How clients choose their psychotherapist:

Influences on selecting and staying with a therapist

David Spalter

September 2013

Word Count: 35,545

Degree awarded by Middlesex University

A joint programme between Middlesex University and Metanoia Institute

Doctorate in Counselling Psychology and Psychotherapy by Professional Studies

ABSTRACT

This study considered how a client chooses a psychotherapist/psychologist working in private practice. This research emerged from a desire to enable clients to make more informed choices in relation to entering psychotherapy. It considered two research questions: How do clients choose their psychotherapist? What impact does the choice of therapist have over whether or not to stay in therapy? Ten male and female participants were interviewed in semi-structured interviews and transcripts were analysed using grounded theory. A three-stage model was developed, which emphasised the relational processes underlying the influences on client's choice of therapist and decision to remain in therapy. At the initial stage of the process, prior to meeting a therapist, clients gathered information, formed expectations, and considered practical matters such as the therapist's location and cost. At the stage of first meeting the therapist, clients took into account aspects of the therapy setting, the information provided by the therapist, as well as their own assessment of the quality of the relationship they experienced at this first meeting. Once clients had begun working with a psychotherapist, they appeared to continually balance the gains made against the cost and convenience of the therapy whilst also continuing to assess the quality of the relationship. This ultimately had an impact on whether or not they stayed in therapy. Findings highlighted the considerable lack of clarity for clients in locating reliable sources of information about therapy and how to make the best choice of therapist. Limitations of the research were discussed and some suggestions for areas of future research were suggested. Implications for therapeutic practice include the provision of more detailed information for clients prior to beginning therapy and also at first meeting in order to demystify therapy, to enable better informed consent, and to potentially reduce client dropout rates.

Table of Contents

LIST OF FIGURES AND TABLES

CHAPTER ONE: INTRODUCTION

How does a person decide which therapist to work with? It is the intention of this project to generate understanding of the process of how a client chooses a therapist. I intend to examine this issue in relation to clients who have sought psychotherapeutic work in private settings rather than NHS or in the voluntary sector. The rationale for this decision is that it allows for the element of choice to be more significantly highlighted as often in the NHS or voluntary sector, client choice is somewhat limited and clients are in general simply allocated to a specific therapist.

If this research is examining client choice, it is important to understand why this issue of client choice matters. Client values are one of the three elements that make up evidence-based practice, which is at the heart of good psychological research and practice. The American Psychological Association policy statement on evidence-based practice in psychology (EBPP) defines EBPP as the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences (APA, 2005). The purpose of EBPP is to promote effective psychological practice and enhance public health by applying empirically supported principles of psychological assessment, case formulation, therapeutic relationship, and intervention. If client preferences and values are seen as an essential part of EBPP, then it is worth developing an understanding of what these preferences and values might be in order to inform and possibly improve practice.

The issue of choice is also of importance because it touches on the issue of informed consent and ethical practice. Informed consent is attained when a person has given their consent based upon a clear conception and understanding of the facts, implications and future consequences of an action. The BPS code of ethics and conduct (BPS, 2009) states that psychologists should:

> *"Ensure that clients, particularly children and vulnerable adults, are given ample opportunity to understand the nature, purpose, and anticipated consequences of any professional services or research participation, so that they may give informed consent to the extent that their capabilities allow."*
> (BPS, 2009, p12)

In relation to choosing a therapist, this is where a client is able to make a decision about who to work with whilst being fully informed about the nature of the work and who they are working with. This has implications in terms of the nature and extent of the information that therapists make available to clients, enabling them to enter into an 'informed consent' arrangement. This also impacts on the client's ability to exercise choice and developing an understanding of what is important to them in making their decision about who to work with. Part of this investigation is to uncover what sort of information needs to be provided to potential clients in order for them to be able to make informed decisions about who to work with and what sense they are able to make of this information. This issue of informed consent also has ethical considerations as one might question whether it is ethically appropriate for a client to enter into therapy without being properly informed about what they are embarking on.

This project is focused on clients who have already come to the decision to find a therapist. I shall not be investigating the process that clients go through in arriving at the decision to seek therapy. This project is about an exploration of the process once the decision to have therapy has been made.

Why am I researching this area, what is my interest?

My experience as a client

This research interest arose as a direct result of my own experience as a client in finding and selecting a therapist. At the time when I was searching for a therapist, I was dating a non–Jewish girl and being Jewish this proved to be an issue for my parents and myself. When I went to visit my therapist for the first time I noticed that he had a "mezuzah" on his door. This is small box with a prayer inside it that is affixed to the doorpost of all Jewish homes, therefore signifying that he was Jewish. At that time, I felt that it would be easier for me to explain my conflict around this issue of a non-Jewish partner to someone who, I assumed by being Jewish, would have a greater understanding of the issues involved. However, I did not embark on my search for a therapist with the religion of the therapist being a factor; it was only after the assessment sessions with my therapist and another therapist (who was not Jewish) whom I visited, that their religion became a mitigating factor for me. After the assessment sessions with both therapists, I had the feeling that my issues had been more closely understood by the Jewish therapist. I felt safer, more contained and I felt able to speak with greater candour with the Jewish therapist than with the other one. My experience emphasised to me that within the process of choosing a therapist, there are a number of conscious and unconscious processes that influence our choice. This experience also highlighted to me how we can make

choices and assumptions from limited amounts of information (my therapist only confirmed that he was Jewish at a much later stage in our work together) and that these snippets of information can have a significant impact on our choice of therapist, how understood we might feel and how willing we are to enter into and maintain therapy.

My experience as a therapist

As a newly qualified psychotherapist attempting to establish my own private practice, developing an understanding of what clients are looking for when choosing a therapist could be of great benefit to my work. The beginning stages of establishing a therapy practice have been challenging, in particular recruiting new clients. Knowing where to advertise my practice has proved to be difficult, as there appears still to be a stigma attached to going into therapy and so a level of discretion is needed. It is difficult to know what is an appropriate amount of information or type of information to offer to clients to promote your practice whilst also maintaining an appropriate therapeutic distance. Being newly qualified means that I have yet to establish myself and develop a reputation, which again has an impact on my ability to recruit clients as from my experience so far, it seems that recommendations have a big part to play in developing contacts with clients. Having an understanding of the process that a client is engaged in during the initial session and how they use this to form an impression of me would be helpful in knowing what to focus on in the first session. It is hoped that through this research a better understanding of the desires of clients will be developed, which will help me to improve and expanding my private practice.

Waiting times for psychological therapies on the NHS have long been acknowledged to be too long. While no reliable figures exist for how long people have to wait for psychological therapies, waiting times of several months are known to be commonplace (MHF, 2006) and in extreme cases waits of up to two years have been recorded. This is in stark contrast to waiting times for hospital operations, which are now tightly measured and limited to 18 weeks in most cases. As a therapist working in primary care, I am aware of the somewhat limited resources within the NHS for psychotherapy. Some but certainly not all GP practices have a counsellor or psychotherapist on their staff but due to stretched budgets, a number have had to make them redundant. This is certainly the case with my local GP's practice and now they are making referrals for private therapy, as there is no longer an on-staff therapist. The IAPT programme has allowed clients more access to therapy (if a service has been set up in their area) however, in relation to the issues that clients can be referred for IAPT's remit is quite narrow. Only non-complicated depression and anxiety will be considered for treatment by IAPT services and only within a CBT model. With long waiting times, the narrow focus of IAPT services and an increase in private therapy referrals, the importance of understanding what clients are looking for in a therapist becomes even more relevant.

Developing a deeper understanding of client experience

It is hoped that this research project will help me to improve my practice by developing a greater understanding of client experience. A significant proportion of training courses have a requirement to have had a number of hours of personal therapy while in training. This requirement is deemed to be important as it allows the trainee to develop a user's perspective of the therapeutic process. I believe that

there is even more relevance in understanding the experience of going into therapy from a non-trainee client perspective. These non-trainees would be less informed about the nature and process of therapy than a trainee psychotherapist. It is hoped that they would offer a perspective that reflects the experience of most people who undertake therapy, given that most people receiving therapy are not therapists.

At the heart of my theory of integration as a therapist is an emphasis on relationship. I believe that human beings are innately motivated to seek relationships because positive relationships activate the desire and ability to fulfil potential. My belief that from birth every person is entitled to nurturing relationships is supported by Rogers' Core Conditions of empathy, unconditional positive regard, and congruence (Rogers, 1951). These core conditions are firmly planted within my practice as an integrative psychological therapist. I postulate that our early experiences of relationship are crucial to our self-experience and that these experiences become internalised, informing our understanding of the world. As Schore (1994) states our relationship with primary caregivers *"provides experiences which shape genetic potential"*. My intention is to provide my client with a relationship that can foster this potential in every psychotherapeutic encounter. I see therapy very much as a collaborative endeavour, with the hope that it can empower clients to make choices in their lives and have a more "authentic" way of living (Cohn, 1997). Therefore, making a choice of which therapist to see is the first step towards empowerment. If I am able to develop a better understanding of what it is that clients are choosing when selecting a therapist as well has how they go about making that choice, then it may be possible to tailor my practice as well as other people's to enable clients to enact these choices in a more impactful and empowering way.

What "official" guidance is there?

In addition to the Department of Health, a number of organisations such as the British Psychology Society (BPS), British Association of Counsellors and Psychotherapists (BACP), United Kingdom Council of Psychotherapists (UKCP) as well as mental health charities such as Mind provide information to the public to help them make an informed choice about entering therapy. Each of these bodies' websites provide a variety of information for the public to read including how to choose a therapist, what types of therapy are available and what to expect from therapy as well as information about different mental health issues. However, due to the varied number of organisations that represent therapists and counsellors, it seems that the public is unaware of where to find this information or that this information is freely available to them as suggested by Browne (2008) who argued that people find the world of therapy a confusing maze where it is difficult to search for and find what they want. In addition, the organisations that represent therapists all have a "find a therapist" section to their websites where one can search for a therapist based on name, location and specialisation. The amount of information provided by therapists for these sections can vary widely, with some providing quite detailed information about their practice, qualifications and different types of issues dealt with whilst others only offer contact details and a name. If one types "how to find a therapist" into Google you get over 7,950,000 hits, which suggests that there is a great deal of advice and information out there for the potential client to consume. However, for the distressed client searching for a therapist could this amount of information be simply bewildering? Perhaps there should be a standardisation of information that is offered, or perhaps a requirement for a

minimum amount of information that would allow a client to make an informed choice.

In a move to improve public understanding and knowledge of mental health issues, January 2009 saw the launch of the 'Time to Change' campaign, England's biggest and most ambitious push to end mental health discrimination. Time to Change is run by mental health charities Mental Health Media, Mind and Rethink and backed by £18 million of funding. It is hoped that campaigns such as this will increase public awareness and reduce stigma around mental health issues as well as helping to inform the public of the various organisations they could contact for help and information.

In an attempt to protect the public and reduce confusion the government introduced statuary regulation of psychologists by the Health and Care Professions Council (HCPC) in 2009. Until the 1st July 2009, anyone could describe themselves as a psychologist and offer their services to the public irrespective of their training or experience. Government legislation came into force which protected seven titles: Clinical Psychologist, Health Psychologist, Counselling Psychologist, Educational Psychologist, Occupational Psychologist, Sport and Exercise Psychologist, and Forensic Psychologist. Post statutory regulation, it is an offence to use one of these titles without being on the HCPC register. The aim is to protect the public from unscrupulous, unregulated and potentially dangerous practitioners. In addition, in February 2007, the government published a White Paper on the future of regulation, *"Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century."* Subject to legislative approval, the White Paper recommended that psychotherapists and counsellors would be regulated by the HCPC in the

future. Statutory regulation might help to reduce confusion amongst the public about psychologists and possibly psychotherapist and counsellors in the future and hopefully reduce potential for harm to the mental well-being of clients. However the HCPC is set up to regulate professionals not to inform the public. There is also a great deal of concern within the psychotherapeutic community about whether the HCPC is the appropriate body to regulate psychotherapists once regulation for this title becomes law. A number of articles have appeared in the press questioning whether the HCPC is suitably equipped to regulate the industry. These articles have been asking whether the HCPC has suitable expertise and understanding of the nuances of counselling and psychotherapy to be the appropriate regulatory body. How far these legislative changes will lead to the protection of the public and reduce ignorance and confusion remains to be seen.

Knowing the "right" service to access is of great importance as a number of clients are ill-informed about the type of therapy that they are accessing and are scared or put off by what they find and therefore do not get the help that they need. The failure to engage clients in therapy continues to be a major mental health services delivery problem (Masi, Miller, & Olson, 2003). When clients do not receive the services they need, they, their therapists, clinics, and eventually society at large pay a heavy cost, both in terms of human suffering and money (Pekarik, 1985).

Aims

The overarching aim of this research is to develop an understanding of the processes that go on for a client when entering into therapy. In order to achieve this, two questions will be asked:

- How do clients choose their therapist?
- What effect does the choice of therapist have over whether or not to stay in therapy?

Methodological issues

One of the main shortcomings that has been levelled at psychotherapy is the profession's over-reliance on quantitative methods for researching counselling (Gordon, 2000; Howe, 1996). Although quantitative methods can be useful in measuring and identifying factors, they are less appropriate for developing an understanding of underlying meanings. A recommended alternative has been to address the client's understanding of counselling by the use of qualitative methods in order to explore in greater detail how clients perceive, experience and make sense of their counselling (Gordon, 2000; Howe, 1996). Merely observing and measuring what people do falls far short of actually understanding their inner experience of the process of counselling, whereas asking clients for their perspectives on counselling helps them *" . . .control the meaning of their own experience and the meanings that others give to that experience"* (Howe, 1996, p.374).

Another issue with current counselling research is that studies highlighting the client's perspective have been comparatively sparse (Bowman & Fine, 2000), particularly compared with the volume of research examining the counsellor's

perspective, most of which used quantitative methodology (Gordon, 2000; Howe, 1996). It is therefore hoped that this study will offer insights into the complexities of client experience.

Previous qualitative research has demonstrated repeatedly that there is more occurring with clients in counselling than is apparent to either the counsellor or an observer (Jinks, 1999). These covert processes involve negative, as well as positive reactions to their counselling and it is some of these processes that this study shall attempt to reveal. It is hoped that by highlighting these processes this study will offer insight to other therapists for their practice.

According to Sexton and Whiston (1996) most counsellors neither read research nor conduct it, therefore increasing the importance of conducting this piece of research, as the hope is that it will turn out to be useful to others' practice as well as my own. The client's perspective is especially valuable due to the lack of a large amount of research evidence that

"demonstrates that client perceptions of the relationship (with a counsellor) are the most consistent predictor of improvement, more so even than therapists' perceptions of the relationship" (Metcalf, Thomas, Duncan, Miller, & Hubble, 1996, p. 335).

What contribution this study will make

Previous research of clients' perceptions of the counselling process has shown that clients' and counsellors' views of counselling often differ in important ways (Gordon,

2000). Developing an understanding of the process that clients go through when entering into therapy could help to reduce these differing views of therapists and clients, as it will offer insight into the client's perspective of therapy. Therapists as well as clients might help themselves by having a greater understanding of the process that a client is engaging in when locating a therapist, especially at the point of first contact and initial session. This might help therapists to understand how to adapt their behaviour and what they might say at the first point of contact. This research could help to produce more "effective" therapy, by increasing awareness of what clients are looking for from their therapist and therapy.

This research could also aid therapists in understanding what information needs to be provided to clients when they initially contact them, during the first session and over the course of therapy. In what has become a consumer-led market place, is it not the responsibility of therapists to be aware of what clients as the consumer are looking for when they decide whom they might choose to work with? Entering into long-term therapy can be an expensive commitment, so perhaps there should be an attempt to offer better value for money by taking into account the factors that clients consider in selecting someone. This may help them to make the most effective choice and hopefully produce successful therapy. Informed client choice is therefore important but it is not sufficient to assume that a client will do his or her own information gathering before approaching a therapist (Windle and Paschall, 1981). This study will hope to tease out the information that clients consider the most important. Offering more informed choices to clients could also have an impact on the number of complaints that are brought against therapists and perhaps help to reduce dropout rates and referrals to other services.

The results of this study could have a bearing on policy regarding the provision of therapeutic services. There has been an ongoing move towards a more participatory model of psychotherapy in which clients can be empowered by their choices of therapist and treatment direction (Coyne and Widiger, 1978). In 2005 the NHS set out its "Our Choices in Mental Health" (CSIP, 2005) programme, which was a national strategy that was designed to engage and encourage local mental health communities to improve and extend the choice that they provide to people who use their services. "Our Choices in Mental Health" identified key 'choice points' along the care pathway for patients with the intention of offering the most value to people using services. The key choice points cover four areas in which to offer more choice to patients. The first of these choice points is the promoting and supporting life choices, which are the choices that people make to manage their own care as much as they are comfortable with and maintain their normal lives as far as possible. The second choice point is offering more choices in accessing and engaging with services. The third area is offering more choices in assessment so that when people need their mental health assessed, they should be able to choose a time and a place for that to happen. The final choice point is offering more choices in care pathways. People who use mental health services and their carers need to be given a range of suitable care options to choose from. They should also be given the information they need about each option and then be supported to make their own decisions. Uncovering what potential clients choose and how they make their choices in relation to their therapist could give indications of more effective ways of implementing this strategy. If a client's active involvement in the selection of a therapist is significant, then this could have an impact on the level of choice that members of the public are given when choosing a therapist and type of therapy. An improvement in the amount of choice available in mental health

services could also have an impact on reducing dropout rates and increasing the therapeutic effectiveness of these services. This study's conclusions could help to shape future mental health policy by offering more effective and cost efficient means of treatment through a more considered approach to pairing up clients and therapists. This study could also be useful to service co-ordinators and assessors in aiding them when considering who to allocate to a particular therapist by offering ideas around better "matching" of client and therapist.

There are some types of services that pay closer attention to the notion of client and therapist matching, in particular counselling services within the gay, lesbian, bisexual and transgender (GLBT) community who will tend to recruit therapists who positively identify as lesbian, gay or bisexual but this is not always carried over into other fields. Perhaps more specific specialist knowledge is needed to work in certain fields and matching the therapist with this knowledge to the correct client could be significant in the success of the therapy and reduce dropouts due to misunderstandings. Additionally, the matching of particular theoretical positions and interventions to specific client groups might aid the success of the therapy. It is hoped that some of the conclusions from this study might contribute to more effective care being provided to those who need it.

Overview

In this chapter, I have outlined what it is that this project will be examining. This research shall consider the process that a client goes through in choosing a therapist. My interest in this research area came about due to my own experience of choosing a therapist, my experience as a therapist and a desire to see clients

being able to make more informed choices when it comes to their therapy. The mental health services within the NHS are going through a period of change where patient choice is high on the agenda and so it is hoped that this study will be able to further illuminate this issue. This research shall be considering two research questions: How do clients choose their therapist? What impact does the choice of therapist have over whether or not to stay in therapy? Through the use of qualitative research methods, it is hoped that the client's subjective experience will be exposed and this will lead to great insight for therapists and therapy providers. This insight could be utilised to improve mental health services and offer clients better value for money and more effective care for those who need it.

In the following chapter, I will review the literature relating to this research question and locate this issue within the wider psychological field. I will then go on to explain the methods that will be used to answer the research questions, outlining the design of the study, who the participants in the study are and how the findings will be obtained. The findings of this research will follow these sections and this study shall conclude with a discussion of the outcomes of the research.

CHAPTER TWO: LITERATURE REVIEW

To understand this research, it is important to locate it within the wider field of Counselling Psychology and psychotherapy. As outlined in the introduction, over recent years one of the critical agendas for mental health service delivery in the UK has been about offering more choice to clients. In 2005 the NHS "Our Choices in Mental Health" (CSIP, 2005) programme set out a national strategy designed to improve and extend choice, including a choice of treatment options. With this in mind, it seems important to understand what potential clients are looking for in and from their therapist and what choices are available to clients.

Clients have a choice in terms of different types of therapy and therapist. The choice of therapist produces a further number of options in relation to gender, sexuality, ethnicity, religion and even personality. The client also has choice over the modality of the therapy, be it long term or short term as well as a choice around price and location. Once an understanding is developed about the number of choices available to clients, it is worth trying to understand why having these choices matter. It is also important to see how the client is positioned as a consumer of a service and what this means in terms of their rights and what information they should be offered. It is also worth considering what the impact of having choice has on the process and outcomes of therapy, including how it impacts on dropout rates. Finally, in order to bring all of this together, it is important to look at what ideas have been proposed about how one might go about implementing this notion of offering choice to clients.

One of the main issues with reviewing research on client choice is that one could define choice in a variety of ways and it is considered differently by various studies.

A small number of studies have focused directly on client choice or preference whilst others have considered issues relating to this subject and so the idea of choice is only implied.

In their meta-analyst of previous research into client preferences, Swift, Callahan and Vollmer (2011) identified three main types of client preferences: role preferences, therapist preference and treatment type. Role preference refers to the types of behaviours and activities that the client expects of themselves and their therapist during therapy (e.g. preference for the therapist to take a more active rather than listening type role). Therapist preference refers to the characteristics that the client hopes their therapist possesses and treatment type which is the client's particular preference for the type of intervention that will be used.

Swift et al (2011) found that client preference has an influence on both dropout rates and treatment outcomes. In particular, they found that for clients who receive a treatment that matches or considers their preference are about one half to a third less likely to drop out of treatment prematurely and are more likely to show improved therapy outcomes than clients whose preferences are ignored or who receive non preferential conditions.

A number of studies have examined specific characteristics of the therapist such as sexual orientation (Liddle, 1997), ethnicity (Coleman, Wampold and Casali 1995), religion (Wikler, 1989) and gender (Jones, Krupnick & Kerig 1987) and considered these aspects in terms of client preference for a particular characteristic and how this impacts on outcomes. Other studies have looked at matching clients with therapist (Berzins, 1977), choice of modality (Lev-Wiesel and Doron, 2004) and the therapeutic relationship (Asay and Lambert, 1999). There have also been studies that have looked at choice in terms of how informed a client is about working with a

particular therapist (Braaten, Otto and Handelsman, 1993), working on the notion that if a client is given information about therapy, they are in a stronger position to make a choice.

What clients choose

Previous research has indicated that clients welcome the chance to make meaningful choices and decisions in their counselling (Kremer & Gesten, 2003; Bowman & Fine, 2000; Maione & Chenail, 1999). Research has also shown that they are keen observers of their counsellors and their surroundings (Jinks, 1999; Yardley, 1990) and this extends to their first impressions of their counsellor. When clients first appear at a counselling agency, they can be strongly affected — positively or negatively – by their first impressions of the physical layout, the office or reception staff (Manthei, 2006). This view could also be extended to clients' first impressions of the surroundings when coming to see someone privately. All therapists should realise that they are being closely scrutinised and assessed by their clients, in much the same way that they are carefully observing and assessing their clients (Hill, Thompson, Cogar, & Denman III, 1993; Yardley, 1990). There is considerable literature on client preferences for counsellor characteristics (Liddle 1997, Colman et al 1995, Wikler 1989 and Jones et al 1987) in which it is clear that not every client-counsellor match is immediately congenial, comfortable and/or successful. For most clients, good match-ups tend to be those that in some way meet their self-perceived needs or demonstrate a similarity to them in some important way (Vera, Speight, Mildner, & Carlson, 1999).

Using meta-analysis, Coleman, Wampold and Casali (1995) surveyed the results of studies comparing ethnic minorities' ratings of ethnically similar and dissimilar therapists and reported that ethnic minority clients, especially those with strong cultural affiliations, prefer ethnically similar therapists to white therapists, suggesting that having some sort of perceived commonality is important. Coleman et al. (1995) also noted that, regardless of ethnic background, when individuals are asked to list the characteristics of the competent therapist, they place ethnic similarity below that of other characteristics such as attitudes, educational level, personality, maturity, and so on. When a therapist's characteristics are not known, it is more likely that clients will choose ethnically similar therapists, presumably, because they may assume that ethnically similar therapists have similar attitudes and values which highlights how assumptions can be made by clients from limited information.

In a similar way to ethnicity, Liddle (1997) suggested that gay men were more likely to select gay or bisexual male therapists, whereas lesbians more often chose lesbian or bisexual women. Liddle proposes that heterosexual therapists should be more able and willing to refer gay or lesbian clients to sexual minority therapists if such therapists are available in their communities. Liddle (1996) found support for therapist-client matching on sexual orientation for gay and lesbian clients. The significant main effect for therapist sexual orientation supports the notion that gay and lesbian clients may benefit from a therapist-client match on sexual orientation. However, the presence of the complicating interaction, with heterosexual women therapists seen as more helpful than heterosexual men and no less helpful than gay, lesbian, and bisexual therapists, demonstrates the importance of examining relationships within factorial models rather than simpler match-mismatch conceptual models. The finding that heterosexual female therapists were no less helpful than

gay, lesbian, and bisexual therapists also demonstrates that heterosexual therapists can be effective with this client population. Thus, while matching on sexual orientation may increase the probability of a satisfactory therapy experience, such a match is clearly not necessary for success and would possibly exclude the client from a potentially different relational experience.

Why choice matters

Informed choice

A client could be seen as a customer and consumer of therapeutic services and as a consumer they should have the right to be properly informed of what they are choosing. The BPS code of ethics (BPS, 2009) argues that clients should be fully informed of the nature of the work with them. The code of ethics and conduct states that:

- o Psychologists should:
  i. Ensure that clients, particularly children and vulnerable adults, are given ample opportunity to understand the nature, purpose, and anticipated consequences of any professional services or research participation, so that they may give informed consent to the extent that their capabilities allow.
  ii. Seek to obtain the informed consent of all clients to whom professional services or research participation are offered.
  iii. Keep adequate records of when, how and from whom consent was obtained.

If the BPS states in its code of ethics that clients should be offered informed consent for the professional service they receive from a psychologist, what should this informed consent consist of and how should it be obtained?

Informed consent

Winborn (1977) suggested that "honest labelling" is necessary if informed choices are to be made. He suggested that one should provide descriptions of skills, qualifications and experience to clients to enable them to make informed choices about goods and services they use. However, this information tended to be a representation of a therapist perspective of what is useful for clients to know, as generally it is therapists who have written this information. There is increased evidence that informed consent does not harm the therapeutic relationship or negatively affect disclosure (Handelsman, 1990; Handelsman & Martin, 1992). Studies have shown that pre-therapeutic induction procedures can reduce dropout rates and anxieties about therapy (Guajardo and Anderson 2007, Van Audenhove and Vertommen, 2000).

Levine, Stolz and Lacks (1983) suggested that to prepare clients for therapy and to accommodate their rights to be fully informed about their treatment, all should receive written material defining psychological terms, modes of therapy available, types of problems treated, typical frequency and length of treatment, responsibilities of the client and therapist, and a procedure for registering complaints.

Many authors have suggested information that needs to be covered in an informed consent process, including: (a) the nature of treatment; (b) benefits and risks of treatment; (c) likely alternative treatments and their benefits and risks; (d) the

probability of reaching successful outcomes; (e) limits of confidentiality; (f) financial costs and arrangements; (g) time, place, setting, and duration of treatment; (h) therapist training, qualifications, and theoretical orientation; (i) the procedure for handling grievances; (j) a statement that any questions about procedures will be answered at any time; and (k) a statement that therapy can be discontinued at any time (Beeman & Scott, 1991; Everstine, Everstine, Heymann, True, Frey, Johnson, & Seiden, 1980; Handelsman & Galvin, 1988; Hare-Mustin, Marecek, Kaplan, & Liss- Levinson, 1979). Of these suggested areas, limits of confidentiality have been suggested most often as an essential point to be covered. However, one must question whether covering all these points is a realistic proposition in a first session and in particular whether it is possible to offer an answer to points (b) and (d) at all as this might create unrealistic expectations of therapy. Points (b) and (d) also assume that there is a uniform structure and content of a client's presenting problem and that treatment will follow consistently standardised procedures.

Braaten, Otto and Handelsman (1993) in their study assessing the information that people want about psychotherapy discovered that overall the most frequently requested information concerned the therapist: experience, credentials, and especially personal characteristics. They found that participants with no therapy experience who received their consent form asked less about personal characteristics than other people. These participants seemed primarily to have been guided by the consent form, which included information about such things as therapist credentials and education, but not about personal characteristics which highlights the impact that these consent forms have on potential clients. Participants placed the least emphasis on appointments, alternatives, and confidentiality. The low emphasis placed on appointments may be due to the fact

that consumers assume that such information is both standard and routine, or that it is to be covered at the first session. Perhaps it is felt that it is not very important in making a decision about whom to work with, as this issue seems to be relatively black and white, either you can or can't make an appointment.

Braaten et al (1993) study reported that people with therapy experience seem to value personal information about the therapist, even when they are cued into other issues about therapy, such as confidentiality and financial arrangements. They argued that this might be due to people with therapy experience having existing notions about the therapy process, specifically about how appointments and money are handled.

The use of written forms to inform clients of the nature of treatment, risks and benefits to be expected, financial arrangements, limits of confidentiality and privilege, and other aspects of psychotherapy is not universally accepted. One survey (Handelsman, Kemper, Kesson-Craig, McLain, & Johnsrud, 1986) found that some clinicians feel that the use of written forms hinders treatment, perhaps by giving the impression of a cold and uncaring therapist who uses forms as a way to create distance from clients. These clinicians are in conflict with those such as Kovacs (1984) who see the consent form as a facilitator of conversations that improve the quality of the client-therapist relationship. This could be seen to highlight the differing ways in which the same pieces of information can be interpreted.

An Informed consent procedure can also be utilised in addressing potential issues in therapy and facilitating dialogue, particularly in areas that can be difficult,

uncomfortable or contentions such as race, sexual orientation and religion. Day-Vines, Wood, Grothaus, Craigen, Holman, Dotson-Blake & Douglass, (2007) discussed the idea of broaching the subject of race, ethnicity and culture during the counselling process. Broaching behaviour refers to a consistent and ongoing attitude of openness with a genuine commitment by the counsellor to continually invite the client to explore issues of diversity. In essence, the counselling relationship becomes the vehicle for navigating a discussion concerning issues of difference related to race, ethnicity, and culture. Broaching invites the counsellor to help the client examine the extent to which socio-political factors such as race and ethnicity influence the client's counselling concerns. Day-Vines et al (2007) proposed that counsellors must at the very least, present clients with an option to consider the embeddedness of racial politics within their personal experiences. This can facilitate a dialogue around these issues and help to create a more open counselling relationship.

Liddle (1996) suggested that her findings might be useful in guiding therapeutic practice with gay and lesbian clients. She suggested that the therapists whom clients find helpful tend to be those who have educated themselves about issues of concern to gay and lesbian clients including societal prejudice, internalized homophobia, relationship issues, and community resources and those who help their clients work toward a positive gay or lesbian identity. Liddle argued that it is also important that therapists do not shy away from issues related to a client's sexual orientation when a client brings these issues up, but neither should a therapist insist on focusing on sexual orientation when the client does not see it as relevant to his or her presenting concerns. Liddle's argument could also be applied to non-gay clients, in that the therapist should not make assumptions about clients,

for example not assuming that difficult or contentious parts of a client's personality or history are directly related to their presenting issue.

Hawkins and Bullock (1995) argue that it is imperative that psychotherapists become more equipped to recognize and treat religious matters in therapy. Hawkins and Bullock (1995) go on to say that when the profession continues to ignore this area or pretend that religious issues are not relevant or suitable to psychotherapy, it is denying religious clients the very thing they most need - an upfront, frank discussion of how religious or spiritual concerns may or may not impact their therapy. They propose that the religious expectations and concerns of both clients and psychotherapists can best be acknowledged in the beginning of therapy as part of the therapeutic contract in the context of informed consent, and continue to be delineated when the topic becomes relevant throughout the process of psychotherapy (Bergin, 1985).

Client as the consumer

Sue (1977) defined the concept of consumerism in counselling as meaning

a) Clients should be active rather than passive participants in therapy.

b) Client's rights should be made explicit to both parties.

c) The counselling process should be demystified by counsellors explaining precisely what they do.

d) The status – power differential between client and therapist should be more evenly balanced.

These points suggest that it is important to cue in potential clients through the use of information sheets. Manthei (1988) argued that by relinquishing some of their

power, therapists might feel that the mystique surrounding therapy would be diminished, thus compromising their influence and the impact of their strategic interventions. However, refusing to give up power or control runs counter to one of the basic tenets of the consumerism-in-counselling movement, which says that the counselling process should be demystified (Sue, 1977) and suggests arrogance from therapists as they assume that they have all the answers and know what is best.

Therapy Today is the official journal of the BACP. In its June 2008 issue the special feature was a focus on the client as the consumer. Sarah Browne (2008), writing the journal, argued that we need to make therapy a more customer-friendly service – more transparent, better understood and easily accessible. It is interesting and perhaps a little disappointing that the same arguments are still being played out over thirty years after they were first proposed by Sue in 1977. This issue also published results of a piece of qualitative research that was carried out on behalf of the BACP to understand what clients need and want from counselling and psychotherapy.

Nicky Forsythe and Simon Confino (2008) carried out a piece of research entitled *"How to Become More Customer-Centric"* on behalf of the BACP. The research, which took in a diverse range of people from 80-year-olds in Grimsby who had never had therapy to 20-year-olds in London who had often used therapy services, found that while there is an overall positive interest in and curiosity about therapy, there appears to be a whole host of obstacles to overcome for people considering seeing a therapist. Forsythe and Confino (2008) argued that therapy has an image problem. They suggest that not only is it still associated with sickness, treatment

and patients, it is seen very much as a hidden profession shrouded in mystery and secrecy and lacking a visible, friendly public face.

Their study proposed that there is a huge and growing appetite for therapy amongst the public. It makes it clear that generally therapy needs to become more customer-friendly and provide a great deal of information that will help to further address the power imbalance between therapist and client. From the clients interviewed, those who tended to be consumerist and proactive in their approach were those who had sought therapy privately, while those who had therapy on the NHS tended to be more passive. However, one could suggest that this is maybe due to pure economics: when you have the money to pay for therapy, you are able to be proactive in seeking treatment, whilst those who cannot afford private therapy are forced to be passive due to the spectre of waiting lists. Forsythe and Confino suggested that this is interesting with regard to the IAPT (Improving Access to Psychological Therapies) programme: if being motivated is an important factor in a successful outcome, then NHS services will need to find ways of instilling this sense of motivation in clients to engage with this service.

The only significant difference between users and prospective users, the research found, was that the latter had not yet reached the crisis point that had triggered the users to seek help. The research argued that in order to seek help in the first place, people have to overcome the stigma of mental illness and the possibility of being seen not to be coping. The very association with the 'psycho' word (psychotherapy, psychology, psychiatry) is apparently enough to put people off. During the research process itself, this societal stigma was apparent when two recruitment specialists, who were approached to find respondents for the study, declined involvement. One

felt that it would be too awkward to ask people if they had had therapy and another did not want people who had had therapy to come to her house.

Browne (2008) argued that once they have overcome the stigma barrier, people find that the world of therapy is a confusing maze where it is difficult to search for and find what they want. Given that people normally look for therapy when they are at crisis point and they want help urgently, this means that they are less discriminating than they might otherwise be. They don't feel equipped with any means of evaluating whether what they find is right for them or not. Brown suggested that most don't even realise that this is a consideration – they just assume that therapy is a uniform approach. She proposed that clients tend to take what comes and don't engage in a process of interviewing or trying out different therapists. This raises the question whether offering choice to clients is what they actually need or want at the time they are searching for a therapist. Perhaps it is more important to educate potential clients about therapy than offering them a choice of therapists that they know nothing about or have limited ability to differentiate.

Once a client has selected a therapist, Forsythe and Confino's (2008) research study found that positive experiences of therapy tend to be linked to a good relationship with the therapist, whether the process was what the client had imagined or wanted and whether the therapy had led to a good outcome in terms of feeling better or managing life better. Approaches that didn't fit with clients' expectations, unresponsive therapists, lack of direction and structure, and emotional pain with no perceived gain were all linked to negative experiences of therapy. Forsythe and Confino (2008) argued that given the assumptions most

clients make about therapy, it is no wonder that many of them end up bewildered and dissatisfied with the process of therapy. People who are new to therapy will assume, particularly with psychotherapy that they are in the hands of a medical practitioner. A common attitude was: 'the therapist will know what is wrong with me and what to do about it.' Agreements between clients and therapists tended to focus on practicalities such as the length of sessions, cost and when and where they would take place. What would happen in the sessions was not explained. And if clients had questions, such as 'What if I don't like it?' 'When will I feel better?' 'How long will it go on for?' they did not ask them. One of the main complaints from respondents to Forsythe and Confino's (2008) study was about the cold unresponsive therapist – the blank screen stereotype of the psychoanalytic approach. No therapeutic method is helpful if the therapist does not take into account the needs of each client who comes to them. Forsythe and Confino (2008) suggested that the perceived warmth and empathy of the therapist are core ingredients of successful therapy. One could argue that if a client is better informed as to what to expect, then complaints would be reduced and a closer matching of therapist to client could occur allowing those who would prefer a more responsive and warm therapist to be able to seek them out.

Forsythe and Confino's (2008) research also highlights the lack of information available for prospective clients and the need for detailed assessment in order to get the right therapy for the right person. Clients often have quite specific wishes or preferences but don't know how that translates into a therapy modality. For example, a client may want mental tools and strategies for dealing with situations where they feel anxious. In this case CBT might fit but they don't know this and in

any case this might end up excluding the client from other equally useful and valid therapeutic experiences.

One of the recommendations to emerge from this research is that BACP should educate and encourage its therapist community to behave in customer-friendly ways. These include being human, warm and friendly; presenting and introducing themselves in an approachable way (e.g. with a photo and some personal information on a website); addressing clear end benefits and not just processes and problems; and supporting people in being customers when they explore choices around therapy. One could argue that certainly the first two of these suggestions are already being offered by therapist. Being able to outline clear end benefits of therapy at the beginning of a clients' therapeutic work however, might prove to be difficult as it might be hard to know the possible outcomes and therefore, induce false expectation for clients.

Emma Munro (2009) in her regular column in Therapy Today, "On finding a therapist" offered some suggestions as to how therapists could become more customer friendly. She argued that a confusing number of professional bodies come up when you Google the word "therapist." She suggested that you are met with a bewildering amount of jargon when you access therapists' websites and you have to be pretty motivated and intelligent to work your way through. She proposed that what was needed was some kind of personal statement explaining in words that the general public can understand where the therapist is coming from and what they are offering.

Clare Jones (2009) a Chartered Marketer, also writing in a regular column in Therapy Today, examined how therapists should be marketing themselves. She proposed that marketing is simply delivering what clients want and need. She argued that good marketing is about advanced communication, getting the right message across to the right target clients in what is a complex and sometimes confusing marketplace, so that they have the opportunity to assess services that are of interest.

Jones (2009) made the case that it is the clients who are in charge and it is up to the therapist to deliver what they are looking for or they will move on. She suggested that the reticence of many practitioners to market themselves has had a negative and counterproductive impact on the whole profession and is potentially unethical too. The public's interest in and knowledge of therapeutic services is vastly untapped and many misunderstandings and myths remain unchallenged. It's confusing and complex for many clients to understand how counselling services differ from a coach, hypnotherapist or NLP practitioner. She proposed that there was a need for clear communication to build awareness of what therapists do. If more practitioners are willing to communicate, then this will benefit the whole profession and ultimately clients.

Thirty years earlier, Morrison (1979) argued for a fully consumer oriented approach to mental health services, recommending that all clients be given printed, easy-to-read information about the process, goals and techniques of therapy. He also suggested that a contract covering time, fees, type of treatment, problem definition and probable effectiveness be drawn up and that personal risk to clients and their primary relationships be discussed with them. He argued that all of these

suggestions would both help to protect a client's rights and lead to an eventual improvement in services.   All of Morrison's arguments are still relevant today and a number have yet to be acted upon.

How clients make choices

Theories of how people make choices

When considering client choice, it is useful to consider theories around how people make choices in general. It was proposed by Payne (1976) that the choice process consists of multiple stages. In his article relating to consumers purchasing products, Payne (1976) elaborated on the structure of the choice process. He claimed that the number of different brands available on the market made it hard to process all the information about all of them. Payne (1976) suggested that the pool of possible purchase alternatives shrunk as the choice process proceeded until there was only one product left in the pool of alternatives, which eventually was purchased. In relation to a client choosing a therapist, this theory suggests that clients would examine and disregard all possible options before deciding on a particular person.

Lussier and Olshavsky (1979) proposed a more specific structure of the choice process which they supported with empirical evidence. They proposed that the process had two stages. The first was general screening, where consumers went through descriptive information available about all the goods, or at least about most of them, and selected several suitable candidates for further consideration. The second stage was final choice, where consumers were choosing one out of the several brands selected during the first stage. They suggested that this type of

"short-listing and final choice" is very common in various other choice processes (e.g. job hiring, Oscars, Nobel and other types of prizes). Later studies by Beihal and Chakravarti (1986) and Russo and Leclerc (1994) also found robust empirical support to this bi-stage structure of the choice process, although they also speculated about the existence of intermediate stages, where the choice set gets more and more distilled. These ideas give us an understanding of one of the ways a client would go through the choosing process by attempting to disseminate information and then deciding on their choice, though how far theories of consumer product selection can be generalized to clients choosing a psychotherapist is unclear.

First impressions

It is important to consider theories around how people make first impressions as these directly relate to the impact of the first session on a client and what choices they make. When two people meet, they form impressions of each other, even if they are only in contact with each other for a minute. Taylor, Peplau, and Sears (2000) suggest that there are two characteristics that people assess when forming impressions: competence and physical attractiveness. They propose that *"in general we like people who are socially skilled, intelligent, and competent."* The type of competence depends on the type of relationship that is being pursued. Therefore if a therapist demonstrates competence in their role, this may in turn lead a client to be more attracted to working with them.

Our first impressions of others can be quite accurate. For example, people are excellent in judging personality traits and complex social characteristics such as dominance, hierarchy, warmth, and threat (Ambady, Bernieri, & Richeson, 2000;

Berry, 1990; Funder, 1987). Accurate first impressions of personality traits have been shown to be possible when observers were exposed to relatively short intervals (4–10 min) of ongoing streams of individuals' behaviour, termed thin slices (Ambady et al., 2000; Ambady & Rosenthal, 1992; Funder, 1987). In fact, observers seem to be able to extract the cues required for impressions even from static photographs presented for 10 seconds (Berry, 1990). In these studies, impressions formed with "zero acquaintance" were typically compared with robust data to infer the accuracy of first impressions, generally resulting in significant correlations. As such, rapidly formed first impressions can facilitate our survival and interaction with the environment. (Of course, first impressions can sometimes be inaccurate and, consequently, misguide our behaviour in a less desirable manner.) These studies confirm that the first session has considerable impact on clients and that therapists need to be aware that clients will rapidly make judgements about them, even if they are inaccurate. This suggests that careful structuring of the first session is important so as to come across as positively as possible.

Impact of choice

Calsyn, Winter and Morse (2000) suggested that research on the efficacy of providing clients with a choice of treatment has assessed two categories of dependent variables: treatment process variables and client outcomes. They argued that most research has shown that providing clients with a choice of treatment produces positive results on the treatment process variables. For example, researchers have reported that clients who had a choice of treatment were more likely to work harder (Langer & Rodin, 1976), have more contact with their treatment program (Calsyn, Winter, & Morse, 2000) and were more likely to

adhere to their treatment program (Thompson & Wankel, 1980). There are indications that the client's sense of control and predictability in therapy (assumed to be increased by choice) can enhance outcome (Strong & Claiborn, 1982). Clients who choose may be more positive about beginning therapy, more motivated to participate, and more hopeful about the outcome (Manthei et al 1982). Therapists, too, may be more motivated and work more effectively with clients who choose them (Holland-Goldfein, 1979) and clients were less likely to drop out of treatment (Rokke, Tomhave, & Jocic, 1999). Iacoviello McCarthy, Barrett, Rynn, Gallop and Barber (2007) found that clients who had a preferred psychotherapy when compared with clients who had wanted drug treatments, experienced greater improvements in the therapeutic alliance over time. However, Bakker, Spinhoven, van Balkom, Vleugel and van Dyck (2000) found that for client with panic disorders, those that had expressed a preference for psychological treatment did not do any better in cognitive therapy that others who were randomly allocated to it.

Impact on process

In a more comprehensive discussion of interaction dynamics in therapy, Strong & Claiborn (1982) emphasized the importance of a client's perceived or inferred choice on how that client will progress in therapy. They noted that choice was an important element in the philosophy and language of therapy and that often efforts are made to induce clients to believe that their actions are chosen or internally caused. Choosing one's own therapist or therapy, therefore, could have a marked impact on a client's commitment to therapy, assuming that choice promotes greater acceptance of responsibility for one's own actions. Hollander-Goldfein (1979)

reported that therapists rated the clients who chose them as more likable and expressed a greater desire to work with them.

Manthei (1983) suggested that the act of being chosen would have effects on the therapist. He suggested they might be more committed to working with the client who chooses them and they might be more willing to make high-risk interventions with the client who chooses them, therefore suggesting more positive outcomes for those who are able to choose. He argued that the simple act of choosing might help to equalise the inherent therapist - client power imbalance and help to increase the active involvement of the client in their therapy. Manthei (1983) quite rightly points out that choice means little unless accurate, prior information about available alternatives is readily accessible to all potential clients, whatever the treatment setting. Manthei (1988) examined the rights of clients to choose their own therapist and suggested that choosing one's own therapist or therapy could have a marked impact on a client's commitment to therapy based on the assumption that choice promotes greater acceptance of responsibility for one's own actions. Manthei (1988) suggests that actively encouraging client control and self–reliance in therapy may have positive effects on therapist as well as clients.

Lev-Wiesel and Doron (2004) in their research on clients choosing the type of arts-based therapy that they preferred found that being given the opportunity to choose the type of therapy seems to contribute to lower ambiguity regarding the therapeutic process. They suggested it might provide clients with some control as well as contribute to their commitment to the process and outcome. Based on the assumption that clients who turn to therapy are interested in making changes for the better in life and the referral itself means taking action, it seems rather apparent

that clients would be interested in receiving information about what form the therapy will take. Many clients are not familiar with either the therapeutic process or the variety of nonverbal therapies and existing techniques.

Therapeutic alliance

The term therapeutic alliance has been constructed in number of different ways in the research literature and there is no one single accepted definition of the concept (Horvarth & Luborsky, 1993; Saketopoulou, 1999). Luborsky (1984) defined therapeutic alliance as:

"the degree to which the patient experiences the relationship with the therapist as helpful in achieving his or her goals" (p. 6).

Clarkson (1995) defined the working alliance as the explicit or implicit contract or agreement between the psychotherapist and the client. She suggested that they must be able to form attachments and be able to invest energy and care in relationships. She proposed that clients need to have a somewhat similar worldview to the therapist and their theoretical perspective in order for a sound working alliance to be created. If the client cannot understand or appreciate what the therapist has to offer, the development of a sound working alliance may be hindered. This suggests that offering choice will help to enable a stronger working alliance, as the client will be able to find a therapist who they feel will be able to understand them.

Bordin (1979) proposed that the working alliance between the person who seeks change and the one who offers to be a change agent is one of the keys, if not *the*

key, to the change process. From Bordin's (1979) perspective, the quality of the alliance is a function of the extent to which the patient and therapist are able to collaborate on therapeutic tasks and goals, as well as the quality of the bond (the extent to which the patient feels understood, respected, etc). Bordin's conceptualization implicitly highlights the interdependence of technical and relational factors by making it clear that different clients will be inclined to find different tasks and goals meaningful as a function of their unique developmental histories and relational schemas. This suggests that if clients are better informed about their therapist and therapy, there would be an increase in the level of collaboration between the therapist and client.

Safran and Muran (2006) have suggested that rather than seeing the alliance as a collaboration between therapist and client, they see it as an on–going negotiation over the course of therapy and not a static variable. They suggest that the on-going process of negotiation is an important change mechanism as it helps the client to learn to negotiate the needs of self and other in a constructive fashion, without compromising the self or treating others as objects. This process of negotiation of needs can help clients to develop some capacity for intersubjectivity and develop their ability for relatedness. Safran and Muran have argued that the concept of the alliance:

"highlights the fact that at a fundamental level the patient's ability to trust, hope and have faith in the therapist's ability to help always plays a central role in the change process" (Safran & Muran, 2000, p. 13).

They suggest that a refined conceptualization of the alliance, as an ongoing process of negotiation between patient and therapist at both conscious and unconscious levels highlights the intrinsic role that this type of negotiation plays in any change process.

The acceptability of the treatment rationale for the client influences the therapeutic alliance, which relies heavily on a shared view of the goals and treatment methods of therapy (Bordin, 1979). A fundamental incompatibility between the client's worldview and the treatment rationale is likely to result in a rupture in the therapeutic alliance, in which the client rejects the goals and tasks of therapy (Safran, Crocker, Mcmain & Murray, 1990). This suggests that a matching of client and therapist with compatible worldviews would be of importance as well as the client being offered more information about their therapist to allow them to judge if their views are compatible and if they are able to build a relationship.

Asay and Lambert's (1999) review of the research on the therapeutic relationship highlights the fact that it is not enough to focus on therapist-provided contributions to the relationship, but that attention should be paid to the relationship itself. No one questions the importance of core conditions like acceptance, accurate empathy and therapist genuineness; but it turns out that client perceptions of the relationship are consistently more correlated with outcome than those of objective raters. In other words, how clients experience the characteristics offered by therapists is more important than what those therapists are 'objectively' offering. This supports the notion of increasing the number of pieces of qualitative research on client experience of therapy. In their meta-analysis of research on the therapeutic alliance, Horvath, Re, Fluckiger and Symonds (2011) suggested that it is important

for therapists to monitor their client's perspective on the alliance throughout treatment as misjudging the client's views of the alliance could make therapeutic interventions less effective.

Erdur, Rude, Baron, Draper and Shankar's (2000) study yielded very little evidence that either the working alliance or client outcome in counselling are affected by therapist-client ethnic similarity. Their finding of no main effects of ethnic similarity on working alliance for most of the ethnic combinations that they examined may reflect that, while clients tend to prefer therapists who are ethnically similar (Coleman, Wampold, Casali, 1995), their working alliances are not necessarily determined by ethnic match.

These results are reminiscent of Vera et al's (1999) findings. Their study examined the effects of similarities and differences between therapists and clients on their counselling relationships. They concluded that client-therapist similarities and differences seem to have no effect on counselling relationships. Moreover, there is strong evidence in the counselling literature that clients put more weight on similar attitudes, values, and personality than on ethnicity (Atkinson, Furlong, Poston, 1986). The results of Erdur et al's (2000) study are similar to Ricker, Nystul, and Waldo's (1999) suggesting no relationship between ethnic similarity and the working alliance. However, it seems that therapists and clients in ethnically similar dyads have less agreement on their working alliance than in dissimilar ones.

Impact on outcomes

Manthei (1983) reviewed eleven studies on client choice of therapist or therapy, and concluded that their small number and lack of research rigor left unanswered the question of the effect of choice on therapy outcomes. A meta-analytic review of

twenty-four studies by Horvath and Symonds (1991) found that the working alliance was positively related to outcome and that client and observer ratings were better predictors of outcome than therapist ratings. Overall it appears from the available evidence that the therapeutic alliance may account for upwards of 45 per cent of outcome variance (Horvath and Greenberg, 1989).

Studies have found that client's levels of active participation in therapy are one of the strongest predictors of outcomes (Orlinsky, Grawe and Parks, 1994). Bachelor (1991) suggested that active participation could account for 20 per cent or more of the improvement alone. A study by Heine and Trosman (1960) found that 67 per cent of clients who saw themselves as having an active part to play in the therapeutic process continued in psychotherapy beyond six weeks compared with just 28 per cent who placed responsibility completely in the hands of their therapist. McCallum and Piper (1999) found that even for clients with "hard to help" psychological problems such as enduring personally disorders, there was a significant correlation between levels of motivation and therapeutic outcomes. This link between motivation and outcomes has been borne out in effectiveness research conducted by Seligman (1995) where "active shoppers" (clients whose idea it was to seek therapy, who asked their therapist about the services they offered and who took a proactive role in the therapeutic tasks) do better than "passive recipients" thus suggesting that offering choice could help to increase a client's active participation and motivation for the therapeutic process.

Another strong predictor of outcomes is clients' level of intrinsic or autonomous motivation for therapy. This is the extent to which clients experience themselves as having freely chosen to enter therapy (Zuroff, Koestner, Moskowitz, McBride,

Marshall and Bagby, 2007). Zuroff et al (2007) found that clients who scored high on autonomous motivation for therapy were almost twice as likely to respond well to therapy as those with average levels of autonomous motivation and almost four times as likely to respond well as those with low levels of autonomous motivation. This suggests that offering clients' choice will increase their motivation for therapy and produce better outcomes.

As well as being motivated for therapy, research has indicated that clients who have a relatively realistic expectation about what will happen in therapy tend to get the most out of it. In particular, clients who "do not anticipate pain or embarrassment "(Mohr, 1995) tend to respond less positively to therapeutic interventions. Bednar, Melnick and Kaul (1974) suggested that clients who have a relatively clear understanding of the process and goals of therapy and their role within it tend to get the most out of the therapeutic work, while those who have a more ambiguous understanding of role are less satisfied, less productive and more defensive. These findings again support the idea that offering more thorough information and greater informed choice could have a more positive effect on the outcomes of a client's therapy.

Calsyn et al (2000) when examining past research on the effect of client choice on client outcomes, stated that mixed results have been produced. Positive effects of client choice have been demonstrated in weight loss of children (Mendonca & Brehm, 1983), increased sense of control and competence in older adults (Langer & Rodin, 1976), and reduced snake phobia (Devine & Fernald, 1973). However, client choice of treatment had no effect on outcomes with clients who had more serious and pervasive problems such as depression in older adults (Rokke,

Tomhave, & Jocic, 1999), psychiatric symptoms in homeless clients (Calsyn et al., 2000) or cocaine addiction (Sterling, Gottheil, Glassman, Weinstein, & Serota, 1997).

Manthei (1988) also argues that although available research on the positive effects of choice on outcome contains inconsistent results, no one has reported evidence that such choice actually harms clients. On the contrary, Manthei et al. (1982) concluded that even though there were no significant effects due to choice, choice-of-therapist clients performed at least as well in therapy as clients assigned by a clinic director. As long as clients are not demonstrably harmed or disadvantaged by choosing, the considerable ethical and legal support for increasing clients' participation in all facets of their own therapy still remain as strong justifications for allowing clients to choose.

One of the significant elements that impacts on choice is whether the client feels that they are suitability matched with their therapist. Berzins (1977) published a comprehensive and critical review of the area of client-therapist matching. He pointed out that although the idea of matching clients and therapists for the best therapeutic outcome is responded to favourably by clinicians and researchers alike, there had yet to be discovered some clear information that could provide an effective guide for applying a matching strategy.

Beutler (1986) found that the most effective therapy occurs where the client feels that they have enough in common with their therapist to feel understood and validated, yet experiences enough attitudinal difference to be invited to challenge their frame of reference. There is however no clear evidence on whether therapists

whose personalities match their clients have better outcomes than therapists whose personalities are opposite to their clients (Beutler, Malik, Alimohamed, Harwood, Talebi and Noble, 2004). As with personality characteristics, there is little empirical evidence that particular therapists' beliefs or "values" are directly related to client outcomes (Beutler et al 2004). There is some evidence to suggest that therapists who hold prejudicial attitudes towards particular disadvantaged groups, such as homosexual clients, women and black or minority clients are less able to engage with these clients and form less effective working alliances (Beutler et al 2004).

There are a number of facets that a client and therapist could be matched together with and which could have an effect on outcomes; I shall consider these below.

The limited research on client-therapist gender match has suggested that match is related to indirect outcomes, such as increased attendance. Zlotnick, Elkin, and Shea (1998) examined whether same-gender matching and mixed-gender matching were related to psychotherapy processes and outcomes. Results indicated that the type of therapist seen (i.e. same-gender or mixed-gender match) was not related to attrition rates, depression ratings after treatment, or client perceptions of therapist empathy. Furthermore, clients' beliefs about who would be more helpful (i.e. a male or female therapist) and their match or mismatch with this expectation was not related to therapeutic outcomes. These findings are in contrast to other studies conducted by Jones and his colleagues (Jones, Krupnick, & Kerig, 1987; Jones & Zoppel, 1982), which have suggested that gender match is related to improved symptom outcome and more satisfaction with therapy. Moreover, some studies on gender match have found interaction effects between gender and other client characteristics such as age, ethnicity, marital status, and diagnosis, as well as

therapist experience, on client satisfaction and treatment duration (Fujino, Okazaki, & Young, 1994; Hill, 1975; Orlinsky & Howard, 1976). It seems that while gender match is related to indirect outcomes, less is known about the relationship between gender match and direct outcomes. However, a review of ten recent studies that compared dropout and improvement rates for male and female therapist found no significant difference between the sexes, with a mean effect size of just 0.01 (Beutler et al 2004).

Sue, Fujino, Hu, Takeuchi and Zane (1991) reported on a large-scale study of the effects of ethnic match on the length of treatment and outcome of African-American outpatients seen in the Los Angeles County Mental Health System. African-American clients who were matched with therapist in ethnicity were compared with clients not matched in ethnicity (i.e. clients seeing a non-African-American therapist). Results revealed that African- Americans who saw an African-American rather than a non-African-American therapist attended a greater number of therapy sessions. However, no differences in treatment outcome were found as a function of matching.

In a qualitative study by Ward (2005) it was found that salience of black identity and ideological similarity where considered important factors by clients in assessing the level of the matching to their therapists. The cultural responsiveness of the therapist was considered an important factor which suggests that offering an understanding of a client's context is a more important factor than a "physical matching" i.e. ethnic matching based on race.

Empirical studies on ethnic match seem to indicate that match may be important for indirect treatment outcomes. Studies with African Americans indicate that while match was not related to direct outcomes (Jones, 1978, 1982; Lerner, 1972), match was related to attendance at a greater number of therapy sessions (Rosenheck, Fontana, & Cottrol, 1995; Sue et al., 1991). For both Asian Americans (Flaskerud & Hu, 1994; Gamst, Dana, Der-Karabetian, & Kramer, 2001; Sue et al., 1991) and Latinos (Flaskerud, 1986; Gamst, Dana, Der-Karabetian, & Kramer, 2000; Sue et al., 1991), matching is associated with less likelihood of dropout and increased length of therapy. Moreover, it appears that ethnic and language match may be especially important for treatment outcomes with limited-English-speaking clients (Sue et al., 1991). In contrast to these studies, Gamst et al. (2000) found that among African Americans at one mental health centre, match was associated with fewer treatment sessions as well as lower scores on Global Assessment of Functioning (GAF). It is not clear whether the findings from Gamst and his colleagues are confined to one institution or have greater generalisability. Thus, the bulk of studies point to the benefit of matching for indirect outcomes, but not direct outcomes.

Whist studying the impact of religion on therapy, Worthington and Sandage (2002) found that therapist and client similarities on levels of religious commitment do not predict better outcomes. Indeed, one study found that initial dissimilarity of religious values correlated significantly with clients' self-ratings of improvement (Martinez, 1991). However if one solely looks at highly religious clients, there is some evidence that they do have a preference for therapists with more religious values (McCullough and Worthington, 1995) and may assume that such therapists will be more effective (Ripley, Worthington and Berry, 2001). Studies suggest that religious

people may anticipate negative experiences with secular or non-religious therapists (Worthington and Sandage, 2002), fearing that their values may be undermined or that they would be misunderstood or misdiagnosed in some way (Worthington, Kurusu, McCullough and Sandage, 1996).

Wikler (1989) found that, based on past and present experiences of therapy, 45 per cent of Orthodox Jewish respondents would prefer to see an Orthodox Jewish therapist and much of this was to do with fears that non–Orthodox therapists would react negatively to them. Interestingly, those respondents who expressed a preference not to see an Orthodox Jewish therapist did so for similar reasons i.e. that they feared an Orthodox Jewish therapist would judge or criticise them. This suggests that one of the key factors in determining clients' preference for particular kinds of therapists may not be similarity in values, per se, but whether or not clients believe that they will be accepted and understood by their therapist. Worthington et al's (1996) findings supported the conclusion that when religious people are actually exposed to counselling, religious or non-religious therapists who behave in similar ways are seen as being equally attractive.

The impact of differing socio-economic status on client outcomes is an area that has not really been explored in research. Sue and Lam (2002) suggested that there is a scarcity of literature on the question of whether therapist – client matching on socio-economic variable relates to successful therapy. Balmforth (2006) interviewed working class clients about their experiences of being in therapy with middle or upper class therapists. She found that many of her participants talked of feeling inferior, uncomfortable and silenced by their therapists; criticised and misunderstood and unable to form good therapeutic alliances because of the

inequity of power. This was a small-scale study, which makes it rather difficult to generalise as being representative of all working class clients' experiences.

Lam and Sue (2001) suggested that advocates from diverse groups have argued the importance of matching, as clients may feel more comfortable, understood, and be more self-disclosing with therapists who are similar. The existing empirical evidence for the benefits of matching is mostly found in client satisfaction variables and indirect outcomes. This is not surprising because match in gender, ethnicity, sexual orientation, or social class are only four of many characteristics that may be matched. They argued that matches in demographic characteristics might be moderator variables because beneficial effects may be dependent on the interaction of match and client characteristics. Further, socio-demographic matches may not result in cultural matches. For example, a highly articulate, non-Chinese-speaking Chinese American therapist may have tremendous difficulties working with a recent Chinese immigrant with limited English proficiency. Thus, match appears to be important in certain, but not all conditions. A final issue to consider is freedom of choice. Some clients do have preferences for these therapist characteristics, and preferences should be honoured in almost all situations.

Crits-Christoph, Baranackie, Kurcias and Beck (1991) calculated that around 9 per cent of the variance in psychotherapeutic outcomes is due to variations across individual therapist. Wampold (2001) converted this 9 per cent into an effect size of around 0.6, which is significant when compared with the effect size of the differences across therapies of just 0.2. In other words, the differences in effectiveness from one therapist to another would seem to be considerably greater than the differences in effectiveness between all therapists. However, Elkin,

Falconnier, Martinovich and Mahoney (2006) using the same data, calculated that clinical outcomes did not differ significantly across therapists. They concluded, that there was very little evidence of statistically significant therapist effects. This variation could be due to a few therapists performing very well and a few very badly (Elkin et al 2006), with the majority of therapists performing at a relatively middling range. What is almost certainly also the case is that some therapists perform better with some groups of clients while other therapists perform better with others. A simpler and possibly more effective alternative to using client preferences to pair clients with therapist or therapy would be to provide clients with information about available options and let them make their own choice (Coyne & Widiger, 1978; Manthei, 1983).

Impact on maintaining or exiting therapy

Social exchange theory (Homans, 1961) can be used as a means for understanding how a client stays or leaves therapy. Social exchange theory proposes that all human relationships are created by the use of a subjective cost-benefit analysis as well as a comparison of alternatives. For example, when a person judges the costs of a relationship as outweighing the perceived benefits, then the theory envisages that the person will choose to leave that relationship. The outcome of a relationship is its rewards minus its costs. How satisfied one is with this outcome depends on one's comparison level and how likely one is to stay in an unsatisfactory relationship is determined by the comparison level for alternatives. If one relates this to the therapeutic relationship, the client can be seen to be weighing up the perceived benefits of therapy against the cost and convenience of the therapy through the therapeutic relationship and uses this weighing up process to decide whether to stay in therapy or not.

There have been a number of studies that have attempted to understand why clients might choose to exit therapy early. Numerous studies, across diverse settings such as inpatient hospital units, community mental health clinics, training clinics, university counselling centres, and private practices, have found that many psychotherapy clients end therapy prematurely (e.g., Baekeland & Lundwall, 1975; DuBrin & Zastowny, 1988; Persons, Burns, & Perloff, 1988; Reder & Tyson, 1980); meta-analytic research indicates that the mean dropout rate reported in the literature is almost 50% (Wierzbicki & Pekarik, 1993). The majority of the attempts to empirically discriminate between clients who did or did not terminate prematurely have met with little or no success, or have yielded contradictory findings (e.g., Baekeland & Lundwall, 1975; Beckham, 1992; DuBrin & Zastowny, 1988). To date, the only relatively consistent findings to emerge from these studies is that premature termination is more likely to occur among clients who are members of cultural or ethnic minority groups, or who are less educated, or who are from low-income groups (Wierzbicki & Pekarik, 1993). These findings may be as a result of the current limitations of psychotherapy service delivery and psychotherapeutic orientations more than the actual characteristics of the clients themselves.

Clients often cite dissatisfaction with the services they received or with the therapist as significant reasons for terminating services early in the therapy process (Acosta, 1980; Cross & Warren, 1984; Hynan, 1990). Therapists, on the other hand, appear to underestimate both the extent of therapy dropout and the impact of client dissatisfaction with the therapy or the therapist on dropout rates (Pekarik & Finney-Owen, 1987). Similarly, Kendall, Kipnis, and Otto-Salaj (1992) reported that, when questioned about the reasons for clients' lack of progress in therapy, therapists

cited client dissatisfaction with the therapist as the least likely cause of lack of progress. This discrepancy between client and therapist perspectives appears to be part of a larger constellation of discrepancies that includes differences regarding the likely duration of treatment and the nature of treatment (Pekarik, 1985a). From this literature, it appears that therapists have a limited appreciation of why clients end therapy prematurely.

Sue and Sue (2003) suggested that factors related to cultural conflict and mistrust can stem from perceived insensitivity to the personal and cultural meaning of clients' experiences, the consequence of which may be the underutilization of and premature departure from counselling services. An emerging body of research has indicated that acknowledgement of cultural factors during the counselling process enhances counsellor credibility, client satisfaction, the depth of client disclosure, and clients' willingness to return for follow-up sessions (Sue & Sundberg, 1996).

In an attempt to understand drop-out rates in private practice, Taube, Burns and Kessler (1984) studied psychotherapists in private practice and found that 63 per cent of clients would drop out of therapy before ten sessions. Rather than this being the result of a deliberately planned brief therapy, these were clients that simply did not return for scheduled appointments. It is worth noting that not all early terminators of therapy should be viewed as treatment failures. Some may have received sufficient help or their problems diminished during their brief stay in psychotherapy. Therefore, the length of time that someone stays in therapy should not necessarily determine the success of his or her therapy.

How to offer choice

Although studies have examined client choice and as Manthei (1988) argues, research on the positive effects of choice on outcome has produced inconsistent results, no one has reported evidence that such choice actually harms clients. There have been very few studies that have offered guidance around how to implement these ideas concerning offering choice.

Van Audenhove and Vertommen's (2000) study proposed what they described as a "negotiation approach to treatment selection." Through this approach they attempt to offer a way of working that allows for the client's choice preferences to be considered. Their approach proposed that the therapist tries to understand the client's perspective but does not merely accept the client's view uncritically. Instead, the client and therapist examine discrepancies and fit between their opinions, preferences and expectations in order to try and achieve a working mutually acceptable therapeutic frame of reference. They suggested four essential elements that underlie their negotiation approach to treatment choice.

The first element is a thorough examination of the client's perspective. This includes developing an understanding of the client's "theory of illness", which is the conception held by the client of his or her problems and complaints and their attributions. A "theory of healing" is also to be investigated which is the pattern of ideas and expectations concerning the course of the healing process, including elements such as problem-solving methods, the setting, format, frequency, duration of the therapy and financial aspects. Finally, in order to understand the client's perspective, Van Audenhove and Vertommen (2000) suggest looking at a "theory of

health," which consists of the goals and values to be reached in psychotherapy. One could argue that the majority of therapists would cover all of these points in assessing a client.

The second element that underlies Van Audenhove and Vertommen's (2000) ideas is informing the client. This is giving them information about the options available, either via handouts or questionnaires. The sort of information that would be provided would be about descriptive hypotheses, about psychological problems, psychotherapy and other treatment possibilities, the course of the treatment, different settings in which the therapy can take place, and also practical information about waiting lists and prices. Van Audenhove and Vertommen (2000) suggest these information-giving interventions have two goals. First, they help the client make up his or her mind about what is acceptable to him or her as a method of change. Second, discrepancies between client's expectations or preferences and the reality of the treatment can be corrected. However, these interventions could also offer too much specific information to clients, who may end up seeing themselves as a set of symptoms rather than considering all of their experience and the person as a whole.

The third element in this approach is conceiving the decision process as a negotiation between the client and therapist. For this purpose, the client's preferences for different aspects and characteristics of the psychotherapy process are elicited systematically: the client's preferences for the method (e.g. does he or she prefer a more action-oriented or a more insight-oriented approach? does he or she prefer to work individually, in a group, with his or her partner or system?); the preferences for characteristics of the therapist (e.g. does the client prefer a

psychiatrist or a psychologist, have a preference regarding age or sex, important beliefs and values, and/or a specific kind of person?); preferences for the role division during psychotherapy (e.g. activity and directivity of the therapist); and preferences for the setting (e.g. private setting or centre) and for the practical aspects of psychotherapy (e.g. duration of the process, duration of the sessions, price). When the client expresses a preference, the motives behind it are explored and, if possible, discussed in relation to the client's problems and complaints. In addition, the clinician presents the alternative possibilities, and their pros and cons are discussed. This assumes that client is in a position at the start of their therapy to be able to have this discussion. In addition, by the time someone has come to see a therapist his or her decisions around a number of these preferences may have already been made. For a client who is entering into therapy in distress, offering this vast array of choices might make them feel uncontained and not offer enough boundaries around the work.

The final element is to leave the client to make the final choice between equivalent alternatives. Van Audenhove and Vertommen (2000) suggest that leaving the final choice to the client has several advantages. Research findings reveal a positive effect of the patient choosing the treatment on the process and effect of psychotherapy (Liem, 1975; Manthei, Vitalo and Ivey 1982; Manthei, 1988; Tracey, 1993). Also, by leaving the final choice to the client, the clinician is not pretending a professional ability which in fact he or she cannot possess in reality: the choice among different but equivalent psychotherapy alternatives cannot be made on the basis of clinical or scientific expertise. By making his or her own choice, however, the client can choose the alternative for which he or she has the highest hopes.

Van Audenhove and Vertommen (2000) argue that their research also confirms the positive effect of negotiation and information on the initial psychotherapeutic behaviour of clients in terms of a stronger impression of the process of change and more constructive self-activity. The influence of the process of psychotherapy choice on the initial psychotherapy behaviour, however, is mediated by the development of more positive expectations toward psychotherapy and by greater compatibility between client expectations and the reality of psychotherapy (Van Audenhove & Vertommen, 1987; Bleyen et al., 1998).

Van Audenhove and Vertommen (2000) put forward the argument that a negotiation approach seems to lead to more efficiency in the intake stages of psychotherapy. A systematic analysis of alternatives to professional help (e.g., self-help groups) and to the treatment options by the client himself or herself implies that a client is not automatically referred to or accepted for professional treatment or for psychotherapy. In settings with waiting lists, this approach to intake can be very helpful in determining which clients to accept and which clients to refer. This approach would not be as effective for private practice clients as they have already made their choice to come for psychotherapy. If the therapist was willing to offer alternative choices in the first session, however, then the client would be able to make more effective choices.

Van Audenhove and Vertommen (2000) advocate that this approach leads not only to a more client-, therapy-, and therapist-oriented approach of intake and treatment choice, but also to an enhancement of patient rights, informed consent, and values in psychotherapy. However, they say it does not reduce the importance of the skill

and professional ability of the clinician in the processes of intake and treatment choice.

Summary and conclusion

The intention of this section has been to understand what potential clients are looking for in and from their therapist and what choices are available to clients. One of the main issues with reviewing research on client choice is that one could define choice in a variety of ways and it is considered differently by various studies. Clients have a choice in terms of different types of therapy and therapist. The choice of therapist varies in relation to different therapist characteristics as well as a choice around price and location. This section then considered why having these choices mattered. It examined how the client is positioned as a consumer of a service and what this meant in terms of their rights and what information they should be offered. This section then went on to consider how clients go about making choices before considering what the impact of having choice had on the process and outcomes of therapy, including how it impacted on dropout rates. Finally, in order to bring all of this together, it was important to look at what ideas have been proposed about how one might go about implementing this notion of offering choice to clients.

CHAPTER THREE: METHODOLOGY

Design

This study utilises a qualitative approach to data collection and analysis and this is achieved by using a Grounded Theory research methodology. Barker, Pistrang and Elliot (2002) suggested that the use of a qualitative methodology allows for a deeper understanding of social phenomena that is unconstrained by pre-existing hypotheses. Grounded Theory is the discovery of theory from data provided by the participants (Glaser & Strauss, 1967). Grounded Theory provides rich descriptions and also endeavours to develop an explanation and generate theory. The primary objective of Grounded Theory is to increase the understanding of a phenomenon by identifying the key elements of that occurrence and then categorizing the relationships of those elements within the context and process of the research. In other words, the aim is to go from the general to the specific without losing sight of what makes it distinctive. Grounded theory has evolved over time and I will be using a version of it from its more recent "incarnation" as a constructivist approach as outlined by Charmaz (2006).

I selected Grounded Theory as the most appropriate research methodology for this study as it fits with the purpose of building a theory as to how a client chooses a therapist and allows for the capturing of participants' perspectives in their own words. The constant shrinking focus of Grounded Theory has helped to identify the particular processes that clients have used to choose their therapist and how those choices have impacted on the course of their therapy. Grounded Theory has also allowed for the constant reframing and refocusing of the interview questions through the simultaneous involvement in both data collection and analysis.

The utilisation of this methodology has allowed for individuals to be studied in depth and in detail as Grounded Theory focuses on how people make meaning of their experiences (Charmaz, 2006). Grounded Theory research attempts to describe the subject matter from the participant's perspective, thereby generating theories that are grounded in the participant's lived experiences (Bowers, 1990). In Grounded Theory research, context is embedded in the phenomenon that is being studied, and consequently an individual's meaning-making process cannot be understood outside of the context in which it occurs (Charmaz, 2006). Charmaz (2006) calls this type of Grounded Theory "Constructivist Grounded Theory."

Constructivism emphasizes an interpretive understanding of an individual's meaning and advocates studying people in their natural setting to better understand their lived experiences (Charmaz, 2006; Lincoln & Guba, 1985). According to the constructivist position, reality is subjective and influenced by the context of the situation, specifically the individual's experience and perceptions, the social environment, and how the individual and the researcher interact with one another. Grounded Theory from a constructivist position allows for multiple interpretations and realities and therefore would fit with the design of this research paradigm as it is looking at a client's experiences and how they have perceived them.

Many Grounded Theory studies (including this one) in counselling psychology have relied on lengthy face-to-face interviews, allowing for fairly intense researcher–participant interaction and discourse. These interactions allow for the examination of the lived experience of the participants and the interpretive understanding of these experiences. Therefore one could understand the epistemology of the

majority of Grounded Theory research and in particular this piece of research as constructivist.

Participant Selection Criteria

A number of specific criteria were identified for recruiting participants:

- Participants were clients that had accessed individual therapy privately.

- Participants had to have chosen to undertake a course of therapy themselves rather than being referred by an outside person or organisation.

- Participants had chosen their therapist themselves.

- Participants had finished their current therapeutic work.

- Selected participants were not trainee therapists or registered psychologists.

The importance of participants having worked with someone in private practice rather than in an agency is that clients have a greater degree of choice when selecting a therapist privately thus making the analysis of the element of choice and the relationship between the client and therapist more significant. The rationale for utilising participants who have chosen to undertake therapy individually is that the impact of the therapist in group or couples work is diluted by the number of people involved and so by looking purely at individual therapy, again the relationship between the client and therapist is more significant. Additionally, by utilising clients who had chosen to enter into therapy, this allowed for the filtering out of those clients who have been referred to a therapist without being given any alternative choices.

The rationale for interviewing participants at the end of their therapeutic work was to have minimal impact on on-going therapeutic work. If the interviews were to occur during the course of therapy, there would be an undoubted impact on the therapeutic relationship. Interviewing clients before they have embarked on therapy would not only be rather difficult in terms of recruitment but again could have had an impact on future therapeutic relationships.

My concern with using counselling psychology trainees and professionals as participants was that they are too well informed of the "rules" of therapy and would therefore tailor their answers accordingly. Clients who are not trainees have hopefully offered a more "naïve" picture of the client experience with fewer expectations of what is the "correct" answer.

Participant Recruitment

In order to generate a sample, I utilised a purposive sampling approach applying a "snowballing" technique. Usually in Grounded Theory research, theoretical sampling is applied, i.e. the initial sampling begins and then additional participants are selected on the basis of the theory that is emerging from the concurrent analysis. This allows for confirmation or disconfirmation of the emerging theory. This research's reliance on snowballing reduced the opportunities for choosing participants on a theoretical basis and so this research protocol deviated from the traditional Grounded Theory procedure of theoretical sampling. However, snowballing proved to be the most pragmatic way of generating a sample in terms of reaching clients who have had therapy privately.

I placed adverts/posters in a number of locations, such as doctor's surgeries, libraries and waiting areas of counselling services where potential ex-clients might go, in an attempt to recruit participants, however I received no useful responses from these adverts. Due to a lack of response, I utilised social networking websites such as Facebook to put me in touch with the initial participants. The first two participants were people who were friends of friends of friends who I had not met before and were not directly known to me. Through these actions, I managed to recruit participants through whom I was then able to recruit additional contributors by asking them if they knew of anyone who had been in a similar position as themselves and had also accessed therapy privately.

Potential participants were sent an information sheet about the project and were able to ask questions about participating before formally consenting to take part. All of those initially approached to take part gave consent.

Participants

Ten people who had chosen to privately undertake a course of individual therapy participated in this study (see table 1). There were 8 female and 2 male participants. Participants' ages ranged from 27 to 57 with an average age of 34.5 years. Education level of the participants was to either degree level or postgraduate qualification. Nine of the ten participants considered themselves to be middle class, the other participant considered herself to be working class. Nine of the participants classified themselves as white while the remaining participant described himself as Afro-Caribbean/ Asian. Four of the participants were single, four had partners, one was married and one was divorced/ widowed. Participants' reasons for seeking

therapy included childhood abuse, suicide of a partner, relationship issues, life issues, depression, suicide of a friend, anxiety, "existential crisis" and bereavement. Participants' level of experience of therapy varied from only one episode of therapy to having worked with a number of therapists (see table 2). Some had shopped around and had a few assessment sessions, where as others had simply worked with the first person they had met. The length of the therapeutic work also varied from six sessions to twice a week for three years.

Although the sample was not strictly selected on the basis of theoretical sampling because of snowballing, I had hoped to find a range of people with different experiences to enhance the heterogeneity of the sample. In this way the emerging theory was not based on a singular type of participant experience. Hence the variation among participants in relation to how many times they had been through the process of choosing a therapist and the choice of therapy modality and duration of therapy, which enabled the development of theory.

Characteristic	n	%
Gender		
Male	2	20
Female	8	80
Age (years)		
25-30	3	30
31-35	5	50
36-40	1	10
41+	1	10
Education		
Bachelor's Degree	8	80
Post-graduate Degree	2	20
Socioeconomic Status		
Working Class	1	10
Middle Class	9	90
Race/ethnicity		
White	9	90
Afro-Caribbean/ Asian	1	10
Partnership Status		
Single	4	40
In a relationship	4	40
Married	1	10
Divorced / widowed	1	10
Reason for therapy [1]		
Childhood abuse	1	
Suicide of a partner	1	
Relationship issues	1	
Life issues	3	
Depression	3	
Suicide of a friend	1	
Anxiety	1	
Existential crisis	1	
Bereavement	1	

Table 1
Demographic Characteristics of participants (N= 10)

---

[1] For reason for therapy, more than one reason can apply

Participant	Experience	
	Assessment	**Therapy**
1	1 with male therapist 1 with female therapist	Female psychotherapist for 1 year
2	Visited 3 different women for assessment	Female psychotherapist for 3 years
3	Saw one female psychoanalyst for assessment	Male counselling psychologist for 3 to 4 months
4		Female Psychoanalyst for 6 sessions Female Psychotherapist for 6/7 months
5		Female psychoanalyst twice a week for 3 years
6	1 Assessment session with female psychoanalyst	Year with male counselling psychologist
7		Female therapist for year and a half
8		Female therapist for year and a half
9	Number of therapists	
10	1 assessment with female therapist	Female therapist for 12 sessions Male CBT therapist for 6 sessions Female therapist for 4 to 5 months

Table 2
Participants' experience of therapy

Data collection procedures

Brief demographic questionnaire

A brief demographic questionnaire (See appendix 1) was used to obtain background information. Questions included age, sex, level of education, socioeconomic status, race/ethnicity and partnership status. Participants completed the 5-minute questionnaire at the end of the interviews.

Interviews

The participants were interviewed separately, in a one-on-one semi-structured interview with the researcher. The interviews were tape-recorded and from these tapes, a verbatim transcript was taken for the purpose of analysis. The initial interview questions were devised to allow the participants to define their perceived experiences of therapy in their own words. Initial questions simply asked "Tell me about your experiences of therapy."

As the interviews progressed, the interview questions became more focused on the perceived critical dimensions and issues across interviews, with the goal of discovering potential emerging theory (Charmaz 2006; Glaser & Strauss, 1967). As a theory began to emerge, participants were re-contacted with additional questions relating to ideas that had come out of some of the later interviews. Participants gave written responses to these questions over email and were also given the opportunity to discuss them in person should they feel that they were unable to express themselves fully though a written response.

The interviewer/primary investigator

Being a therapist and having also been a client in a private practice setting has given me the opportunity to construct further insights of the experiences of being a client. This process is encouraged in Grounded Theory research as it facilitates a more comprehensive understanding of the participants' world and how it is constructed and experienced from their perspective (Bowers, 1990; Charmaz, 2006). This process, however, can be challenging because the researcher has to maintain marginality. Marginality is a process in which the researcher maintains *"one foot in the world of the participants and one foot in the outside world"* (Bowers, 1990, p. 34). Marginality allows the researcher to experience the participants' world while maintaining the distance necessary to raise analytical questions to guide interviews and data analysis (Bowers, 1990).

I attempted to be as open as possible during the interview process and allow the process to be guided by the interviewee. Participant responses to questions helped to guide the formation of other questions during the interview. I was quite aware during the interview process of the potential power dynamics that may play out in the interview process. Participants may have tried too hard to provide the answers they thought that I was looking for or not be as honest as they could have been. There was also the possibility of transferential process that they may have experienced in their own therapy playing out in our interview and therefore guiding their response. The issue of potential interviewer influence was discussed with the participant during the debrief at the end of the interview and this allowed them to consider any further comments that they wished to make at that time.

Data Analysis

After each interview was conducted, it was transcribed to begin analysis. Data analysis procedures were guided by Grounded Theory methodology and dimensional analysis (Bowers, 1990; Charmaz, 2006; Glaser & Strauss, 1967; Kools, McCarthy, Durham, & Robrecht, 1996; and Schatzman, 1991). In utilising dimensional analysis, the objective was to address the question, *"What at all is involved here?"* (Schatzman, 1991, p. 310). According to Kools et al. (1996), the key process in the analysis is to construct and understand the components of a complex multidimensional social phenomenon from the participants' perspective. This construction and comprehension is achieved by conducting a line-by-line dimensional analysis of the transcripts with the goal of identifying the parts of the phenomenon and the interrelation among the parts (Kools et al., 1996).

The first phase of the analysis was an analysis of transcripts, also known as open coding, which allows the researcher to discover and describe the most important dimensions (actions or events) of the phenomenon from the participants' perspective (Bowers, 1990; Charmaz, 2006; Glaser & Strauss, 1967). In a deviation from traditional Grounded Theory, rather than doing a line-by-line analysis of the transcripts, interviews were coded in terms of meaning units of individual concepts (see appendix 2). By this I mean that I would analyse what the participant said and attempt to code from individual points raised rather than on a line-by-line basis. As I coded, I would ask myself "what is the participant attempting to communicate?" and then concepts would be drawn out from what they had said. The code generation was descriptive, so that the name of the category closely reflected the language

used by the participants. This served as a check against moving away from the substance of the data.

The first interview transcript was analyzed and units of meaning were discovered in order to identify the dimensions that the participant reported as being prominent in their experiences of therapy. Salience was determined by language expression, such as phrasing, repetition, and description of meaningful actions and events in therapy.

The data was subjected to a constant comparative analysis, a process by which the categories identified were compared across individual participants and within individual cases to better understand the individualized codes and categories as well as the interrelations among them.

Throughout the analysis process, I utilised memos (see appendix 3) as an aid to questioning and analysis, to expand and decipher processes, assumptions and actions that were contained in the identified categories and to aid me in defining the interrelations among the various categories (Bowers, 1990; Charmaz, 2006; Glaser & Strauss, 1967). For example, one of the memos in this study focused on the assessing process clients engaged in to identify nature of feeling safe in the therapy room.

This process of coding and categorizing, memoing, and constant comparative analysis continued until saturation. Saturation is *"a point in which the researcher cannot discover new dimensions in the data being collected"* (Bowers, 1990, p. 48). In this study, saturation was evident by the eighth interview as no new data was

being seen to be emerging, however for the sake of research rigor two more interviews were conducted in order to be assured that no new data would emerge.

Once saturation was achieved, I moved on to look at the relationships between the identified categories. Some of the categories were seen to be central because they had links with many other categories. Linked categories formed a hierarchical structure in which central categories subsume lower-order categories (see appendix 4).

Trustworthiness

According to Johnson (1997), in qualitative research three types of validity can be considered. First, descriptive validity refers to the factual accuracy of the account as reported by the researcher. Second, interpretive validity is obtained to the degree that the participants' viewpoints, thoughts, intentions, and experiences are accurately understood and reported by the researcher. Third, theoretical validity is obtained to the degree that a theory or theoretical explanation developed from a research study fits the data and is, therefore, credible and defensible.

In order to check descriptive validity of my work, I have collaborated with a colleague whose study is in a similar area to my own to verify the coding procedures for the interview transcripts. Samples of coded and un-coded transcripts and lists of codes were sent to be looked over and commented on. I have also employed someone from outside the field (who has an expertise in research) to look over my coding who has offered an independent and unbiased perspective. I have created an audit trail to increase the transparency of the analysis process (see appendix 5).

When emphasizing the interpretive validity the aim is often to find the "original" meaning exactly as the participant originally experienced or expressed it. In order to facilitate this, the findings section of the manuscript was given to the participants of the study for member checking (Lincoln & Guba, 1985). The participants were instructed to review the results section of the manuscript to determine whether their experiences were accurately described. The feedback indicated that not only was their experience accurately reflected, but also there appeared to be similarity of experience for most of the participants.

The third form of validity, theoretical validity, is the most difficult to ensure and to evaluate. It can be seen as an internal validity of the theoretical framework, and the evaluation is an analysis of the theoretical cohesion of the argumentation in the research. The theoretical validity of this research shall be addressed in the discussion section.

Ethics

Ethical consent was obtained from the Metanoia research ethics committee (see appendix 6). Consent was sought at each stage of this research; the intention has been that prospective participants were able to make an informed decision as to whether they wished to take part or indeed withdraw from this research. Participants were sent a detailed information pack prior to the interviews taking place. The information pack consisted of the participants receiving a "participant information sheet" giving an outline of the nature of the research and research question, the risks and benefits of taking part, how much of their time it would take up and reassurance regarding the confidentially of the interviews. The information sheet also included information regarding the participants' rights to withdraw, the use of the data, compliance with data protection regarding data handling and

storage as well as the contact details of my supervisor and institute where I have been studying. The second part of this pack was a consent form, which they signed and kept a copy of to say that they had agreed to take part. Also included in this information pack, was a copy of the BPS code of ethics and conduct for research. Confidentiality has been maintained by ensuring that all participants are completely anonymous. Those participants who volunteered to be interviewed have only been known to the researcher. Before taking part in a tape recorded interview participants completed the 'informed consent' form. Any identifiable details of the participants were removed from the transcripts and any names were changed to protect participant anonymity. A trained transcriptionist as well as the researcher made transcripts of the recorded data and the names of participants were changed when being reproduced in the findings section. Each transcript was checked for accuracy by the researcher by listening to the interviews alongside the transcript. Not only did this allow for accuracy to be confirmed but also allowed me to further familiarise myself with the nuances of the interviews. In relation to the quotes used to illustrate the findings, minor biographical details have been changed in order to protect the anonymity of the participants.

Participants were informed at every stage that they may change, alter or add anything said or written by them during the course of the research. Additionally, they were informed that they can withdraw from the research at any time they wish and the information they have provided will have been destroyed. At the end of each interview, participants were given a debriefing. This was to ensure that had any adverse outcome occurred as a result of the interviews, for example the participant becoming distressed, the participants were given an opportunity to discuss their concerns. It was made clear on the information sheets that I was not

acting as a therapist in the context of the interviews and that the interviews were not of a therapeutic nature. It was also made clear that should participants want any further support due to the research interviews then that would be arranged for them. As the interviews were focused on the processes that participants went through in choosing their therapist rather than the content of the therapy itself, it was hoped that any adverse reactions were minimised.

CHAPTER FOUR: FINDINGS

I developed a three-stage Grounded Theoretical model that illuminates the processes that clients go through in choosing their therapist, showing the processes that influence their decisions and their on-going assessment over the course of therapy of whether to continue or exit therapy. I have defined this model in terms of "stages" as this provides structure and clarity to the emerging theory. Figure 1 provides an overall picture of the three-stage model.

Figure 1: Overall theory diagram
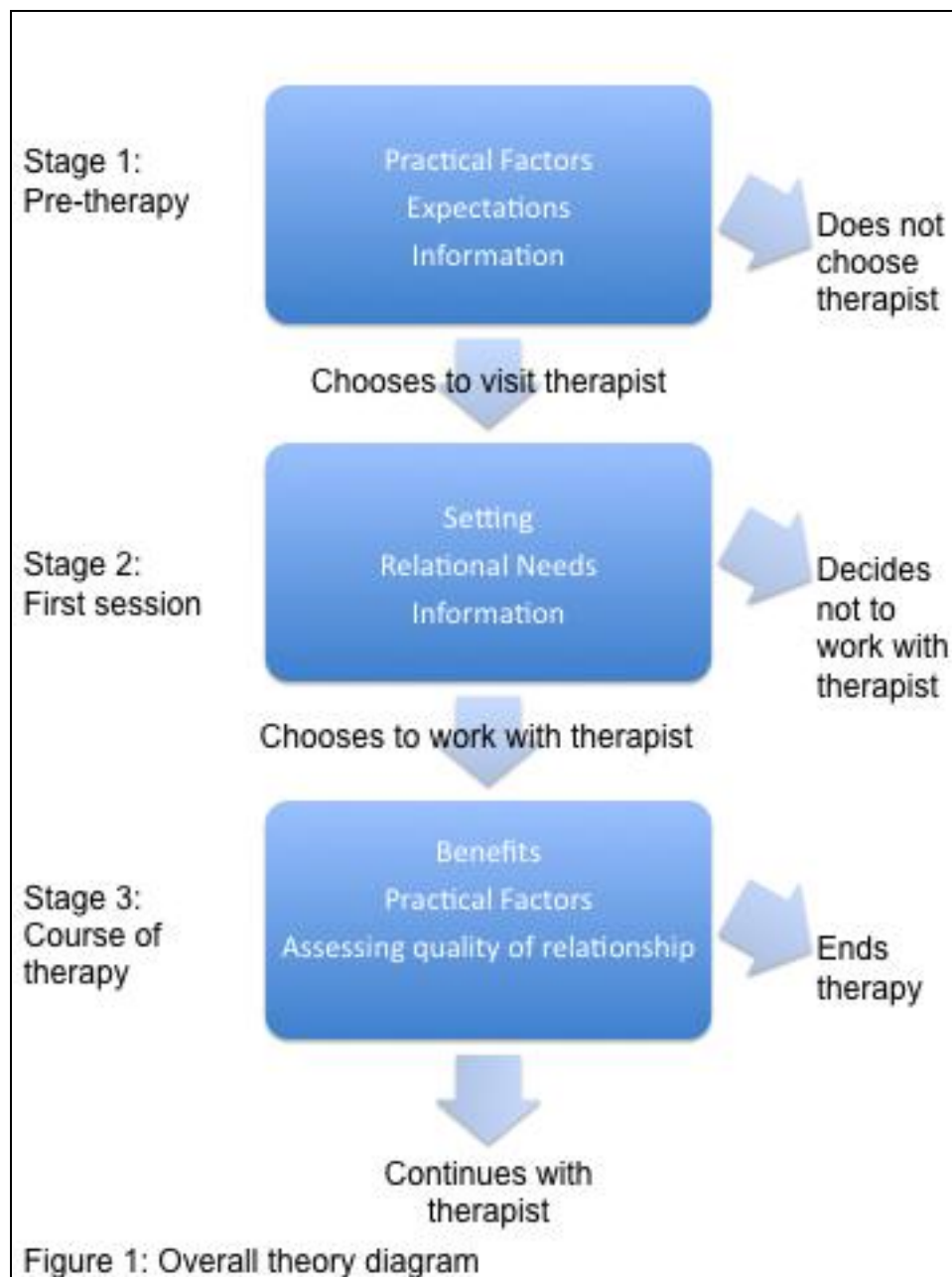
Stage one is an assessment of the therapist suitability prior to meeting. The second stage is concerned with the client making an assessment of the therapist at the first meeting. The third stage considers whether a client continues in therapy to an agreed conclusion or decides to exit therapy early. During these stages, I found a variety of factors influenced the clients' decision about who to work with.

I found that respondents in this study reported going through the same process of weighing up various factors. The weight that each of the clients gave to any one factor depended on the client's individual needs. Each of these factors came into play at different times as the clients made contact with the potential therapist.

This model begins at the point at which the client has decided that the best course of action in dealing with their issues is to seek a therapist privately. Throughout this model the client is making judgements on the quality of the emerging and developing relationship between them and their therapist in order to ascertain if they feel they can work with this person or not.

Stage 1: Assessment of the therapist suitability – Pre therapy

Figure 2. Stage 1: Assessment of the therapist suitability – Pre therapy
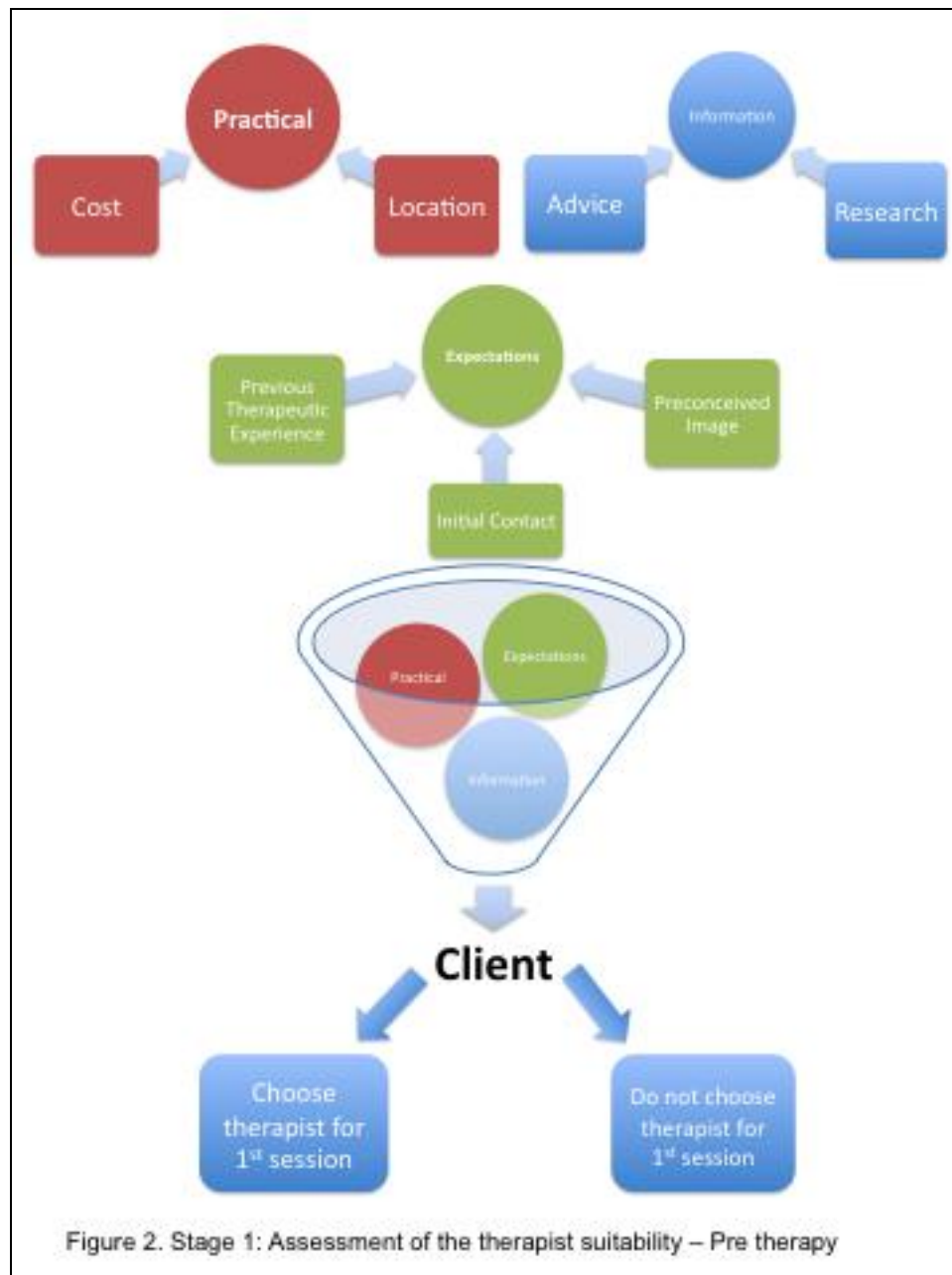
As shown in figure 2, when clients decided that they needed therapy, they were initially influenced by three factors: pre-therapy information, expectations and practical factors.

Pre-therapy information

Clients appeared to begin by gathering information about therapists and therapy. There appeared to be two ways in which they collected information. First, by getting advice from trusted information sources such as friends, colleagues or loved ones who have had experience of therapy themselves. Secondly, the clients researched therapy and therapists by searching on the internet or contacting the various bodies that represent therapists. These two approaches were not mutually exclusive and a client seemed to explore both avenues in order to be as fully informed as possible before making a decision about with whom to work.

Advice

Clients reported that they sought the advice of friends, family, colleagues, GPs or counselling organisations to ascertain the most suitable therapist to go to. They seemed to look to people or organisations whose opinions they respected to offer suggestions of whom to go and see.

> "A friend of mine who's had a lot of therapy in her life and different types of therapy and she simply mentioned this woman and said I've heard she's brilliant." (Participant 4, 29-year-old woman)

> "I spoke to a friend who was studying, studying to be therapist um and I was asking her about it, and she gave me a list of psychotherapists." (Participant 5, 38-year-old man)

It might be that they felt this person had superior insights or expertise about who to see as the participant above suggested or they believed that they could trust their adviser as participant 3 argued:

"I wanted to be referred to somebody I knew and I've got a friend who I trust, who had someone that she highly recommended." (Participant 3, 30-year-old woman)

The advice of others seemed to offer reassurance to clients as they appeared to get a clearer understanding about what to expect and reduced areas of uncertainly that might have caused anxiety.

"I heard about her experiences in detail and I'd heard about him in detail and that made a difference for me, the fact that she recommended him so highly and told me so much about him and I felt, I knew before I made that phone call that he was going to be very nice to me and I knew before I made the phone call that he was a little bit, little bit kind of eh untraditional and a little bit kind of a rambler sometimes about his own life and a bit, I knew that was what I, and I knew that I'd just be getting to go and sit in a room and sit in a chair and have a chat. And I knew that he'd probably wouldn't clock watch and that knowing those things made a big difference." (Participant 6, 31-year-old woman)

The findings of this study suggest that the advice and/or recommendations of trusted friends or loved ones seemed to hold more weight than information unearthed by research:

"I think I would have always preferred to take a recommendation of somebody that I trusted than say do an Internet search or go through like my GP or something like that. I think, I definitely think that knowing that somebody was ok for you; somebody that I trusted would be what would make me choose anybody." (Participant 6, 31-year-old woman)

This advice could also impel the clients to see someone that they discovered was not quite right for them. As someone they trusted suggested them, it appeared that

they would have followed their advice first before making up their own minds as participant 3 and 8 proposed below:

> "I guess that it was just that um that it was recommended by someone who was, who was a very intelligent friend of mine and had had some experience of it and though oh she, somebody, she probably did their research like for her to find them so, so I just took that recommendation… So that first appointment, that first woman I was telling S about this recently, it was really damaging (and) I left that there." (Participant 3, 30-year-old woman)

> "Actually someone at work recommended somebody, um a close friend at work recommended somebody and I looked them up but they seemed to be a bit more sort of Freudian in a certain way as in it sounded a bit more off-putting." (Participant 8 27-year-old woman)

Research

The clients attempted to gather information about therapists and therapy from sources such as the internet, the media or counselling organisations:

> "I just literally went on-line and Googled and found one that was just round the corner from me." (Participant 8 27-year-old woman)

> "I did quite a lot of research into finding a therapist, um I suppose I thought if I was gonna, if I was gonna do it I want to do it properly and for me properly can for right or for wrong reasons equates to the person who'd have the most extensive training." (Participant 2, 32-year-old woman)

As participant 2 suggested, clients were attempting to make a more informed choice about who to work with. Clients were able to gather information about a particular therapist depending on what information the therapist allowed in the public domain or what they chose to tell clients as the quote below suggested:

"I proceeded to actively Google her to find out as much as I could about her and I actually couldn't find anything about her on the web which I found slightly odd, but I was a bit intrigued." (Participant 7, 35-year-old woman)

There appeared to be a relatively high rate of confusion as to where to go for information or how one would go about looking for a therapist as these two participants below argued:

"I didn't know where to go; I didn't know where to look at all." (Participant 4, 29-year-old woman)

"There's lots of different therapies around and what have you and it's quite hard, I would guess it's really hard if you come into on a basis where you think that somebody, well somebody thinks I might need some therapy where you go if you've got no idea it's very hard to know I would imagine, I mean I guess you'd go through officially sanctioned bodies first of all but whether that's exactly the right thing for you and your particular needs I don't know its quite hard to tell." (Participant 5, 38-year-old man)

Practical Factors

Clients also took into consideration certain practical factors when selecting a therapist. These practical factors consist of two main elements: cost and location.

Cost

The cost factor was the clients deciding whether they could afford to see a particular therapist and if they felt that this person was worth the money they were charging.

"Cost does matter um but if you know that beforehand you go with it because if it's too expensive I wouldn't have taken it in the first place." (Participant 9, 57-year-old woman)

It seemed that should they not have been able to afford this therapist or felt it was prohibitively expensive then it was unlikely they would have chosen to work with them as participant 9 proposed above. However, it appeared that if the therapist was more expensive than initially anticipated but the client felt they were worth the extra expense, then they might have decided to work with them:

"I want value for money but I wouldn't if I felt like I'd found someone good I wouldn't, I'd be prepared to pay £10 more a week to see them." (Participant 2, 32-year-old woman)

One participant explained the difference that the offer of a free initial consultation meant to him in selecting a therapist. He highlighted that being in a position where he was able to exercise choice and not feel committed to seeing a particular person helped to make the process less daunting and increased his feelings of safety at that stage.

"I was also very keen to go to someone who would give me a first session without any further commitment and indeed I ended up going to two people I chose and each of them had offered me the chance of the first visit without any charge even, so it wasn't even just

that you were committing to anything further but you didn't pay for the consultation in order that you could figure out uh whether it was going to work or not and that definitely it kind of made it a bit less scary, it made it feel a bit safer and feel a bit less daunting. "(Participant 1, 32-year-old man)

It seemed that the increase in safety helped the facilitation of clients' relationships with their therapist.

Location

The location factor referred to the client determining if the therapist's consulting room was positioned in a location that they would have found it easy to get to:

"Um I knew it had to be someone, it was quite important it wasn't too far away from where I lived and where I worked so it was limited by the location. I mean the searching was limited by the location." (Participant 10, 35-year-old woman)

"Somebody who was very local where I live… I mean I knew where she lived, I already new the street that she lived in and I felt very comfortable about where she lived." (Participant 7 35-year-old woman)

It could be argued that clients tended to not select therapists who were difficult to travel to, unless the therapist proved to be so appealing to work with that they were willing to endure the inconvenience of travelling to their location:

"Where they're located doesn't seem to be particularly relevant. I haven't been to a, no the way, um. I haven't thought it relevant particularly... Um no I don't think if the session goes well it doesn't seem to matter to me where it is." (Participant 9, 57-year-old woman)

Expectations

Clients' expectations prior to entering into therapy appeared to be influenced by a number of areas: preconceived image, previous therapeutic experience and initial contact with the therapist.

Preconceived image

Before the two people have even had any contact, let alone met for therapy, clients seemed to have constructed a preconceived image of the therapist.

> "So I had heard various things from people about what it was like to go and see a therapist and I had various misconceptions, well preconceptions." (Participant 7 35-year-old woman)

This image might have been from cultural or social ideas about what a therapist would be like, from their own previous experiences of therapy or from information obtained from a website, information sheet or telephone conversation with the therapist. From any of these information sources, as well as details such as their address or name, clients would have been able to make assumptions about the therapist's sex, class, ethnicity and age.

> "…. He was quite a bit older and even though I have this image of the person that I was gonna go and meet and that they would be a youngish uh guy and I kind of at the time thought that that was sort of person could understand me and what I'd been going through or what, you know, and help me out of that, he just, he didn't seem to fit this image that I had in my head." (Participant 1, 32-year-old man)

It seemed that clients were then able to make a judgement about the therapist on the basis of how much they fitted in with these preconceived ideas and whether they found this to be reassuring or uncomfortable.

Previous therapeutic experience

Clients' previous therapeutic experiences appeared to influence their expectations about their therapist:

> "I went to meet with Shelley (second therapist) and I was very positive because I'd had such a positive experience with the previous therapist." (Participant 1, 32-year-old man)

This element seemed to help clients to make a choice about which therapist to work with, as it appeared that they felt that they have a better idea of what to expect and had a greater awareness of what would not work for them.

> "Yeah, it's funny, cause even like doing this interview now, this first woman (first therapist) seems so significant but of course it was just a one off event two hours of my life. But I must have you know sub-consciously or consciously made me view the encounter with Trevor (second therapist) differently that made me, it must have had an impact, I kind of forgot about that first thing happening but it must have, yeah it must have made me kind of see things in a different light." (Participant 3, 30-year-old woman)

It seemed that by knowing what to expect, clients were able to make a decision as to whether the therapist meets that expectation or offered a different experience that was more or less appealing.

Initial contact

Once information about a therapist had been collected, then clients would have made contact with the therapist, usually over the telephone.

> "I think I just started phoning around and I definitely remember speaking to someone who said that they have no availability in their schedule and so I moved on to the next one." (Participant 1, 32-year-old man)

Clients seemed to feel empowered by having taken steps to deal with their situation and they suggested that simply contacting a therapist could have been the first step in increasing their feelings of empowerment and helped to reduce discomfort, as participant 6 argued:

> "I think actually, just the steps of actually booking an appointment and going to see somebody made me feel like I was actively taking a little bit of control or engaging a little bit of the fact that I wasn't desperately happy and that in itself I think changes things a little bit…I deliberated over getting in touch with before I got in touch with him for quite long time, once I'd actually got in touch with him the whole process seemed a lot more comfortable but it was making that initial first kind of phone call and saying, not really knowing what to say when I called up and say oh I'm feeling a bit like this, can I come and chat to you, actually making that first phone call is quite difficult." (Participant 6, 31-year-old woman)

During the telephone conversation it seemed that clients were attempting to assess the potential quality of the relationship they were about to start and were looking for someone that they felt comfortable with. They also did not want to feel pressured by the therapist to come and see them as proposed by participant 10:

"There were some people, I remember ringing a couple of people who were extremely brusque on the phone and that put me off them completely. There were other people who, there was one woman who was very pushy about me eh coming to see her and she would explain things in person, um there were people I don't think that ever got back in touch with me. "(Participant 10, 35 year old woman)

Clients gathered information about the therapist from this initial contact. From the phone conversation, clients were able to assume information about the therapist's sex, class, ethnicity and age. It appeared that clients were looking for clues as to the flavour of the relationship that was about to be formed even from limited contact over the phone:

"I think that perhaps if I was advising a future therapist I would say um it's important how you come across in your initial conversation with the person because I would imagine that um eh for a lot of people they kind of make an initial decision as to whether to bother to go and see a particular therapist for a first consultation or not, based on the first conversation." (Participant 10, 35-year-old woman)

Stage 2: Assessment of therapist suitability – first session and beyond

At the point at which the client and therapist finally met, clients had further opportunities to assess the potential relationship with the therapist. Figure 3 attempts to illustrate some of the elements that come in to play at this point.

Figure 3. Stage 2: Assessment of the therapist suitability – 1st session
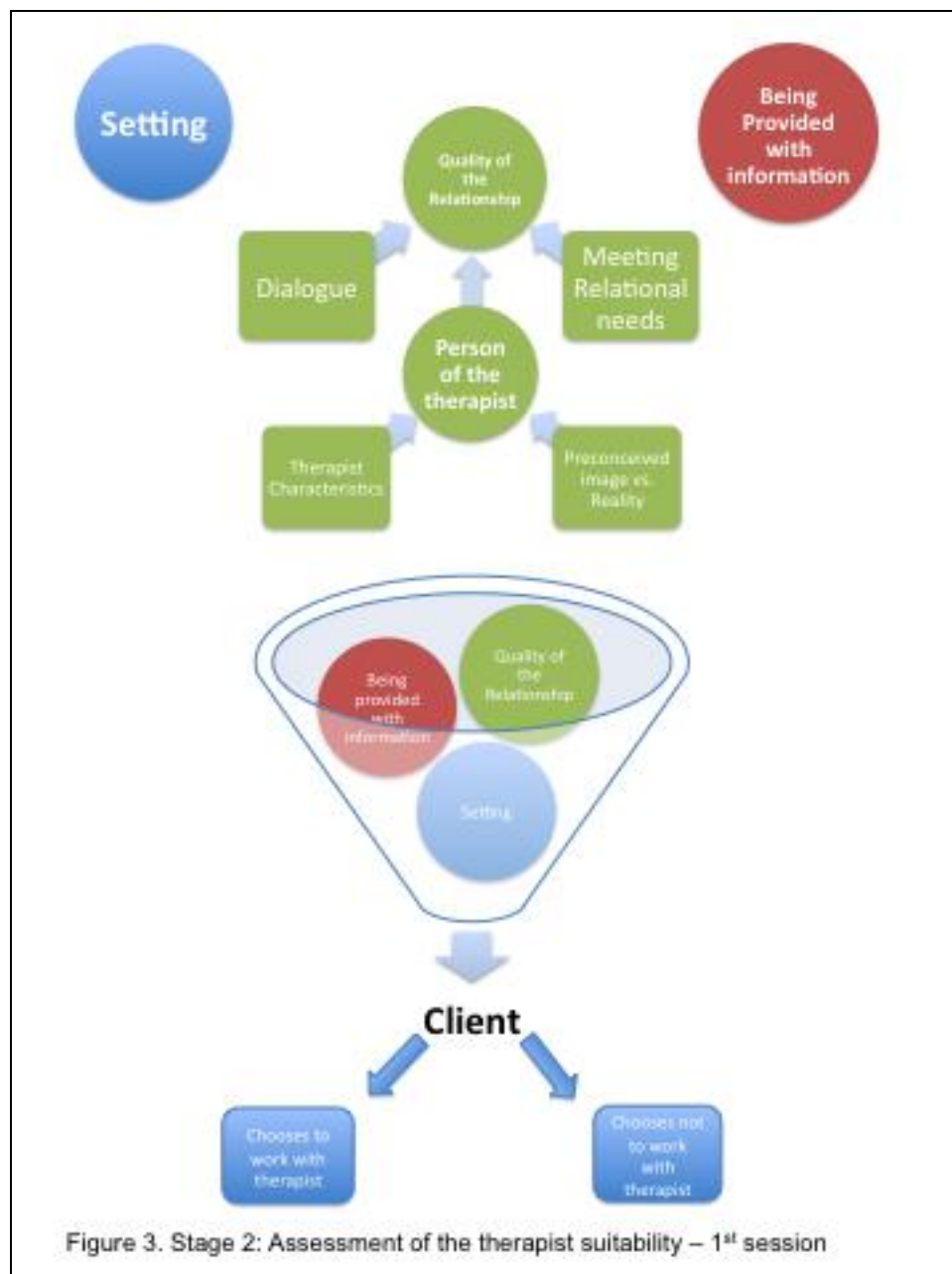
At the first session, four elements had an impact on clients' choice processes: the setting, being provided with information, the quality of the relationship and the person of the therapist.

Setting

Whilst the location element refers to where the consulting room is, the setting element relates to the building and the room where therapy took place. Clients seemed to make an evaluation of the setting based around things such as the level of light in the room, the type and comfort of the furniture, what artwork there was on the walls and whether there were books in the room.

"It sounds really ridiculous that she had no books in her room and I just thought that was really bizarre, I was like I'm meant to be coming to see you because you're a wise person and you've got no books in your room, and I just didn't get a good feeling from her…" (Participant 2, 32-year-old woman)

Clients were attempting to evaluate how the setting might have impacted on them; did they feel comfortable in such a place? Did the setting feel appropriate for therapy? What clues might have the setting be offering about the therapist?

Clients will infer meanings from even the smallest clues and will make assumptions about the therapist from these things such as the book indicating wisdom or the artworks suggesting a certain type of disposition. The setting allowed clients to make judgements about the personal characteristics of the therapist as well as discerning further clues about them:

"So by going into her house I could see the pictures she had on her wall, I could see the way that her room was decorated, um and it felt, I felt very comfortable in those surroundings immediately before we actually even sat down and spoke and that to me was kind of quite important, I felt I was in an environment that I was happy and that was, just suited my sensibility if you like, so that was important and then when we started talking, I felt that she

91

was the kind of a person that was intelligent, thoughtful and considerate and reflective, because to be honest, I'd never been to see anyone before in that context." (Participant 7 35-year-old woman)

"The room was empty like you walked into an old persons' home rather than it didn't seem very professional place as opposed to the other place which was, you walk in you cuddle the dogs and then you go running upstairs and she's got a nice sofa to sit on with lots of pillows for you go hug and a box of tissues if you want to cry and then the other one I think I sat on a wooden chair in a really uncomfortable room and um I fidgeted a lot. This one I could you know just sit and relax and second one would have books all around her because she was so into her work." (Participant 4, 29-year-old woman)

As participant 4 suggested the setting can make an impression on the perceived appropriateness of the therapeutic encounter as clients attempted to gauge how comfortable they might have felt in the surroundings.

"The first place where I had done the short term therapy was in a um a building that was um kind of used in the evenings only, I think it was part of hospital and that was quite kind of, quite cold and um you know you kind of felt like you, you didn't feel that you were sitting on a plastic chair, you just didn't feel particularly comfortable in the space, whereas where I did the long term therapy in someone's living room so it was much more comfortable and it was very quiet um and very private um felt more appropriate as an intimate safe space to discuss kind of intimate feelings." (Participant 10, 35-year-old woman)

The quote above shows how the setting also appeared to influence on how safe the client felt as well as giving them a clue as to whether they would have felt that they had being properly understood. It was as if the clients considered the aspects of the

surroundings to be indicators of the quality of the relationship they were about to experience.

Being provided with information

Clients were provided with a variety of information by the therapist either verbally or on prepared written information sheets. These could have included information about the therapist's experience, areas of expertise, particular orientation or qualifications as well as practical arrangements for therapy.

"I also looked into because she was a psychodynamic psychotherapist or something, something along those, psychodynamics something anyway so I was slightly intrigued to know exactly what that meant so I then proceeded to look into that to see what that might mean to my course of therapy, because not having been to a therapist before I didn't really know, so you know the initial meeting was a sort of discussion about who she was and what she did and what her methods were." (Participant 7 35-year-old woman)

This information or lack of it could have produced either a positive or negative response from the client. Some therapists were offering clients certain pieces of information if asked or voluntarily or they were providing clients with written information sheets and contracts. This information varied in depth and detail from therapist to therapist. The setting would have also provided information to the client about the therapist's level of expertise particularly if they have had certificates on the wall, which could have helped to reassure clients:

"It's quite reassuring to have on the wall, like he had about 3 or 4 certificates on his wall saying he was certified in different things and that, and he told me that anyway so I knew

that was the case and I think as a therapist he would tell you whatever, but I think just having that there and it was right next to me just there, it's like a reassurance like this guy knows what he's talking about. He's got a qualification and I think yeah I did find that quite just reassuring." (Participant 6, 31-year-old woman)

Some participants expressed a desire for greater amounts of information, such as explanations around the "rules of therapy" so as to have had a better idea as to what to have expected from their therapy, therapist and also how to have conducted themselves in the therapy sessions.

"I do think, I do think it would have been easier if I'd know things earlier on. But I didn't ask them early on but that's because I was afraid that you know I might just, you know, she doesn't say hello to me when I call in the door and all that weird stuff. I'm not quite sure what it means but I know there's some kind of you know code of conduct like never say hello to your patients in case she's having a bad day and you know, whatever it is." (Participant 2, 32-year-old woman)

Participants suggested that they felt more contained by being given some indication of how the sessions might have evolved and suggested that a lack of structure could have made clients feel less secure and uncontained.

"Think I remember with the women that she sat and told me a bit about her and how long she'd been doing it and the kind of people that she worked with and she kind of she told me much more about the ground rules that laid, that lay down the boundaries to it than remembered the first guy telling me and I like structure my, in hindsight my criticism of the woman would be that I don't think she structured as far as my overall feelings are concerned, I don't think she structured our sessions as much as I would have liked but certainly one of my attractions to her was that she had structured it more than the first guy had done though." (Participant 1, 32-year-old man)

Quality of relationship

At the assessment/first session, there appeared to have been a significant focus on assessing the quality of the relationship in order to decide if they felt they could have worked with this person. Although I have separated dialogue and the relationship in this theory explanation (for the sake of clarity), one would have had a reciprocal influence on the other as the dialogue would impact on the emerging relationship and the way the relationship develops would have had a bearing on the levels of repartee between therapist and client.

Client would have weighed up all of these influencing factors and made a decision as to whether to enter into therapy with this person. Clients were making a judgement on the quality of the fledgling relationship that was being established as well as deciding if this was a suitable person to help them.

Dialogue

This section refers to firstly the style of the dialogue between therapist and client for example, the use of silences and free association and secondly the content of the dialogue for example being judged or determining the harshness of comments.

One element that seemed to come into play when this first meeting occurred was a judgement about the level of repartee that went on between the two parties. Clients appeared to be trying to decide if there is easiness to the conversation:

> "When you first start off with therapy it's a lot of it is just you talking and them listening. Um and as long as you can feel relatively comfortable with um, relatively comfortable with that person then I guess the more and more you open up but yeah there was nothing that made

me particularly um, there's nothing that made me particularly think, there's no way I'm going to be able to open up in front of this person." (Participant 5, 38-year-old man)

"I can't say until I meet them um, as I say I like someone who, firstly I like someone who will take me by the hand and help me rather than just leave me, so I don't like the silent bit and I don't like, I don't like it when I say something and I don't get a response um I never know then if I'm understood or not." (Participant 9, 57-year-old woman)

Clients seemed to be attempting to determine if they were receiving the "right" sort of responses from the therapist or if they were even being responded to at all:

"Interviewer: So you went to see this person for the first time, so what was it about them that made you say yes to this one?
Participant: Um, well I kind of often wondered this because this might sound odd but I didn't really like the therapist very much um I didn't um but it was just that I think I felt I just needed to tell this stuff to somebody and um she kind of responded in the right way although at first I wasn't sure but I kind of thought I'll just stick with it because it's somebody and its going to help somehow." (Participant 8 27-year-old woman)

"I don't remember it was a long time ago, um 20 years ago, um I went to see one where we did the silent bit and I sat for three-quarters of an hour in silence in painful silence and then I got angry and then I left. I still had to pay. Um so I then found out that that doesn't suit me, the silent one." (Participant 9, 57-year-old woman)

The quote over the page by participant 6 seemed to have suggested that part of the judgement made by clients was based on what they might have felt comfortable with and what was familiar.

"I went to see somebody once and she made me lie on a couch and do associations and think of the first think that came into my mind and I found the whole experience totally alien and confusing and like it didn't see me at all, I never went back." (Participant 6, 31-year-old woman)

If the atmosphere in the sessions was uncomfortable or if the client felt that the exchange with the therapist was too much of a departure from more conventional, everyday dialogue then it seems unlikely that they will have chosen to spend time with that person.

The content of the responses seemed to have a great impact on whether a client would have worked with a particular person or not. Participants reported being concerned about feeling judged or being made to feel abnormal, like they had lots of problems:

"What she did was it was just like voicing this, yeah her judgement of me based on like this immediate encounter and it was just quite a destructive thing for someone with a very good reputation it was just quite a destructive thing to do…I think you want someone to be honest and realistic but you also want reassurance so I think in that first instance yeah you want, I mean I had the feeling that she'd seen a lot of people and that she was very professional but I think you don't, you want to feel like yeah let's somehow, like not abnormal… I think I'd kind of gone there yet expecting some kind of words of comfort and come out of their feeling actually like now I've got a whole load of other problems." (Participant 3, 30-year-old woman)

Participants reported that they responded positively to having their issues normalised and to the therapist having offered a level of understanding and comprehension about what they are bringing:

"He totally normalised it, yeah and he just, and he'd say little things I could always say, he'd always be very positive, very encouraging and very, just very nice to me like even little things like he'd always focus on positive sides of things, he always, um, he'd also always just encourage me to be nice to myself which I think that I and I'm sure lots of people have a tendency of doing which is always looking at the negatives and actually just little things, but coming from a stranger who you just kind of trust a little bit because he's, because he's saying things quite articulately, and he's saying them quite clearly and he's saying them with a kind of a belief from himself and that comes across." (Participant 6, 31-year-old woman)

Clients appeared to have also made an assessment based on the responsiveness of the therapist in order to ascertain how well this particular person related to them and their issues. It is worth noting the impact that statements by the therapist at this early stage of the relationship building process could have had on the client. They could either have aided or hindered the development of the relationship as clients may not have had established a baseline level of trust in the process and therefore felt judged. This perhaps could have caused a client to choose not to have entered into therapy with that particular therapist as the quote below exemplifies:

"I remember very clearly things she said like that I wanted to be a man like something, she said like quite sort of harsh and extreme things and bearing in mind I, we didn't, we weren't striking up relationship, it's kind of a weird thing for somebody to do to be even though I asked her I think she should have been able to say actually I don't want to pass judgement on you now anyway. So when I left there I was quite freaked out that I had loads of problems… so I can't remember the time thing but I left that there." (Participant 3, 30-year-old woman)

Meeting relational needs

All of these elements about the person were held together in the developing relationship. Clients seemed to make a judgement around how directly they felt they could have related to one another and how comfortable and safe they might have felt as participant 10 illustrated:

> "My own vulnerability at that particular point that I needed to feel a bit supported, don't know if nurtured is the right term, um I needed feel quite secure in my relationship with the therapist. Needed to feel that person was listening to me, um and I needed to feel that I was in a safe environment cause I was having at the time I was having panic attacks even just going out of the house and for certain situations the all-round experience needed to be something very calm secure for me." (Participant 10, 35-year-old woman)

That's not to say that feeling discomfort did not appear to be alright for the clients either; a number reported that they did not feel comfortable with their therapist but they felt that this was part of the process and was therefore tolerable.

> "Um I think it's just that you meet anybody, a friend, somebody who then becomes a friend, somebody you just feel comfortable with, you have a rapport with, um the ones that I've stuck with where it didn't feel that immediately have turned out to be, I've stuck with them because maybe I just want to give them the benefit of the doubt, or give the situation the benefit of the doubt. Um that click hasn't happened immediately yet I've stuck with it because I want to try and make it work, but for me and the situation um, so I haven't made discriminatory choices as I see it I just know that the first one felt good and the next one was a disappointment but I stuck with it." (Participant 9, 57-year-old woman)

It seemed that clients could have judged the emerging relationship around how much relational distance or proximity they felt that they had with the therapist:

"Client: Uh possibly, possibly that I didn't feel judged, maybe just more so because I could relate to him, I do feel that, I think that I relate better to people who are more similar to me in that kind of context I suppose because I can get on fine with people who are different … but to me in the everyday world but I relate most to people who are most similar to me. I think probably we all do to an extent and so that worked for me with him." (Participant 6, 31-year-old woman)

It might be that the therapist shared a part of themselves as a means of offering insight to the client about their level of understanding. This could have been inferred by the client as there having been an amount of commonality between them and how well they were relating to one another.

"so you know the fact that the he was saying oh I've been in this situation, I've been in that situation he would have loads of conversations about like some political thing though like Jewish friends, his attitude to Israel or like all different things would come up within the context but it was always, it made it human and it made it feel like there was a connection between us um and a very sort of wholesome like you know, just a connection, just that probably a bit alike." (Participant 3, 30-year-old woman)

This could have aided the client in feeling that there was a person to person meeting going on and so could have left the client feeling they were being respected and understood:

"Really, really worked well for me because it really made me feel like it was a person-to-person conversation, and not a ... to a client conversation which really worked for me with what my needs were. " (Participant 6, 31 year old woman)

"I think for myself anyway, generally myself with people that it takes quite a long time for me to be able to trust them so I was um, I think I was aware of the fact that you know a) that nothing is going to get solved in the first, the first kind of session and b) that if the therapy was going to be meaningful for me in terms of being able to engage with them and trust them but it was going to take a fair amount of time for me to be able to, to be able to trust somebody because of my own personality and how I am about my relationships, the relationships I have with people when I begin to trust them and begin to talk about myself and what have you." (Participant 5, 38-year-old man)

Participant 5 above clearly stated how trust in both the therapist and therapy was of importance in building the relationship and developing engagement in the therapeutic process.

It is interesting to note how some participants did not necessarily perceive their work with their counsellor in terms of a personal relationship but as something different:

"Most ways what I benefited from was the fact that she was totally and utterly disconnected from my life or anything like how can I put it, she, it was just a total outsider….Think the success came from the fact that it was almost as if she was just a complete stranger but was prepared to commit and devote this time to me and, and give me some feedback on my life which I then went away to work on myself…. Wasn't building a relationship with a person I was building a relationship with a therapist but not necessarily the person sitting there, if you see the difference." (Participant 1, 32-year-old man)

Although the client-therapist dynamic is defined as a relationship, it is very different to a non-therapeutic relationship as it is almost entirely one-sided whereas in a relationship outside of therapy there is typically mutual exchange. It might be that

for some clients they were looking for a relational distance between them and their therapist, where as others were looking for closeness:

"That she represented by the gender, by her age by everything was that she was that she was like no part of me at all. It was like what we had in common was the fact that we had nothing in common. And that worked because what I needed was distance. That's what I needed and need someone disconnected from my life." (Participant 5, 38-year-old man)

It is important to note that within this process of finding a therapist, there was the assumption that the client was entering into therapy with an ability to process all these characteristics and pieces of information; however for some clients they were attending therapy in crisis, perhaps in an agitated or depressed state and they were simply looking to get help/relief and offload. However, it seemed that core conditions (Rogers 1951) needed to be established in the relationship even if the distressed client did not overtly consider them.

"At that point I was so depressed I couldn't actually have coped with eh the whole concept of having to try to consider that they had a life outside therapy. For me I needed to go to the therapy having a listening ear and leave again and um not have to think about it or analyse it any further than that, it had to be about my needs from the therapy." (Participant 10, 35-year-old woman)

"I know it sounds awful but I really didn't think about her as, I just felt like it was, it was a service in a way, I know that sounds a bit wrong but I didn't, I think I would have, well I know certainly at the beginning of my sessions I would have offloaded to anyone, because I had suddenly realised all of this stuff and I knew that I had to talk about it." (Participant 8, 27-year-old woman)

For these sorts of clients above, it seemed that to an extent they would have simply decided to work with the first person that they had met and then have made a judgement about that person and the quality of their relationship at a later stage in the work.

Person of the therapist

This element refers to the way that clients would have used their own observations as well as any disclosures that the therapist might have made to form a judgement about the type of person that the therapist seemed to be. Clients appeared to be gathering information in order to decide whether to have worked with this particular person. It seemed that they would have also have been attempting to discern if they fitted with their preconceived image of them.

Characteristics of the therapist

Although there is an on-going assessment of the quality of the relationship from the very start of the process, at the point at which the client and therapist met personally, it appeared that a clearer assessment of the relationship could have been ascertained and more information was revealed. This perhaps would have aided the client in deciding if they felt they could have worked with this person.

Once the client and therapist met, clients were then able to discover observable features of the therapist, such as their race and age and this could have allowed the client to make a further judgement about the therapist. Interactions between client and therapist seemed to have revealed discernible characteristics of the therapist, for instance, the language; tone of voice or speech patterns that the therapist used

might have given an inference about their intelligence, class or education. Clients seemed to have used this information to determine if they felt that they were able to relate to this person as the quote below demonstrated:

"She's very educated and so she kind of, she's very, like I think I needed someone quite bright because my brain is quite, I get really impatient basically and I process information quite quickly and I think and I'm sure psychotherapists are bright but it feels like it's nice to be with someone who's brighter than me. That's a really arrogant thing to say but I think that was quite important. I think that was quite important for me was I think probably the woman I met beforehand not just because she didn't have books on her shelves but I did feel that her questions were quite slow and I was a bit like come on zip, zip, zip you know and I think that like, look obviously completely prejudiced because she spoke slowly and had no books but it doesn't mean she's not clever." (Participant 2, 32-year-old woman)

It appeared that similarities in these factors between clients and therapists could have contributed to clients feeling that therapists had an innate awareness of the client's perspective. Client-therapist matching can refer to similarities between client and therapist along the characteristics listed above or that there is a "fitting together" of two people that allows them to feel that they can work together.

It did make me think about race as well to a degree because they're issues that I have and maybe not even just talk to somebody who was black but to talk to somebody who was because I'm from a I'm a half Afro-Caribbean and half Indian that it might be interesting to talk to somebody who, who had had that experience and who maybe didn't fit into society quite as easily as somebody who was white and middle class, so those things did kind of come up in my mind." (Participant 5, 38-year-old man)

Participant 5 above illustrated how client might have felt closer to their therapist through feeling that they match with them.

During the first session, clients seemed to be intensively assessing the possibility of a match in order to determine whether the therapist was able to relate to them.

"I think the Jewish thing was less important, it was more that she was middle class and came from North London and just kind of understood the world that I live in and that I wasn't going to sit there feeling kind of prejudiced based on my upbringing and my class and my you know the world that I live in." (Participant 2, 32-year-old woman)

Participant 2 above highlighted how clients were looking to see if the therapist was able to understand their worldview and not seem to have judged them.

Other clients felt that the sessions would have been more productive if the therapist had suggested that they have a personal insight and shared experience of the client's world. This seemed to make the client feel that they would not have to overly explain themselves.

"He used to say like that he had a bit of Jewish background in him and he could relate to that kind of Jewishness because obviously being Jewish and being part of a Jewish community has impacted on me in a really significant way and that, even for example when I'd go and say to him it's very important for me to meet somebody Jewish, it was important to me that he understood that or for example if I talk about being part of a community and it was important to me that he understood the kind of nuances of that, like I don't know if that's the right word but, but like if, yes like I do think that there's, in every community I think this is the case but there are certain kind of specific cultural kind of things that are associated with different community groups and I wanted somebody who would just, like intrinsically understand the kind of specifics of the Jewish community without me needing to explain in

great detail what it was about Jews that, you know, or that kind of stuff so that did make a difference." (Participant 6, 31-year-old woman)

Clients might have been more or less attracted to working with a particular therapist because something about their demeanour/age/sex/ethnicity reminded them of a particular person in their life. This enactment could have either helped to build the relationship between therapist and client and increased feelings of safety and trust or it could have caused a rupture in the relationship as something unconscious was acted out in the therapy room. Clients might have been consciously aware of this enactment or they might have simply felt its effect as the quote below illustrated:

"I don't know I just didn't like her. You know it sounds ridiculous she wasn't maternal enough, I'm sure that speaks volumes but I think now looking back on it and knowing what I speak about I think I was kind of looking for someone who's a bit of a kind of mother who I kind of trusted. This woman was a bit young the first one I met and I suppose I just have it in my head that I wanted to see a wise old woman you know because a lot of what I wanted to talk to her about was about um things that I didn't understand about women having grown up children and my ex's relationship with his mother, my relationship with my mother and I suppose I just felt like I wanted, I wanted to be with someone who could talk to me and understand my perspective and also a mother's perspective and um mine had children. She obviously won't tell me about but I know she does, and I can tell you that without her confirming it but she did…" (Participant 2, 32-year-old woman)

Preconceived image versus reality

Clients seemed to be engaged in a process of measuring up the therapist against their idea of what a therapist "should" have been i.e. a particular age, sex, class or

106

socially/culturally constructed ideal and this seemed to have either a positive or negative impact as these two quotes illustrated:

"She kind of lived in North London and she had a couch in the room and was kind of the lady you might see walking on Hampstead Heath that kind of what I imagined a therapist to be. It was kind of Truly, Madly, Deeply, a scene in that of the therapist Matt which was kind of was a bit, I remember the first time I kind of left thinking I can't believe I've been, you know I'm sort of doing this kind of bit strange, to me, I kind of never thought I'd be the sort of person to go and see a therapist I suppose is what I'm saying. What else can I say about it? Eh but I felt really comfortable going to see her, I felt quite sort of safe talking to her and I actually quite enjoyed, I felt quite, yeah I enjoyed talking to her basically." (Participant 7 35-year-old woman)

"Well she made, it's not even that she stigmatised me, she made the experience feel quite stigmatised like the idea that you have, the negative ideas you'd have about therapy in your mind she kind of fitted in quite well with those stereotypes, like go into a room, slightly eccentric woman, lie on the couch, what's the first word you can think of, that kind of stuff is just a little bit too, just a little bit too well, like fits in too much with the stigma of therapy." (Participant 6, 31-year-old woman)

Equally, participants have suggested the extent to which the therapist did not fit in with these preconceived ideas could have been a positive influence. As participant 1 below suggested even if the therapist did not fit into this preconceived image, they might have chosen to work with them.

"…. He was quite a bit older and even though I have this image of the person that I was gonna go and meet and that they would be a youngish uh guy and I kind of at the time thought that that was sort of person could understand me and what I'd been going through

or what, you know, and help me out of that, he just, he didn't seem to fit this image that I had in my head." (Participant 1, 32-year-old man)

Participants have emphasised the value of particular inter-personal qualities, which are consistent with Rogers' (1951) Core Conditions of empathy, unconditional positive regard, and congruence, which seemed to have provided a means of helping them decide who to work with:

"…He had the air of a doddery old man so he's not the kind of person that I would initially, I don't know what kind of therapist I would dream of having, but it wouldn't have necessarily pictured this kind of slightly doddery guy, but yeah he was definitely very warm and approachable and yes, just a sort of down to earth guy and I didn't feel peculiar in his presence, as in, yeah it just all felt a lot more of a normal experience." (Participant 3, 30-year-old woman)

"There was just something very very calming and reassuring and comforting about being able to talk things through and somebody just being quite reassuring. It wasn't, he never really said anything particularly, he'd often just said that's completely normal..." (Participant 6, 31-year-old woman)

Stage 3: The course of therapy

Figure 4 below illustrates the processes that went on over the course of the therapy. Clients made an on-going assessment of the quality of the relationship between them and the therapist as well as an assessment of the perceived benefits of the work.

Figure 4. Stage 3: Course of therapy
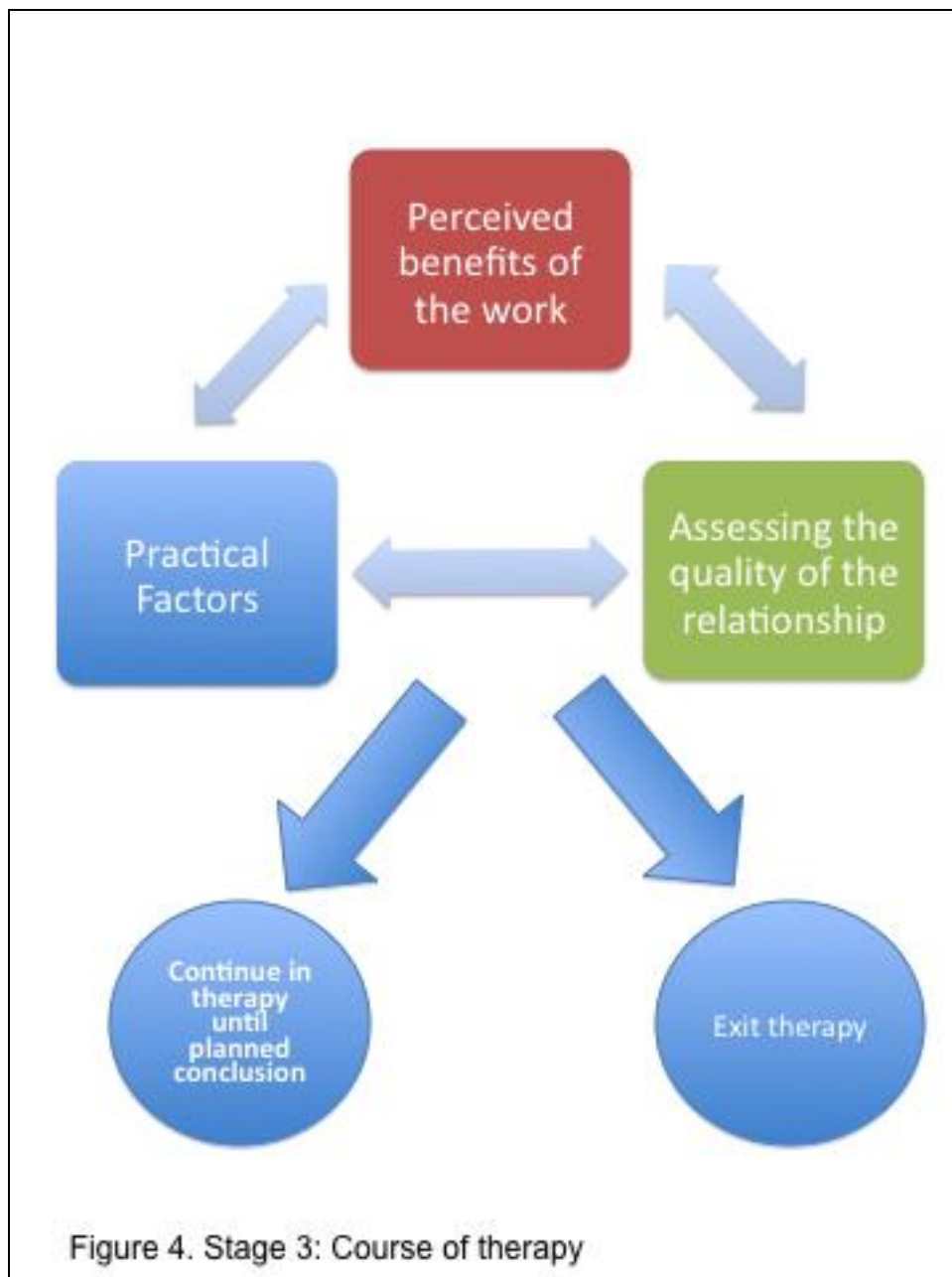
The working alliance between therapist and client would be constantly renegotiated as the work progressed. They would have also been influenced by the practical factors outlined earlier, i.e. cost and location. It seemed there was a constant trade off between the gains made in therapy verses the practical issues relating to the work i.e. the cost and convenience of the therapy versus the quality of the relationship.

Practical factors

Should therapy have become too expensive for clients to afford or the location was no longer convenient or the timing of therapist sessions became too difficult to attend, then it appeared that it became more likely that clients would exit therapy. This may or may not have had anything to do with changes put in place by the therapist and could have equally been due to changes in the client's circumstances such as a change in job or contract.

> "…Also actually he was moving to South London because I thought I can't get here every week you know it was going to take me probably an hour and a half or two hours to get home afterwards and I just thought that I don't need it anymore in that way and it had to end and so yeah that's it really." (Participant 8, 27-year-old woman)

> "I ended my therapy largely out of financial reasons. I had been seeing her weekly for 17 months and we had covered a huge amount of ground. Essentially I had no work and was running out of money and it was something I deemed 'not critical' in my life. We had also come to a point where the main issue was more reconciled than it ever had been. If money was no object, I'd still be seeing her now - and am considering going back if the context of my life demands it." (Participant 7 35-year-old woman)

110

This quote by participant 7 seems to give an indication of how a client managed the trade-off between gains and cost.

Assessing the quality of the relationship

Clients appeared to making a constant assessment of the quality of the therapeutic relationship throughout the work together. Within this decision making process there seemed to be a number of unconscious processes going on. Repetitions of past events that were buried in the subconscious could have been re-enacted in both the choice of therapist and throughout the work. Often these unconscious processes seemed to have played out in the relationship between therapist and client. How much clients were able to tolerate and work through theses unconscious processes would have had a bearing on their on-going assessment of the relationship.

As the quotes below suggested it seems that the unconscious process going on in therapy could have offered reassurance to the client that they were being understood and enabled the working through of issues in the therapeutic work.

"…It added something for me um the age of the woman well you know what one of the things that we went on to deal with was my sexuality and bringing back to family and I guess in some way the fact that here was a woman who was similar in age or certainly what, life status here was a woman that was kind of like my mum telling me it will be OK when you tell your parents like that's that then works for me because again if we go back to this model that I said of what the ideal therapist would have been would have necessarily have believed them in the same way if they were a 35 year old single attractive man gay or straight. They could have said to me eh yes it will be fine when you tell you're mum and your dad don't worry, and I could have gone away either consciously or subconsciously said to myself well

how do you actually know that, you aren't mum or my dad whereas this woman was more like my mother and I guess that made me more ready to accept what she had to say, so that was a good thing." (Participant 1, 32-year-old man)

"I felt so comfortable talking to her about it, I felt that she really understood and had a real insight into what I was going through because the questions that she was asking me and the way she was experiencing our conversations and to me although it was a professional relationship it kind of made me feel that she knew more about the area. I mean maybe that's me thinking I'd like her to think like me…" (Participant 7 35-year-old woman)

Perceived benefits of the work

At various points during the work, clients looked as if they were determining whether their wants and needs were being fulfilled by the work. Clients would have been considering how deeply and effectively the therapy was progressing. They seemed to be looking to see if they were getting anywhere and if they felt better. They also appeared to be evaluating the work to see if they were getting value for money. It seemed that a trade-off was made between these factors as participant 8's evaluation below showed:

"I have that previous week perhaps to think this is not satisfying, let see how this session goes. At the end of the session I'm given that option, do you want to make an appointment for next week. I sit and think either yes or I'll go on like this for ever, it's pointless… it then becomes a chore to have to do it so I think if I'm not getting anywhere I don't want to have to make this time and make this journey and pay this money for no reason, I evaluate it in that respect and say I think I've got as far as I can go with this person." (Participant 8, 27-year-old woman)

"I think I discussed it with the therapist that I felt like I was lacking, as the process went on there was less and less to talk about each week. I suppose I got to a place where I was more contented and happy and I sort of resolved some the initial things that I'd been to see her about. Um but I did kind of remember thinking ok I don't really know, I don't really feel I have much more to talk to this woman about at this point. So I suppose that I had perhaps learnt how to cope with certain things myself and didn't need the sort of sounding board as much." (Participant 10, 35-year-old woman)

Both of these clients above, had reached the same point in their evaluation of the pay off between these factors, one positively and the other negatively which seems to validate the idea that there are different exit points to this model.

Should clients have felt that they were not getting what they wanted from therapy, then it appeared likely that they would have chosen to leave therapy, otherwise they would have continued in therapy until an agreed and arranged conclusion. The quote below illustrated the trading off of factors that went on when clients decided to leave therapy. The participants talked of the work having reached its conclusion as they felt they had less to address on a weekly basis and felt better from having worked through their issues.

"I mean I knew I was ready to end when I stopped thinking about my therapy, whereas I used to use therapy sessions throughout that week or for the month and think about what happened, what I'd said and something she told me to focus on or a new strategy she taught me and that was kind of helpful to get through and the last kind of few months of going I wasn't doing that all and I wasn't really sure what I was going for and I didn't have a specific thing in mind to talk about whereas before I'd always had a specific thing in mind to talk about whereas before I'd always have, things would build up throughout the weeks and I want to then talk about and that had kind of finished and wasn't really doing that anymore

113

and you know I felt better and more confident at work and things were just generally better

so it was kind of feeling that things had come to an end." (Participant 8, 27-year-old woman)

As one can see, each stage of the process of finding and working with a therapist has a number of influencing factors that impact upon the decision-making process. At both the beginning stages and over the course of therapy there is seems to be an on-going assessment of the quality and effectiveness of the client/ therapist relationship to determine whether or not to maintain this working relationship.

CHAPTER FIVE: DISCUSSION

This study set out to answer two research questions; the first concerned how a client would go about choosing their therapist and the second considered what effect that choice would have on whether or not to stay in therapy. In this section I shall firstly consider each of these questions in relation to the findings and the areas outlined in the literature review. I will then move on to consider what the limitations of this study are. I will also consider the difficulties that I encountered in conducting this research and reflect on the impact of the research process. In the final parts of this discussion, I shall propose some areas for further research as well as any possible implications this study might have for theory or therapeutic practice and bring together some conclusions.

How do clients choose their therapist?

The data from this research has generated a model that illuminates the processes a client goes through in choosing their therapist and the factors that influence their decisions.

This study has helped to offer a deeper understanding of client experience of therapy and one of the most interesting findings is the link between the factors considered by clients when choosing a therapist and the relational process that underlies the consideration of these factors. At every stage in the model, the client seems to be making a judgement about the developing relationship with their therapist. It appears that the client is asking themselves a series of questions around this relationship. Can I feel safe with this person? Will they be able to understand me? Will I feel judged when revealing information to this person?

These questions seem to underlie the client's attempts to determine whether they feel they can form a working relationship with this person so that they can get help and feel better. This is the relationship described by Rogers (1967) in which the therapist aims to be respectful, empathic and genuine in order to create an 'I-You' healing relationship. It describes a therapeutic style of relating most similar to those ordinary relationships which people have experienced as 'healing' in their daily lives.

When clients set out to choose a therapist, this study has revealed that there is a large amount of confusion about where to go for information about therapy and how one would go about looking for a therapist. The introduction of this study presented the wide variety of organisations that are available to the public to gather information but very few of the participants interviewed reported having utilised any of them, despite a number of them having expressed a desire to be given more information. Considering that the participants where relatively well educated and seemingly motivated to find a therapist, the fact that they did not contact any of these organisations is even more surprising. This point also makes one question how less educated and less motivated clients are able to access and understand therapy. This issue also highlights the responsibilities that these organisations have in marketing themselves to the public in a more useful way that offers clarity and easy access to information.

The findings have suggested that clients seem to value the recommendations of others as the best way for them to find help. Some of the participants, however, had negative experiences due to recommendations that were not well considered or appropriate, signifying that perhaps the recommendations of others needs to be

fortified with the provision of information or it could indicate something more fundamental about what makes a client feel happy or okay with their therapist. They may value the recommendations of friends or family because they think they will understand their relational needs, but what makes a good relational "match/fit" is perhaps not something that a friend or relation can judge, since their needs may differ from the clients. So what one person found useful, helpful or allowed them to feel good about a therapist may not be the same for another. This highlights the individual and specific needs that a client desires in the therapeutic relationship, which a well-attuned therapist would need to address.

This research supports ideas around informed consent and what information needs to be provided to clients for them to make an informed decision. Participants highlighted their desire to be given both practical procedural information about "rules and regulations" of therapy as well as being informed about how the process of therapy would work and what they could expect. Participants suggested that by being better informed about therapy it would be a way to help them to feel both safe and understood. Opening up the process of therapy and demystifying what goes on in the therapy room might help clients to feel more contained and engaged by their therapy and may reduce the chances of clients dropping out. However, there is the possibility that offering clients more information might establish the work with a particular framework and could produce unrealistic expectations of the work and how it will develop.

What effect does the choice of therapist have over whether or not to stay in therapy?

The model produced by this project's findings has also emphasized how, when deciding whether to continue in or exit therapy, clients make an on-going assessment of their therapist and therapy. There is the constant "trade off" between factors that the client makes throughout their therapy. During the work, the client is balancing the gains made in therapy against the cost and convenience of the therapy whilst also assessing the quality of the relationship. This ultimately has an impact on whether or not they stay in therapy. Participants who reported having negative relationships with their therapist tended to terminate their work earlier than those who reported positive relationships. Equally, those who felt they were not getting what they hoped for from the experience also tended to drop out early. However, some who reported having negative feelings towards their therapist still maintained their therapy, as they seemed to think that it was part of the process or something to work through. Additionally, some who felt they were not getting all they wanted from the work also persevered with their therapy perhaps again seeing this as part of the process or in the hope that things might change. This suggests that there is perhaps a tolerance threshold for clients; when their discomfort or lack of achievement reaches a certain point, they are no longer willing to continue with therapy. It would seem that this threshold would vary from client to client.

Informed choice and information

This research has upheld the view of Van Audenhove and Vertommen (2000) that clients seem to be under-informed about therapy and the process of therapy. As Jones (2009) proposed, there is a need for clear communication to build awareness

of what therapists do and more practitioners who are willing to communicate this. The research findings have highlighted that this communication does not occur as often as it should. The outcomes of this study support Morrison's (1979) argument for a fully consumer oriented approach to mental health services and seem to suggest that this has still not been fully realised. Morrison's (1979) recommendations that all clients be given printed, easy-to-read information about the process, goals and techniques of therapy is still not being acted upon, over 30 years after the paper was published.

Participants in this study have lent support to the argument by Munro (2009) that a confusing number of professional bodies come up when you Google the word "therapist" and that it is difficult to know where the best place is to look for information. This research has supported the idea that the public is still under informed about mental health issues and therapy. It has highlighted the importance of campaigns such as "Time to Change," which, it is hoped, will increase public awareness of mental health problems and help to inform the public of organisations that they could contact for help and information. This study has also reiterated the importance of continuing investment in the IAPT programme. In February 2011, the government published its strategy for mental health services for the next four years (HM Government, 2011). Part of this strategy is the complete roll out of the IAPT programme and this is backed by an investment of around £400 million over the next four years. However, as stated in the introduction to this project, the IAPT programme only offers treatment to people with anxiety and depression with CBT which unfortunately means that there are people who do not receive treatment as they do not fit in within IAPT narrow remit.

Within this issue is the question of government policy and statutory regulation of psychologists. Changes in the law with regard to statutory regulation may help to regulate certain parts of the psychological and therapeutic community and hopefully protect the public from unscrupulous practitioners whilst helping to standardise levels of qualification. However, it remains to be seen what impact this will have, particularly with the on-going debate around regulating psychotherapists and counsellors. It might be the case that people will set themselves up under different unregulated titles and continue as before.

The majority of the research on informed consent has focused on providing clients with procedural information (see Beeman & Scott, 1991; Everstine et al, 1980; Handelsman & Galvin, 1988; Hare-Mustin et al 1979) rather than looking at whether it is appropriate to provide some personal information about the therapist or information about outcomes and effectiveness. Forsythe and Confino (2008) suggested in their research that contractual agreements between clients and therapists tended to focus on practicalities. They suggested that what would happen in the sessions was not explained to clients and if they had questions such as "When will I feel better?" they did not ask them which also seemed to be the case for participants in this study. The latest NICE guideline for treatment of depression (NICE, 2009) proposes that one should *"discuss with the person the uncertainty of the effectiveness of counselling and psychodynamic psychotherapy in treating depression" (p251),* which suggests that it is important to discuss the issue of outcomes and effectiveness with clients even if they do not consider this question themselves so that they are better equipped to make an informed choice. Participants certainly expressed a desire to know more about their treatment and with clients tending to fund treatment themselves, an idea of length of treatment

would certainly be appealing. However, it is often quite difficult to give definitive answers to these sorts of questions, so perhaps incorporating regular reviews is one way to aid clients in knowing how they are progressing and how much longer they might be in therapy. One must also consider what the effect might be on a client who comes along in distress and being relatively vulnerable if a therapist were to create uncertainly for them when having hope may well be the critical intervention. Informing a client about the "uncertainty of the effectiveness of counselling and psychodynamic psychotherapy" may ultimately cause more harm than good. The findings of this study do seem to suggest that new clients want to know more about the work they are about to embark upon but perhaps what is told to them need to balanced against what they might be ready/and or able to hear at the outset of the therapeutic relationship.

This research supports ideas suggested by Bowman & Fine (2000) that clients welcome the chance to make meaningful choices and decisions in their therapy. Participants reported that they would have liked to have more information and be able to make better-informed decisions about who to work with. Manthei (1988) argued that although the majority of research on the positive effects of choice on outcomes has inconsistent results, none of this research has reported that having choice actually harms clients. This would suggest there is still a strong justification for allowing clients to choose. It seems from the results of the study that the possibility of choice aided the participants in increasing their engagement with their therapy. However as Arbuckle (1977) suggested, clients do not always do what is best for them; client's might match themselves with a therapist who meets a particular need rather than someone who might help with their issues. Zuroff et al (2007) argued that a strong predictor of positive outcomes from therapy is the

clients' level of intrinsic or autonomous motivation for therapy. Zuroff et al (2007) describe this as the extent to which clients experience themselves as having freely chosen to enter therapy and to which the choice is felt to come from them. It is difficult to gauge the exact effect of this motivation from the results as all the participants had chosen to enter into therapy themselves rather than being referred.

Setting

The setting of the therapy has been shown in this study to have a significant impact on the client. This research holds up ideas around clients being keen observers of their counsellors and their surroundings (Jinks, 1999; Yardley, 1990) and how this extends to their first impressions of their therapist. As Manthei (2006) suggested, clients can be strongly affected by their first impressions of the physical layout of the therapy room. This has been firmly upheld in the research as participants have reported how the setting impacted on their desire to work with someone and how well they felt they might relate to this person.

Relationship/ therapeutic alliance

This study supports Forsythe and Confino's (2008) ideas that positive experiences of therapy tend to be linked to a good relationship with the therapist. This is despite the possibility that the process was not what the client had preconceived or wanted and whether the therapy had ultimately led to a good outcome. This research upheld the idea that unresponsive therapists, approaches that didn't fit with clients' expectations, lack of direction and structure, and "emotional pain with no gain" were all linked to negative experiences of therapy.

One of the main complaints from respondents to Forsythe and Confino's (2008) study and also in this research was about the cold unresponsive therapist – the blank screen stereotype of the psychoanalytic approach. Forsythe and Confino (2008) argued that no therapeutic method is helpful if the therapist does not take into account the needs of each client who comes to them and suggested that clients often have aims for their therapy but do not know how that relates to a particular therapy modality. This issue was also highlighted by participants who suggested that they would have liked certain things to have occurred in their therapy but were unsure if it was appropriate to request them. As Frank (1973, 1982) argued, clients are unlikely to remain in therapy or to benefit from treatment unless their expectations are consistent with what actually transpires in the process of therapy. This study emphasises the need for therapists to directly explore with clients what their expectations and aims are for therapy and to review this at points along the course of therapy.

Luborsky's (1984) definition of the therapeutic alliance as *"the degree to which the patient experiences the relationship with the therapist as helpful in achieving his or her goals"* can be linked to the findings in this study about why clients decide to leave therapy. The findings showed that clients would exit therapy if they felt they had achieved what they wanted or felt the work would not progress any further. The findings also support Luborsky's idea that it is the relationship that aids clients in achieving their goals. The results of the study also support Bordin's (1979) ideas around the quality of the bond between therapist and client being important i.e. client feeling understood and respected and it seems that a client's choice of therapist offers support to that view. Clarkson (1995) definition of the therapeutic alliance as a contract or agreement between the psychotherapist and the client is

supported by the findings in that, if the contractual agreement is not carried out, then it is unlikely that the client will remain in therapy as their perceived benefits of the work do not seem to be met.

Matching

The literature on client preferences for counsellor characteristics has suggested that not every client-counsellor match is immediately congenial, comfortable and/or successful which the results of this study have also highlighted. Vera et al (1999) suggested that good therapist-client match-ups tend to be those that in some way meet the client's needs or demonstrate a similarity to them, which the findings certainly uphold. Conversely, Safran et al (1990) argued that an incompatibility between the client's worldview and the treatment rationale is likely to result in a rupture in the therapeutic process which could also be seen in some of the choices of participants not to work with a certain therapist.

The findings of this research do offer some support to Swift, Callahan and Vollmer (2011) assertions that client preference has an influence on dropout rates. It seems that for those participants that were able to choose a therapist that matched with some or all of their preferences it was more likely they would remain in therapy to an agreed conclusion.

As Asay and Lambert (1999) argued it is how clients experience the characteristics offered by therapists that are more important than what those therapists are 'objectively' offering. The findings show that the factors that clients consider to be important say much more about their characteristics, such as their needs and

expectations as well as cultural or gender attributes than they do about what the therapist actually offers.

This study supports the idea that an acknowledgement of cultural factors during the counselling process enhances counsellor credibility, client satisfaction, the depth of client disclosure, and clients' willingness to return for follow-up sessions (Sue & Sundberg, 1996). Participants expressed how they felt better understood and reassured by knowing that their therapist had an understanding of their cultural background. The results show religion and the understanding of how religion impacts on the client is an important part of the therapeutic process for some clients. The study reinforces Hawkins and Bullock's (1995) idea that religious issues may need to be addressed in the therapeutic process and that by ignoring them it does the client an injustice particularly if these issues are important to the client. This idea links with Norcross and Wampold's (2011) suggestions that in order to enhance the treatment effectiveness of therapy it is important for the therapist to tailor the work to the individual and their specific situation.

Maintaining/ exiting therapy

The process involved in clients deciding to stay in therapy or not can be understood in terms of social exchange theory (Homans, 1961). As the theory proposes, social behaviour is the result of an exchange process. The purpose of this exchange is to maximize benefits and minimize costs. Participants can be seen to be weighing up the potential benefits and risks of relationships and when the risks outweigh the rewards, participants will terminate or abandon that relationship, which the results of this study demonstrate. This study shows some support to research around why clients terminate their therapy early (Acosta, 1980; Cross & Warren, 1984; Hynan,

1990). The results showed that clients often cited dissatisfaction with the services they received or with the therapist as significant reasons for ending therapy. If one relates these results to the ideas around social exchange theory, then one can see that the client is assessing the pay off between the gains they are receiving against the quality of the relationship. As Taube, Burns and Kessler (1984) suggested, the length of time that a client stays in therapy should not be used as a determinate for the success of the work. It might be that a client has got what they need from the work and through a trade-off between factors has determined that it would be best to end therapy at that point. Safran and Muran's (2006) ideas around the working alliance as an on-going negotiation throughout the therapeutic process seems to fit with participants expressed ideas around dropping out of therapy. The participants proposed that there was a fulfilment of their needs and the tasks and goals of therapy had been fulfilled.

Difficulties/limitations of this study

Participants in this study varied a great deal in the extent to which they could describe the influences on their choice of therapist. It seems that some participants were less able to access the rationale for why they make their choices or were simply unaware of why a particular therapist appealed more than another. In some cases, it seemed they were unable to articulate why they had chosen a particular person and reported that it simply felt "right" or "comfortable." The phenomenon of transference and counter-transference is the idea of repetition of past relationships, patterns of relating and conflicts with significant others, such that feelings, attitudes and behaviours, belonging rightfully in those earlier relationships are unconsciously displaced onto the therapist (Hayes & Gelso, 1991, Gelso & Carter, 1994,

Rosenberger & Hayes, 2002) either positively or negatively. For the participants there was difficultly in teasing out the unconscious processes that were going on when they made their decisions to work with someone and over the course of the therapy. It was also challenging for me to help the participants to identify these processes whilst interviewing them as the very nature of the interviews meant that participants were gaining access to their conscious decision making processes rather than out of awareness processes. The participants seemed to be unaware of enactments in the therapy room, which would be understandable given that they are not psychologically trained. This also might have been due to the therapist not highlighting these processes as they went on or unwillingness by the client to acknowledge them, perhaps due to embarrassment or shame. This might be due to a lack of understanding of unconscious process by clients or it not being framed in such terms by therapists.

One could argue that choice might increase the amount of enactments that go on in the therapy room as clients may choose a therapist who resemble figures in life, particularly parents. As Eric Berne (1972), suggested, people with failure scripts would choose the worst possible therapists since their scripts prohibit them being helped. There does not appear however, to be much evidence that this is the case. Well-trained and aware therapists would not be so easily seduced by their clients and avoid dealing with this issue. Again the issue here might not be a lack of attention by therapists in dealing with this issue but it not being framed for clients in these terms, thus making it difficult for them to report back addressing these issues.

The criteria for selecting participants was that they had chosen their therapist themselves, had accessed therapy privately and had chosen to undertake a course

of therapy themselves rather than being referred by an outside person or organisation in order to be assured that the participant had a choice when deciding who to work with. Some participants reported they felt that they had no choice of whom to see and simply decided to work with the first person they saw. One could therefore suggest that there is a difference for the participants between actual choice and perceived choice. If the participant perceived that they had no choice in deciding with whom to work, then this would negate the effect of the choice element of this study. However, the fact that this issue has been highlighted by this study suggests that increasing the awareness of clients that they have a choice in whom to work with is an important finding. Offering clients more information and encouraging them to shop around and experience other therapists could facilitate this. This issue also offers ideas for future research to give greater insight into the choosing process.

Grounded theory principles emphasize that it is important to gather data from a diverse sample in order to fully explore and discover core dimensions of everything that is involved in the issue that is being studied (Schatzman, 1991). Although a sample size of 10 clients was sufficient for saturation of the data, having a more diverse group of participants might have strengthened the study. Perhaps if I had a larger and more diverse sample in terms of age and class, then it might have been possible to produce a more nuanced final model, however without sampling more widely, it is unknown if this would have been the case.

The question of whether having more choice has a positive effect on outcomes has not been answered by this study. It would be very difficult to ascertain utilising this research design. As mentioned previously, Swift, Callahan and Vollmer (2011)

meta-analysis found that listening to clients' preferences can have a positive impact on dropout rates and treatment outcomes. However, as Swift, Callahan and Vollmer (2011) pointed out, the number of published studies in this area is relatively small. Nevertheless, as stated earlier, there doesn't appear to be a negative impact from being given choice, which suggests that offering choice could be of use in the therapeutic process and would certainly not hinder clients.

Reflections on the research process

As a psychotherapist, researcher and ex-client, I have been straddling the position of both an insider and outsider throughout this study. Despite attempting to approach this research objectively with no presumed hypotheses, my own experiences have had an influence on my expectations and approach to the research. As the constructivist paradigm of this research suggests, reality is subjective and influenced by the context of the situation, namely the individual's experience and perceptions, the social environment, and the interaction between the individual and the researcher. My choice of questions and focus will undoubtedly have had an impact on the responses I received. By asking open-ended questions and allowing the participant to lead the discussions it is hoped that my impact would have been reduced.

As a researcher utilising grounded theory as my research paradigm, I saw my participants as experts in describing their experiences as clients. However my understanding of the process of therapy allows me to understand the behaviour of therapists and make a different interpretation of it. For example, participants might have interpreted behaviours such as therapists not saying hello as rude. My

position as a humanistic, integrative practitioner means that I may offer more of myself in the therapy room than a psychodynamic therapist. This may have had an impact on how I judged my participants interactions with their therapist.

It is interesting to reflect on the potential impact on participants of knowing that as well as being their interviewer, I am also a psychotherapist. It is possible that they may have altered their responses to me.

In regard to my own expectations, I perhaps thought that clients would have made greater efforts in being informed about their therapist and therapy prior to embarking into therapy. I hoped that clients would be more interested in finding out how the process of therapy works and what to expect. Perhaps coming from a more informed position raised my expectations that others would want the same or my professional pride expected that clients would have more interest. Equally, my experience as a client and searching for a therapist myself, (as outlined in the introduction) perhaps led me to expect that clients would also desire to have a therapist who it seemed had some insider knowledge about their background and/or presenting problem, which was not the case for some of my participants.

Suggestions for further research

In order to develop a deeper understanding of the choice process, a future study might examine clients who are given a choice of a number of distinctly different types of therapist and therapy and seeing how and why they chose one over the other. One could also consider interviewing the therapist as well as their clients in order to see why they believe that they were or were not chosen.

In light of some participants' inability to perceive or acknowledge unconscious processes, a future study might consider interviewing the therapist of the clients in order to uncover the potentially unconscious choices of clients. Perhaps this would shed light on possible enactments that went on during the therapy or offer insights into over-identification with the therapist by the client. This also might offer insight into what information needs to be given to clients to highlight any of these issues.

It might also be interesting to conduct a future study that interviews clients at different stages in their therapy. Interviewing clients before they have decided to contact a therapist would give insights into their preconceived ideas of what therapy is about and what they expect from their therapist. By then interviewing the same client during their therapy, one could discover how much their views had changed or been lived up to as well as developing an understanding of how much impact the process of therapy has had. Interviewing clients post therapy could help to ascertain how effective their therapy had been and how far their views had shifted. Interviewing the therapist as well as the client in these scenarios could offer interesting and alternative viewpoints.

Implications for theory and practice

This study has offered insight into how clients view therapists and therapy. The findings have suggested that there is a desire from clients to be better informed about what they are doing and who they are working with. This suggests that therapists need to be more open about how they work and be more willing to demystify the therapeutic process. By offering more information about the rules of

therapy and what to expect prior to starting therapy, clients will be better informed and this could help to reduce misunderstandings, give them more realistic expectations and help to strengthen the therapeutic alliance whilst increasing the clients' sense of empowerment.

For providers of therapeutic services, this study offers some insights into future policies for pairing up clients and therapists. For some of the participants, feeling that they "matched" with their therapist was an important element of the choice process. For those who allocate clients to therapists, taking this into account may help to speed up the enabling of the therapeutic alliance. In the present economic climate, budgets are tight and the number of sessions offered to clients can be limited and so, if there is a possibility to increase the effectiveness of short-term therapy by a more active matching of therapist to client, then this could be an important idea.

If clients are to feel that they are in a position to exercise choice, then therapists need to be more willing to offer assessment sessions for free. Clients would welcome the opportunity to shop around but having to pay for a number of assessment sessions can be off-putting. A client knowing that they could visit a number of therapists without financial penalty would make seeing a therapist more appealing. This policy could in fact open up therapy to people who would have been put off by having to pay an initial fee particularly if they are simply trying to determine if therapy is right for them. In addition, as part of the pre-therapy information perhaps an invitation to the client to try out other therapists would be an important step forward. Ethically, it would seem this is an area in need of improvement as it is important to support clients so that they feel they have more

freedom to choose whichever therapist they prefer. However, financially it is perhaps not an approach that can be afforded by many therapists.

Impact of research on the researcher

One of the most important outcomes from this research has been how it has enabled me to reflect on my work as a therapist and has informed my practice. This research has increased my awareness of how much clients observe their therapist particularly during the initial stages of the work together. The impact that the setting has on the client has offered interesting ideas about how I might set up my therapy room so that they feel that it is an appropriate space for therapy where they may feel safe, understood and held.

This research has also emphasised the importance of regularly checking with clients that they are still engaged by the work and getting what they need from it. Lambert and Shimokawa (2011) found that collecting regular feedback utilising a feedback system can have positive effects. Hatfield, McCullough, Plucinski and Krieger (2010) found that therapist have limited ability to accurately detecting client deterioration or treatment failure and therefore employing regular client feedback can help to compensate for this lack of ability. Incorporating regular reviews throughout the therapeutic work is one way to ensure this.

The outcomes of this study have raised interesting ideas about informed consent. How much information should one provide for a client and what information should that be? How this information impacts on the establishment of a working alliance and the therapeutic process is certainly something to consider and as is often the case, will have to be addressed on a case-by-case basis. Being given more

information might help some clients as they might feel more held and contained by being offered some pointer about and parameters around the therapeutic process. This might increase engagement for some clients whilst for others it might block engagement. I will only be able to judge this by experimenting with offering information and discussing and working through any issues with clients.

This study's results have provided an ethical dilemma with regard to offering choice to future clients. Should clients be informed that they could also go to see someone else in order to decide if they might work better with them or should I assume that I can work with whoever comes through my door? The application of this question would have a potential impact on my future income. Out of respect for my clients however, should I suggest to them to seek out an alternative therapist before deciding who to work with? I believe that only through testing out these dilemmas in real situations with clients or through further research will I be able to make a more informed decision around these issues. This research has certainly encouraged me to consider how these interesting issues may impact on my practice.

Conclusion

The outcomes of this study have offered an explanation of how clients choose their therapist and how that might impact on maintaining therapy. This research has induced a number of further questions and this is an area of study that warrants further and more detailed examination. On a personal note, this study has enabled me to reflect on my own therapeutic practice and offered some interesting ideas to consider in my client work. As Cooper (2008) suggests

"At the heart of most successful therapies, is a client who is willing and able to become involved in making changes to her or his life. If that client then encounters a therapist who she or he trusts, likes and feels able to collaborate with, the client can make use of a wide range of techniques and practices to move closer towards her or his goals. For different clients, different kinds of therapist input may be more or less helpful; and there may be certain kinds of input that are particularly helpful for clients with specific psychological difficulties; but the evidence suggests that the key predictor of outcomes remains the extent to which the client is willing and able to make use of whatever the therapist provides"

Cooper (2008 p 157)

In other words, at the heart of every encounter is the relationship between therapist and client and this is the enabling tool for successful therapy. Therapists need to explore client expectations, preferences, goals, understanding of the process of therapy, offer reviews and openness to feedback and the therapists' flexibility in responding to these that will enable a client to select them and continue to work with them.

REFERENCES

Acosta, F. X. (1980). Self-described reasons for premature termination of psychotherapy by Mexican American, Black American, and Anglo-American patients. *Psychological Reports*, 47, 435-443.

Ambady, N., Bernieri, F. J., & Richeson, J. A. (2000). Toward a histology of social behaviour: Judgmental accuracy from thin slices of the behavioural stream. *Advances in Experimental Social Psychology*, 32, 201–271.

Ambady, N., & Rosenthal, R. (1992). Thin slices of expressive behaviour as pPredictors of interpersonal consequences: A meta-analysis. *Psychological Bulletin*, 111, 256–274

American Psychological Association policy statement on evidence-based practice in psychology August, 2005

Arbuckle, D.S (1977) Consumers make mistakes too: An invited response. *Personnel and Guidance Journal,* 56, 226 – 228.

Atkinson, D, R.; Furlong, M, J.; Poston, W. C, (1986) Afro-American Preferences for Counsellor Characteristics. *Journal of Counselling Psychology.* 33(3):326-330

Asay, T. P., & Lambert, M. J. (1999). The empirical case for the common factors in therapy: Quantitative findings. In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy* (33-56). Washington, DC: American Psychological Association

Bachelor, A. (1991) Comparison and relationship to outcome of diverse dimensions of the helping alliance as seen by client and therapist*. Psychotherapy: Theory, Research, Practice, Training.* 28(4), 534-549.

Baekeland, F., & Lundwall, L. (1975). Dropping out of treatment: A critical review. *Psychological Bulletin*, 82, 738-783.

Bakker, A. Spinhoven, P. van Balkom, A. Vleugel, L. and van Dyck, R (2000) Cognitive therapy by allocation versus cognitive therapy by preference in treatment of panic disorder, *Psychotherapy and Psychosomatics*, 69 (5): 240-43

Balmforth, J (2006) Clients' experience of how perceived differences in social class between counsellor and client affect the therapeutic relationship in G. Proctor, M. Cooper, P. Sanders and B. Malcolm (Eds) *Politicising the person- centred approach: an agenda doe social change*. Ross-on-Wye: PCCS Books

Barker, C., Pistrang, N., Elliot, R. (2002) *Research Methods in Clinical Psychology* (2nd Edition). Chichester: Wiley and Sons Ltd.

Beckham, E. E. (1992). Predicting patient dropout in psychotherapy. *Psychotherapy*, 29, 177-182.

Bednar, R. L., Melnick, J & Kaul, T. J. (1974) Risk, responsibility, and structure: A conceptual framework for initiating group counselling and psychotherapy. *Journal of Counselling Psychology*. 21(1):31-37

Beeman, D. G. & Scott, N. A. (1991). Therapists' attitudes toward psychotherapy informed consent with adolescents. *Professional Psychology: Research and Practice*, 22, 1-5.

Berry, D. S. (1990). Taking people at face value: Evidence for the kernel of truth hypothesis. *Social Cognition*, 8, 343–361.

Berne, E. (1972). *What Do You Say after You Say Hello?* New York: Grove Press.

Bergin, A. E. (1985). Proposed values for guiding and evaluating counselling and psychotherapy. *Counselling and Values*, 29, 99-116.

Berzins J.I. (1977) Therapist- Patient Matching in Gurman. A.S and Razin, A.M (1977) *Effective Psychotherapy: A Handbook of Research* (222 – 251) Exeter: Pergamon Press

Beutler, L. E (1986) Systematic eclectic psychotherapy. In J.C. Norcross (Ed) (1986) *Handbook of Eclectic Psychotherapy*, (94-131) New York: Brunner/Mazel

Beutler, L.E., Malik, M., Alimohamed, S., Harwoood, M.T., Talebi, H and Noble (2004). Therapist Variables in A.E Bergin and S.L. Garfield (Eds), *Handbook of psychotherapy and behaviour change.* Chicago: Wiley.

Biehal, G and Chakravarti, D (1986) Consumers' Use of memory and External Information in Choice: macro and Micro Perspectives *Journal of Consumer Research,* 12, 382-405.

Bleyen, K, Vertommen, H, & Van Audenhove, C (1998) 'A negotiation approach to systematic treatment selection: An evaluation of its impact on the initial phase of psychotherapy', *European Journal Of Psychological Assessment*, 14, 1, 14-25

Bordin, E.S. (1979). The generalisability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research and Practice,* 16**,** 252-260.

Bowers, B. (1990) Grounded theory in B. Sarter (Ed) *Paths to knowledge* New York: National League for Nursing Press.

Bowman, L. & Fine, M. (2000). Client perceptions of couples therapy: helpful and unhelpful aspects. *The American Journal of Family Therapy*, 28, 295–310.

BPS *Code of Ethics and Conduct* (2009). Leicester: The British Psychological Society

Braaten, E. B, Otto, S., Handelsman, M.M., (1993) What do people want to know about psychotherapy? *Psychotherapy: Theory, Research, Practice*, 30, 4

Browne S (2008) The therapy maze. *Therapy Today*, 19, 15

Calsyn, R.J. Winter, J.P and Morse G.A (2000) Do consumers who have a choice of treatment have better outcomes? *Community Mental Health Journal*, 36, 149 - 160

Care Services Improvement Partnership. (2005) *Our Choices in Mental Health*. CSIP, London

Charmaz, K. (2006). Grounded theory: Objectivist and constructivist methods. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (509–534). Thousand Oaks, CA: Sage.

Clarkson P (1995) *The Therapeutic Relationship: In Psychoanalysis, Counselling Psychology and Psychotherapy* London: Whurr

Cohn H.W (1997) *Existential thought and therapeutic practice* London: Sage

Coleman, H. L. K., Wampold, B. E., Casali, S. L. (1995). Ethnic minorities' ratings of ethnically similar and European American counsellors: A meta-Analysis, *Journal of Counselling Psychology,* 42, 55-64.

Cooper, M (2008*) Essential research findings in counselling and psychotherapy* London: Sage

Coyne, J.C and Widiger, T.A (1978) Towards a participatory model of psychotherapy. *Professional Psychology* 700-710

Crits-Christoph, P, Baranackie, K, Kurcias, J. S, and Beck, A. T; (1991) Meta-analysis of therapist effects in psychotherapy outcome studies. *Psychotherapy Research*. 1(2), 81-91

Cross, D. G., & Warren, C. E. (1984). Environmental factors associated with continuers and terminators in adult outpatient psychotherapy. *British Journal of Medical Psychology,* 57, 363-369.

Day-Vines, N. L; Wood, S. M; Grothaus, T; Craigen, L; Holman, A; Dotson-Blake, K; Douglass, M. J. (2007) Broaching the subjects of race, ethnicity, and culture during the counselling process. *Journal of Counselling & Development.* 85(4)

Department of Health (2007) *Trust, Assurance and Safety - The Regulation of Health Professionals in the 21st Century* Cm 7013 London: Stationery Office

Department of Health (2011) *No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of all ages* London: Stationery Office

Devine, D and Fernald P (1973) Outcome effects of receiving a preferred, randomly assigned or non- preferred therapy. *Journal of Consulting and Clinical Psychology*, 41, 104-107

DuBrin, J. R., & Zasrowny, T. R. (1988). Predicting early attrition from psychotherapy: An analysis of a large private practice cohort. *Psychotherapy: Research and Practice*, 25, 393-408.

Elkin, I, Falconnier, L, Martinovich, Z & Mahoney, C. (2006) Therapist effects in the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Psychotherapy Research.* 16(2), 144-160.

Erdur, O, Rude, S, Baron A, Draper M, Shankar L (2000) Working Alliance and Treatment Outcome in Ethnically Similar and Dissimilar Client–Therapist Pairings *The Research Consortium of Counselling & Psychological Services in Higher Education* 1, 1

Everstine, L., Everstine, D. S., Heymann, G. M. , True, R. H., Frey, D. H., Johnson, H. G. & Seiden, R. H. (1980). Privacy and confidentiality in psychotherapy. *American Psychologist*, 35, 828-840.

Flaskerud, J. H. (1986). The effects of culture-compatible intervention on the utilization of mental health services by minority clients. *Community Mental Health Journal,* 22, 127-141.

Flaskerud, J. H., & Hu, L. (1994). Participation in and outcome of treatment for major depression among low income Asian-Americans. *Psychiatry Research*, 53, 289- 300.

Forsythe, N & Confino, S (2008) *What clients really think of us: talking cures seen from the other chair BACP Conference held at Telford International Centre*, Telford

Frank, J. D. (1973). *Persuasion and healin*g Baltimore: Johns Hopkins University Press.

Frank, J. D. (1982). Therapeutic components shared by all psychotherapies. In J. H. Harvey and M. M. Parks (Eds.), *Psychotherapy research and behaviour change. The master lecture series.* Volume I (5-38). Washington, DC: American Psychological Association.

Fujino, D. C., Okazaki, S., & Young, K. (1994). Asian- American women in the mental health system: An examination of ethnic and gender match between therapist and client. *Journal of Community Psychology*, 22, 164-176.

Funder, D. C. (1987). Errors and mistakes: Evaluating the accuracy of social judgment. *Psychological Bulletin*, 101, 75–90.

Gamst, G., Dana, R. H., Der-Karabetian, A., & Kramer, T. (2000). Ethnic match and client ethnicity effects on global assessment and visitation. *Journal of Community Psychology,* 28, 547-564.

Gamst, G., Dana, R. H., Der-Karabetian, A., & Kramer, T. (2001). Asian American mental health clients: Effects of ethnic match and age on global assessment and visitation. *Journal of Mental Health Counselling*, 23, 57-71.

Gelso, C. J & Carter, J. A. (1994) Components of the psychotherapy relationship: Their interaction and unfolding during treatment. *Journal of Counselling Psychology*, 41(3) 296-306.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of ground theory: Strategies for qualitative research*. New York: Aldine.

Gordon, N. S. (2000). Researching psychotherapy, the importance of the client's view: A methodological challenge. *The Qualitative Report*, 4(3/4).

Guajardo, J. M. F and Anderson, T. (2007) An investigation of psychoeducational interventions about therapy. *Psychotherapy Research*. 17(1), 120-127.

Handelsman, M. M. (1990). Do written consent forms influence clients' first impressions of therapists? *Professional Psychology: Research and Practice*, 21, 451-454.

Handelsman, M. M. & Galvin, M. D. (1988). Facilitating informed consent for outpatient psychotherapy: A suggested written format. *Professional Psychology: Research and Practice*, 19, 223-225.

Handelsman, M. M., Kemper, M. B., Kesson-Craig, P., McLain, J., & Johnsrud, C. (1986). Use, content, and readability of written informed consent forms for treatment. *Professional Psychology: Research and Practice*, 17, 514-518.

Handelsman, M. M. & Martin, W. L., Jr. (1992). Effects of readability on the impact and recall of written informed consent material. *Professional Psychology: Research and Practice*, 23, 500-503.

Hare-Mustin, R. T, Marecek, J., Kaplan, A. G. & Liss- Levinson, N. (1979). Rights of clients, responsibilities of therapists. *American Psychologist*, 34, 3-16.

Hatfield, D, McCullough, L, Plucinski, A & Krieger, K (2010) Do we know when our clients get worse? An investigation of therapist's ability to detect negative client change. Clinical Psychology & Psychotherapy, 17 25-32

Hawkins, I.L. & Bullock, S.L (1995) Informed consent and religious values: a neglected area of diversity *Psychotherapy: Theory, Research and Practice* 32/ 2

Hayes, J. A., & Gelso, C. J. (1991). Effects of therapist-trainees' anxiety and empathy on countertransference behaviour. *Journal of Clinical Psychology*, *47*, 284– 290.

Heine, R. W & Trosman, H. (1960) Initial expectations of the doctor-patient interaction as a factor in continuance in psychotherapy. *Psychiatry: Journal for the Study of Interpersonal Processes*. 23, 275-278

Hill, C. E. (1975). Sex of client and sex and experience level of counsellor. *Journal of Counselling Psychology*, *22*, 6– 11.

Hill, C. E., Thompson, B. J., Cogar, M. C., & Denman III, D. W. (1993). Beneath the surface of long-term therapy: therapist and client report of their own and each other's covert processes. *Journal of Counselling Psychology*, 40, 278–287.

Hollander-Goldfein, B. (1979). *Client choice of therapist: The beginnings of the therapeutic relationship*. (Doctoral dissertation, Columbia University, 1979.) Dissertation Abstracts International, 40, 2368B.

Homans, G (1961) *Social Behaviour*. New York: Harcourt, Brace & World

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the working alliance inventory. *Journal of Counselling Psychology*, 36, 223-233.

Horvath, A. O., & Luborsky, L (1993). The role of the therapeutic alliance in psychotherapy. *Journal of Consulting and Clinical Psychology*, 61, 561-573

Horvath, A. O., Re, A.C., Fluckiger, C & Symonds, D (2011) Alliance in individual therapy. In Norcross, J.C. (Eds). *Psychotherapy Relationships that Work* (2nd Ed.). Oxford University Press.

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counselling Psychology*, 38, 139-149.

Howe, D. (1996) Client experiences of counselling and treatment interventions: A qualitative study of family views of family therapy. *British Journal of Guidance and Counselling*, 24, 367–375.

Hynan, D. J. (1990). Client reasons and experiences in treatment that influence termination of psychotherapy. *Journal of Clinical Psychology*, 46, 891-895.

Iacoviello, B.M, McCarthy, K.S, Barrett, M.S, Rynn, M, Gallop, R and Barber, J.P (2007) Treatment preferences affect the therapeutic alliance: implications for randomized control trials. *Journal of Consulting and Clinical Psychology*, 75 (1): 194-8

Johnson RB (1997) Examining the validity structure of qualitative research. *Education*, 118(2): 282 –292.

Jones, E. E. (1978). Effects of race on psychotherapy process and outcome: An exploratory investigation. *Psychotherapy: Theory, Research and Practice*, 15, 226-236.

Jones, E. E. (1982). Psychotherapists' impressions of treatment outcome as a function of race. *Journal of Clinical Psychology*, 38, 722-731

Jinks, G. H. (1999). Intentionality and awareness: a qualitative study of clients' perceptions of change during longer term counselling. *Counselling Psychology Quarterly*, 12, 57–71.

Jones, C (2009) A call to action *Therapy Today*, 20, 1.

Jones, E. E; Krupnick, J. L; Kerig, P. K. (1987) Some gender effects in a brief psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*. 24(3), 336-352.

Jones, E. E., & Zoppel, C. L. (1982). Impact of client and therapist gender on psychotherapy process and outcome. *Journal of Consulting and Clinical Psychology*, 50, 259- 272.

Kendall, P. C., Kipnis, D., & Otto-Salaj, L. (1992). When clients don't progress: Influences on and explanations for lack of therapeutic progress. *Cognitive Therapy and Research*, 16, 269-281.

Kools S, McCarthy M, Durham R, & Robrecht L. (1996). Dimensional analysis: Broadening the conception of grounded theory. *Qualitative Health Research*, 6(3), 312-330.

Kovacs, A. L. (1984). *The increasing malpractice exposure of psychologists*. The Independent Practitioner, 4(2), 12-14.

Kremer, T. G., & Gesten, E. L. (2003). Managed mental health care: the client's perspective. *Professional Psychology: Research and Practice*, 34, 187–196.

Lam, A.G and Sue, S (2001) Client diversity *Psychotherapy: Theory, Research and Practice* 38, 4

Lambert, M. J., & Shimokawa, K. (2011). Collecting client feedback. In J. C. Norcross (Ed.),. *Psychotherapy relationships that work* (2nd ed.). New York: Oxford

Langer, E and Rodin, J (1976) The effects of choice and enhanced personal responsibility for the aged: A field experiment in an intuitional setting. *Journal or Personality and Social Psychology*, 34, 191-198

Lerner, B. (1972). *Therapy in the ghetto: Political impotence and personal disintegration.* Baltimore, Johns Hopkins University Press.

Lev-Wiesel, R., & Doron, H. (2004). Allowing clients to choose their preferable nonverbal therapeutic modality. *The Arts in Psychotherapy*, 31(4), 261-269.

Levine, J. L., Stolz, J. A. & Lacks, P. (1983). Preparing psychotherapy clients: Rationale and suggestions. *Professional Psychology*, 14, 317-322.

Liddle, B.J (1996) Therapist sexual orientation, gender and counselling practices as the relate to ratings on helpfulness by gay and lesbian clients, *Journal of Counselling Psychology,* 43 (4), 394-401

Liddle, B.J (1997) Gay and Lesbian clients' selection of therapists and utilisation of therapy*. Psychotherapy: Theory, Research and Practice*, 34, 1, 11- 18

Liem, G. R (1975) Performance and satisfaction as affected by personal control over salient decisions. *Journal of Personality and Social Psychology*, 31(2), 232-240.

Lincoln, Y. S. & Guba, E. G. (1985). *Naturalistic inquiry.* Beverly Hills, CA:Sage.

Luborsky, L. (1984). *Principles of psychoanalytic psychotherapy: A manual for supportive-expressive (SE) methods.* New York: Basic.

Lussier, D A. and Olshavsky, R. W. (1979) Task Complexity and Contingent Processing in Brand Choice *Journal of Consumer Research*, 6, 154-165.

Maione, P. V., & Chenail, R. J. (1999). Qualitative inquiry in psychotherapy: research on the common factors. In M. A. Hubble, B. L. Duncan & S. D. Miller (Eds.). *The heart and soul of change. What works in therapy.* Washington, DC: APA.

146

Manthei, R. J. (1983). Client choice of therapist or therapy *Personnel and Guidance Journal*, 61, 334-340.

Manthei, R. J (1988) Client choice of therapist: Rationale and implications. *Psychotherapy: Theory, Research and Practice*, 25, 3

Manthei, R. J (2006) What can clients tell us about seeking counselling and their experience of it? *International Journal for the Advancement of Counselling*,13, 5

Manthei, R., Vitalo, R. L. & Ivey, A. E. (1982). The effect of client choice of therapist on therapy outcome. *Community Mental Health Journal*, 18, 220-229.

Martinez, F. I. (1991) Therapist-client convergence and similarity of religious values: Their effect on client improvement. *Journal of Psychology and Christianity.* 10(2), 137-143.

Masi, M.V, Miller, R.B., & Olson, M.M. (2003). Differences in dropout rates among individual, couple and family therapy clients. *Contemporary Family Therapy*, 25(1), 63–72.

McCallum, M & Piper, W. E. (1999) Personality Disorders and Response to Group-Oriented Evening Treatment. *Group Dynamics: Theory, Research, & Practice.* 3(1):3-14,

McCullough, M. E, Worthington, E. L. (1995) College students' perceptions of a psychotherapist's treatment of a religious issue: Partial replication and extension. *Journal of Counselling & Development.* 73(6), 626-634.

Mendonca, P.J and Brehm, S.S (1983) Effects of choice on behavioural treatment of overweight children *Journal of Social and Clinical Psychology*, 1, 343-358

Metcalf, L., Thomas, F. N., Duncan, B. L., Miller, S. D., & Hubble, M. A. (1996). What works in solution-focused brief therapy? In S. D. Miller, M. A. Hubble & B. L.

Duncan (Eds.), *Handbook of solution-focused brief therapy.* San Francisco: Jossey-Bass.

Mental Health Foundation (2006) *We Need to Talk: the case for psychological therapies on the NHS*, MHF, London

Mohr, D C. (1995) Negative outcome in psychotherapy: A critical review. *Psychology: Science and Practice.* 2(1), 1-27.

Morrison, J.K (1979) A consumer- oriented approach to psychotherapy. *Psychotherapy: Theory, Research and Practice,* 16, 381-384

Munro, E (2009) On finding a therapist *Therapy Today*, 20, 1.

National Institute for Clinical Excellence (NICE) (2009) *Depression: the treatment and management of depression in adults* London: National Institute for Clinical Excellence

Norcross, J.C. (1986) *Handbook of Eclectic Psychotherapy.* New York: Brunner/Mazel

Orlinsky, D., Grawe, K. and Parks, B (1994) Process and outcomes in psychotherapy – Noch Einmal in A.E Bergin and S.L. Garfield (Eds), *Handbook of psychotherapy and behaviour change.* (229-269). New York: Wiley.

Orlinsky, D. E., & Howard, K. I. (1976). The effects of sex of therapist on the therapeutic experiences of women. *Psychotherapy: Theory, Research and Practice,* 13, 82- 88.

Payne, J. W. (1976) Task Complexity and Contingent Processing in Decision Making: An Information Search and Protocol Analysis *Organizational Behavior and Human Performance,* 16, 366-387.

Pekarik, G. (1985). Co morbid alcoholism and depression: Treatment issues. *Professional Psychology: Research and Practice*, 16(1), 114–123.

Pekarik, G. (1985a). Coping with dropouts. *Professional Psychology: Research and Practice*, 16, 114-123.

Pekarik, G., & Finney-Owen, K. (1987). Outpatient clinic therapist attitudes and beliefs relevant to client dropout. *Community Mental Health Journal*, 23, 120-130.

Persons, J. B., Burns, D. D., & Perloff, J. M. (1988). Predictors of dropout and outcome in cognitive therapy for depression in a private practice setting. *Cognitive Therapy and Research*, 12, 557-575.

Reder, P., & Tyson, R. L. (1980). Patient dropout from individual psychotherapy. *Bulletin of the Menninger Clinic,* 44, 229-251.

Ricker, M., Nystul, M., & Waldo, M. (1999). Counsellors' and clients' ethnic similarity and therapeutic alliance in time-limited outcomes of counselling. *Psychological Reports,* 84, 674- 676.

Ripley, J. S, Worthington, E. L and Berry, J. W. (2001) The effects of religiosity on preferences and expectations for marital therapy among married Christians. *American Journal of Family Therapy.* 29(1), 39-58.

Rogers, C. (1951). *Client-centred Therapy: Its Current Practice, Implications and Theory.* London: Constable.

Rogers, C. R. (1967). *The therapeutic relationship and its impact: A study of psychotherapy with schizophrenics.* Madison: University of Wisconsin Press.

Rokke, P.D. Tomhave, J.A. and Jocic. Z (1999) The role of client choice and target selection in self- management therapy for depression in older adults. *Psychology and Aging*, 14(1), 155-169

Rosenberger, E, & Hayes, J (2002), Origins, consequences, and management of countertransference: A case study, *Journal Of Counselling Psychology*, 49, 2, 221-232,

Rosenheck, R., Fontana, A., & Cottrol, C. (1995). Effect of clinician-veteran racial pairing in the treatment of posttraumatic stress disorder*. American Journal of Psychiatry,* 152, 555-563.

Russo, J. E and Leclerc, F (1994) An Eye-Fixation Analysis of Choice Processes for Consumer Nondurables *Journal of Consumer Research*, 21, pp. 274-290.

Safran, J. D., Crocker, P., Mcmain, S., & Murray P. (1990). Therapeutic alliance ruptures as a therapy event for empirical investigation. *Psychotherapy*, 27, 154-165.

Safran, J. D., & Muran, J. C. (2000). *Negotiating the therapeutic alliance: A relational treatment guide*. New York: Guilford Press.

Safran, J.D., & Muran, J. C. (2006). Has the concept of the alliance outlived its usefulness? *Psychotherapy: Theory, Research and Practice*, 43, 286-291.

Saketopoulou, A. (1999). The psychotherapeutic alliance in psychodynamic psychotherapy: Theoretical conceptualizations and research. *Psychological Assessment*, 3, 188-195

Schatzman, L (1991)*.* Dimensions analysis: Notes on an alternative approach to the founding of theory in qualitative research. In D. Maines (Ed) *Social organisation and social process: Essay in honour of Anselm Strauss* (303 – 314). Hawthorne: New York

Schore, A. N. (1994). *Affect regulation and the origin of the self. The neurobiology of emotional development*. Hillsdale, NJ: Erlbaum.

Seligman, M. E. P (1995) The Effectiveness of Psychotherapy: The Consumer Reports Study. *American Psychologist.* 50(12):965-974,

Sexton, T. L., & Whiston, S.C. (1996). Integrating counselling research and practice. *Journal of Counselling and Development,* 74, 588-589.

Sterling R.C. Gottheil, E. Glassman, S.D, Weinstein, S.P and Serota, R.D (1997) Patient treatment choice and compliance. *The American Academy of Addiction Psychiatry*, 6, 168-176

Strong, S. R. & Claiborn, C. D. (1982). *Change through Interaction.* New York: John Wiley.

Sue, D.W. (1977) Consumerism in counselling. *Personnel and Guidance Journal*, 56, 197

Sue, S. and Lam A. G. (2002) Cultural and demographic diversity in Norcross, John C (Ed). (2002). *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* New York: Oxford University Press

Sue, D. W., & Sue, D. (2003). *Counselling the culturally diverse: Theory and practice* (4th Ed.). New York: Wiley.

Sue, D., & Sundberg, N. D. (1996). Research and research hypotheses about effectiveness in intercultural counselling. In P. B. Pedersen, J. G. Draguns, W. J. Lonner, & J. E. Trimble (Eds.), *Counselling across cultures* (4th ed., 323– 52). Thousand Oaks, CA: Sage.

Sue, S; Fujino, D. C. ; Hu, L; Takeuchi, D.T.; Zane, N. W. S. (1991) Community Mental Health Services for Ethnic Minority Groups: A Test of the Cultural Responsiveness Hypothesis. *Journal of Consulting & Clinical Psychology*. 59(4):533-540

Swift, J.K., Callahan, J.L., Vollmer, B.M. (2011). Preferences. In Norcross, J.C. (Eds). *Psychotherapy Relationships that Work* (2nd Ed.). Oxford University Press.

Taube, C. A.; Burns, B. J.; Kessler, L. G. (1984) Patients of psychiatrists and psychologists in office-based practice: 1980. *American Psychologist*. 39(12)

Taylor, S. E., Peplau, L. A., & Sears, D. O. (2000). Person perception: Forming impressions of others. In Roberts, N., Webber, B., & Cohen, J. (Eds.), *Social Psychology* (62-97). Upper Saddle River, NJ: Prentice-Hall Inc

Thompson, C.E., & Wankel, L.M. (1980). The effects of perceived activity choice upon frequency of exercise behaviour. *Journal of Applied Social Psychology,* 10, 436–443

Tracey, T. J. (1993). An interpersonal stage model of the therapeutic process. *Journal of Counselling Psychology*, *40*, 396– 409.

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. Mahwah, NJ: Erlbaum.

Ward E. C (2005) Keeping it real: a grounded theory study of African American clients engaging in counselling at a community mental health agency *Journal of Counselling psychology* 52, 4, 471-481

Wierzicki, M., & Pekarik, G. (1993). A meta-analysis of psychotherapy dropout. *Professional Psychology: Research and Practice*, 24, 190- 195.

Wikler, M. (1989) The religion of the therapist: It's meaning to Orthodox Jewish clients. *Hillside Journal of Clinical Psychiatry*. 11(2), 131-146.

Winborn, B.B (1977) Honest labelling and other procedures for the protection of consumers. *Personnel and Guidance Journal*, 56, 206-209

Windle, C and Paschall, N. C. (1981) Client participation in CMHC program evaluation: Increasing incidence, inadequate involvement. *Community Mental Health Journal*, 17, 66-76

Worthington, E.L., Kurusu, T.A., McCullough, M. E. and Sandage, S.J. (1996) Empirical Research on Religion and Psychotherapeutic Processes and Outcomes: A 10-Year Review and Research Prospectus. *Psychological Bulletin.* 119(3):448-487.

Worthington, E.L and Sandage, S.J. (2002) Religion and spirituality in J.C. Norcross (Ed) *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients*. New York: Oxford University Press.

Van Audenhove, C., & Vertommen, H. (1987). Evaluation of a negotiation approach to indication for psychotherapy. In W.Huber (Ed.) , *Progress in psychotherapy research. Proceedings of the Second European Conference on Psychotherapy Research*. Louvain-la-Neuve: 38–53

Van Audenhove, C & Vertommen, H (2000) A Negotiation Approach to Intake and Treatment Choice *Journal of Psychotherapy Integration,* 10, 3

Vera, E. M., Speight, S. L., Mildner, C., & Carlson, H. (1999). Clients' perceptions and evaluations of similarities to and differences from their counsellors. *Journal of Counselling Psychology,* 46, 277-283.

Yardley, K. M. (1990). Psychotherapy process and research: missing persons and missing values. *Counselling Psychology Quarterly*, 3, 43–55.

Zlotnick, C., Elkin, I., & Shea, M. T. (1998). Does the gender of a patient or the gender of a therapist affect the treatment of patients with major depression? *Journal of Consulting and Clinical Psychology*, 66, 655-659.

Zuroff, D. C; Koestner, R, Moskowitz, D. S; McBride, C, Marshall, M and Bagby, M. (2007) Autonomous motivation for therapy: A new common factor in brief treatments for depression. *Psychotherapy Research.* 17(2), 137-147.

APPENDICES

Appendix 1

Demographic questionnaire

Participant number:	
Age:	
Sex:	
Level of education:	
Socioeconomic status:	
Race/ethnicity:	
Partnership status:	
Reason for therapy:	

Appendix 2

Interview codes

Interview 8 codes
<u>Rational for ending</u>
- I knew I was ready to end when I stopped thinking about my therapy, whereas I used to thing about the sessions during the week and focus on new strategies
- Last few months of going was really sure what I was going for and didn't have a specific thing in mind to talk about
- I felt better and more confident at work and things were just generally better so felt that things had come to an end
- Thought I don't need it anymore and it had to end
- Was difficult to know when to end it

<u>Readiness to go into therapy</u>
- Knew I had to go and talk to someone

<u>Qualifications</u>
- Read her qualifications on her website

<u>Therapy sessions</u>
- Did offer me tools and coping strategies that was helpful
- Didn't want to have to pain that picture for someone else so thought just stick with it
- I was there to talk openly but that was probably because we had that relationship

<u>Time</u>

<u>Identification</u>
- Therapist around the age of my mother
- I felt she sometimes wanted to play my mum
- Mother/daughter thing between me and my therapist was present and felt slightly odd
- She was trying to compensate for me relationship with my mother

<u>Therapist responses</u>
- Wanted reassurance
- Wanted someone to talk through things
- Few misunderstandings at the beginning
- She made assumption about my mum and our relationship that were actually not really correct
- I felt my therapist often would make things very black and white
- Miss me a little bit and stirred up not nice feeling about her
- I felt she was judging my family and I was not what I wanted

- Felt intruded on when she said she had been thinking about me
- Maybe her comment on keeping me in mind came at a time when I no longer need her support therefore rejected it
- Just got a feeling from her that she was slightly needy

Client impression of therapist
- As a person I didn't really know if I liked her or not
- Just felt so misjudged when she asked if I wanted a hug
- She was quite low key
- I didn't think of her as sort of a super therapist but more of a homely therapist *
- There was an odd balance at the end as she knew all about me and I knew nothing about her
- Felt she had invested in me somehow and I didn't want that emotional thing between us

Preconceived image
- I built and image in my head of her

Interpersonal chemistry
- Misjudged ending
- Never really thought of her but it was just a service
- Didn't really like therapist very much but just needed to tell stuff and she responded in the right way
- She understood me and what I needed
- Felt safe with my therapist as she didn't take me apart

Religion

Age
- Natural that she was older and in a sense wiser
- Working well that she was older
- Assumed that would be older than me
- Didn't ask her age
- When first went the fact that she wasn't of my mother's age probably helped and made me grow more comfortable

Intellect
Race
Class

Exercising choice
- Didn't shop around
- Thought go for a few weeks and if still not getting anywhere I'll look somewhere else

Sex

Information
- Went online and googled
- Lots of terms for things I didn't understand
- Info on her website

Personal information (therapist)
- She explained her background, her approach and her techniques
- She told me she had come to therapy as a mature student and hadn't been going it for long
- I did wonder if she understood the dynamic 1st hand and if she had mothering experience
- Just bits of info I worked out from going there so long
- Was curious to find out info

Cost
- Worry about cost and thinking it was expensive
- You need to do this, you can't worry about the money thing, you just have to deal with it for now and see
- Did feel it was expensive but not prohibitive
- As long as you feel you're getting something out of it you're happy to keep paying the money out *

Advice/Recommendation
- Spoke to friend who knew much more about it
- I ask my friend
- Recommendation from someone at work
- Spoke to friend of mine
- Link to someone else recommended therefore she was ok
- Advice from friend

Setting
- Setting was quite odd
- A screen to separate from rest of room
- Found it strange going into someone house
- Found it odd but didn't influence me as much as to stop going
- Wasn't necessarily comfortable with it all the time there
- A bit like invading someone's space
- Weird to think I'm in a person's house and they know all about me and I know nothing about her

Investment in self
- Determined to try and sort myself out
- Stick with it because it's somebody and its going to help
- Felt it was going somewhere and I was getting what I wanted out of it so I kept on with it *
- Knew what I needed to make myself feel better which is what therapy taught me

Location
- Found person who was really local
- Found someone round the corner
- Location wise it was perfect
- She was moving to south London so was going to take a long time to get home *

The remit of therapy
- Didn't want to be analysed in that way
- 1st session just went in and off loaded
- Off loading was key thing really
- I wanted proper help
- Not making specific judgement on benefit as going along but was feeling better due to things she had said
- At beginning of my therapy would have offloaded to anyone *
- I was never sure if she didn't want me to stop because she felt I wasn't ready or she wanted the income
- I could say loads of things and it was actually her job to sort it out not me
- Thought she's helping so far and that's good enough and I'll keep going till I don't need it

Reason for going into therapy

- Family issue and therapist had reference to family on website
- I was just desperate in a way

Type of therapy
- Looked them up and they sounded Freudian and off putting
- Sounded like they didn't talk very much and I didn't like the sound of that
- Didn't feel right to be analysed
- I didn't want to be taken apart

Appendix 3

Examples of memos

Interview 2 notes
- What was it about these 2 therapists that made you like them immediately?
- If someone didn't have a similar experience to your own would they be able to understand you?

Interview 3 notes
- What is a normal experience?
- Did client respond badly to 1st therapist as she told her too many home truths?
- Was second therapist "too nice"?/ tell her what she wanted to hear?
  - Want him to like her?
- Lack of self awareness from client

Issues in interviews
- Lack of psychological mindedness/insight into choices
- Conscious/unconscious process
- Memory limited due to length of time since therapy
- Lack of understanding of impact on process of the choices made in deciding on therapist
- Demographics
  - Similar ages
  - Similar class
  - Similar sex

Themes
- Practical factors
  - Location
  - Cost
  - Convenience
- Interpersonal factors
  - Age
  - Sex
  - Chemistry
  - Fit to preconceived image (enactment??)
- Information factors
  - Informed choice
  - Explain process
  - Structure
  - Lack of clear information prevents informed choice

What links theses together? – relationship

What are these themes telling us?

What is the client looking for?
- Safe
- Trust
- Not judged

Appendix 4

Codes organised into hierarchical categories

Practical factors
- Cost
- Location

Observable characteristics
- Sex
- Class
- Race
- Intellect
- Religion
- Age

Quality of relationship factors
- Interpersonal chemistry
- Client impression of therapist
- Preconceived image
- Personal information (therapist)
- Therapist responses
- Identification

Information Factors
- Advice/Recommendation
- Information
- Type of therapy
- Qualifications
- Exercising choice

Timing
- Reason for going into therapy
- Readiness to go into therapy
- Investment in self

Sessions
- The remit of therapy
- Setting
- Time
- Therapy sessions

Appendix 5

Audit trail

no books in her room and I just thought that was really bizarre, I was like I'm meant to be coming to see you cause you're a wise person and you've got no books in your room, and I just didn't get a good feeling from her, which I know is really ridiculous and probably says much more about me than about her but I then went to meet this other woman who's the woman I've been seeing since, I just warmed to her immediately and I think there's something quite familiar about her, she reminds me a bit of friend of mine's mum I think. So that was it really, that's the story. I mean I don't think there are any other criteria really than that so.

— NO BOOK IN HER ROOM + YOU MEANT TO BE A WISE PERSON

— DIDN'T GET GOOD FEELING FROM HER.

— WARMED TO HER IMMEDIATELY, SOME THING FAMILIAR ABOUT HER. REMINDS OF A FRIEND OF MOTHER.

David: So them having a similar background to you was quite important?

Client: At the time I didn't think it was um that important but I kind of, I definitely wanted a woman because I knew that I'd be talking about some issues about sex and about um you know intimacy and I think I knew I 'd feel more comfortable to talking to a woman um and maybe I don't know, I mean maybe at the time, you see at time I thought I would just end up talking to about me and this one individual that I'd been out with and obviously I've ended up talking about something completely different mainly about my parents, so um my mother yeah. So um, so I think that maybe there's something going on that I realised that you know that'd be useful to me. I also just felt you know it means you can talk in a kind of shorthand that you can't with someone who maybe you have to explain more about where you're from and who you are and the language you use and stuff.

— TALKING ABOUT INTIMATE + SEXUAL ISSUES + KNEW WOULD FEEL MORE COMFORTABLE WITH A WOMAN.

— IMAGINED THAT THEY WOULD BE USEFUL TO ME

— SHORTHAND, NO NEED TO EXPLAIN WHERE YOU FROM WHO YOU ARE + LANG

David: So things like the fact that they were Jewish as well was quite an important factor for you?

Client: I don't know actually, because I when I didn't know mum was Jewish until quite recently and I asked here and she has this really weird expression which might be something you learn. She has this really weird expression where she says "what's your fantasy about that Suzanna?" and I'm just like all I can think of is you know you and me in suspenders and lace basically, and I think I said well you know I'd like to know because then I know if I can talk in a kind of shorthand it, and she said yes I am. And I kind of knew she was you can kind of tell. Um but no I think, I think the Jewish thing was less important it was more that she was middle class and came from North London and just kind of understood the world that I live in and that I wasn't going to sit there feeling kind of prejudiced based on my upbringing and my class and my you know the world that I live in, you know, that I didn't want to sit there and have to, because I'd had some when this guy died I'd gone and has some bereavement counselling provided

— LIKE TO KNOW IN ORDER TO TALK IN SHORTHAND.

— IMPORTANT SHE UNDERSTOOD THE WORLD THAT I LIVE IN

— WASN'T GOING TO BE PREJUDICED BASED ON UPBRINGING

by the council which was great but not particularly helpful but the woman that I was talking to was very sweet, she's a volunteer and she's a very sweet Turkish woman and I liked her a lot and she actually was the one that put the idea in my head that I should go and have some longer term therapy but she um you know I had to explain everything to her partly because her English was just quite, I mean she was fluent but it was quite limited but also you know I would have to kind of explain the kind of cultural world that I live in to her and when you're paying £50 - £60 an hour you don't want to spend half of it explaining that ...

David: ... Sure

Client: .. so yeah.

David: And so how did, you know in terms of discovering this information about them, the fact that whether, you know background and that sort thing, how did you think that sort of thing?

Client: Well I saw the house she lives in, and where she lives, um I mean the same way you would with anyone, the way she dresses, the way she speaks, um the books on her shelves um I mean as I said there was something familiar about her um she she had a kind of accent, I still don't know, I think she's South African but I think she might be had left South Africa at some point, she's got that kind of slight tinge um how did I found out, I don't know, I means she's quite in a way, she's quite similar to the original women that I went to see who I liked immensely the one that gave me the kind of referral um and I've since sent loads of people I know to see this woman that gave me the referral and everyone I know thinks she fantastic so I think there was just something about her that I really trusted and I then met this other woman and I just felt comfortable with her.

David: So other people's referrals were quite important?

Client: Oh year crucial. I mean the woman that referred me I would have wanted to see her, I liked her immediately and she I spoke to her for about and hour and a half and she summed up in about 10 minutes things that I've subsequently spent two years working out um so she was brilliant but she wouldn't see me because of the kind of ethical issues.

David: What other criteria did you have in mind?

Client: For ....

David: ... for choosing your therapist?

(Handwritten margin notes:)

- WOULD HAVE TO EXPLAIN CULTURAL WORLD + WHEN PAYING £50/60 AN HOUR YOU DON'T WANT TO SPEND HALF OF IT EXPLAINING THAT

- WAY SHE DRESSES ETC
  - SOMETHING FAMILIAR ABOUT HER.

- QUITE SIMILAR TO ORIGINAL WOMAN - SOMETHING ABOUT HER THAT I REALLY TRUSTED
  - MET OTHER WOMAN + JUST FELT COMFORTABLE.

- I LIKED HER IMMEDIATELY

- SUMMED UP IN 10MINS WHAT I HAVE SPENT 2 YEARS WORKING ON
  - SHE WAS BRILLIAM

Client: Oh, um I wanted something relatively easy to get to cause I'm, I mean I don't have a job in one place, I freelance and generally I work in Central London whatever. Um I wanted to go in the evenings, but when I met this woman I really liked her, she only had one slot which is on a weekday lunchtime and um, I just said that's not going to work and she just said well if you decide you want to see me you'll make it work, you know and I kinda said well my office, well might not like that and she said I think you'll find if you explain to them the situation that any office would. And I've actually never had a problem, I mean I don't really tell my work, you know here I'm on my own, in my last company you know I was, I was kind of I don't really have a boss I was the boss so I just kind of slip away and nobody knows but I suppose that was the criteria It was near and easy to get to. Yeah

— IF YOU WANT TO SEE ME YOU'LL MAKE IT WORK.

David: In terms of the um orientation of the therapist ...

Client: You mean what kind of ....

David: ... what kind of therapy they were offering?

Client: I did quite a lot of research into that um I suppose I thought if I was gonna, if I was gonna do it I want to do it properly and for me properly can for right or for wrong reasons equates to the person who'd have the most extensive training. So I went to the kind of um I wanted I mean I mean are talking in terms of kind of psychoanalysis first as therapy or counselling ...

— DO IT PROPERLY + FOR ME THAT EQUATES TO THE PERSON WITH MOST EXTENSIVE TRAINING

David: ... counter behavioural therapy or systemic or whatever, you know.

Client: Yeah I mean, I've got a really friend whose a clinical psychologist and we spoke a lot and I spoke to her mother who's a psychoanalytic psychotherapist um and we just, and I just decided off the back of that and after doing a lot of reading that I wanted to get to the complete bottom of it and I kind of had an inkling that there was a connection between something way way back and why I'd fallen in love with someone who was clearly quite destructive and so yeah I suppose I suppose I need if I was going to make a commitment then I'd wanna do something that was long term and not something that you know has been criticised as quick fix like CTD or you know NLT or whatever. As to kind of whether they were independent, or Freudian or Yungian I think probably I would have been a distrustful at someone who was completely just you know along one line. I mean that I don't know a lot about it but I think if someone kept trying to fit me into a box I think I probably wouldn't like it. I don't know.

— I THINK IT WOULD HAVE BEEN DISTRUSTFUL WITH SOMEONE WHO WAS JUST ALONG ONE LINE

IF SOMEONE KEPT TRYING TO FIT ME INTO A BOX I WOULDN'T LIKE IT

David: And um you talked about the other woman this morning. You went to see two people um, what was it about other than the books on the wall.

Client: I sound like such a fascist don't I. What was it. It was partly, to be honest it was partly that she lived in way in West London and the only times she could see me was 7am on a Thursday, and to be honest with you I don't make a lot of sense at 7am on a weekday, I'm sure most people don't. Um I don't know I just didn't like her. You know it sounds ridiculous she wasn't maternal enough, I sure that speak volumes but I think now looking back on it and knowing what I speak about I think I was kind of looking for someone who's a bit of a kind of mother who I kind of trusted. This woman was a bit young the first one I met and I suppose I just have it in my head that I wanted to see a wise old woman you know because a lot of what I wanted to talk to her about was about um things that I didn't understand about women having grown up children and my ex's relationship with his mother, my relationship with my mother and I suppose I just felt like I wanted, I wanted to be with someone who could talk to me and understand my perspective and also a mother's perspective and um mine had children. She obviously won't tell me about but I know she does, and I can tell you that without her confirming it but she did, I kind of pestered her but um I think that was it really and the other woman, mean look I'm sure she's very nice I think probably when I went to see her I wasn't quite ready for it because I subsequently didn't go and see my therapist the first time for another few months and a big gap, I was really put off, I was like I don't want to do this. And then eventually I rang this other woman and she said I was wondering when you'd get round to ringing me and I told her what had happened and then that was it. It didn't happen like that, I went, the first woman recommended my first therapist I didn't like and then said to her in the right tone said "I'm really sorry I didn't like her" and she said "fine get back in touch when you're ready to see someone I recommend if I'm around" and it was few months before I then got back in touch. So it wasn't like she there's one here and one here that's who she found.

David: In terms of your present therapist did you think you'd like to know more about them?

Client: Yeah. My fantasy, loads of things, um yeah I, it's really weird because I, I'm always totally unsure of what the etiquette is. Um you know obviously I read a lot about psychotherapy and I read a lot about you know people with the kind of mental illness that my boyfriend had then in therapy but yeah I always want to know more and I don't want to pry am quite aware. I remember reading what's

[handwritten margin notes:]

- SHE WASN'T MATERNAL ENOUGH.

- LOOKING FOR SOMEONE WHO'S A BIT OF A MOTHER WHO I TRUSTED

HALIN HEAD WANTED TO MEET WISE OLD WOMAN.

- WANTED SOMEONE WHO COULD TALK TO ME + UNDERSTAND MY PERSPECTIVE + ALSO A MOTHER'S PERSPECTIVE

- WASN'T QUITE READY - WAS PUT OFF LIKE I DON'T WANT TO DO THIS.

- WANTED TO KNOW MORE BUT DIDN'T WANT TO PRY

it, there's some novel about um ah girl whose mum is a psychotherapist and talks about sitting at the kitchen window twitching the curtains to see the patients arriving at the other door. And there's this slight thing of like I don't want to impinge on her life in the same way that I would never dream of calling her in the holidays. She always assures me if I'm feeling down I can but I would never do that but yeah there's loads of things I want to know about her life and her ...

— DON'T WANT TO IMPINGE ON HER LIFE

— THERE ARE LOADS OF THINGS I WANT TO KNOW ABOUT HER LIFE.

David: Do you think in terms of, in terms of the actual working together and things that you like to know about her actually might enable your work more or you know or perhaps make you feel comfortable earlier one if you'd know certain things .... Unable to tell your mother...

Client: Yeah totally. I mean there are still things that I think if I knew I might be able to tell them or and they're definitely things that I keep from her because I'm not quite sure how she'd react. But not a lot, less and less actually but yeah when I think if I'd known at the beginning um all the things I know about her now I don't know much about her now, it would have been quite different but I also think that things come up at a time when you feel right to ask them so yeah I mean, yeah, I do think, I do think it would have been easier if I'd know things earlier on. But I didn't ask them early on but that's because I was afraid that you know I might just, you know she doesn't say hello to me when I call in the door and all that weird stuff. I'm not quite sure what it means but I know there's some kind of you know code of conduct like never say hello to your patients in case she's having a bad day and you know, whatever it is, I mean I don't know but ...

LESS + LESS OVER TIME

— THERE DEFINATLY THINGS THAT I KEEP FROM HER BECAUSE NOT SURE HOW SHED REACT.

— THINGS WOULD HAVE BEEN DIFFERENT IF I HAD KNOW THING ABOUT HER @ START

— THINK IT WOULD HAVE BEEN EASIER IF I'D KNOWN THING EARLIER ON.

— DIDN'T ASK EARLY ON BECAUSE I WAS AFRAID

— CODE OF CONDUCT — NOT TO SAY HELLO TO PATIENT IN CH HAVING BAD DAY

David: .... Ok. And so some of the things you covered there was a bit of a match between you and your therapist?

Client: Yeah totally. I mean I adore her I think she's I think she's a great woman and she's very kind and I suppose that's what it's about isn't it that developing relationship with a human being, but you know you might not, you know the trying to prepare other relationships through that so yeah I mean I really like her a lot and she feels quite familiar to me as well, so I think that's quite important um yeah. I'll miss here when I leave, yeah, which I think I probably will do quite soon, I don't know we'll see.

— ADORE HER + THINK SHE IS A GREAT WOMAN.

DEVELOPING A RELATIONSHIP WITH A HUMAN BEING.

— LIKE HER ALOT + SHE FEEL FAMILIAR TO ME + THATS QUITE IMPORTANT.

David: Do you think if you were going into therapy now you would choose somebody different?

Client: Um, no. No I think I'd choose her again. I mean it's been quite slow but I think that's, I mean I

Appendix 6

Approval by the Metanoia Research Ethics Committee

METANOIA INSTITUTE

13 North Common Road
Ealing, London W5 2QB
Telephone: 020 8579 2505
Facsimile: 020 8832 3070
www.metanoia.ac.uk

David Spalter
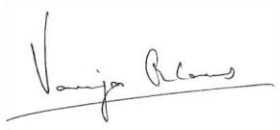16 Cyprus Gardens
Finchley
London, N3 1SP

14th November 2008

Dear David

RE: *How clients choose their psychotherapist: Influences on selecting and staying with a therapist.*

I am pleased to let you know that the above project has been granted ethical approval by Metanoia Research Ethics Committee. If in the course of carrying out the project there are any new developments that may have ethical implications, please discuss these with your research supervisor in the first instance, and inform the Chair of the Research Ethics Committee.

Yours sincerely,

Professor Vanja Orlans
On behalf of the Chair of Metanoia Research Ethics Committee
Joint Head of Integrative Department and Programme Leader, DCPsych
Metanoia Institute