A reflexive thematic analysis study to explore what contributes to initial engagement in therapy from the perspectives of clients and their therapists

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Abstract

When clients first start therapy, the initial sessions set the scene for how the therapy might unfold. Existing research suggests that if the client and their therapist are able to engage with each other early in the process, then this can lead to better outcomes and a reduced likelihood of clients ending therapy prematurely. This study aimed to explore what contributes to initial engagement in therapy from the perspectives of clients and their therapists. To date, research in this area has been predominantly quantitative in design, and has largely focussed on the development of the therapeutic alliance or reasons why clients may prematurely end therapy from either the client's or the therapist's perspective. This study brought these domains of engagement and non-engagement together and, through taking a qualitative approach, presented a unique in-depth perspective on both clients' and therapists' experiences of initial engagement in therapy.

The research took place at a low-cost counselling service in which clients are offered the option to transfer to a new therapist if they feel unable to work with their current therapist. Participants were clients who had transferred from one therapist to another along with one, or both, of their therapists. All of the therapist-participants were trainees and, in total, six clients, four first-therapists and five second-therapists took part. Data were collected through semi-structured interviews and analysed using reflexive thematic analysis, situated within a constructivist paradigm. From this, four themes were developed: (1) 'forming a personal connection with the therapist', (2) 'the therapist's responsiveness to the client', (3) 'is the client in good hands?', and (4) 'the client's decision to change therapist'. Running through all of the themes was an emphasis on the importance of the therapeutic relationship, the therapist's capacity for self-regulation, and the impact that the client and therapist had on each other. The findings highlight the importance of therapists attending to difficulties in their relationship with their clients, and the utility of offering clients the option to transfer to a different therapist. They also draw attention to key areas that impact engagement which could be a focus for training providers and individual therapists.

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Chapter 1: Introduction

1.1 The purpose of the research

When clients start therapy, the early sessions of therapy are particularly important as they are the first chance for clients and therapists to meet, get a sense of each other, and decide if they can work together. If, early in the process of treatment, the client is unable to engage with their therapist then they are likely to drop out of therapy prematurely (Elkin *et al.*, 2014), and this can be detrimental to clients, therapists and therapy services (Barrett, Chua, Crits-Christoph, Gibbons and Thompson, 2008). Some clients, however, choose to transfer to a new therapist and are able to engage in therapy with their new therapist rather than giving up on therapy completely.

The purpose of this research was to explore what contributes to engagement or non-engagement in therapy between a client and their therapist. The study was carried out at the Metanoia Counselling and Psychotherapy Service (MCPS), a service that offers low-cost counselling and psychotherapy with trainee therapists. A defining feature of the service at MCPS is that a client's first four sessions with their therapist are considered 'exploratory' and are a chance for both client and therapist to decide whether they can work well together. If the client doesn't feel that their therapist is right for them, they can request to transfer to a different therapist. For the purposes of this study, this presented a unique opportunity to explore engagement in therapy through gaining the perspective of the client (who changed therapist), the therapist they changed from (and thus didn't engage with), and the therapist they changed to (and engaged with).

While much research has been conducted that looks either at the development of the therapeutic alliance (which can be linked to engagement in therapy) or reasons why clients may prematurely end therapy (which connects to non-engagement in therapy), the bulk of these studies have been quantitative in design. The current research took a qualitative approach in an effort to gain an in-depth sense of participants' experiences, and brought the domains of engagement and non-

engagement together in an exploration of what contributes to initial engagement from the perspectives of clients and therapists who were, and were not, able to engage in therapy.

1.2 Research aim

The aim of this research was to explore what contributes to engagement or non-engagement in therapy between a client and their therapist. The general field of enquiry was the phenomenon of clients changing from one therapist to another and engaging better with their second therapist than their first. Through exploring the experiences of clients and first therapists I hoped to shed light on what hinders engagement in therapy, and through exploring the experiences of clients and second therapists I hoped to gain insight into what facilitates engagement in therapy.

1.3 My interest in this subject area

My interest in this subject area stems from my personal experience of looking for a therapist ten years ago. As part of the process of choosing a therapist I made appointments with four therapists and had an initial session with each. With three of them something didn't feel quite right in the relationship, but with one therapist I immediately had a sense of a better fit between us and I was able to engage in what turned out to be a transformative therapeutic process with that therapist. This led me to become interested in what contributes to a sense of fit between a client and their therapist and enables them to engage in therapy.

The topic is also very relevant to my work in the present day. As an accredited psychotherapist I divide my time between seeing clients privately and conducting assessments for MCPS and understanding more about engagement and non-engagement in therapy would be invaluable in both of these roles. In my private practice I have worked with clients who have come for one or two sessions and not returned, and other clients who have continued in therapy with me. I have found that I can usually anticipate whether or not a client will engage in therapy with me based on my experience of the client in the room, but occasionally I am surprised when a client does or

does not return. In these cases I find myself wondering if there was anything I could have done to facilitate engagement between myself and the client, and also feel concern for the client and hope that they go on to seek therapy elsewhere.

In my work as a clinical assessor, I allocate clients to MCPS therapists. If a client that I have assessed (and allocated to a therapist) requests to be transferred to another therapist, I speak to the client directly to explore what didn't work with their first therapist (and hopefully reallocate the client to a therapist who suits them better). With the client's agreement, I also offer feedback to the client's first therapist to help them to understand what may have happened between themselves and their client. Of the clients I have spoken to, most mentioned that they felt that the therapist they were seeing was inexperienced, and that the therapist did not give them enough guidance about the process of therapy. Some clients also said that they were put-off by the therapist's body language, and others had a sense that the therapist didn't fully understand them.

Hearing the client's perspective from a different position than that of a therapist has been valuable to me both in my role as a clinical assessor and also in my work with my own clients and has fuelled my interest in taking an in-depth look into the initial therapeutic encounter. My cumulative experiences have also shown me how difficult it can be for clients when they are unable to engage with their therapists, and many choose to drop out of therapy rather than transfer to a different therapist. For trainee therapists, it can be traumatic when their clients do not engage as they can feel like they have failed in some way, however these experiences can also provide a rich learning experience which can help them to develop their practice. Within the broader context of MCPS I have noticed that premature terminations and transfers can place extra administrative demands on staff and increase the financial burden on the service.

At a personal level, the outcome of this research could help me to make better allocations and reallocations and may change the way that I conduct assessments and work with my clients. It could also have benefits for the wider field (see section 1.4 below).

1.4 Rationale for this study

It seemed to me that the information that emerged from this study could have benefits for individual therapists, training organisations, therapy clinics, and clients, as well as adding to the literature in the field.

A better understanding of what facilitates engagement may enable therapists to adapt their process so that clients are better able to engage with them (and thus do not need to change therapist or terminate therapy). This would benefit therapists as it may help them to develop their practice and experience fewer premature terminations, as well as understand what may have happened between themselves and their client if a client chooses to terminate with them. Similarly, training organisations may be able to incorporate the findings into their teaching for new counsellors and psychotherapists to better equip them to manage the first few sessions with their clients. In this way this research has the potential to add to the field of counselling psychology through “the integration of psychological theory and research with therapeutic practice” (British Psychological Society, 2020).

At an administrative as well as a clinical level, therapy clinics may be able to use the findings from this study to plan their services better and improve the process of referral. A reduction in premature terminations could save both time and money and mean that more clients benefit from the service they provide.

Of primary importance, all of the above would also be of benefit to clients - increasing the likelihood that clients will be able to engage in therapy may mean that they are more likely to find a therapist who ‘fits’ them better and thus gain more from therapy.

1.5 Structure of this thesis

The aim of this research was to explore what contributes to engagement in therapy between a client and their therapist. In the introduction I described my relationship to the subject area, and the rationale for this study. In the following chapters I will review the literature relating to my research question and locate this issue within the wider psychological field. I will go on to describe my methodology, procedures, and process of analysis in detail, before outlining the findings I have developed from the data. I will conclude with a discussion of the outcomes of the research, along with the limitations of this study and implications for the field.

Chapter 2: Literature Review

2.1 Introduction

The aim of this study was to explore what contributes to engagement in therapy between a client and their therapist within the context of a client choosing to transfer from one therapist to another and staying for longer with their second therapist than their first. As a part of this process clients are prematurely ending with their first therapist and are thus disengaging from therapy with them. They are also choosing to transfer rather than drop out of therapy completely. By staying for longer with their second therapist, they may be demonstrating better engagement with their second therapist than their first.

It feels important to note that I trained as an integrative practitioner and I did not consciously bring any specific aspects of theory to my literature review. As a result, the literature covered in this review focuses largely on a trans-theoretical perspective. While the topics explored below are the main areas that came up as a result of my search, a different search (or one that focussed on a specific theoretical framework) may have unearthed other areas of the literature.

In this review I begin by examining the literature on initial engagement in therapy in an attempt to get a clearer sense the phenomenon. I continue with a focus on the early development of the therapeutic alliance in order to gain an understanding of what facilitates or hinders a client in engaging with their therapist. Next, I explore the literature on why clients might choose to end therapy prematurely, through looking at the prevalence, predictors, and ways of reducing premature termination. As the participants of this study will be trainees, I then touch on the literature on engagement specifically with a trainee sample. I continue by outlining research on transfers between therapists, including the impact of transfers and ways to facilitate a transfer. Finally, I speak briefly about the some of the literature on forming initial impressions as these may impact a client's capacity to engage with their therapist. While I have divided my literature review

into separate sections, it is important to note that the overall process of engagement in therapy is very complex. The sections outlined above are all interrelated and there will be areas of overlap between them (see Figure 1 for a diagram of the main areas of this review).

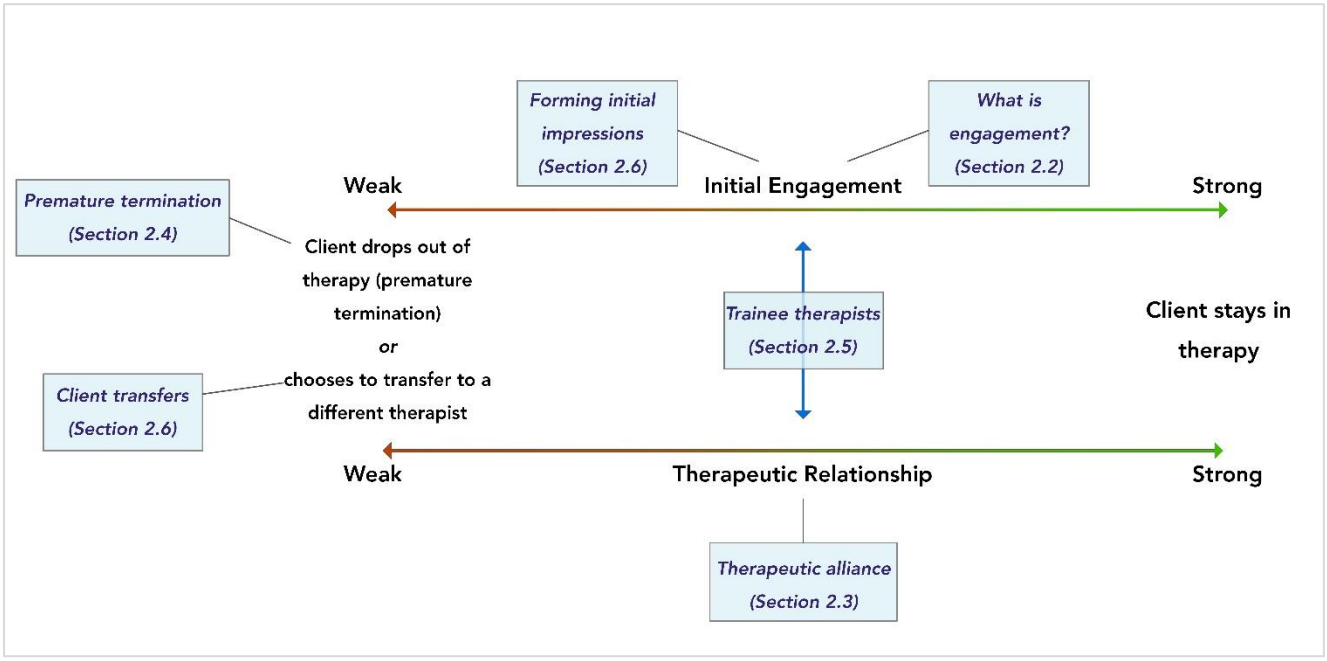

Figure 1 - A diagram of the main areas of this review and the interconnections between them

2.2 What is engagement in therapy?

Therapeutic engagement has been identified as a key component of the therapeutic process (Martin, Garske and Davis, 2000), and associated with positive therapeutic outcomes (Soleymani, Britt and Wallace-Bell, 2018; Holdsworth, Bowen, Brown, and Howat, 2014). The term ‘engagement’ is frequently used in the existing literature but, while most definitions reference client behaviours and attitudes towards treatment, the precise definition and approach to measuring engagement varies between studies.

In a comprehensive review of research into client engagement, Holdsworth and colleagues (2014) found that measures of engagement could be grouped into four dimensions: (i) clients' 'attendance' of sessions, (ii) 'participation or involvement' in sessions (efforts that clients make toward treatment within sessions), (iii) clients' 'compliance or practice' (completion of treatment-prescribed tasks like homework) and (iv) the therapeutic relationship. An additional two dimensions are mentioned in a literature review by Becker, Boustani, Gellatly and Chorpita (2017), who suggest that 'expectancy' (beliefs that treatment will be helpful, and that one can participate successfully in treatment) and 'clarity' (understanding about the treatment approach or the roles of each person involved in treatment) are important to engagement. Most studies explore engagement using one dimension and, of these dimensions, the two most commonly examined are those of attendance and the therapeutic relationship (Holdsworth *et al.*, 2014).

Within the literature the majority of studies use client attendance as a measure of engagement, with poor treatment attendance being generally accepted as an indicator of non-engagement (Holdsworth *et al.*, 2014). This makes sense in that a client has clearly disengaged if they drop out of therapy completely. However, a client could attend sessions without being engaged, or miss sessions for non-treatment-related reasons but feel very engaged in the process (Swift and Greenberg, 2015), and it therefore cannot be assumed that they are engaged if they don't drop out or that they are not engaged if they miss sessions. This suggests that studies looking into engagement solely through the lens of attendance may be missing the essence of the concept – that attendance may be important in that it provides an opportunity for clients to engage, but it does not guarantee that they will engage.

Other studies take a different approach and focus on the therapeutic or working alliance as a measure of a client's engagement. In their review, Holdsworth *et al.* (2014) found that the therapeutic relationship was the most commonly investigated treatment factor in terms of its associations with other engagement variables, which highlights a strong conceptual link between engagement and the therapeutic relationship. It is important to note that while the therapeutic

relationship and the alliance are sometimes considered synonymous (e.g. Henry and Strupp, 1994), the therapeutic relationship is a much broader concept and encompasses more elements than the alliance alone (this is explored in more detail in section 2.3 below). As a way to make sense of the different domains of engagement, Holdsworth *et al.* (2014) proposed a model that distinguishes between 'engagement determinant variables' (i.e. what contributes to a client engaging in therapy, such as the therapeutic alliance), 'engagement process variables' (i.e. what are the indicators of engagement, such as the client's attendance of sessions), and 'engagement outcome variables' (i.e. what is the impact of clients' engagement in therapy, for example on clinical outcomes).

Linking with this, Bright, Kayes, Worrall and McPherson (2015) conducted a conceptual review of engagement within healthcare literature and made a key distinction between engagement as a 'process' ('engaging with') and as a 'state' ('engaged in'). Similar to Holdsworth and colleagues' 'engagement determinant variables', the *process* of engagement centres on the development of a connection between the client and therapist and Bright *et al.* (2015) emphasise its co-constructed, relational nature. In contrast, the *state* of engagement refers to an internal state experienced by the client and expressed via a number of observable behaviours, such as their attendance of sessions and completion of tasks (linking with Holdsworth and colleagues' 'engagement process variables') (see Figure 2 for an illustration of this model).

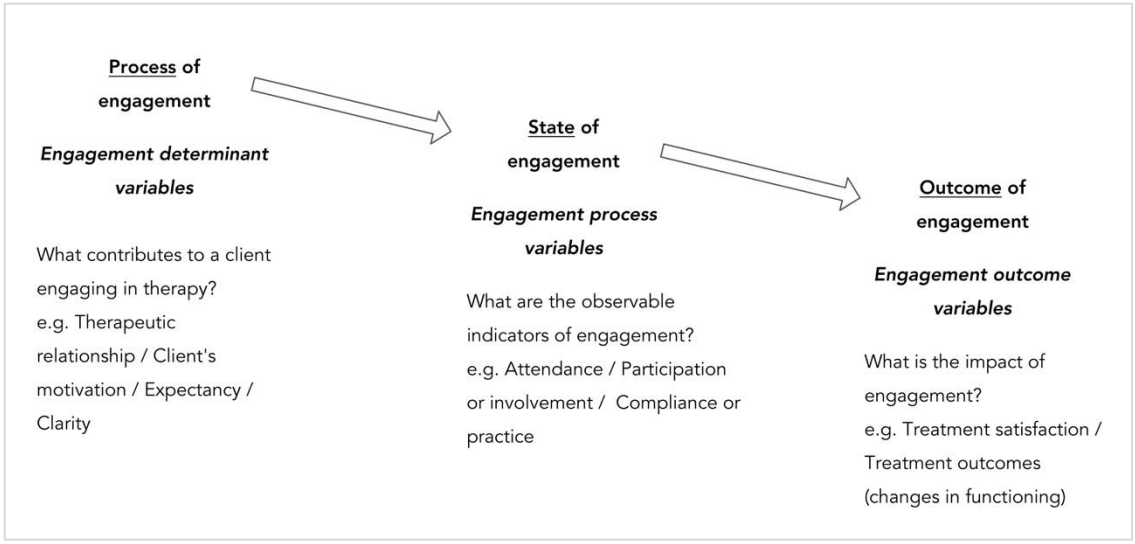

Figure 2 - model of client engagement in therapy, adapted from Holdsworth et al. (2014, p. 430).

As the present study is focussed on exploring what facilitates or hinders initial engagement in therapy, I anticipate that the area of 'engagement determinant variables' (i.e. the development of a relationship between the client and their therapist) will be of most relevance. This is supported by the findings of Holdsworth *et al.* (2014) who commented that within the qualitative research that they reviewed, clients and therapists interpreted engagement in similar terms to the therapeutic alliance.

As another aspect of understanding engagement, Bright *et al.* (2015) also suggest that engagement should be thought of as a continuum with 'tolerating treatment' at one end and increasing levels of involvement and collaboration leading to 'emotional investment in the therapeutic encounter' at the other end. The current study takes this view – when clients choose to transfer to a different therapist they are clearly no longer 'tolerating treatment' with their initial therapist, but by staying for longer with their second therapist they may be engaged to a greater or lesser extent along the continuum.

From the research to date it is clear that engagement is a complex, multidimensional concept that cannot be understood in terms of a single variable or measure. It can be considered as a process, in which a relationship develops between client and therapist, as well as an observable state

which manifests in behaviours like regular attendance. The current study focusses on what may facilitate or hinder the process of engagement between a client and their therapist and, as such, the literature on the therapeutic alliance is likely to be key to the findings.

2.3 Engagement in therapy through the lens of the therapeutic alliance

As the therapeutic alliance is central to many conceptualisations of engagement, and incorporates many of the facets of the therapeutic relationship, this is an important area to explore in more detail. Research on the alliance has been growing exponentially for decades and many studies have been undertaken to examine the factors that facilitate or hinder its development, as well as its impact on therapeutic outcomes (e.g. Ackerman and Hilsenroth, 2001, 2003; Flückiger, Del Re, Wampold, and Horvath, 2018; Horvath and Bedi, 2002; Horvath, Del Re, Flückiger and Symonds, 2011; Martin *et al.*, 2000; Safran, Muran, & Eubanks-Carter, 2011).

Many researchers base their concept of the alliance on Bordin's (1979) pantheoretical version of the alliance (e.g. Ackerman and Hilsenroth, 2003), which he termed the 'working alliance' and emphasises the collaborative aspects of the therapeutic relationship (Bordin, 1979). Bordin's definition focussed on three core features of the relationship: client and therapist agreement on therapeutic *goals* (what the problems are and what the solution would look like), consensus on the *tasks* that make up therapy (what will be done to achieve the goals), and the presence of an interpersonal *bond* (Bordin, 1979). Hatcher and Barends (2006) bring these features together in their description of the alliance as "the degree to which the therapy dyad is engaged in collaborative, purposive work" (p. 293). As such, the alliance can be thought of as a working relationship, rather than just the affective relationship between the client and their therapist. Along these lines, Bordin (1994) described the bond component of the alliance as having different nuances – one is the mutual experience of liking, trust, and respect that develops between a client

and their therapist, and another represents a commitment that is strong enough to undertake the particular tasks of therapy.

Over the years the definition of the alliance has become blurred and there have been differences of opinion around the theoretical bases of the alliance (Hatcher and Barends, 2006). Some researchers treat the therapeutic alliance as synonymous with the therapeutic relationship (for example, Henry and Strupp [1994] use the terms interchangeably), while others emphasise its distinct features as separate from the overall relationship (e.g. Hatcher and Barends, 2006). Some even argue that the traditional concept of the alliance has become superfluous, and that there should be a shift in focus towards a broader understanding of the role that relational factors play in the change process (such as mutual influence and unconscious negotiation between client and therapist, therapist flexibility, and authentic aspects of the relationship; Safran and Muran, 2006).

The third interdivisional APA task force on evidence-based relationships and responsiveness identified a wide range of elements of the therapeutic relationship[1], rating them according to the strength of the research evidence (Norcross and Lambert, 2019). In their discussion of this, Norcross and Lambert (2019) comment "how does one divide the indivisible relationship?" (p. 4), which highlights that a key complexity of the therapeutic relationship is that it contains many highly interrelated elements that cannot be divided into separate parts. This also emphasises a limitation inherent within the predominantly quantitative research within the field – that quantitative approaches are ill equipped to explore the complexities of human experience which often can't be broken down into easily measurable components (Gordon, 2000). For the purposes of the current research, each of the elements of the therapeutic relationship highlighted by Norcross and Lambert (2019) may be relevant to the process of engagement between a client and their

[1] Elements of the therapeutic relationship: the alliance, collaboration, patient preferences, goal consensus, empathy, positive regard and affirmation, feedback, congruence/genuineness, reactance level, real relationship, stages of change, emotional expression, coping style, cultivating positive expectations, promoting treatment credibility, managing countertransference, repairing alliance ruptures, attachment style, and immediacy (Norcross and Lambert, 2019)

therapist. The outcome of this research may give interesting insights into the elements that are viewed as important by clients and their therapists, and the interconnections between them.

In the following section I will first speak about the importance of the early establishment of a therapeutic alliance. I will go on to explore therapist, client, and interpersonal factors that have been found to facilitate or hinder the development of this alliance. In doing so I acknowledge that many of these factors may relate more generally to components of the therapeutic relationship, rather than the therapeutic alliance alone.

2.3.1 Early establishment of the therapeutic alliance

The first few sessions of psychotherapy are often seen as critical for the engagement of the client in the therapy process (e.g., Castonguay, Constantino, and Holtforth, 2006; Henry and Strupp, 1994; Horvath and Luborsky, 1993; Reis and Brown, 1999; Sexton, Littauer, Sexton, and Tømmerås, 2005). These sessions are especially important because they provide the first opportunity for clients and therapists to meet, assess each other, and decide if they can work together. If, early in the process of treatment, the client is unable to engage or begin to develop a bond with their therapist then the client is less likely to continue with treatment (Elkin *et al.*, 2014). This developing bond can be thought of as akin to the therapeutic alliance, which Flückiger *et al.* (2018) describe as “an emergent quality of mutual collaboration and partnership between therapist and client” that “infuses every interaction throughout psychotherapy” (p. 318), and develops early in the first session (Sexton, *et al.*, 2005).

Most of the research into the therapeutic alliance has been quantitative, and several meta-analyses have been conducted that demonstrate a robust link between a strong alliance and better treatment outcomes (Flückiger *et al.*, 2018; Horvath and Bedi, 2002; Horvath *et al.*, 2011; Martin *et al.*, 2000). This is particularly important when the alliance is established and measured early in treatment (Castonguay, Constantino, and Holtforth, 2006; Constantino, Castonguay and Schut, 2002; Hilsenroth and Cromer, 2007; Horvath 2001). The converse is also true in that poor

early alliances have been empirically linked to premature termination of therapy (Constantino *et al.*, 2002; Sharf, Primavera, and Diener, 2010) (see also section 2.4).

As the alliance represents a collaboration between clients and therapists (Hatcher and Barends, 2006), it follows that both client and therapist characteristics, and their interaction, should impact its development. Many studies have focussed on the impact of therapists (see Baldwin and Imel, 2013; Beutler *et al.*, 2004), perhaps due to the fact that the quality of the alliance between client and therapist has been found to be more a result of the therapist's actions or characteristics than the client's (Del Re, Flückiger, Horvath, Symonds, and Wampold, 2012). However, other theorists have claimed that client factors are powerful determinants of therapeutic process and outcome (Elkins, 2012), and researchers estimate that the client themselves and factors in the client's life might account for up to 40% of the variance in outcome (see Bohart and Wade, 2013). In addition, the early assessment of the client with respect to his or her perception of the quality of the therapeutic alliance has been found to be of greater importance than the assessment of the therapist (e.g. Fitzpatrick, Iwakabe, and Stalikas, 2005), highlighting the importance of the client in the engagement process.

While research into the therapeutic alliance has predominantly made use of quantitative methods, there is a growing body of qualitative literature which looks into the experiences of clients and therapists in greater depth (Gordon, 2000; Ponterotto, 2005; Timulak and Elliott, 2018). In the first meta-analysis of its kind, Lavik and colleagues (2018) explored qualitative research into alliance formation processes and identified metathemes relating to the client's and therapist's perspectives. Clients highlighted the importance of (i) meeting a competent and warm therapist, (ii) being understood as a whole person, (iii) feeling appreciated, tolerated, and supported, (iv) gaining new strength and hope for the future, and (v) overcoming initial fears and apprehension about psychotherapy. Therapists focussed on (i) balancing technical interventions and interpersonal warmth, (ii) showing a genuine desire to understand, (iii) openly supporting client agency, (iv) adjusting to create a sense of safety, (v) paying attention to body language, and (vi) providing

helpful experiences during the first session (Lavik, Frøysa, Brattebø, McLeod and Moltu, 2018). Lavik *et al.*'s review builds on other qualitative reviews which have found that clients need to feel understood, supported and accepted by their therapist, experience gains (e.g. insight or empowerment) from the therapy, and be in contact with the therapist as a fellow human being as well as a skilled professional (Levitt, Pomerville, and Surace, 2016; Timulak, 2007).

In the subsequent sections I will explore these in more detail and review the quantitative and qualitative research that sheds light on therapist, client, and interpersonal variables that may impact the therapeutic alliance.

2.3.2 Therapist variables

Within the literature there is strong evidence that some therapists are consistently better at forming alliances with their clients than others (Baldwin *et al.*, 2007; Johns, Barkham, Kellet, and Saxon, 2019). This has led some researchers to suggest that the therapist's role is the most important for achieving beneficial outcomes (Del Re *et al.*, 2012).

A few studies have specifically explored therapist qualities and interventions that facilitate the early formation of a therapeutic alliance. Georgiana Tryon (1985; 1988; 1990) conducted several studies that indicate that, during an initial session, therapists who rated their sessions as deep, valuable, special, powerful, and full (on Stiles' 'Session Evaluation Questionnaire', 1980) were significantly more likely to successfully engage their clients for a second session. She also found that helping clients to develop new understanding and insight was conducive for positive client-therapist relationships, and that clients needed something more than the experience of a smooth or comfortable session to engage. Linking with this, Sexton *et al.* (2005) explored the depth of the client-therapist connection during the initial two sessions of therapy by asking independent raters to watch videos of the sessions and score the quality of the client/therapist connection at 20-second intervals - they found that therapists who delivered a mixture of emotional and cognitive speech content, conveyed warmth, and appeared to be actively listening and exploring were likely

to have better connections with their clients, and the connection was likely to decrease when therapists were less engaged, responding with cognitive rather than emotional content, and providing general information or advice.

In their qualitative meta-analysis of early alliance formation, Lavik and colleagues highlighted that both the person of the therapist and the therapist as a professional are important (Lavik, *et al.,* 2018). This echoes the findings of Timulak and Keogh (2017) who described how clients prioritise therapist personal qualities such as warmth, authenticity, honesty, and dedication, while also valuing therapist technique and expertise.

Consistent with the research mentioned above, within the personal realm the client's experience of their therapist as a fellow human facilitates the development of a strong alliance. For example, studies highlight the importance of clients experiencing their therapist as warm, genuine, congruent and real (e.g. Kolden, Wang, Austin, Chang, and Klein, 2018; Sexton *et al.*, 2005) and feeling like their therapist is interested, engaged, truly understands, and likes them (e.g. Duff and Bedi, 2010; Lavik *et al.*, 2018; Farber, Suzuki and Lynch, 2018).

The importance of a human person-to-person connection between a client and their therapist has been emphasised for decades. Over 60 years ago Carl Rogers (1957) posited that the client's experience of positive regard, genuineness and empathy from the therapist were necessary for therapeutic change. Since his seminal paper much research has been conducted, and several meta-analyses broadly indicate that these conditions are necessary for therapeutic change (e.g. Orlinsky and Howard, 1986; Farber and Doolin, 2011; Farber, Suzuki and Lynch, 2018). In their latest meta-analysis on positive regard and therapeutic outcome, Farber, Suzuki and Lynch (2018) highlight that future research could explore "what specific forms of positive regard have which kinds of effects for which kinds of patients at which points in therapy" (p. 411). The present study could begin to shed light on these areas, as participants may describe the forms of positive regard that facilitated engagement for them during the initial phase of therapy.

The human qualities described above also fit within the concept of the 'real relationship' described by Charles Gelso as "the personal relationship between therapist and patient marked by the extent to which each is genuine with the other and perceives/ experiences the other in ways that befit the other" (Gelso, 2009, p. 119). A recent meta-analysis by Gelso, Kivlighan and Markin (2018) demonstrates a link between the strength of the real relationship and therapeutic outcome, providing additional evidence of the importance of this real, human connection between therapist and client. The concept of the real relationship is highly correlated with Bordin's 'bond' element of the therapeutic alliance (Bordin, 1979) – indeed, Bordin himself found it "hard to understand this distinction" (Bordin, 1994, p. 17) - and Gelso and colleagues' recent meta-analysis provides evidence that they are distinct but highly interrelated concepts (Gelso *et al.*, 2018).

Bridging the gap between the personal and the professional, studies have shown that therapists who have strong facilitative interpersonal skills (including many of the qualities already mentioned) tend to form better alliances with their clients (Anderson, Bautista and Hope, 2016; Heinonen, Lindfors, Laaksonen, and Knekt, 2013). Of particular relevance to this study, Heinonen *et al.* (2013) found that better basic interpersonal skills predicted early alliance formation. They also highlight the work of Orlinsky and Rønnestad (2005) who showed that these abilities constitute the natural talent that trainee therapists may bring to their work, and which show the least change during a career (Orlinsky and Rønnestad, 2005, cited in Heinonen *et al.*, 2013). Linking to this, some theorists have emphasised that from the very beginning of their practice trainee therapists vary in their ability to form a therapeutic relationship (Hill *et al.*, 2016, Hill and Castonguay, 2017). As the therapist participants in the current study are all trainees, it is possible that variations in engagement between themselves and their clients may be due to these inherent characteristics.

At a more professional level research shows that clients need to perceive their therapists as competent, skilled and experienced for an alliance to develop (Bachelor, 1995; Levitt, *et al.*, 2016; Palmstierna and Werbart, 2013; Mallinckrodt and Nelson, 1991). For clients, gaining this sense of

their therapist's competence and skill enables them to feel validated, reassured, supported, and safe (e.g. Bedi and Duff, 2014; Duff and Bedi, 2010; Timulak, 2007).

While some theorists have found that therapists do not necessarily improve with greater experience (e.g. Goldberg *et al.*, 2016; Tracey, Wampold, Lichtenberg, and Goodyear, 2014) others have highlighted that training and experience facilitate the establishment and maintenance of a therapeutic alliance as well as helping trainees to develop the vital skills required for psychotherapy to be successful (Hill et al., 2016; Hill et al., 2015). There is also some evidence that therapists who allow for professional self-doubt (acknowledging difficulties in their practice and not having over-exaggerated self-confidence) and engage in deliberative practice (such as preparing for sessions and attending extra training) can improve outcomes (Chow *et al.* 2015; Hill and Castonguay, 2017; Nissen-Lie *et al.*, 2015).

Therapist techniques have also been linked to the development of the alliance, with communication, accurate interpretation, exploration, understanding, and empathy, as well as working at relational depth, being key components for developing a therapeutic alliance (Ackerman and Hilsenroth, 2003; Elliot, Bohart, Watson and Murphy, 2018; Hilsenroth, Cromer and Ackerman, 2012; Tryon, 1990). Lavik *et al.* (2018) also highlighted the significance of the therapist's capacity to instil hope at the start of therapy.

It makes sense that when therapists fail to demonstrate the qualities mentioned above, or present the opposite to clients, this may impede the development of a therapeutic alliance. Along these lines, therapists who are rigid, aloof, tense, uncertain, defensive, self-focused and critical have been shown to have a negative impact on the formation and maintenance of a therapeutic alliance (Ackerman and Hilsenroth, 2001; Eaton, Abeles and Gutfreund, 1993; Hilsenroth, Cromer and Ackerman, 2012; Horvath, 2001). Communication difficulties and a client's sense that their therapist doesn't understand them, or is making assumptions about them, can also undermine the formation of a strong alliance (Lavik *et al.*, 2018). In addition, a therapist's failure to develop a

therapeutic frame, inappropriate use of self-disclosure, confrontations, and negative processes may negatively impact the alliance (Ackerman and Hilsenroth, 2001; Norcross and Wampold, 2011; Pinto-Coelho, Hill and Kivlighan, 2016).

Wolf, Goldfried and Muran (2017) highlight the damage that negative therapist reactions can have on their relationships with their clients, suggesting that "the therapist's experience of negative reactions to his or her clients represents a serious, perhaps the most serious, source of interference of [any interventions intended to alleviate psychological pain]" (p. 207). They suggest that self-awareness, affect regulation, and reframing (transforming states into more compassionate responses), can all be used to combat these negative reactions and allow therapists to use their responses to their clients in the service of the client. Another way to frame this is through considering the therapist's presence during sessions (Geller and Greenberg, 2002; Geller, Greenberg and Watson, 2010; Hayes and Vinca, 2017) – research has shown that effective therapists are able to be "self-aware, without becoming self-absorbed" (i.e. to attend to and manage their own process during sessions) and to be "attuned to clients without identifying with them" (Hayes and Vinca, 2017, p. 115). The converse is also true - when therapists are unable to be present for enough of the session (for example, due to being unable to manage their countertransference to a client; Hayes, Gelso and Hummel, 2012), their understanding of the client will necessarily be limited, and clients will experience the therapy as less effective (Hayes and Vinca, 2017).

Overall, it is clear that therapists make a significant contribution to the development of a therapeutic alliance. Within this, characteristics of the person of the therapist and the therapist as a professional both have an impact on the alliance and, by extension, the process of engagement in therapy. As many of the variables mentioned in this section are interrelated, an in interesting outcome of this research will be to see which variables are emphasised by the participants of the study, specifically in relation to initial engagement in therapy.

2.3.3 Client variables

In addition to therapist factors, the importance of the client within the therapy process has been recognised since the beginnings of modern psychotherapy. Rogers (1957) believed that it was the client's experience of positive regard, genuineness or empathy that mattered, and the therapist's belief about whether or not they had been demonstrating these qualities was irrelevant to outcome. This has been supported in several analyses, which have found that it is the client's experience of positive regard that matters rather than the therapist's belief about whether or not they hold the client in positive regard (e.g. Lo Coco, Cullo, Prestano, and Gelso, 2011), and broadly highlights the importance of the client's perception of the therapeutic relationship to engagement in therapy and outcome.

Alongside the importance of the client's perception of the therapy relationship, there is wide recognition of the impact of a range of client factors on the development of the therapeutic alliance and psychotherapy outcome (Bohart and Wade, 2013), and the client's contribution to outcome has been found to be greater than that of either the treatment method or the relationship (Lambert, 2013; Norcross and Lambert, 2019; Orlinsky, Rønnestadt, and Willutski, 2004; Wampold and Imel, 2015). Much recent research has focussed on clients' interpersonal patterns and coping styles and, in general, the severity of a client's problems and their capacity to relate to others will impact the development of the therapeutic alliance and outcome (Bohart and Wade, 2013). Accordingly, clients who are capable of forming and maintaining strong healthy relationships with others are better able to create a strong alliance early in the treatment (Clarkin and Levy, 2004; Zilcha-Mano and Errázuriz, 2017), while clients who find it difficult to form and maintain good relationships with others may also have difficulty building an alliance with their therapist (e.g. Bernecker, Levy, and Ellison, 2014; Zilcha-Mano and Errázuriz, 2017). Along these lines, clients' problem severity and type of impairments (such as personality disorders), and quality of object relations or attachments have been shown to impact the therapeutic alliance (e.g. Bernecker *et al.*, 2014; Coyne,

Constantino, Ravitz, and McBride, 2018; Levy, Kivity, Johnson and Gooch, 2018; Flückiger *et al.*, 2013; Forster, Berthollier, and Rawlinson, 2014; Mallinckrodt and Jeong, 2015).

Additional factors such as client motivation and readiness for change (Norcross, Krebs, and Prochaska, 2011) and pre-treatment expectations (Barber *et al.*, 2014; Coyne, Constantino and Muir, 2019) have also been linked to therapeutic process and change, suggesting that clients need to be in the right psychological space before starting therapy in order to engage.

Apart from the specific findings relating to client characteristics, it is generally acknowledged that therapists' behaviour will be influenced by their experiences of their clients and vice versa. Some clients may be more easily liked than others, while others may naturally elicit a less positive response (see Farber, Suzuki, and Lynch, 2019). In addition, it is possible that initial positive feelings between a client and their therapist might encourage behaviour that generates more positive feelings and a deeper relationship in an upward spiral (described by Fitzpatrick and colleagues as a 'positive exploration spiral'), or that the opposite might occur (that an initial negative impression may lead to interactions that reinforce this negative impression) (Fitzpatrick, Janzen, Chamodraka and Park, 2006).

In sum, from the research to date it is clear that client factors have a significant impact on their capacity to engage with their therapists, including their feelings before they start, and their individual ability to form relationships. Additional client factors can also be found in the literature on premature terminations and are summarised in section 2.4.3.1. In the current study, client participants will have engaged better with one therapist than another, which may mean that some of these client factors are less relevant (for example, if a client's personal characteristics make it less likely that they will be able to engage, then this should be the same for both therapists that they see, which is not the case for the participants of this study). However, it is possible that some client variables (e.g. readiness for change) may have changed between one therapist and another,

or that therapist variables interact with client variables in a way that impacts engagement. I will explore these interpersonal effects below.

2.3.4 Responsiveness and interpersonal variables

2.3.4.1 Similarity and difference

In addition to therapist and client individual effects on the therapeutic relationship, an area in which client and therapist characteristics come together is in the similarity and difference between a client and their therapist. In his work on issues of social difference John Burnham, together with Alison Roper-Hall, developed the mnemonic “GGRRAAACCEEESSS” as a way to consider the areas in which social identities and relationships may be understood (Burnham, 2012). “GGRRAAACCEEESSS” stands for gender, geography, race, religion, age, ability, appearance, class, culture, ethnicity, education, employment, sexuality, sexual orientation, and spirituality. Within the therapy room issues of similarity and difference across each of these domains may be visible and voiced, visible and unvoiced, invisible and voiced, or invisible and unvoiced (Burnham, 2012). For the purposes of the current study, similarity or difference across one or several of these domains may have an impact on initial engagement.

Within the psychotherapy research literature, Vera, Speight, Mildner, and Carlson (1999) conducted a study exploring clients’ perceptions of similarities to and differences from their counsellors within established therapeutic relationships. They found that clients focussed on similarity of personality traits (such as agreeableness and conscientiousness) over demographics or personal attributes, and that these similarities were seen as having a positive impact on the therapeutic relationship. With respect to differences, clients highlighted demographic characteristics with equal frequency to personality traits, but personality differences were more likely to be seen as having a good effect on the relationship. This finding is supported by Beutler’s (1986) study in which he suggested that the most effective therapy occurs where the client feels that they have enough in common with their therapist to feel understood and validated (similarity in

their belief systems), yet experiences enough attitudinal difference to be invited to challenge their frame of reference.

The complexities of similarity and difference between client and therapist are also reflected within the literature on matching clients and therapists. Extensive research has examined the influence of client-therapist cultural, ethnic, or racial match on therapeutic outcomes, but reviews have not shown consistent effects across studies (e.g. Cabral and Smith. 2011). A difficulty when trying to match clients and therapists along these lines lies in the fact that there is considerable variation within cultures, and clients who share similarities in terms of race, ethnicity, or culture with their therapists may hold very dissimilar values and beliefs (Ertl, Mann-Saumier, Martin, Graves & Altarriba, 2019). This complexity is addressed within intersectionality theory, which suggests that we can only understand individuals' experiences as a result of multiple simultaneous, intersecting and interconnected identities (Cole 2009). Whereas previous research has tended to focus on specific isolated identities (for example, gender or race), taking an intersectional approach would change what we consider to be a match between client and therapist. As an alternative to focussing on matching, some researchers have highlighted the importance of enhancing therapist multicultural competence (Divac and Heaphy, 2005; Ertl *et al.*, 2019) and there is evidence that multicultural competence is critical to therapeutic outcomes (Chu, Leino, Pflum & Sue, 2016). This involves the therapist having an understanding of their client's cultural group and history, an awareness of their own beliefs and biases, and sufficient skills to work in a culturally sensitive way (Sue, Arredondo, & McDavis, 1992), as well an emotional understanding of the dynamics of power and an awareness of the shifting positions we occupy (Chu, *et al.*, 2016; Divac and Heaphy, 2005).

2.3.4.2 Responsiveness

At a broader level, therapists also adjust their behaviour according to their clients' evolving characteristics and requirements. This has been described as "responsiveness" and is defined as "therapist behaviour being influenced by emerging context" (Kramer and Stiles, 2015 p. 279). Responsiveness is integral to all interpersonal communication, as each person in an interaction continually adjusts their responses to the other (Stiles and Horvath, 2017). In the context of therapy, Stiles and colleagues (1998, 2009, 2013) have coined the term 'appropriate responsiveness' to denote responsiveness that involves practitioners optimising their interventions by adjusting to circumstances in a way that benefits the client. As Hatcher (2015) puts it, "appropriate responsiveness involves knowing what to do and when to do it" (p. 23).

The need to adapt psychotherapy to fit the individual client has been recognized from the beginnings of modern psychotherapy (see Norcross and Wampold, 2019). Historically, much of the empirical research has focussed on matching clients to specific treatments (e.g. see Nathan and Gorman, 2015), but over the past 20 years there has been increasing interest in researching effective adaptations to transdiagnostic client variables (Norcross and Wampold, 2019). The accumulating research demonstrates the positive impact of tailoring psychotherapy to the individual client, and that "different types of clients require different treatments and relationships" (Norcross and Wampold, 2011, p. 131).

In their latest volume on this topic, Norcross and Wampold (2019) have gathered the most recent evidence on specific elements of therapist responsiveness. They highlight that generally research supports therapists adopting a complementary style of interaction with their clients - high levels of complementarity have been linked to the development of a positive alliance, while negative complementarity has been related to difficulties in developing an alliance (Henry and Strupp, 1994; Horvath and Bedi, 2002; Norcross and Wampold, 2019). For example, in a recent study exploring the interaction between therapist activities and client interpersonal patterns, von der Lippe, Oddli

and Halvorsen (2018) found that therapists who were able to complement their client's style (for example, by actively fostering client agency with clients who displayed strong unassertiveness) achieved better outcomes. At other times, research favours therapists adjusting their style (where possible) to meet the preferences of their clients (for example, by adopting a more challenging style for clients who express a preference for confrontation) (Swift, Callahan, Cooper, and Parkin, 2019).

The evidence on what forms of responsiveness can be effective for clients also gives us an insight into what does not work in therapy. Norcross and Wampold (2019) highlight that psychotherapists should be adapting to their clients, not the reverse (clients adapting to their therapists), and that these adaptations should not be limited to one domain (such as culture) as many adaptations succeed. They also warn against therapists imposing their own cultural beliefs on the client and highlight how cultural sensitivity can improve engagement and outcome. Finally, they note that therapists need to balance their responsiveness to their client (and flexibility in their approach) with allegiance to their therapeutic model for therapy to be optimally effective.

While each of the areas that Norcross and Wampold (2019) highlight present a valuable research-informed view on how therapists can focus their responsiveness, these can be considered "tools of responsiveness" rather than responsiveness in itself (Hatcher, 2015, p.10). Indeed, Hatcher (2015) points out that "responsiveness itself is knowing whether, how, and how much to use these and other tools to move the therapy toward an optimal outcome" (p.10) and, as such, responsiveness could be thought of in a more global way, as a skill that therapists employ within their work.

At this more global level, Elkin *et al.* (2014) focussed specifically on initial client engagement and studied the impact of therapist responsiveness using a construct of responsiveness that they had developed themselves. This construct included many of the therapist in-session variables that have already been mentioned in this review (such as the therapist being warm towards the client, see section 2.3.2), indicating that a key aspect of responsiveness is the therapist tailoring

facilitative interventions to fit the client as they present. They found that a ‘positive therapeutic atmosphere’ (which included care, respect, a compatible level of discourse, and appropriate emotional intensity) was the most important aspect of responsiveness that impacted early engagement in therapy, and that negative therapist behaviours (such the therapist disrupting the client’s flow, giving the client lectures, and being judgemental) predicted premature termination of therapy.

2.3.4.3 Collaboration

In addition, a defining aspect of the therapeutic alliance, and one that has been the focus of much recent research, is collaboration between the client and therapist (Hatcher and Barends, 2006). Key to collaboration is a process of accommodating clients’ preferences and sharing treatment decisions (Spencer, Goode, Penix, Trusty and Swift, 2019), and several meta analyses suggest that this can lead to improved satisfaction with treatment, fewer drop-outs and better outcomes (Lindhiem, Bennett, Trentacosta, and McLear, 2014; Swift, *et al.*, 2019; Tryon, Birch and Verkuilen, 2018). Alongside the specifics of listening to clients’ preferences and sharing decisions, collaboration could be considered part of a more global stance that the therapist takes within the therapeutic relationship in which the client is treated as an equal to the therapist, and client and therapist are actively working together during the therapeutic process (Levitt, *et al*, 2016).

The importance of adapting treatment to the individual client makes intuitive sense and almost every therapist will endorse adjusting their therapeutic approach to suit their client. Over the past couple of decades this has received increasing empirical support, and clinicians can be guided by the research on specific areas of adaptation which have been shown to be most effective, as well as the evidence that a globally responsive atmosphere is important within the therapeutic process. The current research will likely shed light on the aspects of responsiveness that are key to the initial engagement process, as well as the areas in which therapists were, and were not, able to be optimally responsive to their clients.

2.3.5 The contextual model

Rather than looking individually at therapist, client and interpersonal effects on the therapeutic relationship, Wampold and colleagues have proposed a 'contextual model' that draws all of these together to explain how clients benefit from psychotherapy (Wampold and Budge, 2012; Wampold and Imel, 2015; Wampold and Ulvenes, 2019). They suggest that the first step for a client to benefit from therapy is the formation of an initial bond. This involves a combination of bottom-up and top-down processing – the bottom-up processing that they describe is driven by the rapid impression that clients will make about their therapist when they first meet (see also section 2.7), while the top-down processing is based on the expectations, prior experiences, and hopes or beliefs that clients bring to the therapy before they start. After the bond is formed Wampold and colleagues (2012, 2015, 2019) suggest three pathways through which change can occur. In the first of these the therapist and client create a 'real relationship' (Gelso, 2009). The next pathway represents clients developing the expectation that through participating in therapy they will experience positive change. Wampold and Ulvenes (2019) link this to the literature on the therapeutic alliance and collaboration between client and therapist. The third pathway involves change that is a result of the client and therapist carrying out treatment actions (the 'specific ingredients' of therapy).

In the contextual model, once an initial bond is created any of the three pathways can lead to therapeutic change, although the combination of all three may be most effective (Wampold and Imel, 2015). As the current study is looking into initial engagement in therapy, the formation of an initial bond is likely to be paramount, and it will be interesting to see which of the pathways of the contextual model are emphasised by participants.

2.3.6 Relevance to this study

A wide range of research has been conducted that looks into the phenomenon of the therapeutic alliance and client, therapist and interpersonal variables have all been shown to have an impact on

the development of an alliance. As the alliance broadly encompasses the elements that relate to initial engagement of clients, all of the factors mentioned above may be important in a client's decision to request a new therapist rather than terminate therapy, and their capacity to engage with that new therapist. A key area within the literature is the interaction between the therapist and client and the therapist's capacity to be responsive to their client. As the current study explores the perspectives of the same client with two different therapists this may shed light on this process.

2.4 Engagement through the lens of premature termination

The phenomenon of premature termination has been clearly linked with poor engagement in therapy and a weak therapeutic alliance. It has detrimental effects on clients, therapists, and psychotherapy services and Swift, Spencer and Goode (2018) describe it as "one of the most significant impediments to the effectiveness of psychotherapy" (p.669). As a result, some authors have argued that prevention of premature termination should be "the most fundamental consideration of clinicians who provide psychotherapy" (Ogrodniczuk *et al.*, 2005, p. 58).

In this section I will describe different approaches to understanding premature termination, its prevalence and impact. I will then summarise the literature to date on predictors of premature termination and strategies for reducing its occurrence. I will conclude with my reflections on the relevance of this research to the current study.

2.4.1 What is premature termination?

Within the research literature and across psychotherapy services the terms 'premature termination', 'premature discontinuation', 'unilateral termination' and 'drop-out' are used interchangeably. Studies also employ different measures to determine premature termination which can lead to inconsistency and confusion. In many studies, a client's failure to attend a specific number of sessions is a criterion for classifying them as having terminated therapy

prematurely. However, different cut-offs are used resulting in inconsistent classification of episodes of premature termination and continuation across studies, and this criterion also leads to some clients being considered to have prematurely terminated when they may have ended therapy appropriately (i.e. they may have achieved their goals; Kivlighan, Egan, Pickett and Goldberg, 2018; Lampropoulos, 2010; Pekarik, 1992).

An alternative approach is to attend to whether clients terminate without consultation with their therapist, rather than basing the decision on mutual collaboration with their therapist (Westmacott *et al.*, 2010; Wierzbiki and Pekarik, 1993). In this approach, and the one used for the current study, a client is thought to prematurely terminate when they start therapy but unilaterally decide to discontinue prior to recovering from their problems (Swift and Greenberg, 2012).

2.4.2 Prevalence and impact of premature termination

Reported rates of premature termination from psychotherapy are typically high. In a review of 669 studies, Swift and Greenberg (2012) reported an average rate of 19.7%, with the highest rates (30.4%) being found within a training clinic environment. A subsequent study reported a rate of 69.4% within psychology training clinics (Callahan *et al.* 2014). At its best this suggests that one in five clients are terminating therapy prematurely, constituting a major issue for psychotherapy providers. It leads to increased costs due to extra administration time, the expense of wasted sessions, and the fact that many premature terminators tend to over-utilize psychotherapy services (Barrett, *et al.*, 2008; Ogrodniczuk *et al.*, 2005; Reis and Brown, 1999).

Premature termination is also detrimental to both clients and therapists. For clients, studies have shown that those who attend only one or two sessions tend to become worse or more symptomatic (depending on the measure) than those attending more sessions and may not have recovered from their difficulties (Cahill *et al.*, 2003; Pekarik, 1992; Reis and Brown, 1999). Clients who drop out also report feeling less satisfied with treatment and their therapist (Björk, Björck, Clinton, Sohlberg, and Norring, 2009; Knox, Adrians, Everson, Hess, Hill, and Crook-Lyon, 2011).

For therapists, having clients terminate without warning can impair the therapist's self-confidence and effectiveness (Ogrodniczuk, Joyce and Piper, 2005; Piselli, Halgin, and MacEwan, 2011; Sledge, Moras, Hartley, and Levine, 1990) and create feelings of guilt about not being able to help (Garfield, 1995; Piselli *et al.*, 2011).

2.4.3 Predictors of premature termination

As premature termination is such a widespread phenomenon, much research has been conducted to elucidate its possible causes and find ways to reduce its occurrence. A number of reviews and meta-analyses have been undertaken but these have produced few consistent results (e.g., Barrett *et al.*, 2008; Reis and Brown, 1999; Swift and Greenberg, 2012). Studies have broadly explored client, therapist and interpersonal variables, as well as looking into the phenomenon from client and therapists' perspectives.

2.4.3.1 Client variables

Many client demographic and clinical variables have been examined, but with inconclusive results. Client gender, age, social stability, diagnosis, symptom level, presenting problem and amount of previous therapy have been found to be related to premature termination in some studies, unrelated in others, or contradicting results have been found (e.g. Baekland and Lundwall, 1975; Garfield, 1995; Reis and Brown, 1999; Swift and Greenberg, 2012). For example, Swift and Greenberg (2012) found that younger clients are more likely to prematurely terminate from therapy (but noted this was a small effect size), Rubin, Dolev and Zilcha-Mano (2016) found the opposite, that older clients are more likely to terminate (however this study was based within a student population), and Al-Jabari, Murrell, Callahan, Cox and Lester (2018) found no significant association between age and premature termination.

More conclusive results have been found for counselling readiness and psychological mindedness, with higher levels predicting continuation and lower levels relating to premature

termination (Piper *et al.*, 1999; Rubin *et al.*, 2016). Other client traits that are reliably associated with premature termination include low frustration tolerance, poor motivation, and poor introspection abilities (see Reis and Brown, 1999). In addition, premature termination has been consistently associated with socioeconomic disadvantage and non-White ethnicity (Wierzbicki and Pekarik, 1993; Williams, Ketring, and Salts, 2005), but this was not supported in Swift and Greenberg's (2012) meta-analysis.

2.4.3.2 Therapist variables

Studies examining therapist variables that impact client attrition also tend to show inconsistent effects (Anderson, 2018). Therapist age, gender, ethnicity and theoretical orientation cannot be consistently linked with premature termination (Wampold, Baldwin, Grosse, and Imel, 2017). One more consistent finding is that therapists with less experience and/or training are likely to have more clients who prematurely terminate (Goldberg *et al.*, 2016; Reis and Brown, 1999; Swift and Greenberg, 2012). This may be particularly relevant in the current study as the therapist-participants will all be trainee therapists (please see section 2.5 below for a consideration of engagement with trainee therapists).

2.4.3.3 Interpersonal variables

Studies investigating the impact of interpersonal variables on the occurrence of premature termination have thrown up the most consistent results, leading to some theorists recommending that the best thing to study is relational nature of therapeutic process (Corning *et al.*, 2007).

A reliable predictor of premature termination is client and therapist agreement on the nature and severity of the presenting problem - when there is greater agreement, clients are less likely to end therapy prematurely (Corning *et al.*, 2007). Clients' expectations of therapy (e.g. its effectiveness, what will happen during the sessions, and the duration of treatment) have also been linked to premature endings, with higher incidence of termination when their expectations are not met

(Aubuchon-Endsley and Callahan, 2009; Callahan, Aubuchon-Endsley, Borja & Swift, 2009; Callahan *et al.*, 2014; Greenberg, Constantino and Bruce, 2006).

Another interpersonal aspect can be seen in the area of difference and diversity. Williams, Ketring and Salts (2005) found that interactions of client income and ethnicity and therapist gender and ethnicity were the most useful demographic data indicators of premature termination, and other studies have linked ethnic match and client retention (e.g. Presley and Day, 2019). However, as discussed in section 2.3.4.1, exploring client-therapist match based on one or two variables (e.g. ethnicity and gender) can be problematic as it doesn't take the intersectionality of experience into account.

A plethora of studies have also highlighted the importance of the quality of the therapeutic alliance in predicting treatment outcome (e.g. O'Keeffe *et al.*, 2018). In the first meta-analysis to examine therapeutic alliance as a predictor of dropout, Sharf, Primavera and Diener (2010) found a moderately strong relationship between dropout and the therapeutic alliance, in which clients with weaker alliances were more likely to drop out of therapy. This finding has been replicated across multiple settings (e.g. Westmacott *et al.*, 2010; Kegel and Flückiger, 2015) and theoretical orientations (e.g. Jordan *et al.*, 2017; Saatsi, Hardy and Cahill, 2007). It is clear that the quality of the alliance impacts the type of ending in therapy (e.g. Westmacott *et al.*, 2010), and Ogrodniczuk *et al.* (2005) comment that "it is becoming increasingly clear that a strong therapeutic alliance is critical not only for facilitating a positive outcome, but also for keeping the patient engaged in treatment" (p.67).

2.4.3.4 Client perspectives on why they terminated therapy

Given that it is clients who choose whether or not to drop out of therapy, exploring clients' perspectives on why they terminated therapy is invaluable. From the research that has been conducted, clients self-reported reasons for terminating therapy fall broadly into three categories: (1) satisfaction with the progress they have made, (2) circumstantial barriers (for example

scheduling conflicts), and (3) therapist or therapy-centred reasons such as dissatisfaction with the progress made, perceptions of therapist incompetence or dislike of therapist or therapy (e.g. Hunsley, Aubry, Vestervelt, and Vito, 1999; Pekarik, 1992; Roe, Dekel, Harel, and Fennig, 2006; Westmacott, 2010; Westmacott, 2011). In the present study the 'therapist or therapy-centred reasons' will be most relevant as the selection criteria for client participants will exclude clients who transferred due to circumstantial reasons or because they were satisfied with their progress.

Across studies the percentage of clients choosing to end due to dissatisfaction with the therapy or therapist ranges from 8% (Todd, Deane and Bragdon, 2003) to 46.7% (Bados, Balaguer, & Saldaña, 2007). Roe *et al.* (1999) found that clients ended when they felt like they were not being helped (or even actively harmed) by the therapy, when there was a lack of chemistry with their therapist, or if they felt like their therapist was unprofessional or disliked them. Similarly, Westmacott *et al.* (2010) noted that clients who prematurely terminated were likely to report feeling that therapy was going nowhere and a lack of confidence in their therapist's ability to help.

2.4.3.5 Therapist perspectives on why clients terminate therapy

Interestingly, while there is some correspondence between client and therapist reported reasons for premature termination based on client satisfaction and circumstantial barriers, 'therapist or therapy-centred reasons' are generally not identified by therapists (Todd, 2003). Westmacott and Hunsley (2017) described therapists attributing termination to client issues (such as insufficient motivation) rather than attending to problems within the process of therapy, and other findings suggest that therapists consistently underestimate their clients' negative perceptions of both therapy and themselves, as well as underestimating the proportion of premature terminators in their practices (Pekarik and Finney-Owen, 1987; Pulford, Adams, and Sheridan, 2008). This may mean that therapists are missing signals that would alert them to problems in the therapeutic relationship that could be addressed.

2.4.4 Reducing premature termination / increasing therapeutic engagement

Given the impact and prevalence of premature termination, it is unsurprising that many studies have looked into how premature termination can be reduced. Ogrodniczuk *et al.* (2005) reviewed 39 studies conducted between 1970 and 2004 in an attempt to draw together the research that had been undertaken. They suggest that pre-therapy preparation (to educate clients about the process of therapy), screening clients for the therapy/therapist that is best suited to them, and offering clients short term contracts might reduce the occurrence of premature termination. In addition, they highlight the significance of treatment negotiation (working with the client to negotiate the problem to be worked on, the length of treatment etc) and motivating clients (increasing their willingness to enter into, continue, and adhere to a specific change strategy; Ogrodniczuk *et al.*, 2005). These findings have been supported in subsequent reviews, which also highlight the importance of strengthening hope, increasing client motivation for treatment, facilitating the therapeutic alliance, and systematic monitoring of client progress (e.g. Barrett *et al.*, 2008; Swift and Greenberg, 2015).

In addition, Swift, Greenberg, Whipple and Komina (2012) suggest that premature termination can be understood as a costs-benefits analysis on the part of the client: If the perceived benefits (such as hope for change) outweigh the costs (such as the emotional challenge of opening up) then the client is unlikely to prematurely terminate. Following on from this, Swift and Greenberg (2015) recommend that therapists employ strategies to increase clients' perception and anticipation of the benefits of therapy, and minimise the costs, in an effort to reduce the incidence of premature termination.

Interestingly, a study by Westmacott and Hunsley (2017) exploring psychologists' perspectives on premature termination and their use of engagement strategies found that therapists routinely use some, but not all, engagement strategies. They echo Swift and Greenberg's (2015)

recommendation that therapists should consider implementing engagement strategies that fit with their practices.

2.4.5 Relevance to this study

From the literature on premature termination it is clear that the phenomenon of premature termination is complex and its predictors are difficult to measure. Indeed, Corning *et al.* (2007) comment that “despite decades of studies aimed at identifying the factors that influence premature termination, almost no predictors have emerged conclusively from this literature” (p. 193).

It is interesting that despite consistently inconclusive results, demographic variables have been heavily researched as predictors of premature termination, perhaps due to the ease with which they can be accessed. However, as Anderson *et al.* (2018) point out, while this has been helpful in understanding some of the characteristics that may lead to early dropout, many of the variables that are frequently used to predict dropout are not amenable to a therapist’s intervention and the research does not address the mechanism by which these variables lead to client attrition. They recommend an increased focus on the complex interpersonal mechanisms that lead to dropout.

Indeed, one of the few clear predictors of premature termination is the quality of the therapeutic alliance and, alongside this, a wide range of elements have been highlighted that may impact the likelihood that a client will prematurely terminate therapy. For the purposes of this study the presence, or lack, of these elements could be a factor that influences the client’s decision to terminate therapy or request a different therapist.

2.5 Engagement in therapy with trainee therapists

As the therapist-participants in the current study will be trainees, the literature that explores engagement specifically with trainee therapists may be relevant. Research within this area indicates that trainees face specific challenges when starting to work with clients. For example,

trainees often have to contend with overwhelming emotions and anxieties, and experience difficulties with identification and regulation of emotional states (Rønnestad, Orlinsky, Schröder, Skovholt, & Willutzki, 2019; Skovholt and Rønnestad, 2003). Trainees can also find it difficult to negotiate the boundaries between their personal and professional roles (Hill, Sullivan, Knox & Scholler, 2007), may have problems managing boundaries with their clients (Hill and Knox, 2009), a lack of insight into ruptures in the therapeutic alliance (Safran, Muran, Samstag, & Stevens, 2001), and difficulties processing and making use of emotional states in treatment (Melton, Nofzinger-Collins, Wynne & Susman, 2005).

With greater experience, research shows that trainees' anxiety levels decrease and they demonstrate an increase in self-efficacy, therapeutic skill, and countertransference management (Lent, Hill, and Hoffman, 2003; Williams, Judge, Hill, and Hoffman, 1997). In their review of the empirical literature on training and supervision, Hill and Knox (2013) describe how beginning trainees learn to implement helping skills (such as reflecting feelings, offering interpretations and using exploratory interventions) and minimise undesired behaviours (such as giving unsolicited advice and interrupting) while they are training.

Interestingly while studies demonstrate that trainee-therapists improve in effectiveness over the course of their training (Dyason, Shanley, Hawkins, Morrissey & Lambert, 2019; Hill *et al.*, 2015), there is also mixed evidence when it comes to outcomes. Research shows that some trainee therapists are as effective as registered therapists (e.g. Nyman, Nafziger, and Smith, 2010) and that trainee therapists vary in their ability to form a therapeutic relationship (Hill *et al.*, 2016, Hill and Castonguay, 2017). In addition, some studies have found no evidence that therapists on average improve over time (e.g. Goldberg *at al.*, 2016). This seems to indicate that there is considerable variation in outcomes between therapists that cannot be explained by experience alone (Okiishi *et al*., 2006; Goldberg *et al.*, 2016).

However, as noted earlier (p. 31), a consistent finding is that trainee therapists experience more premature terminations than more experienced therapists, which highlights the fact that clients are less likely to engage in therapy with trainees. In their meta-analysis exploring premature discontinuation of therapy, Swift and Greenberg (2012) suggest that this could be because experienced therapists are more responsive and better able to develop an initial therapeutic relationship than trainee therapists.

From the research outlined above it is clear that trainee therapists face specific challenges when starting to see clients, but that there is also variation in trainees' capacity to engage with their clients. For the purposes of this study this trainee-specific literature may shed light on the process of engagement or non-engagement between the participants.

2.6 Client transfers

Forced transfers of clients from one therapist to another are common in clinical practice, especially in settings where psychology students are being trained (Zimmermann *et al.*, 2019; Clark *et al.*, 2011/2014; Flowers and Booraem,1995). These transfers occur when therapists can no longer provide the necessary treatment or when therapists leave the clinic which necessitates the client being transferred to another therapist (this often happens in clinics who employ trainee therapists who then rotate into other placements).

Although a common occurrence, the forced transfer of clients is an overlooked stage of the therapeutic treatment process and there has been very little research into the phenomenon (Zimmermann *et al.*, 2019; Clark *et al.*, 2011/2014; Flowers and Booraem,1995). Of the research that has been conducted, several studies have examined what happens when circumstances arise that necessitate a client being transferred to a different therapist, and focus on the impact of transfers on clients, and the link between transfers and client attrition. There is almost no literature

that looks into transfers that have been driven by the client. However, in my search I found two quantitative studies that incorporated clients making a choice between therapists into their design (Alexander, Barber, Luborsky, Crits-Christoph, and Auerbach, 1993; Hollander-Goldfein, Fosshapairingee, and Bahr, 1989) as well two qualitative studies exploring clients' choice of therapist (May, 2018; Spalter, 2014).

In this section I will initially explore the impact of transfers on clients. This may give some insight into the decision made by clients to request to transfer. I will then outline the research on successful transfers versus client attrition. I continue by summarising the studies that focus on the client's choice of therapist. I will conclude with my reflections on the relevance of this research to the current study.

2.6.1 Impact of transfers on clients

Much of the research to date has looked into the negative impact of transfers on clients and studies have documented a range of negative effects such as feelings of abandonment, grief, loss, and increased anxiety (Clark *et al.*, 2014; Bostik, Shadid, and Blotcky, 1996), along with depression and pain, and some clients may experience a reoccurrence or worsening of their symptoms (Bostik, Shadid, and Blotcky, 1996). This can lead to withdrawal from the therapy process (Penn, 1990), missed appointments, and dropping out of therapy (Gardner, Hurt, Maltman, Greenberg, and Holtzman, 1985; O'Reilly, 1987). The cumulative evidence of a negative impact on clients has led to the assumption that the transfer process will be disruptive and potentially harmful (Clark *et al.*, 2011). In addition, when clients are transferred they have to start again with a new therapist which may be stressful and anxiety provoking. In a study exploring the impact of transfers on clients, Clark *et al.* (2014) noted that clients were concerned about not bonding with their next therapist and having to tell their story again. In addition, the broad literature on initial engagement in therapy speaks to what a challenging or uncomfortable process this can be (Vogel, Wester and Larson, 2007).

Although it is clear that therapy transfers can have a negative impact on clients, some studies counter the prevailing assumption that the transfer process will be disruptive. For example, although client anxiety is mentioned in the literature as a common response to being transferred (Clark *et al.*, 2014; Bostik, Shadid, and Blotcky, 1996), a study of pre-transfer clients found no difference in anxiety levels between transferring and non-transferring clients (Hutchinson, Uhl-Wagner, Robison, and Barrick, 1988). More recently Zimmerman *et al.* (2019) found that therapy transfers have no long-lasting negative effects on either symptom impairment or the therapeutic alliance, and Flowers and Booraem (1995) found no difference in general contentment or diagnostic outcomes between clients who were and were not transferred. This may suggest that any adverse effects of transfers on clients are temporary.

Other researchers have also suggested that transfers may have a positive impact on clients. A new therapist may have a fresh perspective and enthusiasm for the case (O'Reilly, 1987, *in* Williams and Winter, 2009), a new understanding of the client's problem or a better client-therapist match (Flowers and Booraem, 1995), or the transfer may present an opportunity for the client to re-experience and rework earlier object losses (Scher,1970, *in* Williams and Winter, 2009). Duncan, Miller and Sparks (2004) even suggest that if the client experiences relatively few therapeutic gains during the initial therapy sessions, they may actually benefit from a transfer to a new therapist who may be able to offer a more effective approach. Caplan (2014) adds to the discussion, suggesting that transfers can be advantageous when handled well, in that the new therapist inherits a disruption, the repair of which can lead to a stronger therapeutic alliance.

Taken one step further, some researchers even suggest that clients should be transferred to ameliorate the possibility of their dropping out of therapy. Meier *et al.* (2006) highlighted the fact that clients who have weaker alliances with their therapists are more likely to terminate therapy. They speculate that for client therapist dyads with weak alliances, a client transfer to a new therapist might be indicated to give the client a better chance of developing a supportive alliance and thus remain in therapy. This may be particularly salient in the current study as participants will

be clients who have chosen to change therapist in the hope that they will develop a better, and more helpful, relationship with their next therapist than they experienced with their first.

2.6.2 Successful transfers and client attrition

Statistics from many psychotherapy services demonstrate a strong link between transfers and dropouts and, as highlighted in the previous section, this can be detrimental to clients, therapists and therapy services. Studies report dropout rates from 19.4% (Clark, 2011) to as high as 69% after a transfer (Tantam and Klerman, 1979; Wapner, Klein, Friedlander, and Andrasik, 1986). This may be because many clients find the process of starting again with a new therapist too daunting and choose to drop out rather than endure the stress of transferring (Clark *et al.,* 2014). These findings indicate that many clients don't remain in therapy following a transfer, and it is critical that we try to understand more about what goes on during this process to train clinicians to help prevent premature termination.

When looking into what can help create a successful transfer (i.e. client's not dropping out of therapy after the transfer) most studies found no difference in client variables (such as client and therapist gender, age and therapist's modality) between those who did and did not drop out following a transfer (e.g. Clark *et al.*, 2011; Zimmermann *et al.*, 2019). However, a recent study by Sauer, Richardson, Rice, and Roberts (2017) did find that male clients and clients with avoidant attachment styles may have an increase of symptoms following a transfer, and Zimmerman *et al.* (2019) highlighted that clients "bring their own ability to form a therapeutic alliance along, no matter who has previously treated them" (p. 142).

One replicated finding has been that clients who have experienced previous transfers (Clark, 2011) or who have had previous experiences of therapy (Wapner *et al.*, 1986; Zimmerman *et al.*, 2019) are more likely to transfer successfully. This may be because clients who have tolerated the distress of one transfer know that they can (Clark, 2011; Tryon, 1990) or that clients with prior therapy experience have faith that they can be helped by therapy.

Focussing on therapist variables that could facilitate a successful transfer, Clark *et al.* (2014) spoke about the importance of therapists managing their own affective responses, their professionalism and building trust with the client, and noted that successful transfer clients felt that their new therapists' competencies and effectiveness facilitated their ability to navigate their transfers. Clark *et al.* (2014) commented that once the transfer has taken place the new therapist faces the same task as the old therapist of establishing a therapeutic alliance. They also noted that in cases of successful transfers the process felt seamless for the clients, and clients were able to have a positive attitude and form a strong alliance with their new therapists.

2.6.3 Clients' choice of therapist

In my review of the literature I found two studies using quantitative methodologies that incorporated the option for clients to choose between therapists into their design. To determine what criteria clients would view as important when choosing a therapist, Alexander *et al.* (1993) gave participants the opportunity to have two sessions each with two different therapists before choosing the therapist that they would like to continue in therapy with. They found that clients chose therapists who they perceived as more helpful and more likable, providing support for the importance of the early development of a therapeutic alliance. They also found that the majority of clients chose to stay with their second therapist and speculate that this may be because people are "reluctant decision makers" (p. 144) - as long as their current therapist was good enough, clients wouldn't make the decision to change back to their previous therapist.

Another study conducted by Hollander-Goldfein *et al.* (1989) asked participants to interview three possible therapists and then make a choice between them, in order to explore what contributes to a client's choice of therapist. They found that the chosen therapists were rated as more likeable, competent and understanding, and possessing of traits and qualities that clients believed were important. In addition, the therapists who were chosen liked and had positive perceptions of the

clients who ultimately chose them, suggesting that within successful therapeutic dyads a mutual process of positive regard is operational.

Taking a different approach, Spalter (2014) used a qualitative methodology to explore how a client chooses their therapist. He developed a 3-stage model in which a client first gathers information and forms expectations prior to meeting a therapist, then upon meeting the therapist the client focusses on the quality of the relationship (as well as aspects of the therapy setting). The final phase involves the client continually assessing the quality of the relationship and balancing gains against costs as part of their decision about whether or not to remain in therapy. Key within this Spalter (2014) emphasised the relational processes underlying the client's choice of therapist and decision to remain in therapy. This was also supported in May's recent study (2018) in which she found that the therapist's ability to relate to the client was a key feature in the client's choice of therapist.

2.6.4 Relevance to this study

The literature suggests that transferring from one therapist to another has the potential to be a negative experience for clients and can result in anxiety and grief, an increase in symptoms, and drop-out from treatment. However, the transfer process may also be a positive experience for clients, particularly if their relationship with their first therapist was not strong.

Although the bulk of studies that have been conducted have examined the impact of forced transfers of clients between therapists, much of this research may be relevant. Even when transfers are not driven by the client, the client still has the option to drop out of therapy rather than follow through with the transfer. This was highlighted by Zimmermann *et al.* (2019) who studied forced transfers (due to therapist leaving service) and noted that the participants of their study were clients who chose to change therapist, and those who didn't take part dropped out of therapy. Generally the findings from the literature on transfers echo the emphasis on the importance of building a strong therapeutic relationship (and the factors involved in doing so)

found in the research on the therapeutic alliance and premature termination, which highlights that this is a key aspect of therapeutic engagement regardless of whether or not a transfer has taken place.

2.7 Forming initial impressions

When two people meet, they form instant impressions of each other based on what they can observe and unconscious processes between them. As the focus of the current study is on exploring initial engagement in therapy, it is likely that the initial impressions that clients and their therapists have of each other will have a lasting impact on their capacity to engage with each other, particularly in the heightened context of the therapy situation (Hill, 2005).

Upon meeting someone new, research shows that humans make a very rapid determination (in as little as 34 milliseconds) of whether a person is likeable, trustworthy and competent based on viewing their face (Holmes, 2016; Todorov, Olivola, Dotsch, and Mende-Siedlecki, 2015; Willis and Todorov, 2006). Wampold and Imel (2015) reference these immediate impressions, claiming that the formation of the initial bond between a client and their therapist is a combination of bottom-up and top-down processing – clients create an instant impression through their bottom-up processing, and integrate this with slower, more conscious, top-down processing. However, although these judgements can be powerful, they are influenced by a range of non-perceptual factors and are not necessarily accurate (Todorov *et al.*, 2015).

Another way that clients may form initial impressions of their therapists can be found within the neuropsychology literature in the writings of Dr Allan Schore on right-brain to right-brain implicit communication. He writes extensively about the clinical importance of this implicit communication in the healing therapeutic process and describes intuition as “a complex right brain primary process, an affectively charged embodied cognition that is adaptive for ‘implicit feeling or knowing,’

especially in moments of relational uncertainty" (Schore, 2011, p. 89). While Schore mainly focusses on the clinical use of intuition by therapists, it can be thought of as a two-way process, with both clients and therapists picking up an intuitive sense of each other. Indeed, the initial therapeutic encounter is certainly a 'moment of relational uncertainty', in which the use of right-brain to right-brain communication may be particularly salient.

In addition, there is evidence that clients draw on multiple other sources of information to develop an initial impression of their therapist. Wampold and Ulvenes (2019) state that "the psychotherapy context itself is critical" (p.72) and studies show that clients make rapid judgments about their therapists based on the therapist's appearance, the arrangement and decoration of the room, and impressions from the general setting of the sessions (Gelso *et al.*, 2018; Spalter, 2014; Wampold and Imel, 2015; Wampold and Ulvenes, 2019).

2.8 Conclusion

The research reviewed here demonstrates the complexity inherent within the process of engagement in therapy. The literature on the development of a therapeutic alliance helps us to understand how clients and therapists may engage in therapy, while the literature on premature termination allows us to explore this phenomenon from the perspective of non-engagement in therapy. Throughout the literature the domain of the therapeutic relationship appears to be paramount and many client, therapist, and interpersonal variables have been identified that may have an impact on engagement in therapy.

Within the literature there is a predominance of research using quantitative methods, which sit within positivist and post-positivist research paradigms (Ponterotto, 2005). These assume a fixed and measurable reality that can be characterised as a system of parts. While these can be valuable in that these studies can lead to strong conclusions and often causal inferences can be drawn from them (Yardley and Bishop, 2017), many have argued that human beings and their interactions cannot be reduced to measurables, and that quantitative approaches are ill-suited to understanding subjective experience and underlying meaning (e.g. Gordon, 2000; Guba and Lincoln, 1994). Qualitative approaches, by contrast, allow us to embrace the complexity inherent within human interactions (Gordon, 2000).

Within the field of psychotherapy there is broad acceptance that qualitative and quantitative approaches provide complementary perspectives (McLeod, 2011). In taking a qualitative approach, the current study adds to the growing body of qualitative research in the field, and harnesses the value of this type of study to gain an in-depth understanding of what clients and therapists view as most important to the process of initial engagement in therapy.

Chapter 3: Methodology

The aim of this research was to explore what contributes to engagement or non-engagement in therapy between a client and their therapist. To conduct this study, I interviewed clients and their first and second therapists about their experiences of initial engagement, and used reflexive thematic analysis situated within a constructivist epistemological framework to analyse the data.

In the following sections I first outline the thought processes that led to my choice of methodology. I then describe myself as a researcher, my consideration of the ethical issues involved, and the steps I took to ensure the quality of this study. I continue with a description of my research design, and a step-by-step account of how I proceeded with the analysis, before presenting my findings in the subsequent chapter.

3.1 Research paradigm

I consider reality and meaning to be constructed through interaction between ourselves and our environment and, as such, I situated this research within a constructivist paradigm. Rather than positing the existence of a single objective reality, this stance takes the view that there are multiple, co-constructed realities which are influenced by the context of the situation, the social environment and the interaction between myself as a researcher and my participants (Morrow, 2007; Ponterotto, 2005).

Consistent with my philosophical position, I felt that qualitative research was best suited to my research question (Ponterotto, 2005). Taking this stance embraces the complexity inherent within human interactions and challenges the dominant “uncritical quantitative approaches that reduce human beings to measurables” (Gordon, 2000, p. 8). While I believe that there is value in both quantitative and qualitative approaches to research within psychology, I agree with a criticism of

quantitative studies that in order to achieve internal validity the aspects of psychology that are studied are not representative of everyday practice or the complexity of human interactions (Guba and Lincoln, 1994). I feel that qualitative studies are better able to capture the more complex nuances of what happens between clients and their therapists.

At a personal level, rather than approaching reality as a set of concrete facts which are directly accessible for us to understand, I believe that our experience and understanding of every situation is co-created, and thus a research method which acknowledges the influence of the researcher on the data and outcome fit with my philosophical stance. This approach also aligns well with my professional model as an integral part of my therapeutic practice is the construction of meaning from the lived experience of my clients in interaction with myself as a therapist.

3.2 Choice of methodology

When choosing an appropriate methodology I initially considered using constructivist grounded theory (Charmaz, 2006) as it seemed to be a methodology well suited to both the complexity of my research topic and my epistemological stance (Wooley, Butler and Wampler, 2000). However, through consultation with colleagues and further reading I realised that I was running the risk of conducting what Braun and Clark (2006) describe as “grounded theory ‘lite’” rather than “‘full-fat’ grounded theory” (p.81) (which Braun and Clark believe is rarely used, even when a grounded theory method is claimed). In addition, the explicit focus of grounded theory is on theory generation and, while theory may have emerged during the process of analysis, the emphasis in the current project was on exploration of the phenomenon rather than theory generation.

I also considered various case study methodologies as the data I was collecting naturally fell into cases of clients and their two therapists (McLeod, 2010). However, as I was planning primarily to analyse the data across-case (i.e. looking for patterns relating to initial engagement in therapy

across the whole data set rather than specifically within each case), I did not feel that these methodologies were a good enough fit with my research aim.

Another methodology that I could have chosen was Interpretative Phenomenological Analysis (IPA) as, in line with my philosophical stance, this places participant experience at the centre of the analysis. However, at the time I felt that taking a phenomenological approach would not place sufficient emphasis on the impact of the researcher on the data and findings. Further reading has helped me to recognise that my understanding of phenomenology was limited to what Willig (2012) describes as “descriptive phenomenology”. Willig contrasts this with “interpretative phenomenology”, which involves the researcher’s interpretation of participant experience in terms of a wider (social, cultural, psychological) context, as well as allowing space for researcher reflexivity (Willig, 2012), and could have been a suitable methodology for this research.

During my consideration of different methodologies, it became clear to me that many approaches overlap and could be considered “variations on the same method” (Timulak and Elliott, 2018, p. 10). Elliott and Timulak (2005) highlight the fact that many ‘brand name’ descriptive-interpretative qualitative research methods share common elements. While using a ‘brand name’ approach (such as IPA) may afford the research the benefit of greater credibility with reviewers and readers, it does not mean that using a specific approach will have a distinct impact on findings when compared to other brands (Elliott and Timulak, 2005) and may lead to the loss of researcher flexibility and creativity that could bring a richer perspective to the subject of study. In addition, there is evidence of variation in the actual methods used by studies claiming to use the same methodology, and studies reporting different methodologies have been shown to sometimes share the same procedures (Levitt, Pomerville, Surace, & Grabowski, 2017).

In light of the above, I ultimately arrived at the decision that thematic analysis, situated within a constructivist paradigm, was most appropriate to my research - I felt that it was the most systematic and transparent way to analyse my data as it allowed me to ground my analysis within

my own epistemological frame, offered me the flexibility I needed for the complex design of my research, clear guidelines for the analysis of the data, and the capacity to provide a “rich and detailed, yet complex” account of my data (Braun and Clarke, 2006, p. 78). Thematic analysis is “a method for systematically identifying, organizing, and offering insight into patterns of meaning (themes) across a data set” (Braun and Clarke, 2012, p. 57). As an analytical method, rather than a methodology, thematic analysis is independent of theory and epistemology and, as such, it could be subject to the “anything goes” criticism of qualitative research (Antaki, Billig, Edwards, and Potter, 2002). To guard against this, Clarke and Braun (2018) emphasise that the researcher must explicitly choose the theories that inform their use of thematic analysis and demonstrate how these will be implemented.

Along these lines, since the publication of their seminal paper on thematic analysis in 2006, Braun and Clarke (2019) note that many studies citing their approach are actually doing something different, without any discussion or acknowledgement of the differences. To distinguish their approach from other approaches they have named it ‘reflexive thematic analysis’ and situate it within a fully qualitative paradigm. They place the researcher’s role in knowledge production at the heart of their approach, and emphasise the importance of deep reflection on, and engagement with, data (Braun and Clarke, 2019). In the current study, by embedding my analysis within a constructivist paradigm, and being transparent about my analytical choices and assumptions, I believe that my use of reflexive thematic analysis can be considered a rigorous and important method in its own right (McLeod, 2011).

In my role of researcher, I viewed myself as a co-constructor of meaning with my participants in the generation of data (Schwandt, 2003). Consistent with this, I chose to interview my participants (for data collection) which allowed for an in-depth exploration of the phenomenon under investigation. Similar to therapeutic interactions, during the process of interviewing participants I was able to gain an empathic felt sense of what it was like to be in the participants’ worlds, which

meant that my values and beliefs were affected by the worlds of my participants (Cutcliffe, 2003; Hutchinson and Wilson, 1994).

3.2.1 Reflexivity about methodology

The positioning of thematic analysis within a constructivist paradigm demanded that I recognise the impact that myself as the researcher and the experiences of my participants had on the outcome of the data. I cannot separate an objective reality from the research participant who is experiencing, processing, and labelling the reality and, equally, my interpretation of the data influenced the patterns I observed. This led me to take an inductive approach to analysing the data, relying as much as possible on my participants' views on engagement in therapy (Creswell, 2007) and seeing them as experts on their own experience.

Rather than expecting themes to 'emerge' from the data, I acknowledge my active role in developing themes through my engagement with the data. As such, any interpretations I made were subject to what Steinar Kvale describes as "perspectival subjectivity" in that a different researcher looking at the same data may arrive at different conclusions. Perspectival subjectivity can be viewed as adding "richness and strength" (Kvale, 1996, p. 212) and act as a thoughtful elaboration of meaning within a constructivist paradigm (while it may be considered 'poor interrater agreement' if viewed through a positivist frame).

In taking this stance I chose not to seek external consensus of my codes (i.e. looking for inter-rater reliability), as this would have assumed that there is an accurate reality in the data that can be captured through coding (Clarke and Braun, 2018). However, I did consult with colleagues and supervisors to sense-check my findings - to ensure that I was not simply imposing my own meanings on the themes I was developing, to check the internal consistency of my themes, and to consider alternative interpretations of the data. As another way to shift my perspectives on the outcomes of the research, I also offered my participants the opportunity to review my findings (Levitt, 2017).

3.3 Me as a researcher

As a researcher-practitioner, it was inevitable that my own biases, assumptions, personality and experiences would have an impact on the process of conducting this research and the findings that I developed (Shaw, 2010) and that my worldview and background will have impacted the lens through which I viewed the data and thus will have shaped the findings of the study (Berger, 2015). To attend to this, I saw the need for reflexivity and transparency at every stage of the process. As a goal of reflexivity is "to enhance the credibility of the findings by accounting for researcher values, beliefs, knowledge, and biases" (Cutcliffe, 2003, p. 137), I have outlined my personal characteristics that I believe may have impacted the research below.

I am a 37-year-old, British, White-Asian, middle-class woman, a UKCP registered Integrative Psychotherapist, and Counselling and Psychotherapy doctoral student. Although I have brown skin, I do not identify as brown or Indian and am not comfortable with being labelled as any specific ethnicity. This may have led to a level of 'colourblindness' in my professional work (see Hartmann, 2017) as I have noticed that I tend not to remember the colour of someone's skin, for example after I have conducted an assessment. This 'colourblindness' is something that I am actively addressing in my clinical work as it can lead to me missing important aspects of my clients' experience, and minimises my awareness of the impact of difference for my clients (Neville, Spanierman & Doan, 2006). Similarly, within this research my 'colourblindness' may mean that I am not as sensitive to any issues of diversity that come up in participant accounts as another researcher might be, which has the potential to impact the findings of this study.

My training and practice as an integrative psychotherapist will also have an impact on this research, as my understanding of therapeutic process is largely informed by pantheoretical models of therapy. As I'll be drawing on my own knowledge as I explore and develop themes from the data, it is likely that this pantheoretical perspective will be reflected in the findings and discussion of this study.

Another aspect that might have an impact on the process and findings of this research relates to my positioning in relation to the research. My first clinical placement was at MCPS and I am now employed by MCPS as a clinical assessor and clinical development officer. My main supervisor for this research is my boss in my employed work, as well as the head of the service at MCPS. The links between myself, my research, and the Metanoia Counselling and Psychotherapy Service placed me in a complex 'insider' position which will have had an impact on process and findings of the research (Berger, 2015; Evered and Louis, 1981).

For example, as I was exploring the perspectives of clients and therapists who were not able to engage with each other in therapy, it was possible that some of my findings would highlight issues with the way that the service was being run, creating a tension between my relationship with the service as an employee and as a researcher. There was also the possibility that boundaries would become blurred due to the multiple roles that I was occupying (Dickson-Swift, James, Kippen, and Liamputtong, 2006). For example, participants might reveal something to me as a researcher that I felt was important to act on in some way or feed back to the service as an employee (I have written about an example of this that arose during my research in Appendix 12). Throughout the process, I tried to attend to these complex dynamics and reflect on the way that they might be impacting the research, attempting to find the delicate balance between my role as a researcher and my responsibility to interact in a humane, non-exploitative way with my participants (Guillemin and Gillam, 2004).

Additional considerations connecting to my 'insider' position relate to the power dynamics between myself and my participants and are explored in my ethical considerations below (see 'the research relationship', p. 53).

3.4 Ethical considerations

Ethical approval for this project was obtained from the Metanoia Institute, the Metanoia Institute Counselling and Psychotherapy Service, and the University of Middlesex (Appendix 1). As an accredited psychotherapist, I abide by the Metanoia Institute's and UK Council for Psychotherapy's professional ethical guidelines and a personal ethical commitment that forms an integral part of my practice. I agree with Brinkmann and Kvale (2017) that ethical areas could be considered "fields of uncertainty" (p. 261) that cannot be settled once and for all, but rather require myself as a researcher to take an ongoing reflective stance with careful consideration of ethical issues throughout my project.

3.4.1 The research relationship

I was aware that the dynamic between me as a researcher and my participants created a "hierarchy of power and potential influence" (Haverkamp, 2005, p. 153) which I could seek to moderate through transparency and ongoing reflexivity, but which was also to some extent inescapable (McDermid, Peters, Jackson, and Daly, 2014). In my position as an accredited therapist, assessor at MCPS and employee of the Metanoia Institute, as well as my status as a doctoral researcher, I was aware of the power differential which would influence my research relationship with my participants. I had not assessed any of the client participants who took part in my research, but the therapist participants would all have had some contact with me in my role of Clinical Development Officer at the Metanoia Institute. To acknowledge and moderate the power dynamics I was transparent about the purpose of the research and my various roles in the information that I sent to participants, during the pre-interview consent process, and during the interviews themselves. Throughout the process I highlighted the collaborative, co-created, and non-judgemental nature of my research, and tried to encourage open communication with my participants (Karnieli-Miller, Strier, and Pessach, 2009).

As I carried out my research, I was also aware of different tensions – I had power as a researcher and was carrying out a project that would be of benefit to myself, while also believing that my project could be empowering to my participants and be beneficial to them as well as to the wider field. I had a desire to respect each individual and be faithful to the participant voices and was also mindful of the potential impact that the research could have on my participants, particularly where they heard the perspectives of other participants about themselves.

I was also aware that the context of MCPS, the semi-structured nature of the interview, and my experience as a therapist may have helped me to gain the trust of my participants and facilitate a sense of connection with them and engagement in my research. In this way, my 'insider' position may have facilitated "access to the 'field'" (Berger, 2015, p. 220) in that my participants may have been more willing to share their experience with me by experiencing me as sympathetic to their situation. Alongside this I was acutely aware of the need to be attentive to issues of power, influence, and coercion, and to ensure that I acted in a boundaried ethical way that did not breach what my participants had consented to.

Another complexity of my research design was that I would hear the perspectives of clients and therapists about each other, and also be privy to what had happened with the same client and two different therapists. This placed me in a position where I was the holder of knowledge about the cases I was exploring and I was aware that I needed to be sensitive to all of the parties involved while also ensuring that I accurately represented the phenomenon I was exploring (Dwyer and Buckle, 2009; Grafanaki, 1996).

3.4.2 Informed consent

I tried to make all written information and discussion about the research as clear and as comprehensive as possible to facilitate my participants' decision making. However, I was also aware that unforeseen issues may arise and risks cannot be fully predicted (McDermid *et al.*,

2014). On this basis informed consent was considered as an ongoing process rather than a one-off decision made by the participant.

Prior to meeting with each participant, I sent them a comprehensive information sheet about the research and a consent form to sign (see Appendices 2-5). When we met, I explored confidentiality, consent, and withdrawal procedures with each participant, as well as talking through the project, interview procedure, and my use of the findings. I made it clear to client participants that their participation (or choice not to participate) would not impact any future therapy that they received at MCPS, and that their personal details would be kept completely confidential. Similarly, I assured therapist participants that their participation (or choice not to participate) would not impact their training during their time at the Metanoia Institute, and that their personal details would be kept completely confidential.

All participants were informed that they could stop the research process and withdraw at any stage without penalty, and that there was a support system in place should any issues arise for them as a result of their participation. To facilitate the process of ongoing consent, I let participants know that I would offer them the opportunity to review a draft of my findings before my thesis was submitted to ensure that they were still willing to participate in the research.

3.4.3 Confidentiality

Particularly given the setting at the Metanoia Institute and the participants' potential for continuing involvement either with the service (as clients) or the institution (as students), the confidentiality of my participants was paramount. Confidentiality was an explicit item in the Information Sheet. Before interviewing participants, I explained to them that the only foreseeable reason for me to break confidentiality was my professional, ethical obligation of disclosing threatened harm to self or other. I also discussed with participants that the structure of the research necessitated a limit to confidentiality. As the findings would partly be presented case-by-case, participants would be able to recognise themselves and, by extension, they would also recognise input from the other people

in their case. This was clearly explained to participants on the information sheets (see Appendices 2 and 4) and I explicitly explored it with participants before we commenced the interview to ensure that they understood and were happy to proceed on this basis.

In order to protect participants' identities (from recognition by people outside of their specific case), clients chose their own pseudonyms or were given pseudonyms by me. Clients' first therapists were named 'T1-[client]', and their second therapists 'T2-[client]'. Any identifying details for participants were changed by me in the written report.

3.4.4 Data protection

Name and contact details for participants were stored separately from research data and will be destroyed after research completion. The storage and use of data complies with the legal requirements as set down by the Data Protection Act (1998) and any subsequent similar acts. Where the transcription was not carried out by myself, a General Data Protection Regulation (GDPR) compliant service was used.

3.4.5 Risk of harm or distress

While I hoped that participants would benefit from taking part, as has been shown in other studies (see Wolgemuth *et al.*, 2014), participating in my research did carry with it possible risks of harm that I needed to fully consider and discuss with my research supervisor before embarking on the project, and my participants during the consent process.

As described above, the limits to confidentiality meant that clients and therapists would gain an insight into what the other had said about them, something that rarely happens between client and their therapist. Reading about what their client/therapist had said about them had the potential to be painful for participants, particularly in the instances where the client and therapist were unable to engage in therapy. John McLeod (2010) has drawn attention to the ethical complexity inherent in this kind of research and emphasises the importance of the researcher adopting a continually

reflexive stance, being mindful of relational ethics (the responsibilities that come from being in a relationship with another person), and consulting regularly with a supervisor to manage these risks.

To facilitate my participants in making an informed decision about whether to take part, I gave them the opportunity to explore the impact of participating in the research. I informed them of the nature of the project and the procedures involved in an attempt to protect them and help them protect themselves from harm or distress. I endeavoured to describe what the participant may not have anticipated in taking part, such as the personal nature of the interview, the recall of painful memories, or that they may disclose more than they were comfortable with. I saw myself as having sufficient training and experience to respond sensitively and supportively if participants were distressed during the interview.

I also offered participants a debrief after their involvement in the research. In the event that unsettling material came up for client participants during an interview, they would have been offered the option of returning to MCPS or being referred to another service for additional therapy. In the event that unsettling material came up for therapist participants, they had the support of their own personal therapy and supervision to process this. At the point when I invited participants to read a draft of my findings, I let them know that I was available to talk through any issues that may come up for them and provide additional context to what had been written, and checked in with them once they had had a chance to read the findings.

During the interviews none of the participants reported or showed any signs of distress that needed action on my part. However, consistent with previous research findings (Furlong, 2006) my participants had a range of reactions to reading the draft of my findings. I describe and reflect on their reactions in the discussion chapter of this thesis (p. 130).

For myself, I arranged supervision and discussion time with my supervisor in case of unforeseen risks or ethical dilemmas during the project. I also collaborated with researcher-peers on my and

their projects to stimulate my reflexivity and gain support with the process. As many researchers have highlighted, participating in research can carry inherent risks, but there are also potential benefits both to the participants and the wider field (e.g. Brinkmann and Kvale, 2014; Hutchinson and Wilson, 1994; McLeod, 2010). Through careful consideration of the risks and adopting a reflexive stance I hoped to minimise the risks and create an environment in which my participants would ultimately benefit from taking part.

3.4.6 Inclusion

There was no participant exclusion based on socio-educational status, ethnicity, gender, age, language, literacy or special needs. I did not have to make any provision for language, literacy or special needs for any participant.

3.5 Trustworthiness and validity

To ensure the quality of this research I considered Lucy Yardley's (2000) guidelines for good qualitative research from the outset. The following table (Table 1) charts her four essential qualities and the supporting evidence of these qualities being met within this research project.

Table 1 - Lucy Yardley's 'Characteristics of good (qualitative) research' (2000, p. 219) with adaptations from Braun and Clarke (2013) and notes and evidence of how I have met each characteristic within this study

Characteristic		Evidence of meeting this characteristic
1. Sensitivity to context	• Contextualising research in relation to relevant literature	See Literature Review (p. 6)
	• Being sensitive to participants' perspectives and socio-cultural context	During data collection: asking open-ended questions that encourage participants to present their own perspectives (see Appendix 6 – semi structured interview guide)
	• Being sensitive to issues of power	See Ethical considerations (p. 53)
	• Being sensitive to the data by not simply imposing the researcher's meanings on the data and being open to alternative interpretations of, and the complexities and inconsistencies in, the data	Through ongoing reflexivity and keeping a reflective journal (see Appendix 7), requesting participant feedback (p. 72) and sense checking my developing findings with colleagues (p. 72)
2. Commitment and Rigour	• In-depth engagement with the topic	Through my work as a therapist and assessor, and through the process of conducting this research
	• development of competence and skill in methods used	By thorough reading of the topic and discussion with a supervisor who specialises in thematic analysis
	• thorough data collection and immersion in the data	See Research Design (p. 60) and Data Analysis (p. 68) sections
3. Transparency and Coherence	• clarity and power of description through persuasive and convincing interpretation of data	See Findings section (p. 73)
	• Fit between research question, theoretical framework, and the methods used to collect and analyse the data	See Methodology section (p. 46)
	• Transparent account of how data were collected and analysed	See Methodology section (p. 46
	• Reflexivity through considering how the researcher and the use of particular methods shaped the research	Reflexive journal kept throughout the process (see Appendix 7)
4. Impact and importance	• Impact for practitioners, organisations and clients, theoretical impact and socio-cultural impact	See Rationale for this Study (p. 4) and Discussion section (p. 111)

3.6 Research design

To explore the process of initial engagement in therapy I interviewed clients who had transferred from one therapist to another and their therapists about their experiences. Below I describe the process of collecting data, including the context, participants, recruitment and interviews, before outlining the stages of data analysis in the subsequent section.

3.6.1 Context and participants

Participants were clients and their therapists, sourced from the Metanoia Counselling and Psychotherapy Service (MCPS), a low-cost counselling and psychotherapy service based in West London. At MCPS clients are first seen by a clinical assessor, and then referred to one of the volunteer therapists working at MCPS. All of the therapists at MCPS are trainees, usually at the beginning of their training (although their levels of experience can vary). A policy at MCPS is that a client's first four sessions are considered exploratory and are a chance for the client to develop a sense of whether they feel that their therapist will work for them. Clients are explicitly told during their assessment session that they have the option of changing therapist if they feel that their current therapist isn't right for them, and clients only sign a therapeutic contract with their therapist after their first four sessions (see Figure 3).

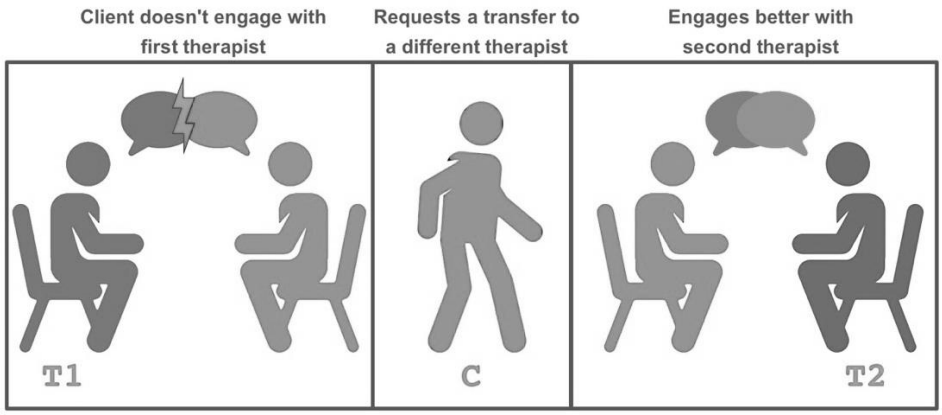

Figure 3 - Illustration of client changing from one therapist to another. Client (C), first therapist (T1) and second therapist (T2) are all participants of this study

3.6.2 Recruitment

My initial intention was to interview four clients along with both their first and their second therapists. However, I was aware that gaining consent - not just from the client, but also from both of their therapists - might present a challenge. As I anticipated, recruiting participants for my study was difficult as the majority of the potential participants I contacted did not respond to my invitation to take part and, when client participants expressed an interest in being involved, their therapists were sometimes unwilling to join the project. Faced with these challenges, and in light of the fact that my primary interest was in what broadly facilitates or hinders engagement (rather than what was happening specifically case by case), I ultimately felt that so long as the client and at least one of their therapists consented to take part I would be able to collect rich data that met my research aims.

To find potential participants I was able to use the records held by MCPS to create a list of clients who met my selection criteria. I then contacted these clients by post or email, with an overview of my project and an invitation to take part. If a client responded with interest, I spoke with them over the phone and sent them additional information about the project. I also contacted each of their therapists to see if they would be willing to take part and, if they too expressed interest, I also sent them further information on the project (see Appendices 2 and 4). If the client and at least one of their therapists were willing to contribute to my research, I contacted each of them to arrange a suitable time for an interview (see section **Error! Reference source not found.**).

3.6.2.1 Selection criteria for client participants

I originally considered engagement in a binary way – that clients who requested to transfer during their first four sessions had not engaged, and those who stayed beyond four sessions had engaged in therapy. My selection criteria for participants reflected this in that client participants should have (i) attended between one and four sessions with their first therapist before requesting to transfer and (ii) stayed beyond four sessions with their second therapist. I thus determined that

these participants had not engaged with their first therapists and had engaged with their second therapists.

However, as I began to interact with clients, both through the recruitment process and during initial interviews, my conceptualisation of engagement began to evolve. Rather than talking about it in a binary way, my client participants articulated levels of engagement along a continuum and this, in turn, altered my thinking around the concept. I chose to expand my selection criteria to accept client participants who had (i) requested to transfer to a different therapist, (ii) stayed for more sessions with their second therapist than their first, and (iii) felt that they engaged better with their second therapist than their first. I see this shift as consistent with my epistemological position, in that it allows for me to be impacted by my interactions with my participants and, as Terry and colleagues note, this "flexibility to shift focus is one of the joys of qualitative research" (Terry *et al.*, 2017, p. 30)

Additional criteria for client participants were (i) that they had ended therapy with their second therapist (this was to ensure that the interviews that were conducted as part of the research would not affect the relationship between the client and their therapist; McLeod, 2010) and (ii) that they had previously agreed to take part in research at the Metanoia Institute (which gave me ethical grounds to contact them about my research).

3.6.2.2 Selection criteria for therapist participants

Along with client participants, I also invited therapists to take part. The only criterion for therapist participants was that they had been either the therapist that the client had transferred *from* (i.e. the client's *first* therapist) or the therapist that the client had transferred *to* (i.e. the client's *second* therapist). All of the therapists at MCPS receive regular supervision (from a supervisor approved by their course but external to MCPS) and are in personal therapy, to aid them in their clinical work and personal development.

3.6.2.3 Outcome of recruitment

The recruitment and interviewing phase took place between May 2016 and August 2018. The span of this period was partly due to a personal break from the research between September 2016 and November 2017, and also due to the recruitment challenges described. In total I conducted 21 interviews and I was able to analyse the data from 15 of these (see section 3.6.3.2 below for rationale for inclusion and exclusion of data). The interviews I was able to analyse formed three complete cases (in which the client and both of their therapists chose to take part) and three incomplete cases (one in which the client and their first therapist took part, and two in which the client and their second therapist took part) (see Table 2 for a list of the interviews conducted and analysed or not analysed).

Table 2 - Interviews conducted and analysed / not analysed. The numbers in brackets after each participant name denote where the participant came in the interview order.

	CASES ANALYSED:			
Case	**Client**	**First therapist**	**Second therapist**	**Notes**
1	Jane (2)	T1-Jane (1)	T2-Jane (3)	Complete triad
2	Paul (5)	*Declined to take part*	T2-Paul (6)	Incomplete triad
3	Robert (4)	T1-Robert (7)	*Declined to take part*	Incomplete triad
4	Daphne (8)	T1-Daphne (10)	T2-Daphne (11)	Complete triad
5	Emma (9)	*Declined to take part*	T2-Emma (12)	Incomplete triad
6	Claire (13)	T1-Claire (15)	T2-Claire (14)	Complete triad
	CASES NOT ANALYSED:			
Case	**Client**	**First therapist**	**Second therapist**	**Notes**
7	C7	T1-C7	T2-C7	All interviews completed, but client didn't engage with their second therapist.
8	*C8 - Consent withdrawn due to lack of response*	T1-C8	*Interview not arranged*	T1 interviewed, client did not attend arranged interview and didn't respond to further contact
9	*C9 - Consent withdrawn due to lack of response*	*Interview not arranged*	T2-C9	T2 interviewed, client did not attend arranged interview and didn't respond to further contact
10	C10	*Interview not arranged*	*Interview not arranged*	Discovered during client interview that client didn't engage with their second therapist.

3.6.3 The interviews

All of the interviews were conducted by me and lasted around 50 minutes. All but two of the interviews were face-to-face, in a private room, at a site convenient for me and the participant (most of these were at the Metanoia Institute, and one was at my home as the participant lived close by and this was most convenient for her). Two of the interviews with therapist participants were via an online video-call as the participants did not live in London. Congruent with the conclusions of O'Connor, Madge and Shaw (2008), I found that the data collected through these online interviews was as rich and valuable as that from my in-person interviews. All of the interviews were audio-recorded and transcribed verbatim (see Appendices 7 and 8 for an extract of an interview and my notation system).

Prior to starting each interview, I gave participants an overview of the purpose of the research and talked through issues around consent (see section 3.4.2). All participants were happy to continue, and so we explored participants' views through open-ended questions. I used a semi-structured interview guide (see Appendix 6) as a prompt for myself, but mostly used a non-directive style to leave space for each participant to tell their own story.

The recruitment process meant that generally participants were interviewed case by case. However, so that I could conduct the interviews at times that were most convenient to participants, and because I was not prioritising the experience of one type of participant over another, I did not deliberately impose any particular order on the interviews. This meant that sometimes clients were interviewed first, sometimes therapists, and the interviews did not all take place case by case (see Table 2 for interview order).

3.6.3.1 My experience of the interviews

During the process of conducting the interviews I noticed that every interview sparked ideas and developed my thinking on the topic of engagement, which then impacted what I brought to the subsequent one. I found myself noticing similar topics that seemed to come up across multiple interviews, some just articulated by clients, some just by therapists, and some that spanned the different participant groups. When interviewing participants from within the same case, I also naturally began to develop a complex picture of the process of engagement specifically within that case.

In an effort to create a collaborative, exploratory atmosphere, I was transparent about my own interest in the topic and the purpose of my research with participants. I particularly emphasised that in my own work I really value hearing about what did or didn't work for my clients (and those who chose not to stay with me) as it can help me to develop as a reflective practitioner, and understand what was going on from the client's perspective. This self-disclosure was consciously done in an attempt to develop rapport and balance the researcher-participant hierarchy (Audet, 2011; Braun and Clarke, 2014; Rapley, 2001), and I found that it helped participants to feel freer to express their experiences without fear of judgement from me or negative repercussions. Initially some clients were reserved about saying anything that could be perceived as negative about their first therapists, and some of the first therapists were anxious about opening up about their experiences. However, once I had explained my position and they had experienced sitting with me in a non-judgemental, exploratory space, they were able to relax and be open about their experiences

Interestingly, given that clients knew that I would be interviewing their therapists and vice versa, I found that the interview acted in some ways like a channel through which the therapists and clients could process and reflect on their experiences, and perhaps communicate something to each other that they were unable to do in person. For example, Jane's first therapist commented

“overall there’s just a warm tingling sense of fixing something – it kind of feels like I’ve fixed something, and that I think is very positive for my moving forward. And, like you said at the start, something about maybe [Jane] will hear some of my words and I’ll hear some of hers, and maybe we’ll indirectly be able to fix some of what didn’t work out so well for us. So, a positive experience”. In this way, the interviews may have benefitted some participants by giving them a sense of catharsis, purpose and healing (Hutchinson, 1994).

3.6.3.2 Inclusion and exclusion of data

In total I conducted 21 interviews. However, during the process of interviewing participants I found that I was unable to use some of the data that I had collected - in two cases the client did not attend our arranged interview (or respond to further contact) after I had interviewed one of their therapists, and in two other cases I discovered during the interview with the client that they did not feel that they had engaged with either of their therapists. I did not consider these interviews to be wasted, however, as each interview helped to enhance my understanding of the phenomenon.

I was able to analyse the data from 15 of the interviews. While I was conducting the interviews, I noticed that participants naturally spoke about other clients/therapists that they had seen in the past. For example, Robert claimed that he engaged better with his second therapist than his first at MCPS, but that he had experienced better engagement with an earlier therapist, and ultimately ended therapy with his second therapist because of this. In these instances, I treated all of the data on initial engagement as relevant to my analysis, which was focussed on what generally facilitates and hinders initial engagement.

An additional complexity occurred when I was interviewing Claire (Case 6). Claire mentioned that she had briefly seen another therapist in-between the two therapists that were noted in the MCPS records. However, as she felt that she had engaged least well / best with the two therapists who were recorded in the system, I chose to interview these therapists and not her middle therapist as I (and Claire) felt that they presented a clearer case of non-engagement / engagement.

3.6.3.3 Transcription of the interviews

I transcribed the first four interviews myself and then, due to time constraints, I chose to use a secure transcription service for the remaining interviews. Many authors advocate self-transcription of interviews to enable the researcher to immerse themselves in the data (e.g. Mitchell, 2015). To compensate for not doing all of the transcriptions myself I listened to each recording several times alongside the transcription. This enabled me to check the transcription quality and make sure that it represented what I heard on the recordings, as well as to immerse myself in the data. I found that once I had listened to each recording three or four times, I was able to hear the participant's voice in my head, with their emphases and intonations, when I read excerpts of their interview.

I considered the transcripts to be representations (rather than mirror images) of the data, as they would necessarily be influenced (or constructed) by me as a researcher (Braun and Clarke, 2013; Hammersley, 2010). In this way, my analysis began with transcription of the first interview, and continued throughout the data collection, analysis and writing up phases of the research (Braun and Clarke, 2012).

Throughout the process of conducting this research I kept a reflexive journal (see Appendix 7 for an extract). I treated the journal as a tool to reflect on the process of conducting the research as well as to note any "flashes of insight or ideas" (Cutcliffe, 2003, p. 145). This enabled me to provide a detailed reflexive account without inhibiting my tacit knowledge and creativity (see Cutcliffe, 2003).

3.7 Data analysis

To engage with the phenomenon of initial engagement in therapy I chose to analyse all of the participant interviews and developed general themes relating to what facilitates and hinders engagement from the data. I began by analysing my client participant interviews using reflexive thematic analysis and did the same for the therapist participant interviews.

I primarily took an inductive approach, in which the codes and themes I generated were driven by what was in the data, rather than deliberately using ideas and concepts to inform my coding. As it was inevitable that I would make use of my training, practice and knowledge of theory to help me know what and how to code my data, analysis also involved a level of deduction in my coding (Braun and Clarke, 2012). I see this approach as consistent with my constructivist epistemology as I prioritised the experience of my participants, while also acknowledging my personal impact on the data and the co-constructed nature of the findings.

As I was analysing the data, I found that I was interested both in the general themes relating to initial engagement in therapy and what was happening in each specific case. I chose to focus primarily on the themes that appeared across cases, but, for completeness, to also include tables in my appendices to present how each theme manifested in each case (see Appendix 9). While this second part doesn't represent a separate analysis as such, it feels important to include it partly because I believe that seeing what happened in each case adds an extra dimension to the themes that I developed, and also out of consideration to my participants who all expressed interest in reading about what happened in their respective cases.

Below, I present a reflective account of the stages of my analysis, broadly following the six phases outlined by Braun and Clarke (2012). Rather than this being a linear process, however, I experienced this as recursive and simultaneously worked on several phases and moved back and forth between them.

3.7.1 Familiarising myself with the data and generating initial codes – phases 1 & 2

I began transcribing the first interview as soon as it was completed and continued to transcribe and familiarise myself with data throughout the period of data collection. The process of interviewing each participant, transcribing and reviewing transcriptions of the interviews, and listening to the recording several times, left me with a live sense of the participant, including their intonations and gestures when I read each completed transcript. As I read and listened to the interviews, I jotted down any initial ideas as they occurred to me, underlined words and important passages, and made links between different sections of text and different participants (see Figure 4 (i)). I found that this process helped me to separate the narrative of the interview from the concepts being expressed, to begin to ask questions of the data, and to feel intimately connected to what was being expressed in relation to my research question.

I then moved to listing preliminary codes relating to initial engagement in therapy. Annotating the first transcript made me aware of the huge volume of codes and quotes that could be generated from the fifteen transcripts. I did the same for every transcript, finding that I got better at generating concise accurate codes as I gained experience with the process. I then imported the transcripts into NVivo, which I felt would help me to manage and organise such a large quantity of data and give me the facility to search for codes with their associated interview extracts.

Once the transcripts had been imported, I initially chose to focus on the interviews with my client participants to explore the phenomenon in depth from their perspective. I found that physically handling and arranging my codes enabled me to engage closely with the data, while the structured organisation of NVivo served as a way of keeping track of the process and acted as an “online filing system” (Braun and Clarke, 2013, p.219). I experienced this part of the analysis as simultaneously exciting, chaotic, and overwhelming. To manage the vast amount of data I worked with each code on a separate piece of paper, created numerous spider diagrams, and moved back and forth between the codes and transcripts to check for missing pieces and generate more ideas

about what might be happening with the data. Moving between paper codes and NVivo helped me to remain grounded and gain distance from the individual interviews as I began to look for patterns across the data set, while also being able to easily connect back into the context of each code (see Figure 4 for an illustration of my creative organising processes).

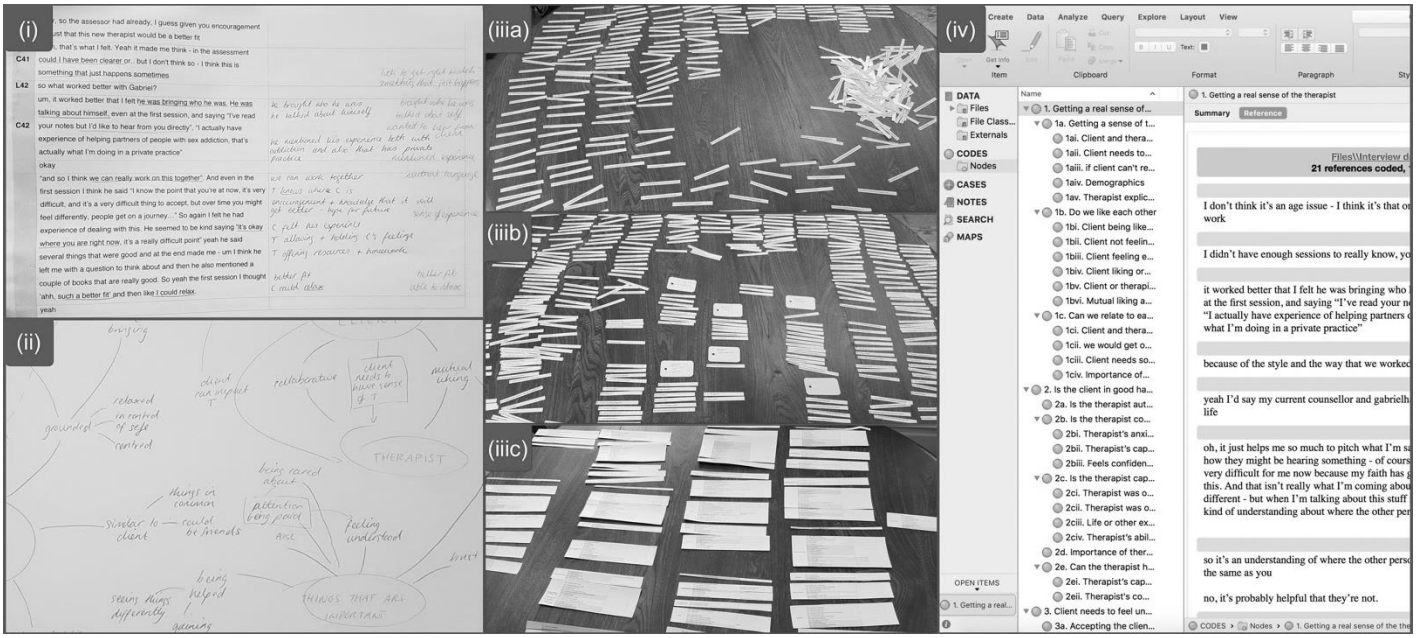

Figure 4 – box showing four coding processes: (i) notes on transcripts, (ii) visualising connections using spider diagrams, (iii a-c) sorting individual paper codes, (iv) organisation using NVivo.

3.7.2 Searching for themes – phase 3

As I continued to move between the original transcripts, codes on paper, and coding in NVivo, I was gradually able to group my codes, reducing them in quantity, and clustering them into more meaningful patterns. I continued to return to my transcripts to check for expressions of codes and patterns that I might have missed on the previous read. I found that this helped me to stay in touch with the individual participant experience while also capturing all that felt relevant to the concept of initial engagement in therapy.

While I wouldn't say that themes 'emerged' from the data, as this suggests passivity on the part of the researcher, the word 'constructed' also doesn't feel quite right, as this indicates a very

conscious process. For me, my absolute immersion in the data, combined with both conscious and unconscious processing, helped me to develop ideas about possible ‘core concepts’ that might underpin themes (Clarke and Braun, 2018).

Once I had developed possible themes from the client interviews, I turned my attention to the therapist interviews. At this point I felt like I was holding the potential themes from the client interviews lightly, allowing space for them to evolve while exploring how to make sense of the therapist data. Initially I was unsure whether or not my engagement with the therapist interviews would produce completely different themes to those of the client interviews.

Separately from the client data, I followed the same process of generating and refining initial codes with my therapist data and found that I was noticing patterns that clustered within similar core concepts to those I had found with my client participants. With this in mind, I chose to explore the data set as a whole and developed candidate themes based on all of my participant interviews. In doing so I found that aspects of the therapist and client accounts were expressed to different extents within each possible theme. Through this process I developed a list of candidate themes.

3.7.3 Reviewing and defining themes – phases 5 & 6

I then began a process of quality checking my themes to ensure that they represented my participants’ accounts. To do this I examined all of the coded extracts under each theme, to ensure that they linked to the central organising concept for that theme, captured the essence of the theme, and represented the diversity of perspectives within that theme. I also checked the theme against the whole dataset to ensure that nothing had been missed, and that I hadn’t lost touch with the key stories in the data while developing the analysis.

As well as considering the individual themes, I also considered whether my themes were distinct from each other, and made sense in relation to each other. The process felt a bit like a tangram puzzle, as I constantly shifted codes and themes around before stepping back get an overview of

the picture I had formed, and then moving closer to reshuffle some more. I was acutely aware at this stage of my role in interpreting the data, and of the multiple (and equally valid) possible themes that could be developed to tell the story of what was happening in the data (Kvale, 1996).

I also consulted with colleagues and supervisors to sense-check my findings. This served as a way to ensure that I was not simply imposing my own meanings onto the themes I was developing, to check the internal consistency of my themes, and to consider alternative interpretations of the data.

3.7.4 Producing the report

As I began to write up my findings I found that the analysis deepened as I developed a coherent narrative from the data. The process of writing helped to generate new ideas as well as to refine the themes that I had developed.

3.7.5 Participant consultation

Once I had written a draft of my findings I wrote to all of my participants to invite them to read and comment on what I had developed. While member-checks have often been cited within the literature as a way for increasing validity (e.g. Lincoln and Guba, 1985), others have argued against their utility for enhancing a study's credibility (e.g. Thomas, 2017). My intention when inviting participants to review my findings was to recognise their active participation as a part of the ongoing consent process, and, given the ethical complexities of this kind of research, to ensure that participants had the option to request any changes to the data I had included (Thomas, 2017). It was also possible that consultation with my participants might stimulate deeper analysis or shift my perspectives on what I had developed (Levitt, 2017). I present a reflective account of this process on page 130.

Chapter 4: Findings

To present my findings I start by outlining the way I have annotated my findings, and provide an introduction to my participants. I then present a thematic map as a visual guide to the main themes and interconnections between them, before describing each theme in detail. I follow this with tables of themes that include example quotes from my participants.

4.1 Presentation of findings

Throughout the piece I refer to clients by pseudonyms (these were all chosen or approved by the clients themselves). I refer to the therapists that the clients first saw before requesting to transfer as '[client]'s first therapist', 'T1-[client]' or 'T1'. For example, I might mention 'Jane's first therapist', 'T1-Jane' or just 'T1'. Similarly, I refer to the therapists that clients transferred to as '[client]'s second therapist', 'T2-[client]', or 'T2' (i.e. 'Jane's second therapist' or 'T2-Jane' or 'T2'). The use of three ways to reference a participant is intended to increase the readability of the findings.

My voice will be present as researcher (Lia in the extracts) and writer.

In my transcription of the participant interviews, I used three consecutive dots (with no spaces) represent a pause in the participant's speech. I also used square brackets (e.g. [ ]) to enclose words intended to clarify meaning, change details to protect confidentiality, or to help integrate the quote into the sentence where it is being used.

In any direct quotes from participants, I have used ellipsis points (a series of three dots with spaces between them) within square brackets when I have left some words out of the participant's original quote (e.g. [. . .]). I have taken care that these ellipses are only used to clarify the point intended through the use of the quote and do not alter the quotation in a way that inaccurately or unfairly represents the original text. Where the participant emphasised a particular word, this word appears in italics in the direct quotes.

4.2 Introduction to the participants

Participants in this study ranged in age, gender and ethnicity. Of the client participants, four were female and two male, ranging in age from early 30s to early 50s. Five of the six clients had previously experienced therapy. Of the therapist participants six were female and three male, ranging in age from late 20s to late 50s. Their theoretical orientations spanned the humanistic, integrative, person-centred, and transactional analysis modalities. Most of the therapists had very little prior clinical experience, but two of them (T1-Claire and T2-Jane) were very experienced.

Table 3 - Participant information

	Participant category	Name	Age	Gender	Ethnicity	Sessions with T1	Sessions with T2	Previous therapy (Clients)?	Theoretical Orientation (therapists)	Level of prior experience (therapists)
1	Client	Jane	Mid-30s	F	White	3	9	Yes	/	/
	First therapist	T1-Jane	Mid-30s	M	White	/	/	/	Integrative	One of first few clients
	Second therapist	T2-Jane	Early 50s	M	White	/	/	/	Integrative	Very experienced
2	Client	Paul	Late 40s	M	Afro-Carribean	3	10	No	/	/
	First therapist *Not interviewed*	T1-Paul	Mid 40s	M	Black	/	/	/	Humanistic	One of first few clients
	Second therapist	T2-Paul	Mid 40s	F	White	/	/	/	Person-centred	Approximately 40 hours of experience
3	Client	Robert	Mid 30s	M	White	6	13	Yes	/	/
	First therapist	T1-Robert	Early 30s	F	White	/	/	/		One of first few clients
	Second therapist *Not interviewed*	T2-Robert	Late 20s	F	unknown	/	/	/	Person-centred	One of first few clients
4	Client	Daphne	Early 50s	F	Black	4	A little less than 6 months	Yes	/	/
	First therapist	T1-Daphne	Late 40s	F	White	/	/	/	Humanistic	Daphne was T1's first ever client
	Second therapist	T2-Daphne	Early 30s	F	White	/	/	/	Integrative	One of first few clients
5	Client	Emma	Early 30s	F	White	1	Over 6 months	Yes	/	/
	First therapist *Not interviewed*	T1-Emma	Early 40s	F	Black	/	/	/	Person-centred	One of first few clients
	Second therapist	T2-Emma	Mid 50s	M	White	/	/	/	Integrative	One of first few clients
6	Client	Claire	Early 40s	F	Asian (Indian)	2	About 6 months	Yes	/	/
	First therapist	T1-Claire	Late 20s	F	White	/	/	/	Transactional Analysis	Very experienced, but first session in English
	Second therapist	T2-Claire	Early 40s	F	White	/	/	/	Person-centred	Claire was T1's first ever client

4.3 Overview of themes

Through the process of interacting with the data, searching for themes by grouping my codes, I was able to develop four themes that relate to the research question:

Theme 1: Forming a personal connection with the therapist

"I've instantly liked them, I've instantly understood what they are about, and I've instantly felt comfortable that they understood what I was about" (Robert on the therapists he engaged well with)

Subtheme 1: Clients need to get a sense of their therapist as a person

"it worked better that I felt he was bringing who he was" (Jane on T2)

Subtheme 2: Clients need to feel heard and truly understood by their therapists

"I felt like she didn't see me, and it wouldn't have mattered what I said" (Daphne on T1)

Subtheme 3: Mutual positive regard and forming a personal relationship

"I would have probably connected with her on a personal level" (Claire on T2)

Theme 2: The therapist's responsiveness to their client

"She was leading the partnership, but you felt like an equal" (Paul on T2)

Theme 3: Is the client in good hands?

"one had nailed it and one was still trying to get there" (Paul on both of this therapists)

Subtheme 1: Therapists' responses to their clients

"it was easy for me to connect" (T2-Daphne) versus "I don't want her to know that I'm freaking out" (T1-Daphne)

Subtheme 2: The client's experience of their therapist as authentic, composed and capable

"it was really important for me to know that they can handle it" (Emma on both of her therapists)

Subtheme 3: How clients felt in the room with their therapists

"I clamped up" versus "stuff just flooded out" (Paul on each of this therapists)

Theme 4: The client's decision to change therapist

"It was never going to work out for either one of us" (T1-Daphne)

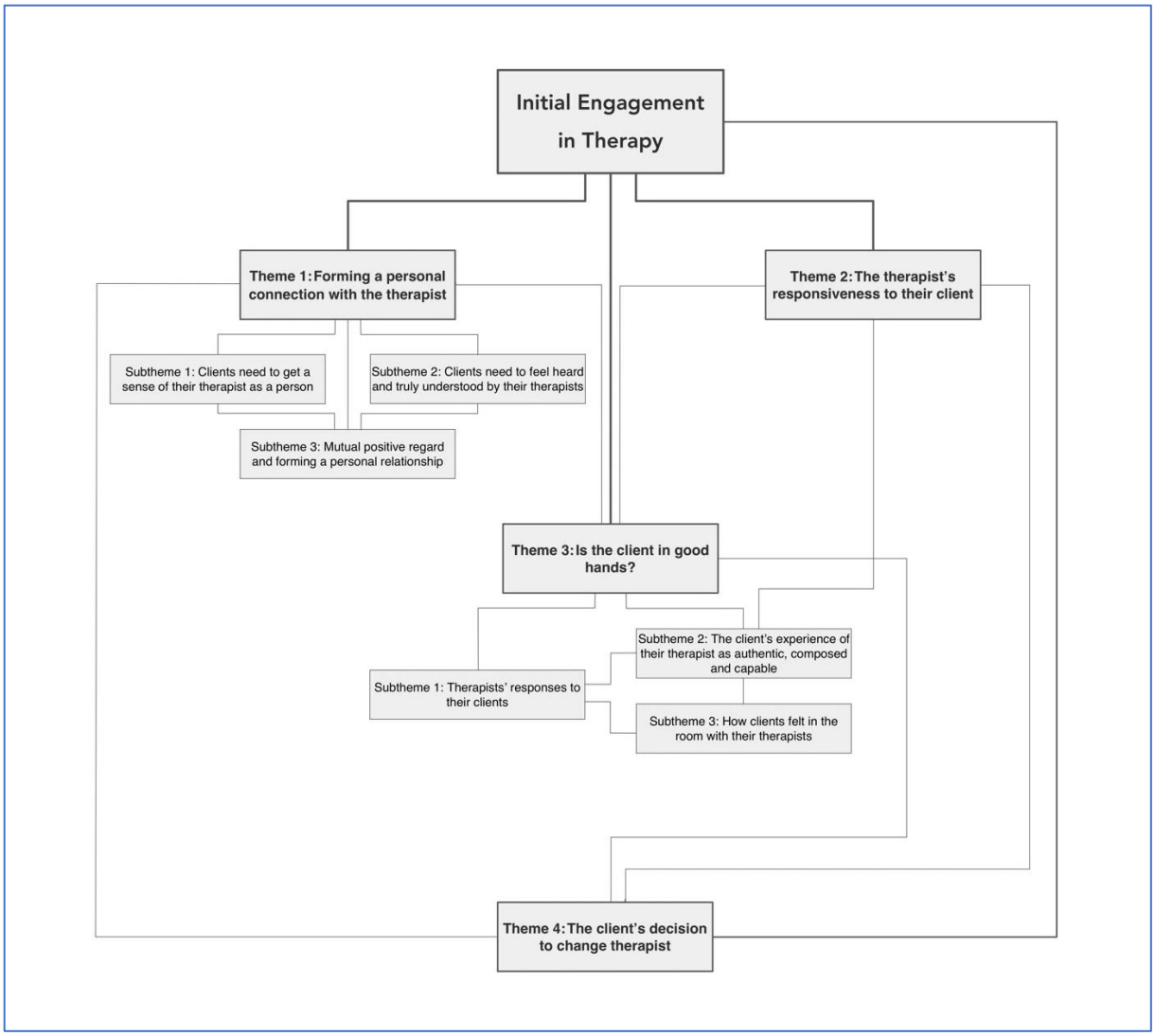

Figure 5 - Thematic map showing themes, subthemes and their interconnections

4.4 Detailed descriptions of themes

Theme 1 Forming a personal connection with the therapist

"I've instantly liked them, I've instantly understood what they are about, and I've instantly felt comfortable that they understood what I was about" (Robert)

This theme describes the development of a connection between the client and their therapist at a personal level. Clients expressed a need to get a sense of who their therapist was as a fellow human, as well as to feel like their therapist could truly understand them. If the client was able to read their therapist and felt understood by them this paved the way for a personal relationship, based on mutual positive regard and a balance of similarity and difference, between the client and their therapist to develop.

Theme 1, Subtheme 1: Clients need to get a sense of their therapist as a person

"it worked better that I felt he was bringing who he was" (Jane)

As one of the first aspects of engaging with their therapist, clients emphasized the importance of getting a sense of who their therapist was as a person – being able to see through them "like a window" (Daphne) – and this led on to the client being able to ascertain other important aspects of the therapeutic relationship. Clients developed this understanding of their therapist through a combination of processes. The first of these was almost instantaneous, at an implicit, felt level. For example, Paul explained his sense of awkwardness with his first therapist as "a chemical thing", Daphne made a reference to her "spider senses" saying "yes", and Emma spoke about a "gut feeling" which was based on "nothing that they did wrong or said wrong. It was almost mannerisms, and it was just the sense that I got that I don't think I can open up to this person".

Alongside this felt sense, clients drew on a variety of other sources of data to ascertain information about their therapist. Therapist characteristics of being "approachable and warm" (Claire) and "compassionate" and "open" (Robert) facilitated engagement, while therapists who were "stand-offish" (Robert) were less easy to connect to. Clients also spoke about information that they picked

up from the therapy environment, such as the size or arrangement of the room, and the journey to and from the room. For example, Paul said that with his first therapist “the room played a little bit of a thing. It did feel like a big cavernous room to be getting intimate” and compared this with the “interview room” in which he saw T2 and could “feel safe, it’s like a little cocoon”. Interestingly, the therapy environment seemed to be more of a focus for clients when they were experiencing difficulty in engaging with their therapists, perhaps indicating that in these cases clients tried to find evidence to support how they were feeling. Paul alluded to this, saying “if you’re engaged enough with someone you won’t notice. Maybe I used this space as an excuse because I wasn’t engaged”.

Interestingly, all client participants considered demographic variables (such as age and ethnicity), which present a clear source of information about their therapists, but concluded that they were not primary influences on their engagement in therapy. Paul referenced this, claiming that when he discovered his first therapist’s ethnicity he initially thought that “this should work” because “we can at least talk about issues of race and character and identity”. However, he went on to say “on paper, I was like, this is perfect. But it wasn’t”, which demonstrated that, for him, the ethnic match wasn’t facilitative of engagement. Along with ethnicity, several clients mentioned their therapists’ age, but also concluded that it was not a primary influence on their capacity to engage. For example, Jane initially said: “And I have to say that once you feel that, since we’re a similar age, that is a problem - coz the style’s difficult for me that makes me feel like he’s not experienced”. She went on to comment: “I don’t think it’s an age issue - I think it’s that once I had worked out that it wasn’t going to work”, articulating her recognition that age wasn’t the primary factor in her lack of engagement with her first therapist.

Alongside details that they could observe about their therapists, clients appreciated it when their therapists were willing to share themselves and their experiences (e.g., “it worked better that I felt he was bringing who he was. He was talking about himself, even at the first session”, Jane). Paul described his first session with his second therapist:

Paul: *Yes, we sat down, we talked, we discussed things, we discussed how to approach things, what type of branch of therapy she's been studying and she's approaching.*

Lia: *It sounds like she was already telling you a bit more about herself than [T1-Paul] did, perhaps.*

Paul: *What I needed to know, yes. Definitely what I needed to know.*

Here Paul speaks about his therapist sharing "what [he] needed to know", indicating that there might be an element of balance – that there are certain types or amounts of sharing that clients find helpful. Claire also commented that her second therapist "would give her own insights about certain things. Well, within boundaries, and I think that helps as well because it makes that person seem more human" and Jane expressed a similar sentiment, wanting to know "just enough. I'm certainly not looking for someone to tell me a lot". This may suggest that there is an optimal level of knowledge of their therapists that facilitates engagement and tipping too far in either direction may act as a hinderance.

If clients were not able to develop a sense of who their therapist was, they sometimes tried to fill in the gaps and imagine who their therapist might be, perhaps as a way to understand the lack of connection between them. For example, Daphne described "filling in [T1's] backstory" and assumed that her first therapist was a "middle class wife" and she was just "doing this because it was something for her to do" and Paul spoke about how his "mind was racing" as he wondered if his therapist "was a pastor, and *now* he's going to be a counsellor" because "someone told him he was really good at counselling at Church". These imagined narratives centered around therapists acting in their own interests rather than the client's, and emphasized the client's sense of difference between themselves and their therapist, which then precluded any possibility for clients to engage with their therapists. Paul described this process, saying that "the narrative was so strong that there wasn't enough time to open up about myself. I was too busy thinking about what he's up to". This led him to "put blocks up" rather than be able to connect to his therapist.

Within more engaged therapeutic dyads, clients felt that they had a sense of who their therapists were, and this enabled them to read their therapists' responses to them. Robert commented (of therapists with whom he was able to connect well) "I've instantly understood what they are about, and I've instantly felt comfortable that they understood what I was about", highlighting the link between his understanding of his therapist and sensing that his therapist understood him.

Theme 1, Subtheme 2: Clients need to feel heard and truly understood by their therapists

"I felt like she didn't see me, and it wouldn't have mattered what I said" (Daphne)

As Robert mentioned, another key aspect for clients to be able to form a personal relationship with their therapist was feeling understood by them. This sense of being truly understood manifested at several levels, from a more concrete, literal level in which the client's words and phrases were understood, to a more abstract, implicit level, in which meanings behind the client's words, or even intuitive understanding without words, were acknowledged. Clients also valued the efforts that therapists made towards understanding them, from a willingness to hear things directly from the client and not make any assumptions, to active efforts the therapist made to understand the client's world from their perspective.

From the first moments of therapy clients expressed their need for therapists to "start from scratch" (Jane) and not make assumptions about them. Even though clients were aware that their therapist had probably read their assessment notes, it was important that their therapist wanted to hear things directly from them and gave them the opportunity to tell their stories (e.g., "I *want* to tell the story of why I'm coming. Because even if the person has read it, it's not the same", Jane). Without this the client didn't feel understood and was less able to engage with their therapist (e.g., "I felt like she didn't see me, and it wouldn't have mattered what I said", Daphne). Along the same lines, Claire spoke about how important it was for her therapist to get to know her before expecting her to open up: "you can't expect to talk about really deep stuff in the first even three or four sessions

until that person gets a good way of how you are, and what your background is and how you interact and things like that".

When therapists appeared open and interested in hearing things from the client's perspective this helped clients to feel like they were being deeply understood. Paul described this as "someone's really taking me in" and said he "got that with the first person …, who assessed me, and then with [T2]. And yes, it didn't come across with [T1]" indicating that he felt understood by his assessor and second therapist, and less so by his first therapist. Coming hand in hand with this was the client experiencing a lack of judgement from their second therapist. Paul commented: "Yes, she wasn't judging me… I never got that from her. Absolutely never", and Daphne knew from the start that her second therapist was "that sort of person that I could talk to like a therapist and wouldn't judge me".

When clients felt negatively judged by their therapists this had a detrimental impact on engagement. Daphne spoke about the impact of feeling judged by her first therapist:

Daphne: *that was it and I thought "oh, okay".*

Lia: *So what did that mean to you?*

Daphne: *That was a judgement.*

Lia: *Okay. So, at that moment, you felt she was judging you?*

Daphne: *Yeah. I have grown-up children [. . .] she asked their ages, and I said, and she goes "oh" and I thought, "okay. So you're doing the calculation on whatever she perceived me as, my kids are X age, so". That that was it. That was the… Yeah.*

Lia: *That was a moment for you? Is it hard to connect back into that?*

Daphne: *Yeah, because… I can see her trying to do the maths in her head and I was thinking you have my file and does it matter? Anyway [visibly upset].*

Lia: *What I can see is that it, even now, it still feels upsetting to have felt judged by her.*

Daphne: *Yeah.*

Lia: *And what do you think feeling judged does to you?*

Daphne: *[. . .] I got a bit defensive that she doesn't know me. This is all internally - she doesn't know me - and then I thought – "oh my god" I thought "if she can make a decision about that, what else could she make a decision about?"*

Lia: *It sounds like that was quite a big, difficult moment.*

Daphne: *Yeah, it was a jolt because… I didn't cry in front her; I was just kind of… And I didn't even make it look as though it could have… But I feel ugch … Up to that point, she had the benefit of the doubt and I'm thinking "no no, it's fine, it's okay", and then that happened.*

Here it is clear that feeling judged had (and still has) a big impact on Daphne and "that was it" for her – she was unable to continue with her therapist beyond that point. When a client feels judged or not held in positive regard by their therapist, the therapy environment is no longer a safe space in which the client can open up, and this leads to disengagement from their therapist.

Alongside a general sense of their therapist understanding and not judging them, several clients spoke more specifically about having to repeat themselves due to their therapist not understanding what they were trying to say. For example, Claire commented "every time I was in real flow trying to explain something and she would say 'stop', and then it would disrupt what I was trying to say in the next sentence because she wasn't understanding what I was saying". These interruptions disrupted the contact between the client and the therapist and sometimes also indicated misunderstanding at a deeper level. Claire found that her first therapist wasn't "fully grasping the meaning of what I was trying to say, even when I was trying to explain", and Emma spoke about her "hope that I had that I'd be able to express some of the things without having to necessarily explain them", which highlights that clients hoped that their therapists would understand both the explicit and implicit meanings in their words.

Running alongside this, clients spoke about the importance of their therapist's motivation if and when they asked the client to clarify. For example, Emma talked about how vital it was to her that her therapist asked her to repeat something if they hadn't understood rather than "not asking" and "ignoring it", but the specific way the therapist asked was important:

Emma: *I think the way it's done is really important because, yes, sometimes, you can be asked to be repeated and it just makes... it seems like a put-down and then the connection is lost without particular conversation going. So it's more than... yes. It's more their interest and their engagement with you as well as wanting to be...*

The "interest and engagement" that Emma refers to relates to a level of effort that therapists make within the therapeutic encounter and the underlying intention behind any intervention – clients need to feel like their therapists are actively working to understand them, rather than passive in the encounter, as well as interacting from a place of positive regard.

This was echoed in the accounts of the clients' second therapists, who all emphasised the active effort they made to understand the clients' world from their perspectives. For example, Emma's second therapist talked about his "struggle… to understand her and to understand where her issues were coming from" and indicated a willingness to engage in that process with her. Alongside this, all of the second therapists highlighted the importance of trying to understand the client's experience from their point of view to facilitate engagement (e.g., "Being able to let go of my own frame of reference [. . .] and enter my client's frame of reference is hugely important in terms of how deeply I am able to engage with the client", T2-Paul). Second therapists also made efforts to accept whatever their client was bringing. For example, Daphne's second therapist commented "this space was for her and I wanted to make sure that I didn't assume anything or didn't presume anything. But that I was just here to witness what she wants to bring".

While clients and their second therapists appeared to be aligned in their experiences of each other, with first therapists there was more of a disconnect between the client's experience of sessions and their therapist's understanding of what was happening. For example, both Claire and

her first therapist spoke about where they were each sitting in the room but understood their positioning differently: Claire explained “it was just the way she positioned herself in the room as well [. . .] There’s a long row of sofas, and she could’ve chosen to sit opposite me, but she chose to sit there rather than opposite. I just thought that [T1-Claire] is not really interested”. T1-Claire understood this a different way, commenting that Claire “chose to sit on almost the end of the room, on the very back. In a way she put the table between us” and determined from this that Claire “needed time to just trust and to feel comfortable”. While T1-Claire may have been accurately sensing her client’s discomfort, she wasn’t aware that anything she was doing might be contributing to it.

This disconnect could also be seen in the fact that most first therapists didn’t reference their level of understanding of their clients, or any judgements about them. An exception was T1-Daphne, who did mention that she didn’t feel able “to really understand what [Daphne] was going through”, which correlated with Daphne’s experience of her. In addition, T1-Jane acknowledged that he did have some judgements of Jane: “I started to develop a really strong negative countertransference” towards Jane, and was thinking “oh this anger isn’t about what’s happened here, you’re just an angry lady and you’ve got anger issues”. The fact that it was just these two therapists who spoke about these aspects may indicate that in general first therapists were unaware that their clients didn’t feel understood by them, or that their energies were directed elsewhere.

Theme 1, Subtheme 3: Mutual positive regard and forming a personal relationship

“I would have probably connected with her on a personal level” (Claire)

When clients were able to understand and felt understood by their therapist they were able to sense whether their therapist liked them and held them in positive regard. Daphne gave a beautiful analogy of “the resonance of me being a tuning fork”, suggesting that when client and therapist are able to engage they are both vibrating at a harmonic frequency. In these situations, clients spoke about liking and feeling liked by their therapists, and therapists spoke about liking and being liked

by their clients. For example, clients felt that their therapists “really want the best for you” (Jane), and emphasised the value of feeling empathy from their therapists (e.g., “the empathy level was incredible”, Paul). Likewise, clients’ second therapists spoke about how much they “appreciated” (T2-Paul), “admired” (T2-Claire), and “had a lot of respect for” (T2-Daphne) their clients.

Less clarity can be seen between clients and their first therapists. Clients were less sure of how their therapists felt about them (e.g., “I don't know whether she didn't like me”, Daphne) and first therapists were more muted in their feelings, with some saying that there were “definitely parts” of their clients that they “didn’t like” (T1-Robert) and others expressing their difficulty in empathising with their clients (for example, T1-Jane said that his capacity to empathise was “foreclosed” on meeting the client).

Following on from mutual positive regard, clients likened connecting with their therapists to connecting with people in real life. For example, Robert commented: “Well, just as you do in life, when you meet someone, and they seem to understand the way in which you communicate… When you communicate well with someone, then you’re linked in some way. You have a similar way of doing things, similar way of seeing things. That’s why that works or doesn’t”. The capacity to relate to each other was often connected to having things in common (e.g., “she was on the same wavelength as me. She appreciated the same things as me as well”, Claire). This was also picked up by clients’ second therapists – for example, T2-Daphne commented: “there were a lot of commonalities that I wasn’t aware of in that first meeting, but that, I think, underlied a kind of general similarity in the way we approach the world”.

When clients and therapists had things in common this could allow them to understand each other’s worlds, and the opposite was also true – fewer points of connection could hinder engagement in therapy. For example, Daphne said of her first therapist “when we were talking, I didn't feel that she could latch onto something in her life that resonated in what I said so that she could rebound it and understand that I'm feeling like that… there was no… What's the word that

they use? Association with anything". Without this resonance the client felt less understood and it was difficult for client and therapist to engage.

Along with similarity, clients also emphasized the importance of difference between them. Emma articulated the distinction for her:

Emma: *I think there are... there's definitely things that - I need to recognize something in them that is like me, that there's something, but also, enough of a gap, whether it's age gap or race or whether it's man [. . .] there has to be a general understanding that they would understand me, and I don't know where that comes from. I can't necessarily be pin it down with this thing.*

Lia: *So they have enough points of contact with you - they're enough like you that they can understand where you're coming from.*

Emma: *Yes.*

Lia: *But enough difference for you to not feel like you need to look after them.*

Emma: *Yes. And to challenge me.*

Lia: *Okay, yes. So to be able to see things not from your perspective.*

Emma: *Yes. [T2] did challenge me, which is definitely needed. You can't just agree – "oh, you had a shit day, that sounds awful. I don't know. This is unfair on anyone". And at times, you absolutely need that to confirm and to agree it, but it's this probing getting more out of you.*

Here Emma talks about the importance of her therapist being similar enough to be able to understand her, and also highlights that difference between herself and her therapist is important for her to feel like her therapist can be separate enough to take care of her (rather than the other way around) and guide her to a deeper level of understanding within the therapy.

The balance between appreciation of similarity and recognition of difference was also described by clients' second therapists. Paul's second therapist articulated the value of this particularly well: "I felt a connection with him because he said he grew up in a [. . . shire] village. And I was like 'well so did I'. But I think we had a deeper relationship when I really understood what it might have been like for him walking around that village". Here she is commenting on the fact that both she and Paul grew up in small villages in a similar area and this helped her to understand something about the place where he grew up. However, they are from very different ethnic backgrounds, and it was the point at which she recognized just how different their experience of those villages was that they developed a deeper connection.

Tying in with the capacity to relate to each other, most clients felt that they could have been friends with their second therapists if they had met under different circumstances. Daphne clearly expressed this, saying "I still felt like if life had been different, we could have gone out clubbing together, we could go out clubbing together now [giggly], we still kind of…. But, yeah, it was that kind of, yeah, my kind of people kind of thing, you know. That's what it felt like, kindred". Here Daphne alludes to the fact that the therapy situation is different to everyday life. Claire spoke about this more directly, saying "I think if she hadn't been my therapist, I would have probably connected to her on a personal level. She's very approachable as well, which I think is important in therapy." This recognition of the uniqueness of the therapeutic situation was important to clients' capacity to engage with their therapists as it allowed clients to use the therapy in a different way to how they would speak with their friends. For example, Daphne said of her second therapist "she is that sort of person that I could talk to like a therapist and wouldn't judge me. That's what I felt like. There are people that I know, that I've known since childhood, that I couldn't… I could, as you say, go clubbing with them, but I still feel embarrassed about doing and talking about that"

While getting a sense of the therapist as a person and feeling heard and truly understood by the therapist were primarily expressed by client participants, the forming of a personal relationship was a mutual process. This was demonstrated across second therapists' accounts, where a sense

of mutual appreciation and regulation was evident between themselves and their clients. For example, T2 Paul commented, “I think it was a mutual, we were struck by each other, you know, there was a connection because of it”. In addition, T2-Daphne commented: “all that I could feel from her was this real, genuine openness, and this warmth. And with that, all the anxieties shifted down a bit and I just focused on getting to know her and trying to hold space for her”, indicating that her client’s warmth helped her to relax.

Conclusion of Theme 1

Overall, the development of a personal relationship between the client and their therapist seemed to be of paramount importance to the possibility of engagement between them. In order for this relationship to develop, clients needed to understand and feel understood by their therapists, and both parties needed to experience a sense of mutual positive regard. There appeared to be a disconnect between how clients and their first therapists experienced each other and their sessions, and ultimately a relationship at a personal level did not develop. This contrasts with how aligned clients and their second therapists were in their understanding and care for each other, which facilitated engagement between them.

Theme 2 The therapist’s responsiveness to the client

“She was leading the partnership, but you felt like an equal” (Paul)

Alongside the personal connection between clients and their therapists, both clients and therapists spoke about the therapist’s responsiveness to their client. This came through in the therapist’s attentiveness and the power balance of ‘leading and being led’ between the client and their therapist.

Linking to the active efforts that therapists made to understand their clients (described in Theme 1, Subtheme 2), a primary aspect within this theme was the client getting a sense of their therapist as

actively interested and engaged with what they were saying. Jane commented that her second therapist was "paying a lot of attention" and Paul spoke about his second therapist "*really* taking me in". Clients described several ways through which they experienced this active interest from their therapists, such as referring back to what they had said in previous sessions, checking in with them during sessions, and paying attention to the measures that clients filled out.

Jane commented on this process with her second therapist:

Jane: *he would either bring a question, or let's say a clarification on what I had said - "do you remember when you said such and such, I wonder if I got what you were saying, could you say a bit more?" meaning that I felt that there was a connection between the sessions*

Lia: *okay, so you knew that he had been thinking about you*

Jane: *yeah, and what we had talked about*

Here Jane highlights how important it was that she was being held in mind by her therapist, not just during sessions but also in-between sessions.

Another dimension of this active interest was expressed by Paul, who spoke about his second therapist's use of the measures: "she looks like she's glancing at it and putting it down, but she's not, because she's going, oh, that's good, because last week you said this, and so there's a slight change there. She would acknowledge everything you gave her, including raw data". The value of the therapist paying attention to "everything" that their client gave them, such as the way they filled out the measures, how they presented in sessions, and the content and underlying meaning behind what they were saying, was emphasised by all clients. This was also a focus for second therapists: For example, T2-Jane commented "if you really are listening very attentively to someone, especially as long as they're in the same room, they just know you are" and T2-Daphne spoke about how this helped clients to feel like "somebody genuinely gives a shit".

If, instead, a therapist appeared disinterested, then the client was less able to engage with them. Emma spoke about therapists with whom she wasn't able to engage: "Some that I've experienced they're not very present - it seems really unfair. I'm sure they just had a bad day, and we all do - But as soon as I feel that, I'm not going to be opening up about stuff that I'm here for". Emma's comment about it being "unfair" highlights clients' general expectation that their therapist will be present and interested in them during sessions, and when this expectation of the therapist's role isn't met then the client closes down.

Paul also gave a particularly salient example:

Paul: *We were talking, I'm trying to think… I can't remember what I was talking about. But it was deep enough to feel like I was getting my flow into something. And his phone went. He had a thing about phones, he had two or three phones. Which was never easy for me thinking, this guy must be a pastor or something, because why would you have so many different phones? He must have other things going on. A bit of a distraction [. . .]*

But you usually have it on [. . .] aeroplane mode [. . .] and that's fine. But yes, his phone went off, and that's fine. The phone went off, but he answered it. And that's where I was like, "hang on".

Because I was in the middle of saying something and then he answered it, he went, "hi [Laura], yes, I can't speak to you right now, I'm doing something, yes, I'll talk to you later, okay, great, okay, bye". Put the phone down, and then he went, "so, where were we?" And I was just, I was thinking, "we were nowhere, mate, not now, because I was in the middle of saying something". But that was the point where I just went, how unprofessional can you be?

Here Paul's use of the word "unprofessional" seemed to be a polite way of describing his experience of his therapist's complete disregard for him – his therapist had seemed distracted from the start, which was difficult enough, but the breaking point was when he actually answered his phone. This clearly demonstrated to Paul that he was not a priority to his therapist and, as a result, there was no chance that they would engage in therapy with each other.

On the therapists' side, first therapists spoke less about not prioritising their clients, and instead alluded to how their personal process may have interrupted engagement between them. This connects to therapists' responses to their clients and is explored in Theme 3, Subtheme 1 (p. 95).

Tying in with the active presence of their therapists, clients articulated a delicate balance of power between themselves and their therapists, wanting their therapist to take the lead and guide sessions, whilst also being responsive to, and led by, their clients. Paul described this with his second therapist - "she was leading the partnership, but you felt like an equal" - and Jane expanded on this, contrasting therapy with a hospital visit:

Jane: *I want to feel I can lean on the other person to lead me. But yes, to also feel that I'm not - I'm not a patient, in the way what when you go to the hospital they put you in the gown and suddenly you're a patient and you have no control over anything really. It's very clear that the doctor has the power and you are the patient, and yet in counselling you're trying to - I feel - you're hoping to balance that a bit more and to come in need but then to be able to sit as an equal partner to the counsellor.*

Here Jane alludes to the inherent power imbalance between clients and their therapists, and the importance of a collaborative stance (in which the therapist takes the lead, but clients are treated as equal partners) to redress the balance. Along these lines, Claire gave the example that her therapist "made it very easy that if I wanted to speak up for myself at any point that I could speak up and say that I didn't agree with the way the session was going. She actually wanted feedback", demonstrating that her therapist was actively encouraging a collaborative atmosphere and was able to respond to her needs.

A contrast can be seen in clients' experiences with their first therapists, with whom clients experienced a lack of responsiveness. Clients gave examples of explicitly requesting something different from their therapist and their therapist not being able to adjust in return. On this topic Jane commented "I finally said [. . .] 'actually, I'm struggling because I feel like I need a bit more help - even probing questions or something' and he said 'what is it about that that makes you

interested in that?' and I was kind of like 'sigh, okay'". Similarly, Robert said "I did request a little bit more interaction each time I went and that didn't seem to come forth".

Alongside responsiveness, it was still important for therapists to be in a facilitative professional role. With their second therapists, clients spoke about how helpful it was when their therapist was "leading" (Jane), "gently steer[ing]" (Daphne) and "probing" (Emma), highlighting the active role that their therapists took in guiding the therapy sessions. Daphne described how her therapist "would let [her] ramble and then pick bits out or gently steer [her] into 'you've talked about this, let's talk about the next part on there', or 'you're stuck in this bit, let's move forward a little bit'", which shows how Daphne's therapist both gave her space and guided her within the sessions.

Emma also referenced this dynamic:

Lia: *How were the sessions, were they led by him, led by you?*

Emma: *Definitely led by me, I think. But he would ask good questions. I mean, he would repeat it back to me - I really needed it at the time - if that makes sense.*

Lia: *So the questions helped in some way.*

Emma: *Yes. Definitely. Yes.*

Lia: *What do you think they did?*

Emma: *Just changed my view on it. Or sometimes he would just say it slightly differently or in a slightly different tone. I'd think 'It doesn't make sense anymore. It doesn't carry as much, whatever that is'. So that definitely helps.*

Here Emma speaks about how she led the sessions, but her therapist asked questions or repeated what she had said in a way that helped to develop her understanding of what was going on. The value of therapists asking questions and challenging their clients and leading them to understand things in a different way, or at a different level, was emphasised by all clients (e.g.,

“she did challenge my thinking if she thought it was wrong. She didn’t just let me just carry on talking”, Claire).

A contrast can be seen in in clients’ descriptions of their interactions with their first therapists – in all cases engagement was disrupted due to the power dynamic being upset, but in different ways. In some cases, the therapist didn’t take enough of a lead in sessions. For example, Jane experienced her therapist as very passive and asserted “I don’t want a completely non-directive counsellor, kind of parroting back kind of style” because “I start to feel like I’m leading, and I don’t want to do that”. Similarly, clients didn’t want to have to do all of the work in the sessions. Robert commented:

Robert: *There was a lot of me thinking of things to say.*

Lia: *Right, right. So, you had to work quite hard?*

Robert: *Yes, I did. And I wasn’t willing to work that hard, to be honest.*

Clients also expressed a need for their therapists to pace sessions and provide a level of containment or regulation. An example can be seen in Claire’s descriptions of each of her therapists - with her first therapist, Claire spoke about how she “walked out feeling really overwhelmed thinking I’ve just disclosed really my whole life. There was no wind down session at the end, you know where you can just slowly wind down, and get that person a bit calmer because you don’t know how it’s going to affect them”. In contrast, Claire’s second therapist would “try and make sure that I was okay before I finished something and she would check I was okay before I left the room”. This had a regulatory effect and allowed Claire to feel safer about opening up during sessions.

While clients emphasised the way that their second therapists *led* sessions, second therapists focussed less on their guidance of sessions and more on how they encouraged their clients to direct the sessions. For example, T2-Claire described her approach as “following her, not directing

the sessions, not deciding what the agenda needed to be and deciding what the most important elements of her experience were to address. That allowed her the control of the things that she wanted to work through at any given time, I think really staying with her". Here T2-Claire's focus was on giving her client control of the session, but staying with her and providing a level of containment in the process.

Similarly, T2-Jane explained: "I suppose I do generally give my clients a lot of space. I think I do. I do allow that. I consciously allow whatever needs to unfold unfold. You know, most of the time, in a pretty nondirective way". While T2-Jane's description of the way that he works is 'nondirective', his use of the word 'consciously' indicates how active he was in the process. From this it seems that the second therapists' focus was more on creating a safe container for the client (e.g., "I think she felt, I imagine I would've felt containing to her", T2-Jane) and this then allowed clients to bring what they needed to bring and use the space the way they needed to use it. Indeed, Paul commented about his second therapist: "she created a safe space with her mannerisms, her words, her open approach".

Clients' first therapists felt less able to provide this level of containment for their clients and alluded to the power dynamic between themselves and their clients not being balanced. For example, T1-Robert mentioned feeling a sense of "pressure" from her client – "this pressure to get things right. Get things done", perhaps referencing the weight that the client was exerting within the dyad. Along these lines, several first therapists described the client coming across as more powerful than them. T1-Claire highlighted this, giving the analogy of "a power ladder" and saying "to me in that moment, I was one step down and she was one step up in a way. I didn't feel my presence so strong". She went on to say that Claire was "really talking a lot [. . .] She doesn't let you a lot of space to talk, [. . .] and so it was difficult to interact, in the moment to block her, to do some questions. You really have to take your space if you want to say something". This highlighted that, in a way, T1-Claire felt unable to pace or take control of the session with Claire. Similarly, T1-

Daphne commented that her client “went full into it”, and she was left feeling powerless to intervene.

Key within this theme was a sense of balance between a client and their therapist. While clients need therapists to be present and able to guide sessions, therapists must also be responsive to, and guided by, their clients. When this balance was upset client and therapist were unable to engage, while when there was parity between them therapy became a safe space in which the client’s needs could be met.

Theme 3 Is the client in good hands?

“one had nailed it and one was still trying to get there” (Paul)

Another key aspect of engagement centered around both clients and their therapists feeling like the client was in good hands with their therapist. Therapists needed to feel like they could cope with what the client was bringing, while clients needed to experience their therapists as authentic, composed and competent to be able to trust them within the therapeutic process.

Theme 3, Subtheme 1: Therapists’ responses to their clients

“it was easy for me to connect” (T2-Daphne) versus “I don’t want her to know that I’m freaking out” (T1-Daphne)

For therapists, their internal responses in the room with their clients impacted their sense of whether the client was in good hands with them (i.e. whether they could handle what the client was bringing) and this, in turn, impacted how they behaved with their clients during sessions. While clients uniformly expressed feelings of discomfort with their first therapists (see Subtheme 3 below), first therapists described a range of reactions to their clients. Some therapists “felt comfortable” (T1-Claire), and others felt anxious or drained. For example, T1-Daphne described her sessions with her client as an “emotionally draining experience”, and T1-Robert commented

that she was “thinking am I doing the right thing all the time? Second questioning myself. My anxieties being there, taking up more than it could have done”.

T1-Robert went on to say “I think there was less of me available to connect, because there was so much of me managing my own emotions and feelings, that there wasn’t as much to be able to connect with him”. This highlights how therapists’ emotional reactions could impact their availability to their clients. Adding to this, several other first therapists spoke about feeling “overwhelmed" by their clients (e.g., “I think that there was a degree of being overwhelmed by the energy of her anger”, T1-Jane), indicating that therapist composure was related to the therapist being able to manage, or regulate, all of their own emotions, not just anxiety.

At a more extreme end, some of the clients’ first therapists even experienced their clients as a threat to them, or like they were under attack. Daphne’s first therapist likened what her client was bringing to a “little bomb going off” or a “fireball of energy” and Jane’s first therapist described the walk with Jane up the stairs as “treacherous” and Jane as a “pitbull terrier [. . .] biting my ankles, and me wanting to boot her away”. For these therapists the client was experienced as a powerful presence that they needed to defend themselves against and this, in turn, left them unavailable to engage with their client. Along these lines, Jane’s first therapist spoke about being “pinned back” by his experience of her, and this paralysed him within the sessions and left him unable to engage with her.

When therapists had these strong internal responses to their clients, they were not able to be their natural selves during sessions and alluded to “defaulting” (T1-Robert) to a particular therapeutic style, rather than being able to work in a natural, authentic way. For example, Jane’s first therapist said, “contrary to my way of working - I’m very here and now, I’m very right brained, I’m very instinctual - and so for me to not take an emotion seriously and want to bypass that straight into a more interpretive classical stance is just, it’s just not how I work”. Here he highlights that he wasn’t working the way he would naturally work with Jane and was not able to be authentic in his

presence and interventions. In addition, T1-Daphne gave insight into the amount of energy that some therapists needed to direct towards containing their own discomfort, commenting “I don’t want her to know that I’m freaking out, so I was just sort-of-like calm and a bit like a duck. On the surface calm but underneath going ‘brrr’, paddling furiously”.

In these cases therapists clearly didn’t feel like they were able to handle what the client was bringing. Several therapists put this down to their relative lack of experience. However, they also mentioned that they were able to engage with other clients in the same timeframe, which suggests that experience alone does not account for clients engaging or not engaging in therapy. For example, Daphne’s first therapist said that she “wasn’t experienced enough at that stage” to be able to “bring help to [Daphne]”, but she also commented “I don’t think I came across any differently particularly with the next clients” (who both stayed with her for an entire year and had equally complex presenting issues). This suggests that, while experience may play a role, there are clearly other elements that intersect with it and contribute to engagement in therapy.

When reflecting on what had happened between themselves and their clients, most first therapists noticed that their capacity to manage their own personal histories had impacted their availability to their clients. For example, with Jane, T1-Jane realised that to an extent he was “wrapping [himself] in cotton wool” because he had been through a difficult time recently and “needed bolstering, [he] had been in a difficult place, [he] was still recovering”. Here T1-Jane was so focussed on trying to manage his own process that he was unable to give sufficient attention to his client. This also came across with other first therapists, for example T1-Robert acknowledged “part of my life script, and my history from my family, was don’t feel negative emotions [which meant that] I probably wasn’t able to connect with his ‘don’t feel anger’ as much as I could have done now”.

In contrast to first therapists, clients’ second therapists’ experience of therapy with their clients was strikingly different. They emphasised how much they valued and enjoyed working with their clients (e.g., “I enjoyed seeing her, so I enjoyed being there and I enjoyed seeing her”, T2-Emma) and

spoke about it being a “real privilege” (T2-Paul) to experience a connection in the room with them. Daphne’s second therapist commented: “I feel like [Daphne] taught me almost as much as I hopefully experienced with her. I really felt like I’d learnt from her, and witnessing her journey was actually a real privilege”.

Second therapists generally felt “comfortable” (T2-Emma), “relaxed and calm” (T2-Claire) and “fairly confident” (T2-Jane) with their clients, and this enabled them to be present and more composed. Even in the face of potentially unsettling material from the client, second therapists were “not fazed” (T2-Jane) and felt “able to handle pretty much anything” (T2-Emma). With less energy directed towards managing feelings of discomfort with their clients, second therapists were able to be more natural and genuine in sessions, and also described this as a focus for them. For example, Emma’s second therapist said “for me being who I am and being natural is an important part of who I am as a therapist…That I authentically come across as ‘yes, I do really get where you’re coming from, I understand why this is so difficult for you, I understand the feeling behind who you are’… I suppose it also goes along with bringing myself into the room and bringing who I am”. Here T2-Emma makes a clear link between authenticity and bringing himself into the room and has integrated this into the way that he works.

Second therapists also described efforts they made to be reliable to their clients, such as always being prepared for sessions. For example, Daphne’s second therapist commented: “I think there’s a certain practicality, normality about coming to the same room, sitting in the same seat, me always being where I’m supposed to be at the right time, with the right kind of paperwork. And I always made sure that I was here about an hour early and that I had everything sorted and I was calm and organised before going into the room. I think that gives a kind of reliability.”

Theme 3, Subtheme 2: The client's experience of their therapist as authentic, composed and capable

"it was really important for me to know that they can handle it" (Emma)

For clients, a primary aspect of feeling like they were in good hands was their perception of their therapist's authenticity, as this impacted their capacity to trust their therapist. This feeling of authenticity was clearly present for clients with their second therapists, for example Paul spoke about how his therapist "had this air of someone who was doing, being" and went on to say that she was "being it, rather than acting it", emphasising the naturalness of his therapist's approach. In addition, Claire highlighted two important aspects of authenticity – therapist motivation and genuineness – claiming "I got the idea that not only she was motivated, [. . .] but she actually genuinely wanted to help people who were in that position as well".

In contrast, clients described a general sense of inauthenticity with their first therapists. Emma gave an example of a moment with her first therapist, saying "there was this thing that I was talking about work and the way [the therapist] said 'for you, this must have been really difficult'. And I just didn't feel it". Here her therapist made an appropriate-sounding response, but Emma sensed a disconnect, or lack of congruence, between her therapist's words and what her therapist was feeling and doubted her genuineness. Other clients also experienced their therapists as inauthentic. For example, Claire described her first therapist as "robotic" and Daphne's impression was that "boxes were being ticked and she was answering as the book says", rather than responding in a genuine way.

Alongside authenticity, clients needed to experience their therapists as composed. When a client's therapist appeared anxious or flustered, the client couldn't trust that their therapist would be able to look after them, and might even feel the reverse – like they needed to take care of their therapist. Emma described this process when she met her first therapist, saying "They were really out of breath. They were sweating a little bit. And then they seemed a little bit nervous [. . .] .

Instinctively, on those situations, you would want to look after that person. And [. . .] for me, [. . .] that just didn't work". She went on to say "definitely, I need to feel like they are in control of themselves. And as soon as I don't, I'm like... because I just feel like such a burden on them". Emma then presented a contrast when describing her second therapist who "was just really relaxed. He would take his shoes off and sit with his legs underneath him and he can just put you at ease with that" which allowed Emma to relax and make use of the therapeutic space. This reflects a view expressed by all clients, that their therapist needs to appear relaxed and in control of themselves and the situation for the client to be able to engage with them.

When therapists were composed clients felt like their therapists were able to prioritise them and this facilitated engagement, while a lack of composure had the opposite effect. Emma gave an example of her therapist running late and then, when she arrived, going straight into the session without taking a moment to compose herself. She commented: "when someone's riding on the train and they texted you, they're going to be 15 minutes late, and that's absolutely fine. But then, again, when they arrive, now that's a different experience. But it's almost like it makes sense when the sessions were delayed long enough for them to be composed rather than carry on because you absorb it". Here Emma suggests that lateness on its own would be okay depending on the way that it is handled, but if the therapist is not composed then she ends up absorbing the therapist's stress and this is not helpful to her. In these cases, the therapist is prioritising the client's time, but the client's deeper relational need is for therapist to be available.

Therapists' capacity to be authentic and composed also led clients to make assumptions about their therapists' level of experience and, generally, clients assumed that the therapists with whom they were able to engage were more experienced than the therapists that clients had trouble engaging with. Interestingly, this did not always correlate with their therapist's actual level of experience – for example, Paul said of his second therapist "The sense of experience came across much more so than someone who was a student. She didn't seem like a student" but, in reality, Paul's second therapist had only had a few clients before meeting him. Similarly, Claire

commented of her first therapist: “I didn’t know what she had done before, but it didn’t feel like she had any personal experience of whether it’s in voluntary work or anything before she’d done this” suggesting that Claire felt her first therapist was inexperienced both personally and professionally, but actually Claire’s first therapist had years and years of experience practicing in Italy before she met Claire.

Theme 3, Subtheme 3: How clients felt in the room with their therapists

“I clamped up” versus “stuff just flooded out” (Paul)

Another thread that contributed to clients’ sense of being in good hands was how they felt when they were in the room with their therapists, and the impact that this had on their capacity to open up. Within non-engaged dyads, clients “clamped up” (Paul), “closed down” (Paul), and “disconnected” (Daphne), and didn’t feel like they could talk openly to their therapists (e.g., “I don't think I can talk to this person about this”, Emma). They also expressed a level of discomfort, describing sessions as “awkward” (Jane), feeling “embarrassed” (Daphne), and unable to relax. Claire commented: “With [T1] I picked up very quickly that I didn’t feel comfortable in her presence, so I thought ‘if I don’t feel comfortable around you, I’m not going to feel comfortable talking about things that are a bit more on a deeper level’”.

As well as discomfort, clients also referenced an absence of positive feeling with their first therapists. For example, Daphne claimed that “there was nothing” between herself and her first therapist, and Paul commented “I just wasn’t feeling anything with him, even after a couple of sessions”, which may suggest that clients need to actively feel something positive about their therapists in order to engage.

These more positive feelings could be seen in how clients experienced sessions with therapists with whom they were able to engage. For example, Robert explained that he feels “more comfortable” which means that “the process can work better” and sessions feel “straightforward and easy” with therapists that he engages better with. In addition, Paul commented that with his

second therapist “stuff just flooded out. It was like I needed to talk, and it just came out”, highlighting the ease with which he was able to use the therapy space to meet his needs.

Along these lines, Emma said of her second therapist: “He did definitely make me more comfortable and was easy to be around. And discuss really distressing matters at the same time”. Inherent within Emma’s comment is a sense of being able to trust her second therapist and feel safe enough to discuss “distressing matters”. The importance of trust and safety was expressed by all clients. Paul described it beautifully, saying that he “could feel safe, it’s like a little cocoon” and his “whole body just went [gesture of sinking into chair], and [he] felt like [he] could relax”. Alongside this, clients felt hope that things would get better in their lives with their second therapists. For example, Jane commented that her therapist was able to “say things that gave me the hope that I wouldn’t always be in that place”, and Emma explained that her therapist’s “approach definitely came across as, ‘we'll be fine, we'll sort this out’”.

Conclusion of Theme 3

The findings within this theme demonstrate the importance of both clients and their therapists feeling like the client is in good hands with the therapist to the process of engagement. Between clients and their first therapists, clients felt uncomfortable and unable to open up and first therapists felt unable to support their clients and sometimes responded as though the client presented a threat to them. First therapists also described how their own process got in the way of connecting with their clients. Between clients and their second therapists the process felt easier for both – clients were able to speak to their therapists with ease and their second therapists felt composed and capable of handling whatever the client brought to the sessions.

Theme 4 The client's decision to change therapist

"It was never going to work out for either one of us" (T1-Daphne)

The final theme that I developed from the data speaks about the decision to change therapist. As this theme relates to the client's decision, the predominant voices within it are those of the client participants. When considering whether or not to stay with their therapist, clients spoke about the process by which they made the decision, and the factors they considered before requesting to transfer. Interestingly, the decision-making process seemed to happen at two levels. One was an almost instantaneous feeling that the client had about their therapist, and another was a slower, more conscious process, based on the developing relationship between the client and their therapist.

Most client participants described knowing whether or not they would be able to engage with their therapists almost immediately. For example, Emma said that her sense that it wouldn't work with her first therapist "was pretty instant", while Paul knew "right from the first moment [that T2-Paul was] going to be a good therapist [for him]". When a client's immediate sense was that it would be difficult to engage with their therapist, they sometimes gave it time in the hope that that things would get better and spoke with family to double check their impressions, indicating that they were reluctant to request a transfer. For example, Daphne remembered saying to herself "no, come on [Daphne], you're only coming once a week, so just try", and "going back to [her] partner, saying 'I'm not sure whether this is working, but I'll go back'". However, she ultimately decided that "[she] wasn't going to come back because [she] knew that there wasn't a connection there". None of the clients mentioned having a negative initial reaction to their second therapists.

Beyond that initial impression, clients also needed to feel like they would achieve tangible benefits from the therapy. Claire commented "I don't need to pay someone just to create that space. I do that a lot with my sister anyway. [. . .] I actually need someone to be able to give me tools that I can handle things in a different way". This articulates a view expressed by most clients, and may

suggest that engagement in therapy is contingent on clients believing that they will benefit from the process with their therapist.

These gains were evident when clients were able to engage with their therapists. When speaking about their second therapists, clients experienced multiple benefits from the therapy (e.g., “She was helpful, and in lots of different ways”, Paul), such as therapy helping them to regulate and process their emotions, as well as see things at a deeper level, or navigate out of a stuck process. For example, Claire commented “I think she practically helped me get to the root of trying to connect with my emotions and what I was feeling, and acknowledging that was important, but also what practical steps I could take to overcome what the actual problem was”. Clients also emphasised the lasting impact of the therapy – that they had gained skills or techniques that they were able to use after the therapy had ended (e.g., “constructive feedback on what I can do to keep myself going”, Paul). While these impressions were based on many sessions of therapy, clients emphasised that they anticipated positive change from the beginning. For example, Daphne commented “I think people know from the first session” and Emma mentioned that with her second therapist “it did work just so much better, actually, a lot easier. Again, I think I knew quite quickly”. Along these lines, both clients and their second therapists seemed to be invested in the process of therapy, with clients commenting that they “want to go on that journey with them” (Jane) and therapists describing how much they enjoyed working with their clients.

In cases when clients were not able to engage with their therapists, they did not feel like they would achieve any benefit from the therapy. At best clients felt that they were not benefitting, or would not benefit (e.g., “I tried to think that I came away every time thinking that something new had changed, but I didn't”, Daphne), and at worst they actually felt like they were being harmed by the therapy (e.g. “it was getting to the point where it was actually frustrating me. Visiting here and getting nothing was actually making me worse”, Robert). In these situations, clients described a process of weighing up whether or not it was worth them continuing in therapy. Each client spoke

about their levels of distress, and how they “really needed help so [they] needed to move on” (Jane) and “didn't want to keep going just for the sake of keep on coming back” (Daphne).

Clients also expressed hope that there would be a better therapist out there for them. Jane commented “I did have some hopes that there would be someone better - I remember thinking ‘there must be a better fit’” and Emma spoke about how she was “quite determined to get a better fit”. This “better fit” that Emma mentioned also indicates that clients weren’t looking for, or didn’t expect, a perfect match with their therapists. An example of this can be seen with Jane, who said “I certainly didn’t have - and I don’t now - have the feeling like who [T2-Jane] is exactly the type of counsellor that I’d always want to have, but I think that there was enough there”. From this it seems that a therapist doesn’t need to be perfect, there just needs to be enough of a match for their client’s needs (e.g.,“if it’s overall working”, Jane), and that different therapists might work for clients at different times (e.g. “I am judging the [therapists I have seen] on very different criteria. Because, my state of mind was much different”, Robert).

Even if they didn’t have the option of changing or the hope of a better therapist, clients commented that they “still would have stopped” (Jane) as they didn’t believe that it was going to get better with their first therapist. This suggests that ending therapy was preferable to continuing in a therapeutic relationship that wasn’t giving them what they wanted or needed.

From the therapists’ perspective, first therapists didn’t express the same sense of knowing immediately whether the therapy would work, and instead said that they would have liked more time to develop the relationship with their clients (e.g., “I didn’t feel that we didn’t engage, I felt that it was really little time, and she had lots to say”, T1-Claire). Several of the clients’ first therapists were surprised that their clients chose to request to transfer as they were aware that something wasn’t quite right for their clients but hoped that they would be able to work through the issues. For example, T1-Jane commented “I was surprised actually that she didn’t come back because my sense was that ‘we’re missing each other here - she’s in a really difficult position, she’s very angry,

it’s early days for me, this is a big piece of work’ but [. . .] I thought we’d have more of a battle [. . .] but the fact that she just cut it - I was surprised by that”. From this it seems that first therapists were not aware of the extent of the difficulties between themselves and their clients.

Overall, it is clear that for clients to engage in therapy they needed to feel like the therapy would meet their needs to some extent. Clients had an initial, immediate sense of this, as well as a gradual sense that developed over time. They described weighing up whether the therapy would be good enough to for them to continue, before making their decision about whether or not to request to transfer to a different therapist. This decision was not taken lightly, and clients only requested to transfer when they were sure that things wouldn’t work with their first therapist, and would have dropped out had the option to transfer not been available.

4.5 Tables of themes with example quotes

Table 4 - Theme 1 with example quotes

	THEME 1 - Forming a personal connection with the therapist *"I've instantly liked them, I've instantly understood what they are about, and I've instantly felt comfortable that they understood what I was about" (Robert)*		
	SUBTHEME 1 **Clients need to get a sense of their therapist as a person** *"it worked better that I felt he was bringing who he was" (Jane)*	**SUBTHEME 2** **Clients need to feel heard and truly understood by their therapists** *"I felt like she didn't see me, and it wouldn't have mattered what I said" (Daphne)*	**SUBTHEME 3** **Mutual positive regard, and forming a personal relationship** *"I would have probably connected with her on a personal level" (Claire)*
CLIENT QUOTES	Daphne on T2: I'm sticking with you because everything, all my spider senses, were saying yes Jane on T1: feel that helps me just to know enough about the person. I don't want a blank slate really. I know some people do, but I don't Daphne on T1: I made an assumption that she may have been a middle-class wife and she was doing something outside Claire on T2: I appreciate it when therapists actually give, not personal details but just experiences of what they've gone through in certain things.	Jane: every counsellor should start from scratch with every person that comes… they should start with what the person coming wants to explain about their situation… not making any assumptions… Paul on T2: Yes, she wasn't judging me. And if she was, she's a bloody good actress [. . .] I never got that from her. Absolutely never. Robert on T2: I've instantly felt comfortable that they understood what I was about… She understood.	Emma on T1: I felt like that they don't like me as a person enough me to work with them. And then sometimes you can't push past this and so it's really, it's difficult. Paul on T2: The empathy level was incredible compared to [T1] Emma on T2: when you recognize somebody... or there's a hope that I suppose had that I'd be able to express some of the things without having to necessarily explain them - which comes from a certain background…I need to recognize something in them that is like me
T1 QUOTES	T1-Jane: it meant that I didn't bring in my personal self, which to be perfectly honest with you having had therapy for 10-12 years and now I'm a wounded healer in the fairly classical sense, work here and now, most of what I bring is the personal me with a professional frame.	T1-Jane: I started to develop a really strong negative countertransference "oh this anger isn't about what's happened here, you're just an angry lady and you've got anger issues, and stuff went on with your dad or you hate men" T1-Jane: drawing quite a lot of conclusions at a far too early stage	T1-Jane: I had this sense of feeling I think I had a sense of maybe feeling more empathy for [Jane's partner] than for her T1-Claire: No no no, there wasn't something in common that I perceived in that moment [. . .] we are definitely from different culture, and this is really evident.
T2 QUOTES	T2-Claire: I think a lot of it is unspoken. It's about how you feel in the room with somebody. T2-Emma: I'm also quite happy with disclosure in the sense of bringing part of me into the room and talking about, and I'm quite happy to bring in my private life if I think it's relevant to touch on	T2- Paul: I think being able to not have prejudices [. . .] a lack of judgement to really just try and... Yes, I always think about my own philosophy of being a counsellor is to really try and accept people as they are. T2-Emma: I authentically come across as yes, I do really get where you're coming from, I understand why this is so difficult for you, I understand the feeling behind who you are.	T2-Paul: yes, I did feel real positive regard for him and it was a mutual... it was a mutual thing because the more he was able to show himself, the more I was able... the more I felt this deep regard for him because as I said I saw him working so hard. T2-Daphne: a lot of commonalities that I wasn't aware of in that first meeting, but that, I think, underlied a kind of general similarity in the way we approach the world.

Table 5 - Theme 2 with example quotes

	THEME 2 **The therapist's responsiveness to their client** *"She was leading the partnership, but you felt like an equal" (Paul)*
CLIENT QUOTES	Emma: Some that I've experienced they're not very present - it seems really unfair. I'm sure they just had a bad day, and we all do - But as soon as I feel that, I'm not going to be opening up about stuff that I'm here for Jane on T2: I felt that there was a connection between the sessions Paul on T2: She was leading the partnership, but you felt like an equal [. . .] Because they're leading without even having to try [. . .] That sense of... The trust was much stronger… Actively get someone who knows how to engage at the right time, and almost point you in the right direction without dictating to you what to do.
T1 QUOTES	T1-Daphne: it was quite powerful, it was quite a strong thing going on so I didn't really find a moment to... Again, I was do I say something? Do I? I just didn't really know how to handle this because she didn't want to come in and discuss it. It wasn't a discussion. She didn't want a discussion. She wanted to sit there and go back. T1-Claire: if you want to put on a power ladder, you know, like a - if you see a ladder step up step down, yes. To me in that moment, I was one step down and she was one step up in a way. I didn't feel my presence so strong
T2 QUOTES	T2-Jane: being available to them in every sense T2-Daphne: I think there is an importance to give the client the space they need in a safe environment to be or to bring whatever they want T2-Claire: allowing her to find her own pace and to direct the topic of conversation within the room, it allowed her to cope with material as and when she was able to, when she had the resources and the resilience to, and not to be totally overwhelmed by very difficult feelings

Table 6 - Theme 3 with example quotes

	THEME 3 **Is the client in good hands?** *"one had nailed it and one was still trying to get there" (Paul)*		
	SUBTHEME 1 **Therapists' responses to their clients** *"it was easy for me to connect" (T2-Daphne) versus "I don't want her to know that I'm freaking out" (T1-Daphne)*	**SUBTHEME 2** **The client's experience of their therapist as authentic, composed and capable** *"it was really important for me to know that they can handle it" (Emma)*	**SUBTHEME 3** **How clients felt in the room with their therapists** *"I clamped up" versus "stuff just flooded out" (Paul)*
CLIENT QUOTES		Paul: One was like a first- or second-year student, the other was like a post-grad. Do you know what I mean? It was that difference. Emma on T1: they were really flustered…They were really out of breath. They were sweating a little bit. And then they seemed a little bit nervous…[. . .] it's difficult to sense that as a client. Jane on T2: I felt he had experience of dealing with this…And also he has experience of the issues	Paul on T1: I clamped up instantly, because I was in the middle of a sentence… Yes, I closed down because he was too easily distracted, in a sense. Paul on T2: It just, stuff just flooded out. Daphne on T1: Yeah and I didn't feel like... I didn't feel like I would want to tell her certain things because I felt a bit embarrassed…
T1 QUOTES	T1-Daphne: Well I was quite shocked [. . .] It was a bit of a baptism by fire. When I was in the room with her, it was quite emotionally draining experience in the room with her T1-Jane: a degree of being overwhelmed by the energy of her anger and the energy of her frustration, agitation, annoyance, and like I say, in a bodily sense I very much felt like I was pinned back.		
T2 QUOTES	T2-Daphne: she looked up and she had this really warm smile and presence… And with that, all [my] anxieties shifted down a bit and I just focused on getting to know her and trying to hold space for her. T2 Paul: it was quite easy to... for me to feel positive regard T2-Claire: I felt quite relaxed and calm, even though she wasn't…		

Table 7 - Theme 4 with example quotes

	THEME 4 **The client's decision to change therapist** *"It was never going to work out for either one of us"*
CLIENT QUOTES	Jane on T2: my first impression in the first session… oh good, good, this is exactly what I want… Emma on T2: At the time, I did continue to go and I did believe I was improving Robert on T1: the upshot was that I wasn't being helped. Daphne: I knew that if I did come back and see [T1], I wouldn't have got as much out as I have with [T2], even though I didn't know [T2] existed until I met her.
T1 QUOTES	T1-Claire: I didn't feel that we didn't engage, I felt that it was really little time, and she had lots to say T1-Daphne: I wasn't what she needed or wanted [. . .] I did feel we'd both been slightly let down. What I had was a situation which was never going to be something I could... It was never going to work out for either one of us
T2 QUOTES	T2-Claire: There was clearly something about working with me that was working for her [. . .] It's quite rewarding, I suppose, as a therapist to get the feedback that what's happening in the room is working. T2-Emma: I think probably offer them, at least give them the opportunity to feel safe, to have someone who reacts differently to what they're used to… So I guess in some ways, I will often respond differently than maybe they're used to.

Chapter 5: Discussion

The aim of this study was to explore the phenomenon of clients changing from one therapist to another in an effort to learn about what contributes to engagement or non-engagement in therapy. By analyzing the data from interviews with clients along with their therapists I was able to develop four themes that shed light on this phenomenon.

The first theme highlights the importance of a personal relationship developing between the client and their therapist. Within this, key aspects are that the client gets a sense of who their therapist is, the client feels truly understood, and there is mutual positive regard between the client and therapist, enabling a real relationship to develop. The second theme focusses on the therapist's responsiveness to the client. Of particular importance is the therapist's attentiveness and the client and therapist maintaining a delicate balance of 'leading and being led'. The third theme speaks to the client's and therapist's sense of whether the client is in good hands. Therapists need to remain regulated and feel able to cope with the client's presentation, while clients need to feel like their therapist is authentic, composed and capable. The fourth and final theme explores the client's choice to change therapist. Clients described an immediate sense of whether it would work with their therapist, alongside a process of weighing up the costs and benefits of staying with their therapist.

In the following sections I first situate my findings within the broader literature. I then present a reflective account of requesting feedback from participants. I continue with my conclusions, implications and recommendations based on the findings of this research, along with the limitations of this project. I conclude with some final words based on my experience of doing this research.

5.1 Situating findings within broader literature

5.1.1 Theme 1 – forming a personal connection with the therapist

At its core, the relationship between a client and their therapist is based on a human-to-human connection. There is growing evidence which demonstrates the impact of the person of the therapist on engagement in therapy (e.g. Lavik *et al.*, 2018) as well as presenting the real relationship as a pathway through which therapeutic change can occur (Wampold and Budge, 2012). The importance of this human connection has been upheld in the present study, with clients needing to have a sense of who their therapists are and experience warmth and understanding from them to allow a personal relationship to develop between themselves and their therapists.

Gelso and colleagues distinguish between the personal, non-work connection between the client and their therapist, which they call the 'real relationship', and the relationship at a more professional, working level (Gelso *et al.*, 2018). The real relationship is "the personal relationship between therapist and patient marked by the extent to which each is genuine with the other and perceives/ experiences the other in ways that befit the other" (Gelso, 2009, p. 119). Key within this is the client perceiving the person of the therapist, experiencing a sense of warmth, empathy and understanding from their therapist, and a real, person-to-person relationship developing between them, all of which map closely onto the findings of the present study.

In order to get a sense of their therapist, clients drew on intuitive knowledge as well as more explicit information gained from therapist self-disclosure and observations about their therapists. The intuitive sense that clients described may link to the right-brain to right-brain unconscious communication described by Schore (2011; 2018). While Schore focusses on therapists intuiting their client's inner states, a client will also develop an unconscious sense of their therapist. This highlights the importance of the therapist's capacity to remain regulated and grounded, particularly in the early moments of therapy (Quillman, 2012), as clients will intuit their therapist's internal state and find it harder to engage if their therapist is unsettled.

While studies into the therapeutic alliance and engagement have made brief references to the intuitive sense that clients get of their therapists (e.g. Hill, 2005; Wampold and Imel, 2015), and there is a growing body of neurobiological literature on unconscious communication between clients and therapists (e.g. Schore, 2018; Solomon and Siegel, 2017) , I was unable to find any studies that bring these together in an exploration of initial engagement in therapy through implicit processes. This presents a rich avenue for further research, as therapists could explicitly make use of this intuitive process to inform how they respond to their clients, and potentially facilitate engagement between them.

At a more explicit level, therapist self-disclosure provides a key source of information for clients about their therapist. A recent meta-analysis by Hill, Knox and Pinto Coelho (2018) demonstrated a link between therapist self-disclosure and an enhanced therapeutic relationship, and several studies emphasize that knowing something of their therapist enables clients to feel like they and their therapist are "connecting as two human beings" (Audet, 2011, p. 93). Consistent with the findings of this study, for self-disclosure to be helpful it must be used appropriately – too much disclosure, or disclosures that are made without the client's best interests in mind, have the potential to adversely affect client-therapist boundaries, whereas too little disclosure may leave the client feeling objectified and compromise their capacity to develop a relationship with their therapist (Audet, 2011; Hill *et al.*, 2018; Levitt *et al.*, 2016; Ziv-Beiman, Keinan, Livneh, Malone, and Shahar, 2017).

It is also worth noting that the participants in this study valued disclosures that revealed something about the person of the therapist (e.g. "I love art, she loved nature, she loved all the things that we could both laugh about or enjoy", Claire) as well as disclosures that articulated the therapist's feelings towards the client, treatment, or therapeutic relationship (e.g. "she made it very clear, she said it all along. She said I'm going to really miss you and I really enjoyed working with you" Claire). Hill and colleagues (2018) distinguish between these by labelling the former as 'therapist self-disclosure' and the latter as 'immediacy', while other theorists have used the terms 'non-

immediate' and 'immediate' self-disclosure (e.g. Ziv-Beiman *et al.*, 2016). The former type of disclosure is more often associated with enhanced therapy relationships, whereas the latter is associated more often with clients opening up and being immediate, both of which may facilitate engagement in therapy (Hill *et al.*, 2018).

In the current study, when therapists did not disclose enough about themselves, or presented with a "blank screen" (Jane), clients felt a sense of discomfort and found it harder to engage. This finding is supported within the empirical literature – in one of the first studies of helpful and unhelpful effects of disclosure and non-disclosure, Hanson (2005) found that clients were twice as likely to find non-disclosure as unhelpful rather than helpful, and that therapist non-disclosure had a detrimental impact on the therapeutic relationship.

In addition to self-disclosure, and linking with previous research, this study found that client participants draw on multiple other sources to ascertain information about their therapists, such as the therapist's appearance and the setting (e.g. Gelso *et al.*, 2018; Spalter, 2014). This ties in with the literature on intersectionality as clients described many elements that combined to give them a sense of fit between themselves and their therapists (Cole, 2009). Interestingly, these variables seemed more important when the client was already aware that something wasn't quite right in their relationship with their therapist. Bedi and Duff (2014) conducted a study to explore clients' perspectives on alliance formation variables and found that elements such as the therapist's presentation were rated as among the least important. This suggests that while there are many variables that contribute to engagement in therapy, they may not hold equal weight in the engagement process, and it is possible that clients only pay attention to the more peripheral issues when they are weighing up whether or not the relationship will work for them.

In the present study, another key aspect in the development of a personal relationship between the client and their therapist was the client's experience of being truly understood by their therapist. In a recent meta-analysis, Elliot and colleagues (2018) equated this sense of

understanding with the concept of empathy, describing empathy as a “co-created experience between a therapist trying to understand the client and a client trying to communicate with the therapist and be understood”. Consistent with the findings of this study, empathy is about more than understanding the content of the words that are being spoken, and extends into the nuances and implicit understanding behind the words (Elliott *et al.*, 2018). Within the research literature empathy has consistently been linked with engagement in therapy (Elkin *et al.*, 2014; Holdsworth *et al.*, 2014).

Interwoven with feeling truly understood, the participants in this study also viewed being held in positive regard and not judged by their therapists as vital to engagement in therapy. This finding is supported in the Elliott *et al.* (2018) meta-analysis, which demonstrated that empathy is highly correlated with other relational conditions such as positive regard and genuineness, as well as decades of research that demonstrate a link between positive regard and an enhanced therapeutic relationship (see recent meta-analysis by Farber, Suzuki, and Lynch, 2018). Also consistent with the findings of this study, research has shown that the opposite is also true – that negative therapist behaviours, such as being critical, judgemental and invalidating, can damage the therapeutic alliance and increase the likelihood of premature termination or the client requesting to transfer (Elkin *et al.*, 2014; Gülüm *et al.*, 2018).

In the current study, the development of a real relationship also included a growing sense of rapport between the client and their therapist, with both describing their understanding of each other and feelings of positive regard as mutual processes. This links to research on the real relationship and empathy: Gelso used the analogy of the client and therapist being “in the same tribe” (Gelso, 2018, p. 54), and having enough in common to understand and resonate with each other’s worlds, and Elliott *et al.* (2018) described how the degree of similarity (e.g., of values) between therapist and client may influence the level of empathy. It also fits well with previous studies which demonstrate that a client’s perception of similar personality traits between themselves and their therapist positively impacts the therapeutic relationship (Vera *et al.*, 1999).

Participants also described an optimal balance of similarity and difference between themselves and their therapists. This finding is supported by Beutler's (1986) study in which he suggested that the most effective therapy occurs when the client feels that they have enough in common with their therapist to feel understood and validated, yet enough difference to challenge their frame of reference. While the sense of validation has received a lot of empirical support (see Duff and Bedi, 2010), the facilitative power of difference between clients and their therapists has received less investigative attention and may present an avenue for future research.

Broadly, the findings of this theme add to a growing body of research that highlights the importance of a real human-to-human connection, based on empathy, mutual understanding, and positive regard, between clients and their therapists. These aspects map onto the first pathway for therapeutic change described in Wampold's contextual model (Wampold and Budge, 2012; Wampold and Imel, 2015) and contribute to the body of research into the real relationship, an overarching concept which Gelso and colleagues comment has received relatively little attention to date, particularly from a qualitative perspective (Gelso *et al.*, 2018). In addition, this theme aligns with the literature on cultural competence which explores how culturally competent therapists are able to create a therapeutic context which is attuned to clients' worldviews, values, and experiences, and fosters clients' feelings of being understood and empowered by their therapists (Chu, et al., 2016). Overall, these findings demonstrate that the development of a human-to-human connection and deep understanding between a client and their therapist is vital not only to outcomes, but to engaging the client during the first few sessions of therapy.

5.1.2 Theme 2 – the therapist's responsiveness to their client

This theme describes clients' expectations that their therapist will be attentive to them, as well as a delicate balance of power between the client and their therapist in which the therapist guides sessions whilst also being responsive to their client and treating them as an equal partner in the

relationship. While Theme 1 relates to the development of a personal relationship between clients and their therapists, this theme connects more to the therapist as a professional (although the two are highly interrelated).

Consistent with research in the field, the present study found that therapist attentiveness was important to client engagement in therapy, with (1) clients choosing to leave therapists who they experienced as distracted and stay with therapists who were actively listening to them, (2) second therapists emphasising their active efforts to understand their clients, and (3) first therapists speaking about how their own process impacted their capacity to be present. This correlates with the work of Sexton and colleagues (2005), who found that therapists who were actively listening to their clients tended to have better engagement with them, and that the connection decreased when therapists were "less engaged, when therapist utterances were devoid of emotional content, and when they were providing general information or advice" (p. 103). Linking to this, Lavik and colleagues' recent qualitative meta-analysis (2018) found that "seeking to understand as a therapist" was important to the alliance formation process. In the Lavik *et al.* (2018) study this theme was developed through examining therapist behaviour, but the results of the current study indicate that the client also needs to experience this "seeking to understand" from their therapist. This correlates with Rogers' (1957) contention that a necessary condition for therapeutic change is that the client needs to experience their therapist's empathic understanding, and suggests that active interest from the therapist, along with the client being able to perceive this interest, could be thought to facilitate engagement in therapy.

Alongside the attentiveness of therapists, in the current study clients emphasised how second-therapists were "leading the partnership, but [the client] felt like an equal" and second-therapists spoke about how they were "following [the client], not directing the sessions". This delicate balance of 'leading and being led' highlights the facilitative impact of collaboration between clients and their therapists, with both parties influencing the direction and content of the sessions. This is supported within the research literature, with multiple studies connecting collaboration to the

process and outcome of therapy (e.g. Levitt *et al.*, 2016; Lindhiem *et al.,* 2014; Spencer *et al.*, 2019; Swift *et al.*, 2018; Tryon, Birch and Verkuilen, 2018). Of particular relevance to the present study, in an article summarising theoretical and research support for establishing a collaborative relationship, Spencer and colleagues (2019) explicitly link collaboration with initial engagement in therapy. They describe it as a "hope building process" that is "an essential first element that can lead to a willingness to engage in psychotherapy" (2019, p. 8) and hold the view that a collaborative relationship reminds clients that their voice and perspectives matter and that they are personally capable of change, which allows for greater client agency within sessions. In their qualitative meta-analysis of clients' experiences of psychotherapy, Levitt *et al.* (2016) add to this, suggesting that by encouraging a collaborative atmosphere with their clients, therapists empower the client as an 'active self-healer' (Bohart, 2007), enabling them to use the therapeutic space in a way that meets their needs. This certainly came across in the current study as clients contrasted their sense that they were not being heard by their first therapists, with feeling like their second therapists were listening, treating them as equals and their needs were being met. Similarly, second therapists emphasised their focus on giving their clients control of the sessions so that their clients could influence how the therapeutic process unfolded.

While a collaborative atmosphere and a sense of equality between the client and their therapist are clearly important to engagement in therapy, this does not mean that the client and therapist assume similar roles. Based on the findings from the current research, an aspect of the therapist's role may be to use their professional skill to facilitate or guide the client along the therapeutic journey. This was supported in the study by Levitt and colleagues (2016), who found that clients value support from their therapists and appreciate regular check-ins and appropriate guidance. Similarly, in their qualitative review of the client's perspective of psychotherapy, Timulak and Keogh (2017) described how clients valued therapists who were expert and capable of guiding them (alongside being caring). Timulak and Keogh (2017) also spoke about how detrimental it can be when clients feel emotionally overwhelmed during sessions. An example of this from the

current research can be seen in clients' emphasis on the importance of therapists pacing sessions appropriately (which was also echoed in second-therapists' descriptions of how they helped their clients to regulate their affect).

All of the aspects mentioned within this theme intertwine under the umbrella of the therapist's responsiveness to their client. In the recent psychotherapy literature, "responsiveness" is often identified with the writings of Stiles and his colleagues and defined as "therapist behaviour being influenced by emerging context" (Kramer and Stiles, 2015 p. 279). In their study focussing on the link between responsiveness and initial engagement in therapy Elkin *et al.* (2014) narrowed the scope of the definition, describing responsiveness as ''the degree to which the therapist is attentive to the patient; is acknowledging and attempting to understand the patient's current concerns; is clearly interested in and responding to the patient's communication, both in terms of content and feelings; and is caring, affirming, and respectful towards the patient'' (p. 53). The findings of the current study map closely onto this narrower definition, perhaps indicating that these aspects of responsiveness (i.e. attentiveness, listening and responding to what the client is communicating, and adopting an attitude of respect and equality) are particularly salient during the initial engagement phase of therapy.

Interestingly, Elkin and colleagues did not find a relationship between the specific responsiveness behaviours they measured and initial engagement in therapy, but they did find that more global measures of responsiveness predicted engagement. This may suggest that the aspects of attentiveness and collaboration highlighted in the present study contribute to a global sense of a "positive atmosphere in which the client can feel truly responded to as a person" (Elkin *et al.*, 2014, p. 62) which would facilitate engagement in therapy. Supporting this supposition, the delicate balance of 'leading and being led' demonstrated in the present study could be considered a nuance of 'appropriate responsiveness' (Stiles, 2009; 2013) in which second therapists were able to adjust their input and guidance of sessions in a way that benefitted their clients (Hatcher, 2015; Stiles and Horvath, 2017). In the present study, the difference in clients' experiences of the

levels of responsiveness between their first and second therapists is also supported by Stiles and Horvath's (2017) suggestion that therapist differences in appropriate responsiveness may explain why some therapists are more effective than others.

The balance of 'leading and being led' demonstrated in the present study can also be viewed through the lens of power dynamics between the client and their therapist. In his thesis exploring therapists' experience of power in the psychotherapy relationship, Andrew Day (2010) found that therapists reported that with some clients they felt powerless, while with others a shared power dynamic was established. When therapists felt powerless they were left feeling vulnerable and ungrounded which then impacted how they behaved in the relationship, while when a shared power dynamic was established therapists noted that their relationships with their clients deepened (Day, 2010). In the present study, clients and first therapists spoke about a power imbalance within their relationship, with some first therapists feeling like their clients were more powerful than them (and thus they were unable to take the lead in sessions), and some clients feeling like they didn't have any power to impact the relationship with their first therapists, both of which hindered engagement between them. In contrast, clients and second therapists spoke about the facilitative effect of their shared power dynamic. This draws attention to the impact that these subtle power dynamics between the client and therapist may have on engagement in therapy. Although these power dynamics are referenced indirectly within the literature on engagement in therapy (for example, taking a collaborative stance necessitates a balance of power; e.g. Tompkins, Swift & Callahan, 2013), and the very concept of the working alliance captures an aspect of the shared power dynamic (Day, 2010), it seems that power dynamics have not explicitly been explored in relation to the development of an initial relationship with a client. This presents a valuable avenue for further research, which may lead to a deeper understanding of what contributes to initial engagement in therapy.

In sum, the findings within this theme build on the burgeoning literature on the importance of therapist' responsiveness to engagement in therapy, and particularly emphasise the aspects of

attentiveness and collaboration between clients and therapists. Participants highlighted a global sense of responsiveness in which therapists and clients achieved a balance of 'leading and being led' which may represent a nuance of appropriate responsiveness. In addition, participants drew attention to the power dynamics within the therapeutic relationship and highlighted that a balance of power between client and therapist may facilitate engagement in therapy, while an imbalance may hinder the engagement process. This draws attention to the importance of therapists attending to the power dynamics between themselves and their clients and actively collaborating with their clients to facilitate engagement in therapy.

5.1.3 Theme 3 – is the client in good hands?

Building on the development of a personal relationship between the client and their therapist, and the therapist's responsiveness to the client, the third theme in the present study relates to whether or not the client is in good hands with their therapist. In order to feel safe and comfortable with their therapist, clients needed to experience them as authentic, composed and capable. In turn, therapists could only be authentic and composed if they felt able to cope with the client and what they were bringing. The interaction of these internal responses to each other was a key factor in the process of initial engagement between them.

Within the present study, therapists described a range of internal reactions to their clients. First therapists generally felt anxious or drained, and some responded as though the client presented a threat to them. In contrast second therapists relayed a general sense of composure and confidence in their work with their clients. These affective reactions can be understood within the framework of countertransference, defined by Gelso and Hayes (2007) as "the therapist's internal and external reactions that are shaped by the therapist's past and present emotional conflicts and

vulnerabilities" (p. 25)[2]. Interestingly, within the countertransference literature anxiety is seen as the most basic emotional state and occurs as a response to some form of threat to the therapist (Hayes *et al.*, 2019) and so the range of responses of first therapists to their clients (from mild anxiety to feeling like they needed to defend themselves) may lie on a continuum of countertransferential reactions.

Current conceptualisations of countertransference see it as both a hinderance and potential aid to treatment (Hayes *et al.*, 2019). When therapists are unable to manage their countertransferential reactions to their clients, this can lead to poorer therapy outcomes (Hayes, Gelso, and Hummel, 2011), and can interfere with the therapist's presence with their clients (Hayes and Vinca, 2017). Indeed, Wolf, Goldfried and Muran (2017) emphasise just how damaging therapists' negative reactions can be on their relationships with their clients and suggest that these reactions seriously interfere with any efforts that the therapist makes to help their client. In contrast, when managed effectively, countertransference can facilitate treatment by helping the therapist to understand their client more deeply and make better treatment choices (Hayes, Nelson and Faulth, 2015).

In the present study first therapists' internal responses to their clients often led to the therapists feeling less composed, less present, overwhelmed, unable to be their natural authentic selves, and defaulting to a particular therapeutic style with their client (rather than integrating technique into their natural way of working). They also spoke about how their personal process impacted their capacity to connect with their client. These findings are consistent with literature on the experiences of trainees when they start to work with clients (e.g. Rønnestad *et al.*, 2019) and supplement the work of countertransference scholars, who suggest that anxiety, withdrawal and overwhelm (amongst others) are common countertransference reactions (e.g. Betan, Heim, Zittel Conklin, and Westen, 2005; Hayes, Nelson and Faulth, 2015; Hayes and Vinca, 2017). As such,

[2] In this work I am using Gelso and Hayes' (2007) integrative definition of countertransference, rather than the classical psychoanalytic version proposed by Freud (1910) (see Gelso and Hayes, 2007).

this study sheds some light onto the ways in which countertransference may impact engagement in therapy and outcome, an area in which there has been relatively little research to date (Hayes *et al.*, 2019).

The theoretical and empirical literature on managing countertransference suggests that therapists need to develop their understanding of themselves and their client, as well as their capacity for self-integration and regulation in order to utilise their countertransferential responses to facilitate (rather than hinder) the therapeutic process (Perez-Rojas *et al.*, 2017; Wolf, Goldfried and Muran, 2017). The current research supports this conceptualisation, as clients and therapists were more likely to engage when the therapist was able to notice and manage their own internal reactions, freeing them to act in the service of the client. Mapping onto this, the literature on therapist 'presence' highlights that in order to be present therapists must simultaneously be paying attention to their own inner state as well as their client. In doing so "effective therapists are able to be self-aware without becoming self-absorbed and are simultaneously able to be attuned to clients without identifying with them" (Hayes and Vinca, 2017, p. 115). In the present study, first therapists were unable to maintain this dual attention and were either unaware of how their own process was impacting the sessions or focussed on managing their own process to the extent that they were unable to remain attentive to the client.

Taken together, the findings of this research and the literature in the field seem to indicate that therapists need to attend to and manage their internal reactions so that they are able to maintain a therapeutic presence in sessions. When a therapist is unable to manage or regulate their internal responses to their client, their energy is more focussed on themselves (either consciously or unconsciously) than on their client and this hinders engagement between them (Hayes *et al.*, 2011).

When reflecting on what hindered engagement between themselves and their clients, most of the first therapists spoke about their lack of experience as a primary factor, but also mentioned that

they managed to engage well with other clients during the same timeframe. This matches the findings of Hill and colleagues (2015; 2016) who suggest that that training and experience help novice therapists to develop skills for establishing a therapeutic alliance with clients (Hill *et al.*, 2015; Hill *et al.,* 2016). Alongside this, Hill *et al.* (2017) posit that some novice therapists are able to use skills from their own life experiences to establish a therapeutic relationship with less complicated clients, but that their natural talent is not sufficient for them to be able to work with more difficult clients, which could help us to understand why first therapists were able to engage well with other clients during the same timeframe. However, it does not explain why the clients that did not engage with first therapists were able to go on to engage with other novice therapists and, as such, ignores the key element of how a client's process will interact with their therapist's process in a way that impacts engagement.

This interaction between the client's and therapist's responses to each other could be clearly seen in the present study where the therapist's management of their affective responses to their client seemed to directly link to the client's experience of their therapist. For example, when a therapist was unable to manage their countertransferential anxiety with a client, this led them to be less authentic and available to the client, which the client then picked up and, in turn, this may have hindered engagement between them. Hill (2005) articulates this well in her proposition that "therapist techniques, client involvement, and the therapeutic relationship are inextricably intertwined and need to be considered together in any discussion of the therapy process".

Focussing on the client's perspective, the findings within this theme suggest that clients need to perceive their therapists as authentic, composed and competent in order to feel like they are in good hands with them. The importance of therapist authenticity has been supported by research over decades. For example, Carl Rogers (1957) proposed congruence as one of his sufficient and necessary conditions for therapeutic change, and Charles Gelso (2002) identified genuineness as a fundamental aspect of the real relationship, defining it as "the ability to be who one truly is, to be nonphony, to be authentic in the here and now ... being in touch with oneself and sharing inner

experience" (p. 37). Multiple studies have shown that authenticity is an essential (but not fully sufficient) component of the therapeutic relationship (see recent meta-analysis by Kolden *et al.*, 2018). The present research contributes to this body of work and demonstrates the importance of authenticity from the first moments of therapy to the development of an engaged therapeutic relationship.

Alongside authenticity, there is considerable evidence of the impact of therapist composure on engagement in therapy. Studies have shown that when clients experience their therapists as tense, uncertain and nervous this can have a negative impact on the formation of the therapeutic alliance (Ackerman and Hilsenroth, 2001; Heinonen *et al.*, 2013; Saunders, 1999; Sexton, Hembre and Kvarme, 1996), while therapists who appear composed and confident engender stronger alliances with their clients (Ackerman and Hilsenroth, 2003; Bachelor, 1995). This makes intuitive sense – as Ackerman and Hilsenroth (2003) point out, the ability of a therapist to invoke their client's confidence and trust is essential to therapeutic success and if the therapist is not confident in themselves the client will not be either. Linking to composure, in the current research the client's perception of their therapist's level of experience (based on their perception of their therapist's competence) was important to engagement in therapy. This correlates with research into the client's experience of therapy which demonstrates that the client's belief in their therapist's competence is an important aspect of engaging in therapy (e.g. Lavik *et al.*, 2018).

The resulting strength of the relationship has an impact on the way that clients feel during sessions. In their study exploring therapy microprocesses, Sexton *et al.* (1996) suggested that clients who develop a strong initial alliance feel almost immediately safe enough to speak openly with their therapists, whereas those who do not form a strong initial alliance adopt a more guarded stance. Adding to this, in a study exploring clients' affective experiences of therapy, Saunders (1999) found that clients feel distressed, inhibited, and withdrawn when they perceive their therapist to be distracted or uninterested. This was reflected in the current study as clients spoke about the ease with which they opened up to their second therapists (who they perceived as

present), and the safety they felt with them, versus the way they closed down with their first therapists (who they perceived as less available).

Overall, the findings from this theme speak to the importance of therapists paying attention to their own internal state as well as their client, monitoring their reactions to their clients, and regulating their own affect. When therapists were able to do this, clients experienced them as authentic, composed, and capable and described a sense of ease within the encounter. When therapists were unable to manage their responses to their clients, this impacted their presence in the room, and clients felt less comfortable and found it difficult to open up. These aspects knitted together to create an overall sense of whether the client was in good hands with their therapist, which then impacted engagement between them.

5.1.4 Theme 4 – the client's decision to change therapist

Building on the processes described in the previous themes, this theme speaks to the client's decision to change therapist. Clients described two processes by which they considered their decision - the first was an almost instantaneous felt sense of whether they felt that they would be able to work with their therapist, and the second was a slower, more conscious process of weighing up.

The immediate impression that clients form about the possibility of engaging with their therapist is congruent with social perception research, which suggests that humans make very rapid determination of whether a person is likeable, trustworthy and competent based on viewing their face (Holmes, 2016; Todorov, *et al.*, 2015; Willis and Todorov, 2006). Todorov *et al.* (2015) point out that people also draw on other information, such as the person's appearance and the context, to inform this first impression. While therapists can't change the way that their facial features are perceived by their clients, there are many variables that they could consider that might impact the

first impression that the client develops, such as the way that they present themselves, their facial expressions, and the arrangement of the setting (Bedi, Davis and Williams, 2005; Gelso *et al.*, 2018; Spalter, 2014; Wampold and Imel, 2015; Wampold and Ulvenes, 2019).

Alongside an immediate sense of whether or not they'd be able to work with their therapists, clients described a process of weighing up the value of staying in therapy. This is consistent with Swift *et al.*'s (2012) costs-benefits conceptualisation of premature termination of therapy – as engaging in psychotherapy can be difficult (for example due to the financial cost and time involved, and the emotional challenge of disclosing and processing potentially painful topics), clients must anticipate benefits that outweigh those costs (such as receiving support, or believing that therapy may lead to change) in order to engage. Congruent with this costs-benefits analysis, clients in the present study emphasised that they didn't need a perfect fit between themselves and their therapist and only requested to transfer when they were sure that things wouldn't work with their first therapist (i.e. the costs to them if they stayed clearly outweighed the benefits). This supports the supposition made by Anderson *et al.* (1993) that people are "reluctant decision makers" (p. 144), and so clients would prefer to stay with their therapist if they were getting enough from the relationship. Indeed, the fact that clients would have ended even if they didn't have the opportunity to request to transfer adds further weight to this hypothesis, as they were willing to forgo help with their problem rather than continue in a relationship that wasn't working for them. This finding emphasises the potential importance of offering the client the option to transfer to a different therapist as, in the present study, the clients involved would have dropped out if they couldn't transfer and thus would not have received the help that they needed. This supports Meier *et al.*'s (2006) supposition that clients may be better off transferring to a different therapist when there is a weak therapeutic relationship between themselves and their therapist.

Interestingly, the majority of client participants in this study spoke extremely positively about their second therapists (rather than as though they were just 'good enough') and both clients and their second therapists seemed invested in working together. This may link to the "positive emotion–

exploration spiral" postulated by Fitzpatrick and colleagues (2006) – they suggest that in early therapy, positive feelings and exploration may interact to produce an upward spiral that promotes further exploration and positive feelings. For example, a client may feel positively towards their therapist, which allows them to be more open, which facilitates a deeper exploration and connection with their therapist, and the process continues like this.

When asked about their decision to transfer from their first therapists rather than drop-out of therapy, clients spoke about their hope that there might be a better fit out there for them. The literature on therapy transfers suggests that clients who have experienced previous transfers (Clark, 2011) or who have had previous experiences of therapy (Wapner *et al.*, 1986; Zimmerman *et al.*, 2019) are more likely to transfer successfully. This may be because clients who have tolerated the distress of one transfer know that they can (Clark, 2011) or that clients with prior therapy experience have faith that they can be helped by therapy. This may be the case in the present study – most of the clients had experienced therapy before, and the one client who hadn't had therapy before spoke about what a positive and connected experience he had with his assessor, which may have given him this hope. Interestingly, once they had transferred clients spoke about the same processes of forming an initial impression and weighing up the pros and cons of staying with their second therapist, which lends weight to Clark and colleagues' (2014) comment that once the transfer has taken place new therapists face the same task as the previous ones of developing a relationship with their clients.

From the first therapists' side, the findings of this study were mixed. Most of the first therapists were surprised that their clients chose to transfer and seemed unaware of the extent of the difficulties between themselves and their clients. This is supported in the literature that has consistently found that therapists underestimate difficulties between themselves and their clients (Westmacott and Hunsley, 2017), and adds weight to Crits-Christoph, Crits-Christoph, and Gibbons' (2010) suggestion that therapists need to attend more to the process between

themselves and their clients in the moment, to engage in alliance-building activities, and act to strengthen the therapeutic relationship when they can.

In contrast to previous research which shows that therapists attribute client drop-out to client-related issues (Todd *et al.*, 2003), the first therapists interviewed for this study were very engaged in retrospectively exploring how their own process and actions had impacted their relationship with their clients. This may be due to the design of the present study as therapist participants knew that the clients who had not engaged with them had gone on to engage with another therapist, or fact that the interviews took place when the participants had more experience, training and supervision than they had when they were seeing their client and were therefore better equipped to reflect on what had happened between them.

Overall, this theme represents a culmination of the processes described by participants that impacted their engagement in therapy. Clients seemed to develop an immediate sense of whether or not they would be able to engage with their therapists, as well as taking time to weigh up the benefits and costs of staying with their therapist. When they determined that it was not worth continuing with their current therapist they would have dropped out if they hadn't had the option to transfer, which draws attention to the potential value of offering clients this option. Once clients transferred, the process of initial engagement began again with their new therapist.

5.2 Reflective account of my participants' feedback on the findings

Once I had completed a draft of my findings, I contacted all of my participants by email to invite them to read and comment on the draft (if they wanted to do so). I was aware that I wanted to give my participants the opportunity to continue to contribute to the research process, while also respecting their right not to respond and being mindful not to be intrusive or make them feel obligated to spend time reviewing my draft (Thomas, 2017). Ten participants responded to my email, and eight of these participants expressed interest in reading my findings (see Table 8). I sent the findings together with a summary table relating to their specific case to those who had requested it. I then followed up by phone or in person (depending on what the participant felt would be most helpful) once they had read the findings to talk to them about their responses, reflect together on any comments they made, and provide additional context to what had been written.

Table 8 - table of participants' responses to my invitation to read a draft of my findings

Case	Participant	Wanted to read findings?
1	Jane	Yes
	T1-Jane	No response
	T2-Jane	Yes
2	Paul	No response
	T2-Paul	Yes
3	Robert	Yes
	T1-Robert	No response
4	Daphne	Yes
	T1-Daphne	Yes
	T2-Daphne	No response
5	Emma	Yes
	T2-Emma	Responded but didn't feel a need to read findings
6	Claire	No response
	T1-Claire	Responded but didn't ask to read findings
	T2-Claire	Yes

Most participants found the findings interesting and valued reading them and expressed their continuing support for the project, but a few participants also mentioned that elements of what they had read had been difficult for them. I contacted all of the participants who had read the findings to talk through how they had responded to what they had read. One participant, Jane, was quite distressed upon reading the findings. Jane and I agreed to meet face-to-face so that she could fully express and discuss her reaction with me. During the meeting I realised that her interview had taken place so long ago that she did not remember the parameters of the research and was taken by surprise when she read my account of what happened between her and her two therapists. It was also upsetting for her to read what I had written about her first therapist's response to her as it triggered issues that have been present for her for a long time. During our discussion I was able to explain some of the context of what had been said, for example that her first therapist did care for her and that his response to her was more to do with his own process than a reflection of her as a person. Jane seemed much more settled by the end of our discussion and my sense was that the process had been helpful to both of us. Jane expressed that she felt like she had been heard by me, had a renewed interest in the research, and was able to make an informed decision about her ongoing commitment to be part of the process.

For me, an important aspect of my participants reading the draft was that it enabled them to indicate their continued consent to be a part of my project, and created space for us to reflect together on my findings. An ethical complexity of this project was that participants would be able to recognise the input from other participants in their case and it felt important to me to ensure that they were comfortable with what had been written before the study was submitted. None of the participants requested major changes to the findings. I have detailed participants comments on my draft and any small changes I made in appendix 11.

Engaging with the feedback from participants has been really valuable to me as a researcher and made me reflect on the importance of the process of ongoing consent, along with the complex issues that might arise when a participant reads something that has been written about them

(Furlong, 2006; Goldblatt, Karnieli-Miller, Neumann, 2011; Thomas, 2017). It has also highlighted the many dimensions of our ethical choices as researchers, particularly when conducting this sort of qualitative research (Ellis, 2007; Guillemin and Gillam, 2004; McLeod, 2010) – in my project I was adhering to 'procedural ethics', but had a limited awareness and sensitivity to the moment by moment 'microethics' that needed to be negotiated (Guillemin and Gillam, 2004). For example, during my conversation with Jane I realised that I had been so immersed in my research that it hadn't occurred to me that my participants might have forgotten the details of what the research was about. Jane's distress when reading the findings made me consider that she might be at risk of harm that I had not anticipated, and it was important that we met so that we could assuage this risk. As a novice researcher I did not have an experience-driven knowledge of the 'microethical moments' that could arise during the process of conducting the research (Ellis, 2007). Seeking supervision at key moments of ethical complexity (McLeod, 2010), as well as working through issues as they arose collaboratively with my participants, has helped me to develop my ethical sensitivity as a researcher and as a practitioner.

5.3 Conclusions

This research study offers an in-depth perspective on the process of initial engagement in therapy through drawing on the experiences of clients and their therapists with whom they were and were-not able to engage. The findings support existing literature on the development of a therapeutic relationship, add to a growing body of work on pantheoretical relationship constructs (such as the real relationship and countertransference: Gelso, 2018; Gelso and Hayes, 2007), and highlight areas that would benefit from further research. They also demonstrate the utility of using qualitative research to enrich our understanding of the complex task that clients and therapists face when they first meet and, as such, illuminate established quantitative findings in the field (e.g. Norcross and Lambert, 2019).

A key finding of this research was the emphasis on different levels of relationship between a client and their therapist. Clients need to get a sense of their therapist as a person as well as a professional, and feel a human-to-human connection with them alongside a working relationship. As such this research adds to a growing body of evidence supporting the concept of the real relationship (Gelso, 2018) and contextual model (Wampold and Budge, 2012), as well as highlighting the importance of the Rogerian conditions of the therapist's congruence, unconditional positive regard (UPR) and empathic understanding, as well as the client's experience of UPR and empathy from their therapist, to engagement during the early sessions of therapy (Rogers, 1957). Within Wampold's contextual model, theme 1 ('forming a personal connection with the therapist') in the current study linked closely to the first pathway (the 'real relationship'), while themes 2, 3 and 4 ('the therapist's responsiveness to their client', 'is the client in good hands?', and 'the client's decision to change therapist') can be connected to the second pathway in which the client and their therapist set up expectations regarding whether or not the therapy will be effective. This suggests that the establishment of these two pathways is important to initial engagement in therapy and sets the scene for the 'specific ingredients' of therapy to effect change further into the process (Wampold and Budge, 2012; Wampold and Imel, 2015).

This research also draws attention to the importance of interpersonal aspects in the process of engagement in therapy. Previous studies that treat the client and therapist as separate unrelated entities miss the essence of therapeutic practice – the inescapability of each person impacting and changing the other (Kramer and Stiles, 2015). The present study demonstrated the impact of the client and therapist on each other, and the resulting effect that this had on engagement in therapy was evident. Within this interpersonal realm, a delicate balance of 'leading and being led' between client and therapist was proposed as a nuance of appropriate responsiveness (Stiles, 2009; 2013), alongside the facilitative impact of collaboration between client and therapist. The findings also highlighted subtle power dynamics within the therapeutic relationship and demonstrated that therapists need to strive for a relationship of shared power with their clients (Day, 2010).

In addition, running through every theme, and key to the process of initial engagement in therapy, was the therapist's capacity for self-regulation (Hayes and Vinca, 2017; Perez-Rojas *et al.*, 2017; Wolf, Goldfried and Muran, 2017). When a therapist was dysregulated, they were likely to act in ways that hindered engagement (such as coming across as distracted or inauthentic), while when they were able to regulate their affect during sessions clients expressed a sense of safety, comfort and ease, which facilitated engagement between them.

When considering whether or not to stay with their therapist, clients alluded to two processes that seemed to act in parallel. One of these was an instant, implicit and intuitive sense that the clients had of their therapists and the possibility of engagement with them. This intuitive sense links engagement in therapy with the domains of neuroscience (e.g. Schore, 2018) and human perception (e.g. Todorov, *et al.*, 2015), but has remained relatively unexplored within the literature on the therapeutic relationship and presents a fascinating area for further research. In parallel with the intuitive sense, clients also described a process of weighing up whether the benefits of being in therapy outweighed the costs involved (Swift *et al.*, 2012). This more conscious process culminated in the client's decision about whether to transfer to a different therapist, at which point all the same considerations relating to initial engagement began again.

5.3.1 Recommendations:

Based on the findings of this study and the supporting literature the following recommendations can be made for therapists, service providers, and training providers:

For therapists:

Given that therapists are often unaware of difficulties between themselves and their clients, therapists should pay greater attention to the process between themselves and their clients on a moment-to-moment basis.

Areas of particular importance may be:

i. A focus on what might not be working between themselves and their client.
ii. Attending to the power dynamics between themselves and their client and trying to develop a collaborative atmosphere in which the therapist is both leading and being led by the client.
iii. Noticing any strong reactions that the therapist is having to their client and attending to these so they don't interfere with therapeutic work.

Along the same lines, therapists should develop their understanding of themselves and their reactions to their clients as well as working on their capacity for self-regulation so that they can use their internal responses to their clients in a way that facilitates, rather than hinders, the therapeutic process.

For service providers:

Given that the client-participants in this study would have ended therapy even if they didn't have the opportunity to request to transfer, but were able to engage in therapy with a different therapist, service providers should consider how they could facilitate transfers when a client isn't able to

engage with their first therapist. This has the potential to save time and resources, and may mean that more clients benefit from the service they provide.

For training providers:

The findings of this study represent a pantheoretical perspective on what facilitates engagement in therapy and highlight issues that come up between trainee therapists and their clients. Given that trainees experience higher levels of premature termination than more experienced therapists, and that trainees improve in effectiveness over the course of their training, the findings of this study could help providers to focus their teaching on areas that would help students to manage their first few sessions with clients.

Specifically, training providers could incorporate the following topics:

- Teaching students about different levels of the therapeutic relationship and the importance of the personal relationship alongside the professional relationship between a client and their therapist.
- Developing students' cultural competence to facilitate a deeper understanding of their clients.
- Exploring appropriate self-disclosure and how it can be used to develop the initial relationship with a client.
- Highlighting the importance of the therapist's responsiveness to their client, as well as collaboration and a balance of power between themselves and their client.
- Encouraging students to attend to their levels of anxiety and exploring ways in which they can remain regulated during sessions.
- Discussing the use of supervision to attend to difficulties in the relationship and countertransference towards their clients, as well as the importance of therapy to develop therapists' capacity for affect regulation and self-integration

5.3.2 Limitations

While this study has generated some valuable insights into the phenomenon of initial engagement in therapy, there are a number of important limitations that need to be acknowledged.

Firstly, the small sample size and the specific nature of the setting means that we cannot assume that similar findings would come from other clients and therapists in similar or different settings. However, the development of common themes from the data, along with their links to pre-existing research, suggests the potential wider applicability of the findings and that the findings may stimulate further research into the phenomenon.

Furthermore, the findings of this study represent a largely trans-theoretical perspective on engagement in therapy. This may limit the applicability of the findings as each of the concepts highlighted may apply to a greater or lesser extent when viewed through the lens of a specific modality. For example, the emphasis placed on the Rogerian core conditions in this research may be helpful to person-centred therapists, but less applicable within a psychodynamic model of therapy. Similarly, the fact that the therapist-participants were training on integrative, person-centred, or transactional analysis courses, and other modalities (e.g. cognitive-behavioural or psychodynamic) were not included, may limit the representativeness of the sample.

The trainee status of the therapist-participants also had an impact on the findings as many of the experiences reported by therapist participants are typical of characteristics observed in trainees (such as high levels of anxiety). This may mean that the implications of this study are more relevant to trainees than to qualified therapists. It is also possible that trainees are less able to reflect on the subtleties of their own practice than more experienced therapists, which may have impacted the level of insight I was able to gain into the process of engagement. Future research could use the same design as the current study, with experienced therapists as participants rather than trainees to explore whether the process of engagement differs between clients and more experienced therapists.

Also related to the selection criteria for this study, choosing to interview client participants once they had ended therapy with their second therapists meant that both clients and their second therapists based their responses on greater cumulative experience of their relationship when considering initial engagement in therapy. This may mean that the data on what hinders engagement (i.e. between the client and their first therapist) may be specific to initial engagement, while the data pertaining to what facilitates engagement (i.e. between a client and their second therapist) might speak more to what works over the longer process of therapy. Future research could interview clients and therapists about the process of engagement between them after their second session together, and then see which of these clients go on to transfer. This may give a different insight into the process of engagement as the therapist's perspective would be captured before they know if the client will request to transfer.

In addition, the structure of this research emphasised client experience as the same client was interviewed in relation to their experiences with two therapists and, in total, more clients (6) were interviewed than either first (4) or second therapists (5). It would be interesting to explore the perspective of one therapist with several clients to focus more on the therapist's perspective.

Another consideration lies in the direction of causal influence between participant behaviours and engagement in therapy. While I have spoken about elements that may facilitate and hinder initial engagement, in many cases the direction of influence is not clear cut. For example, the therapist's responsiveness to their client (Theme 2) may facilitate initial engagement between a client and their therapist but, equally, the engagement between them may increase the therapist's responsiveness to their client. In addition, many of the concepts described are highly interrelated (for example, empathy and the real relationship; Gelso, 2018) and other unexplored variables may also interact with these, which means that the findings are limited to inferences. Further research is needed to explore the interactions between all of the variables in greater depth.

Methodologically, my use of reflexive thematic analysis had both advantages and disadvantages. An advantage was that it allowed me flexibility in my approach while ensuring a rigorous and systematic engagement with my data. To ensure quality of my study, throughout the research process I checked my procedures against Braun and Clarke's 15-point checklist (2006, p. 96), and explicitly stated the choices I made in my application of reflexive thematic analysis. However, the very flexibility of the approach means that there are many possible variants of thematic analysis. Using a more established methodology may have had the advantage of gaining credibility with editors, reviewers and readers, and meant that there are many other studies using the same methodology that can be referenced (although some would argue that there is wide variation in the actual procedures used within the same methodology, e.g. Timulak and Elliott, 2018). Terry and colleagues anticipate clearer articulation of different versions of thematic analysis in the future (Terry, Hayfield, Clarke and Braun, 2017) which would go some way to address this issue.

Finally, a choice point for this research lay in the direction of analysis. When approaching the analysis phase of this research I had the choice of doing an across-case analysis (i.e. exploring therapists' and clients' views on initial engagement in therapy) or within-case analysis (i.e. what impacted engagement in each particular case). From the outset my main focus was on what contributes to initial engagement, and the across-case analysis fit well with this. However, I am aware that this approach to the analysis meant that some interesting aspects of the data were not represented. For example, through interviewing clients and the therapists they saw, I could have discussed the particularities of one client with several therapists. This is a relatively unexplored area and presents a valuable opportunity for future research.

5.3.3 Implications for further research

As noted throughout this discussion chapter, this project raises interesting new research questions and highlights areas for additional research. In this section I bring these together to underline some implications of this study.

One such avenue for further research could be an exploration of the implicit and intuitive processes that are part of the initial engagement process. For example, clients and therapists could be asked specifically about their intuitive sense of each other after their first session together. This would provide a fascinating insight into what clients initially sense about their therapists, which therapists may then be able to draw on to explicitly address any aspects that could impede engagement. Exploring therapists' intuitive understanding of their clients may also help to guide therapists with how to use this understanding to aid their treatment decisions.

Another rich area for further research relates to the delicate balance of power between a client and their therapist that was highlighted in the present study. It would be interesting to explore this in greater depth, for example by specifically asking clients and therapists about their experience of the power dynamics between them during the first few sessions of therapy. This may give researchers a more nuanced understanding of what contributes to this balance of power and which aspects are particularly important to early engagement in therapy.

In addition, as the current research did not look specifically at the therapist's level of experience or theoretical orientation in relation to engaging in therapy, future projects could recruit therapist-participants with varying levels of experience and from a range of modalities to explore whether this has an impact on engagement. This may lead to findings that are generalisable beyond a trainee sample and/or applicable within specific modalities.

Along similar lines, attending to similarities and differences between a client's first and second therapists may give an insight into what might be important for specific clients and help guide

assessors when reallocating clients. For example, researchers could examine whether transferring a client to a second therapist who works within a different modality to their first therapist has an impact on whether or not the client is able to engage. Taking this further, it would be fascinating to explore engagement on a case by case basis, to gain an in-depth understanding of the process of engagement that is specific to an individual client and their therapists.

Finally, in looking at engagement through the phenomenon of clients choosing to transfer from one therapist to another, this research addresses a very specific area (client-driven transfers) which has not been researched in this way before and generates some interesting questions. The fact that the client-participants all indicated that they would have dropped out of therapy had they not been given the option to transfer to a new therapist raises the question of whether explicitly offering clients the opportunity to transfer might result in fewer premature terminations. On a similar vein, it would also be valuable to understand what helps clients to request to transfer (when this option is available) rather than dropping out of therapy. If a client chooses to transfer and is able to engage with their subsequent therapist, another interesting area to explore would be whether this has an impact on clinical outcomes, as clients who transfer may be more likely to find a therapist with whom they are able to work well and thus benefit more from the therapy.

5.4 Final words

This research sheds light on some of the complex processes involved as a client and their therapist engage in therapy. Key within this is the development of a strong therapeutic relationship, based on a real connection between the client and their therapist, the therapist's responsiveness to their client, and the therapist's capacity to manage what the client is bringing as well as their own internal responses to the client. Together these elements facilitate initial engagement in therapy and set the scene for ongoing therapeutic work. In parallel with the findings of this study, this research would not have been possible without developing real relationships with my participants, and I feel like their engagement with the topic and collaborative input has enriched this project as well as my practice.

On a personal note, the process of conducting this research has helped me to develop as a researcher and as a practitioner has led to an evolution in my professional identity as a counselling psychologist as well as a psychotherapist. During the taught years of my course, greater emphasis was placed on becoming a psychotherapist and there was less of a focus on research (perhaps because the course had evolved from a pure psychotherapy training into a counselling and psychotherapy doctorate). I gained my registration as a psychotherapist in 2014 and have been working in that professional role since then. This has meant that over the past few years I have identified more as a psychotherapist than as a counselling psychologist, and research has felt like something I do on the side. However, while conducting this research I have noticed a shift in my identity - I now feel more grounded in my researcher self-state, and feel that my clinical work is both supported by, and engaged with, research within the counselling psychology field.

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Lia Foa
DCPsych programme
Metanoia Institute

11th March 2016

Ref: *3/15-16*

Dear Lia

Re: Engaging in therapy: exploring the perspectives of clients and their therapists when a client chooses to change therapist

I am pleased to let you know that the above project has been granted ethical approval by Metanoia Institute Research Ethics Committee. If in the course of carrying out the project there are any new developments that may have ethical implications, please inform me as DCPsych representative for the Metanoia Institute Research Ethics Committee.

Yours sincerely,

Dr Patricia Moran
Subject Specialist (Research), DCPsych Programme
Faculty of Applied Research and Clinical Practice

On behalf of Metanoia Institute Research Ethics Committee

Registered in England at the above address No. 2918520

Registered Charity No. 1050175

INFORMATION SHEET

ENGAGING IN THERAPY: EXPLORING THE PERSPECTIVES OF CLIENTS AND THEIR THERAPISTS WHEN A CLIENT CHOOSES TO CHANGE THERAPIST

I am inviting you to take part in my research study. Below I have described the purpose of the study, and what it will involve. Please read the information carefully so that you can decide whether you'd like to take part. You're welcome to ask me if there is anything that is not clear or if you would like more information.

What is the purpose of the study?
The purpose of my study is to explore what helps clients to connect, or engage, with their therapists. Learning more about engaging in therapy will help services like ours to find the right therapist for clients, and help therapists to understand what works best for their clients.

Why am I being invited to take part?
I am inviting you to take part because you changed from one therapist to another while you were coming to the Metanoia Counselling Service. This will have given you a sense of what worked and didn't work for you with each therapist and I'm interested in hearing about your experiences.

I will also be asking your first and second therapists to take part so I can get as full a picture as possible of what helps clients to connect with their therapists.

Do I have to take part?
It is up to you to decide whether or not to take part. Even if you decide to take part you are still free to withdraw at any time, without giving a reason.

What will I have to do?
If you would like to take part I will invite you to come in and talk to me about your experience of therapy with each of your therapists. I am interested in your view on what made it hard to connect with your first therapist, and what helped you to connect with your second therapist.

I will arrange for you to come in on a day and time that suits you, and the interview will last 60 to 90 minutes. The interview will be taped and then transcribed. I might also contact you after the interview with follow up questions, and to invite you to comment on the findings of the research.

If you are happy for me to do so, I will also look at data from the demographic form, ARM-5 (which looks at the relationship between you and your therapist) and end of therapy forms that you completed when you were receiving therapy at Metanoia. You don't have to allow me to use this data and it will not affect whether you can take part in the research.

Are there any risks of taking part?
There may be a small risk that unsettling material comes up during your interview. If this is the case I will give you the option of returning to the Metanoia Counselling Service or I will refer you to an alternative service for additional therapy.

What are the possible benefits of taking part?
I hope that participating in this study will be both interesting and helpful to you, as it will give you a chance to talk about your experiences of therapy. In taking part you will also be helping therapy organisations like Metanoia to find the right therapist for their clients, and therapists to learn about how to connect better with their clients.

What about confidentiality?
All information that is collected about you during the course of the research will be kept completely confidential. I will remove your name and address from any information about you that is used so that you cannot be recognised from it.

However, as I will also be interviewing your therapists, they may recognise your contribution in the final write-up of the research and read what you have said about them.

How will you store my data?
All data will be stored, analysed and reported in compliance with the UK Data Protection Act 1998.

Will you check the findings with me?
When I am writing up the research I might want to quote parts of what you have said to me. I will check with you before I write anything that you have told me. I will also give you a chance to read and comment on what I have written.

What will happen to the results of the research study?
The results of the research will be published as part of my doctoral thesis and may be published in professional journals. No personal data will be used so you won't be recognisable in the published pieces. Let me know if you would like a copy of my thesis and I'll post it to you once it is complete.

Who has reviewed the study?
This study has been reviewed and approved by Metanoia's Research Ethics Committee.

Please note that in order to ensure quality this project may be checked by member of Metanoia's Research Ethics Committee. This means that the designated member can request to see signed consent forms. If this is the case your signed consent form will only be accessed by the designated member, and will be kept confidential.

Any Questions?
Please feel free to ask me any questions now, or contact me by email / phone (email: lia.foa@metanoia.ac.uk / phone: 020 8832 3085).

You're also welcome to contact my research supervisor – Dr Biljana Van Rijn (email: Biljana.Vanrijn@metanoia.ac.uk).

Thank you for taking time to read this information sheet!

CONSENT FORM

Title of Project: <u>Engaging in therapy: exploring the perspectives of clients and their therapists when a client chooses to change therapist</u>

Participant Identification Number:

Name of Researcher: Lia Foa

- ☐ I confirm that I have read and understand the information sheet dated 8/2/18 for the above project and have had the opportunity to ask questions.
- ☐ I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. If I choose to withdraw, I can decide what happens to any data I have provided.
- ☐ I understand that my interview will be taped and subsequently transcribed.
- ☐ I understand my identity will be protected at all times.
- ☐ I agree to the use of data from the forms that I completed while I was receiving therapy at MCPS (optional).
- ☐ I agree to take part in the above study.
- ☐ I agree that this form that bears my name and signature may be seen by a designated auditor.

_____	_____	_____
Name of participant	Date	Signature
_____	_____	_____
Researcher	Date	Signature

INFORMATION SHEET

ENGAGING IN THERAPY: EXPLORING THE PERSPECTIVES OF CLIENTS AND THEIR THERAPISTS WHEN A CLIENT CHOOSES TO CHANGE THERAPIST

I am inviting you to take part in my research study. Below I have described the purpose of the study, and what it will involve. Please read the information carefully so that you can decide whether you'd like to take part. You're welcome to ask me if there is anything that is not clear or if you would like more information.

What is the purpose of the study?
When clients start therapy, they sometimes find it difficult to engage in therapy with their therapist. Some of these clients transfer to a new therapist and are able to engage in therapy with their new therapist. **The purpose of this study is to explore the phenomenon of clients changing from one therapist to another so that we can learn about what contributes to engagement or non-engagement in therapy**.

Who are the participants of this study?
This study will take place at the Metanoia Counselling and Psychotherapy Service (MCPS). I will be interviewing clients who changed therapist while they were receiving therapy at MCPS, along with their first therapist (who they changed from) and second therapist (who they changed to). I anticipate that I will interview four triads of clients and their therapists.

Why am I being invited to take part?
I am inviting you to take part because you were one of the therapists for client at MCPS who transferred from one therapist to another.

Do I have to take part?
It is up to you to decide whether or not to take part. Even if you decide to take part you are still free to withdraw at any time, without giving a reason.

What will I have to do?
If you would like to take part I will invite you to come in to Metanoia and talk about your experience of therapy with your client. I am interested in what you felt worked well, and what worked less well, for your client.

I will arrange for you to come in on a day and time that suits you, and the interview will last 60 to 90 minutes. The interview will be taped and then transcribed. I might also contact you after the interview with follow up questions, and to invite you to comment on the findings of the research.

Are there any risks of taking part?
It is unlikely that there will be any risk to you through taking part in the research. However, in the event that unsettling material comes up as a result of the research I believe that you will be well supported by your clinical supervisor.

What are the possible benefits of taking part?
I hope that participating in this study will be both interesting and helpful to you as a therapist as it will explore the process of engagement in therapy and what works best for clients. By learning more about engagement and non-engagement in therapy I believe that the results of this study could also have wide-reaching benefits for therapists, organisations and clients in the future.

What about confidentiality?
All information that is collected about you during the course of the research will be kept strictly confidential. Any information about you that is used will have your name and address removed so that you cannot be recognised from it.

Please note that although all data will be anonymised, your data will be linked to that of your client and their other therapist in the findings section. This means that you will be able to recognise the contribution of your client and their other therapist, and they will be able to recognise your contribution in the write-up of the research.

How will you store my data?
All data will be stored, analysed and reported in compliance with the UK Data Protection Act 1998.

Will you check the findings with me?
When I am writing up the research I might want to use extracts from the interviews. I will check with you before I quote anything from your interview. I will also give you a chance to read and comment on what I have written.

What will happen to the results of the research study?
The results of the research will be published as part of my doctoral thesis and may be published in professional journals. No personal data will be used so you won't be recognisable in the published pieces. Let me know if you would like a copy of my thesis and I'll post it to you once it is complete.

Who has reviewed the study?
This study has been reviewed and approved by Metanoia's Research Ethics Committee.

Please note that in order to ensure quality this project may be checked by member of Metanoia's Research Ethics Committee. This means that the designated member can request to see signed consent forms. If this is the case your signed consent form will only be accessed by the designated member, and will be kept confidential.

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Any Questions?
Please feel free to ask me any questions now, or contact me by email / phone (email: lia.foa@metanoia.ac.uk / phone: 020 8832 3085).

You're also welcome to contact my research supervisor – Dr Biljana Van Rijn (email: Biljana.Vanrijn@metanoia.ac.uk).

Thank you for taking time to read this information sheet!

CONSENT FORM

Title of Project: <u>Engaging in therapy: exploring the perspectives of clients and their therapists when a client chooses to change therapist</u>

Participant Identification Number:

Name of Researcher: Lia Foa

- ☐ I confirm that I have read and understand the information sheet dated 3/2/18 for the above project and have had the opportunity to ask questions.
- ☐ I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. If I choose to withdraw, I can decide what happens to any data I have provided.
- ☐ I understand that my interview will be taped and subsequently transcribed.
- ☐ I understand my identity will be protected at all times.
- ☐ I agree to take part in the above study.
- ☐ I agree that this form that bears my name and signature may be seen by a designated auditor.

_____	_____	_____
Name of participant	Date	Signature
_____	_____	_____
Researcher	Date	Signature

Semi-structured interview guide

Please note that this is a rough guide to the questions that I intend to ask and the specific questions will vary depending on the outcome of the first pilot interviews, and what emerges from the interviews as they proceed.

I will take time at the beginning of each interview to introduce myself and the purpose of the interview, and make the participant feel at ease. I will also spend time at the end concluding the interview.

Questions for clients:

- Broadly tell me about your experiences of therapy with each of your therapists at Metanoia
- Was there anything about the therapy with your first therapist that worked for you?
- Was there anything about the therapy with your first therapist that didn't work for you?
- In your opinion were you unable to engage in therapy with your first therapist?
    - If so or if not, what might have contributed to this?
- What contributed to your asking to change therapist?
- Was there anything about the therapy with your second therapist that worked for you?
- Was there anything about the therapy with your second therapist that didn't work for you?
- In your opinion were you able to engage in therapy with your second therapist?
    - If so or if not, what might have contributed to this?
- From your experiences of therapy with the two therapists at Metanoia, do you have a sense of what might have contributed to your ability to engage or not to engage in therapy?
- Is there anything else you'd like to discuss with me about this topic?

Questions for therapists:

- Broadly tell me about your experience of therapy with your client
- Do you have a sense of what facilitated / hindered engagement with your client?
- In your opinion, what might have contributed to your client requesting to change therapist?
- From your experiences with this client, do you have a sense of what might contribute to a client engaging or not engaging in therapy?
- Is there anything else you'd like to discuss with me about this topic?

9.12.18	finding the mass of codes daunting, refining the codes is difficult
10.12.18	working on refining the codes - grouping the ones that are similar
20.12.18	Feel like I have some good preliminary themes - going to check them with with my colleagues at the research retreat I'm hosting in January
4.1.19	Thinking about the best way to code the remaining data Having started to code the T1 interviews, I realised that this didn't seem to make sense as it felt like I was splitting up the data and losing some of the interesting complexity - going to try looking across the cases with reference to the themes from the client interviews
5/1/19	Research day - 9-5 - with colleagues - useful to work with them on their own projects. Also very useful for them to have a look at my client codes and themes and let me know whether they make sense / need to change. Generally things made sense to them, but a couple of themes that need further thought were identified
7.1.19	Going over the T1 interviews I am struck by the complexity of coding not just for the explicit, but also trying to capture the dynamics of what is going on between client and therapist - for example the therapist being vicariously traumatised by the client - when the therapist doesn't talk about this explicitly
	also, how useful this might be for training courses - that the T1s seemed to not be able to cope with the force of what the client is bringing, perhaps how to manage / stay grounded / slow things down should be more of a focus
	Completed initial coding of T1 nodes
13/1/19	interestingly, as I code the T1 data I see how one-sided it is, how much of the complexity is lost without having the client's perspective too
29/1/19	Not sure whether to integrate the T1 codes into the C codes, or to analyse them separately
2/1/19	Have coded T1 data alongside client data. Will look at whole dataset once have coded T2 data
	Starting to code T2 data
	Haven't coded section on what hinders therapy generally for C2T2 as not sure that it's relevant
5/2/19	completed coding on T2 interviews, beginning to sort initial codes
8/2/19	This feels like such a challenging process - in a way I feel overwhelmed, or like I'm drowning in data. I keep moving things around on the page without feeling like I'm making any progress. But I also have to trust that as I work with the data things will become clearer - which codes fit together will become intuitive
13/2/19	I've noticed that I'm looking more at what helps the client to engage, not the therapist to engage. **The therapists talk about both sides, what helps/hinders them to engage with the client, and what helps/hinders the client to engage with them**
19/2/19	Reading through all of the transcript again to check for any missed coding
22/2/19	Thinking more about the themes that I have developed - at the moment I think that I have too many themes, and that I am staying more at the surface level of the data rather than being more interpretative and telling a story. I need to revisit the data, and think again about the themes and see if I can refine them.
23/2/19	Research retreat with four colleagues - taking the time to gather their ideas on what might be going on with my research
1/3/19	Happy (for now) with themes and sub themes Putting quotes next to my codes - it's interesting how at the moment I'm looking across case, but there's a pull to show quotes from each case that relate to each other - gives weight to analysing the data in both directions!
4/3/19	Thinking about how to write the results up in a way that is faithful to participant accounts, but also respectful to the participants and not likely to hurt the participants
7/3/19	I have started to write the within case analysis under sub-theme headings. As I write it, I wonder if it might be better to link to the subthemes, but not divide the text in that way, as it feels like each section is linked and I'm repeating myself. However, the sub themes do give some structure to this section…
15/3/19	Starting to tackle the literature review. Struck by the vastness of the topic. Also, getting drawn into general stuff, while perhaps need to focus on initial engagement specifically!

Feature	Notation
Emotions and gestures	Where the participant made a gesture or showed an emotion that seemed relevant this is included in square brackets (e.g. '[hitting chair]')
Emphasis on particular words	Where the participant emphasised a particular word, this appears in *italics* in the transcript
Identifying information	Any identifying information used within my thesis has been altered and put into square brackets
Identity of the speaker	Interviewer is written by first name ('Lia'). Participants are named by their acronym or code (e.g. 'Jane' or 'T1-Jane')
Inaudible speech	Labelled as [inaudible]
Non-verbal utterances	These are entered phonetically
Pauses	Three consecutive dots '…' are used to represent a pause in the participant's speech
Reported speech	Indicated by using inverted commas
Use of punctuation	Throughout the transcripts I have used punctuation to enhance the readability of the data

33.58	
Daphne	Maybe, yeah.
Lia	So maybe what you're describing is a lack of a feeling that she liked you. Is that right?
Daphne	I think so, yeah, yeah… I remember what set it off. Oh no. We were talking about I said about my children and she asked their ages and I told them and she went 'oh' and I thought 'you should've read my notes, you would know how old I am so this wouldn't be a surprise to you'. And that was it and I thought 'oh, okay'.
Lia	So what did that mean to you?
Daphne	That was a judgement.
Lia	Okay. So, at that moment, you felt she was judging you?
Daphne	Yeah. I have grown-up children. I'm [age] and I've got grown-up children and so, when I met her, I was [age] or whatever, but we didn't talk about how old we are and she asked and I said my children and she asked their ages and I said 'na na na' and she goes 'oh' and I thought, 'okay. So you're doing the calculation on whatever she perceived me as, my kids are X age, so'. That that that was it. That was the… Yeah.
34:47	
Lia	That was a moment for you?... Is it hard to connect back into that?
Daphne	Yeah, because… I can see her trying to do the maths in her head and I was thinking 'you have my file and does it matter?' Anyway [visibly upset].
Lia	What I can see is that it, even now, it still feels upsetting to have felt judged by her.
Daphne	Yeah.
Lia	And what do you think feeling judged does to you?
Daphne	I have issues about people. I want to be liked, I want people to like me, I want people to think that I'm nice. So… having someone work out the kids are X age and she's whatever or whatever age that they thought that I was, you know. Maybe that's when I got the middle-aged thing. She probably thinks that, you know, she doesn't know and then I got a bit defensive that she doesn't know me. This is all internally - she doesn't know *me* - and then I thought –

Case 1 – Jane and her two therapists

Jane was a white female client in her mid 30s. Both of her therapists were white males – T1 was in his early 30s and T2 was in his early 50s. Jane stayed for 3 sessions with her first therapist and had 9 sessions with her second therapist. Jane was one of T1's first few clients, while T2 had over 500 clinical hours before meeting Jane.

	First therapist	**Client with T1**	**Client with T2**	**Second therapist**
Theme 1: Forming a personal connection with the therapist				
Subtheme 1: Clients need to get a sense of the therapist as a person	*I didn't bring in my personal self*	*I didn't have enough sessions to really know, you know about anything else about him*	*it worked better that I felt he was bringing who he was. He was talking about himself, even at the first session*	*I told her in the very first session that I had some training in this area*
Subtheme 2: Clients need to feel heard and truly understood by their therapists	*I had this sense of feeling I think I had a sense of maybe feeling more empathy for him than for her*	*I didn't feel that he was connected - even trying to connect*	*it felt like he was paying a lot of attention* *it's made a big difference to feel that they understand the issues*	*I think she really needed to be heard, so I think that, certainly in the beginning, I'd like to think that she received that from me*
Subtheme 3: Mutual liking, positive regard, and forming a personal relationship	*I say - my sense was - that she didn't like me, but I think that was coming from the developing let's call it 'a sense of missing eachother, not getting eachother'*	*when you have somebody who is non-directive you're not getting [a sense of being liked] back from them I guess*	*so much of it is whether you like the person or not [. . .] and whether they like you. And I think you can always tell that*	*I never really had a sense of what she made of me in our relationship*
Jane's first therapist commented that he wasn't able to bring his personal self into the room and became very 'blank screen' and this was echoed in Jane's sense of not knowing who T1 was. Jane didn't feel like T1 was even trying to understand her and wasn't getting a sense of care from T1. She felt completely differently about T2 as she had much more of a sense of who he was, and felt understood and cared about by him. Interestingly, neither T1 or T2 were sure of what Jane made of them, which indicates that their experience of her may have been similar.				
Theme 2: The therapist's responsiveness to their client	*I've never really identified with a classical approach, yet I was very blank screen - more than I've ever been in any other of my work*	*my first impression in the first session was that he didn't direct me at all [. . .] I don't want a completely non-directive counsellor, kind of parroting back kind of style*	*I want to feel I can lean on the other person to lead me. [. . .] but then to be able to sit as an equal partner to the counsellor*	*I suppose I do generally give my clients a lot of space. I think I do. I do allow that. I consciously allow whatever needs to unfold unfold. You know, most of the time, in a pretty nondirective way.*
Jane's experience of T1 was that he wasn't leading the sessions at all, and instead presented with a "blank screen" which didn't work for her. T1's account correlated with this – he felt 'pinned back' and was more blank screen than he would usually be. In contrast, Jane felt like T2 was someone that she could lean on, and who achieved a balance between leading and treating Jane as an equal. T2 described himself as "nondirective" but was actively creating a safe space for Jane.				

Case 1 continued…

	First therapist	Client with T1	Client with T2	Second therapist
Theme 3: Is the client in good hands?				
Subtheme 1: Therapists' responses to their clients	*a degree of being overwhelmed by the energy of her anger and the energy of her frustration, agitation, annoyance, and like I say, in a bodily sense I very much felt like I was pinned back* *I knew that I was not feeling like I was handling that well*			*it would be quite easy to be wrongfooted by the forcefulness of her nature certainly at the beginning. I just think it helped that I had a bit of experience under my belt and I wasn't sort of bowled over by it, if you know what I mean* *I imagine I would've felt containing to her*
Subtheme 2: Client's experience of therapist as authentic, composed and capable		*coz the style's difficult for me that makes me feel like he's not experienced*	*experienced enough to say things that gave me the hope that I wouldn't always be in that place*	*I suppose I felt she was a client within my scope of competence. She wasn't the sort of client where I thought, oh shit, I don't know what to do or unsettled by her*
Subtheme 3: How clients felt in the room with their therapists		*I feel very awkward - I start to feel like I'm leading, and I don't want to do that*	*the first session I thought 'ahh, such a better fit' and then like I could relax.* *I felt I could trust him*	
Both T1 and T2 described Jane as a powerful presence but, while T2 was able to stay regulated in her presence, T1 responded to Jane as though she presented a danger to him that he needed to defend himself against. This led T1 to freeze and meant that Jane felt like she had to lead the sessions, upsetting the balance of power between them. T2 felt able to handle what Jane was bringing, and Jane felt in much better hands with him as a result.				
Theme 4: Client's decision to change therapist	*I was surprised actually that she didn't come back because my sense was that 'we're missing each other here - she's in a really difficult position, she's very angry, it's early days for me, this is a big piece of work' but [. . .] I thought we'd have more of a battle [. . .] but the fact that she just cut it - I was surprised by that*	*I didn't think it was worth continuing on* *did have some hopes that there would be someone better - I remember thinking 'there must be a better fit*	*it was a good, short-term time with him [. . .] yeah, the right kind of support for me*	*they vote with their feet, for one thing, don't they, and she did stay for a while*
Jane emphasised how much she was struggling and needed help. She didn't feel like it would be worth continuing with T1, and hoped that there might be someone better out there for her. T1 was surprised that Jane chose to end rather than work through the difficulties between them, perhaps indicating that he wasn't aware of the extent of the difficulties. In contrast, Jane felt like T2 was meeting her needs and this helped her to engage with him.				
Researcher's reflections	For me, an interesting part of this case is that T1 and T2 agreed in lots of respects about the way that Jane presented. Both of them commented on her powerful nature and how angry she felt at the time, and neither were sure how she perceived them. None of these elements were brought up by Jane herself. While both of Jane's therapists agreed on her powerful nature and complexity, her second therapist was better able to work with this presentation. He had considerably more experience, which may have helped him to stay grounded and manage his own process in the face of a complex client. He and Jane were able to engage well and build a positive relationship. In contrast, Jane's first therapist was unable to manage his own process, leading him to freeze and feel a need to defend himself from her, which blocked the process of engagement between them.			

Case 2 – Paul and his second therapist

Paul was an Afro-Carribean (British) male client in his late 40s. T1 was a Black-British man in his late 40s, and T1 was a White-British woman in her mid 40s. Paul stayed for 3 sessions with his first therapist and had about 10 sessions with his second therapist. Paul was one of T1's first few clients, and T2 had around 40 clinical hours before meeting Paul.

	First therapist *(not interviewed)*	**Client with T1**	**Client with T2**	**Second therapist**
Theme 1: Forming a personal connection with the therapist				
Subtheme 1: Clients need to get a sense of the therapist as a person		*[T1] was harder to read because he had his head down more* *the Christian thing. It was playing in the back of my mind of, is he a pastor? Would I feel comfortable talking to a…? Is he old-school African, women should know their place…*	*we sat down, we talked, we discussed things, we discussed how to approach things, what type of branch of therapy she's been studying and she's approaching*	
Subtheme 2: Clients need to feel heard and truly understood by their therapists		*I closed down because he was too easily distracted*	*someone's really taking me in* *No matter what distance, you felt she was listening to you anyway*	*And really seeing what it must be like for him I think helped definitely helped develop our relationship*
Subtheme 3: Mutual liking, positive regard, and forming a personal relationship			*The empathy level was incredible compared to [T1's]*	*we were... I think it was a mutual, we were struck by each other, you know, there was a connection because of it*
Paul wasn't able to get much of a sense of T1 and drew on what he could observe (ethnicity and the fact that he had lots of phones) and imagined that he might be a pastor. He didn't feel like T1 was paying a lot of attention (T1 forgot his name and answered his phone in a session) which meant that he didn't feel heard by T1 and was unable to engage with him. Paul had a completely different experience with T2 who shared more of herself with him and seemed to understand and care about him. This was a mutual feeling as T2 expressed how connected she felt to Paul from the beginning of their work together.				
Theme 2: The therapist's responsiveness to their client		*The phone went off, but he answered it. And that's where I was like, 'hang on'*	*She was leading the partnership, but you felt like an equal* *she created a safe space with her, mannerisms, her words, her open approach and the room we used*	*A client who just doesn't want to go near what they want to touch. It's to honour that and acknowledge that and not try and take them to a place where you feel it would be beneficial for them to go*
Rather than treating Paul as a priority, T1 answered his phone during a session which was the final straw for Paul and he completely disengaged from the therapy. T2, in contrast, was much more responsive to Paul. Paul experienced her as leading the sessions, but treating him as equal, and T2 spoke about respecting what Paul was willing to explore. In this way, she and Paul achieved a balance of 'leading and being led', which facilitated engagement between them.				

Case 2 continued…

	First therapist *(not interviewed)*	**Client with T1**	**Client with T2**	**Second therapist**
Theme 3: Is the client in good hands?				
Subtheme 1: Therapists' responses to their clients				*it was quite easy to... for me to feel positive regard* *I felt it was quite a successful relationship actually. And it boosted my self esteem*
Subtheme 2: Client's experience of therapist as authentic, composed and capable		*that was the point where I just went, how unprofessional can you be*	*she just came across as more with it. When I say professional [. . .] She got it, why she was doing it, she got it a lot more. It wasn't like a… She was being it, rather than acting it*	
Subtheme 3: How clients felt in the room with their therapists		*the whole session had just been toxic*	*You open up, you feel you can trust this person a lot more. The therapy went a lot further a lot quicker, a lot deeper a lot quicker, than even I imagined*	
Paul didn't feel in good hands with his first therapist who came across as very unprofessional through his behaviour during sessions. This led Paul to close down and disconnect from him. He felt like T2 was much more authentic, and she created a safe space in which he could explore what was going on for him at a deep level. T2 felt confident working with Paul, and could clearly perceive that he valued the therapy which had a positive impact on her too.				
Theme 4: Client's decision to change therapist		*These sorts of things that made me go, 'no, this isn't right, and I don't want to battle through this'*	*She was helpful, and in lots of different ways*	*the more he opened up and was showing more of his vulnerability the more I was able to acknowledge that and show my regard. And so it became a deepening relationship*
For Paul, several specific experiences with his first therapist gave him evidence that the relationship wouldn't work for him and that it wouldn't be worth him continuing in therapy with T1. With T2 he experienced a complete contrast – he gained a lot from the therapy, there seemed to be a mutual sense of appreciation between them and both he and T2 valued the time that they spent together.				
Researcher's reflections	For me, an interesting aspect of this case is the extreme difference between Paul's experience of T1 and of T2. With T1 an initial negative impression was confirmed by a series of difficult moments with his therapist, creating a dynamic that made engagement between them impossible. A complete contrast can be seen with T2, in which a positive initial impression allowed him to feel cared about and understood and created a safe space within which he could explore his difficulties. The experience between Paul and T2 was mutual and T2 also valued, and benefitted from, the work that they did together.			

Case 3 – Robert and his first therapist

Robert was a White male client in his mid-30s. His first therapist was a White female practitioner in her early 30s. Robert stayed for 7 sessions with his first therapist, and 13 with his second. Robert felt like he engaged better with T2 than T1, but didn't engage with either of them as well as with a previous therapist at MCPS.

	First therapist	**Client with T1**	**Client with T2**	**Second therapist** *(not interviewed)*
Theme 1: Forming a personal connection with the therapist				
Subtheme 1: Clients need to get a sense of the therapist as a person	*I was trying to be quite person-centred in my approach I think. And just sort of not necessarily direct him or guide him in any particular way*	*[T1] was quieter. [T1] was more stand offish. She asked me less questions. She said less generally*	*[T2] was closer, kinder, more open, more accepting.*	
Subtheme 2: Clients need to feel heard and truly understood by their therapists		*I thought she was very attentive. She seemed to understand me when I spoke to her. But, wasn't able to give me what I wanted*	*She understood. When I spoke about things that hurt me, she understood them*	
Subtheme 3: Mutual liking, positive regard, and forming a personal relationship	*I'm not sure that [Robert] would have been someone that I would choose as a person to be around*	*I don't want to say that I didn't like her, because that's not true. I didn't know her either*	*I felt much more comfortable. I felt more like we would get on outside of the therapy room*	
Robert was able to form a better personal relationship with T2 than T1, partly because he experienced T2 as more open and understanding which allowed him to feel more comfortable. The relationship with T1 was more challenging – Robert experienced her as quieter and unable to meet his needs, and T1 was focussed on being 'person-centred' and this made her less responsive to Robert.				
Theme 2: The therapist's responsiveness to their client	*for some reason, I was defaulting, always, to person-centred. And I am only just now beginning to pull myself out of that and not be as person-centred. Or trying to work with that client on what they need*	*There was a lot of expectation for me to do a lot of the talking [. . .] I wanted to have more of a, sort of conversational type relationship [. . .] I did request a little bit more interaction each time I went and that didn't seem to come forth*	*I did manage to get across the idea that I wanted a conversation and I wanted her to say more things and suggest more things. Which she did. She reacted to that fairly quickly*	
Robert wanted a therapist who would be interactive with him and for the relationship to be more balanced. He didn't experience this with T1 and, when he gave her feedback on what he needed, she wasn't able to adjust to meet his needs sufficiently. T1 found that she was "defaulting" to a person-centred stance in that she wanted to "be with him on his journey" and didn't feel (at the time) that her model allowed her to intervene or make suggestions.				

Case 3 continued…

	First therapist	**Client with T1**	**Client with T2**	**Second therapist** *(not interviewed)*
Theme 3: Is the client in good hands?				
Subtheme 1: Therapists' responses to their clients	*I think there was less of me available to connect, because there was so much of me managing my own emotions and feelings, that there wasn't as much to be able to connect with him*			
Subtheme 2: Client's experience of therapist as authentic, composed and capable		*I understand that this is a place that teaches these things and therefore there is a chance that these people might not necessarily be of the best of their game at this moment, they might be learning. In which case they might be bereft in some skills.*		
Subtheme 3: How clients felt in the room with their therapists		*it was actually frustrating me [. . .] it felt like a struggle*	*I did feel much more comfortable*	
Robert didn't feel like he was in good enough hands with T1. He was very aware of her student status and sessions felt like a struggle. T1 was aware that her anxiety and own process around anger were impacting her capacity to be available to Robert.				
Theme 4: Client's decision to change therapist	*he mentioned that he wasn't necessarily getting what he thought he was going to get out of therapy. He didn't mention ending to me. I kind of felt like I was never going to… Anything I said was never going to be right*	*But the upshot was that I wasn't being helped. And that's the point of being here. Is to get help, is to feel like it's working, it's to feel like if you're better. And it was getting to the point, where it was actually frustrating me. Visiting here and getting nothing was actually making me worse.*	*I felt like it was working better, that it was more suited to me [T2] was a better fit, but it still wasn't perfect. Which was why I then stopped.*	
Robert was getting increasingly frustrated with T1 not managing to meet his needs, and this was making him feel worse. T1 was aware of his frustration, and felt like there was nothing she could to that would make things better, but was also surprised that he chose to end. While his experiences with T2 worked better for him, Robert still felt like therapy with T2 wasn't meeting his needs enough to keep him in therapy.				
Researcher's reflections	In this case it seems as though T1's anxieties meant that she was trying to stick to a person-centred model and this left her unable to be responsive to what Robert needed. However, even Robert himself wasn't sure if it was possible at the time for any therapist to meet his needs and, although he engaged better with T2, he ultimately ended because his needs weren't being met by either therapist.			

Case 4 – Daphne and her two therapists

Daphne was a Black-Carribean female client in her early 50s. Her therapists were both white and female. T1 was in her late 30s and T2 was in her early 30s. Neither had much clinical experience before meeting Daphne, but T2 spoke about life experience that she drew on in the work. Daphne stayed for four sessions with her first therapist and spent about 6 months with her second.

	First therapist	**Client with T1**	**Client with T2**	**Second therapist**
Theme 1: Forming a personal connection with the therapist				
Subtheme 1: Clients need to get a sense of the therapist as a person	*I don't want her to know that I'm freaking out so I was just sortoflike calm and a bit like a duck. On the surface calm but underneath going "brrr", paddling furiously*	*I made an assumption that she may have been a middle-class wife and she was doing something outside* *I was filling in her backstory*	*all my spider senses, were saying yes*	*it was just an aspirational hope for connection. And then that's very easy for me to connect into, because somebody's already opened the door. Which I hope I had done for her as well*
Subtheme 2: Clients need to feel heard and truly understood by their therapists	*I wasn't able to even - let alone even help - to really understand what she was going through*	*I didn't feel that she could latch onto something in her life that resonated in what I said so that she could rebound it and understand that I'm feeling like that*	*she is that sort of person that I could talk to like a therapist and wouldn't judge me*	*this space was for her and I wanted to make sure that I didn't assume anything or didn't presume anything. But that I was just here to witness what she wants to bring*
Subtheme 3: Mutual liking, positive regard, and forming a personal relationship	*I liked her, I was a bit like 'whoa' because there was so much going on*	*It was a raw type of disconnection. I couldn't see anything in me in her, so I couldn't… so there was nothing that I could latch on to say, well, there's that bit that I can relate to*	*my kind of people kind of thing, you know. That's what it felt like, kindred. It felt, yeah, and that made… Inside, I sighed a sigh of relief and it was, okay, I get someone now*	*So, there were a lot of commonalities that I wasn't aware of in that first meeting, but that, I think, underlied a kind of general similarity in the way we approach the world*
Daphne's first therapist described having a strong internal reaction to what Daphne was presenting with and couldn't let Daphne know how she was feeling. This meant that Daphne wasn't able to get a sense of who T1 was as a person, and she ended up imagining that T1 was just doing therapy as something to do, rather than authentically wanting to be there for her. T1 didn't feel able to truly understand what Daphne was going through, and Daphne had a sense of this. The lack of perceived common ground meant that they were unable to connect with each other. In contrast, Daphne and her second therapist felt an instant sense of connection and described an implicit understanding of each other. There seemed to be a similarity in the way that they both approached the world which helped them to connect at a personal level.				
Theme 2: The therapist's responsiveness to their client	*I just didn't really know how to handle this because she didn't want to come in and discuss it. It wasn't a discussion. She didn't want a discussion. She wanted to sit there and go back*	*Just asking questions about or just repeating back and saying blah blah blah leaves me in that circle instead of saying step outside*	*[T2} would let me ramble and then pick bits out or gently steer me into you've talked about this, let's talk about the next part on there, you're stuck in this bit, let's move forward a little bit and I'd want to go, I would want to move on*	*in as quiet and gentle way as I could, because I could feel her anxiety, I just opened the discussion for her to speak about whatever it was that she wanted to bring*
Daphne's first therapist didn't know how to work with what Daphne was bringing and felt powerless to intervene. This came across in Daphne's account, as she didn't experience T1 as responsive to her needs or able to facilitate a deeper exploration of her difficulties. In a way, the power dynamic seemed to be out of balance between them, with T1 experiencing Daphne as more powerful than her, and Daphne relating that T1 didn't facilitate the sessions in a way that was helpful. Daphne experienced T2 as more responsive and spoke about how T2 would give her space while also guiding her. Correlating with this, T2 described holding the space for Daphne, and letting her use it the way she needed to. This fits in well with the delicate balance of 'leading and being led' described by participants.				

Case 4 continued…

Theme 3: Is the client in good hands?				
Subtheme 1: Therapists' responses to their clients	*it was literally a little bomb going off* *I was a bit like whoa because there was so much going on*			*all that I could feel from her was this real, genuine openness, and this warmth. And with that, all the anxieties shifted down a bit*
Subtheme 2: Client's experience of therapist as authentic, composed and capable		*It felt as though, to me, boxes was being ticked and she was answering as the book says*	*my connection with people that I can share information with is a trust that they are in tune with what's going on and also have maybe perhaps an alternative spin on things, asking those questions*	
Subtheme 3: How clients felt in the room with their therapists		*It didn't click, I didn't click with her. I didn't feel like I could just relax*	*I felt comfortable and safe and that I could… She realised things in me that I didn't know why I acted in particular ways*	
Daphne's first therapist didn't feel able to handle what Daphne was bringing, and her experience of what Daphne was saying was like "a little bomb going off". She was focussed on managing her own response to Daphne (and working out how to handle the sessions) and this impacted her capacity to be available and authentic with Daphne. Daphne didn't pick up on how her first therapist was feeling, but did sense that her first therapist wasn't authentically present, and didn't feel like there was a connection or able to relax with her. Between Daphne and her second therapist there was a mutual sense of regulation, with T2 feeling calm and confident in the work, and Daphne feeling comfortable and safe.				
Theme 4: Client's decision to change therapist	*I did feel we'd both been slightly let down. What I had was a situation which was never going to be something I could… It was never going to work out for either one of us*	*I tried to think that I came away every time thinking that something new had changed, but I didn't*	*I know I can recognise them and I can step out and say calm down, take a breath, think about it, and use the techniques that I've learned through [T2]*	*I feel like Daphne taught me almost as much as I hopefully experienced with her. I really felt like I'd learnt from her, and witnessing her journey was actually a real privilege*
Both Daphne and her first therapist were aware that something wasn't quite working between them. Daphne's first therapist felt like her lack of experience and the complexity of what Daphne was bringing meant that it couldn't work between them, and Daphne knew that she wasn't going to get what she needed from the relationship. Both Daphne and her second therapist felt like they got something positive from their interactions, with Daphne commenting on specific things that her second therapist had done to help her.				
Researcher's reflections	For me, an interesting element of this case is that both Daphne's first and second therapists had very little clinical experience but T2 had life experience which may have played a role in her confidence working with Daphne. The two therapists had very different immediate internal responses to Daphne which seemed to have a huge impact on the process between themselves and their client. T1 felt overwhelmed and unable to help, which led her to be less immediate and available to Daphne, which then impacted Daphne's connection with her. Daphne and T2 felt an instant connection with each other, beginning before a word was spoken between them, which then led into a sequence of positive interactions that were helpful to both of them.			

Case 5 – Emma and her second therapist

Emma was a White (Northern European) female client in her early 30s. Her first therapist was a Black (British) female in her early 40s, and her second therapist was a White (British) Male in his mid 50s. Neither therapist had much clinical experience before meeting Emma, but T2 had a lot of professional experience that was relevant to his work as a therapist. Emma had one session with her first therapist and spent over 6 months with her second therapist.

	First therapist *(not interviewed)*	**Client with T1**	**Client with T2**	**Second therapist**
Theme 1: Forming a personal connection with the therapist				
Subtheme 1: Clients need to get a sense of the therapist as a person		*it was very much a gut feeling that I don't think we can work together for nothing that they did wrong or said wrong. It was almost mannerisms, and it was just the sense that I got that I don't think I can open up to this person*	*on some level it's liking them as a person, there was just something appealing about them*	*I'm also quite happy with disclosure in the sense of bringing part of me into the room and talking about, and I'm quite happy to bring in my private life if I think it's relevant to touch on. So yes, I very much believe in brining myself into the room and not being some kind of blank screen*
Subtheme 2: Clients need to feel heard and truly understood by their therapists		*it was about not understanding - I would say something and then it would be misinterpreted almost*	*When you connect with somebody and you discuss something and then it's like, oh, it makes sense. And you do feel truly understood. But yes, so I think that's the human aspect of it*	*someone she could actually talk to about what was going on with her, someone who's prepared to try and understand what it was like for her*
Subtheme 3: Mutual liking, positive regard, and forming a personal relationship			*I thought he was okay, and he wanted to work with me*	*Lia: I'm getting the sense that you cared about her from what you're talking about?* *T2: Yes, very much so*
Emma had an immediate sense of T1 based on her mannerisms which made her feel like she wouldn't be able to work with her. She didn't feel understood by T1 and was unable to engage with her. In contrast, there was a sense of mutual liking between Emma and T2 – Emma felt understood at a deeper level and appreciated by her therapist, and T2 was investing in understanding what was going on for her and liked and enjoyed working with her.				
Theme 2: The therapist's responsiveness to their client		*Some that I've experienced they're not very present - it seems really unfair. I'm sure they just had a bad day, and we all do - But as soon as I feel that, I'm not going to be opening up about stuff that I'm here for*	*Lia: How were the sessions, was it led by him, led by you?* *Emma: Definitely led by me, I think. But he would ask good questions. I mean, he would repeat it back to me - I really needed it at the time - if that makes sense.*	*I like giving people, if you like space to unfold and without necessarily challenging and pushing too much to early anyway*
Emma didn't experience T1 as present enough. When a therapist isn't present, they are unable to be responsive to their client, and this means that the client is unable to trust them enough to open up. With T2, Emma described how he created space for her to lead the sessions, while also helping her to get to a deeper level of understanding of what was going on for her. Emma's sense of the sessions was congruent with T2's description of giving space to allow things to unfold between himself and his client.				

Case 5 continued…

Theme 3: Is the client in good hands?				
Subtheme 1: Therapists' responses to their clients				*I naturally in some ways provide a safe container and I tend to give the impression that whatever you throw at me you're not going to bother me. So I'm aware that I can, I suppose that's the feeling I give people*
Subtheme 2: Client's experience of therapist as authentic, composed and capable		*And partly, I think they were a little bit late [. . .] they were really flustered*	*He was just really relaxed. He would take his shoes off and sit with his legs underneath him and he can just put you at ease with that.*	
Subtheme 3: How clients felt in the room with their therapists		*I couldn't say some of the stuff that I was just going through or those experience because I want to protect them*	*Yes, it was just easy.* *He did definitely make me more comfortable and easy to be around. And discuss really distressing matters at the same time.*	
For Emma, her first therapist being late and flustered made her feel like she might have to look after her, and that she wouldn't be able to handle what Emma needed to bring to the therapy. In contrast, T2's body language and presence gave Emma a sense of his composure and authenticity and this helped her to relax during the sessions. Correlating with this, T2 felt relaxed and confident working with Emma, and felt like they were connecting well.				
Theme 4: Client's decision to change therapist		*Lia: it sounds like you knew very quickly that you didn't feel like you could open up to [T1]* *Emma: It was pretty instant, actually*	*And then it did work just so much better, actually, a lot easier. Again, I think I knew quite quickly I definitely wanted to try and make this work better.*	*it felt that there was work to do and that we had a chance to do some at work*
Emma had an instant sense that she wouldn't be able to work with T1 and that she would be able to work with T2. T2 also felt confident that they would be able to work well together.				
Researcher's reflections	An interesting aspect of this case is that Emma had an immediate, implicit sense of whether or not she'd be able to work with each therapist, which was then built on by her experiences with each of them. She seemed to pick up on T2's confidence, composure, and willingness to engage in the work with her, and this helped her to feel safe and engage with him.			

Case 6 – Claire and her two therapists

Claire was a British Indian lady in her early 40s. Both of her therapists were female. T1 was a female White-Italian practitioner in her late 20s, and T2 was a female White-British practitioner in her early 40s. Claire had 3 sessions with T1 and about 6 months of therapy with T2.

	First therapist	**Client with T1**	**Client with T2**	**Second therapist**
Theme 1: Forming a personal connection with the therapist				
Subtheme 1: Clients need to get a sense of the therapist as a person	*I didn't feel my presence so strong*	*I didn't pick up any sense of [T1's] personality at all*	*She would give her own insights about certain things. Well within boundaries and I think that helps as well because it makes that person seem more human*	*She didn't know anything much about me outside of the room, but she was perceptive*
Subtheme 2: Clients need to feel heard and truly understood by their therapists	*actually I didn't have any problem to talk or to understand her"*	*every time I was in real flow trying to explain something and she would say stop, and then it would disrupt what I was trying to say in the next sentence because she wasn't understanding what I was saying*	*she was on the same wavelength as me. She appreciated the same things as me as well. I love art, she loved nature, she loved all the things that we could both laugh about or enjoy*	*I guess we call it empathic following in person-centred therapy, really staying alongside her, but also knowing her, taking the time to know her through our sessions*
Subtheme 3: Mutual liking, positive regard, and forming a personal relationship	*there wasn't something in common that I perceived in that moment*	*As soon as we sat down it felt more business like almost like let's get on with it. I just felt very much… It wasn't the human side that was coming though*	*she made it very clear, she said it all along. She said I'm going to really miss you and I really enjoyed working with you. That makes you feel comfortable as well*	*I felt empathy for [Claire] right from the beginning Intuitively, I got the sense that she liked me and that she respected me*
Claire didn't have a sense of who T1 was as a person and felt like T1 didn't understand her. Claire primarily thought that this was due to the language barrier between them, but T1 didn't feel like she had any problem understanding Claire. Claire had more of a sense of T2, appreciated what she said about herself, and felt like they were on the same wavelength. There was a mutual sense of care between herself and T2.				
Theme 2: The therapist's responsiveness to their client	*it was difficult to interact, in the moment to block her, to do some questions. You really have to take your space if you want to say something* *I felt like a container in that moment, I were just holding actually. So, I was listening, holding her, and that was my focus at the beginning*	*she wanted to know a lot about, it's almost like she wanted to know quite a lot of information all in the first session, which I found a little bit overwhelming*	*She used to really create that space so that I felt comfortable in talking about anything that I wanted to talk about*	*by allowing her to find her own pace and to direct the topic of conversation within the room, it allowed her to cope with material as and when she was able to, when she had the resources and the resilience to, and not to be totally overwhelmed by very difficult feelings*
Claire's experience was that T1 asked her lots of questions and wanted to know a lot of detail right from the beginning and this was overwhelming for her. T1 had a contrasting experience, that Claire was talking a lot, and that it was difficult to slow her down or ask any questions. T1 felt like she was a container, holding the space for Claire, but Claire didn't experience the sessions like this. In contrast, Claire's experience with T2 was that she created a safe space in which Claire could talk about whatever she needed to, and T2 echoed this focus.				

Case 6 continued…

Theme 3: Is the client in good hands?				
Subtheme 1: Therapists' responses to their clients	*I felt comfortable. Personally, I felt completely…*			*I felt quite relaxed and calm, even though she wasn't [. . .] I felt hopeful that this could be something that might work for her, and I was conscious that I wanted it to work for her.*
Subtheme 2: Client's experience of therapist as authentic, composed and capable		*I found [T1] quite generic [. . .] it all felt a bit more robotic*	*she actually genuinely wanted to help people who were in that position as well, if that makes sense*	
Subtheme 3: How clients felt in the room with their therapists		*I walked out feeling really overwhelmed thinking I've just disclosed really my whole life. [. . .] It is quite traumatic every time you have to explain everything all over again.*	*she made it very comfortable for me [. . .] she made it very easy that if I wanted to speak up for myself at any point that I could speak up.*	
T1 was anxious about her English, but generally confident working with trauma. Her anxiety may have impacted how she came across in the room with Claire, who experienced her as 'robotic' rather than authentic. With T1 Claire didn't experience the therapy space as safe and containing, and instead felt overwhelmed. In contrast, Claire felt comfortable and safe with T2 and experienced her as more authentic. T2 felt relaxed and calm working with Claire and like she could handle what Claire was bringing.				
Theme 4: Client's decision to change therapist	*I didn't felt that we didn't engage, I felt that it was really little time, and she had lots to say* *she needed time to just trust and to feel comfortable*	*I said I don't need to pay someone just to create that space. I do that a lot with my sister anyway. I said I actually need some to be able to give me tools that I can handle things in a different way*	*she practically helped me get to the root of trying to connect with my emotions and what I was feeling, and acknowledging that was important, but also what practical steps I could take to overcome what the actual problem was*	*There was clearly something about working with me that was working for her [. . .] It's quite rewarding, I suppose, as a therapist to get the feedback that what's happening in the room is working.*
T1 wasn't aware of how Claire felt about the sessions, and didn't feel like they didn't engage, rather that they needed more time. Claire, instead, was clear that she wasn't getting what she needed from T1. With T2 Claire was clearly getting more from the therapy, and T2 could sense during the sessions that the therapy was working for her.				
Researcher's reflections	For me a very interesting element of this case is the difference between how Claire and T1 experienced the sessions – while Claire felt like T1 was asking too many questions and didn't seem containing or regulating for her, T1 was trying to slow the sessions down and create a safe container for Claire, but didn't feel like Claire was allowing any space for questions. Similarly Claire thought that language was a major issue and didn't feel understood by T1, while T1 didn't experience any problems in understanding Claire, and was paying close attention to everything she was saying. Claire and T2 were much more aligned in their experience of the sessions.			

Participant	Participant response and any changes made	Any changes made to the thesis
Jane	*Having met with Jane and talked through her concerns and thoughts about the research she indicated that she would like to include a brief statement about her response to reading the findings:* "I met with Lia in 2016 and then forgot the parameters of the research so that when she contacted me in 2019 with the results, it caught me off guard and was difficult to read. The honesty of my first counsellor hurt my feelings since I hadn't realised he had felt such strong negative feelings about our sessions. It would've helped to be reminded that the research wouldn't be confidential and might include things I didn't already know. That being said, Lia met with me after this and helped me to understand what had been said. It was really helpful."	*Increasing the anonymity of the participants (for example by using age categories instead of exact ages)*
T2-Jane	*Upon reading the findings T2-Jane emailed me the following feedback:* "it was really interesting to read and for me personally very encouraging and facilitative to receive. It's pretty much a unique experience to see an unfiltered, honest appraisal by a client of how I impacted them and their experience of me and for that I am grateful."	
T2-Paul	During a phone call with T2-Paul after she had read the findings she related how touched she was to read what Paul had said about her. She commented that in some ways it might have been more helpful to have been Paul's first therapist reading the findings as this would have helped her to know what to change in her practice. She overall found the piece fascinating to read.	
Robert	*Read findings but chose not to comment on them*	
Daphne	During a phone call with Daphne after she had read the findings she described how she felt like reading the piece was like the "closing of a circle" – that it helped her to understand and process her experiences between herself and each of her therapists. She mentioned that reading the piece brought back some of the feelings that she had had when she was in therapy with her therapists, which was difficult for her, but she was also able to manage those feelings. She valued the opportunity to take part and felt like it had overall been a very positive experience	
T1-Daphne	During a phone call with T1-Daphne after she had read the findings she said that she felt that something that did not come across sufficiently in the findings was that Daphne was her first ever client and she didn't have enough training or experience to work with Daphne's complexity. She felt that Daphne would been challenging for any trainee with no experience to work with. At the time it didn't feel ethical or moral for her to work with Daphne and she felt that she didn't receive enough support from the service when she tried to voice this. She also wondered whether Daphne might have started therapy with her second therapist in a different way to how she had started with T1-	*Noting that Daphne was T1's first ever client in the text*

	Daphne (for example Daphne might not have described her experiences so graphically right from the beginning), which could have impacted the way that they engaged. On reading the findings T1-Daphne felt sad that she wasn't able to help Daphne, and it was a little upsetting to read about Daphne's assumptions about her, but she was also glad that Daphne went on to have a successful relationship with her second therapist.	*Changing the use of one of the quotes from T1-Daphne*
Emma	During a phone call with Emma after she had read the findings she commented that is was really interesting to see the process both from her side and also from the side of her second therapist. She didn't find anything in the findings upsetting, and valued the opportunity to read them. The overall process of taking part in the research was "a really positive experience", particularly as it allowed her to address something that happened during the therapy that had not been resolved between herself and T2-Emma (see appendix 12).	
T2-Claire	*Upon reading the findings T2-Claire emailed me the following feedback:* "As a trainee, it's interesting for me to look back on that very first client relationship. I have now worked with around 15 clients and sometimes still ask myself that all-important question - am I offering my clients enough? Am I helping them? When that question emerges for me, I usually come to realise quite quickly that I'm challenging what Rogers termed "the necessary and sufficient conditions for personality change." I'm asking myself whether, along with the other 3 conditions, empathy, congruence and UPR really are sufficient, particularly when I am working with a client with a complex trauma history, such as my first client, Claire. When I am tussling with this, I often think back to my relationship with Claire, and it reminds me of what Rogers' conditions provide for our clients - autonomy, self-direction, space and safety to work at their own pace, a relationship based on mutual trust and a sense of equality in the relationship, and really importantly, a relationship in which I am aiming to be always along-side them - not ahead of or above them. As a trainee and beyond, these are the things I want to continually remind myself of. It's been very humbling to read Claire's comments and understand the therapy relationship from her perspective. At the time of working together, I felt privileged to be able to hear her story and offer her a relationship in return. I really heard her when she said that she didn't find therapy easy, and that made the relationship all the more precious and delicate to me."	

Although not relevant to the topic of my research, an ethical complexity linked to my roles as a researcher and an employee arose when I was interviewing Emma and her second therapist. During my interview with Emma, before she could speak about initial engagement with her second therapist, she needed to tell me about the ending of her therapy with him which was very traumatic for her and so we devoted some time to talking about this. Emma said that her therapist's placement was coming to an end they were working towards an ending. However, he didn't turn up for their last two sessions and Emma wasn't informed either time before she arrived for her sessions. She didn't hear from him after that and had no idea what had happened (and even was convinced at some point that he had died). While I was able to assure her that he hadn't died, I didn't have any details that I could share with her about what had happened, and was aware of feeling a duty to her to find out what had happened, but also not wanting to open up a clinical matter which, as a researcher, I had no right to be involved in.

When I interviewed Emma's second therapist the first thing he spoke about was their ending and how "devastated" he was by what had happened. He had been very unwell for their final two sessions and had asked the service to get in touch with Emma which they hadn't done (it is the policy at MCPS that practitioners should contact their own clients when they are unwell, but he was not aware of this at the time). It was only after he recovered that he discovered that she had turned up twice and he wasn't there. He tried several times to get in touch with her over email to explain things and arrange an ending session, but didn't receive a reply.

This issue of the ending was clearly very upsetting for both Emma and her second therapist, and felt unresolved between them. I was in a position of holding both of their stories and, although this was not relevant to my research question, I didn't feel like I could ethically ignore the information that I had about the two of them but also didn't have a clear sense of how to proceed. While I was considering how to resolve this, Emma got in touch with the service about her experiences with her therapist, wanting some understanding of what had happened. I spoke with my supervisor (the head of the service at MCPS) about this and we discussed the possibility that Emma could meet with her therapist for a one-off session to talk things through if that is what they both wanted to do. Having met with both of them for my research interviews, I felt that this is something that they might both be interested in doing.

I spoke with Emma (in my role as an assessor at MCPS) about this and proposed that I could contact her second therapist and see if he'd be willing to meet with her. She was keen to proceed, and, when I spoke with her second therapist, he was very happy to meet for an agreed one-off session. They arranged this between themselves and they both fed back to me afterwards that this was very helpful to them – Emma's therapist discovered that he had sent the ending emails to the wrong address and was able to show Emma that he did in fact care, and Emma felt glad that she had had the opportunity to talk things through with him. For both of them this was a positive unintended outcome of taking part in my research.