

On: 15 February 2013, At: 03:33

Publisher: Routledge

Informa Ltd Registered in England and Wales Registered Number: 1072954 Registered office: Mortimer House, 37-41 Mortimer Street, London W1T 3JH, UK



Counselling and Psychotherapy Research: Linking research with practice

Publication details, including instructions for authors and subscription information:

<http://www.tandfonline.com/loi/rcpr20>

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Version of record first published: 15 Feb 2013.

To cite this article: Ellie Brown, Naomi Moller & Christine Ramsey-Wade (2013): Recording therapy sessions: What do clients and therapists really think?, *Counselling and Psychotherapy Research: Linking research with practice*, DOI:10.1080/14733145.2013.768286

To link to this article: <http://dx.doi.org/10.1080/14733145.2013.768286>

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Recording therapy sessions: What do clients and therapists really think?

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Abstract

Aims: Recording therapy sessions has become part of routine practice amongst trainee psychotherapists. To date most research has focused on the benefits of recording sessions to support clinical supervision. There are few data about the benefits or risks for clients. This study aimed to explore the views of clients who had had their therapy sessions recorded and therapists who had recorded sessions. *Design:* Five clients and 25 therapists completed a qualitative survey, the results of which were analysed using thematic analysis. *Findings:* All clients and several therapists reported that the recording devices are soon forgotten. Both therapists and clients reported the benefits of recording as being purely for the therapist with none identified for clients. *Conclusions:* It was observed that clients perhaps did not always understand how recordings were used, suggesting the need for clearer practice guidance.

Keywords: recording; therapy; counselling; thematic analysis

Background

It is often accepted by students training in a variety of therapies that they will need to audio or video record a proportion of their therapy sessions as part of their training course (e.g. Gothard & Bojuwoye, 1992). For example, in the UK the Improving Access to Psychological Therapies (IAPT) programme has trained 3700 new therapists over the past three years (IAPT, 2013) and a core element of its training and assessment is the submission of recorded therapy sessions.

The IAPT curriculum and commissioning guidelines (March 2011, p. 11) state, 'each therapy session should be video- or audio-taped. Three audio/ videotapes of clinical sessions with each patient should be submitted for formal examination'. Determining trainee competence is important in ensuring that therapists are able to practice safely. Organisations such as the British Association of Counsellors and Psychotherapists (BACP) and the British Association of Behavioural and Cognitive Psychotherapies (BABCP) that accredit training programmes also require that recording sessions be used to determine trainee competences. Despite this requirement for large numbers of trainees to frequently provide

'in-vitro' examples of their work, there is little research or theoretical writing on the impact it may have on trainees as well as their clients.

Authors that have written about recording therapy sessions have argued from alternative perspectives, with some advocating the practice, stating it helps practitioners develop their clinical skills (see for example, Abbas, 2004; Aveline, 1992), whilst others have reasoned against the practice stating that it is a barrier to the therapeutic relationship (see for example, Brown, 1990; Gelso, 1973, 1974; Huhra, Yamokoski-Maynhart, & Prieto, 2008; Lamb & Mahl, 1956; Roberts & Renzaglia, 1965; Van Atta, 1969).

Much of the recording therapy literature published to date has focused on the experience of the trainee therapist. Of particular focus has been how recording sessions can influence the therapeutic process or the trainee's experience of supervision (e.g. Aveline, 1992; Ellis, 2010; Haggerty & Hilsenrot, 2011). Aveline (1992) suggested that resistance to recording sessions originates from trainee therapists' own feelings of anxiety and vulnerability because of how the recordings can be used to evaluate and review their clinical practice. Haggerty and Hilsenrot (2011) reported findings of a systematic review

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of the literature around the use of videotapes in psychotherapy supervision. They suggest the use of video recording in therapy sessions provides more effective supervision for trainee therapists. They also question relying on a therapist's memory to vividly recall a therapy session, emphasising that videoing sessions allows supervisor and therapist to observe non-verbal behaviour, facilitating better reflection of the therapeutic process. Similar conclusions were noted by Levenson and Strupp (1999) from two large surveys of the views of practitioners and training course directors from which they suggested that American training programmes in brief psychodynamic therapy should use videotapes for supervision and training. From their observations they argued that they had experienced few negative effects from its use and agreed with Aveline (1992) that resistance tended to lie in therapists who either consciously or unconsciously feared having their work scrutinised. Gossman and Miller (2012) interviewed 13 trainee counsellors about the recording of therapy sessions. Despite doubts expressed over the ability to be 'completely present' when their therapy sessions were recorded, almost all participants felt that the practice helped them to develop their clinical skills and that perceived benefits outweighed drawbacks to the practice. Ellis' (2010) clinical summary of research and supervisory experiences posited that it is a myth that recording therapy sessions is overwhelming and anxiety producing for therapists and counter-therapeutic for clients, stating that when clients know that the purpose of recording sessions is to train therapists and improve the quality of their therapy, they are generally happy to consent.

Research into the client's experience of having sessions recorded is dated. Most studies were undertaken between 1950 and 1980 (Brown, 1990; Friedman, Yamamoto, Wolkon, & David, 1978; Gelso, 1973, 1974; Lamb & Mahl, 1956; Roberts & Renzaglia, 1965; Van Atta, 1969; Zinberg, 1985). These authors all concluded that recording therapy sessions could have a negative effect on the client, therapist and the therapeutic relationship. For example, Roberts and Renzaglia's (1965) study of eight participants found that clients made more favourable self-reference (talking positively about themselves) when they knew they were being recorded and more unfavourable references when not recorded. They concluded that as self-references are quite relevant aspects of the therapeutic situation, the different recording conditions did affect the therapeutic process. These findings were achieved by comparing

recordings from covertly and overtly recorded sessions. It is noteworthy that this methodological approach would be impossible to defend ethically today, where all research participants are required to give informed consent. This, amongst other methodological constraints may explain in part why relatively little research into this area has been undertaken in the intervening decades.

A study by Shepherd, Salkovskis, and Morris (2009) investigated the impact recording had on 31 clients receiving cognitive behavioural-therapy (CBT) at a centre specialising in anxiety disorders. Recording was integrated into the structure of therapy, with clients being provided with a copy of their session each week for them to listen to afterwards. Clients were asked how they felt about having their sessions recorded and being issued a copy for their use each week. The most frequent advantage reported by clients was that recordings acted as a good memory aid of what went on during the session. The authors reported that their results were consistent with research in physical health settings such as oncology, where patients generally report positive attitudes towards recordings of appointments and being able to listen back to them (McHugh et al., 1995; Ong et al., 2000; Van der Meulen, Jansen, Van Dulmen, Bensing, & van Weert, 2008). It is hard to generalise from Shepherd et al.'s study however, as client involvement with recording both in and out of sessions is not routine practice in most mental health services. Generally, recordings are only listened to by the therapist outside of sessions and it is unusual for clients to be given a copy of recordings. It might also be argued that the processes involved in psychological therapy are very different to those in physical care, although further exploration of this assumption would be informative.

The focus of current literature has been on the benefits to a therapist's training and supervision. It is hard therefore to draw strong conclusions about the impact that recording therapy sessions has on the therapeutic process as well as clients' willingness to fully engage in therapy. Arguments are frequently made in the literature that it is trainees' anxiety about being recorded and 'found-out' which drives the negative ideas around recording clients. There has been little on-going reflection about the impact recording may be having on clients. This study aimed to gain an up-to-date insight into how clients and therapist feel about recording therapy session.

Method

Design

A qualitative survey was chosen over more traditional interviews due to this study being an initial pilot. This allowed for a larger and potentially broader sample of views to be obtained (Clarke, Ellis, Peel, & Riggs, 2010). This method was also felt to be the least intrusive way of gathering data from a vulnerable clinical population. Additionally it typically allows for data collection to occur on a larger scale, particularly in comparison to conducting interviews, which consume considerable time and resources. There were two versions of the survey, paper and electronic, questions were identical in both. This allowed for fast collection of data from a potentially broad participant population (Harding & Peel, 2007). An additional reason for using data collection via surveys was its long and substantive history within research, as explained in Czaja and Blair (2005) and Groves et al. (2009).

Data collection

Participants were invited to complete the survey that included basic demographic information (age, gender, ethnicity) and for clients, a question to check whether they had received an adequate explanation about why their session was being recorded. To avoid bias in data collection, questions remained broad and open-ended. This was instead of using questions originating from quotes from the research literature (e.g. “some people have said that recording therapy sessions gets in the way of the therapeutic relationship” What do you think about this?), which could have been perceived as leading. Participants were asked to respond to the following open-ended questions in as much detail as possible:

- (1) Overall, what was your experience of having your therapy sessions recorded/recording therapy sessions?
- (2) What may be the advantages of recording therapy sessions? Can you think of any specific examples?
- (3) What may be the disadvantages of recording therapy sessions? Can you think of any specific examples?
- (4) Have you experienced the recording being used in your therapy/in the therapy sessions you have provided? If so, how? [This question was included to gather information on activities such as those in Shepherd et al. (2009).]

Study participants

Two participant groups were invited to take part in the study:

- (1) Clients who had had at least one therapy sessions recorded,
- (2) Any practising psychological therapist who had experience of recording their clients.

Clients. Recruitment was undertaken in three services in the South West of England where therapists recorded therapy sessions. Within the services a variety of therapeutic approaches were used. These services were: a charitable drug and alcohol agency; a University counselling service; and an NHS-run IAPT service. Therapists in these services who were currently recording client sessions were asked to approach any clients who had been recorded to consider completing the survey. It may have been preferable to write directly to clients to invite them to take part, but this was not possible because of data protection issues, i.e. personally identifiable data can only be accessed by members of the treating clinical team.

Therapists. A snowballing (chain referral sampling) technique was used to identify potential therapist participants, i.e. through contacts who know therapists that may have been interested in taking part (Biernacki & Waldorf, 1981). Adverts were also placed with the British Psychology Society (BPS) website and email service to gain a wider sample of therapists who have experienced recording sessions.

Thirty-one participants were recruited, five (16%) clients, 26 (84%) therapists. Thirty clients were approached to complete the questionnaire with a return rate of five. Table I shows the demographic characteristics of client participants. The mean age of clients was 47, they all defined themselves as British and all felt they had had the reason for having their sessions recorded adequately explained to them.

Table II shows the demographic data for therapist participants. Fairly typical of this professional group, participants were predominantly female, white British but with an average age of 35 (range 25–58 years), which is slightly younger than may be anticipated. The most common type of therapy provided was CBT ($n = 12$) followed by integrative counselling ($n = 11$).

Table I. Client demographics.

Characteristic	Client 1	Client 2	Client 3	Client 4	Client 5
Age (years)	44	53	53	39	59
Gender	M	M	M	F	F
Client defined ethnicity	British	British	British	British	British
Type of therapy	Person-centred	Unsure	Unsure	Unsure	CBT
Service receiving therapy in	Drug & alcohol	Drug & alcohol	Drug & alcohol	NHS	NHS
Recording explained	Y	Y	Y	Y	Y
Happy with explanation	Y	Y	Y	Y	Y

Table II. Therapist demographics.

Characteristic	<i>N</i> = 26
Age (mean, SD)	35 (8.6)
Female (<i>n</i> ,%)	24 (92)
British ethnicity (<i>n</i> ,%)	25 (96)
Providing CBT therapy (<i>n</i> ,%)	12 (46)
Providing therapy in NHS service (<i>n</i> ,%)	16 (62)

Data analysis

The qualitative approach adopted was thematic analysis. This predominantly ‘essentialist’ method reports experiences, meanings and the reality described by participants but also allows the researchers to ‘unpick or unravel the surface of “reality”’ (Braun & Clarke, 2006, p. 81). It involves an integrative, interpretative process between the data and the researcher in order to ‘code’ the data. Thematic analysis involves the careful reading of all the data, looking to identify meaningful units of text that are relevant to the area being researched and assigning these ‘codes’. Analysis then moves to the broader level of ‘themes’, whereby codes are combined to form an overarching theme. Braun and Clarke argue that equal attention should be paid to each item of data when generating codes and themes. Each of the two data sets (clients and therapists) were analysed independently of each other.

Ethics

The study was approved as a service evaluation by the University of the West of England Ethics Committee and by the mental health services participating in the project. Consolidated criteria for reporting qualitative research (COREQ) standards for reporting qualitative studies were complied with throughout (Tong, Sainsbury, & Craig, 2007).

Reflexivity

As a qualitative researcher I am conscious of my own perspective on recording of therapy sessions. When analysing data I have been mindful of this, considering the effect that my own beliefs and values can have on the interpretations that I derive from the data. As part of my therapy training I am required to record therapy sessions. My own views about the topic are mixed, both seeing the necessity of the activity but also at times feeling anxious when having to ask clients if they consent to being recorded as it can feel a personal thing to ask for my own benefit. I feel my own ambivalence toward recording helped me remain open to interpreting the data in this study.

Results

The overall aim of this study was to explore client and therapist views of recording therapy sessions and the main themes are outlined in Table III.

Thematic analysis

Clients. Four themes came through from the client data. These were ‘Recording devices are soon forgotten’, ‘It’s good for my therapist’, ‘It may be an issue for some people’ and ‘Is there a lack of understanding about recording?’

Table III. Main themes from analysis.

	Main Themes
Clients	Recording devices are soon forgotten It’s good for my therapist It may be an issue for some people Is there a lack of understanding about recording?
Therapists	Recording is beneficial to me We never really know how it impacts our clients or us Refusal is surprisingly infrequent My feelings about recording sessions change during the process Technology failures get in the way

Client theme 1: Recording devices are soon forgotten: Clients frequently reported that although they were potentially aware of the recording device at the start of their therapy, this was soon forgotten. A number of reasons for this were mentioned, including their presenting problems taking priority and being used to being recorded.

I think that knowing that you are under pressure with problems, I didn't really take any notice (P5).

[Being recorded was] no different from my perspective, I'm used to it. (P2)

Client theme 2: It's good for my therapist: Positively, all clients that participated recognised the benefits recording sessions holds for therapists. Clients seemed to see therapy as an active process that extended beyond the therapy session. There was also an appreciation that a lot can happen in a session and having the chance to review what was said can be helpful.

The therapist can... isolate certain themes which he or she can work upon. (P1)

[It's an] aid for reflection and personal development [for my therapist]. (P4)

Client theme 3: It may be an issue for some people: Clients recognised that not everyone will feel comfortable having therapy sessions recorded. It was suggested that it could lead to sessions feeling unnatural. Despite this, participants were clear that that was not the case for them.

Somebody could be worried about what they're saying and therefore not open up completely. (P4)

Some individuals may find them intrusive and so be unable to communicate in a natural relaxed manner. (P1)

Client theme 4: Is there a lack of understanding about recording?: There was a sense from the data that some clients didn't fully grasp why sessions were recorded and what the recordings was used for, perhaps because of the information their therapist has given them. They felt that the recordings were used beyond supervision and professional development.

[An advantage is] to further the trains of thought within the organisation. (P3)

If you ever returned for therapy sessions [the therapist] will be able to find out whether it is a repeated problem [by listening to old tapes]. (P5)

Therapists. Data gathered from therapists generated 31 codes that were then collapsed into five main themes using Braun and Clark's (2006) six stages of thematic analysis. These were 'Recording is beneficial to me', 'We never really know how it impacts our clients or us', 'Refusal is surprisingly infrequent', 'My feelings about recording sessions change during the process' and 'Technology failures get in the way'.

Therapist theme 1: Recording is beneficial to me: Therapists reported several benefits to recording therapy sessions, that were nearly all related to themselves, not their clients. Benefits included noticing things that were missed in the session:

I found it particularly helpful to review a whole/part of a session. (P1)

You can reflect on things you may miss in the moment. (P8)

Taping was also reported to be a useful learning tool for professional development. Participants frequently said that the use of recordings in supervision helped them reflect on their work with clients.

You can listen back over your sessions to see what you can improve on or what went well. (P2)

Listening [back] can enable therapists to reflect on what was going on during specific parts of therapy sessions. (P21)

Trainee therapists specifically highlighted the need to have recordings to successfully complete assignments as part of their programme of study and achieve qualification.

It's useful for assignments e.g. process reports... it's useful for CBT, if assessing CTS-R [cognitive therapy scale revised] etc. (P5)

The aim of recording was to provide the recorder, alongside a process report, to my training course. (P19)

Therapist theme 2: We never really know how it impacts our clients or us: Concern about how taping

affects the therapeutic process was raised by participants. This worry reflects the lack of research on the impact of recording sessions on clients. An idea that frequently came through in this theme was the sense that recording sessions made it feel that there was 'a third person in the room':

Sometimes clients say things . . . and I really don't think they're saying it for me, but for those who may listen to the tape. As if there is another audience to this confidential space (P5);

A client once said that the tape machine was a third person in the room. (P24)

As this final quote may demonstrate, therapists questioned whether recording sessions changed how clients presented in sessions, potentially holding back things they might have said.

Perhaps they would feel uncomfortable and less likely to disclose. (P20)

Clients can find themselves holding back and not talking as openly as they might usually talk. (P11)

Therapists also questioned whether recording had a negative impact on the therapeutic relationship and made suggestions as to why this might be:

Some clients felt paranoid and suspicious which could damage the therapeutic relationship. (P21)

The therapeutic relationship can be strained due to both parties being overly self-conscious. (P11)

Despite these possibilities, therapists rarely cited examples of this happening and seemed more likely to suggest that although this was a possibility, it had not happened to them.

If clients are self-conscious it may affect the relationship, don't think this has happened to my clients. (P13)

Therapist theme 3: Refusal is surprisingly infrequent: Therapists were quick to report that they had rarely had clients refuse to be recorded, which on reflection surprised them.

I have been amazed how willing my clients are to be recorded. (P3)

I haven't experienced any clients refusing to be recorded as yet. (P15)

Some therapists expressed concern over whether this was because clients are too compliant and find it hard to say no. Although this concern was expressed, there were no suggestions made to overcome this.

Some clients may not want to be recorded and agree out of a sense of obligation. (P12)

Clients may not feel comfortable or able to refuse consent to have sessions recorded. (P7)

Therapist theme 4: My feelings about recording sessions change during the process: Therapists frequently reported how recording clients made them feel. Most apparent was the sense of anxiety that initially existed, especially around having to ask during the first session. Therapists reflected that after this initial feeling of awkwardness it soon began to feel more natural to an extent that they often forgot the session was being recorded.

It was initially very anxiety provoking, as though a tutor was sitting in the room criticising. I gradually got used to it. (P24)

I quickly forgot the recorder was in the room. (P7)

I was anxious about doing so but once I had recorded one or two this lessened and I forgot about the recording device being present. (P9)

I have found that over time recording sessions becomes more natural. (P14)

Therapist theme 5: Technology failures get in the way: The final theme captures the expression that occasionally the technology being used to record interferes with the therapy session which seems to have a significant impact on the therapy.

I have had sessions where the dictaphone has beeped and stopped working . . . It's as if a silent person has suddenly interrupted and made their presence known when otherwise it would have gone unnoticed. (P5)

The battery has run out and the machine squealed. (P24)

Discussion

The aim of this study was to explore the views of clients and therapists about the recording of therapy sessions. The findings from the study fall broadly into two areas: benefits and ethics.

Benefits of recording sessions

Generally, clients were amenable to having therapy sessions recorded and recognised benefits, particularly for their therapist. This is consistent with the work of Ellis (2010) who felt that when clients know why recording was occurring they were happy to consent. The observation by Roberts and Renzaglia's (1965) and Gelso (1973) that taping was a barrier to effective therapeutic working was not reported by participants in this study. For clinicians that record sessions, it may be reassuring to know that clients who agree to being recorded are generally happy to do so and that recording instruments are quickly forgotten. The sample for this study was clients who had agreed to be recorded and who were compliant with the request to complete a questionnaire. It is perhaps therefore not surprising that their views were by and large positive. That so few clients who were asked agreed to participate may cast a shadow over the generalisability of these observations. It would be informative to survey clients who had refused to be recorded and to get their perspective as to why this was. This could be carried out using a similar methodology to the present study with therapists asking clients for their consent to be contacted by researchers to complete a survey or interview.

In this study, participants did not identify any benefits to themselves of having sessions recorded. This seems to be a largely consistent observation with the only research that has demonstrated client benefit being Shepherd et al. (2009). In their study it was the practice of giving copies of recordings that was being tested. As this practice was not reported as occurring by any of this study's participants, it is probably not surprising they did not identify any benefit to themselves.

A further theme suggested that clients acknowledge that recording sessions holds benefits for their therapist and it is for this reason they are happy to consent. This implies that procedures for explaining why therapists are proposing to record therapy sessions need to be articulated more clearly. Indeed, is there a sense that it is not ethically sound to offer

an intervention (session recording) when there is no reported benefit from clients of participating in this?

Turning to the therapist participants, they also acknowledged the benefits of recording to their professional development, which was consistent with both what the clients said and previous research (Haggerty & Hilsenrot, 2011; Levenson & Strupp, 1999). Again it was only therapists who had previously recorded clients who were eligible to take part in the study so there was no sense from therapists who have not recorded clients about their views on this.

It was positive to find that many of the themes presented in this study paralleled those found by Gossman and Miller (2012). Themes in their investigation included 'a third person in the room', 'moving from extreme nervousness to a more relaxed style', 'aiding development of counselling practice' and 'the relationship between counsellor and client' (p. 28). There is considerable overlap between these themes and the ones currently presented, adding support for the generalisability, or 'trustworthiness' of the findings in the study.

Ethics of recording sessions

The finding that clients might not understand exactly why they are being recorded and what the recordings are used for, was troubling. Indeed, this finding suggests that some clients are agreeing to an intervention (audio recording) without an adequate understanding enabling them to give informed consent. This is surely not ethical practice. On reflection, it would have been helpful to obtain copies of the information sheets given to clients by participating therapists as this may have provided some insight into what information clients have been given about recording sessions.

It may be possible that the clients who took part in this study were those that tend to passively consent to whatever they are asked to do by a therapist. This was echoed by one of the themes raised by therapists who worry that clients are possibly too compliant. Previous studies in this area have not suggested that this may be the case (Ellis, 2010). This raises a question for therapy and supervision. Is it an atypical group of clients who consent to have their sessions recorded and therefore how representative of the trainees' work are their recordings? Some support for this perspective was reported by Van Atta (1969) who found that over a quarter of clients would reject

counselling altogether if they were required to be recorded.

One theme that did emerge from the data that has not been previously reported was that of their surprise at how infrequently clients declined to have sessions recorded. This observation contrasts with that of Van Atta (1969) who argued that resistance to having sessions recorded was common. It may be that in the decades since this study was done attitudes towards having sessions recorded have changed as technology has become a part of everyday life. Gossman and Miller's study perhaps lends some support to this argument as they reported that more intrusive video recording distracts therapists and possibly clients as well. Even if clients have become more used to having technology present in the session, the theme of 'technology failures get in the way' in this current study suggests that therapists worry that equipment failures could impact on the therapeutic relationship.

Returning to the issue of infrequent refusal, data were not collected on whether therapists were working with clients with common mental disorders (for example anxiety and depression) or within secondary services with clients with severe mental illness. It can therefore only be speculated as to whether the client population influences willingness to be recorded. For example, it may be hypothesised that clients with schizophrenia would be less likely to agree to having their therapy sessions recorded.

Limitations

In addition to problems with bias (non-response bias and sampling bias), recruitment of clients was problematic due to issues of confidentiality. As a researcher independent of the services where clients had accessed therapy, the author was unaware of client identifiable data. Potential clients were therefore contacted via their therapists, who enquired as to their willingness to participate, and paper copies of the questionnaire were provided for them to return either to their therapist or in a self-addressed envelope.

Even despite these difficulties, recruitment of clients was disappointingly low. This was possibly due to busy practicing therapists who were unable to adequately promote involvement in the study to their clients. An important consideration is how to increase recruitment in the future, perhaps with the researchers being more actively involved in the client recruitment process, for example having more

frequent, direct contact with therapists in the services recruitment was being conducted. Necessary ethical consideration would need to be given to ensure strict client confidentiality is maintained.

Due to the methodology used to recruit therapists, it was not possible to know how many potential participants were unable to or unwilling to take part. Whilst this approach was effective in generating a sample, it could be criticised for introducing a systematic bias; contacts are likely to refer therapists who are willing to discuss this issue, negating those who may be extremely resistant to recording clients for potentially a variety of reasons.

Recommendations

Despite these limitations, this study has generated important new data in a narrow field of research. Perhaps the most practical implication of this research is the need for psychotherapy training programmes to better ensure clients are providing informed consent to have their sessions recorded as part of their therapist's training. Expanding this study into a larger piece of work with a greater number of clients taking part is the next step to gaining a greater understanding of how clients really feel about having their therapy sessions recorded.

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