. I: Yes, yes 281. P: I can do that on my own anyway, erm, but it is nice to go and see somebody professional and get it out and then the counsellor would say 'and do you think, or maybe this is, or what'. It is getting that professional input to help me deal, because I could have all the thoughts, it is all in there, wish washy washing, but it is how I sort of deal with them, that is where you need the help and 282. I: Yes 283. P: Because having all those thoughts can send you down into a depression and I have got to be careful that it doesn't happen because I can feel it, do you know what I mean? 284. I: Humm, sure 285. P: I get more, I start to think oh god and it gets me upset and I think 'why am I thinking like that?' And I know it is building because I am starting to cry again, it is always the trigger, so I know that those issues are still really fresh and have not been resolved, there has been no closure on them, they are just back out in the open, so whether that is a

job isn't done feels unsatisfactory. Getting the client to work on their issues themselves - yes - but not unsupported. It needs the input from the counsellor which is missing in this case. **Counsellor would come up with ideas and offer another viewpoint.(281)** I need the professional help - I do a lot of thinking - but I need the help to sort it out. Thinking about all the stuff can make me slide into depression. I get upset with all these thoughts because it's not been resolved, it's not sorted and I don't know if this is good or whether I should have not opened it all up? Maybe I shouldn't have gone to counselling if I couldn't have completed the work. 285/295 Questioning the point of counselling - Is the point of counselling to talk or to get closure.	good thing or whether I should have just left well alone and left them... 286. I: Humm, it feels the jury is still out a little bit on that 287. P: Do you know what I mean whether... 288. I: Are you okay to continue? 289. P: Oh yes fine, yes as long as you are alright? 290. I: Sure 291. P: [unclear 0.42.26] remembers somebody is coming and he might walk in his underpants [laughs] 292. I: Okay [laughs] 293. P: He won't, I have not heard he would be growling [laughter] – if he thinks there is burglar upstairs don't you. 294. I: He has been so good 295. P: But you know, ahhh, I don't, you know looking back as much as the positives, I mean it is only now that you are bringing it up because I never really thought, you know, thought about it but now that I have got talking about it, you almost wonder 'should I have just left well alone', you know was it the right thing to sort of bring it up because there isn't any closure. Now whether is the point of counselling to have closure, I don't really know? Or is the point of it is just talking? 296. I: Well what was your point of it when you went into it? 297. P: I wanted to talk to somebody, I wanted insight into the problems and the issues that I am having and in a sense I wanted, I did want closure, if I have to be honest, I did want... 298. I: That was an aim? 299. P: It was an aim 300. I: Yes 301. P: But not within the timescales that were set. 302. I: What about insights? 303. P: Insights, yes I do have insights, I mean there are things that the counsellor said that, don't ask me, I probably put it in my forms, that I thought 'oh yes' and do you know I never really thought of it like that. You know, yes I think yeah you are right there, so there were moments like that. 304. I: Do you want to have a look through the forms at all, would it? 305. P: Erm 306. I: Would it prompt you just to have a quick, you know... 307. P: Yeah go on then 308. I: Just to have a quick, I use them sort of as an aide memoire, just as a reminder.

Client's goal = 297 1. **I want to talk to someone.** **2. To get insight into the problems.** **3. To get closure.**	309. P: Err, yes because this bit here that's the bit that, yeah I mean there is a lot of things that, that you sort of raise, that you couldn't really raise, I couldn't say [dog growling] things to other people, oy shut up. I couldn't say things to other people because I didn't want to hurt them. 310. I: Humm, so she was a place that you could bring all of this? 311. P: I will tell you what we did come to the conclusion [laughs] is which I didn't really raise, is that I want to control things in my life that really was an enlightenment.
I couldn't achieve my goals in the time allowed. The service restrictions set this therapy up to fail ? I did get insights Therapist response highlighted other ways to think about things which created insights.	312. I: Ah-ah 313. P: Erm and now I look at it I think 'yes you are definitely right', because that's part of my coping strategy is erm, that I think because of what has happened to me I couldn't control that situation, so that's in there when I got my cancer, I couldn't control that at all, erm, so all these, and now I have still got ill health, you know, I thought that when I had my cancer that I was going to get better? Isn't that, I have got rid of the cancer but I didn't get better, I didn't seem to have the control. So the counsellor picked up on that, that I want, and it is like with the kids and my husband everything in my life I want to have input and control and that really came out, it is like even if it was, it's like I wrap the kids up in cotton wool, he is 20 my son, do you know what I mean? But I still want to protect him, I still want to, I don't want him to get hurt.
I can't say what I want to say to other people in case I hurt them.	314. I: Sure 315. P: And that came out very strongly in the counsellings because I don't want the people around me to be hurt the way I have been hurt, do you know what I mean? So... 316. I: You want to keep them safe.
Things came out of the counselling which were surprising but enlightening. 311 The counsellor was right in picking up on client's way of being - giving really useful responses that develop the work. Therapist insight highlights to client aspects that she hadn't realised herself.313 I learned about myself.	317. P: I want to keep them safe, I want them to be happy, I want them to be well adjusted. I don't want them to go through their adult life of all the neurosis, I can...., but then I don't want to make them neurotic and my son, I think he is getting to be a bit like a hypochondriac [laughs], he is terrible and I thought 'is he getting that from me? I don't know'. [unclear 0.46.33] going to look back and go and see a counsellor because of what [laughs] I did over Mother, you know, who is to know, do you know what I mean? 318. I: Oh a lot of questions, a lot of questions. 319. P: But it's just, but that whole part of, I mean that's just, now I didn't realise that or if I did in a subliminal way sort of maybe did.

Learning about myself. Learning about myself. These insights came out of the counselling and we could work on it and learn from it.	320. I: But it actually emerged that [unclear over talking 0.46.56] 321. P: But it actually emerged and we were able to pick on it and pick it apart and look at all the different ways that I do control, not control in a negative way, I am controlling it because I want to help. 322. I: Sure, sure. 323. P: It doesn't always get seen as being help but... 324. I: The need to try and keep things right? 325. I: Keep it even because if I can control it then it's not gonna go off the rails and erm, it is like the kids want to go, we don't go on holidays abroad, apart from my health I couldn't even walk. We go away in this country, we go to cottages and we do, and I can control that because, the only thing I can't control is if there is an accident on the motorway, but you could get around it, but if you were going abroad, oh god, you know that the airport people are going strike, something would happen out of my control, so the anxs..the tension is building, you know, we were talking about it in the sessions I could FEEL the tension, I thought I can't, that tenseness is there that it is only when I get the control back that I can [unclear dog growling? 0.48.04]. 326. I: Then you can relax, yes. 327. P: And when the, if like an event is coming up I get tense because I don't know what is going to happen and anything could happen between now, and oh my God, and when that date has gone and that thing has gone, ahh, oh yes, relax again. 328. I: A relief 329. P: I hate having things to deal with because I get so anxious and tense I would much rather not have that because I can't... One of the things I said to the counsellor it's like I go like that even have a pain, I get anxiety, I get tension. It just takes one little thing and it is like a house of cards. 330. I: Right 331. P: It all collapses, I can't deal with that one extra little thing, but I am dealing with a constant level every day, a constant level of pain, fatigue, anxiety... 332. I: A tremendous amount 333. P: All sorts but it just takes one little thing and I can't cope. 334. I: Then it becomes not copeable? 335. P: And then it is like, it is literally like a house of cards, the whole lot, it doesn't just fall back down to where it was, the whole lot...

Talking about what matters provokes feelings. I tell the therapist what's going on for me. I did learn about myself, how I am and what I do. The sessions help me to learn this is how I am **but not what to do about it** .337	336. I: It just collapses? 337. P: And then I have to start building myself back up again and that really can't, so you know that was a positive thing you know, to actually see that that's how erm, what happens. Again you can argue that 'well what do I do about that' that didn't come out of the sessions. It came out that that's the way I am, that maybe there is not a lot done but how do I...? 338. I: There was a learning for you of actually this is how I am, but what can we do about it? 339. P: But what can we do about it. 340. I: Yes, yes 341. P: Which is like the whole thing do you know what I mean? [unclear 0.49.42] there is like this is how I am but no conclusion as to how to get this fixed or how to get it so that it doesn't bother me or it doesn't bring my... it doesn't, you know what I mean? The counselling is the talking. 342. I: So let me put that question again. If you were to design a counselling service that did for you whatever you need it to do, so that it was really effective for you, how would you describe what it did? 343. P: Let me put the dog out, oh God. Erm, I think within the timescale that you have got that it wouldn't work, because like I say it literally took three quarters of the time to get to the bare bones of what, so you were leaving... 344. I: So it would have to be more time? 345. P: There would have to be more time, now whether it is the skill of the counsellor to sort of bring you to that point earlier in the session, I don't know how that could work but... 346. I: Ah-ah. 347. P: You need to be at that point where the problem is earlier in the session so you have got the time to analyse it... 348. I: Okay 349. P: ...to go through it, to really look at where it is bothering you. What, why do you think it is doing. I mean there was questions that the counsellor would ask that I thought 'I don't even understand the question', do you know what I mean? It was just phuhh, I don't know. But there needs to be within the session if you are bringing up a problem that an area of your life, an area that has obviously affected you greatly, you need to sort of look in more depth, well how can you, like I said I don't think you change it because it has happened, what has happened has happened, it dealing with the

	thoughts that it gives you now. 350. I: Yes 351. P: And that the negatives that there is then now, how can we change that. It is like what I said to you may be looking at that path of where, if I had of been the one to stay, if Mum had only took the child that she knew was my step-father's child and left us two behind, how would it have, would my life have been better? I don't know. To look at that, that would have maybe given you some sort of closure or outcome because you are looking, you think your life is miserable now, my God, [laughs] it's...
Within the timescale the counselling wouldn't work. 343	
	352. I: It is hard to explore how it might have been different?
There needs to be more time or the counsellor needs to get you there more quickly	353. P: It could have been different yes. It could have been different for the better, it could have been different for much worse, do you know what I mean. So that would have been a way of dealing with those thoughts...
Does the counsellor need to move the work along faster? Does this mean being more directive ? 345/347 To really focus on what is important. There were some questions I didn't understand !	354. I: Sure 355. P: ...but we didn't sort of go down that road. Now that could have been my fault as well that I didn't sort of emphasis that that was what I wanted to talk about, but then again, it is like I said, I didn't really have, by the time I got to that point, time was ticking.
There were questions from the counsellor that were not understood by the client 349. What is going on here ?	356. I: Sure
There needs to be time to look in more depth at important issues.	357. P: But that is something, if you are bringing up an issue you need to have sort of some... where it is going to go and to bring it to a conclusion, not sort of leave it up there, but, oh and we will look at this again next week, because next week this doesn't happen.
Time to question how things could have been different.	358. I: You have gone to somewhere else? 359. P: You have gone somewhere else so... 360. I: A different place. 361. P: ...you might not get closure within the session but you need to have, if you are bringing up that area you need to have some sort of settlement on it, it like... 362. I: Time to work it through? 363. P: ...work it through a bit more, I mean, but to get it out for a lot of people may be a big step, do you know what I mean, I am only talking about my experience, you know, somebody else just even getting that out might be all the session can do, do you know what I mean?
Client recognising her role in the therapy dyad - but again it comes down to time.	364. I: Sure it's an individual thing but... 365. P: Everybody is different, you know, my problems might seem absolutely trivial compared to others

	you know, but it's how it affects me and to be frank when I am in that session, I couldn't give a toss about other people, do you know what I mean, this is my time...
	366. I: It absolutely is
	367. P: ...I don't care about them, you know, you might be thinking of them but I am not thinking of them [laughs]
	368. I: No
Frustration that issues were left in the air and not dealt with because of time limitations 357.	369. P: This is my problems, I want to talk about them and I want to sort of look into them so, I can't say that getting a closure would be the perfect way, because a lot of this you can't get closure on, but I do feel that within the whole sess... leaving yourself up there, where you have built yourself up to talking about, leaving yourself up there is not necessarily good, so you have to sort of bring it back down, but bringing it back down not just by 'oh right we have run out of time' do you know what I mean?
You need to have time to settle issues.	
Simply managing to talk about an issue might be all that is possible for some people, never mind getting it settled.	370. I: Yes, that's almost switching it off?
	371. P: That's switching it off, you are still up there
	372. I: Yes
	373. P: ... you have just switched it off
	374. I: And was it up there every session or were there some sessions where actually...?
But other people aside - in the session it is my time and I need it to do what is right for me.	375. P: Erm no, I would have said there would be some, because like I say it was prob..., it wasn't every, I didn't get talking about that issue till quite a few sessions in, do you know what I mean? In my head in every session I knew that that's where, I know I want [unclear over talking 0.54.40]
	376. I: You know your own stuff, sure.
I am only focusing on me - I don't care about anyone else.	377. P: I know that's the route of all my problems but you sort of, I don't know her well enough. You know, it takes you that length of time to sort of build up your bond.
	378. I: To build the relationship.
These are my problems and I want the time to look into them. But having talked about them I don't want to be left up in the air with them because we're out of time.	379. P: Umm, and the trust, I mean I trusted her from the beginning, she was really nice, but do you know what I mean, it was like you know what I mean, I am amazed that I can tell you it's because I don't know whether I am going to see you again, you know that's the whole part of it.
Stranded with issues left unresolved.	380. I: Yes, yes
	381. P: You know you are the person at the bus stop that people can tell everything [unclear over talking 0.55.09]
	382. I: Outside of everything yes
	383. I: You don't know them, you are not going to see them again, well please don't let me see them

	again, but...
	384. I: [laughs]
	385. P: But do you know what I mean, so but you have to still build it up
	386. I: Sure
	387. P: and so I have forgot the thread of where I was going with this. Erm, ...
	388. I: I said to you was it always left live?
	389. P: Oh yes, so the beginning sessions it wasn't always left up there because to be fair we maybe didn't get into the real pain and angst areas, do you know what I mean, so it was easier to bring it down do you know what I mean?
Although I knew what I wanted to talk about it took a while to actually be able to discuss it.	
	390. I: Yes, yes
It takes a client time to come to the issues that matters for them . 375	391. P: But having said that the sessions where that happened were still things that I wanted to talk about, there were still things, you know, about my health, about my pains, about my fatigue, my anxieties, all those things but the biggie is the fam... do you know what I mean that's the, that's where I know it all hurts and I really don't think that I talked that through. I talked that through more with my counsellor at college than what I did in this.
Time to build the bond because I didn't know her well enough - 377	
I trusted her from the beginning - "amazed that I can tell you it" because I may not see you again.	
	392. I: I am really intrigued about what made it different, the actual nuts and bolts?
The person at the bus stop - a stranger with no connections.	393. P: I think it's the time restraints of it, it definitely was. I knew that, with Dave at college and there was no time restrictions, cos I could see him for 3 years, do you know what I mean, and I literally did...
Even though the freedom to speak comes from speaking to a stranger - it still takes time to build the bond.	394. I: It was open ended yes
	395. P: It was just open ended you could see him when you needed and he could just [unclear over talking 0.56.32]
	396. I: You could talk freely
	397. P: You didn't have that 'oh well Agnes'... the other time [unclear] what I was finishing Uni, but even well before then he sort of winded up, well that was when we brought up about don't speak to me parents because I was at the end of college, [letting dog in – come in then]. Erm so but that was different, I think the whole time restriction in this counselling, whether that is the same with every bodies health authority, you know whatever, that there is a time rest... I don't know well whether it is just Manchester's, you get 12 weeks that's all we can offer you.
Earlier sessions weren't really where the pain was so I didn't go as deep and wasn't left up there when we ended.	
Time was spent on issues that mattered to me - but not where the major pain was - that didn't get talked through. My previous counsellor covered that more thoroughly	398. I: Sure, I mean talking of time I know we are sort of coming towards the end, what has struck me is that the HAT Forms generally are really quite

	positive 399. P: Hmm 400. I: There's a realisation of having someone there to speak to, a place to be able to talk, but there is a thinking that today there is much more reflection on actually this wasn't helpful, or what I could have done with is, you know...
Time restraints make the difference between counselling that can deal thoroughly with issues and those that leave issues up in the air. 393	401. P: Hmm 402. I: ..more time, it wasn't so good to close it down sort of 10 minutes before hand.
	403. P: Yes
The time restriction - you get 12 weeks and that's it	404. I: Generally speaking is this a therapy that you would recommend? 405. P: I definitely would. I think for people it depends what their issues are, do you know what I mean?
	406. I: Sure 407. P: And I don't want to sound my issue is bigger than yours, do you know what I mean, but for some people that might just be all they need, that might just be completely enough and that would make them feel so much better. It made me feel better after, you know I did, but it just wasn't long enough. [Phone rings & dog barking – 0.58.14] – Speaking on phone. 408. P: I hate call centres, solar energy. 409. I: [laughs]
Difference in reflection between the HAT forms and the Interview. 398 / 400	410. P: Solar panels 411. I: In this country? [laughs] 412. P: Sorry what was that yeah, sorry what was the question again? 413. I: The question was really would you recommend the therapy?
I would recommend this therapy.	414. P: I would recommend it, definitely recommend it, because some people when they say 12 weeks it is not 12 weeks, but that length of time is probably, it could be more than enough and it just might help them to realise where their issues lie and maybe they can go off and get help somewhere else or whatever, but for some people though, they do, it is not enough time.
	415. I: Sure
It depends on the issues - for some it might be all they need - for me it wasn't long enough.	416. P: Erm, I mean I am 50 I have had 42 years of this, it is not going to be fixed in 10 weeks or whatever, do you know what I mean? 417. I: Sure 418. P: It is just not. You know you get, I mean, cos god that makes me feel – 42 years, because that's when, how long it has been, I can't, and that's what annoys me because 42 years it is long enough to let this bug me, do you know what I mean? It's more than my life is worth, do you know what I mean, it

For some people 12 weeks would be fine - but it's not enough for me. Why should people have to go and get help somewhere else - why not give sufficient to finish the job ? Recognition that issues of long standing are not going to be fixed in a short period of time. Enough already - it's taken up too much of my life. You do get a lot from the sessions - but - but I could continue to see you every month needing that support. Wanting the support to continue - not to stop dead. Floundering with no follow up and you're on your own with it again.	should, enough is enough of it. 419. I: Ah-ah 420. P: So but for some people their problems might not be like that and those sort of little sessions could be enough but I am sure there is a lot of people like me that have got a, big issues, big and that is, that is, as much as you get a lot out of going to the sessions, I mean it is like I said to the counsellor I could come and see you every week, not every week, once a month... 421. I: Yes 422. P: ...just to know you had that support that, or you know, see more often and then wind it down to once a month or something like that. Because that's what I have noticed before and I have brought it out, with these things that's it, cut dead, off, you are on your own. 423. I: Yes. Go, go, go, go every week and then nothing. 424. P: Yes that's you away you go, aargh, and you are sort of floundering, there is no 'oh we could see you again in 6 months and we will see...' 425. I: There is no follow up. 426. P: No follow up, and that was the same with the CBT thing, there is no follow up and I think God, okay you might walk away thinking, yeah, yeah, yeah, yeah, yeah I am done, and then your pain, your fatigue, all your problems and, 'oh well I am going to try and keep positive' but they are still there, do you know and event.... yeah, and they are still, and then you are back. Before you know it you are back down again. 427. I: You are on your own with it again 428. P: Yes and ohhh...and that's when I could just do with another few sessions just to go and perk myself back up again. 429. I: Sure 430. P: But then it would be like a crutch and you could go on for ever you know so you have to have a coun..., I don't know. It's, you know, if there was enough money in the NHS or whoever pays for it then you could just love to go forever, but it is not the way of the world is it and unfortunately you could argue well what is the point of having it, if it is not gonna give you the benefit on the long term basis,(CAPE et al., 2010) it is a short term fix and it is sort of leaving you, well you know this is all, now you go off and do it, you know you have got the tools to sort of think it through and do it yourself, you know? 431. I: Ah-ah

	432. P: But we can't all do that – (clicking noise) oops, is that the end of the tape? [laughs] – that's it [laughs]
	433. I: That's worse than looking at my watch [laughter}
	434. P: No there was a definite click wasn't there [laughs]
Same as with the CBT.	435. I: The tablet is still recording
All the therapies leave you on your own at the end with no onward support and you end up back down again.	436. P: Do you not think that that is just the way it is, you know in a perfect world you would have as many sessions as you need till you felt 'right I am off on my own now, I can deal with all this'. It is not a perfect world.
I need more sessions.	437. I: Sure
	438. P: If it was a perfect world then we wouldn't be in these problems anyway, so...
	439. I: And that feels a real realisation?
	440. P: It is yeah
	441. I: Yes
Recognition of being dependent on it. In an ideal world I would love to go forever - but that's not possible.	442. P: I think I do realise a lot of me issues and you do, but it is just at the times when you just, I think when I went through a bad spell before I was diagnosed with Fibromyalgia, where I didn't know what was wrong with me, do you know what I mean, and I was in real depression I could watch the telly and cry, just at the drop of hat, it was a real depress....because I was in pain, I was, all these prob... Oh I was so tired that, and I thought God what a lazy cow you are, why are you so, and then when you got the diagnosis of Fibromyalgia 'Oh my God yes', you could tick, tick, tick, tick.
What's the point of having it if it's only a short term fix? What's the point of having it if it doesn't do the job for the long term. 430	443. I: Ah, this is why
	444. P: But then you realise that people don't even understand Fibromyalgia and its phhhh, you are still back, you know people still look at you and think, you are lazy, well that's what I felt, that's issues that we brought up, but what I thought people were thinking....
	445. I: Ah-ha
	446. P: ...it's completely different to what they are
	447. I: Sure
	448. P: But you know it's just, I think the whole, I would recommend it but there definitely needs to look, not everybody is the same, every...., but then who judges who is the same, I don't, you know, you could open doors all over, so but not everybody needs maybe the 10 weeks, but there are still people that need more.
In a perfect world you would have as many sessions as you need till you felt 'right I am off on my own now, I can deal with this'. It is not a perfect world. 436	449. I: Absolutely yes
	450. P: And maybe it's not one thing meets everybody's requirements, you know, everybody is different and I think maybe they should need to, you know if

I would recommend it but it needs to take account of people's differing needs. Not everyone needs 10 weeks - but some need more. **It's not one size fits all. It needs to recognise everyone is different. 450** By setting the limit at the start it's off putting because my problems are too big- we won't have time to get through the work.	it got to the stage [unclear 1.04.16] I would have been, 'Agnes actually I think you might need more, I think you could benefit with more...what do you think?' 451. I: A little more tailor made? 452. P: Yes tailor made 453. I: Yes, yeah 454. P: Rather than this is what you get 455. I: Yes, this is not just a paracetamol everybody gets one paracetamol.... 456. P: ... paracetamol, you know, if it was tailor made that's the perfect word because, because by setting the limit right at the outset, my problems are too big, we are never gonna get thru.... you know what I mean, it almost puts you off when it shouldn't, do you know what I mean and I think if you were half way through and the counsellor said to me gosh, you know we have opened a real can of worms here, I don't think 12 weeks is going to be enough, I think, you know we can go on here and..' 457. I: Have that flexibility yes. 458. P: Oh God that would have been great and we could have, you know I could have probably got a lot more out of it but because you sort of know that you are limited right from the get-go, it does sort of hold you back a bit and even though you get stuff out of it, it is still holds you back from the deep, deep, deep stuff because your sessions are time limited and the number of your sessions are time limited, so [unclear over talking 1.05.27] 459. I: And that has been the thread through all of today. 460. P: That's been the whole thread, looking back, no matter how good the counsellor is, no matter how good the organisation is, it is too restricted, it does and tailor made is what it needs to be to the individual. Some person might want, like when my mum died and I went, oh God I never even said that, I did see a grief counsellor, oh my God, I went to one session I thought pfff, you are rubbish, honestly, don't ask me why I thought, it was just there was no bond, no click... 461. I: Right 462. P: I don't know whether it was because he was a man, although I have seen Dave, he was a man. 463. I: Yes 464. P: So I can't put it like that, but... 465. I: Something here was really different 466. P: When my mum died you can imagine all the unanswered issues and the grief I went through, plus it was right in the middle of my cancer you

The time limit even at the beginning is off putting. To have the flexibility to extend the time would be great. What I needed was more time, I would have got more out of it and that would have been so much better. 458 **Being time limited holds you back.** 458 **Regardless of how good the counsellor is - the time limitation restricts the work.** Grief counsellor was rubbish because the was no bond.	know I was just finished chemo and she had died. 467. I: Oh, horrendously difficult 468. P: And I got the worst bloody counsellor, it was awf... it was awful. And that was another area that came up that I just, there is a lot of people that have died in my life I don't let it bother me like it did with my mother, but I am not going through that again and that grief counsellor was rubbish. 469. I: Ah-ha 470. P: So that put me off a bit, so when like I said that first session, it was all jargon it was like 'oh no, here we go again', but it did, once you get into the nitty gritty it was great but maybe they need to sort of cut back on that, because somebody else might, they might, they might not understand, I didn't understand it and I am educated, do you know what I mean, so... 471. I: Absolutely yeah. 472. P: So somebody that maybe [unclear 1.07.01] get this so maybe they need to sort of be a bit less like they are just out of university themselves with a degree in counselling or whatever they have and... 473. I: Ah-ha 474. P: ....people want to go and just 'thank God I want to talk, do you know what I mean and just go... 475. I: Yes, just open up that space. 476. P: And that is what I wanted, but it is not necessarily what the service, because you know.... 477. I: That's the fine language 'what I wanted' that's not necessarily what the service is about. 478. P: But the service is regimented with the time, this is what we do, this is how we do it, erm, but it is like you said, it needs to be tailored... 479. I: Tailor made 480. P: ...tailor made, we are not all in a text book, you know you are going to hopefully go away and look at this and say to people you know 'this isn't the model that...'. It is not a model, do you know what I mean, it's not a model is this a counsellor session... 481. I: What does model mean to you? 482. P: Its, it's scripted, it is regimented, this is a model, this is the way it is done. It does that, that, that, that, that and if you tick all those boxes that's the perfect way that a counselling session is done. That is not what I want out of a counselling session, erm, I don't want the tick boxes 'oh well we have done that, we have done that' because we are not tick, we are just not tick boxes, you know we are not a model. You could go away and you could write up your pi – your dissertation and it could be a model that you are going to do, you know, this is the way

It's vital there is a bind between counsellor and client.	that this should be done and again it is a model, but things should change it shouldn't be, restrict it to that. It is like the tailor made, they have got a model now, you have got 12 weeks, first week erm, runs into the second week where we are going to talk about what we are gonna, der, de, der and the last week we are going to wind, you know talk about, but I want to go bam straight in because that first, I have been waiting on a waiting list... 483. I: Absolutely 484. P: I want to go straight, I don't want to be this is how we do it, this is the model, because it makes us all like we are the same and problems affect us the same way... 485. I: This is so clear
There are awful counsellors out there. They need to cut back on the jargon because people may not understand.	486. P: ...our problems don't, it doesn't affect you the same way. My, people could say 'why do you let, why do you let that affect you like...?' I don't know why it affects me, it just does. It might not, my sister worked through the same thing, it doesn't affect her the same way. 487. I: This is you and what is going on for you... 488. P: I am not part of a model, I am 'ME'! 489. I: Yes 490. P: You know so... 491. I: Absolutely
Forget the jargon and just let me talk. The service dictates what happens - but it needs to match what the individual wants.	492. P: ...as much, I mean I feel bad now about saying all the negative things [laughs] because honestly I didn't feel like the negative, but now that you bring it up and you look back, I think I don't feel bad, I just feel disappointed in the sense that it could have been great, but it just fell sh.. if it had been longer, ra-ra-ra, it could have been great for me, but I don't feel, now that I have finished it and weeks are going on I am still in the same place but only things are a bit more open... 493. I: Yes
Forget the model - this is a counselling session. *Its, it's scripted, it is regimented, this is a model, this is the way it is done. It does that, that, that, that, that and if you tick all those boxes that's the perfect way that a counselling session is done. That is not what I want out of a counselling session, erm, I don't want the tick boxes 'oh well we have*	494. P: ...and I would just like to get them back in the box so it could have been great but maybe it wasn't, but for somebody else that went it could be absolutely the saviour that they need 495. I: Sure 496. P: Who knows we are all different and that's the thing, we are all different but they are treating us all... 497. I: And that's the bit that needs recognising. 498. P: ... but they are treating us all the same, we are ticking the boxes, so you have got problems with your, oh mummy problems, well that sort of takes the, you know, I don't know, but you know the counsellor was great I can't fault her in the sense

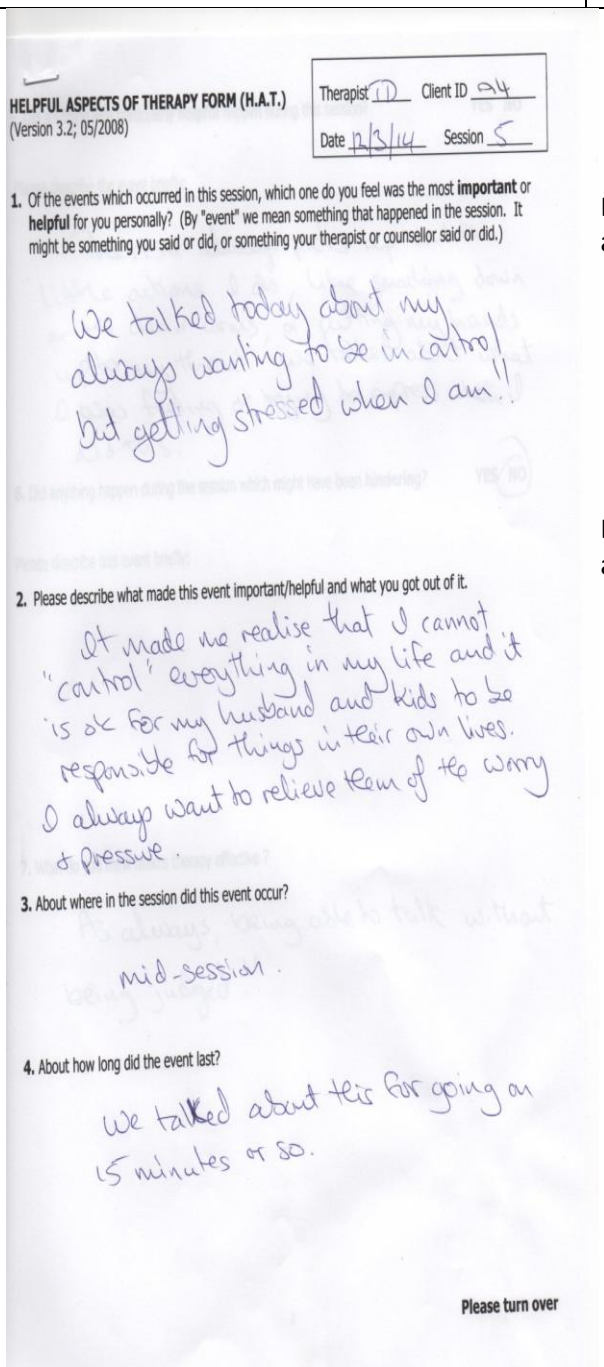
done that, we have done that' because we are not tick, we are just not tick boxes, you know we are not a model. The model described at 482 is prescriptive and directive. Very different to the "model" of CfD. What is going on here ? I don't want to be in a situation where this is how you do it - because that means everyone is treated the same - and we are not all the same. I am not part of a model - I am ME Don't lump me together with everyone else **- I am an individual and I want treating as an individual.** It's disappointing that what could have been great - because we did good things - fell short because we didn't have enough time. **We are all different - but they are treating us all the same - ticking the boxes - 496** The counsellor was great when she got past the admin.	when she got past the paperwork side of it. 499. I: Past all the admin? Yeah. 500. P: Past the admin, the person to person. 501. I: So the counsellor and the client relationship... 502. P: Was great 503. I: ...was great, but the admin, the management of the time... 504. P: The structure of it 505. I: That's the bit that was not great? 506. P: That's the bit that needs looking at 507. I: Yeah 508. P: ...and adjust it to the individual, but the counsellor herself I couldn't fault, and I thought, I mean she did say those sort of, I thought 'oh my God, how did you pick that out', but then she would ask some questions but 'What, speak English'! Do you know what I mean, it was like 'What?' So what do you mean, do you know what I mean, I think so there's a wee bit, maybe now and again a wee bit of counsellor speak would come in, do you know what I mean and it... 509. I: Have you got an example of that? 510. P: No, I can't think of, I just remember at the time think... 'What?', you part of it also because of me hearing that I have got problems hearing but it was just the odd little time that a bit of counsellor speak would.... or the way she asked the question, it was just 'What do you mean by that?' you know, but the question itself 'What?' I just didn't understand what she was asking me, would you clarify what exactly, and 'oh yes right okay'. But just at fir... it sort of made you sit back, 'What? What are you saying'?, it just, oh... but that's, it didn't happen a lot it just happened the odd time... 511. I: Yes, sure 512. P: You know she has probably picked that out of a text [laughs], that's what you ask, I don't know, that's terrible, but erm, it was just, but I noticed that with the CBT woman as well that's why I, that was much more text book... 513. I: Ah-ha 514. P: ...the way she spoke and the way, I just, there was no real bond like there was with this counsellor 515. I: Yes you recognised the difference. 516. P: There was def..., you know and I thought, but I persevered with it, it did get me through a situation at the time which was amazing but that is something that you have to sort of deal with yourself after, you know they sort of give you this sort of things, the coping mechanisms, but you

	have still got, again great to go back and say 'oh I have got another sess...' like a top-up?
	517. I: Yes a refresher course?
	518. P: A refresher a top-up, are you doing, you know, are you using this, because you know at the end of the day you have got to do it for yourself but you have still got all the issues, plus all the new issues...
	519. I: Sure
How did she pick that out ?	520. P: ....sometimes you just, it, you can feel it just getting too much again...
A sense of wonderment that the counsellor could pick up on that.	521. I: It just builds
	522. P: ...and it was just nice to have that 'oh I know I am going to see the counsellor again in 3 month's time' you know, and then if I need it again 'Well Agnes do you want some more coun..., shall we have some more, do you feel...?' And I thought 'yes please!' Do you know what I mean....
Sometimes I couldn't understand what she was asking - "counsellor speak"	523. I: Yes, that's the very opposite of actually this is all you can have and it is done now?
A way of talking designated "counsellor speak" that was not understandable by the client.	524. P: Yes and it's the sort of phhh, you want sort of, not looking after but you are sort of cast adrift and that's the feeling...
	525. I: Left to your own devices?
It made you sit back - This wasn't exactly comfortable	526. P: Yes you are left back...which is where you were before it all started, do you know what I mean so.
	527. I: I know we are going to have to wrap up shortly, I feel really bad about 'We are out of time' ! [laughter]
Counsellor's response was learned as in "this is how you do it". Much more with CBT.	528. P: Yes
	529. I: Is there anything you want to add that we haven't touched on?
	530. P: No I don't think so
Counsellor's approach was copied from a "text book" - this is how you do it and the CBT woman, even more.	531. I: We have covered it all?
	532. P: I just like I say, I feel a wee bit guilty because I have sort of run it down, but I don't, at the time it didn't feel that way, it is only now like you said, you know like looking back and you can sort of dissect it and pull it apart.
No bond with CBT therapist but there was with this counsellor. Is this due to the model or the counsellor ?	533. I: Sure
	534. P: But at the time, you know at the time it feels 'oh yeah, you know those feelings you get them out blah, blah, blah', but looking back is a different thing. Well I wish, I wish you know what I mean, it is like that I wish this had happened or whatever so who is to say, you know, what would have happened if they had longer do you know what I mean [unclear 1.14.28] – who knows.
Even so - it did help - it was "amazing", but you still have to deal with it yourself after getting the coping mechanisms. 516	535. I: Sure
	536. P: Who knows, who knows, maybe in another few years I will have to have counselling again and I will be on the waiting list again.
A refresher course would be useful	

because new issues get added to the old issues and you have to cope with it all. It would be good to know I have someone there to help me. 522 I don't want to be cast adrift. I didn't feel so negative about it at the time - but reflecting on it now I can see it differently. There's a clarity that comes in looking back . A wistful acknowledgement that it would have been better if it was done differently - 534 Maybe I'll need more counselling and go on the waiting list again.	537. I: Oh Gosh 538. P: Which will be a real shame because it means that it didn't really do what it was meant to do, but hey-ho. 539. I: Awww 540. P: But it was nice to meet you 541. I: Oh it was lovely to meet you, I am going to turn this off now. [dog barking] 542. P: I am not going, he thinks I am going out. I got him from the dogs' home and do you know trust me to pick a dog that has got..... End of recording – 1.14.56

Client knows the way these things work. It didn't do what it was meant to do - Maybe this doesn't work due to the limitations which stop it doing what it should - but I'll give it another go - 538	

Appendix 17: Agnes - HAT form specimen

Client concerns		Themes
Client exploring how she is and what happens for her. Learning about how I am. Talking about what matters to the client. Learning from the discussion. Two exclamation marks - signify some realisation. These reflections are very much about the client's own processing - but not about how the therapy is helping her to do this . Realisations of "this is what I do, but it is not helpful" and consideration of other ways of doing it. Learning for the client from the discussions in session.	 HELPFUL ASPECTS OF THERAPY FORM (H.A.T.) (Version 3.2; 05/2008) Therapist ID Client ID 94 Date 12/3/14 Session 5 1. Of the events which occurred in this session, which one do you feel was the most **important** or **helpful** for you personally? (By "event" we mean something that happened in the session. It might be something you said or did, or something your therapist or counsellor said or did.) We talked today about my always wanting to be in control but getting stressed when I am!! 2. Please describe what made this event important/helpful and what you got out of it. It made me realise that I cannot "control" everything in my life and it is ok for my husband and kids to be responsible for things in their own lives. I always want to relieve them of the worry & pressure. 3. About where in the session did this event occur? mid-session. 4. About how long did the event last? We talked about this for going on 15 minutes or so. Please turn over	Learning about myself Learning about myself

Appendix 18: Agnes - Developing Emergent Themes

Emergent Themes	Original Transcript	Comments / Queries
No Admin / No "text-book"	A1. it was just a bit too jargony for me, do you know what I mean? It was like text book.	Too scripted - doesn't mean anything to client. Doesn't relate to where client is.
It's the talking that's important.	A1. I do need to speak to someone.	I just want to talk
Having someone to talk to.	A6. so I'd lost that somebody to talk to.	The counsellor fulfils an important role in being the someone to talk to.
The process is "amazing".	A12. I was amazed.	Clients say counselling is amazing - but can't identify why.
Realisations and understanding.	A16. : I didn't realise it's festering in there. And it was just when I sat down, I don't how we got into it, but we always managed to get to whatever the problem was.	Part of the "magical process"? I don't know how we did it - but we always did.
Amazing.	A18. It just seemed amazing that and you come away and think Oh god that's better out than in.	
Better out than in. Good to talk.		Again - amazing
How does Counselling work?	A20. It always struck me that how the hell did that happen?	Client's don't know how the counselling works.
I don't know how it works - but it is great.	A22. I didn't think I was going to be talking about that. and I don't know whether it was the counsellor's skill, a mixture of everything, but when I	

Not fixed the problem.	came away from the sessions I was a bit lighter on my feet and you know, it's great.	
Gained knowledge.	A24. But it's highlighted to me where.	
The sessions were a place to explore things usually kept hidden.	A26. Because you can't deal with it every day and then so in those sessions it came out of the box.	
Counsellor response created insight.	A28. Counsellor sort of made points - do you think? I thought oh my God yeah.	
Time limitation.	A30. But I can't honestly say that I'm fixed, do you know what I mean and that my depression's gone. Those issues are still there. The problem with it is that you know it's a finite number of weeks.	This is not a criticism of the model as designed, but is a result of the service provision.
Time limitation closes the work down.	A34. You knew you only had maybe a couple more, so you sort of backed up a bit. I could bring this all out of the woods and this is my last week.	Again, this is a function of the time limit.
Wanting the sessions to continue.	A34. I said to the Counsellor I could come and see you every week, every fortnight, whatever, once a month.	This is working - I want more.
Time limitation.	A38. It's too limited	Stated clearly.
It takes time to get into the work.	A40. You think at the beginning, oh twelve, ten sessions, whatever, twelve, oh that's ages, well we won't, but honestly, it takes half of that before you really get to what is.	
Scared of letting it all out because there's nowhere to	A42. Each week it's like you're picking a different	You are building the work over the weeks - but when you're close to getting there

go with it.	area. But then as the weeks go on, you're actually, it's actually leading you to where the issues all arise from, but, but, you're getting there, you know, you've only got, oh I've only got a few more weeks, and you're sort of getting a bit scared, not scared, but, I was apprehensive that I'm going to bring this all out and I've got nowhere to go with it.	you realise time is running out.
Wanting it to be open ended.	A42. I could have done with her saying - oh don't worry we've got as many weeks as it takes.	No time limit.
Need more time.	A44.That's where it falls down because your problems aren't limited to ten weeks.	Criticism of service provision.
Realisation of needs.	A46. I can understand the demand on the system. The fact, you know, you've got to give everybody a chance, but it's only when you get in to the counselling that you realise how much you actually do need it.	
Realisation of needs. Time limitation. I'm not getting what I need.	A48./50. It's me I want to sort out, I want to be sorted out, I need this help. But I've only got a few more weeks so what's the point of digging it all out?	Mother didn't meet needs (truth). Counselling didn't meet needs (time).
The weeks build towards the real issue. Skill in developing the work. Panic at running out of time.	A56. Every week you're dealing with something, but it's only as you get through towards the middle onwards that you're really heading towards what's really, you know, that's the skill of it, you know, it's bringing it out, and then for me you're backing off a bit because you're thinking oh my god,	Skill, enabling talk

Not enough time.	you're panicking because you think I don't have enough time to, you know, I want to talk, this is something that's huge and it needs more than the next three sessions.	Not enough time
Massive amount of benefit.	A56. But it's not to say that I didn't get massive amount of benefit off the weeks I had.	Despite the time limit - it still was beneficial.
Things left open and not fully worked through.	A58/62/64. But it has slightly opened the old wounds and the old can of worms and I've nowhere to go with it. They're festering. They're out there now. I've got to let it go. But it's bouncing back in my head again.	Work is not completed. Things are stirred up - but not settled.
Time limitation closes the work down.	A68. Might as well back up now, because otherwise I'm going to get in too deep with that and I've not got enough time to sort of go though it and analyse it.	I'm not getting what I need
Time issue was a major downfall. Despite the time - it works well.	A70. So I think that whole issue of the time was a major downfall of the counselling system, but it's not to say that in the time that you do have it doesn't work very well.	It works
Client knows how she would like to work.	A78. I would have liked to have sort of gone more deeper into it.	Client's needs are not met.
	A78. I mean whether it's just me blaming something and that's the something, do you know what I mean, that I'm blaming? Is it really that or is it other things?	Is this a reflection triggered by the research interview ?
Scared to open things up	A84. I think that's probably a good point. I didn't want to	

because they can't be worked through in the time available.	come away, because I 'd opened all that out and not dealt with it and not talked about it and then you think I feel worse, oh god, this isn't what was supposed to happen.	
Client taking control of her disclosure.	A86. So I left it at a point, where I didn't go down too deeply.	Is this an appropriate referral for brief therapy? But the model as designed is 20 sessions - had it been delivered as designed, would that have been enough?
Counselling is helpful.	A95.Things that you deal with in the counselling, you know it helps you to get through the things.	
The service should meet my needs and not be time limited.	A101. I mean I understand that it's oversubscribed and its, but it just seems, there shouldn't be a time limit. It should be, do you know, from my point of view, it should be as long as I need it.	
Enough time to do the job properly.	A104. Whether it's just a case of having the time to really look in depth at all those issues.	
I'm left to do the work myself, because the time ran out.	A121/126. This is something I would have liked maybe to analyse more with the counsellor, but because it's all out in my head, I'm analysing it myself. It's like homework, taking it away.	The work doesn't stop because the therapy ends - it continues afterwards.
This is not easy work	A141. I don't know whether it's that I was scared to open up about it too much, but I did open up about it. Do you know what I mean? We did get started talking, because it always upset me,	
I could have done with a lot	A141.. I could have done	

more time.	with a lot more time.	Stated clearly.
There's a lot of material to talk about. It takes time to get to what matters.	A149. We could have stopped talking about everything else before and just gone straight into that. That's the way it should have gone, but that's not the way it goes, because there's other things that you know, we talked about. There's other, loads of things.	The system would suggest you go straight to the problem and fix it - but people don't work that way. It takes time.
The counselling is helping me to change my thinking.	A151.That's hopefully where the counselling is helping me to sort of think like that.	Odd to hear a phrase more suited to CBT ??
The counsellor's approach was off putting.	A153/155. When I first went I almost was put off by the first session. That's not what I want to hear. It's like a bit of a turn off. I might have gone away and thought no I'm not going back.	Was this dictated by the service provider ? Because later she says she cannot fault the counsellor. Line 498.
The counsellor's approach was off putting.	A157. I could have not returned because I didn't get the sense of that closeness, you know, that the counsellor was a good listener. Because it was too text-bookie. Do you know what I mean ? It's like when I did the CBT. It's like, you could have almost had a text-book when she was speaking - this is what I need to say, this is what you, oh, I need to do.	This description of the "text-book script feels surprising - more expected with CBT - but CfD is supposed to be a relational model and there's no sense of the relationship in place in the first two sessions - is this because the service procedures are getting in the way or is this actually the model?
Counsellor agenda for first 2 sessions.	A159. It was like a session went into the next session, all that pre-amble stuff. It was literally the third session before we fully got into counselling. A159./161 But it was like an eye-opener when I went for	2 sessions where the client doesn't get what she needs.

We talked. I just want to talk.	my third session - because we talked.	
		Client finally gets what she needs 3 sessions in.
Modality means nothing to a client.	A161/162/165. She told me what kind of therapist she was. I thought for the life of me, I can't remember what the hell she said. Didn't mean anything to me. . I don't care what kind of counsellor you are, I just want to talk to somebody.	
Service agenda takes precedence over client agenda.	A169. So when it was just all this babble about the kind of service it is and you know, and this is the kind of counsellor I am, and you know, we need to, I thought, oh god, all I want to do from week 1 is talk.	Client clearly knows what she wants.
The sessions need to be about me. Not about the service.	A173/177. I don't understand why it has to be done ? Why it took so long ? They must prepare the whole course structure, you know we have to do this. Then we've got to have a, at the end we have to have a whole review thing of what we've talked about. And to be fair for the person, the client, err me, I don't give a toss about that. I want every week to be about me.	
The sessions provide something not provided anywhere else.	A183. I know that having time that's out of the house, out of where my problems are, that's me time. And that's what I got from the sessions.	
Client struggling to answer the counsellor's questions.	A185.How am I supposed to answer this ? Do you know, what does she want to hear? I was trying to think what does she want to hear?	This doesn't sound Person

Service agenda takes precedence over client agenda.	A189. I can remember the feeling of sitting there thinking how am I supposed to answer this without offending or upsetting or ... Do you know what I mean ? You sort of want to be the perfect client ... you know, the perfect ..yes, yes I'm getting loads. And I was, but do you know what I mean ? But I don't want to be stopped.	Centred ??? The service agenda creates a situation where the client is trying to please the counsellor.
Service agenda takes precedence over client agenda.	A192/195/197. Actually the first two sessions were about her explaining to me how the service was, what kind of therapy she practices. It was kind of her stuff. It's sort of wasted. Hang on, you're in my two weeks here. Do you know what I mean ? I've only got twelve weeks and you've just wasted two flippin' weeks there.	Contrasts with Caledonian ********** Caledonian: C109. , I know like the sessions were only like an hour or so each but she never, even when I, well I didn't sort of look at my watch but you know I would think it must be getting near the end of the time now, but she never ever sort of made me feel as though I had to hurry up.
Counsellor's action brings a focus on the shortness of time.	A199. Do not look at your bloody watch because that immediately, oh god, time's getting short.	
Time limitation curtails the work.	A203/207. It was sort of emphasising in your head, we've only got ten minutes, so I'd better not go down that road. It was a distraction. Um, cos it just then made you aware that time is short.	
Time limitation curtails the work.	A213. You thought, oh I get an hour's counselling, you don't. You literally don't. It's 40 minutes because that last is a bit of a wind ... it's not	<u>Focus on time.</u> - not enough sessions and not enough time in each session.

Both number of sessions and length of sessions is too short. Running out of time. Prevented from doing the work because of the shortness of time. Dead on time.	even 40 minutes because you are winding down. A219/221. Three quarters of the way through the block of sessions, you could almost say it's almost three quarters of the way through the individual session that you were getting to the nitty gritty. Then suddenly she looks at her watch and I think oh shit. A221. Now whether it was just that's the way it felt because the way she works, she's building it up so that it is by then that you start everything comes out. Do you know what I mean ? She's been pussy-footing around and it's literally, but then it's come to whatever the real bug-bind is for that day, and oh, but we haven't got really time. A224/225/226. Digging down and searching for something and peeling away the layers and uncovering and uncovering. You're just within sight of it, and then you've got to start covering and packing it all away again. You've got to put it away. and when you come back next week it's not where you start off. Then three quarters of the way through you are getting back to that. A233. You have got your slot and you have got to fit in that slot that's, and there is no leeway. She's dead on time.	Shortness of time limits the depth of work, because the client pulls back in preparation for the session ending. Is it due to the counsellor's way of working ? Being too cautious and then running out of time just when the important work is starting?

No flexibility.		
	A245. It really does stand out, it is all based on a set amount of, you are given a set amount of time.	Recognition that this keeping to appointment time happens NOWHERE else.
No flexibility.		
	A245/246. When I was at University/College I went to see the student counsellor there. He was just completely different, I mean he was amazing. I could go in there and from the get go straight down to business.	
I could talk.		The use of the word amazing to describe counselling going well.
	A257/265. The time restraints and that is, how can somebody open up and lay it all out bare then somebody comes we have got to wind it up. It was too, you know, too, too short a time definitely, too short a time.	
Prevented from doing the work because of the shortness of time.		
	A269/275. Is it better to see a lot of people and give them a short time? To be waiting, waiting and then to be seen and you are still, it is still restricted, that just doesn't seem right do you know what I mean. If you are going to wait you might as well wait another month or two and then have as long as you need.	
It' s not fair to have to wait and then still not to get what you need.		Querying use of resources - is it better to see a lot of people for a short time - or see fewer, but work longer ?
	A281. It is nice to go and see somebody professional and get it out and then the counsellor would say 'and do you think, or maybe this is, or what'. It is getting that professional input to help me deal, because I could have all the thoughts, it is all in there,	
Counsellor would come up with ideas and another viewpoint.		

	wish washy washing, but it is how I sort of deal with them, that is where you need the help.	
Issues are not resolved.	A285. So I know that those issues are still really fresh and have not been resolved, there has been no closure on them, they are just back out in the open, so whether that is a good thing or whether I should have just left well alone.	
Better not to have gone		
Client's goals.	A297. I wanted to talk to somebody, I wanted insight into the problems and the issues that I am having and in a sense I wanted, I did want closure,	
Gaining insights.	A303. Insights, yes I do have insights, I mean there are things that the counsellor said that I thought 'oh yes' and do you know I never really thought of it like that.	This is a client who clearly know what she wanted from her sessions - but who didn't get it due to the restrictions placed on the service.
A space to be able to talk. Speaking to a stranger I may never see again.	A309. I couldn't really say things to other people because I didn't want to hurt them.	
Things came out of the counselling which were surprising but enlightening.	A311. will tell you what we did come to the conclusion that I want to control things in my life that really was an enlightenment.	
Therapist insight highlights to client aspects that she	A313/ 320. Now I look at it I think 'yes you are definitely right'. It actually emerged and we were able to pick on it and pick it apart.	

hadn't realised herself. Learning about myself. Working together. Learning about myself but not what to do about it. Time limitation limit the work. Counsellor needs to manage the time better. Client struggling to answer the counsellor's questions. It could have been different. I could have been more active. We could have had more time. I need a conclusion to the work.	A341. There is like this is how I am but no conclusion as to how to get this fixed. A343. I think within the timescale that you have got that it wouldn't work. A344/ 346. There would have to be more time, now whether it is the skill of the counsellor to sort of bring you to that point earlier in the session. You need to be at that point where the problem is earlier in the session so you have got the time to analyse it. A349. I mean there was questions the counsellor would ask that I thought 'I don't even understand the question' A355. But we didn't sort of go down that road. Now that could have been my fault as well that I didn't sort of emphasis that that was what I wanted to talk about, but then again, it is like I said, I didn't really have, by the time I got to that point, time was ticking. A357. But that is something, if you are bringing up an issue you need to have sort of some... where it is going to go and to bring it to a conclusion, not sort of leave	Client is very clear on this. Does this mean being more directive ? What's happening in the therapeutic relationship here?

	it up there, but, oh and we will look at this again next week, because next week this doesn't happen.	
Stranded with issues left unresolved.	A369. Leaving yourself up there, where you have built yourself up to talking about, leaving yourself up there is not necessarily good, so you have to sort of bring it back down, but bringing it back down not just by 'oh right we have run out of time'.	
It takes time to get to what matters.	A375. I didn't get talking about that issue till quite a few sessions in.	
It takes time to build the bond with the counsellor.	A377. It takes you that length of time to sort of build up your bond.	
Counsellor engendered trust from the start.	A379. I mean I trusted her from the beginning, she was really nice.	This contradicts I nearly left after the first week. A153/155
Speaking to a stranger I may never see again.	A379. I am amazed that I can tell you it's because I don't know whether I am going to see you again, you know that's the whole part of it.	Use again of the word Amazed
Speaking to a stranger I may never see again.	A381/ 383. You know you are the person at the bus stop that people can tell everything. You don't know them, you are not going to see them again, well please don't let me see them again (laughing).	

Prevented from doing the work by shortness of time.	A391/393/395. That's where I know it all hurts and I really don't think that I talked that through. I talked that through more with my counsellor at college than what I did in this. I think it's the time restraints of it, it definitely was. I knew that, with the counsellor at college and there was no time restrictions, cos I could see him for 3 years. It was just open ended you could see him when you needed and you could just keep going.	Time restraints make the difference between counselling that can deal thoroughly with issues and those that leave issues up in the air.
I would recommend this therapy.	A405/414. I would recommend this therapy.	
The time was too short.	A407. For some people that might just be all they need, that might just be completely enough and that would make them feel so much better. It made me feel better after, you know I did, but it just wasn't long enough.	
The time was too short.	A416. I mean I am 50 I have had 42 years of this, it is not going to be fixed in 10 weeks.	Recognition that issues of long standing are not going to be fixed in a short period of time.
Wanting the support to continue - not stop dead.	A422. Just to know you had that support that, or you know, see more often and then wind it down to once a month or something like that.	

	Because that's what I have noticed before and I have brought it out, with these things that's it, cut dead, off, you are on your own.	
Without follow up you slide back down.	A426. No follow up, and that was the same with the CBT thing, there is no follow up and I think God, okay you might walk away thinking, yeah, yeah, yeah, yeah, yeah I am done, and then your pain, your fatigue, all your problems and, 'oh well I am going to try and keep positive' but they are still there, do you know and event.... yeah, and they are still, and then you are back. Before you know it you are back down again.	
It doesn't do the job for the long term.	A430. You could argue well what is the point of having it, if it is not gonna give you the benefit on the long term basis, it is a short term fix and it is sort of leaving you, well you know this is all, now you go off and do it, you know you have got the tools to sort of think it through and do it yourself.	
	A436. In a perfect world you would have as many sessions as you need till you felt 'right I am off on my own now, I can deal with all this'. It is not a perfect world.	
Recognising individual need.	A448. I would recommend it but there definitely needs to	One size does not fit all.

	look, not everybody is the same.	
Recognising individual need.	A450. Maybe it's not one thing meets everybody's requirements, you know, everybody is different.	
Put off by the small number of sessions.	A456. By setting the limit right at the outset, my problems are too big, we are never gonna get thru.... you know what I mean, it almost puts you off when it shouldn't.	
Put off by the small number of sessions and time restrictions.	A458. Because you sort of know that you are limited right from the get-go, it does sort of hold you back a bit and even though you get stuff out of it, it is still holds you back from the deep, deep, deep stuff because your sessions are time limited and the number of your sessions are time limited.	
Recognising individual need.	A460. Looking back, no matter how good the counsellor is, no matter how good the organisation is, it is too restricted, and tailor made is what it needs to be to the individual.	Regardless of how good the counsellor is - the time limitation restricts the work.
There has to be a bond with the counsellor.	A460. I did see a grief counsellor, oh my God, I went to one session I thought pfff, you are rubbish, honestly, don't ask me why I thought, it was just there was no bond, no click..	
Get rid of the jargon	A470. That first session, it was all jargon it was like 'oh no, here we go again', but it did, once you get into the	Get rid of the jargon - people don't want it and

	nitty gritty it was great but maybe they need to sort of cut back on that, because somebody else might, they might not understand.	won't understand it.
I just want to talk.	A474. People want to go and just 'thank God I want to talk.	
The service agenda takes priority.	A478. But the service is regimented with the time, this is what we do, this is how we do it.	
Forget the theory. Recognise we are individuals.	A480. We are not all in a text book, you know you are going to hopefully go away and look at this and say to people you know 'this isn't the model that...'. It is not a model, do you know what I mean, it's not a model is this a counsellor session.	
Forget the theory. Recognise we are individuals.	A482. It's scripted, it is regimented, this is a model, this is the way it is done. It does that, that, that, that, that and if you tick all those boxes that's the perfect way that a counselling session is done. That is not what I want out of a counselling session, erm, I don't want the tick boxes 'oh well we have done that, we have done that' because we are not tick, we are just not tick boxes, you know we are not a model.	The model described at Line482 is prescriptive and directive. Very different to the "model" of CfD. What is going on here?
Service agenda takes precedence over client	A482. They have got a model now, you have got 12 weeks, first week erm, runs into the	

agenda.	second week where we are going to talk about what we are gonna, der, de, der and the last week we are going to wind, you know talk about, but I want to go bam straight in because that first, I have been waiting on a waiting list.	
Recognise me as an individual.	A484 /486 I want to go straight, I don't want to be this is how we do it, this is the model, because it makes us all like we are the same and problems affect us the same way. Our problems don't, it doesn't affect you the same way.	
I am not part of a model, I am 'ME'!	A488. I am not part of a model, I am 'ME'!	
It could have been great but it wasn't long enough to finish the work - time restrictions.	A492. I just feel disappointed in the sense that it could have been great, but it just fell sh.. if it had been longer, ra-ra-ra, it could have been great for me, but I don't feel, now that I have finished it and weeks are going on I am still in the same place but only things are a bit more open.	
We are all different.	A496/498. Who knows we are all different and that's the thing, we are all different but they are treating us all, but they are treating us all the same, we are ticking the boxes, so you have got problems with your, oh mummy problems, well that sort of takes the, but you	

The relationship with the counsellor was great.	know the counsellor was great. I can't fault her in the sense when she got past the paperwork side of it.	
Counsellor insight.	A508. The counsellor herself I couldn't fault, and I thought, I mean she did say those sort of, I thought 'oh my God, how did you pick that out'?	
Counsellor speak.	A508.Then she would ask some questions but 'What, speak English'! There's a wee bit, maybe now and again a wee bit of counsellor speak would come in.	A way of talking designated "counsellor speak" that was not understandable by the client.
It didn't really do what it was meant to do.	A536/538. Who knows, who knows, maybe in another few years I will have to have counselling again and I will be on the waiting list, Which will be a real shame because it means that it didn't really do what it was meant to do, but hey-ho.	Maybe this doesn't work due to the limitations which stop it doing what it should - but I'll give it another go -
	HAT FORM DATA	
	A s1p1	
A place to realise the truth of the situation.	Q1. I got upset when I talked about harming myself.	It is not easy
This work is difficult.		
Answers don't come easy - it takes a lot of thought.	Q2. It's stressful to admit these thoughts to anyone. Only the counsellor knows.	Someone there for me
Relief that's it's out in the open.	Q3. How hard I found this question to answer.	

Only the counsellors knows. Here is someone I can talk to who understands me and doesn't judge me. This place is safe for me to talk. A safe place to say your deepest thoughts. Brings client's attention to the reality of what is going on for her. Counsellor highlighting material out of awareness or hard to accept. Going to places client usually avoids. Counsellor highlighting material out of awareness. Client learning about herself from counsellor reflections. Counsellor qualities - non judgemental / easy to talk to / listens / reflects /explores Client gets relief from the session. "A REVIEW SESSION" A place to talk openly. I can tell her things and confide in her. A relief to have a person to tell these things to. Non judgemental counsellor. My time = time for me Being heard and paid	<u>A s1p2</u> Q.5 It was helpful to talk out loud and not feel judged. Q7. You can talk about things that you bottle up and would never tell anyone else. <u>A s2p1</u> Q1. Talking about being better off dead. Q2. Counsellor picked up on what I was saying. <u>As2p2</u> Q5.Counsellor was insightful when she pointed out..... Q7. Non-judgemental - easy to talk to. Picks up on things I say. <u>As3p1</u> Q1. Main benefit is talking openly. Q2. Counsellor is non-judgemental. It's my time to get it off my chest.	There is freedom to talk Freedom to talk Talk about anything Counsellor skills Counsellor skilful Non-judgemental / counsellor qualities Freedom to talk Accepting / my time to talk

attention to. Client identifying what she wants out the sessions. Good to talk to someone outside the situation. Non-judgemental. Being heard and paid attention to. I could do here what I needed to do. Freedom to show my feelings - a place to be able to cry. Something positive gained in the release of tension. A place to discuss concerns. A place to explore feelings. Free to say exactly what I want to say. - no censorship Talking about what matters to the client. Learning from the discussion.	<u>As3p2.</u> Q5. I told the counsellor I would like to concentrate on accepting my condition. Q7.Benificial to talk to someone who does not know you or your family, so cannot judge you. The therapist is completely focused on you. <u>As4p1</u> Q2. I t was such a release - a real good cry. <u>As4p2</u> Q5. Discussed feeling a "failure". Q7. Being able to talk to someone in a way you can't to the people you know. Talking to the counsellor I can say exactly what I want to say.	Client goal Talking to a stranger A relief gained Freedom to say anything Freedom to talk

Learning for the client from the discussions in session. She notices what I do - Acknowledgement of the counsellor's focus on the client and awareness of what they do, how they do it and what it means. Freedom to talk without being judged. A space to discuss what matters. Focus on concerns causes distress. It's helpful to be able to talk freely - a release . Realisation in the distress that this really affects me. The way I usually handle this doesn't help. I need to do it differently. Talking to someone who listens. The sessions provide a release - make me lighter. No pressing matters initially, but the session identified a crucial issue that still brings tears. The counselling finds the focus on what matters.	As5p1 Q1. Wanting to be in control but getting stressed when I am. Q2. It made me realise ..... As5p2 Q5.The counsellor always picks up on the little actions I do. Q7. As always being able to talk without being judged. As6p1 Q1. Talking about specific things. Q2. It was a release to talk openly. It doesn't help to keep things bottled up. Q7. As always - talking to someone who listens. As7p1 Q1. I wasn't sure what I was	Learning about me Learning about me Counsellor skills Not being judged talking Benefits of talking Freedom to talk

Identifications of things not settled and this is the core of it all. Major realisations. Amazement at the power of it to distress.	going to talk about ..... but we got talking about a situation that still reduces me to tears.	Talking / uncertainty
Good to talk "out loud". A release of tension	Q2. I thought I had put it behind me, but I realise I haven't. I know this is where the issues start from and I'm amazed it still affects me so much.	Learning about me
	<u>As7p2</u>	
	Q7. It's good to speak out loud about these things.	It's good to talk
	<u>As8p1</u>	
The realisation about events and learning - enlightenment.	Q1. Realising how my mood has changed over the weeks.	The most important event was summing up ? This clashes with client's interview data - where she wants more time to talk and to choose her own agenda rather than the counsellors ?
Positives identified - able to face the future/ optimistic / positive - but can't say how it helped. Hard to explain. "It's just a fact it has"		
	<u>As8p2</u>	
Greater self awareness and understanding. Knowing what to do now. Realisation of a <u>lot</u> of positives - clarity in seeing things differently. Surprise at getting a different perspective.	Q5. Understanding how I've come to be the person I am today. knowing what I have to do. An "eye opener" to <u>realise</u> there are a lot of positives.	Learning about me

Freedom to speak without worrying about the person who hears it. Wanting it to go on forever. Confirmation of feeling better at the end.	Q7. Therapy sessions are ME time to let it all out. I'd like it to carry on once a month for ever. I am better now than I was at the start.	Me time

The HAT forms are positive - the interview much more negative.

Time restrictions curtail the work and prevent clients from going deeper because they are scared the sessions will end before they have time to work things through.

Modality and the "kind" of counsellor their therapist is, means nothing to the client. They don't want to know about the "text-book" theory - they want the sessions to be about them and recognise their individuality.

Having a safe space to talk in important.

Being listened to non-judgementally.

Learning about themselves and insight come out of the sessions but clients struggle to identify how it happens. Summed up as "it is amazing"

In a perfect world you would have as many sessions as you need till you felt ‘right I am off on my own now, I can deal with all this’. It is not a perfect world.

Client would recommend this therapy.

Appendix 19: Quotes supporting themes

A Helpful Process

It works (12 participants - 1,2,3,4,5,6,7,8,9,10,11,12)

Agnes: A95.Things that you deal with in the counselling, you know it helps you to get through the things.

Agnes: HAT/7: It really helps to "speak out loud" about these things. Usually I only think about them. It is such a release of tension.

Agnes: HAT /8:. Therapy sessions are "me" time to let it all out. I'd like it to carry on once a month for ever. I am better now than I was at the start.

Joanne: J215. It really helped me to understand that, accept it and move on from it and make different choices now, so really really useful. It couldn't have happened at a better time really. I needed it.

Caledonian: C47. What I have been sort of thinking is that the counsellor has, she hasn't said to me do this, do that, but just talking with her and she sort of like gently would ask a question, but never suggest anything and I think she has made me think differently.

Caledonian: C289. I have got two different lots of antidepressants prescribed by my doctor and they are not doing anywhere near the good that the counselling has done.

Sandra: S182-4. I would say it was a really positive experience, just being able to sit with somebody who is prepared to listen, not judge but also be able to feedback what's going on. Basically, to help me clarify what was happening, and I would say it is really good if you are struggling with things, like struggling with something in your life, it just gives you, there is someone there who can help you clarify what is going on and help you work things out for yourself. What is best for you, you know, there is no advice, they don't tell you what to do, because a lot of people think when they go they think 'oh you know yeah they will tell me what I should do. And that is not what it's about because it is about knowing what you need to do for yourself.

Sandra: S254. All those kind of things that just mean that you can just talk and listening honestly and reflecting, well the whole process of the listening, the reflecting erm, not feeling judged, really comfortable and the equality of the relationship. The whole thing I think just really worked for me.

Gillian: G17. I thought I would just give it a go and then after about the fourth session I did like I enjoyed going, but I found like I could tell her things that I can't discuss with friends or family, I mean it did help, it did help.

Sarah: S102. You know it was just so brilliant, it just worked. You know it really worked for me. So, you know, the right counsellor. Someone who wasn't fazed by my tears because I cried

for 19 of the 20 sessions. Um, somebody who wasn't fazed by anything I was going to say. Who wasn't fazed by my uncomfortableness. Which was massive. Um. So, you know, it just, it just kind of worked.

Sarah: S250 - 256. I feel amazed. I feel amazed. I wanna laugh. I feel really joyous about it because I am so different. And you know, so much has changed for me, just so different. I'm just a different person. It's a new person, um, there's new bits to me, but I've got some of the old bits back that I missed.

Steve: S.94 So it has helped and it just seems like some sense of pride has come back.

Steve: S202. I would rate it really very high, I mean for me to be sat in here now looking at this and I can see work surfaces and I can see the floor, I say it was 100% personally.

Lorraine: HAT/8: By talking it is allowing me to take some personal weight off my shoulders.

Lorraine: HAT/9: Again it is talking and this session in particular was a turning point. I feel lighter, determined.

Lorraine: HAT/11: To know that both the counsellor and I could see that I had made significant progress.

Lorraine: HAT/11: The counsellor made me look deep into my life and thoughts. It enabled me to take stock and to let my family know I need to be supported too. I know that it is going to be life changing.

Lorraine: L286. To be honest it has been life changing.

Lorraine: L340. Helpful. I think for me it has been, it is life changing in the sense of the point in my life, this point in my life, erm, I think this point where I am uncertain of my future and I am quite scared about the future, it has made me be, to refocus I suppose, it is being able to allow me to talk about it and look at it and sort of calm down about it and be more, do practical things to put things in place now and to enjoy things now, so it is to bring back into my life the things I enjoy

Isabel: HAT/4: Digging deep and peeling back the layers underneath to find out some reasons why we are the way we are. Not for everybody but for me it's working.

Isabel: I126. It does work, it worked for me.

Isabel: I145. Just for me it has been a really great experience.

Henry: H153. From personal experience I found it had been a very, 110% help for me

Henry: H308. It has helped me 110% and I feel I have gained a great deal from it, a great deal of understanding, a great deal of help from it.

Olivia: HAT/10: It felt I was lifting a weight from my shoulders.

Lily: HAT/4: Being able to face life and not need any further counselling for the time being.

Surprise that it works (7 participants - 1,3,4,5,6,7,10)

Agnes: A22. I didn't think I was going to be talking about that. and I don't know whether it was the counsellor's skill, a mixture of everything, but when I came away from the sessions I was a bit lighter on my feet and you know, it's great.

Caledonian: C9. I went in with the mind-set that it was a load of nonsense, how could talking to somebody be any use whatsoever?

Caledonian: C39. So I mean the counsellor, I mean I just, somebody should give her a halo, I think people like her are amazing and I went in totally believing it was going to be a complete waste of time.

Sandra: S310. I really thought it was amazing because I just felt that I progressed so much in a short period of time to be honest.

Gillian: G83. Yes I am a stronger person and you think like the 12 sessions erm, I didn't think I would feel like this but I can see a difference in myself.

Sarah: S310. You need to do this work, yeah, you need to do this work and I can wait until you're ready. And, I think it made me think about it and have to take the lead and have to talk about it, and I mean it's quite amazing I'm sitting here now. You know, I would never have done this before.

Steve: S312. I didn't come out of any sessions thinking 'oh that was crap', I only came out of the sessions thinking you know 'cor I didn't realise I had that in me.

Isabel: HAT/6: I never thought it would work and I was shocked at how effective this therapy is.

Isabel: I82. I broke down, completely broke down in that session but I also felt that that was really good for me because it just showed me what was in there and how real something like that could be, I didn't think that would work but it really worked.

I don't know how it works - it's just great ! (6 participants - 1,3,4,5,7,10)

Agnes: A18 -20. It just seemed amazing that you come away and think Oh god that's better out than in. But it always struck me that how the hell did that happen? Do you know what I mean ? How did that happen?

Agnes: HAT/8: I feel more able to face the future and I feel more optimistic and positive. It was hard to explain what exactly the counselling has done to help - it is just a fact that it has.

Gillian: G97: And I said to her 'you know what you would be surprised, you would be surprised how it does help'. It is not, it is just getting it all off your chest, you might not get to the answers to what you want to hear, but you do get a lot off your chest and it does like clear

your mind a bit.

Caledonian: C33. After a few weeks I felt brilliant, this has been strange because although the counsellor can't give me a magic pill and make everything better, inside, each week I felt a bit calmer because I had got something else out.

Caledonian: C87. Well I don't know how I would answer that because I don't feel I understand myself how it has worked and I would probably say, 'I know everybody is not the same but all you can do is give it a try and see how you feel', which is exactly what I did. I totally thought it was just absolute nonsense and now if anybody was to say 'my doctor has recommended counselling'. I would say "go".

Caledonian: C205. Actually I can't really understand how she has had such a big influence in how I am thinking about things, when she actually says very little each week. It was me that gabbed on and on and on and on, and so for all she said very little the input I did get from her was positive and I have spent my whole life being put down by anybody I came into contact with.

Sandra: S310: , I really thought it was amazing because I just felt that I progressed so much in a short period of time to be honest.

Sarah: S158. It was just such a gradual process of change within the sessions, you know, the development through the 20 weeks. I used to joke that she had a magic wand because it felt like that sometimes, that, you know, that I could just bring it and talk about it, so it became easier for me to talk.

Sarah: S170. There was a mystery and a magic about it.

Sarah: S288. It's quite difficult to get hold of it because it actually did feel quite magical.

Isabel: I92. Which as I say was brilliant because I didn't think it would work and I found myself at the beginning thinking oh no how is this going to go and am I going to look silly and I thought I am not going to pretend, it has got to be how it would be, but it just, it did and it helped me immensely.

Appendix 20 : Abstraction of Themes

Appendix 21 : "Freedom to talk" post-its

Appendix 22: Themes on post-its

Appendix 23 : Supervision and Training Record

Supervision Date	Writing	Reading	Other Activities	Training
1. 4.11.2013	Presentation - for Celebrating Research Day - Nov 8th 2013 350 words on CfD studies in lit review 300 words - Methodology.	Elliott, R., Greenberg, L.S.,Watson, J.C., Timulak, L.& Freire,E.(2013). Research on humanistic-experiential psychotherapies. In Bergin & Garfield's *Handbook of Psychotherapy and Behavior Change.* (pp.495-538). New York: John Wiley & Sons.	Amendments to PIS and consent form. Submission to NRES. Approval received 3.10.2013 CRB etc sent to R&D depts X2. Letter of Access received from Manchester Psychological services. Email to David Rees to check next steps. Email to North/South/Central Manchester Primary Care Mental Health Team - enquiring as to the next steps. Sign up to Argyll lone worker policy.	CfD conference 21.9.2013

Supervision Date	Writing	Reading	Other Activities	Training

2.12.2013	Methodology Lit Review Summary of meeting sent to Mcr North.	Phenomenology papers - Reiners (2012) IPA - Smith et al (2009) Attributions of Responsibility - Wall & Hayes (2000)	Contacted Mcr. Central Psych Trust - only one CfD counsellor in training. Meeting set up for Mcr. North - 26.11.2013 Chasing Rochdale R&D for research passport. Research Passport approved 29.10.2013 Meeting at Mcr. North - Paul Evans and Theresa Derbyshire. 1-3 possible counsellors seeing 16-18 clients a week - not all CfD tho. Agreed to start study 13.1.2014.	Speed Reading 6.11.2013 Practising Existential Psychotherapy - Prof. E. Spinelli -15.11.2013

Supervision Date	Writing	Reading	Other Activities	Training
3. 10.2.2014	Methodology 7,400 words Separating Intro and background from Lit review Total: 21,000 ish words	Heatherington et al 2013 - Client perspectives on corrective experiences in psychotherapy. IPA Depression studies.	Hat forms to Clayton surgery. Counsellor meeting for Wythenshawe surgery. 22.1.2014 Email documents to service manager Ajit Raghoo at HMR - Pennine Trust Discussion with Wendy Saint -	Transcript of "Trainer's view of CfD" - Kate Hayes 15.2.2014 Video of Jonathan Smith explaining "Good Quality IPA Studies"

			clinical lead HMR. Will take study to meeting 12.2.2014 and let me know. Contact with Sandra Castle - Wythenshawe practice. Paperwork packs to both Clayton and Wythenshawe practices Letter introducing study to Rochdale counsellors. Peter Pearce intro to Jackie Townsend - Devon Partnership Trust.	28.2.2014

Supervision Date	Writing	Reading	Other Activities	Training
4. 27.3.2014	Re-write of Introduction - 7092 Re-write of Lit Rev - 7100 words Started re-write of Methodology - 9400 words.	Adams, M. (2013). *Existential Counselling*. London : Sage Lopez, K.A. & Willis D.G. (2004). Descriptive versus interpretive phenomenology : their contribution to nursing knowledge. *Qualitative Health Research, 4*(5), 726-735.	Email to Trish Hobman and Lynne Laycock re recruitment. 11.2.14 - *Reply: They will be willing to contact their students Mid-March.* Emailed amended Consent form with client contact info to Manchester and Rochdale R&D depts. 11.2.14. / No response so re-sent : 26.2.2014 Ok to use amended consent	NVivo - 2 days 24/25 Feb 2014 - difficult to understand and poor and rushed explanations given. Struggle to get software installed - abandoned attempt.

			form - email to come from Anna Banister 0161 625 7434. Doesn't need to go back to full IRAS. 4.3.2014 Completed R&D Annual Audit 4.3.2014 Spoke to David Jeffries @ Devon Trust. Need R&D ethical permissions. Email to Dr. Judith Belam to start process. 4.3.2014 Maureen - Counsellor in South Mcr trust - giving packs out and engaged in the study. Judith Belam advised moved from R&D so emailed documents to Polly Tarrant and Tobit Emmens @ Devon Partnership Trust. 19.3.2014	19.3.2014 Co- presenter of Ethics presentation to Prof. Doc students 20.3.2014

Supervision Date	Writing	Reading	Other Activities	Training
5. 1.5.2014	Design poster for CPR conference. Flyer for Jane Hunt / Andy Hill		Sent documents a third time to Devon. Chased Mcr counsellors to recruit for more participants. Email to York St John to check if they had any response to my	IPA training on Method and Analysis - Virginia Eatough 31.3.2014

			plea for counsellors. Email Dr. Jane Hunt at Keele University for participant support. 8.4.2014: Approval received from Devon R&D. 9.4.2014: Jackie Townsend - Devon - discussed arrangements for interviewing 2 clients for pilot study. 10.4.2014 Invitation received to present study to 2 team meetings at Rochdale. 11.4.2014 Participation notice placed on BACP Research Noticeboard./ Therapy Today notice board. 13.4.2014. Preparation of flyers for Rochdale / Jane Hunt/ Research Conference 15.4.2014: Jane Hunt - administrator to circulate CfD flyer to CfD Counsellors on their database.	9.4.2014 - One-to-one training on referencing : Suzanne Waugh.

			Made up participant packs and HAT form packs for Rochdale and Devon. 24.4.2014: Attended Rochdale Team meeting. Extremely negative response. Was told CfD doesn't exist as a model - purely for political means so counsellors can wear an IAPT badge. Cannot proceed with this team for the study. 3.5.2014 Email to Susan Waine R&D Rochdale - to advise study withdrawal.	

Supervision Date	Writing	Reading	Other Activities	Training
6. 9.6.2014	Completed Methodology re-write Transcribed Sarah Analysis begun for Sarah Transcribing "Agnes".	Service user papers. Sanders, P. & Hill, A. (2014). *Counselling for Depression*. London: Sage	Visit to Devon to interview "Sarah" and meet with Devon counsellors. 29.4.2014 Interviewed "Agnes". 7.5.2014 Email to LH to check if she still wished to recruit for me. Chasing Manchester counsellors for recruitment.	BACP Research Conference 15-17.May 2014.
Supervision Date	Writing	Reading	Other Activities	Training

7.7.2014	Search strategy. Literature Review - re-write Transcriptions completed. Analysis ongoing.	Transcripts for analysis.	Contacted Mind (Leeds). Pointed towards Leeds Counselling service - but 2 counsellors there are in the middle of training and none are qualified yet.16.6.2014 Emailed Peter Pearce to check on Cornwall contact. 10.6.2014 Emailed counsellors in Manchester /Devon for updates on recruitment. 2.7.2014	11.6.2014 IPA forum meeting. LinkedIn training 30.6.2014 8.7.2014 7 Secrets of the successful researcher seminar.

Supervision Date	Writing	Reading	Other Activities	Training
8. 4.8.2014	Agnes analysis / emergent themes. Joanne transcription Joanne analysis Analysis - 8000 words Abstract for BACP research conference 2015. Abstraction of Themes Summary to Date. Preparation of Internal Evaluation Report.	Linda Finlay (2002). Negotiating the swamp: the opportunity and challenge of reflexivity in research practice. *Qualitative Research, 2,* 209-230.	Joanne interview 9.7.2014 Emailed Manchester North-West for permission to conduct study in their trust. 10.7.2014 24.7.2014 Email to AB & SM wondering if stopping recruiting is an option !!! Potential 11 clients if all commit to the study. Emailed the counsellors at Manchester IAPT to advise about stopping recruitment 28.7.2014.	Peer Review of Analysis 30.7.2014

			Emailed the counsellors at Devon IAPT to advise about stopping recruitment 28.7.2014	

Supervision Date	Writing	Reading	Other Activities	Training
23.10.2014	Therapy Today article 21.9.2014 Analysis of Emergent Themes - Sarah Re-write of Therapy Today article 24.9.2014 Transcription of "Gillian". Analysis of Sandra Analysis of Gillian Analysis of Emergent Themes - Sandra Analysis of Emergent Themes - Gillian.	Reviewed IE feedback (MH) Humanism as a common factor in psychotherapy. Wampold (2012). New opportunities to bridge clinical research and practice. Kazdin (2008). Eagly, A. H., & Riger, S. (2014, July 21). Feminism and Psychology: Critiques of Methods and Epistemology. American Psychologist. Advance online publication. http://dx.doi.org/10.1037/a0037372	Checking endings of clients with Counsellors. 18.9.2014. Interview with "Gillian" 23.9.2014 Submitted article "Story of a research study" to Therapy Today 30.9.2014 29.10.2014: Received notice - BACP article accepted for publication (yippee). Spoke to JT and clarified her queries. Good rel in place. She is happy to be interviewed on ending her therapy. 11.11.2014: Devon interviews arranged with DG and JW. Awaiting 2 more clients to	IPA forum meeting 12.8.2014 BACP Private Practice Conference 13.9.2014

			come back to me for apts on 5.12.2014.	

Supervision Date	Writing	Reading	Other Activities	Training
27.11.2014	Amendments from IE made to text - Reflections and Ontology sections.	Carere-Comes, T. (2014). One or Two Psychotherapies?. *Journal of Psychotherapy Integration*. Advance online publication. http://dx.doi.org/10.1037/a0038133	Interview arranged with SK for 28.11.2014 3 X interviews arranged for Devon 4.12.2014	

Supervision Date	Writing	Reading	Other Activities	Training
29.1.2015	Transcription: Steve, Henry, Isabel. Analysing Hat forms: Steve, Henry. Analysis of Henry interview. Analysis of Steve interview. Ontology - re social constructionism. Presentation for BACP conference Presentation for SPARC conference	Burr, V. (1995)). *An introduction to social constructionism.* London: Routledge.	Attended Depression and Anxiety Service in Paignton and interviewed 2 participants. One other participant didn't attend and a fourth re-arranged for January. Voicemail and emailed for update on Manchester participants. 15.1.2015 Interview Lorraine 23.1.2015	Tutorial - Suriya Nayak for guidance on Social Constructionism 13.1.2015

Supervision Date	Writing	Reading	Other Activities	Training
5.3.2015	Analysis of Isabel Transcription Lorraine Analysis of Lorraine Transcription of Caledonian Analysis of Caledonian Development of themes Attended to proof of Therapy Today article (due for publishing in March 2015 edition of journal).	Beutler, L. E. & Forrester, B. (2014). What needs to change: Moving from "research informed" practice to "empirically effective" practice. *Journal of Psychotherapy Integration,24* (3), 168-177. Tolin, D. F. (2014). Beating a dead dodo bird: Looking at signal vs. noise in cognitive behavioural therapy for anxiety disorders. *Clinical Psychology Science and Practice, 21,* (4),351-362 Pilgrim, D. & Carey, T. (2012). Improving access to psychological therapies: an account of recent policy aspirations in the UK and Australia. *Advances in Mental Health, 10* (2), 117-126.	Letter to RC to arrange interview 30.1.2015 RC interview 12.2.2015 Voicemail / email to counsellor at Manchester for update on participants. 10.2.2015 Voicemail to GP surgery for update on Manchester participants. 12.2.2015 Talking through analysis / discussion layout with IPA group members.	Turbo-charge your writing workshop: 16.2.2015

Supervision Date	Writing	Reading	Other Activities	Training
5. 29.4.2015	Analysed HAT form data. Presentation for BACP research conference.	Jones, s. A., Latchford, G. & Tober, G. (2015). Client experiences of motivational interviewing: An interpersonal process recall study.	Reviewed BACP presentation with Dr. Surayia Nayak. 24.4.2015	Putting Theory to Work 9/10.3.2015

	Participant Information table. Analysed Hat forms - Olivia / Lily Writing Chapter 4 - Findings	*Psychology and Psychotherapy: Theory, Research and Practice*, 1-18. doi: 10.1111/papt.12061		Presenting at Conferences 27.4.2015

Supervision Date	Writing	Reading	Other Activities	Training
9.6.2015	Writing Chapter 4 - Findings - cont ..... Wrote conference presentation for SPARC 2015	Linde, K., Sigterman, K., Levente, K. Rucker, G., Jamil,S., Meissner,K. & Schneider, A. (2015). Effective psychological treatments for depressive disorders in primary care systematic review and meta-analysis. *Annals of family medicine, 13* (1), 56-68	Presented some of the thesis findings at the BACP Research Conference 14.5.2015 Presented some of the thesis findings at the SPARC Research Conference 27.5.2015	BACP Research Conference 14 - 16.5.2015 SPARC Research Conference 27.5.2015

Supervision Date	Writing	Reading	Other Activities	Training
20.7.2015	First draft of Discussion chapter First draft of Conclusion chapter	Wampold, B.E. & Budge, S.L. (2012). The 2011 Leona Tyler Award Address: The relationship and its relationship to the common and specific factors of psychotherapy. *The Counseling Psychologist, 40*(4), 601-623. Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling*	Formatted thesis. Sorted out appendices.	IPA forum meeting. 17.7.2015

		Psychology, 52(2), 250-260.		

Supervision Date	Writing	Reading	Other Activities	Training
19.8.2015	Re-write Discussion chapter RE-write Conclusion chapter.	McNamee, S. (2004). Relational Bridges Between Constructionism and Constructivism . University of New Hampshire. Chamberlain, K. (2000). Methodolatry and qualitative health research. *Journal of health psychology, 5*(3), 285-296.	Format and checking full draft thesis.	

Appendix 24 : Effective Therapy

(These are the answers to the question "What do you think makes therapy effective"?)
The post-it notes used to represent the individuals are shown in italics.)

(Agnes - *yellow square*)

- Confirming what I need to do
- Looking at why I've made the choice I've made.
- Looking at why it has happened.
- Making sense of the confusion and conflict.
- Counsellor exploration of the situation helped to make sense of it.
- More helpful to focus on the way I did what I did.
- More helpful to focus on feelings.
- Looks at why you accept stuff happening.
- Gain control of what happens in my life.
- Focus on behaviour patterns.
- Looking at the reasons why things happen.
- How you feel about yourself.
- You can talk about things that you bottle up and would never tell anyone else. You don't want to hurt or upset the people you love by telling them you are so unhappy and are having morbid thoughts.

(Joanne - *pink square*)

- Change the negativity I'm left with.
- To look at problems in more depth.
- To really focus on what is important.

(Isabel - *green square*)

- Like a guidebook showing you where to go.
- A learning process.
- Learning ways to manage your life and get over experiences.
- Gaining tools to help you back to the positive side of things.
- Support, someone prepared to listen.
- Comfortable environment.
- The counsellor showing the client that only you can make the changes.
- Digging deep and peeling back the layers underneath to find out some reasons why we are the way we are.
- I realise I didn't like what I was hearing from my counsellor. I needed to hear this because I am making

(Steve - *blue square*)

- Being able to discuss all your problems with one person
- Seeing the same person for that continuous period of time.

(Caledonian - *yellow speech* bubble

- I think the fact that it makes me question myself)

(Lilly - *Aloha*)

- Trusting the counsellor and talking.
- Being able to talk and explain about how a person feels. and being able to find comfort at last for a few minutes.
- Knowing I have help at hand and someone who is not biased or too close to the situation.
- Someone to listen to me.

• Being able to talk without being judged. (Olivia - *orange stripe*) • For someone to spend the time to listen. • Being able to talk to someone who listens. • Being able to talk frankly. • Being able to talk to someone not involved in the situation • Being able to talk things through. • Being able to discuss matters and examine my feelings more closely. • Being able to talk about how I was feeling. (Sarah - *yellow flower*) • Something that has a good end result. • Something where you feel comfortable enough to talk about yourself. • A place where you learn about yourself. • Learn new skills to manage life. • It's progressive - moving at your own pace.	changes. • Listening and highlighting the things I have said. This shows me the counsellor is attentively taking in what I'm saying. • Helpful tools and ways to change the way we think. (Lorraine - *white speech bubble)* • The main thing is that you can come away with a focus . So the fact that each week we pretty much spoke about 'A' particular thing, then you know, I would go back and reflect on that and what kind of changes can I make. • The counselling allows you the space to talk and think and then you can take that away and use it in a positive, productive way, • I mean she didn't really say or come up with any practical things, it was just literally just talking about it and me thinking. • To be able to be in a space where you can be honest. • The sense that you re-evaluate your thoughts and put them into boxes of what is really important. • The counsellor made me look deep into my	(Gillian - *green tulip*) • Being able to speak to someone just there to listen. (Sandra - *pink tulip*) • Connection with the counsellor • Not being judged. • Providing core conditions • Being able to go to somebody else about who you are and how you are, and the realisation of being able to move forward. • Not relying on others but helping you to rely on yourself. • Identifying the strength in yourself. (Henry - *orange square*) • Being able to really express how you feel. • Getting more and more control of me

• To recognise things in yourself so you can move on and not slip back into old patterns of thinking. • It's encouraging. • It's amazing.	life and thoughts. It enabled me to take stock and to let my family know I need to be supported too. I know that it is going to be life changing.	.

Appendix 25 : Extract from reflective diary

April 24th 2014

My first impressions were of Sarah being friendly and smiley. I had a sense that her aim was to please me by giving me useful material for my study and that it was important for her to be helpful to me. I was aware she was looking expectantly at me to lead the session and this increased my nervousness to facilitate a good interview. Once we got started it was fine and it flowed. Sarah was keen to talk and I was savouring her words. Often Sarah would ask if she was giving me what I needed and I would reassure her that what she was saying absolutely answered my questions.

I was aware of the difference in my responses as a researcher. As a counsellor I never would have offered such direct reassurance that she was doing the right thing in answering my questions. As a counsellor I would have reflected the question back and opened it out for exploration making it the work of the counselling. Also, in the interview there were times when Sarah reflected on her reasons for entering counselling and the material she worked on in the sessions with her counsellor. I was conscious not to respond in a way that would open this material up because this was not a counselling interview, it was a research interview. Further, my purpose in this interview was to gain answers to my research questions, not to be a counsellor for my research participant. The boundaries have to be maintained and I am aware of holding separate threads, some that can be followed and some that definitely must not be pursued.