CLIENTS` EXPERIENCES OF CHANGE IN COGNITIVE BEHAVIOURAL THERAPY AND PERSON-CENTRED THERAPY IN PRIMARY CARE: A QUALITATIVE ANALYSIS

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Abstract

The aim of this qualitative research project was to investigate the experiences of clients who had received Cognitive Behavioural Therapy (CBT) and Person Centred Therapy (PCT) in primary care. The rationale for the investigation was to inform the assessment and referral process whereby prospective clients are assigned to the two different therapies.

A total of 16 clients responded to an invitation to attend an unstructured interview (PCT = 9; CBT = 7) to talk about their experiences of therapy. The resulting transcripts were analysed using Grounded Theory methodology. Transcripts were broken down into meaning units and conceptualised as categories, using the constant comparison method. The categories were integrated, a core category conceptualised and a theory generated.

A comparison of the accounts revealed similar and contrasting experiences. The main categories (eg Accessing therapy, Engaging with the therapy) could be organised in the chronological order of the client`s journey through therapy. All participants entered therapy with a particular view of reality. In successful therapy this view changed and they went on to manage their lives in a more constructive way. Participants attributed this change to different elements of the therapy (categorised as It did the trick) which brought about a new understanding (categorised as The key). Where therapy was unsuccessful this did not occur. The mechanism of change was personal to the individual and did not appear to be specific to either therapy. Some of the mechanisms appeared to be consistent with the therapy received (eg. Carrying out tasks, in the CBT group). Others appeared counterintuitive (eg. Putting me straight, in the PCT group).

The differences and similarities in the participant`s experiences appeared to be due to the therapist and client`s capacity to respond to each other in order to make the therapy "work." The Core Category, Reciprocal Responsiveness, was chosen to explain this. The findings also suggest that the ability of the therapist and client to respond to each other will affect the outcome of therapy. The theory was constructed that the outcome of therapy is determined by the occurrence of a sufficient degree of Reciprocal Responsiveness.

This study has implications for the assessment process as the findings suggests that, when making a referral, it may be helpful, to take into account the potential client`s activity and responsiveness rather than relying solely on diagnosis. It also contributes to the growing body of literature emphasising the importance of therapist responsiveness to the individual needs of the client, rather than strict adherence to one therapeutic approach.

The study is limited to two therapies within primary care. Future studies may consider clients experiences within other settings and with other therapeutic approaches.

Declaration

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

Copyright Statement

1. INTRODUCTION

1.1 INTRODUCTION TO THE CHAPTER

Short term Person-Centred Therapy (PCT) and Cognitive Behavioural Therapy (CBT) are both interventions in primary mental health care. The philosophy, theory and interventions of the two approaches are very different, while in routine practice they have been demonstrated to be similarly effective and beneficial (eg. Stiles, et al, 2008). In this thesis I present an account of a qualitative research study into the experiences of clients who have received the two different kinds of therapy, CBT and PCT. I conducted this research over a period of four years in the naturalistic setting of a primary mental health team (PMHT) in the National Health Service (NHS) in England. The PMHT offers both CBT and PCT to potential clients and decisions are made about people`s suitability for either therapy during the assessment procedure. I undertook this research with the aim of informing the assessment and referral procedure, and of contributing to the development of a theoretical basis for the integration of different therapies in a single service.

In this introductory chapter, I hope to give the reader an understanding of the operational, political and personal context in which the research took place. The operational context is relatively straightforward. However, the situation in the NHS and the wider world of psychotherapy is extremely complex and this account will reflect the multilayered and often confusing situation which, for me, is an everyday reality. I begin by outlining the background to the project. This consists of a brief account of the development of psychological therapies within the NHS and a description of the PMHT where the research took place. I follow this with a short discussion of the political situation in the NHS and the wider psychotherapy world, and of my own position in relation to the project. I then go on to give a brief explanation of the rationale for the research. I will make some reference to the supporting literature in this chapter, but the greater part is presented within the Literature Review of this thesis. I hope the reader will appreciate that the complexity of the circumstances and the limits of space means that this account will inevitably be far from complete. I end the chapter with a brief overview of the structure of the whole thesis. In presenting this account I also

acknowledge that it will be subjective and I will aim for transparency by acknowledging my personal situation of researcher, manager and person-centred therapist.

1.2. PSYCHOLOGICAL THERAPIES IN THE NHS

In 2006, a report by The Centre for Economic Performance`s Mental Health Policy Group, which has become known as The Layard Report, estimated that 16% of the UK population have common mental health problems such as anxiety and depression (Layard, et al, 2006, p.4). As many of these present to their General Practitioner (GP) for treatment there is a demand for psychological therapy provided by the NHS. To begin with much of this demand in primary care was met by counselling so that at the end of the twentieth century it was estimated that 50% of general practices in the UK employed a primary care counsellor (Mellor-Clark, Simms-Ellis and Burton, 2001). Many primary care counsellors integrated CBT into their practice (eg. Hudson-Allez, 1997). Elsewhere in the NHS, CBT was delivered by clinical psychologists or by mental health and psychiatric nurses, but there was a lack of trained CBT therapists (Layard, et al, 2006).

The NHS is driven by government policy and the end of the 1990`s saw the start of a series of government initiatives to improve the quality of patient care within the NHS. The most important of these was the requirement for Evidence Based Practice to ensure that only Empirically Supported Treatments, those which had been demonstrated to be clinically and cost effective, were offered to patients (Department of Health, 1999). The National Institute for Clinical Excellence (NICE) (now the National Institute for Health and Clinical Excellence) was established to assess evidence, and produce clinical practice guidelines to inform both clinical practice and commissioning decisions (eg. NICE, 2010; 2011). The requirement for clinicians, service providers and commissioners to follow NICE`s recommendations, have had a marked effect on the delivery of mental health services in the UK. According to the evidence based practice model which underpins NICE, randomised controlled trials and their aggregation into systematic reviews and meta-analyses are considered to provide the best form of evidence for identifying effective treatments (NICE, 2009, p.159). There is a

considerable amount of this type of evidence for the effectiveness of CBT while PCT is characterised by a lack of evidence of this type.

The NICE guidelines recommend CBT as the treatment of choice for all primary mental health conditions (NICE, 2010, p.213, p.296; NICE, 2011, p.131, p.177). Both guidelines attribute the development of counselling to Carl Rogers (NICE, 2010, p.261; NICE, 2011, p.137) but describe counselling today as a generic term used to describe a broad range of interventions into which counsellors integrate other approaches (Bower, Rowland and Hardy, 2003). The guideline for the treatment of generalised anxiety disorder (GAD) reviews the evidence for "non-directive therapy" and concludes that they can make no recommendations in the treatment of GAD due to the absence of evidence (NICE, 2011, p.174). The guideline for the treatment of depression reviews the evidence for counselling and recommends counselling for people with persistent subthreshold depressive symptoms or mild to moderate depression, who decline the other recommended treatments, providing the practitioner "discuss with the person the uncertainty of the effectiveness of counselling.....in treating depression," (NICE, 2010, p.297).

The Layard Report (Layard, et al, 2006) highlighted NICE`s recommendation for CBT and calculated that an extra 10,000 CBT therapists were needed if the recommendations were to be met. In response, the UK Government instituted The Improving Access to Psychological Therapies (IAPT) Program with the aim of developing teams of therapists from a range of professional groups who had been given rigorous training in CBT. These would provide services that delivered treatments for depression and anxiety disorders which are approved by NICE (Department of Health, 2007; 2011).

1.3. THE PRIMARY MENTAL HEALTH TEAM (PMHT)

This section provides a brief introduction to the PMHT, it`s history, development and my own involvement with it. The counselling service, of which I was manager, began in 2001 in response to the demand for psychological therapy in primary care and was commissioned to provide a service to the GP practices in the locality. Initially, counsellors were employed as part of a clinical psychology service and only counsellors

who operated within the person-centred model were employed as it was considered important to offer a different approach to the clinical psychologists. In 2005, the counselling service was reorganised into a PMHT along with nurses, CBT therapists and the new primary care mental health workers. In this new arrangement the counselling service continued only to offer PCT. The rationale for this continued to be the need to offer an alternative to the CBT offered by the other professional groups and the counselling service continued to receive funding equal to that of the CBT service.

The PMHT operated a model of Stepped Care (Bower and Gilbody, 2005, NICE, 2010, p.32). This provides a framework for referral and treatment where an individual may enter at any step, but the aim is to ensure that each individual receives the least intensive intervention to meet their needs. GPs in the locality could refer either to a step 2 worker based in their practice or direct to the PMHT. Step 2 workers provided a low intensity intervention, consisting of guided self help, based on CBT principles, and a number of brief interventions including behavioural activation, books on prescription, advice on diet, sleep hygiene etc. Both CBT and counselling services were located at step 3 of the stepped care model as a high intensity intervention. Individuals who did not respond to a step 2 intervention could be referred on to either PCT or CBT, or to a nurse for further assessment. Nurses in the PMHT provided a "single point of access" for all mental health referrals providing assessment and referral to CBT or PCT, or referral on to steps 4 and 5 in the stepped care model. Services at steps 4 and 5 include Complex Care and Treatment Teams, Crisis Teams and Inpatient Units where interventions often involve combined treatments from a number of professionals.

In 2008, in addition to the management of the counselling service, I also took on the management of the CBT service within the PMHT. When I began the research there were 4 CBT therapists (3 whole time equivalents (WTE)) and 6 part time counsellors (4 WTE) in the primary mental health team. Due to another Government initiative to introduce competition into the NHS, the PMHT had been put out to tender in 2007, although, for reasons which remain unclear, this process was never completed. The tendering process meant that we were potentially in competition with other providers already delivering IAPT services and so we had already begun to implement many of the IAPT operational requirements. In 2011 the service received the extra funding. Becoming an IAPT service meant a significant investment in the CBT service, with the

appointment of six full time trainee High Intensity CBT therapists. 2011 also saw the introduction of other NICE approved/evidence-based interventions into IAPT. One of these was Counselling for Depression (CfD). This was an IAPT approved training in a therapeutic model which integrated Person-Centred Therapy and Emotion-Focused Therapy and was produced by The British Association for Counselling and Psychotherapy (BACP) with the aim of bringing the practices of the existing counselling workforce in line with the evidence base (Hill, 2011).

1.4 THE POLITICAL CONTEXT AND MY PERSONAL POSITION

There is general agreement that these are and have been unstable times in the international psychotherapy world. The move towards the evidence based practice paradigm in the commissioning and delivery of services, and competition for limited resources, has lead to what Norcross and Lambert (2011, p.3) call the "culture wars," and Hubble, Duncan, Miller and Wampold (2010, p.23) call "model mania," and "the battle of the brands." These have also been unstable times in the UK. The NHS is said to be the fifth largest organisation in the world (Alexander, 2012), and within the duration of this research project a change in national government began what is, "arguably the biggest reorganisation the service has seen in its 63-year history" (Timmins, 2012, p.12.). As part of this reorganisation the primary care trust, by whom I was employed at the beginning of the project merged with a large mental health foundation trust. This meant that, as a manager, I had to negotiate my services through significant organisational changes. The tendering process resulted in considerable uncertainty regarding the future of the service and staff employment and the IAPT developments caused still further reorganisation and changes in working practice. As a researcher I was affected by a change in research ethos. The primary care trust supported practitioner research while the mental health trust had a well established research culture favouring clinical trials and organisational support for the project ended.

The evidence based practice agenda and the rise to prominence of CBT has caused great consternation in the international counselling community (eg. Bohart, O`Hara and Leitner, 1998) and in the UK, in all the different traditions (eg. Guy, et al, 2012). Many

counsellors in the UK regard the CBT community as a threat and much negative criticism has been levelled at the approach (eg. House and Loewenthal, 2008). Cooper (2012, p.14) describes a situation where "the future of counselling is on the line," and McInnes (2012) writes that, "the crisis is well underway," while members of the CBT community see themselves as reaping the benefits of their decades of hard work in demonstrating its effectiveness (eg. Palmer, 2008). There is no doubt that, through IAPT, there has been significant investment in CBT resulting in large number of full time posts for high intensity CBT therapists while the existing counselling posts have been under threat (eg. Gibbons, 2011) and where many primary care counsellors have lost their jobs or retrained as CBT therapists (eg. Moorman, 2011). I am fortunate to have a permanent post and an evaluation of the counselling service which I conducted established PCT as an effective alternative to CBT in this locality (Gibbard and Hanley, 2008). This means that I have not felt so personally threatened by the rise of CBT.

I originally trained and obtained employment in the NHS as a person-centred counsellor and have maintained my clinical practice after taking on the management role. My personal position as a person-centred counsellor can be a place of conflict with the evidence based agenda of the NHS and the medical and scientific models which underpin it. As a person-centred therapist my aim is to trust the innate tendency of human beings to grow and develop and fulfil their potential, and to provide them with the conditions in which to do this. On the other hand my experience as a manager is that many clients who have received CBT describe life changing experiences. Despite the recommendations of NICE, I believe that CBT and PCT are similarly effective, in that some people are helped by each intervention, but some people are not, and I was motivated to conduct this research in order to improve people`s experience of mental health services and of therapy.

1.5 THE RATIONALE FOR THE RESEARCH

The rationale for this research project consists of a number of convergent strands, both practical and theoretical. One strand originates in the operational difficulties presented by the lack of formal guidelines for the assessment and referral process. Other strands originate in the lack of clarity about the way clients change in therapy and our limited

knowledge about how clients may use the different therapeutic approaches. The final strand of the rationale comes from the relative scarcity of studies which investigate therapy from the perspective of the person receiving it.

- **Guidelines for assessment**

The aim of the assessment and referral process is to ensure that potential clients are referred to the therapy which will benefit them the most. This requires a decision making process which has been a point of debate and development as, despite considerable research efforts over many years, we still do not know what therapy works best for whom. A question I was frequently asked from both clinicians and management was, "How do we decide who to refer to CBT and who to PCT?" Potential clients may have a preference for a particular therapy, but where this is not the case the lack of formal guidelines has meant that often individual clinicians have implemented informal referral systems, where factors are used in the decision making process such as the particular preferences of the referrer for either therapy or the relative lengths of the waiting lists.

In line with the research which investigates the effectiveness of therapy with particular disorders, NICE make their recommendations according to diagnosis. The preponderance of positive evidence for CBT can lead to the impression that it is a "panacea for psychological distress in all its forms," (Blenkiron, 1999, p.226) leading to expectations which cannot always be met by the delivery of CBT in primary care. From the perspective of a clinical practitioner trying to make an assessment, there are drawbacks to the emphasis placed by NICE on quantitative outcome research as it demonstrates that a therapeutic approach is statistically effective, but it is of limited value when making clinical decisions about individual clients, as it cannot predict whether or not a particular therapy will benefit a particular individual. The problem from a clinical perspective is that for some people the therapy is not effective. This poses the interesting question of whether certain individuals will benefit from one therapy and not the other, or whether it is the same individuals who will benefit from either therapy. This has been an area of enquiry which has received attention and there have been research efforts to "match" clients with certain characteristics with different therapies which have been largely unsuccessful (eg. Project MATCH, 1997).

There have been limited attempts to inform the assessment procedure from within the CBT and PCT approaches. The Suitability for Short-term Cognitive Therapy scale is an objective rating scale consisting of 9 dimensions each with 5 scale points which includes, for example, the client`s ability to access thoughts, awareness of emotions, acceptance of personal responsibility for change and an ability to form a therapeutic alliance (Safran and Segal, 1990, Safran, et al, 1993). Wilkins (2005, p.128) describes how assessment has traditionally been regarded as incompatible with classical person-centred theory and practice, and puts forward a model for assessment drawing on person centred principles. Here the practitioner asks a number of questions which include, for example, asking if the therapist and potential client are able to make and maintain contact, if the therapist can offer the therapeutic conditions of unconditional positive regard and empathy to the client and if the client is able to perceive them. It could be argued that these criteria and questions in both procedures could be applied when assessing clients entering all psychological therapies. My hope was that the findings from this project would shed more light on this assessment process.

- **The change process**.

My experience of managing both CBT and PCT services illustrates the paradox, highlighted by a number of researchers, that therapies with apparently different theory, philosophy and practice are similarly effective. In other words therapies appear to have equivalent outcomes but non-equivalent processes (eg. Stiles, 1999). Many researchers have conducted investigations into the interior of therapy in order to understand the processes and mechanisms by which clients change (Llewellyn and Hardy (2001) have produced a detailed review of some of this research). The rationale behind this line of enquiry is that if more is known about how clients change in therapy this knowledge can be used to increase effectiveness. Some of this research investigates the way change occurs during different therapies (eg. Nilsson, et al, 2007), but none have made a direct comparison between PCT and CBT. The aim of this project is to extend this literature and contribute to our knowledge of how clients change in different therapies. This will be useful in deciding which therapy is likely to benefit a specific individual

There have been efforts to counteract the movement towards empirically supported treatments by promoting the role of the relationship (Norcross, 2011) and of the Common Factors, elements of the therapy which are common to all approaches (Duncan, et al, 2010), in the effectiveness of therapy. There is also a small, but increasing, body of evidence to support the view that people are not passive recipients of therapy but active agents in making therapy work by using interventions in their own unique and creative ways (Bohart and Tallman, 1999). By focusing on the activity of the client, I hope that this project will contribute to this body of literature. The rationale is that if more is known about how clients make use different therapies then this a may also be useful in deciding which therapy will be best for whom.

- **Research from the perspective of the client**

Historically, studies of therapy have been made from the point of view of those who deliver them rather than those who receive them, and the aspects of the client`s mental health which are measured are determined by the researcher. In this research the experience and the voice of the individual is lost. This is contrary to the stated aim of the NHS, which is to put the patient at the centre of their care and the decisions made about them (DoH, 2008). Qualitative research, gives a voice to individual clients and puts them at the centre of the research. Social science research has been conducted into the experiences of individuals with mental health problems which have given some insights into the client`s understanding of their difficulties and how they have recovered (eg. Ridge and Zeibland, 2006). There is also a growing awareness of the importance of the client`s perspective in developing our understanding of therapy. Psychotherapy research from the client`s perspective has been conducted across different approaches and has pursued several different lines of enquiry (Elliott, 2008). Again, this project would extend this literature and use the voices of individual clients to increase our understanding of how therapy works and the contribution the individual makes to their own recovery. The drawback is that such research is not taken into consideration by NICE when making recommendations regarding treatment. NICE takes account of the qualitative research when making recommendations about the delivery of services, but not about the kind of therapy to provide (NICE, 2010, p.86).

1.7. THE STRUCTURE OF THE THESIS

In presenting the research I have followed many of the traditional conventions that exist within academic presentations. There are six chapters: Introduction, Literature Review, Methodology, Findings, Discussion, and Final Summary and Conclusions. The Introduction has set the scene by describing the operational and political context in which I conceived and conducted the research and by outlining the rationale for the research. In the Literature Review I will present an overview of the existing research in this area, and the research questions that the thesis seeks to address. In the Methodology chapter I will discuss the research design and the methods I implemented to collect and analyse the data in order to answer the research questions. In the Findings chapter I will describe the analysis and present the main findings, and in the Discussion chapter I will reflect on these findings in the light of the literature reviewed earlier. I will draw the thesis to a close with a final summary of the project and the conclusions that may be drawn from it. I will also give brief consideration to the drawbacks of the methodology, possible avenues for future research and some final personal reflections. With regard the rhetorical structure, in order to remain true to the underlying constructivist philosophy of this study (for reasons which I will elaborate in more detail in the Methodology chapter) I will use the first person throughout this account.

2. LITERATURE REVIEW

2.1. INTRODUCTION TO THE CHAPTER

The purpose of a literature review is to place the proposed research project in context, McLeod (2003). More specifically its purpose is to demonstrate competence in identifying and critically evaluating the literature relevant to the proposed study, to identify the 'gap' in the research that the study is attempting to address and to produce a rationale or justification for the study (Hart, 1998). Traditionally, therefore, a research review is carried out before embarking on a research project. As this study is a Grounded Theory study there is a degree of conflict with the purpose of a literature review outlined above. According to Corbin and Strauss (2008) it is neither necessary nor desirable to conduct a thorough review of the literature before conducting the investigation and analysis. The discovery orientated nature of a Grounded Theory study requires that the researcher remains open to concepts emerging from the data and there is a danger that too much knowledge of the literature will restrict the researcher, predetermine the concepts that emerge and prevent the discovery of something new. However, as I elaborate further in the methodology chapter which follows, it is impossible to have trained and worked as a person-centred therapist without a knowledge of the person-centred literature. It was also necessary to have reviewed the wider literature in order to give a rationale for a project and construct a research proposal which met the requirements of a university review panel. In practice, reviewing the literature was a process in which I engaged in parallel with the data collection and analysis. As concepts emerged from the data I turned to the literature to establish the state of current knowledge, discussions and opinion.

I have structured the review itself according to a number of different themes, each covering an area of literature relating to the research project. The literature is complex and this chapter proved difficult to organise, with some research appearing in more than one section. I have tried to bring some order to the complexity by constructing a narrative and relating it to the aims of the project in a way which is meaningful to the reader. The number of publications in the different areas is extensive and so I hope the

reader will appreciate that it is beyond the scope of this account to provide a comprehensive review. In writing this review I have drawn on a variety of sources. I utilised online databases PsycINFO, Medline and Google Scholar. I followed up references from the publications I accessed and I have also made use of a number of sources that I have collected during my career as a counsellor.

The starting point for the rationale for conducting this research was that CBT and PCT appear equally effective in terms of their outcome, but different in terms of their philosophy, theory and interventions. I will begin the review at this point with the supporting evidence for the "equivalence paradox" (Stiles, 1999; Stiles, Honos-Webb and Surko, 1998). In the second section I will describe the different theories of change in PCT and CBT, the two therapies which are the focus of this investigation and some of the related literature. In the third section I will introduce the Common Factors Theory (Duncan, et al, 2010). This provides an alternative to therapy specific theories as it states that it is the factors which are common to all therapies which bring about change rather than the factors which are specific to the different therapies. This leads on to the fourth section which elaborates one of the common factors, the client. In this section I will concentrate specifically on the Active Client Theory (Bohart and Tallman, 1999), and some of the research that supports it. In the final section I will introduce some of the research conducted into the experience of the client. This is a body of literature which was of particular relevance in influencing my choice of methodology and it leads into the following, Methodology chapter. In this review I have referred to an international body of literature, but in my discussions I have tried to relate this primarily to the context of therapy in the NHS in the UK and particularly to primary mental health care and IAPT.

2.2. THE EQUIVALENCE OF CBT AND PCT

There is a body of literature which supports the observation that different therapies are equally effective and in this section I will review some of that literature. Ever since Eysenck (1952) showed that two thirds of people diagnosed with neuroses recovered without any psychological intervention, psychotherapy research has been dominated by the need to demonstrate its effectiveness. The results of a large number of studies and

numerous reviews over several decades have consistently demonstrated that therapy is more beneficial than no therapy (eg. Wampold, 2010, p.55). While it is now generally accepted that therapy is effective, attention has turned to demonstrating the relative effectiveness of different therapeutic approaches. In the UK, as internationally, the evidence from a randomised controlled trial (RCT) or a meta-analysis of randomised controlled trials is considered the best form of evidence for identifying effective treatments (NICE, 2009, p.159). Many researchers claim to have demonstrated the superiority of one therapy over another (eg. Rush, et al, 1977; Kovacs, et al, 1981; Rush, et al, 1981; Robinson, Berman and Neimeyer, 1990). Others say these claims can be accounted for by the phenomenon of researcher allegiance where the researchers favour the superior therapy, or by using comparator treatments which are not bona fide therapies such as supportive therapy (eg. Wampold, 2010; Elliott and Freire, 2010).

Other attempts to demonstrate the superiority of one therapy over another have been unsuccessful. In the USA, the National Institute of Mental Health (NIMH) treatment of depression collaborative research program was carried out in the late 1980s (Elkin, et al, 1989). This was an RCT evaluating the effectiveness of CBT, interpersonal therapy (IPT), antidepressant medication and a placebo control. Ablon and Jones (2002, p.776) described it as "the most carefully conducted and methodologically sound randomized, controlled clinical trial comparing different forms of brief psychological therapy," yet it failed to find significant differences between the effectiveness of CBT and IPT across a range of indicators. In the UK, the Second Sheffield Psychotherapy Project was conducted comparing the effectiveness of CBT and IPT also found that they were similarly effective (Shapiro, et al, 1990). Another, more recent clinical trial, also conducted in the UK, compared CBT with non-directive counselling and, again, found little difference in their effectiveness. (Ward, et al, 2000). Over the years, several researchers have carried out meta-analyses (eg. Wampold, et al, 1997; Cuijpers, et al, 2008) which have found little difference in efficacy between different therapies. Such studies have led Duncan, Miller and Sparks (2004, p.9) to conclude that the data from over 40 decades of psychotherapy research shows "little support for the superiority if any therapeutic approach over any other." Practice based evidence from the UK has also agreed with the findings from clinical trials, demonstrating that in routine clinical practice different therapies are similarly effective (Stiles, et al, 2006; 2007). The IAPT data appears to show, that, while CBT is more effective with the anxiety disorders, there

are no large differences between CBT and counselling with depression (Gyani, et al, 2011). In a different approach, a study by Okiishi, et al (2003) examined outcome data collected on 1841 clients seen by 91 therapists in a university counselling centre. They found that there was a significant amount of variation among the improvement rates of individual therapists, but that the theoretical orientation of the therapist did not account for this.

This lack of evidence for the superiority of one therapeutic approach over another has led some to conclude that all therapies are equally effective. According to Duncan (2010), Rosenzweig (1936/2010) was the first to use the term "Dodo bird verdict" to describe this situation. This term is taken from Lewis Carroll`s children`s book, Alice in Wonderland, where the animals have a race with different starting points and times and they all run in different directions. Eventually the dodo-bird calls a halt with the words, "Everybody has won, and all must have prizes." A considerable amount of controversy and disagreement surrounds this issue. Opponents of the dodo-bird verdict are many (eg, Chambless, 2002; Barlow, 2010). They explain the apparent equivalence of therapies by the lack of development of methodologies sophisticated enough to measure the differences, or by differences in the degree of suitability of the different therapies for individual patients.

At the same time as the research appeared to demonstrate that different therapies were similarly effective, efforts also went into showing that there were differences in the way contrasting therapies were delivered, and that these differences were consistent with their underlying theory (eg. Hill, O'Grady and Elkin, 1992). According to Stiles (1999) the evidence for this is at least as robust as that for the equivalence of their outcomes. He described the psychotherapy world as "on the horns of a dilemma". On one horn is the apparent equivalence of the effectiveness of therapies, while on the other is the apparent non-equivalence of their interventions and processes. In the section which follows I will describe the different theories which underlie CBT and PCT and look at some of the related research.

2.3. THEORIES OF CHANGE

In this section I will introduce the two therapies which are the focus of this research study and compare the theories which have been put forward to explain how individuals change in each therapy. It is therefore possible to make comparisons between the theories from the literature and the change processes described by the participants themselves. If the theories are valid then the participants` accounts of their experiences might be expected to reflect them.

PCT is based on the work of Rogers during the 1950s and 60s (Rogers, 1951; 1959; 1961). He originally called the approach Non-Directive Therapy, based on his rejection of traditional therapist directed therapy. He subsequently changed the name to Client Centred Therapy, then modified it to Person-Centred Therapy and the Person Centred Approach, reflecting the widening of the application of his ideas to a range of situations such as education, and organisations. According to Rogers, psychological disturbance is due to conflict between an individual`s internal valuing system and their self concept (the person`s view of himself). This arises from the individual`s need for positive regard, which the individual experiences as conditional. Rogers believed that every individual possesses the innate tendency to actualise and fulfil his potential and that, if the individual could experience the right conditions, this actualising tendency would become a reality. The result would be that the individual`s self concept becomes more aligned with their internal valuing system, and growth and develop would occur in a positive and constructive direction.

The person-centred approach has continued to develop over the years resulting in the "family" of person-centred and experiential therapies (Sanders, 2007a) or the "tribes of the person-centred nation" (Warner, 2000; Sanders 2012). Classical PCT continued to develop as diological or relationship-orientated approaches (Schmid, 1998; Mearns and Cooper, 2005). Alongside this has developed the experiential therapies (Greenberg, Watson and Lietaer, 1998). Rogers described therapy in terms of a continuum or directional process (Rogers, 1961, p.125) where the client moves from (among other qualities) a state of rigid constructs, remote from his inner experiencing towards fluidity of constructs and openness to his experiencing. Rogers proposed that an increased awareness and depth of experiencing is the *result* of therapeutic change. The

experiential therapies were developed later on the basis that it is the individual`s ability to access and engage with their experiencing which is the *cause* of therapeutic change. The roots of these approaches lie within the work of Rice, (1974) and Gendlin (1974, 1978). They include Focusing-oriented therapy (Gendlin, 1996; Purton 2004), Experiential therapy (Rennie, 1998), and Process–experiential, or Emotion Focused therapy (Elliott, et al, 2004). The experiential approaches are directive in terms of process and so controversy surrounds their inclusion under the person-centred umbrella (Levitt, 2005).

In a similar way to PCT, CBT has become an overarching term for a broad domain (Dobson, 2010, pxi) or a whole cluster of therapies (Twohig, 2012). The behavioural component of CBT originates in the work of Pavlov in the 1920s and Skinner in the 1940`s (Hayes, 2004). Behaviour therapy focuses directly on changing problematic behaviour by the use of a range of methods based on classical and operant conditioning, which had been identified in laboratory animals. Exposure therapy, for example exposes the individual to stimuli which produce distressing emotions, leading to desensitisation. The cognitive component is based on the work of Beck (Beck 1967; Beck, et al, 1979;) and Ellis (1962; 1970) during the 1960s and 1970s, who recognised the effect of an individual`s core beliefs (the person`s underlying assumptions) and thought processes on their mood and behaviour. Beck`s Cognitive Therapy focused on helping clients to challenge problematic, dysfunctional or negative core beliefs and thoughts, and replace them with more helpful, realistic or positive ones.

Hayes (2004) describes the preceding approaches as the first two "waves" of behaviourism. The third wave developed in the 1990`s. This consisted of a number of different therapies including Mindfulness-Based Cognitive Therapy (Segal, Williams and Teesdale, 2002), Acceptance and Commitment Therapy (Hayes, Strosahl and Wilson, 1999) and Compassionate Mind Therapy (Gilbert, 2009). Common to these newer therapies is the focus on an individual accepting their thoughts, and feelings and changing their relationship to them rather than changing their content (Brown, Ryan and Cresswell, 2007, p.13; Hayes, Strosahl and Wilson, 2006, p.4).

- **The theory of change in PCT: the role of the therapeutic conditions**

> "If I can provide a certain type of relationship, the other person will discover within himself the capacity to use that relationship for growth, and change and personal development will occur." (Rogers, 1961, p.33)

This is described as the "if-then" hypothesis (Sanders, 2007b, p.14). *If* the necessary and sufficient conditions are present, *then* therapeutic change will occur (Rogers, 1959, p.212). No other elements or factors are necessary. Rogers set out the conditions for such a relationship as "The necessary and sufficient conditions of therapeutic personality change," (Rogers 1957; 1959, p.213). The 1959 version is set out below:

1. That two persons are in contact.
2. That the first person, whom we shall term the client, is in a state of incongruence, being vulnerable or anxious.
3. That the second person, whom we shall term the therapist, is congruent in the relationship.
4. That the therapist is experiencing unconditional positive regard toward the client.
5. That the therapist is experiencing an empathic understanding of the client`s internal frame of reference.
6. That the client perceives, at least to a minimal degree, conditions 4 and 5, the unconditional positive regard of the therapist, and the empathic understanding of the therapist.

Rogers` hypothesis has stimulated an enormous body of literature and research, particularly in relation to the three conditions provided by the therapist of empathy, congruence and unconditional positive regard, which have come be known as the Core Conditions (Mearns and Thorne, 2007, p.17). His hypothesis caused controversy at the time, and this has continued until the present day, with a considerable body of literature regarding their sufficiency, and continuing efforts to describe their exact nature.

Empathy is probably the concept which has received the most attention. Rogers originally described empathy as, "to perceive the internal frame of reference of another

with accuracy, and with the emotional components and meanings which pertain thereto, as if one were the other person, but without ever losing the "as if" condition." (Rogers, 1959, p.210). Rogers continued to developed this concept and later described it in a more holistic and experiential manner as an empathic way of being, "entering another person`s world…being sensitive, moment by moment, to the changing felt meanings…living in the others life, moving about in it delicately without making judgements, sensing meanings… looking with fresh and unfrightened eyes at elements of which he or she is fearful." (Rogers, 1980, p.142.). In explaining the term, congruence, Rogers writes that "the therapist`s symbolisation of his own experience in the relationship must be accurate…..he should accurately `be himself,`" (Rogers, 1959, p.214). About the term unconditional positive regard, Rogers writes: "to value the person, irrespective of the differential values which one might place on his specific behaviours," (Rogers, 1959, p.208).

In order to test the validity of Rogers` hypothesis it was necessary to develop instruments to measure the conditions. In spite of the many attempts to do so (Friere and Grafanaki, 2010) there are many in the person-centred community would ask whether the conditions are measurable. There is the view that Rogers conceptualised the conditions separately, as different and independent variables, in order to make his hypothesis acceptable within the dominant positivistic culture, and that in practice they cannot be separated. In testing their validity researchers have found it difficult to define and separate out the different conditions. It has proved difficult to measure them, with the client, therapist and independent observer often disagreeing in their rating of their presence in a therapy session (Ibid, p.208). As part of the review undertaken by the American Psychological Association (APA) Division of Psychotherapy task force into the evidence for the effectiveness of the therapeutic relationship (Norcross, 2011), meta-analyses were conducted into the three core conditions, of empathy (Elliott, et al, 2011), congruence (Farber and Doolin, 2011) and unconditional positive regard (Kolden, et al, 2011). All three conditions were shown to be correlated with a positive outcome of therapy. Overall the task force concluded that empathy was demonstrably effective, positive regard was probably effective and congruence was promising but with insufficient research to judge.

According to classical person centred theory, an individual`s increasing ability to access his inner experiencing is one of the consequences of therapy. Early research demonstrated a correlation between levels of experiencing and outcome, but not that one is the cause or effect of the other (Rogers, et al, 1967). Gendlin (1974) concluded that it is the clients` ability to access their experiencing which is a cause of therapeutic movement, not a consequence of it, and he developed a series of steps to help an individual learn to turn their attention inwards and focus on their inner experiencing (Gendlin, 1978). The experiential approaches also recognise the role emotions play in psychological disturbance, particularly inadequately processed emotional experiences (Greenberg and Paivio, 1997). Experiential practitioners have developed ways of helping the client to access and explore the emotions associated with inadequately processed experiences (Watson, Greenberg and Lietaer, 1998; Elliott, at al, 2004) in order to relieve psychological distress.

Research by experiential practitioners into the relationship between client`s levels of experiencing and outcome has consistently demonstrated a positive association (Watson, Greenberg and Lietaer, 2010). This appears to support the experiential theory of change. However, this is not confined to experiential therapies. For example, Watson and Bedard (2006) found that good outcome clients in both emotion focused therapy and CBT for depression began, continued and ended therapy with higher levels of experiencing than clients with a poor outcome. They conclude that level of experiencing is an ingredient of change, regardless of the therapeutic approach. Process experiential-emotion focused practitioners have also conducted a comprehensive program of research into the effectiveness of the methods they use which they use to provide empirical support for their interventions (see reviews by Elliott and Greenberg, 2002; Watson Greenberg and Lietaer, 2010).

- **Theories of change in CBT: do thoughts influence mood, or does mood influence thoughts?**

According to the cognitive mediation hypothesis (Burns and Spangler, 2001) psychological disturbance is caused by dysfunctional though processes, and therefore a change in thinking style produces an improvement in the symptoms of psychological distress. For example, depression is caused by frequent negative automatic thoughts

which are caused by negative core beliefs. Cognitive therapy acts by challenging the negative core beliefs and reducing the frequency of negative automatic thoughts, thereby reducing the symptoms of depression (Beck, et al, 1979). The evidence for the cognitive mediation hypothesis is mixed. Oei and Free (1995) conducted a review of studies of the process and outcome of CBT. This showed that there was a change in thinking style in CBT and that the change in negative thinking seemed to be related to a change in the symptoms of depression. However, the results did not show whether the change in thinking style preceded, and therefore were likely to have caused the change in depressive symptoms. These authors also found similar results from studies of drug therapy, and miscellaneous psychological therapies showing that a change in thinking styles was not confined to CBT. Burns and Spangler (2001) found similar results in a study investigating the link between dysfunctional attitudes and the symptoms of anxiety and depression. They demonstrated that a change in dysfunctional attitudes was positively correlated with a change in levels of anxiety and depression, but not that either one was the cause of the other.

A different line of enquiry, investigating whether it is mood which influences thinking, demonstrated that mild depressed moods could activate negative thoughts in non-depressed people (Segal, Williams and Teasdale, 2002, p.28). This led to the hypothesis that, where individuals suffer from chronic depression, there is a learned association between depressed mood and negative thinking. Such people are vulnerable to relapse as transient low mood activates these negative thought patterns, which can escalate into a cycle of depressive thinking they call depressive interlock (Teasdale, Segal and Williams, 1995, p.29)

Whisman (1999) argued that the cognitive mediation hypothesis should be viewed tentatively and asked for repeated assessments of cognitive change and symptom change, to determine if cognitive change precedes symptom change in CT. Tang and DeRubeis (1999), conducted a time course analysis of CBT for depression. In their study many patients experienced large symptom improvements in a single interval between sessions, they called sudden gains. This improvement was preceded by cognitive changes. They concluded that it was likely that the cognitive changes were triggers of the sudden gains and concluded that their findings supported the cognitive mediation model. Tang and DeRubeis (1999) proposed a 3-stage model of cognitive

change based on their research into sudden gains. They found that clients initially responded favourably when taught the cognitive model (preparation stage) and then experience a critical belief or schema change which led to a sudden decrease in depression (critical session). In turn this lead to an improved alliance and a greater receptivity of the client to cognitive interventions which in turn leads to lowered depression and eventual recovery (upward spiral). They hypothesised that clients who recover without showing such sudden gains do so by a different mechanism. These finding have been replicated (Tang, et al, 2005; Hardy, et al, 2005) but other research has shown such sudden gains in supportive, expressive therapy (Tang, Luborsky and Andusyna, 2000) and in a wide range of psychological therapies in an NHS setting (Stiles, et al, 2003). Other studies of CBT have not found evidence that sudden gains are preceded by cognitive changes (Hofmann, et al, 2006; Bohn, et al, 2013) which seems to cast some doubt on the cognitive mediation hypothesis.

In contrast to mainstream CBT, the theory underlying all the third wave therapies is that change is mediated by acceptance of thoughts rather than by changing them. Common to all these therapies is the practice of Mindfulness, the origins of which lie in Buddhist meditation. Kabat-Zin (2003, p.145) proposes a working definition: "the awareness that emerges through paying attention, on purpose, in the present moment, and non-judgementally to the unfolding of experience moment by moment." There have been a number of attempts to formulate a mechanism by which mindfulness produces change (see reviews by Baer, 2003; Brown, Ryan and Cresswell, 2007). For example, it is suggested that mindfulness may act in a similar way to exposure therapy, where the individual experiences distressing emotions, paying them non-judgemental attention without attempts to avoid them, leading to desensitisation (Baer, 2003, p.128; Brown, Ryan and Cresswell, 2007, p.226). However, third wave theorists suggest that Mindfulness brings about a change in the individual`s perspective on their process of thinking. Teasdale (1999) proposes that it facilitates "metacognitive insight", a process of "stepping-back," and observing one`s thoughts as they come into awareness, which leads to an experiencing of the thoughts simply as mental events rather than expressions of reality. Shapiro, et al (2006, p.377) suggest a similar shift in perspective which they have termed "reperceiving." The shift in perspective is believed to be further facilitated by cultivating the attitude of acceptance towards these thought processes. Hayes (2004) puts forward the theory that by changing one`s attitude towards or relationship with

one`s thoughts and feelings, it alters their function and they will have much less impact and influence. However, it remains unclear how mindfulness brings about change (Coelho, Canter and Ernst, 2007). It is has not been demonstrated that individuals taking part in mindfulness training achieve a state of mindfulness and it is possible that mindfulness training may just be another relaxation technique (Bishop, 2002).

There have been a small number of qualitative studies attempting to explore the therapeutic process of CBT described by participants themselves. These studies have had mixed results. Rees, et al (2001), researchers in the second Sheffield Psychotherapy Project, a comparative study of the efficacy of CBT and psychodynamic interpersonal therapy (IPT) for depression, carried out a comprehensive process analysis of a client identified significant event in CBT. The change processes they identified coincided with the steps that would be expected from a CBT intervention for problem clarification and they concluded that their analysis supported the cognitive theory of change. On the other hand, in a qualitative investigation of clients` perceptions of the change process in CBT, Clarke, Rees and Hardy (2004) found that client`s description of change could be mapped to the stages of change described in the assimilation model (Stiles, et al, 1990), rather than a CBT model of change. Mason and Hargreaves (2001) investigated people`s experiences of mindfulness training. They found that their participants accounts of their experiences supported the cognitive theories of change mediated by acceptance. Participants also described a process of "stepping-out of" or "distancing from" negative thinking which could be interpreted as evidence of a metacognitive state. On the other hand some of the accounts in a different study by Allen, et al (2009) highlighted non-specific factors such as the group experience. These researchers concluded that mindfulness training brought about change by a complex interaction of specific and non-specific factors.

- **CBT and the therapeutic conditions**

The therapeutic conditions were originally conceived in the context of PCT, and their perception within the CBT community is mixed. Leahy (2008) describes how CBT has often been criticised for ignoring the role of the relationship and that, because of the need to demonstrate the effectiveness of the specific techniques of different treatments, there is a danger that CBT will become "technolatry". In CBT the term "therapeutic

conditions" is sometimes used interchangeably with the term "therapeutic alliance" (eg. Leahy, 2008). Other authorities regard them as two distinct concepts, with the alliance as one way of conceptualising what has been achieved by the appropriate use of the relationship (Horvath, et al, 2011, p.56). Studies have demonstrated that both the therapeutic conditions and the therapeutic alliance are positively associated with the outcome of CBT (eg. Keijsers, Schaap and Hoogduin, 2000). A meta analysis of empathy (Bohart, et al, 2002) showed that there was a stronger correlation between empathy and outcome in CBT than humanistic therapies. However, this finding was not confirmed in a later analysis (Elliott, et al, 2011).

Qualitative studies which have demonstrated that clients find the relationship factors helpful in therapy have also included individuals who received CBT (eg. Paulson, Truscott and Stuart, 1999). In contrast, Clarke, Rees and Hardy (2004) carried out a qualitative interview study of clients who had received a brief course of CBT for depression. They found that, when asked about their experience of change and the aspects of the therapy they had thought brought the change about, their participants talked about specific CBT ingredients such as dealing with thoughts, testing things out and understanding patterns and beliefs. Although one of the clusters of categories they found, the listening therapist, covered a range of non-specific factors, their participants did not describe the therapeutic conditions.

Thwaites and Bennett-Levy (2007) try to rectify the lack of discussion or research on the therapeutic conditions in the CBT literature by conceptualising the role of empathy in CBT. They suggest that empathy has a role in assessment and formulation by facilitating the expression of thoughts, feelings and behaviours that are potentially painful or shameful. They also have a role in forming a therapeutic alliance and a safe working environment which ensures the success of the intervention. They argue that when cognitive therapists ask a client to engage in difficult and emotionally challenging tasks, empathy becomes even more important. They also see a growing recognition within the third wave approaches that an empathic relationship can be an agent of change in itself.

It can be appreciated that considerable efforts have been made to find support for the different theories of how clients change in therapy, but that these efforts have largely

been inconclusive. Researchers in each tradition are inclined to focus on elements specific to their particular therapy and there has been a tendency for proponents of an approach to find evidence which supports their particular theory of change. Other researchers have compared clients` experience of change in a number of contrasting therapies, and these too have found different results.

- **Comparison Studies**

Nilsson, et al (2007) asked individuals discharged from a psychiatric outpatient clinic, who had received either CBT or Psychodynamic therapy (PDT), how they had changed and what aspects of the therapy they thought had contributed to the changes. Participants reported many helpful experiences in common, such as the support of their therapist. They also reported different aspects of the therapy contributing to the change which, on the whole, were consistent with the therapy they received. According to the participants the CBT process was focused and structured and the perceived mechanism of change was described as the gradual confrontation of specific fears. The PDT process was open-ended sometimes painful process of self-exploration.

On the other hand, Binder, Holgerson and Nielsen (2009) found that the particular "brand name" of therapy did not appear important for their participants. They found that their participants gave meaning to change processes and events clustered around the following themes: (i) Being in a relationship with a wise, warm and competent professional, (ii) Being in a relationship with continuity when suffering from feelings of inner discontinuity, (iii) Having assumptions and beliefs about oneself and one's relational world corrected, (iv) Creating new meaning and seeing new connections in one's life patterns. Carey, et al (2007) found that their participants clearly identified changes in terms of their feelings, thoughts and actions. Aspects that their participants thought had brought about change were: motivation and readiness, tools and strategies, learning, interaction with the therapist and the relief of talking. They found a number of participants described change as a gradual process or as a discreet memorable moment and not as a series of stages. They contrast their findings to those of Clarke, Rees and Hardy (2004), described earlier, who found that client`s description of change in CBT could be mapped to the stages of change described in the assimilation model.

Perren, Godfrey, and Rowland (2009) investigated clients` perspectives on the aspects of therapy which had contributed to ongoing change, after therapy had finished, and the long-term effects of therapy. They found that in order for the benefits of therapy to be lasting the clients needed to be actively engaged during and between sessions, to work toward their own solutions. And they needed to acquire a 'box of skills' which could be used and added to once counselling had ended. They developed a model of the change process of counselling which moved through the distinct phases of engagement, exploration of internal and external worlds, consolidation and negotiated ending.

A different line of enquiry has been the search for Aptitude by Treatment Interactions. These are attempts to match treatment to client characteristics in order to determine if different kinds of client might benefit differentially from different therapies. If the different theories are correct it might be expected that, for example, clients with cognitive problems would benefit more from cognitive therapy. There is some evidence that this is the case. (eg Stiles, et al, 1997; Addis and Jacobson, 1996). However, Project MATCH (1997), a large RCT which examined the effectiveness of CBT, Motivational Enhancement Therapy and the Twelve Step model for individuals with alcohol problems, did not find that there were particular matches between client characteristics and the outcome of therapy.

There is a body of literature from the Social Science tradition which has investigated people`s individual experience of depression and the personal meanings they give to their experiences of recovery from depression. These studies show that people have a rich variety of ways of describing their recovery which include, but are not limited to, the traditional definitions of depression as a reduction in symptoms (eg. Johnson, Gunn and Kokanovic, 2009). There is growing recognition, within this literature of the gendered nature of depression, that it affects women and men in different ways, (Fullagar and O`Brien, 2012), something that does not appear in the psychotherapy literature. These studies have found that women, in particular, use metaphors for their recovery from depression which involve self knowledge and a change in identity (eg. Schreiber, 1996; 1998) such as the transformation of the self (Karp, 1994) or being true to an authentic self (Ridge and Ziebland, 2009). These studies also show how individuals value talking therapies as means of reducing isolation and gaining insight into their thoughts and feelings, but that much insight work took place outside therapy.

It can be appreciated that the evidence relating to the different change theories, is open to doubt and despite considerable efforts, the mechanisms by which individuals change in the different therapies remains unclear. If the theories are correct, it would be expected that clients would change in different ways in the different therapies in response to the interventions which are specific to each therapy. In other words, clients who receive CBT would change their behaviour and their thinking styles in response to the cognitive behavioural interventions, while clients who received PCT would grow and develop towards their full potential in response to their experiencing of the therapeutic conditions. Conversely, there is a body of literature which contradicts the premise that it is the specific factors of the different therapeutic approaches that bring about change. Rather, it is factors which are common to all therapeutic approaches. As the aim of this study was to investigate clients` experiences of the change process it was useful to have an appreciation of this literature also as, if this is the case, then it could be expected that clients who have received different therapies would change in similar ways.

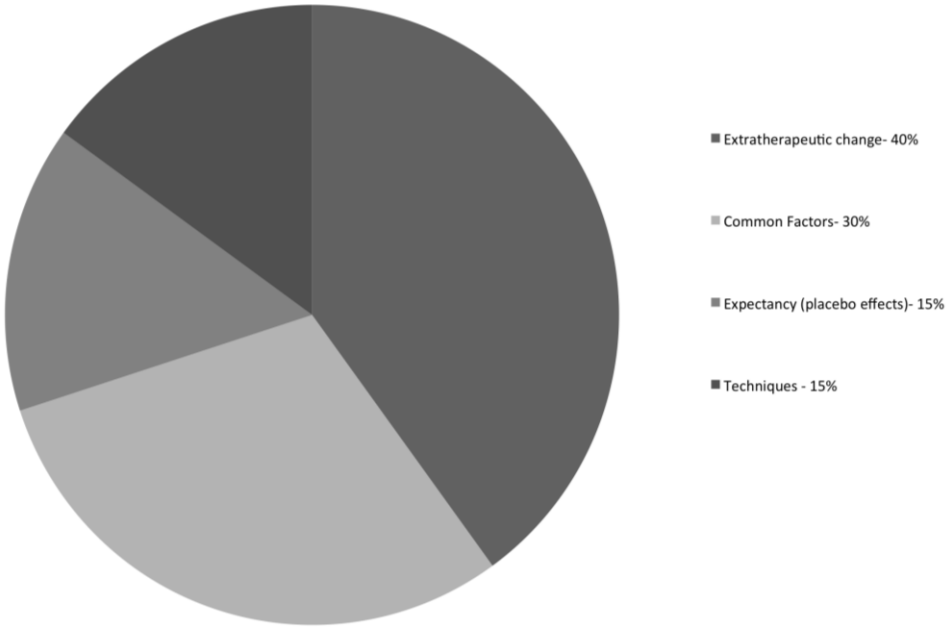
2.4. THE COMMON FACTORS THEORY

To begin this section I will first remind the reader of the dodo-bird verdict, introduced in a previous section, where, in the race to prove superiority, the effectiveness of all adequately researched therapies are equal, so that "all have won and all must have prizes." One explanation for this finding is the common factors model, which states that the main cause of change in therapy are the factors which are common to all therapies rather than those which are specific to a particular therapeutic approach. Llewellyn and Hardy (2001, p.16), in their review of how the different process factors relate to outcome write that, "A fair but rather disappointing conclusion seems to be that some techniques have been found helpful in some contexts." Ahn and Wampold (2001, p.254) in their meta-analysis of component studies aimed at the identification of specific ingredients, came to the somewhat firmer conclusion that, "there is no evidence that the specific ingredients of psychological treatments are responsible for the beneficial outcomes of counseling and psychotherapy." In a recent review, Norcross and Lambert (2011, p.12) summarise "thousands of outcome studies and hundreds of meta-analyses,"

and represent the factors which account for the outcome of therapy as a simple pie chart, in a way which has become known as, "Lambert`s Pie," (Asay and Lambert, 1999), reproduced in Figure 1.

Figure 1

Lambert`s Pie



After consideration of the evidence, Hubble, et al (2010, p.33) conclude "The evidence is indisputable: Change as a result of psychotherapy derives from key ingredients or elements that transcend all approaches." Not surprisingly, the common factors model has also caused a great deal of debate and disagreement over the intervening years. There have been many efforts, over a number of years to identify and categorize the common factors. Grencavage and Norcross (1990), for example conducted a review of the literature. They found 89 different common factors of which 41% were change processes, 21% were therapist qualities, 17% related to the treatment structure, 15% to the therapeutic relationship and only 6% were client characteristics.

Accounts of the common factors and their estimated contribution to the outcome of therapy have varied over the years. Wampold (2010, p.66) explains that the difficulty in categorising and investigating the common factors is because they cannot be

experimentally manipulated in the same way as the specific factors. It is not possible, for example, to remove the relationship from therapy and have something left that resembles therapy. He describes the intertwined nature of the common factors. For example, the therapeutic alliance has consistently been shown to be correlated with outcome (Horvath, et al, 2011). However a formation of a good therapeutic alliance is dependent on other client, therapist and contextual factors. It may be that some clients come to therapy with the ability to form an alliance. It may also be the case that some therapists are better at forming alliances with clients than others or that some therapists are better at forming an alliance with some clients than with others, or that some therapists are good at forming an alliance with a wide variety of different clients. In addition, it is difficult to separate the formation of an alliance from the delivery of the particular treatment. Horvath, et al (2011) put forward the view that agreement on the goals and tasks of therapy and their successful implementation are part of the process by which the alliance is formed.

It would also appear that such a clear division into different factors in Lambert`s pie is difficult to sustain. Extratherapeutic factors, sometimes synonymous with client factors are those which affect change but are regarded as independent of the therapy. Clients have varying amounts of resources within themselves and outside therapy, on which to call, in order to help themselves and sometimes events happen outside therapy that influence the outcome. Bohart and Tallman (1999) believe that the client is the most neglected common factor and so, it would appear that this separation as no longer warranted. Separation of expectancy from common factors and treatment models is also difficult to justify. Research has demonstrated that when a placebo is provided in a way which fosters positive expectations for improvement it causes a change similar to a recognised treatment (Honos-Webb, 2005). There have been a number of studies that have shown that clients` expectations are positively correlated to therapy outcome. This has led to the hypothesis that clients who have positive expectations that the therapy will be helpful will have better outcomes (Greenberg, Constantino and Bruce, 2006). Expectancy would therefore seem to be a factor common to all therapeutic approaches which is crucial for the success of therapy.

In an effort to counteract the current emphasis on the evidence for the effectiveness of specific approaches, the American Psychological Association (APA) Division of

Psychotherapy undertook a review of evidence for the effectiveness of common factors, (Norcross and Lambert, 2011). The aim was to determine effective methods of tailoring therapy to the individual client and to make specific recommendations about how therapists could proceed in order to improve outcomes. There are a number of elements provided by the therapist which have been shown to relate to a positive therapy outcome. The task force concentrated on a number of factors which included, among others, the alliance, and the therapeutic conditions as well as, for example, collecting client feedback and repairing alliance ruptures. The task force made recommendations regarding the ways in which therapists could provide these different elements. The research reviewed showed that, where empathy is concerned (Elliott, et al, 2011), for example, it is the client`s perceptions of feeling understood by their therapists that related to more positive outcomes. However, some studies showed that some clients, such as those who are particularly sensitive, suspicious or poorly motivated, found empathic responses unhelpful. These individuals tended to find their therapists` expressions of empathy too intrusive, directive, or uncomfortable. On the basis of this, their clinical recommendations are that therapists make efforts to understand their clients and respond empathically, but also that therapists need to be able to sense when a client will find an empathic response unhelpful and provide a respectful therapeutic distance.

The task force also made recommendations for tailoring therapy to particular types of client or client characteristics, such as, among others, differing levels of resistance, stages of change, coping styles, attachment styles, preferences and expectations. The research on the client`s coping style, for example, showed that this characteristic did have an effect on the outcome of therapy. They recommend that clinicians make an assessment of the client`s coping style and match treatment accordingly. So that, for example, people with externalising tendencies are offered treatments that are focused on skill building while those with a tendency towards self criticism and avoidance are given more indirect insight oriented treatments (Beutler, et al, 2011). Where client preferences are concerned, the research demonstrates that clients who receive their preferred therapy are less likely to drop out of treatment and more likely to achieve a positive outcome than those who do not receive their preferred option. They therefore recommend that clients are asked their preferences and accommodated wherever possible (Constantino, et al, 2011).

The Task Force concluded that the therapy relationship accounted for the outcome of therapy just as much as the particular therapy treatment. They classified the different relationship elements and the methods of adapting therapy to particular client characteristics into those which are demonstrably effective, those which are probably effective and those which are promising but for which there is insufficient research to judge. They recommend that therapists cultivate therapy relationships characterised by the elements of the relationship which have been shown to be demonstrably and probably effective and to tailor therapy to those specific client characteristics in ways that have been shown to be demonstrably and probably effective.

Space does not allow a detailed examination of both sides of the argument, but, suffice it to say that there has been a clear division in what Norcross and Lambert (2011, p.3) call the "culture wars." On one side are those who attribute the change process in a therapeutic approach to its specific ingredients, and on the other side are those who believe that common factors, such as the quality of the relationship and a belief in the rationale for treatment, are the factors which bring about change. In some quarters there may be a more recent movement towards compromise. Hubble, Duncan, Miller and Wampold (2010, p.23) write of "the decline of model mania," and "the waning of the battle of the brands." In their introduction to the review of the evidence for the therapeutic relationship, Norcross and Lambert (2011, p.3) write that, "decades of psychotherapy research consistently attest that the patient, the therapist, their relationship, the treatment method, and the context all contribute to treatment success (and failure)."

Norcross and Lambert (2011, p.3) begin their review by stating that, "the patient`s contribution to psychotherapy outcome is vastly greater than that of either the particular treatment method or the therapy relationship." As stated previously, it is the belief of Bohart and Tallman (2010b) that the client is the neglected common factor in psychotherapy, and there is a body of literature which relates to this. As the aim of this investigation was to give particular attention to the activity of the client and their contribution to the change process it was important to have a detailed understanding of this literature. In the next section I will describe the active client theory, which

emphasises the role of the client as a self-healing agent in therapy, and some of the published research which supports this theory.

2.5. THE ACTIVE CLIENT THEORY

I will begin this section by comparing the active client model with the dominant medical model. Duncan and Miller (2000) describe how the medical model casts the therapy and the therapist in the heroic roles in the drama of therapy, while the role in which the client is cast is either a dull and slow witted dinosaur or as a monster with the new diagnostic category, "Godzilla Personality Disorder." Such a description may appear to denigrate the medical model. However my intention, in making this comparison, is not to do so, but only to indicate the difference.

The medical model regards psychological distress as a disorder, with recognisable symptoms which can be diagnosed and then treated with evidence based interventions, which results in symptom reduction and recovery. It can be represented by the following equations:

Proper diagnosis + prescriptive intervention = effective treatment

or

Targeted diagnostic groups + evidence-based-treatments = symptom reduction

(Duncan Miller and Sparks, 2004, p.6)

This model implies a linear causal relationship where the treatment acts on the patient to produce the outcome. Bohart (2000) describes it in the following way:

Treatment ----- operates on patient ------- to produce effects

Duncan, Miller and Sparks (2004) have focussed their efforts on recasting the drama of therapy with the "heroic client" in the leading role and as "the heart and soul of change"

(Duncan, 2010). Bohart and Tallman (1999; 2010a; 2010b.) have written extensively about their belief that it is the active efforts of the client which are responsible for making therapy work, not the therapist or the intervention. Both sets of authors offer an alternative to the medical model, which Bohart (2000) conceptualises as:

Client ------- operates on treatments or procedures ------- to produce effects

According to Bohart and Tallman (1999) it is also the activity of the client which is responsible for the dodo-bird effect and the equivalence of therapies, because the client is able to transcend any differences between approaches. Each approach works equally well because clients are able to use whatever each approach provides to help themselves.

- **Evidence supporting the active client theory**

Bohart and Tallman (2010a) provide a detailed survey of the evidence supporting the active client theory, which, for economy of space, I will mention briefly. First of all, there is evidence that individuals recover from psychological distress and overcome personal problems without therapy. (See Gianakis and Carey (2011) for a recent discussion of this). Bohart and Tallman believe this is due to the individual`s efforts to help himself. Individual`s often make substantial gains with only a minimal degree of therapist input, demonstrated by investigations into the effectiveness of self-help material, books, leaflets and computer programmes (eg. NICE, 2010, p.171).

Evidence for the active client theory is also found in the placebo effect, which occurs in clinical trials of medication, where a significant number of participants who take placebos are found to have improved. It is unclear how the placebo effect works, but the finding has led some researchers to conclude that it takes effect by activating the participant`s self-healing capacity (Anderson, Lunnen and Ogles, 2010). Further evidence is provided by the phenomenon of resilience, that despite experiencing trauma and deprivation many children manage to grow and thrive, and that many people who experience trauma in adult life do not then develop post-traumatic stress disorder, they find ways of getting over it on their own. This is supported by the work of Linley and Joseph (2004) who found that some people who have experienced trauma go on to

develop in ways they characterise as growth. People often report that their view of themselves, others and their appreciation of life and what is important changes, and they see their trauma as a valued learning opportunity (Joseph and Linley, 2005).

Bohart and Tallman put forward the view that clients are active agents who operate on the therapeutic interventions and modify it to achieve their own ends. There have been a number of studies carried out which provide evidence that clients are actively trying to shape the therapeutic process to make it more useful to them. In a series of studies of humanistic therapies, Rennie investigated clients` experiences of therapy (Rennie 1992, 1994a; 1994b; 2000b; 2001; 2007). He found that participants were actively thinking during the therapy hour, but they did not tell the therapist what they were thinking (Rennie, 1992). Participants exerted control over what happened within the therapy hour in a number of different ways. They formed a plan for a given session and devised strategies for achieving that plan, and they changed or adjusted the plan according to the demands of the moment (Rennie, 2000b). Rennie found that participants used different strategies to manage distressing emotions during the session. Participants described how they used storytelling to lead up to experiencing painful and disturbing emotions or to delay addressing directly something that they thought would be distressing (Rennie, 1994b). Rennie also found that clients tended to pursue a line of enquiry or exploration that was important to them. Participants reported that if they considered the therapist responses were relevant to them they took account of them and worked with them. If they thought the therapist responses were irrelevant to the particular line of enquiry they were pursuing, they either ignored the therapist or they appeared to work with them, while secretly continuing to work in the way which was relevant to them. Rennie also found that the participants found ways of managing their therapist. They evaluated them and offered them material which they believed the therapist would find acceptable. They tried to understand the therapist in order to align themselves with their approach and they tried to meet the therapist`s expectations. Where there was a disruption in the therapeutic alliance they decided whether to address it or leave it be (Rennie, 2001). Rennie found that where clients are uncomfortable about what was happening in the therapy they were very reluctant to voice this discomfort. Instead they deferred to the therapist. This was for a number of reasons which included a fear of criticising the therapist in case the therapist thought less of them, a reluctance to threaten the therapist`s self-esteem, an acceptance of the therapist`s limitations, and a feeling of

being indebted to the therapist (Rennie, 1994a). The findings of a study by Watson and Rennie (1994), which investigated clients` involvement in resolving problematic events in experiential therapy, are also consistent with this. They found that clients often had their own ideas of how to deal with their experiences, but deferred to their therapists, even when this put a strain on the therapeutic alliance. Rennie conceptualised the term "reflexivity" to describe the client`s ability to actively attend to themselves, the therapist and the therapy in different ways and at different levels at once. In other words, individuals think and feel and, at the same time they think and feel about their thoughts and feelings. He defines reflexivity as self-awareness and agency within that self-awareness (eg. Rennie, 1998, p.11; Rennie, 2006, p.71).

Evidence for the active client theory also comes from the work of Levitt, Butler and Hill (2006). They interviewed clients who had recently completed therapy about their experiences, and asked what they had found helpful or significant. Like Rennie, they also found that their participants were active in therapy sessions in a covert way. Participants in their study described their efforts to control the session, regulate the relationship and avoid discussion of vulnerable issues. They also found that clients deferred to their therapists. Clients concealed their opinions and kept quiet when they were confused about the therapy, or when they perceived a lack of progress. They did this because they were reluctant to hurt or challenge therapist, and wanted to avoid disapproval or upset. When things went wrong or did not progress they blamed themselves for being poor clients. Several of the studies of significant events in therapy have demonstrated the activity of the client in this way in managing therapy sessions. Rhodes, et al (1994) found that clients are active in resolving misunderstandings by initiating discussions and voicing their thoughts and feelings. Henretty, Levitt and Matthews (2008) found that clients actively moved away from sadness for periods of time when it became too distressing, while Frankel and Levitt (2009) found that clients disengage to manage distress and maintain control over the therapy session.

Research undertaken by Bohart and his colleagues found that clients actively manipulate their therapists` interventions to make them more relevant and useful to them (Bohart and Tallman, 1999). He conducted a study where participants were given vapid, and superficial empathic responses. The impact of these unhelpful responses was notable as sometimes the interaction stopped for several seconds. Nevertheless, some

participants continued to work with these responses and were able to make productive gains, to "make lemonade out of these lemons." In line with Rennie`s work some participants tried to support the therapist by going along with their responses before steering the conversation in a more productive direction. Other participants simply ignored what the therapist had said and continued along their own track of exploration. In another study he found that clients interpreted the therapist`s interventions in ways that were helpful to them but different from the intentions of the therapist (Bohart and Tallman, 2010). One participant reported that her aim in therapy was to become more assertive. The therapist used a two–chair dialogue intervention with the intention of helping the client access her feelings. The client interpreted this as an assertiveness exercise and found it very helpful. Neither client nor therapist were aware of their different purposes and from each one`s perspective the exercise went well and according to plan. In a similar study, one client, who was looking for support, interpreted her therapist`s empathic interventions as supportive and another, who wanted insight and understanding found the therapist`s empathic responses gave her both (Bohart and Tallman, 2010).

Mackrill (2008) compared the diaries kept by clients and their therapists. This study showed that clients brought their own ideas of what they needed to do in order to change, into the therapy. Once in therapy, some clients abandoned their own ideas and applied the strategies suggested by the therapist. Others however kept their own strategies and this affected how they used the therapy. One client, for example, entered therapy believing that the way of dealing with his difficulties was to maintain a positive mental attitude. Meanwhile the therapist was not sure what he meant by this and was implementing other strategies. Therapy was effective because the client interpreted the therapist`s communications and interventions to fit with his own belief about what he needed to do to think positively. Dundas, et al (2009) investigated how students dealt with the therapist`s suggestions that they replace negative self-statements with more positive self-statements in order to combat test anxiety about their approaching examinations. The results showed that the students had reservations about the positive self-statements, thinking they were untrue or deceptive or they conflicted with their values, and they made changes to make them more acceptable. Some of the students told their therapists about their reservations and made the changes in discussion. Some of the students did not tell their therapists and made changes alone.

Participants in the study by Levitt, Butler and Hill (2006), also described how they scrutinised their therapists for signs of caring, and that they made the decision to trust the therapist and reveal vulnerable aspects of themselves. This last finding is also supported by the research by McMillan and McLeod (2006) and Knox and Cooper (2011) into moments of relational depth. Most respondents reported that it was their decision to "let go," to trust the therapist, to give up their protectiveness and defensiveness, make themselves vulnerable, and take the relationship to a deeper level. McMillan and McLeod found that this decision to let go was based on two main factors: the client`s readiness to engage and their perception of the therapist`s willingness to engage at a deep level. If the client was not ready to be fully involved in the relationship or did not think their therapist was sufficiently safe and caring, the clients carefully controlled what they talked about and would not allow the relationship to develop. They also focused on aspects which hindered the relationship, and by doing so, found reasons for the relationship not to "work." On the other hand if the client was ready to engage and thought the therapist was right they disregarded any hindering factors and committed themselves fully to the relationship

Some studies have directly addressed how clients use the therapy outside the therapy sessions. Dreier (1998), for example, investigated the activity of clients undergoing family therapy. He asked clients during the course of therapy how they were using the therapy in their everyday lives. He found that the clients did not use all of what took place in the sessions. They were selective, taking away only some, sometimes minor aspects of the session, often different aspects than the therapist thought they had. The clients continued to process those aspects of the sessions that they had selected and taken away. They used aspects of the sessions in ways that differ from the therapist`s intentions. This may have been constructive, or not, as he found that clients would use their therapist`s interventions as weapons against each other during family arguments between sessions. Knox, et al (1999) found that clients imagined and used their therapists in between sessions in different ways. They continued the process of self exploration by having an imaginary therapeutic dialogue with their therapists and they used their imaginary therapist as a companion while they integrated what they have learned in therapy into their lives. Kuhnlein (1999) conducted a study of the autobiographical narratives of individuals who had received CBT. This study showed

that an important aspect of their recovery was that clients make sense of the experience of their illness, transform and translate professional and medical terms into their own language, in order to integrate their experience into their own biography. She concluded that clients took what they found useful from the therapy sessions and integrated it into their previously held schemas. Levitt, Butler and Hill (2006) also found participants were active in many different ways between sessions. Participants described negotiating the transition between therapy and real life by allowing themselves time before or after sessions and consciously deciding to become less emotional towards the end of sessions. Between sessions clients reflected on what went on in therapy, read self-help books and engaged in self-questioning.

It can therefore be appreciated that there is significant evidence for the activity of the client both within and outside therapy. Clients are actively involved in creating and maintaining a therapeutic relationship and therapeutic alliance. They operate covertly during the session, manipulating the therapist and the therapy so they can gain maximum benefit, often in ways that the therapist is unaware of. They do not necessarily engage with the therapy as the therapist intends or the theory predicts. They select and modify interventions to make them more meaningful to them. They also engage in activities outside therapy that the therapist is unaware of. The aim of this project is to extend this literature and contribute towards the further development of the theory.

- **The therapeutic conditions and the active client theory**

From a therapy-centric view it is the therapeutic conditions which are the agent of change. Watson (2001, p.460), for example, writes that empathy is an "active ingredient of change," which acts to deconstruct the clients view of reality and helps clients to regulate their affect and learn to soothe themselves. However, according to Rogers (1961, p.33), and in a way which is consistent with the active client theory, the conditions are facilitative but it is the client who uses the relationship to grow and develop. Rogers described how the individual might do this:

> "If the clients finds herself really listened to in this intense, sensitive and deep way, she begins to listen to herself more: "What is going on in me?" In other words the

> empathic attitude on the part of the therapist encourages in the client a more sensitive listening to herself. As the therapist exhibits more of a positive and unconditional caring toward the client, the client begins to feel: "Possibly I am worthwhile, possibly I can care for myself more, possibly I can regard myself with greater respect." And there she begins to change the often very negative self-attitudes which are so common in clients. So it begins to develop a more positive self-concept in the client." (Rogers 1980/2007, p.4)

Bohart (2004; 2007) has constructed a theory of how clients make therapy work by using the concepts of "invariants" and "affordances." Invariants are stabilities or regularities in the environment. Clients do not react piecemeal to therapists individual responses, they extract an invariant from their whole experience of the therapeutic encounter. So, clients extract their perception of the therapist as empathic, not from specific responses, but from a variety of behaviours and responses over the whole course of therapy. In PCT clients take from the way they are being treated that the therapist is intending that they should treat themselves in the same way. So, in PCT, the client experiences a therapist who does not direct, but trusts them find their own solutions to their difficulties. They extract from this that they can trust themselves. Similarly, if a client experiences being prized over a period of time they will take from the experience that they should prize themselves. Clients also take from the non-judgemental nature of their therapist`s responses that what they are saying is not so unusual and so normalise their situation.

Affordances are the properties of an object which afford it certain uses. A piece of wood, for example, can be used in many different ways, such as a walking aid, a plant support or a weapon. Therapist`s responses and interventions are affordances or tools which the clients can use to create change. According to Bohart (2002), clients think in dysfunctional ways when they feel helpless, defensive or under stress. Therapy facilitates clients moving from a helpless or defensive state of mind into a productive thinking state, where they begin to operate on the interventions of the therapist to transform them into useful ways of changing their dysfunctional thought processes, solving their own problems or forming ideas for new ways of behaving. Bohart (2004) also suggests that, in PCT, they use the relationship to further their exploration of their reality. Rogers (1957; 1959) proposed that the purpose of empathic reflections is to

check the therapist`s understanding of his client. Bohart believes it is also the means by which clients check their understanding of themselves and validate understandings which may have been tentative.

- **Client Agency**

I will end this section of the review of the literature regarding the active client theory with a brief consideration of a closely related concept to that of the activity of the client, that of client agency. Human agency is the capacity of a person to act and includes the capacity to make choices, to control one`s actions and incorporates an awareness of what one is doing. Client agency can be conceptualised in terms of what they *do* within the therapy session (which can be equated with the active client theory), or what they do in their lives outside the therapy and in general (Mackrill, 2009). Agency is a key concept in both PCT and CBT. In fact the aim of both can be regarded as a process of fostering or facilitating the client`s agency (Williams and Levitt, 2007a). PCT fosters agency because of the trust put in the client by the therapist, to direct the therapy, the client develops trust in himself and discovers his capacity for growth and self-direction. CBT fosters agency, because it gives the client a number of skills and techniques which gives them more options for dealing with their problems.

Williams and Levitt (2007b) interviewed prominent therapists from different orientations and asked about their understanding of the role of the client`s agency in therapy and about the ways they fostered agency. They identified two contrasting strategies, one by teaching skills and conveying information and the other by encouraging introspective reflection. They also found that some therapists used both strategies. They encouraged introspection when they thought their client had the necessary skills to change themselves, and taught skills when they saw clients did not have them. The authors formulated a set of principles to guide therapist`s moment-to-moment decision making process in facilitating client agency. However by taking the view that it is the therapist or therapy which fosters agency these authors retain a therapy/therapist-centric view of change. A further therapy-centric view of change is demonstrated by one of the studies reviewed earlier. Nilsson, et al (2007) asked clients who had received CBT or PDT what aspects of the therapy they thought had contributed to the changes after therapy. Half of the participants from both therapy groups regarded

themselves as the prime agent of change. This is described in the narrative as "an awareness of one`s self agency and responsibility as a change agent," but warrants no further discussion. In contrast, Hoener, et al (2012) conducted a grounded theory analysis of client experiences and opinions of a number of different types of therapy. They found that, regardless of the therapy they received, clients valued their own agency and saw themselves as responsible for doing the work of therapy. They also found that clients had different ideas about how their agency was facilitated by the therapy. One who had received prescriptive therapy thought that the explicit tasks enabled her to take responsibility for herself, where as she would not have accomplished anything in exploratory therapy. Another who had received exploratory therapy thought that he had come to his own insights and healed himself, where as prescriptive therapy would be like someone "fixing him."

In the preceding sections I have reviewed some of the literature which relates to the different theoretical viewpoints of the mechanisms which bring about change during therapy. The different theories of change predict that people may either change in different ways according to the factors specific to the therapy, or they may change in similar ways in response to the factors which are common to all therapeutic approaches. A third position is that clients change in different ways as they use the therapy to aid their own recovery. This review of the literature shows that, although much is now known, much remains unclear about how clients change and recover from mental health problems. In this review my aim has been to support the rationale for this investigation and to demonstrate how this study may extend this literature and contribute to theory as well as informing the practical delivery of therapy. There is a growing awareness of the importance of researching the experience of the individual in developing our understanding of therapy. As the aim of this study was to investigate the experiences of people who had received therapy it was important to have an awareness of the research which has already been done in this area. In the next section I will look at some of the research into client experience. Reviewing this literature was of particular relevance in developing the methodology, which is outlined in the following chapter.

2.6. RESEARCH INTO CLIENT EXPERIENCE

In this section I will first look at the rationale for asking clients about their experiences, and I will follow this with a review of some of the research into this area. Research into client experience has been conducted following a number of different lines of enquiry and using a variety of different methods, both quantitative and qualitative (Elliott, 2008). However, I will be concentrating on the qualitative research which allows participants to give their account in their own words, rather than the research where self-report questionnaires are used, as these only allow participants to respond according to categories which have already been defined by the researcher.

The need to investigate clients` experiences of therapy arose from the observation that clients differ from both their therapists and external observers in terms of how they perceive the process and outcomes of therapy (Orlinsky, 2010). An example of this is a study by Llewellyn (1988) who compared therapist and client views concerning the helpful and unhelpful events which took place in therapy. She found that, during therapy, clients found the reassurance and relief provided by therapy most helpful and, in retrospect, valued most the problem-solving aspects of therapy. In contrast, their therapists, both during therapy and in retrospect, thought that the insights clients experienced were most helpful. She also found that the more disparity there was between the two perspectives, the poorer was the outcome. A good therapeutic alliance has consistently been shown to be positively correlated with successful therapy (Horvath, et al, 2011). However, Tryon, Blackwell and Hammell (2007) conducted a meta-analysis of studies which have compared clients and therapists perspectives of the therapeutic alliance. Overall results demonstrated that therapists ratings were only moderately correlated with client`s ratings. Horvath, et al (2011) found that client ratings were a better predictor of a positive outcome than the ratings of the therapist. This has led some researchers to privilege the experience and perspective of the client, suggesting that this "contributes to a better understanding of what is really happening," (Orlinsky, 2010, p.xxiii).

As research in psychotherapy tends to be conducted from the point of view of the therapist or the therapy, qualitative research which captures client experience can be a useful reminder for therapists of what it is like to be a client (McLeod, 2011).

Therapists often make assumptions about their clients, such as the reasons for a client`s silence or disengagement, which can be challenged by research into client` experiences (Levitt, 2001; Frankel and Levitt, 2009). As with the research reviewed earlier, the main aim of research into client experience is to increase effectiveness (eg. McLeod, 2003, Elliott, 2008). If researchers can come to a better understanding of what it is like for the client, how they have experienced themselves changing and the aspects of therapy they found helpful and unhelpful, therapists should be able to use this to inform the way they deliver therapy to clients and make therapy more effective.

- **Methods of investigation**

Researchers have used a variety of methods to obtain client accounts of their experiences of therapy. Some researchers have analysed written accounts in the form of diaries as therapy progresses (eg. Mackrill, 2008). Retrospective interviews, which may be structured, semi structured or unstructured have been used by many researchers (eg. Dale, Allen and Measor, 1998). Questionnaires consisting of open questions to which the participants may respond in their own words have also been used (eg. Rhodes, et al, 1994). Researchers have investigated different units of the therapy process ranging from whole episodes of therapy to short, discreet events within the therapy session. Different units of analysis and different methods yield different kinds of data. Interviews can be used to investigate the client`s overall experience of therapy, the overall processes, the processes which may have occurred outside the session, and how people have adapted and integrated aspects of the therapy into their lives. However, interviews, which by their nature must be retrospective, cannot investigate accurately clients` experiences of individual interventions and interactions, as the person is recounting their experience from memory.

The "significant events" literature concerns research into events perceived by clients as having been significant or helpful. The rationale for this research is that such events are likely to be significant in the change process and so may indicate the elements of the therapy that contributed to or brought about change for that individual. So, by examining the moment-to-moment processes which occur within the therapeutic process, it is hoped this will further our understanding of how psychotherapy works (Elliott, 1984; Timulak, 2007). Interpersonal Process Recall (IPR), which was

originally devised for use in therapy training, (Kagan, 1980) has been used to investigate significant events. In this method a recording is made of therapy session. Soon after the end of the session an interview is carried out. The participants listen to the recording and are asked to stop the tape at points which are significant to them, and to describe what they were thinking and how they were feeling at that point in the original session. Rennie (1994a; 1994b; 2000b; 2001) used this method in the series of studies reviewed earlier. He demonstrated that clients are involved in numerous activities during therapy, working both conversationally and silently. His participants did not report to therapists all that they were thinking and they tried to manipulate the therapy to meet their needs.

As this method of investigation has proved to be very time consuming, Elliott (1984) devised a modified version of IPR called Brief Structured Recall where the participant identifies one most significant event for intensive analysis. The participant then listens to a recording of the event and the researcher asks a number of questions about the meaning and impact of the event. A further modification is Comprehensive Process Analysis (eg. Elliott, et al, 1994). In this method a significant event which the client has identified is examined from a variety of perspectives, and trained researchers reach a consensus about the change processes involved. This method enables researchers to address the context in which a significant event occurs, how the client experiences it, and its effect over the course of therapy. It is then possible to construct clinically rich models of change processes.

Research into client experience has contributed to our understanding in a number of different ways. One line of enquiry has been to investigate the experiences of different client groups. Dale, Allen and Measor (1998), for example examined the experiences of therapy of clients who were abused as children. In another example, Israel, et al (2008) investigated the experiences of lesbian, gay, bisexual, and transgender individuals who had had therapy. Research of this nature does not suggest that such clients can be considered as a uniform group, or that they should be treated in ways that differ substantially from the general client population, but that there are certain aspects of the therapy which may have a particular meaning and significance for clients in these groups. The findings of such studies are very useful for practitioners who may be

engaging with a particular client group in sensitizing them to the possible needs of their clients.

- **Research into helpful and hindering aspects of therapy**

The rationale for this approach to investigation is that if therapists know what clients find helpful and unhelpful, they can do more of what is helpful; and less of what is not. It is also useful to establish if this is consistent with the different theories of change. Researchers from the scientific paradigm have used a quantitative approach to investigate helpful and hindering aspects of therapy. Gershefski, Arnkoff and Glass (1996) compared clients` perspectives on the helpful aspects of the different treatments in the NIMH treatment of depression collaborative. They found that factors common to the treatments such as learning something new, the helpfulness of the therapist and improved symptoms were reported most frequently. However, this research was reviewed by Rennie (1996), looking at it from a qualitative perspective. He pointed out that the researchers had used a questionnaire where the questions consisted of researcher defined categories derived from the literature about specific and common factors. He concluded that what the findings demonstrated was not necessarily what the participants found helpful, but what the researchers predicted that they would find helpful from the theory.

Qualitative research has been conducted into a number of different aspects of clients` experiences. There have been investigations of different client groups in different contexts which have demonstrated a wide range of aspects that clients find helpful or unhelpful in therapy, both factors specific to a particular therapy and factors common to all therapies. An early review by Elliott and James (1988) found five categories of helpful aspects of therapy. These are: facilitative therapist characteristics, client self understanding/insight, client self expression, a supportive relationship and the therapist encouraging clients to practise new skills outside of therapy. A later study by Paulson, Truscott and Stuart (1999), into individuals who had experienced different counselling approaches including CBT, humanist, behavioural and family systems, identified nine themes of helpful experiences. These are: counsellor facilitative interpersonal style, counsellor interventions, generating client resources, new perspectives, client self disclosure, emotional relief, gaining knowledge, accessibility and client resolutions. A

similar study (Paulson, Everall, and Stuart, 2001), identified nine aspects of therapy that clients found either unhelpful or hindering. These were: concerns about vulnerability, lack of commitment or motivation, uncertain expectations, lack of connection, barriers to feeling understood, structure of counselling, negative counsellor behaviours, insufficient counsellor directiveness and lack of responsiveness. The study carried out by Clarke, Rees and Hardy (2004) into clients who had received CBT found that their participants valued factors which were specific to the CBT model: dealing with thoughts, understanding/ patterns/core beliefs, but they also valued common factors, such as being listened to in a safe, trusting environment. Levitt, Butler and Hill (2006), also found that what participants found most helpful was a caring relationship which encouraged and supported reflexivity rather than specific symptom focused interventions. More recently, Lynass, Pykhtina and Cooper (2012) investigated young people`s experience of counselling in secondary schools. Helpful aspects focussed mainly on having the opportunity to talk with a counsellor whose personal qualities made talking easier.

- **Significant events literature**

IPR has been used by a number of different research groups to investigate a range of different events in therapy, the rationale for this being that significant events are likely to be integral to the change process. Interestingly, from the active client perspective, it is often significant events, identified by the client, which are seemingly minor occurrences from the point of view of the therapist, and not what the therapist would identify as significant. Elliott, et al (1994) compared insight events in CBT and psychodynamic-interpersonal therapy. They found that moments of insight were similar in each therapy. They were likely to be preceded by the client`s partial awareness, which was then facilitated by the therapist, sometimes by attempting an interpretation on a number of occasions until the right words were used. Hardy, et al (1998) carried out a CPA on a "vague awareness" event in psychodynamic therapy. In a similar way Rees, et al (2001) carried out a CPA of a problem clarification event in CBT. In the second of these studies the researchers found that the change processes they identified coincided with the steps that would be expected from a CBT intervention for problem clarification. In both studies the change process the researchers identified coincided with the allowing/accepting model of vague awareness events proposed by Greenberg

and Safran (1987) and both studies also found that the change processes could be mapped on to the assimilation model (Stiles, et al, 1990.)

IPR has been used to investigate helpful moments on therapy. Timulak and Lietaer (2001), for example, used IPR to investigate helpful moments in brief person-centred counselling. The most frequently reported positive client experiences were associated with a sense of empowerment of the client's self and the strengthening of the therapeutic relationship. Timulak (2007) conducted a meta analysis of the significant events which clients` found helpful in a range of different therapies and contexts. He identified nine core categories identified by the client as helpful. These were: awareness/insight/self-understanding, behavioural change/problem solution, empowerment, relief, exploring feeling/emotional experiencing, feeling understood, client involvement, reassurance/support/safety and personal contact. These findings support both theories of common and specific factors.

Not all significant events are helpful events and investigating these sheds light on the change process by identifying the factors which act against it. Watson and Rennie (1994) investigated clients` involvement in resolving problematic events in experiential therapy. They found that clients` participation in the activity of dealing with problematic reactions was complex as they had to deal with it the way their therapist wanted them to. Most clients deferred to their therapists, but for others the insistence of the therapist in them taking part in their suggested activity caused difficulties as it prevented them from dealing with it in their preferred way and put a strain on the relationship and the alliance. (Rhodes, et al, 1994) investigated client`s experiences of misunderstanding events in therapy. They found that when there was a good relationship, when the client was willing to voice their thoughts and feelings and when therapists made efforts to repair the relationship, then the misunderstanding could be resolved. When the relationship was poor so that client did not feel able to voice their opinion, or the therapist was unwilling to discuss their feelings or accept a negative reaction, then the misunderstandings remained unresolved and often the client dropped out of therapy. Sometimes the client “went underground” and the therapist was unaware of the misunderstanding. If the therapist became aware of the situation or the client initiated a discussion, then it could take several sessions to resolve it.

Henretty, Levitt, and Matthews (2008) investigated clients` experiences of moments of sadness. The theories differ about the need for clients to experience and express sadness in therapy. These researchers found that clients experienced an internal struggle. Participants in their study believed it to be helpful to experience sadness, express and explore their sadness, but sometimes the duration and intensity was too distressing and they needed to move away for periods of time. This study supports both the active client theory and the theory which underlies the experiential approaches.

Also supportive of the active client theory is Frankel and Levitt`s (2009) investigation of client`s experiences of disengaged moments in therapy. Therapists often interpret disengagement as resistance or ambivalence towards the therapy. They found that clients withdraw, distance themselves or lessen their intensity of involvement for a number of different reasons. It could be to divert attention from sensitive topics and protect themselves from painful emotions or because they thought the therapist was not fully engaged with them. They also disengaged to give them a distance from their experiences in order to gain a broader view of themselves and master their difficulties. Sometimes they disengaged because they needed to collect their resources, work out their role in therapy and their relationship with their therapist, or to prevent a worsening of their mood and a deterioration of their ability to function outside therapy.

It can be appreciated, from the preceding sections, that research into client experience has given a different perspective to that of the therapist and has made a significant contribution to our understanding of therapy. It has challenged the assumptions that theorists and therapists make about therapy and helped us to appreciate that clients often experience therapy very differently from the therapist, and the way the theory predicts. It has also demonstrated the active role clients take in making therapy work. My aim, in conducting this research was to make a contribution to this literature by investigating clients experience of the two therapies provided in a primary care setting. My hope, in conducting this research is that the findings would add to our understanding of how clients change in the different therapies, that this would contribute to increasing the effectiveness of the therapy and help practitioners to predict which therapy is more likely to work for whom.

2.7. CHAPTER REVIEW AND RESEARCH QUESTIONS

In this chapter I have tried to present a coherent review of some of the literature which is relevant to this study. I discussed the equivalence paradox, the apparent equivalence of the effectiveness of therapies, and their apparent non-equivalence of their processes and interventions. I presented some of the research that supports this while recognising that some researchers have continued to assert the superiority of one therapy over the others. Some researchers have turned their attention to the interior and process of therapy in order to better understand the therapeutic process. However, despite considerable efforts, the mechanisms by which clients change is still unclear.

I described the change theories which underlie PCT and CBT, the two approaches which were the focus of this study, and how each approach may operate by different mechanisms. It appears that support for the contrasting theories of change can be found in the research literature, with adherents of a particular therapy inclined to find evidence for the theory underlying their approach. A significant contribution to the literature has come from proponents of the Common Factors Theory, who believe that it is not the techniques and interventions specific to the different therapeutic approaches which effects change, but the factors which are common to all therapies. Support for this too can be found in the literature

I followed this with a discussion of the Active Client Theory which holds that the client is the most important common factor. This theory states that it is the active efforts of the client which makes therapy work and is the explanation for the apparent equivalence of therapies, as it will transcend any differences between them. I presented some of the evidence for this theory and followed this with a possible theory of the mechanism by which clients may use the therapeutic conditions to help themselves. I also gave a brief review of the concept of agency and how its promotion in the client is a factor in both PCT and CBT.

A productive line of enquiry has been to investigate the experiences of clients in the belief that this will give a better understanding of the process of therapy. This has

implemented a number of different methodologies to investigate what has been significant for the client, what was helpful or unhelpful, and how the client describes the way they have changed.

In reflecting upon the literature and the contribution I hoped this project would make I formulated the following research questions:

1. How do clients report that they make use of therapeutic interventions in CBT and PCT?
2. How do clients modify and adapt interventions to suit their own particular needs?
3. What part do the therapeutic conditions, as theorised by Rogers, play in this process?
4. What is the mechanism by which clients receiving both PCT and CBT undergo change?

In the next chapter I will describe the methodology of the study, the design of the research, its underlying philosophy and epistemology, and the methods I employed in collecting and analysing the data in order to answer these questions.

3. METHODOLOGY

3.1 INTRODUCTION TO THE CHAPTER

Crotty (1998, p.13) writes of how, typically, research arises out of a "real life issue that needs to be addressed, a problem that needs to be solved, a question that needs to be answered." McLeod (1999, p.8) agrees, and with particular reference to practitioner research he writes that, "the research question is born out of personal experience and a need to know." As I have described earlier in this thesis, this research project started from a real life question I was asked, in my role as service manager, from both clinicians and management. This was, "Of all these people referred to the primary mental health service for treatment, how do we decide who to refer to CBT and who to PCT?" In the sections that follow I will outline the research design that I have adopted to answer this question.

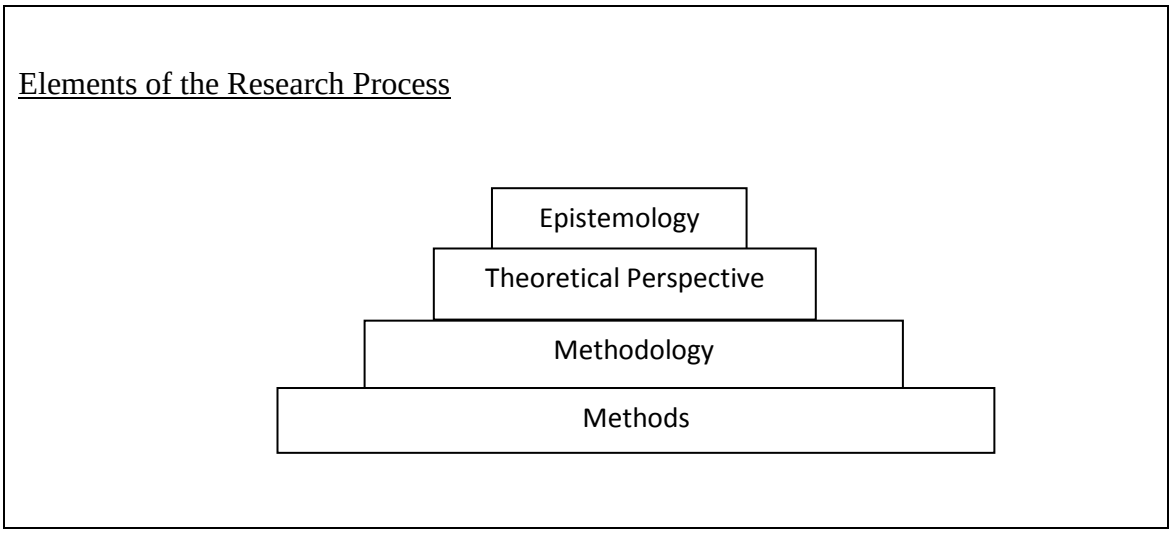
This chapter is divided into sections which relate to the main phases of the research project. The first section relates to the design of the research, and the different elements and processes that constitute the design. I then set out the specific questions the research was designed to address. This is followed by a brief consideration of the place of reflexivity in a qualitative study, and how the person of the researcher impacts on the research. I then give the rationale for my choice of a qualitative study in general and of a Grounded Theory methodology in particular. In line with the design process I describe at the beginning of this chapter I will investigate the philosophy underpinning my chosen methodology which I hope will demonstrate the methodological consistency of my choices. This is followed by a more detailed description of the methods by which I collected and analysed the data, where my aim is to be transparent to the reader about the decision making process and the resulting procedures. I then address the quality or trustworthiness of the study and finally I give brief consideration to the ethical considerations the study elicited.

3.2. THE RESEARCH DESIGN

When designing a research project it is inevitable that the researcher will bring to the design a number of beliefs and assumptions. First of all assumptions are made about the nature of reality (Ontology). Does a single, objective reality exist outside the human consciousness of it, or is reality constructed by the individual experiencing it? There are assumptions about the nature of knowledge (Epistemology). How do we know that what we see and discover is true? Are there absolute truths or are there different versions of the truth according to the person constructing the account. How does knowledge develop? Is what is true now, true for all time or does knowledge change and develop over time? Then there are assumptions about the role of values and beliefs in research (Axiology). Can research be objective? Is it possible to eliminate the values of the researcher? If not, what is the place of values in research? These are the philosophical assumptions which make up the basic elements of the research process, together with the practical procedures which are used to gather and analyse the data (Methods) and the overall approach which lies behind the choice of the particular methods (Methodology). Different authorities in the research literature have different opinions on the matter, but a consistent theme is that, when designing a research project, the aim is to assemble the different elements into a coherent rationale where the methods which are chosen are consistent with the methodology and the underlying philosophy (eg. McLeod, 2011; Morrow, 2005; Cresswell, et al, 2007). This is necessary as the philosophical base of the study will determine how the credibility of the study will be evaluated (Havercamp and Young, 2007).

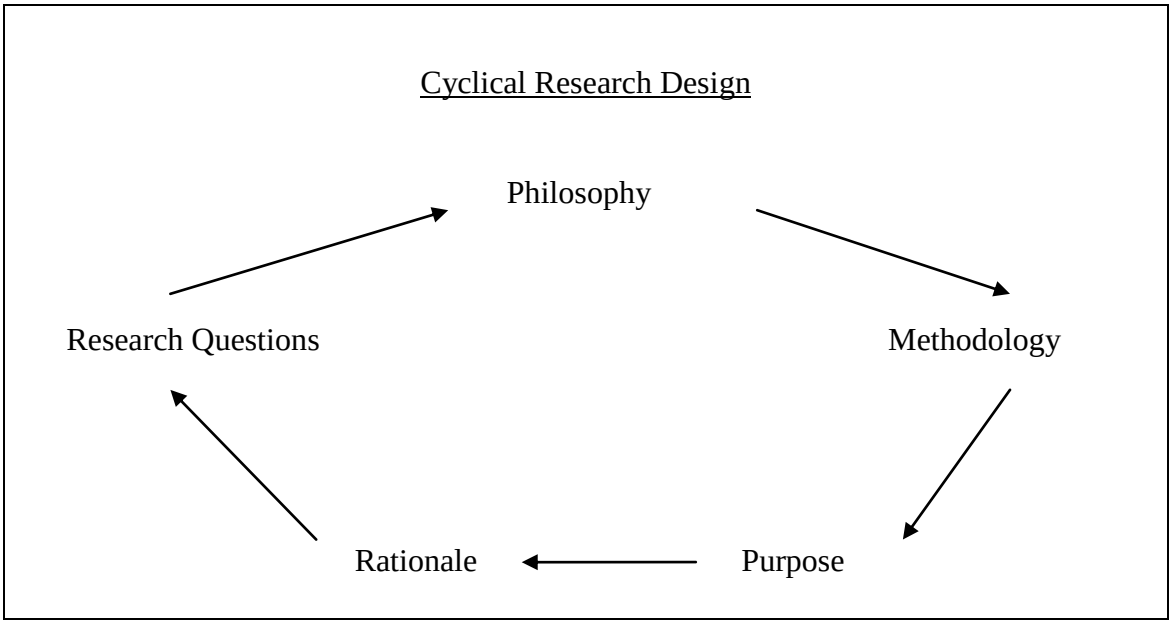
Different authors advocate different ways of putting these elements together. Crotty (1998, p.6) outlines four basic elements of any research process: epistemology, theoretical perspective, methodology and methods, where the theoretical perspective and epistemology together constitute the philosophical beliefs and assumptions which underlie the methodology. Crotty suggests a framework or scaffolding to guide the research process made up of these four elements that inform each other and ensure that decisions are made are philosophically and methodologically consistent (Figure 2.)

Figure 2



This gives the impression of a hierarchy of elements, one building on the base of the other. Some see it this way. Cresswell, et al (2007) suggest that selecting the philosophical paradigm should be the first step in designing a research project, after which the methodology and methods are selected which match that philosophy. Crotty however, recommends that the design begin with the aims and objectives of the research. This leads to the formulation of the research questions, which in turn leads to deciding which methodology and methods will best answer the questions. The researcher then provides a rationale to justify these choices by investigating the philosophy which lies behind the chosen methodology. Havercamp and Young (2007) do not believe the design of a qualitative research project will proceed in such an orderly manner. They suggest that the process should be flexible and open-ended and reflect the discovery oriented nature of qualitative research. They describe a process which involves, first of all, deciding the purpose and rationale of the research. This leads to formulating the research questions, in line with the paradigmatic stance, and the kind of understanding the researcher want to achieve. This is a non-linear, cyclical process where the researcher may revisit choices as the project proceeds (Figure 3).

Figure 3



My experience of conducting this research project is that the choices I have made have not necessarily been once and for all decisions. I have experienced the design process as a cyclical, reflexive process whereby I have returned to the different elements, reflecting on my choices as I learned more about the specifics of the research project. I re-appraised or refined my choices, or perhaps confirmed them, in the light of the further knowledge and deeper understanding which resulted from that reflection. Examples of the cyclical reflexive nature of the design will, I hope, be evident to the reader throughout this thesis.

- **The Research Questions**

As with the literature review, there is a degree of conflict with the formulation of research questions at the start of a qualitative study, of which I was unaware at the time. The cyclical, reflexive process where it is best if the design is flexible, so that the researcher can be open to new discoveries and surprises which may emerge during the investigation, seems to conflict with the process of deciding on a fixed number of specific questions at the start of the project. As I will describe later in this Methodology chapter, I have been through a journey of transformation from a quantitative to a qualitative researcher. Along with the other adjustments, which I will elaborate later, the

specific questions which I formulated for the research proposal have changed into areas of interest and concern. I was interested to hear about participants experiences of therapy, from their own perspective and in their own words. I knew what they should have been doing according to the theory, but I was curious to know if this was the case and I was particularly interested to hear about their own contribution and what they were "doing." Were they engaging with the therapy according to the theory, were they adapting it to better suit their needs, or were they "doing" something else? I was also interested to know how they believed they had changed in response to therapy they had received and if this was consistent with the different theories. I hoped that investigating these areas of interest would increase our understanding of how people change in therapy, which would, in turn, help practitioners consider if some people would benefit from one therapy rather than another. However, it was necessary to include research questions in a research proposal to meet the requirements of a university review panel, and the research questions found at the end of Chapter 2 are the questions I generated at the time.

- **Reflexivity**

The scientific view of research is that it is possible to be objective by keeping the personal involvement of the researcher to a minimum. In contrast, the qualitative view is that conducting research is a very personal activity and that objectivity is impossible to achieve. The increased prevalence of qualitative research has brought about a corresponding recognition of the importance of reflexivity and in this section I will give some consideration to this important component of qualitative research.

Reflexivity is the process of reflecting critically on the self as researcher, the human instrument (eg. Guba and Lincoln, 2005). It implies a capacity for bending back, or turning back ones awareness on oneself (McLeod, 2011). McLeod describes an inward reflexivity whereby a researcher brings her own knowledge and assumptions to the research which will inevitably influence the way the research is planned and carried out. Gergen and Gergen (1991), writing from a social constructivist view, describe an outward reflexivity taking into account that the researcher is influenced by the language and culture within which they live and work. Etherington (2004, p.31), appears to combine the two viewpoints and describes reflexivity, as "the capacity of the researcher

to acknowledge how their own experiences and contexts (which might be fluid and changing) inform the process and outcomes of inquiry." It is common for qualitative researchers to make their worldviews, assumptions and biases explicit in a reflexive statement (eg. Rhodes, et al, 1994; Knox, et al, 2008). Some researchers believe this enables the researcher to bracket such influences in the interest of objectivity (see Fischer, 2009, for a discussion of this). For others, in making clear the influences which have acted on the researcher, a reflexive statement serves to foster transparency so the reader may themselves make an assessment of the trustworthiness of the research (eg. Morrow, 2005). This demonstrates the different philosophical positions a Grounded Theory researcher may take (I will return to the phenomenon of bracketing later in this chapter, when describing the analysis). I take the view that making beliefs and assumptions explicit will not necessarily limit their influence, but in the interests of transparency, I will briefly outline my personal position.

I regard myself as a practitioner researcher (McLeod, 1999) as I am motivated to conduct research in order to inform the practice of therapy and improve people`s experience of therapy. My personal and philosophical beliefs and assumptions come from my person-centred, humanistic stance. I believe that there is no single, objective reality to be found, but each individual views their reality from their own frame of reference, which is personal to them (Rogers, 1951, p.483). I believe it is part of the human condition to try to understand and make sense of reality, but in practice I know it can be viewed from multiple perspectives. There are phenomena or events which happen outside the individual`s consciousness, but each individual will experience it in a different way according to their own world view, life experiences, attitudes, beliefs, etc (eg. Corbin and Strauss, 2008, p.10). In contrast to radical relativism where there are multiple truths and each has equal weighting (Guba and Lincoln, 2005), I believe that some truths may be partial or incomplete. I also believe that we can be reasonably certain about some truths over others and that some truths are more useful than others. There is a growing body of knowledge, which increases as time goes on, where different people can make a contribution and old knowledge is reviewed in the light of new knowledge. So, I believe that the findings from this study will not be "true" but there may be some truth in them, which may make a contribution to the growing body of knowledge about psychological therapy and which others may find interesting and, I hope, useful. I also believe it is crucial to be honest and conduct research with integrity,

regardless of how I may be disappointed or challenged by the results. I believe, in line with Rogers that "The facts are friendly."

> "I have perhaps been slow in coming to realise that the facts are *always* friendly. Every bit of evidence one can acquire, in any area, leads one that much closer to what is true. And being closer to the truth can never be a harmful or dangerous or unsatisfying thing." (Rogers, 1961, p.25)

I am aware that my personal stance could be regarded as a place of conflict with the evidence based agenda of the NHS in line with the medical and scientific models. I have given a description of the various organisational and cultural influences on me, and therefore on this research, in the introductory chapter. My management position within the NHS organisation gives me an "insider perspective," in that I am familiar with the workings of a mental health service in which the participants have received treatment. My role as a person-centred therapist means that I am very familiar with the workings and vocabulary of PCT but not of CBT. I could therefore describe myself as having an "insider perspective" with regard to PCT but an "outsider perspective" with regard to CBT. Despite the recommendations of NICE, my management experience tells me that CBT and PCT are similarly effective. In my role as a manager I have had many dealings with the clients of both services. I have found many to be active participants in the therapeutic process, exercising choice in terms of the therapy and therapist.

- **The choice of a qualitative study**

In this section I will explain my choice of qualitative design and justify this by examining the philosophy which underpins qualitative inquiry. According to Elliott, Fischer and Rennie (1999, p.216), in their attempt to formulate criteria by which the trustworthiness of a qualitative piece of research can be assessed, the aim of qualitative research is "to understand and present the experiences and actions of people as they encounter, engage and live through situations." The researcher "attempts to develop understandings of phenomena under study, based as much as possible on the perspective

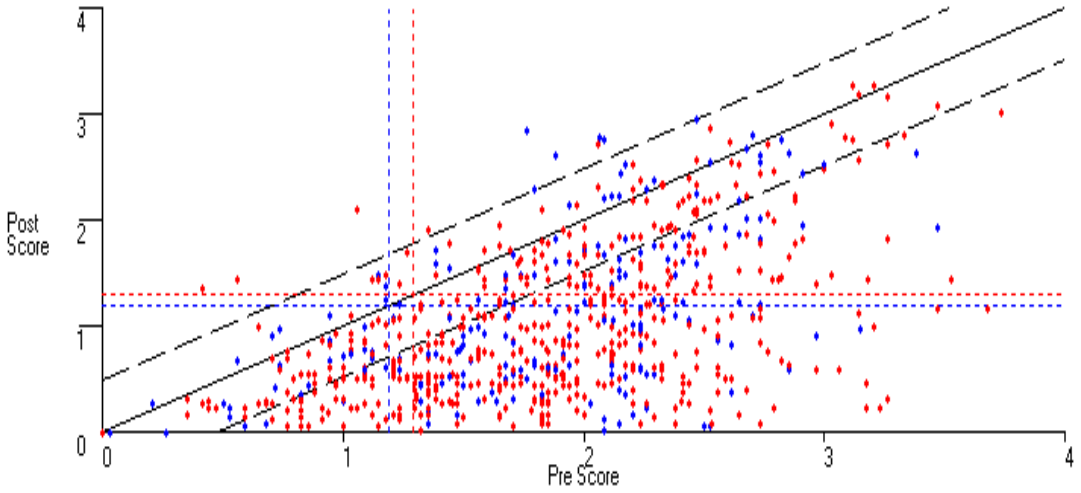
of those being studied." These descriptions are congruent with my aim to investigate therapy from the point of view of the client.

Ponterrotto and Grieger (2007) describe how qualitative researchers, who begin as quantitative researchers, must undergo a methodological transformation of sorts as they have to leave behind many of the certainties of the scientific approaches. Rennie, Phillips and Quartaro (1988) describe their apprehension at undergoing such a shift as it involved them abandoning their quantitative principles, unsure if the qualitative process they were contemplating was credible. They write of how it resulted in a transformation of their relationship to the research process. In designing and conducting this research I found myself experiencing a similar methodological shift, although perhaps I was less apprehensive due to the passage of time since Rennie`s pioneering studies, during which qualitative approaches have become established in the research world, with an increasing body of literature to support them.

I had already conducted a quantitative study investigating the effectiveness of PCT in routine clinical practice in primary care by collecting outcome data (Gibbard and Hanley, 2008). It was in conducting that study that I experienced some of the limitations of applying quantitative research in everyday practice. The findings were statistically helpful in showing that a certain percentage of individuals who received PCT demonstrated a measurable improvement in their mood. However the study could not explain why some clients improved while others did not and if those who did not improve would have benefitted more from a different therapy. Nor could it help identify clients who would potentially benefit from a particular therapy in order to increase the appropriateness of referrals, a finding that would be particularly useful from a managerial perspective. The findings could be represented in terms of a scatter diagram (Figure 4).

Figure 4

Scatter Plot – Comparison Between Pre-therapy and Post-therapy Outcome Measure Scores



To me, this clearly illustrates the reductionist nature of quantitative data, where each person, their life stories and therapy experience are reduced to a dot. From my perspective this meant that the range and depth of human experience was lost and I became interested in why each dot was positioned where it was. Who was this person? What brought them to therapy? What were their experiences of therapy? I became more interested in the stories behind the dots. In order to find answers to those questions it seemed reasonable to ask the people who had undergone therapy about their experiences, to hear what it was like for them. When I investigated further I found that the activity of doing a qualitative study often involves meeting the other person on a one to one basis, establishing a relationship where the participant feels comfortable enough to disclose personal information, entering their world, understanding their experiences. This is very similar to the activity of therapy. As I am a therapist, it seemed reasonable to conduct a qualitative study to collect and analyse information expressed by the people who had experienced therapy.

A beginning qualitative researcher is faced with a confusing array of methodologies to choose from, including, among others, Case Study, Phenomenology and Grounded Theory (Denzin and Lincoln, 2005). These authors point out that each of these strategies is connected to a complex literature with its own history, exemplary works, and preferred methods of implementation. The extent of this literature leads McLeod (2011) to question of it is possible for a student to read enough about each approach to be able to make an informed choice. According to Cresswell, et al (2007) the kind of questions the study is designed to answer will govern the choice of methodology. Phenomenological approaches, for example, Interpretive Phenomenological Analysis (Smith, Flowers and Larkin, 2009), aim to understand the lived experience of individuals, to investigate what is common to different individual`s experiences in order to deepen our understanding of a phenomenon. Case Study research (McLeod, 2010) provides detailed stories about the experiences of individuals, while Grounded Theory compares the experiences of individuals of a phenomenon in order to generate a theory, where there is no theory or current theories are inadequate (Cresswell, et al, 2007, p.241). As demonstrated in the previous chapter, a review of the literature showed that, despite a number of different change theories, a full understanding of the way clients change remains elusive, so it seemed reasonable to conduct a Grounded Theory study

- **The choice of Grounded Theory methodology**

In this section I provide a brief description of Grounded Theory and the reasons for my choosing that particular methodology. I also justify my choice by exploring the philosophy which underlies it. Grounded Theory is a specific methodology developed by Glazer and Strauss (1967) for the purpose of generating theory from qualitative data. It involves the collection of data, usually in the form of a transcript and its subsequent analysis. The analysis involves dividing the data into fragments or sections of text and conceptualising codes or categories according to the meaning of the fragment. Codes and categories are grouped into higher categories until a core category is identified and a theory generated. The researcher records her beliefs and assumptions and any thoughts and ideas in the form of memos and diagrams as the analysis proceeds. (I will describe the procedure in more detail later in this chapter.)

I chose this methodology for a number of reasons. Grounded Theory has become well established in the world of research, and is described as the most widely used methodology (Bryant and Charmaz, 2007a). Grounded Theory is regarded as particularly suitable for novice qualitative researchers like myself, who are venturing from more positivist paradigms into more constructive approaches (Fassinger, 2005). It is attractive to a beginning qualitative researcher because of its explicit guidelines and a series of steps and the number of exemplar papers to refer to. Grounded Theory originated in a healthcare setting (Glazer and Strauss, 1967) and its use by researchers in this setting has continued (eg. Schreiber, 1996; 1998; Ridge and Zeibland, 2006), giving medical professionals an understanding of the experiences of their patients. The systematic nature of the analysis has meant that it has been taken seriously by a community where the scientific approach is dominant and for someone who works in a healthcare setting this also counted in its favour.

Some Grounded Theory studies involve the researcher and participant co-constructing the research, sometimes involving further interviews, or inviting the participants to comment on the emerging theory (eg Schreiber, 1996; 1998). However this is not necessary. Many Grounded Theory studies have involved a single interview and nothing more. This would be relatively less intense for the participant, which I reasoned would be preferable for individuals who have had, or may still have ongoing mental health problems. Grounded Theory is considered particularly suitable for investigating therapeutic processes (Cresswell, et al, 2007) and it involves comparing the experiences of different individuals (Corbin and Strauss, 2008). I was interested in investigating the processes of the two different therapies by comparing the experiences of individuals. I wanted to see if it was possible to construct a theory of change, which would be developed from or grounded in the participants` accounts of their experiences.

One of the drawbacks of choosing a Grounded Theory methodology is that there have been differences and disagreements between proponents of the approach over the years since its inception. Space does not allow for detailed discussion of these disagreements, but the result is that there are now several variants, or ways of doing, a Grounded Theory (eg. Breckenridge, et al, 2012; Kelle, 2007), so that Bryant and Charmaz (2007a, p.11) describe Grounded Theory as a family of methods. In this analysis I have tried to follow the methods described by Corbin and Strauss (2008) and Rennie (Rennie,

Philips and Quartaro, 1988; Rennie, 2006a) as the latter was developed specifically for use in psychotherapy research. As my intention was to investigate the activity of clients in therapy, in a similar way to Rennie, it seemed reasonable to adopt a similar method.

- **The philosophical stance underlying Grounded Theory**

Fassinger (2005) describes a qualitative paradigmatic continuum on which a researcher doing qualitative research may locate themselves in any number of positions. Most authors position Grounded Theory within a constructivist paradigm (eg. Denzin and Lincoln, 2005; McLeod, 2011; Ponterotto 2005). According to Fassinger (2005) and Williams and Morrow (2009) a researcher employing a Grounded Theory methodology may take a number of different philosophical positions. These range from a relatively more realist/postpositivist position through the more relativist, interpretive, co-constructivist position (eg Shreiber 1996; 1998) to a more radical position where Grounded Theory may be used to advance social justice (eg Charmaz, 2005; 2007). As described earlier in this chapter the different philosophical positions taken by researchers influences the methods used and the evaluation of its credibility (See Williams and Morrow (2009) for a discussion of this). Some researchers employ "counts" where a calculation is made of the number of participants who are represented in each category (eg. Williams and Levitt, 2008). Some researchers use consensus between a group of researchers (eg Hill, et al, 2005, Israel, et al, 2008), while others appoint an auditor (eg. Knox and Cooper, 2011), in order to limit their subjective interpretation. Ponterotto (2005, p.127) describes this as "postpositivising constructivist qualitative methods, which is akin to forcing a round peg into a square hole." I will discuss this in more detail in later sections of this chapter in relation to my own choices in designing and conducting the research.

Those researchers who take a more constructivist stance (eg. Charmaz, 2005; 2007) believe that it is not possible to limit subjectivity. They regard participants` accounts as constructions of their experiences which may be constructed differently for different audiences. They may deliberately choose to tell them in different ways or their accounts may be unintentionally influenced by their values, beliefs, cultural backgrounds etc. Similarly, any attempt on the part of the researcher to understand the meaning of the participant`s account inevitably involves interpretation which will

inevitably be influenced by the values and beliefs of the analyst. So in a Grounded Theory study there will be as many realities as there are participants plus the researcher (Morrow, 2007). People are interpreters of their experience and it may not be possible for the analyst to form an interpretation that is the "right" one. A Constructivist position of a Grounded Theory analysis, therefore, allows for more than one story to be derived from the data. It allows for multiple interpretations of the data so that different analysts working with the same data, by focussing on different aspects of the data, interpreting things differently and identifying different meanings may produce different findings, and arrive at different conclusions. It is also possible that the same analyst might look at the same data differently at different times. However, all these are acceptable as each finding will be accountable to or grounded in the data (Corbin and Strauss, 2008).

The number of different philosophical positions a Grounded Theory researcher may take has led Rennie to position Grounded Theory in the middle ground between the positivist and constructivist positions. He originally wrote of the role of Grounded Theory as "reconciling realism and relativism," (Rennie, 2000a) and later changed this to "accommodating realism and relativism" (Rennie and Fergus, 2006, p. 496). Fassinger (2005) refers to the way that Grounded Theory can also be used with the goal of social change and describes the methodology as a bridge between post-positivist and constructive paradigms and critical approaches. Bryant and Charmaz (2007b) also locate Grounded Theory in the middle ground between realist and postmodern positions. Rennie (2006a) describes how, as Grounded Theory methodology has developed, it has shifted from positivism to constructivism and describes his own development as a Grounded Theory researcher as a gradual detachment from the grip of positivism (Rennie, 2006b).

My position has moved somewhat as the research project has proceeded, starting from a relatively post-positivist position and moving gradually in a more constructivist direction. So, I began with an interview protocol, which I ceased using. I started by using member checks, I attempted to recruit my supervisor as auditor, both of which I abandoned as I became more comfortable and more confident with a constructivist position. (Again, I will describe this in more detail in later sections of this chapter). I initially decided against the use of counts because of the danger that by importing

postpositive values into a constructionist study, this would significantly alter the nature of the study (Ponterotto, 2005). Information about the number of units of text which revealed a certain category may be useful in demonstrating the sheer scale of the organisational task that the analysis involved, but this could be determined by the way in which the interview is conducted and the transcript divided, and so, I believed, would have limited usefulness. However the number of participants represented in each category may useful to the reader and so in the interest of transparency I have included this information in the narrative.

According to Ponterotto (2005, p.132) rhetorical structure flows from the researcher`s epistemological stance. For example, the third person may be is used in an account to convey a more objective and scientific stance. In line with the constructivist philosophy of this study I am using the first person in this account. In this way, following the advice of Crotty (1998), my aim has been to be consistently constructivist.

3.3. DATA COLLECTION

This next part of this chapter describes the methods I used in this research project and the decision making process I went through in selecting them. It will reflect some of the methodological shifts that I have been through during the process of undertaking the work and which I have alluded to in the previous section. I have outlined the influences on my choice of methods in the introduction and earlier this chapter. These ranged from my personal beliefs, to the practical and ethical implications of recruiting potentially vulnerable people, and researching in a busy mental health service during a period of continuous organisational change. I was also influenced by the literature relating to the methodology of qualitative research, to which I make reference during the account. As I described earlier, the decisions I made changed and were adapted during the course of the project. My aim has been to be transparent about this and I have included extracts from the interview transcripts to illustrate and support my rationale (Interview extracts appear in italics. The notation "*PCT"* or "*CBT"* followed by a number represent the participant, and "*I"* denotes me, the interviewer. I will explain the reasoning behind this notation in the next, findings chapter.) Firstly I describe how the participants were recruited and then I go on to describe how I collected and analysed the data.

- **Recruitment of participants**

Polkinghorne (2005) believes it is misleading to use the term sampling in qualitative research as it implies that the participants are representative of a population and that the findings can be generalised. He suggests the term "selection" more closely describes the purposive method of data collection in qualitative research. Participants in qualitative research are not chosen because they represent a larger population, they are selected because it is hoped they will provide rich and descriptive information about the experience under investigation. The purpose of recruiting numbers of participants is not to validate the findings but to add a range and variety of information.

Participants had a variety of routes into their therapy which were not recorded for the purposes of this research project. If there was sufficient information in the GP referral letter they were referred straight to CBT or PCT. Others received an assessment by a practitioner in the Single Point of Access. During the assessment process the assessor explored the history that brought them to the service, including previous engagement with services. A risk assessment was undertaken in terms of the risk of deliberate harm to themselves or others, their vulnerability and possible need for safeguarding. The assessor explored their individual needs and expectations of treatment, discussed the different options available together with their preference for treatment and, based on this discussion, a referral was made to the CBT or counselling service. Alternatively participants received a step 2 intervention consisting of a brief episode of guided self help based on CBT principles. If it became evident, either to the participant or the therapist, that a different approach was required, this would be the basis of a referral to PCT. If it became evident that a more intensive CBT intervention was required, this would be the basis of a referral to the CBT service.

In this study, 45 individuals who had received PCT were invited of which 10 responded and 9 (6 female and 3 male) attended an interview. 38 individuals who had received CBT were invited of which 9 responded and 7 (5 female and 2 male) attended an interview. 3 people who returned a reply slip agreeing to participate, subsequently did not attend for interview. This was because I was either unable to contact them or it was

not possible to arrange a convenient time and place for interview. All participants were white, reflecting the nature of the wider population served by the PMHT. The participants were representative of the range of age, gender, social class, education, employment and presenting problems that are usual for the PMHT. Participants ranged from a senior manager of a local firm to a shop floor worker, a truck driver, and public sector workers. Some were in full time work, others were claiming sickness or disability benefit. Their age varied from a young woman in her twenties to a retired woman in her late 60s. Further details can be found in Appendix 1. (These tables also include pre and post therapy outcome measures using GAD7 and PHQ9 which comprise part of the IAPT minimum dataset. These outcome measures can be found in Appendix 2).

A true Grounded Theory study employs the process of theoretical sampling, where data collection and data analysis are interconnected processes and the selection of participants is guided by the research (Corbin and Strauss, 2008, p.143). Data analysis commences after the first interview and results in a number of categories and possible theories. As the study proceeds, participants are invited who it is hoped will further deepen, expand or elaborate the researcher`s understanding of the experience and the emerging theory (Stern, 2007 p. 117). Selection of participants depends on finding people who are willing to be interviewed, as attending an interview requires the investment of time and effort on the part of participant. As my own time and resources were limited I was unable to employ a true theoretical sampling method. I invited everyone, who did not have a diagnosis of a mental illness, who had finished PCT or CBT and been discharged from service, thus eliminating those with more severe and complex presentations, who may not have fully recovered and still have been involved in mental health services. I identified potential participants during the normal administrative discharge procedure and I sent them paperwork giving information about the project and inviting them to take part (Appendix 3). When I received their reply slip I contacted them and arranged a suitable time and venue. Three interviews took place in the participant`s own home. All the others took place in consulting rooms in NHS primary care locations convenient to the participant. I will discuss the ethical implications of this procedure later in this chapter.

Morrow (2005) writes of how one of the criteria for assessing the trustworthiness of the research is the adequacy of the data. I considered it was important to have participants who had had therapy from a range of different therapists in order to avoid idiosyncratic ways of working distorting the data. I made the decision to have no more than 2 participants from each therapist, so when I had interviewed 2 participants who had received therapy from a particular therapist, I did not invite any more of their clients to participate. The 7 CBT participants had 5 different CBT therapists. The 9 PCT participants had 6 different therapists. I did not invite my own clients to participate. There are differences of opinion among qualitative authors regarding the number of participants needed to produce adequate data. In a Grounded Theory study the number of participants is not decided at the outset. Analysis and data collection should continue until the categories are saturated so that new interviews do not yield new information (Corbin and Strauss, 2008, p.324; Hood, 2007, p.161). This raises the question of how one can know that categories are saturated (eg. Dey, 2007, p.185; Stern, 2007, p.117), as it is always possible that the next interview may reveal new and exciting information. There are guidelines for sample sizes ranging from 6-50 (Guest, Bunce and Johnson, 2006). McLeod (2011) suggests 8-20 individuals, as the optimum number to produce data which can be analysed meaningfully. In practice, the uncertainty regarding the future of the service and my position as manager limited the number of interviews I could conduct. However, an important factor in the decision to stop was that I had examples of negative cases in both PCT and CBT therapy groups. Negative cases are those which do not fit the pattern of responses of the other participants, but which add to the richness of the data and allow for a fuller analysis (Morse, 2007, p.240; Corbin and Strauss, 2008, p.84).

The literature relating to Grounded Theory tends to focus on the analysis of data, how it is managed, the researcher`s sensitivity to it, and her understanding and interpretation of it. Little attention seems to have been given to the method of data collection (Fassinger, 2005 p.158.) The exception to this is Rennie`s account (1992) in which he goes into some detail about his interview procedure. My own experience of previous research had shown me that a good analysis is dependent on good quality data. I therefore began this study with the view that the method of data collection would inevitably determine the end result, and so I gave considerable attention to this procedure with the aim of obtaining excellent data (Morse, 2007, p.230). After surveying published research

regarding interviews, Knox and Burkard (2009) conclude that there is little transparency about either the rationale for using interviews as the method of data collection, or in the actual interview techniques used and call for researchers to give more information in this regard. In this section of the chapter, and in line with this call, I will demonstrate the reasons for my choice of a single face to face, retrospective interview with each participant. I will also outline my rationale for deciding the number and timing of the interviews, the interview procedure, how it was influenced and developed and it`s congruence with the underlying philosophy of the research design. I will also provide a rationale and description of the interview techniques used.

- **The choice of interviews**

When designing the research I considered a number of methods of collecting data. Open ended questionnaires (eg Llewellyn, et al, 1988) would give participants the opportunity to describe their experiences in their own words. However, I reasoned that such a method may only provide surface information and not the richness and fullness of the experience that I was looking for. A focus group (Kamberelis and Dimitriadis, 2005) could allow data to be gathered from a number of individuals and give a number of perspectives, but the complex dynamics may not provide sufficient safety to disclose sensitive and personal information, and the interactions of the group may mean that members defer to or dominate each other so that information becomes distorted or valuable information lost. Journaling would be a method which would allow them to respond in own words (eg. Mackrill, 2008), but it may prove onerous for the participant, it may not provide the breadth and depth of information I was hoping for and, again, information may be lost. I therefore chose interviews in order to "gain a full and detailed account of the experience under study," (Polkinghorne, 2005). I considered telephone interviews as a way of reducing the burden on the participant and increasing efficiency (Knox and Burkard, 2009). I decided against this method, informed by my experience of telephone counselling, because non-verbal cues, which would enrich my understanding of the participant`s account would not be available to me, and so, I reasoned, would impoverish the data.

I considered conducting interviews during therapy (eg. Rennie, 1994a; 1994b, Dreier, 1998), but decided that this would be unwise. I reasoned that the likelihood that

prospective participants would still be in a relatively distressed or vulnerable state which might reduce the chance of them agreeing to take part. If the individual agreed to participate there was the danger of the research interfering with the process of therapy and the possibility of causing harm. I therefore decided to invite people to participate after therapy had ended. Here I had to take into consideration the passage of time as I would be relying on the participant`s memories of their experiences, which may change over time (Polkinghorne, 2005, p.143). Too soon after the end of therapy and an invitation may seem onerous, the potential participant may decline involvement, wanting to "be left alone to get on with their lives." To long after the end of therapy and the memory of their experiences may have changed or been forgotten. I therefore attempted to strike a balance. I aimed to contact people within a month from the end of therapy and to interview them as soon as could be arranged. All interviews were conducted within 3 months from the end of therapy.

There are differences of opinion among qualitative authors regarding the number of interviews needed to generate data of worthwhile quality. Some researchers rely on a single interview while others conduct multiple interviews (Knox and Burkard, 2009). According to Polkinghorne (2005), two or three interviews may be necessary in order to establish a relationship where the participant feels comfortable enough to explore the depth and breadth of their experience, where as Hill, et al (2005) found that second interviews were not as productive as they had hoped. I was reluctant to increase the burden of the process such that participants would not want to take part. Attending an interview requires a degree of emotional investment at a time when participants had recently recovered or may still be recovering from mental and emotional difficulties (this is an ethical consideration elaborated later in this chapter). I reasoned that, due to my experience as a therapist in primary care, where large numbers of individuals are treated quickly, I had the ability to rapidly establish a safe and comfortable relationship. I therefore decided to conduct a single interview. In a qualitative study the length of interview is determined by the quality of the data rather than the amount of time elapsed. A standard therapy session is 50 minutes to an hour long, and I predicted interviews would last a similar length. In practice the length of interviews varied from 45 minutes to 75 minutes, depending on the focus of the participant, their willingness and energy in talking and the richness of the information I had obtained.

- **The interview procedure**

It is widely known to therapists that often people do not disclose all that they are thinking, either intentionally or unintentionally, and that what a person reveals may be less important that what they keep to themselves. I recognised, that it was crucial to the quality of the research to conduct the interviews in a way which facilitated participants to give rich and meaningful accounts of their experience of therapy. Although the purpose of a research interview is very different from that of a therapeutic interview, I believed I would be able to bring my experience as a practitioner to the interview process. This is supported by Mearns and McLeod (1984), who write of how the principles of PCT can offer an effective basis for qualitative data gathering. The primary aim of PCT is to enter the client`s world to walk around in it and to see it thought their eyes (Rogers, 1980, p.142). If the therapist can establish a relationship with a client characterised by congruence, empathy and respect the client will allow the therapist entry into that world. The aim of qualitative interviews is to "explore the ways in which subjects experience and understand their world" (Kvale, 2007, p.9). It therefore seemed reasonable to believe that by importing these therapeutic techniques into the interview process I would be able to obtain good quality data. I undertook a small number of practice interviews with colleagues and friends and invited their feedback concerning their experience and their suggestions for improving the procedure. I then conducted four pilot interviews, after which I spent time in reflection and refinement of my interview technique. In line with the reflexive research process I described earlier in this chapter I continued to reflect and refine after each interview and throughout the analysis. The interview protocol with which I began the research can be found in Appendix 4. As I described earlier in this chapter, I ceased using it in line with my move towards constructivism as it seemed important to be open to the aspects of the therapy were important to the client, rather than aspects important to me in relation to the theory. However the guide does give an indication of the areas of therapy that were of interest.

The philosophy underlying interviewing

Before describing the interview procedure in more detail I will give some consideration to the philosophical stance underlying the interview procedure (Kvale, 2007, p.20).

Interviews may be conducted in a variety of ways according to the underlying philosophy of the particular methodology employed. From a more positivist viewpoint, the interviewer may take an objective stance and obtain a true account of an experience. The constructivist viewpoint is that this is impossible and that the participant`s account will be constructed differently according to their perceived requirements of the situation, which will include the person of the interviewer and the way the interview is carried out. The underlying philosophy determines the amount of structure in the interview, the kind of responses used by the interviewer and the extent of their activity. In this section I will look at my role as an interviewer, the nature and extent of my involvement, and how this fits with the underlying constructivist philosophy of the study (Fassinger, 2005, p.158). Kvale (2007, p.19) uses two different metaphors to describe the role of the interviewer. The first is that of a miner digging for nuggets of buried metal in the participant`s interior. The second is that of a traveller exploring a distant country. The traveller wanders together with local inhabitants and encourages them to tell their stories. The first is a more positivistic view, where the role of the interviewer is trying to uncover the truth of what the participant is saying. The second is consistent with a constructivist view of the interview process, and represents the way I tried to engage with the interview process.

A critique of interviewing

Reflecting the more realist aspect of Grounded Theory (Bryant and Charmaz, 2007b), my aim, in the interview procedure, was elicit an accurate account of the participant`s perspective of their experiences, rather than deliberately engaging with the participant in ways which would co-construct the data (Finlay and Evans, 2009) by making personal disclosures or commenting on the dialogue (Etherington, 2004, p.77). Ideally, I wanted significant experiences to emerge naturally during the interview process. On the other hand I recognised that I was asking participants to describe these experiences from memory where memories can change over time, they can be influenced by later experiences, by the individual`s present emotional state and by other people. My experience as a therapist informed me that people will give an account of their experiences in ways which are inevitably influenced by their perception of the situation. Participants would therefore use impression management strategies. A particular participant may want to portray a particular image of himself, perhaps as a good client,

or he may want to show the therapist in a favourable light, perhaps out of gratitude. He may be comparing himself to a social ideal and respond in the way he thinks he should or he thinks will be acceptable. He may be concerned about the judgement of the interviewer and deliberately withhold or modify the experience in ways which he believes will avoid criticism. I was mindful that the extent to which this occurs will inevitably be influenced by the presence and activity of the interviewer. I have therefore taken the stance that during data collection there are a series of balances to be struck with regard to the amount of structure and the activity of the interviewer.

The amount of structure

The amount of structure in an interview also reflects the underlying philosophy. Some researchers, with positivist leanings, use a standard interview protocol in order to obtain consistent areas of information and to compare findings across participants (eg Hill, et al, 2005). Ponterotto (2005), on the other hand, points out the danger that categories will already be formed by the interview questions. My aim was for the participant to decide what was important for them, and not fit their stories into already defined categories and I found that, when participants talked freely and spontaneously about their therapy experiences, the resulting accounts were rich in concepts and meaning. On the other hand I wanted to avoid participants diverting their accounts into areas of experience which were not relevant to the research questions. For my research proposal I formulated a semi structured interview protocol (Kvale, 2007, p.51) but in line with my shift from post-positivism to constructivism, I stopped referring to it. I began the interview by inviting each participant to talk about their experience of therapy. I only introduced topics of particular relevance to me when the participant seemed to run out if steam or were in danger of going off at a tangent.

The activity of the interviewer

Some interviewers advocate keeping their responses to a minimum in order to limit the influence of the interviewer on the participant (eg. Elliott and Shapiro, 1992). My experience as a therapist tells me that clients may interpret the lack of a response on the part of the therapist according to their own assumptions. I reasoned, therefore, that a lack of response on the part of the interviewer may influence the participant as much as

a response. Some people are less comfortable talking about their experiences than others. I reasoned that taking a less active role with such an individual would produce relatively superficial data, not the accounts rich in experience and meaning that I was looking for. So I tended to be more active with participants who seemed uncomfortable and wary in the interview situation and less active with those who showed less discomfort and seemed ready and eager to talk.

The data derived from an interview also depends on the participant`s ability to access their experiences, put them into words and communicate them to the interviewer. It is certainly the case that participants often struggled to describe their experiences or explain what they meant. I saw my role as an interviewer to help the participant put their experiences into words. Rennie (1992) points out that too little involvement may result in the participant being unable to find a way to express his experiences and so information is lost. On the other hand too much involvement may mean that the participant defers to the therapist and information becomes distorted or inaccurate. I therefore tried to govern my actions according to the participant. Where the participant appeared to be comfortably engaged in seeking for their own explanation I was less active. The following example illustrates the participant`s search for meaning within herself which she eventually manages to articulate.

> *PCT1.....But I always felt – it`s really weird because it`s bugging me that I can`t explain what she did, because she did talk a lot (pause). It`s not like she sat and there was loads of silence and waiting for me to speak. There was none of that. It always felt like there was a lot of to-ing and fro-ing (pause). So I guess when I first started saying and said I kind of led it, no it was a very reciprocal kind of interaction (pause). I know how I can describe it. It felt like she was walking along side me (pause). That`s what it was.*

I was more active when the participant was clearly having difficulty in articulating their experience.

> *CBT7. We just, it was just unlucky, but, you know, what can I say – you know, I get some bloke shouting at me - he picked the argument, you know. I didn`t go shouting*

at him, calling him, you know. Then, I phoned the police and they told me to go and get your injuries looked at and then we`ll come to you. And what do the police do?

I. And then they come and arrest you?

CBT7. Yeah, they come and arrest me.

I. So all that`s happened has just reinforced.

CBT7. my core beliefs.

I. How you feel, that life just gives you a load of crap.

CBT7. If you`d been in that situation, you know, you just couldn`t make it up.

I. So you can hardly believe it, really, that such a lot can happen to one person.

CBT7. No, that`s why (sighs) – that`s why I am like I am, I suppose (pause).

I. So it`s, kind of, understandable that you`re depressed because such a lot of bad stuff`s happen to you.

CBT7. And I said to her, "Is it me? Am I stupid? You know, am I stupid I give someone £150 because my son`s accidentally scratched their car?"

I. So what did she say?

CBT7. She didn`t say anything.

I. So you`re still thinking, "Is it me?"?

CBT7. (pause) They can`t, you know, it`s like - everybody - they can`t be judgemental, can they? You know, they`ve got to be non-judgemental (pause)

I. It just sounds like you`re still left trying to make sense of something that doesn`t make sense.

CBT7. Yeah, yeah, that`s it.

I. Like, I give this guy money to mend his car

CBT7. That`s it.

I. Because my son accidentally scratched it and what happens, I get arrested and accused of attacking him. It`s like – how did that happen?

This participant`s repetition of the phrase "*that`s it*," suggests that my interpretation that he is still trying to make sense of his experiences is correct.

The use of reflection

At the beginning of the research project, from my initial post-positivistic stance, I was concerned that the kind of empathic reflective responses employed in PCT would be

inappropriate for a research interview. Elliott and Shapiro (1992) advocate limiting the use person centred reflections on the grounds that they can "lead" the participant. Initially, therefore, I thought I would curtail my tendency to respond empathically in an effort to minimise my influence. However, feedback from the practice interview participants showed that they were concerned about whether their accounts "made sense," and were "the kind of thing I wanted." If I did not respond they were left uncertain, which made them less comfortable and more careful about what they were saying. They found it helpful when I responded empathically as it assured them that they were engaging constructively with the research process.

The person-centred attitude is recognised by Kvale (2007, p.17) as a valid interview technique. As the project proceeded, and in line with the methodological shift I was experiencing, and which I have described earlier, I grew in confidence using my person-centred skills, as the person centred approach to interviewing seemed to be producing vivid and interesting data. This is illustrated by the following extract, in which a participant gives an account of her intrusive thoughts:

CBT5 .....I know, when I feel terrible, when I`m having a really bad day with it, I`ll think, "I can`t go in my car today because they`ll be really bad and I`ll think something could happen." And now I know that I have to get in the car to show myself it`s not going to happen.

I. So it`s important not to believe these thoughts.

CBT5. Yeah. And just to put them as that, as a thought like any other thought. I think that`s what she put in my discharge letter as well, she said, there`s nothing more we can teach her, because she knows. And it`s just, I think, enjoying life a bit more than I were. You know I`m a lot better than I were 2 years ago, because I just didn`t enjoy life at all, it was just horrible. Well I thought it was horrible.

I. So all these thoughts just spoiled.

CBT5. Yeah, like she said to me, "They`re just raining on your parade," And it was exactly that. Every time I`d go somewhere I wanted to come home. But then I was, like, "What`s the point in coming home because they`re still going to be there when I get home." So I`d try and stay out as long as I could at this place. I were at a christening on Sunday and they were really bad on Sunday because I was with a lot

of new people that I didn`t know. But I still stayed there. I think now, "What`s the point in coming home, because they`re still going to be there."

I. So the thoughts are still there, you just try to ignore them now.

CBT5. Yeah, I just try not to take them on and not let them upset me. I felt horrified, really upset and I thought, "I`ve got to go home," You know, that`s what I kept thinking in my head. I never told anybody I wanted to go home.

I. You never show what`s going on inside you.

CBT5. No, I`d carry on as normal, but then I could feel this sense of dread. And I think that`s it, she`s learned me not to feel the dread when they come.

Mindful of the next step in the procedure, the analysis, reflections are also useful in checking out my understanding at this early stage, as demonstrated in the following extract where a participant is describing how he behaved differently during a walk with his wife and mother in law.

PCT6. I just said, "Right OK, the three of us will go." But when they tried to link arms I got in between them and made myself a part of it without that, kind of, resentment and irritation building up. And we all had a fun walk. It just – spotting that early. Where as in the past I would have spotted that three or four days later when I was doing a post mortem on why that was such a horrible walk..

I. Did you, sort of, plan to do that, to get in between?

PCT6. Yes, when the 3 of us were going I thought, "Right, I`ve got to make sure I`m in amongst this."

I. So you pushed yourself to do it differently.

PCT6. And we walked a lot further than we would have normally done as well, because we chatted that much. It was just doing things that bit different and spotting sooner the, "I don`t like this." And taking control of it rather than just letting it all happen and the resentment building up and just spoiling it for everybody, really.

I. So, kind of, understanding what would have gone wrong in the way you would have handled it previously and doing it differently.

PCT6. Making a conscious effort to do this differently.

The rationale for using this interview technique is that by using reflection, the participant feels heard and understood and this gives them confidence to continue with

their account. It also enables the researcher to gain a clearer overall understanding of the meaning during the interview, which can be deepened during the subsequent analysis.

The use of questions

I also used exploratory questions to elicit more detailed information and to bring out the depth and breadth of the participant`s experiencing, and I used clarifying questions when I was unsure of my understanding of what the participant was saying (Kvale, 2007, p. 56). Both are illustrated by the following example where the participant is talking about her reasons for accessing counselling.

> *PCT9. I knew, for healing to take place and everything, I had to heal myself, which was very hard to do.*
> *I. Can you tell me more about that?*
> *PCT9. Well it`s (pause) trying to be more positive and trying – I mean, I would say the relationship with my daughter isn`t great. I don`t think it is going to be but - it`s the thing – recognition that it`s not me, it`s you know...*
> *I. And you said that you did know that before therapy, somehow it got lost?*
> *P. Yeah, definitely, because there was that much coming at me, so negatively, so critical - you know, your fault, your fault, your fault.*
> *I. Who was that?*
> *P. Well, professionals along the way – "Why did you? Why did it take so long to get diagnosed? Why this? Why that?*

In this section I have tried to give a transparent account of the methods of data collection. In the following section I will deal similarly with the data analysis.

3.4 DATA ANALYSIS

Throughout this project I have realised the appropriateness of the statement by Corbin and Strauss (2008, p.16) that Grounded Theory "is something that researchers have to feel their way through, something that can only be learned by doing." In this section I

will attempt to provide a transparent account of the analytical process. Sixteen hour long interviews results in a large amount of data and I used the computer software programme NVIVO to organise the quantity and complexity of the data. In this section I will first of all give consideration to the aspect of subjectivity in the analysis. I will then describe each step of the process of categorisation, first by dividing the text into smaller units and then allotting categories to these units. In endeavouring to give meaning to this process I will attempt to address the question of where categories come from and the place of creativity in a Grounded Theory analysis. Finally I will describe the conceptualisation of the Core Category and the construction of the theory.

- **Beginning the Analysis**

Traditionally, the Grounded Theory researcher does not review the literature in preparation for the analysis (Strauss and Corbin, 1990). This is in order to remain open minded as to what may emerge from the data, and to limit the likelihood that the researcher will impose preconceived categories and theory onto the data. However, this would appear to be impossible when researching an approach within which one has trained and continued to develop professionally, both of which requires reading the literature. There is also the view that a grounding in the literature reduces bias as it introduces the researcher to different ways of viewing phenomena (Morrow, 2005). There are also Grounded Theory researchers who make use of the literature during the analysis in writing memos, and who regard knowledge of the literature as necessary to develop the theory (Lempert, 2007, p.254).

The original method of Strauss and Corbin (1990) also requires the phenomenon of bracketing, where the researcher records her beliefs and assumptions in the belief that by explicitly acknowledging them this will reduce their influence on the analysis. Rennie (2000a) questions if this is possible. He argues that a Grounded Theory methodology is a type of hermeneutic inquiry where the reader strives to gain an understanding of the meaning of the text. This understanding is inevitably influenced by the subjective viewpoint of the researcher and so involves interpretation. He also questions if it is desirable to try to limit subjectivity, making the case that if researchers aim for objectivity then they run the risk of restricting their creativity and impoverishing the analysis. He believes that a balance must be struck between subjectivity and

objectivity. Too little subjectivity could result in the analyst missing something of the participant`s experience. On the other hand, too much subjectivity may express the experience of the analyst rather than the participant. "Good interpretation involves living inside and outside the experience and monitoring of the degree of fit between the two aspects" (Ibid, p.487). This is similar to PCT where the therapist alternates between her own frame of reference and that of the client. I have therefore tried to strike that balance in this research.

In this project I both conducted and transcribed the interview and, although this was time consuming, I believe it was beneficial as I became deeply familiar with the data and believe I experienced the "progressive understanding" and "hermeneutic circle" described by Rennie (2000a, p.484). I obtained an overall understanding of the whole account from my experience of the interview and my reading of the transcript as a whole. This overall understanding influenced the way I interpreted a unit of text. This understanding of a part of the text, in turn, influenced my understanding of the account as a whole. I saw aspects that I had not noticed at the time, some aspects became clearer and others, on reflection, changed their meaning.

According to Strauss and Corbin (1990) Grounded Theory analysis begins with the process of open coding where the researcher codes each line of the text according to her understanding of its meaning (see also Holton, 2007). In the variant developed by Rennie (1988, 1992, 2006a), the term lower categories are used in place of codes, and in line with Rennie, I will use the term category throughout. Rennie, Philips and Quartaro (1988, p.42) divide the text into larger sections, or meaning units which can vary from one to many lines. These are sections of text where the participant seems to be making a point, and after having made it they move on to something else. Rennie and his research team developed a system of index cards in order to organise the data analysis. Each meaning unit was reduced to a "one liner" which attempted to describe the key concepts. This was then assigned to categories accordingly. I used NVIVO in a similar way. NVIVO allows units of text to be coded and stored in nodes. Stored within each node was a list of one liners representing all the meaning units that had been assigned to that category. While reflecting during the analysis it was a simple operation to open the full text to check it`s meaning.

Before going on to elaborate the process of categorisation I will explain the choice I made to have one data set rather than two. While conducting the four pilot interviews I began analysing the data from the two therapy groups separately, with the aim of making comparisons between the categories which emerged. In practice I found the main categories which were emerging from the two therapy groups were very much the same, and any differences were at the lower levels of categorisation. I experienced a tendency to believe I should be finding more significant differences and I reasoned that separating the data ran the risk of imposing differences between the two therapy groups which did not necessarily exist. As comparison within categories is an integral part of a Grounded Theory analysis it seemed unnecessary to keep them separate in order to make a comparison. After the pilot interviews I decided to combine the data into a single data set, which continued until the analysis was complete.

- **Conceptualising categories**

In this section I will attempt to give a comprehensive account of how I conceptualised the categories and I will use extracts from the interview transcripts to illustrate the process. Interview extracts are presented in italics, while the categories themselves are presented in bold text

The place of creativity

Before describing the process by which the categories were conceptualised I will consider the place of creativity in that process. Grounded theorists do not often describe how they generate their categories. Similar to Kvale`s mining metaphor with regard to interviews, Corbin (2008, p.66) uses the term "mining the data," to describe the process of coding, where the analyst is digging beneath the surface to discover the hidden treasures contained within the data. She describes the process as intuitive, which requires trust in oneself to make the right decision (ibid, p.71). However she also describes in detail the use of cognitive strategies which enable the analyst to think about or interact with the data, and help the analyst to understand the possible meaning of the account. These involve the analyst asking questions about an incident and thinking about the possible range of answers, making comparisons between incidents for similarities and differences, thinking about the various meanings of a word or phrase

and finding the opposite of a word to obtain a different perspective. She supports the use of personal experience and highlights the importance of recognising and questioning biases and assumptions, either on the part of the analyst or the participant. She also advocates looking at and questioning the language, looking for emotions, for words that indicate time, thinking in terms of metaphors and similes, and looking for negative cases that do not fit the pattern.

Rennie concentrates less on cognitive strategies and more on the analyst`s bodily experiencing. He describes how, during the activity of categorisation, the analyst is engaged in the activity of understanding (Rennie and Fergus, 2006, p.493). This understanding involves the kind of bodily experiencing or the felt sense described by Gendlin (1978; 1996). Hearing or reading the participant`s account of an experience inevitably generates a felt sense within the analyst. If attention is paid to that felt sense it brings about symbolisation of the phenomenon present in the account in terms of memories, associations and images within the analyst. As the analyst struggles to come up with a word or phrase to symbolise the account she has a sense of the adequacy of the fit of each possibility with her own bodily experiencing. A word or phrase that fits causes a sense of satisfaction or resolution within the analyst. Gendlin decribes this as similar to a poet finding a word or line for a poem. The poet struggles to find the right words, and knows when the right ones are found. Rennie and Fergus believe that this embodied categorisation can result in imaginative, abstract categories that strike to the heart of the phenomenon under study. I have found that satisfied sense of fit rather elusive. It may be that this is the inevitable consequence of remaining open to new interpretations as the analysis proceeds. This may have been so for Rennie and Fergus too. They describe a sense of stillness and stability, at least for the present, which would indicate that this state did not necessarily continue throughout the analysis (Ibid, p.495).

Generating categories

In my wording of categories I was inevitably influenced by the research questions as one of the questions I asked myself during the categorisation process was, "What is this participant *doing*?" Charmaz (2005, p.517) describes the wording of Grounded Theory categories as active, immediate and short, that focus on defining action, explicating

assumptions and seeing processes. Rennie (2006a) describes categories that have grab value, are pithy and where a great deal of complexity is summed up in a single word. This makes the concept easy to grasp, and to remember. My aim, in conceptualising the first categories in a way which would be grounded, was to stay as close to wording the participant as possible. Where the wording is descriptive, I used the same words and in this case the resulting categories are termed invivo categories (Corbin and Strauss, 2008, p.65). For example, in one of the interviews, the participant said of his therapist, "He put me straight." This term is very descriptive of what happened and it would have been difficult for me to have found a better term.

In generating concepts which did not use the participants` words, I was aware that, as a person-centred counsellor, there was a danger that I would impose person-centred categories into the data. So, while my aim was to reflect the meaning of the participant, it is probably inevitable that the kind of categories I generated depend on the language system I am most familiar with. This can be seen in Rennie`s work which is filled with humanistic and experiential language and concepts, and it is therefore interesting to speculate if a CBT therapist would have categorised the data in a very different way.

Creating lower and higher order categories

Traditionally, after lower categories have been conceptualised from the text, the next stage of the analysis involves grouping categories with similar meanings together into higher order categories to produce a hierarchical conceptual system, where the lower level categories become the properties and dimensions of the higher level ones. The term "properties" refers to the characteristics or components of a category and the term "dimensions" refers to the variations of a property along a range (Corbin and Strauss, 2008, p.45). However, in my own experience, the analysis did not proceed in such an orderly and systematic fashion. Comments by Grounded Theory analysts appear to corroborate this. Rennie (2006a) suggests that, at the beginning of the analysis, one`s sense of each category is best left fluid. Corbin and Strauss (2008) describe how at first the analysis is open and free, much like brainstorming, as early in the analysis the researcher may not be certain if a category is a lower level one or a higher level one.

The following important interview extract illustrates the categorisation process.

CBT1.....One of the other things is that because of the job I did, and we`d a lot of younger workers that, as an older and more experienced worker, I felt a lot of responsibility to them, therefore I couldn`t show any sign of weakness or not coping. Having gone through CBT now I realise how hard I was on myself, because, even something as simple as - I remember once we were doing a pie chart where I took on all the responsibility for what we were talking about. Then my therapist got me to look at it in a different way, where the responsibility wasn`t totally mine. And that simple exercise was like lifting a weight off my shoulders.

I. Do you know how that happened, how you saw that it wasn`t all you`re responsibility?

CBT1. In a way a lot of it was common sense. But this sense of responsibility, I`d taken, far too serious, well too - I`d taken too much of it on. And I felt guilty that it - you know, I am responsible for everything that happens, where in fact I`m not. The trick was actually - I remember it clearly - the trick was actually seeing it physically drawn, and divided far more equally.

This participant describes herself in the past as a person who had to cope, and who took all the responsibility for situations upon herself. She describes how during therapy this view of herself changed. She realised she was not responsible for everything, that she had been hard on herself. This change resulted from engaging in a CBT exercise, the Responsibility Pie. According to Rennie (Rennie, Phillips and Quartaro, 1988, p.143: Rennie, 2006a, P.67), each unit is assigned to as many categories as the researcher can find meanings. I therefore categorised this extract as follows (the brackets following the categories contain the one liners which describe that particular aspect of the meaning unit.)

seeing myself before therapy - feeling responsible (coping, taking on all the responsibility)
looking at myself differently after therapy – sharing the responsibility (not responsible for everything that happens)
seeing myself differently in the past (realise how hard I was on myself)
taking part in exercises (doing a pie chart)
therapist as agent of change (got me to look at it a different way)

emotional response (lifting a weight off my shoulders)
It did the trick (seeing it physically drawn and divided equally)

At this point in the analysis it was unclear which are lower and which are higher order, and it can be seen that with the first two categories I have conceptualised both lower and higher order categories simultaneously.

Constant comparison

During the analysis I used the technique of constant comparison (eg. Maykut and Morehouse, 1994; Rennie, 2006a; Corbin and Strauss, 2008). This is where each new meaning unit under analysis is compared to the meaning of all the others. If the researcher considers the meaning is the same as an already existing category it is assigned to that one. If not a new category is created. When a new category is conceptualised after a number of meaning units have been analysed, the researcher then goes back to the previous meaning units to see if that meaning can be found in any of them. If so they are assigned to that category too. So the researcher goes back over the text many times in the course of the analysis.

As I continued with the analysis, I assigned other meaning units to each of these categories. For example the meaning unit which contained the following fragment was also added to the category **seeing myself before therapy – feeling responsible.**

> *PCT1. And that was a big thing that ran through my – I was feeling responsible for my dad, my mum- like at 13 not thinking you can tell your parents because they can`t cope – all that.*
> *I. So you`ve always felt responsible.*
> *PCT1. And I took on that role with all my family members.*

Similarly I assigned this meaning unit, a complex narrative where the participant related how his father had a stroke and had been taken to hospital, to the category, **looking at myself differently after therapy - sharing the responsibility.**

PCT7. I was upset when my mum rang up and I just said to her, I said, "I`m not coming down, mum." Chris, one of my other brothers was on his way down, ambulance was there to take him to hospital. What else could I do? And my wife was saying, "Why?" I said, "No," I said, "At the end of the day, I`ve got my own problems to deal with and I`ll deal with them." I went down the following day. Once dad was back out of hospital I seen him.

I. How did it feel, saying that, because you said this is going to sound horrible?

PCT7. To me, it`s like – how could you? I feel guilty, it`s like – what are you doing? Why aren`t you taking him to hospital?..../.....Because (name of wife ) said to me, she said, "I`ll take you down." I said, "No, I`m not going, there`s nothing I can do. At the end of the day," I said, "I`ve got my own problems. I`ve got you and the kids to sort out."

I. So you put you and your immediate family....

PCT7. I put myself first, which I would never have done.

I. I was going to say that sounds really unusual and a bit uncomfortable.

PCT7. It was initially uncomfortable but it was a case of, " Sorry, I`ve got 5 brothers they can all...."

I. So you just realised there were other brothers.

PCT7. There`s others there. It`s not all down to me.

Further lower order categories emerged as interviews were added to the analysis, which were added to the higher order categories. So, **seeing myself before therapy** also included, among others, such categories as **feeling worthless** and **couldn`t say no.** While, **looking at myself differently after therapy** also included categories such as **having a more realistic/positive view of self** and **a different person/finding myself**. Rennie advocates that a category contain a broad range of properties and dimensions. So, **looking at myself differently after therapy** also included those meaning units categorised as **not looking at myself differently** and so on. At the same time I also created still higher order categories. For example, I placed **taking part in exercises** into a higher order category **activity during sessions** which, in turn, I placed in an even higher order category **engaging with the therapy.** So, as the analysis proceeded, with many revisions and adjustments a hierarchical system of categories did, eventually, emerge.

During the categorising process I also recorded any thoughts and ideas that I had about the categories in the form of memos and the relationships between them in the form of diagrams (Corbin and Strauss, 2008, p.117). Memos and diagrams are considered essential to Grounded Theory as they are used in the process of conceptualising the core category and in generating the theory (Lempert, 2007, p.245).

- **Integrating categories, conceptualising a core category and generating theory**

At this point in the analysis I began to doubt that I had actually conducted a Grounded Theory analysis, but that the analysis I was engaged in was a "Generic Inductive Qualitative Model" (Hood, 2007), with a straightforward comparison of themes. In line with the cyclical reflexive nature of the research design I described at the beginning of this chapter, I returned to the literature about qualitative analysis and Grounded Theory in particular. After reading some of the literature I achieved a deeper understanding of the methodology. I gleaned that it is possible and perfectly valid to carry out a themed comparison by using Grounded Theory techniques, without constructing theory (Corbin and Strauss, 2008, p.263) and I came to a deeper understanding of the nature of theory construction.

Just as Grounded Theorists do not often describe how they conceptualise their categories they often do not explain how they conceptualise the core category. It is sometimes described as emerging from the data (Holton, 2007), but the process by which it emerges is not always clear. Corbin and Strauss (2008, p.93) admit that the process is not easy for novice researchers. They describe how the concepts in qualitative data exist in complex relationships, how experienced researchers develop different ways by which they keep track of these relationships and how a beginning researcher may become overwhelmed. The process is that of searching for "a unifying concept" or "a coherent overarching story." (Ibid, p.105). They suggest that, at this point in the analysis, a researcher has been immersed in the data for some time and so has a "gut" sense of what the research is all about (Ibid, p.106). They describe an "aha" experience, where ideas for a unifying concept appear to come out of nowhere (Ibid, p.109). It is easy to see that relying on such an intuitive sense may leave the researcher open to the criticism of imposing theory on the data. They point out that it is also

necessary that the researcher can trust herself (Ibid, p.16). I used the techniques they propose to help in the search (Ibid, p.274). I reviewed and sorted through memos, looking for recurrent themes. I constructed diagrams which related categories together, and wrote the storyline of the analysis. I turned to the literature and spent a great deal of time in thought.

Corbin and Strauss provide a list of criteria to be applied to the emerging Core Category as part of the decision making process (Ibid, p.105). They state that all other categories should relate to it, there should be indicators, pointing to the concept, which occur frequently in the data, there should be no forcing of the data to make it fit with the concept, it should be sufficiently abstract so that research can be carried out in other situations which will lead to the development of a more general theory, and it should grow and develop as more categories are related to it. Ultimately they describe how the analytic story "falls into place and feels right". This again, highlights the subjective and interpretive nature of Grounded Theory. The analysis I have conducted "feels right" to me, but I must acknowledge that it may well not feel right to others.

In principle the hermeneutic circle resulting in progressive understanding is never-ending as there will always be the possibility that further analysis would lead to further insights and interpretations of the data. However, at this point I was then able to construct a theory, and the analysis reached the kind of stability, described by Rennie and Fergus (2006, p.495). I will elaborate the theory along with the core category in the next, Findings, chapter.

3.5. TRUSTWORTHINESS

One of the challenges which face qualitative researchers who want their research to be taken seriously in a culture dominated by the scientific paradigm is to be able to demonstrate the quality of the research. For many qualitative researchers terms like validity and reliability belong in the quantitative paradigms and they favour the terms trustworthiness, credibility, transferability, dependability and confirmability (Denzin and Lincoln, 2005, p.24). Trustworthiness is a term which has been most widely adopted in the qualitative literature (eg. Morrow, 2005). There have been a number of

attempts to list the criteria by which the trustworthiness of a qualitative piece of research can be assessed (eg. Stiles, 1993; Elliott, Fischer and Rennie, 1999; Morrow, 2005; Williams and Morrow, 2009). Corbin and Strauss (2008, p. 307) provide a detailed list of criteria for judging the quality of a Grounded Theory study in particular, and Charmaz (2005, p.528) lists the criteria for a constructivist Grounded Theory study. In this section I will give an overview of how I have attempted to demonstrate the trustworthiness of this study and I will go into some detail about the role of credibility checks. I will do this using the criteria set out by Elliott, Fischer and Rennie (1999). Briefly put, these are: 1) Owning one`s perspective, 2) Situating the sample, 3) Grounding in examples, 4) Providing credibility checks, 5) Coherence, 6) Accomplishing general vs specific research tasks, and 7) Resonating with readers.

First of all, in the introductory chapter, and earlier in this chapter, I have given an explanation of my background, beliefs and assumptions in order to be transparent about the perspective I have brought to the research. I have also aimed for transparency in my reports, in the methods section of this chapter, of my changing thoughts and situation during the project. Of course, the reader cannot assume that these are exhaustive reports. It was difficult to decide how much personal information to include and there may well be aspects which I left out which could been relevant in making an informed assessment of the study. Inevitably there will be aspects of my internal processes of which I am unaware or which I have unintentionally distorted. I have also given a description, in the introductory chapter, of the organisational, political and clinical context in which I conducted the research and, in the methods section, of the client sample, which I hope is sufficient for the reader to assess the relevance of the study. In this chapter I have tried to give a detailed account of the decision making process and the resulting method of data collection, supported by extracts from the interview transcripts. I have attempted to provide a coherent account of the analysis and the process by which the categories were generated, providing evidence from the interview transcripts to illustrate this. In the next chapter I will present the findings in a way which I hope will demonstrate the relationships between the categories, I will explain the process by which I decided on the core category and how the theory evolved and support this with examples from the interview transcripts. My aim has been to give the reader an account of my interpretation of the participants` interpretations of their experiences of therapy, while acknowledging that this is one of many possible, credible

sets of findings. My hope is that it will resonate with the reader and enable an assessment of my understanding of the data, in the light of other, possible alternatives.

- **Credibility Checks**

According to Elliott, Fischer and Rennie (1999) there are a number of methods for checking the credibility of the findings. The researcher`s understanding can be checked with participants themselves, or by using a group of analysts or an auditor, by comparing two or more varied qualitative perspectives or by triangulation with external factors or quantitative data. Some researchers question if such checks are a measure of credibility in qualitative research given the acceptance of multiple realities (Morrow, 2007) and, as I discussed earlier in this chapter, credibility checks can be regarded as importing positivist values into the research design (Ponterotto, 2005). However, some Grounded Theory researchers report employing this procedure (eg. Frankell and Levitt, 2009) and, in keeping with my initial post-positive stance I began by sending a summary of my findings from their interviews to individual participants, and asking them to comment on the accuracy of the findings. I did this by listing the main categories with brief explanations, and allowing space for comments (An example of this can be found in Appendix 5). I sent this to the first four participants, two from each therapy group. This procedure immediately generated a number of ethical, practical and analytical issues, some of which I outline here.

Firstly, I had no way of knowing what was happening in each participant`s life. Circumstances may have been such that the participant found receiving the findings distressing or intrusive. Inevitably there would be a time delay between the interview and the participant receiving the findings, as I would need time for transcription and analysis. The longer the delay the more likely it would be that the participant had forgotten what they talked about. This created pressure to analyse the interviews rapidly, which was not always possible due to the uneven response rate and other demands on my time. Each interview generated a large amount of complex information and I would need to present it in a way which was palatable and undemanding. By making them user friendly there was a danger that I might leave out important information. There are a number of possible psychological processes occurring within the participant which might limit the usefulness of such credibility checks (Rennie,

2002). The participant may be the best judge of the meaning of their experiences, but on the other hand they may not understand themselves fully, or be defensive about aspects of themselves or their experiences. They may not have liked my interpretation. The ways that people construct their experiences is changed both by talking about them and by time. Therefore the interview process itself, and the time between the interview and receiving the findings, may have changed further their understanding of their experiences. This raises the question about what I would do in the event of a disagreement. Finally, when I sent out the member checks the analysis was in its infancy. As the analysis continued I identified new themes and revised ones I had already identified. Corbin and Strauss (2008, p.197) explain that this is a normal occurrence and that new insights and subsequent changes to the analytical structure often continue until the end of the study. Such reasoning reduces the helpfulness of credibility checks where participants had already agreed to the categories generated at the beginning of the analysis.

In the event, all four of the participants agreed with all my interpretations. PCT1 added as an overall comment:

> *"Thank you for listening so well that you could summarise so effectively*
> *Very easy questionnaire to answer, reflected my comments perfectly."*

However, CBT1 demonstrated that the process of member checking was disturbing for her.

> *"I initially looked at the questionnaire and put it back in the envelope as seeing it made me feel anxious and uneasy. Looked at it twice more over next few days. Decided on the spur of the moment to complete it and accepted that while it referenced what I had been through I was able to stay calm and complete it. This was about saying my illness and work are in the past; I have to keep looking forward, not back."*

The fifth participant, CBT3 did not return her member check. After considering the ethical implications and in line with my movement in a constructivist direction, I have

referred to throughout this chapter, I decided that the limited usefulness could not justify their continued use and stopped the procedure.

I also made an attempt to recruit an auditor in the form of my supervisor, a procedure which also highlighted a number of drawbacks. First of all he had limited time investment, which may have meant that he could only reach a partial understanding of the text so that that my interpretation may have been questioned because he could not "see" it. I may then have deferred to his interpretation because I perceived him as having a position of greater experience and authority. On the other hand there was also a danger that he would defer to my interpretation because it "seems about right," or that, despite his attempts to put preconceptions to one side, I had already influenced his interpretation by the extensive discussion we had had in the months previously. Although the categories he generated were not dissimilar to mine, we decided that a considerable investment of time and effort on the part of the auditor would be required in order to carry out a meaningful audit, and, even then, its usefulness in adding credibility was limited. So we abandoned the attempt, agreeing with Rennie (1992) who believes that the single analyst becomes the expert on the phenomenon under investigation and is thus in the best position to understand and express it. The exercise did, however, give me some reassurance regarding the usefulness of my analysis and some confidence to continue.

3.6. ETHICAL CONSIDERATIONS

A detailed discussion of the ethical issues involved is beyond the scope of this chapter. (See Havercamp (2005) for a discussion about the ethical issues of qualitative research and Kvale (2007) for a discussion about the ethical issues of interviewing). This study was carried out within the ethical framework (BACP, 2013) and the ethical guidelines for researching counselling and psychotherapy (Bond, 2004) of the British Association for Counselling and Psychotherapy. I obtained ethical approval from the NHS Local Research Ethics Committee, which was ratified by the University Ethics Committee. The main principle underpinning the study was that it will contribute to our understanding of therapy, but that no harm should be done to those involved. In this section I will give some consideration of the main ethical challenges that arose in the

course of the study. The first can be loosely grouped around the issue of boundaries and my different roles as researcher and manager of the service from which participants were recruited. The second concerned the issue of consent and the impact of the interview on the participant.

- **Boundaries between researcher and manager**

As service manager I had been involved been involved in the process by which the participants accessed their therapy and I managed the therapists who had delivered it. I made every attempt to keep the two roles of researcher and manager separate. The participants were informed that I was the manager of the service. Where participants had clearly not maintained the improvement they had achieved in therapy, or expressed a desire for further therapy, I addressed such concerns on an individual basis. In each case I conducted a risk assessment, and gave them information regarding access to further help, in line with the policies and procedures of the organisation. Therapists had not given their consent to participate in the research, and I was mindful of receiving information about their performance. Therapists were informed that I was conducting the research, but specific information remained confidential to the research and anonymous within it.

- **Consent and the impact of the interview**

While conducting this research project I was mindful that those who took part in the study had had moderate to severe mental health difficulties and so were potentially still a vulnerable group, and I gave careful consideration to the possibility of causing further psychological distress. I obtained written informed consent from participants (Appendix 6). However, as the interviews were open-ended and flexible, it was not possible for the participants to be certain of the effect that taking part in the research might have on them. I therefore regarded this informed consent as an ongoing, mutually negotiated process rather than a single event (Haverkamp, 2005). It was made clear that the participant may withdraw at any time but the power imbalance between participant and professional is such that the participants may not have felt able to voice

this. I therefore took care to monitor if the individual participant was comfortable with the discussion. This is demonstrated by the following extract.

I. So, you didn`t do anything with it until you went back to counselling the following week, yeah? So can you tell me what you did then?

PCT1. I`ll probably get upset. You`ll have to bear with me if I get upset.

I. Can I just check out - is that OK?

PCT1. O it`s absolutely fine. I just get upset, because it actually – that was my turning point. So it will upset me to – it`s the relief of – and because it was – this is going to sound a bit weird. It was quite a beautiful moment because it, it meant so much to me that I was turning my corner at last. That I`d actually addressed it, and I felt like - from that point on it was move forward. So it`s emotional in the sense of a positive emotion, not a negative, if you like.

I. So it`s a good upset.

PCT1. Yeah, yeah (laughs).

There were occasions when a participant touched on areas which were potentially emotionally distressing as in the following example:

PCT4. Yeah. I felt bad because we discussed, like- he asked me the scenario of, like, what happened, like, with Danielle. I don`t know if I might do or not, If I might cry or not. He just said, like, "What happened?" I said, "Look, Danielle got a brain tumour diagnosed when she were 11 with a brain tumour. She had an operation, 2 days or she`d have died, to see what this tumour what was in her brain. (sighs) And then.....

I. I don`t want to upset you.

PCT4. No, you`re not upset me. I`m not – he has learned me. I can talk about it.

I. So you can talk about it without crying so much.

Where the interview itself provoked distressing feelings I took the view, shared by many qualitative researchers (eg. Suzuki, et al, 2007), that the welfare of the participant must take precedence over data collection. Here there was an ethical challenge to tread a difficult line between interviewer and therapist (Haverkamp, 2005). There is

potentially an overlap between the skills of an interviewer and the skills of a therapist and I took care to avoid responding therapeutically.

At the end of each interview I asked the individual participant to reflect on their experience of the interview and asked for feedback to inform how I conducted future interviews. None had any adverse comments or suggestions for improvement. There is also the view that research should benefit participants, and I hoped that participants would find the process helpful. This seems to have been the case. Several participants reporting that they had found the interview itself a therapeutic experience, as demonstrated by the following two extracts:

I: Can I just ask you how you`ve found the process of this interview?
PCT6: It`s been fine. No problem. It`s been like another counselling session.

I: How has this interview been?
CBT4: It`s been great, if you`ve got another hour to spare, you know.

Participants also used the interview to reflect on the therapy and to assess and consolidate their progress.

PCT9. It`s been good. It`s made me realise how much I have actually come on really. Because probably, if you`d seen me 6 months ago I`d have been in tears every 2 seconds.

CBT3. It`s been OK. It`s been good. I`ve quite enjoyed it - re-living the stuff. Because I`ve not thought too much about how it`s helped. And it`s only when you come in and talk, later and think how much better you are dealing with things. I mean, I know in my head that I feel better, but when you actually talk and compare to how you used to deal with things, it`s quite good.

3.7. CHAPTER REVIEW

In this chapter I have attempted to give a transparent and coherent account of the qualitative, Grounded Theory methodology I implemented in order to answer the research questions and my rationale for the choices I made in designing the research. I investigated the philosophy underlying qualitative methodologies and the Grounded Theory methodology, and I gave a detailed account of the interview method of data collection, and the Grounded Theory method of data analysis. My aim has been to be consistently constructivist and provide the reader with sufficient information about the context and the methods and procedures I employed to judge the trustworthiness of the study. In the next chapter I will give an account of the main findings which resulted from the analysis of the data I collected. Overall my aim has been, not to discover the truth, but to contribute to a growing body of knowledge regarding the client`s experience of therapy in order to inform the practice and delivery of therapy in primary care.

4. THE FINDINGS

4.1 INTRODUCTION TO THE CHAPTER

In this chapter I will present the main findings of the research project. There is a convention in Grounded Theory studies to present the Core Category first and to order the categories which emerged within that overarching concept. However I considered it might prove more meaningful to "tell the story" of the analysis. In conducting the analysis I conceptualised the lower and higher categories at the beginning of the analysis and the Core Category at the end, before finally constructing the theory and I have constructed this chapter in the order in which the analysis progressed and unfolded. The chapter consists of five sections. In the first section I will present an overview of the findings and the higher categories which emerged from the analysis. In the second section I will describe each of the higher categories and some of the lower categories contained within them. In the third section I will focus on the two categories which proved central to the analysis, **It did the trick** and **The key**. I will describe how these categories emerged and how their importance became apparent. I will also give a detailed account of the key understandings and realisations for each participant and some of the different elements of therapy that brought them about. In the fourth section I will explain how I went about integrating the categories and constructing the theory, and the fifth and final section will be a review of the chapter.

In writing up a qualitative study it is common to give pseudonyms to participants in keeping with the personal and individual nature of the experience being investigated. I have chosen, instead, to use the abbreviations PCT1, PCT2, etc, to refer to the participants who received PCT, and CBT1, CBT2 etc to refer to the participants who received CBT. This may seem to depersonalise the accounts but I hope it will be useful to the reader as it identifies at a glance which therapy the participant received and also locates the interview in the time line of the analysis. Hence the notation *PCT1* immediately identifies an extract from the first of the PCT interviews, likewise *CBT7* identifies an extract from the seventh and final CBT interview. In the interview extracts the abbreviation *"I"* denotes me, the interviewer. In this chapter I will continue to

present the categories in bold text while interview extracts are presented in italics. A series of dots.....denotes where superfluous text is missing.

4.2. OVERVIEW OF THE FINDINGS

Taking an overview, most of the participants in each therapy group reported the success of their therapy, describing themselves as feeling better, happier, calmer and more relaxed. However, the extent of the participant`s recovery varied. For example, within the Person Centred therapy group, PCT2 described how she still felt anxious and experienced panic attacks, but felt more able to manage these feelings. PCT7 described how he was *not right* and that he still *got stressed*. There was a similar range within the CBT therapy group. CBT3 reported that *everything was getting on top of me again* and CBT5 described how her intrusive thoughts were still creating anxiety, but that she now tried to ignore them and carry on with her daily activities despite them. Each group also contained a representative of the negative case, PCT3 and CBT7. These participants felt better while they were engaged with therapy, but the improvements they made during therapy were not maintained after discharge.

There were differences between the experiences related by the participants in each therapy group, but there were also striking similarities. All participants talked about themselves in the past and in the present. Participants compared their present with their past selves, *now* and *before*, and attributed the changes to different elements of the therapy. PCT6, was quite explicit about this in one of his responses.

> PCT6. *I`ll talk about (name of participant) pre-counselling and (name of participant) post counselling.*

During the analysis, I found that the categories which were emerging could be organised into higher categories which related to the sequence of occurrence within a chronology or time line through therapy. Participants entered therapy with the accumulation of their previous life experiences, and a particular view of their reality. During therapy they engaged with a number of different activities and made sense of their reality. Where therapy was successful participants` view of their reality changed and they went on to

manage their difficulties and life situations in a different, more positive and constructive way. Participants attributed this change to different elements of the therapy. A list of the higher categories may be found in Table 1. I have indicated the number of participants in each therapy group represented in each category in both the table and the narrative. Each category contains a range of properties so that, for example, the higher category **doing things differently** includes those who had difficulties doing things differently and those who continue to do things the same. Figure 5 shows how the higher categories can be linked together in a process map of the journey through therapy. In the next section I will outline the higher categories with some elaboration of the lower categories contained within them and their properties and dimensions.

Table 1

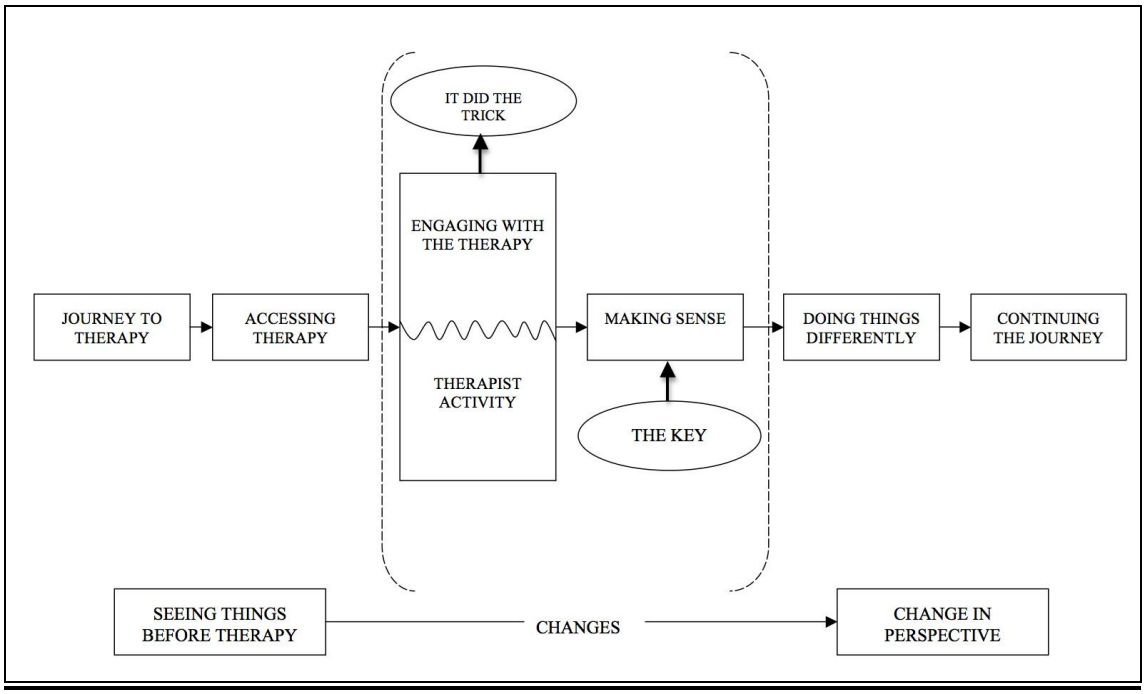
Higher Categories

Categories	**Number of Participants**	
	CBT total=7	**PCT** total=9
1. JOURNEY TO THERAPY		
Experiencing problems and difficulties	7	8
Engaging in activity before therapy	4	4
Having therapy before	3	8
Changing before therapy	3	3
2. ACCESSING THERAPY		
Being in a dark place	5	8
Seeking help	5	7
Having expectations of therapy	5	9
3. SEEING THINGS BEFORE THERAPY		
Seeing myself in the past	2	4
Seeing myself before therapy - feeling worthless, blaming myself, criticising myself, feeling responsible, couldn`t say no	6	8
Seeing others before therapy	4	3
4. ENGAGING WITH THE THERAPY		
• Activity outside sessions		
Managing emotions	1	2
Reading and researching	5	2
Writing	2	4
Thinking and reflecting	1	4
Carrying out tasks	6	3

• Activity during sessions		
Talking-content - past experiences, present experiences, between session activity, doing things differently, about feelings	7	9
Talking-process - deciding what to talk about, avoiding painful subjects, flow	5	9
Creating order	1	8
Taking part in exercises	3	-
Attending to the therapist and the relationship	7	5
Managing and expressing emotion	2	7
5. THERAPIST ACTIVITY		
Therapist as an agent of change	6	7
The caring therapist	4	7
Therapist`s interventions Questioning, giving an explanation, putting me straight, sharing experiences Giving affirmation and encouragement, giving approval and reassurance, giving confidence Giving exercises and techniques, adapting exercises, giving paperwork, giving procedures for doing things differently, making suggestions. Reminding and reinforcing	7	9
It did the trick	6	8
6. MAKING SENSE		
Understanding myself - understanding where things came from, understanding what I do, having a label	7	8
Coming to terms	4	7
Finding meaning	2	3
The key	6	8
7. CHANGE IN PERSEPECTIVE		
Confirming my view of things	1	2
Looking at myself differently – feeling better, happier, calmer, more confident, valuing myself	7	9
Seeing myself differently in the past	6	8
Looking at others differently	7	9
8. DOING THINGS DIFFERENTLY		
Implementing techniques	6	-
Deciding what to do	3	4
Implementing plans	1	1
Happened naturally	2	3
9. CONTINUING THE JOURNEY		
Ongoing difficulties	3	5
Engaging in activity after therapy	1	2
Engaging in activity in the interview	2	7
Needing more help	2	2

Figure 5

Process Map of Higher Categories



4.3. HIGHER CATEGORIES

There are nine higher categories which vary in size reflecting the amount of time the participant spent in the interview talking about the themes within them. As the aim of this project was to investigate the participants` experience of therapy, it can be appreciated that the central categories which relate directly to the therapy experience, are larger than those relating to the participants experiences at the beginning and end, and before and after therapy. These differences in size are also reflected in the narrative. In this section I will take each higher category, numbered in turn, in the order in which they occur during the process of therapy. Economy of space does not allow me to present a complete elaboration so a full list of categories can be found in Appendix 7.

1. JOURNEY TO THERAPY

The first higher category represents all the participant`s life experiences before therapy which is, inevitably, imprecise and incomplete. Most participants described **experiencing problems and difficulties** (7 CBT, 8 PCT) which contributed to each one accessing therapy. Presenting problems included abuse, trauma, bereavement, work related stress, relationship difficulties, agoraphobia, intrusive thoughts, depression, panic and anxiety.

Participants reported **engaging in activity before therapy** (4 CBT, 4 PCT) by using self-help materials, books and the internet, activities that had varying degrees of success.

> *CBT3: I`d looked into it, actually. I`d had a bit of a dabble on the internet. But then I haven`t got the self discipline to keep going, because you`re supposed to do it regular, aren`t you? I`d had a look and tried it out and thought, "Yeah that sounds really good." When you`ve got a proper appointment, you`ll do it won`t you. Where as if I`ve got to do it on my computer, I won`t.*

Some had made significant attempts to help themselves in terms of understanding and making sense of themselves and their difficulties

PCT8. I`ve spent a lot of time analysing it....I do analyse it because I need to try and understand it. And once you understand it, I think it helps.

Several participants reported **having therapy before** (3 CBT, 8 PCT). Their experiences were mixed.

PCT1: I`d been to counselling a couple of times before, in my past, and I`d found that helpful but it just, kind of, hadn`t - either I wasn`t at the right place at the time, or it wasn`t the right approach. I`m not quite sure what it was. It was helpful, but it didn`t, kind of, deal with what I needed to deal with in a way that I could then move forward.

CBT5: I tried counselling. I was put on the waiting list and it seemed to take for ages, so I went to see a counsellor. They were OK, but I didn`t really know myself what was wrong with me at the time.

PCT9: I`ve had the CBT, it wasn`t very helpful. I found, in the end, the counsellor – I felt like he was winding me up. I felt it was counterproductive.

PCT7: So I went to a counselling session.....I walked in and this gentleman said to me, "Right this is the first of 6 sessions....I`ve got a CD which I`ll give to you, you suffer from anxiety. And that`s before I said anything. And I just sat there and listened to him talking to me and then he gave me the CD and I put it in the car driving home. I rang (the agency) and said, "Forget it, if that`s what you give to employees who have got problems."

Some participants had already experienced **changing before therapy** (3 CBT, 3 PCT).

PCT1: I think I`d gone in with an almost like a state of mind shift at the beginning of – I wasn`t going to allow it to make me feel to be a victim any more. I was not going to feel like that.

PCT1 also described being ready for therapy this time. She described how she used all her previous life experiences, including previous episodes of therapy to give her the confidence to address and deal with the abuse she had suffered as a child

PCT1. It had taken me those previous two experiences, my life as it is now, and my life experiences, my support network at the moment, all those things, for me to be in that place to be able to feel that confident.

2. ACCESSING THERAPY

The concepts included in the second higher category were associated with the participants` experiences at the time of entering therapy. Participants described **being in a dark place** (5 CBT, 8 PCT), where they felt low, depressed and frightened. The following quotes demonstrate a similarity between participants who received the two different therapies.

CBT6. I was feeling ill. I was dead ill – don`t know what it is. And then all of a sudden I just cracked.... I was off work, I had just gone to a dark place, I don`t know where it was.

PCT9. O, it was a dark, horrible place to be. I wouldn`t want to be there again.

PCT4. I wanted help, because I didn`t want to be here. I was frightened, I was terrified.

CBT5. And so frightened of what was in my head. I said to her, "I think I need to be locked up,"

Several participants reported being frightened that they were going mad.

CBT1: I was scared, I guess, that I was perhaps, you know that there was something going mentally wrong with me.

PCT2: There were times where I felt like I was going mad and that worried me because, you know, I do quite a responsible job and I seriously wondered whether there was something wrong with my sanity.

Participants also reported feeling that this was *not me*.

CBT1: And that was probably one of the things I remember thinking and saying when I became ill, "I`m just sick of other people`s problems. I don`t want to know." And that`s totally opposite, completely opposite to where I used to be as a - you know, wanting to help and assist other people.

PCT2: Last year I was just becoming not myself any more. I was weak, I couldn`t cope with anything. I was anxious, I was frightened, I was scared. I just wasn`t me any more.

It was recognising that they were in this dark place and that they were unable to move out of it on their own, that resulted in participants **seeking help** (5 CBT, 7 PCT). They either came to this decision alone, or it was suggested or facilitated by family members, friends, GP or, in PCT7`s case, the police.

CBT1: I don`t think I even - like I said I didn`t realise how ill I`d become. But had it not been for a weekend of tears, and then my husband taking me to the doctors first thing on Monday morning, I would have gone back into work.

PCT7. The day I was arrested, I know this sounds very strange, but I`m glad what happened happened because it was the shock that I needed to realise something was wrong. The police were absolutely brilliant with me and when I was discharged from (Name of police station) and I said to them, "I don`t know where my car is." And so one of the officers who had done the interviewing, he said, "I`ll take you back," and when we were driving back he said, "You need to get help."

Each participant`s individual journey to therapy resulted in them **having expectations of therapy** (5 CBT, 7 PCT). There was a range of different expectations with some participants knowing what to expect while others did not.

PCT2. So when I was referred to the counsellor on this occasion it wasn`t because I knew exactly what counselling was about or what I would get out of it.

CBT6: I just didn`t think, I didn`t think it would help at all, but it did.....I thought, you know, give it a try. And it worked.

CBT7. I didn`t know what to expect

PCT7. I was expecting what the (company) offered but this was totally different.

This proved to be an important category in the final stages of the analysis when I was conceptualising the core category and generating the theory. I will elaborate this in more detail later in this chapter.

CBT2 reported that she had initially seen a different therapist. She was unhappy as it was not what she expected and had asked for a different therapist.

CBT2. I thought, "I`m not going back there again." That`s when I got in touch with them and said, "It really isn`t for me." This isn`t what I would have thought CBT was about.

PCT1 described how, in pervious episodes of therapy, she had stayed in therapy, even when it was not helping, but that this time she had the confidence to ask for a different therapist.

3. SEEING THINGS BEFORE THERAPY

The third higher category relates to the participants` view of themselves, others and their world before therapy. Individuals "see" their reality, and they also have thoughts, feelings, values and beliefs about it which are included within this category. Participants described this phenomenon in terms of **seeing myself before therapy.** Many of the properties and dimensions of this category were clustered around

participants` "negative" views of themselves, associated with low self esteem and a low sense of worth. Both PCT and CBT participants described **feeling worthless** (3 CBT, 3 PCT).

PCT9: It was all these, sort of, low self esteem, negative thoughts that I had. You know, I wasn`t worth it, why should I bother? It`s that inability to cope with anything and make that decision and do the steps to actually make you feel better. You know, that overriding I wasn`t worth it any more and what`s the point?

CBT4: When I started I was like, very negative, had no confidence. I just allowed people to use me like a doormat.

Participants in both therapy groups described **blaming myself** (2 CBT, 4 PCT). PCT1 blamed herself for the abuse she suffered as a child, and CBT1 blamed herself *if anything happened.*

PCT1: I used to blame myself and used to say, "Why didn`t you find different ways home?" even though I did. All the practical things at first. I used to blame myself for, you know – could I not have ridden my bike faster? Could I not have gone a different way? - all those things.

CBT1: My eldest son, who has Downs Syndrome and he`s learning to drive. And there was always this part of me that thought, "If anything happens to him when he`s driving - say he passes his test - if anything happens to him it will be my fault.

Participants described **criticising myself** (2 CBT, 3 PCT). PCT6 described criticising himself in his work role.

PCT6: Part of the role is presenting to the main board at work. And 90% of what I`d done they thought was great, I was doing a good job, but the 10% that they criticised, the 10% that I could have done better, I could have done different, was the bit I focused on. I wasn`t able to look at, "90% of that they really liked, they were impressed," but, "O, I should have known the answer to that, or I should have done this." I was focusing very much on the bits that didn`t go right.

Others described **feeling responsible** (2 CBT, 3 PCT). CBT1 and PCT6 both described feeling responsible for their work colleagues in similar ways.

CBT1: Because of the job I did, and we`d a lot of younger workers that, as an older and more experienced worker, I felt a lot of responsibility to them, therefore I couldn`t show any sign of weakness

PCT6: One of the things I found really hard to cope with at work was, I felt I had a responsibility for everything, in a team of nearly 40 people. I was asking people to do things and when they brought stuff back that wasn`t up to the standard I wanted and the way I wanted, instead of sending them off to sort it out, I said, "Right, thanks for that," and I took it on and I changed it, I re-did it. So I was doing the 80 hour weeks and the rest of it.

Both PCT and CBT participants describes how they **couldn`t say no** (3 CBT, 4 PCT). CBT6 and PCT7 used very similar terms.

CBT6: I would always stand (gestures standing to attention), "Yes, I`ll do it, I`ll do it." No matter what the consequences to my health or ill health, you know..... I would always say, yes, I couldn`t say, no, if you can get my meaning.

PCT7: I mean, a girl, when I went off work last year....came round and she said, "The problem with you, (name of participant) is you never say no."... Like people that I work with, "(Name of participant) can you?" and, "Yeah, I`ll do it, I`ll do it."

Some participants contrasted this view of themselves before they came into therapy with **seeing myself in the past** (CBT 2, PCT 4), their view of themselves before the experience which caused the disturbance . These properties and dimensions tended to range around more "positive" views. PCT1 described herself as *bubbly* and *confident.* PCT 2 and PCT9 both saw themselves as *strong* people who did not have mental health problems or who needed help.

Participants also described **seeing others before therapy** (4 CBT, 3 PCT). They had more positive views of other people, and were concerned about the opinions of others.

CBT6: I`ve always thought people were better than me

4. ENGAGING WITH THE THERAPY

As might be expected this higher category is the largest of the categories. It consists of two clusters conceptualising participants` activity during therapy, both within and outside sessions. Many of the activities were common to both therapy groups.

- **Activity Outside Sessions**

Participants reported how they engaged in **activity outside sessions** which they either generated themselves or were generated by the therapist. Participants described **managing emotions** (1 CBT, 2 PCT) between sessions.

PCT6. But it was hard as well, because you take a lot of emotion out of the sessions as well. I found it hard, sometimes to, kind of, put a lid on it after the hour with the counsellor. The clock comes round faster than you know it.

Some described **reading and researching** (5 CBT, 2 PCT). CBT therapists provided their clients with information and self help material for them to work through between sessions. CBT1 found this particularly helpful and clearly described the process involved.

CBT1. I had a lot of reading to do and a lot of questioning throughout the work that - stuff I was reading - that challenged me. But I learned so much about myself, and there was some things within the paperwork that I was being given to read – I mean I can remember one particular paper that was on procrastination, and it was just like reading about myself. That in turn gave it some validation that I thought, "This isn`t just me that feels so wretched." Reading about procrastination also gave me some answers, some techniques..... I could read and I could understand it, and then I could

analyse it, and then I could look at myself and think, "Yes practise some of - this would be useful to me, that would be useful to me."

Several participants spent time **writing** (2 CBT, 4 PCT) in between sessions. This was either suggested by the therapist, or they decided to write themselves. CBT1 wrote her thoughts down. PCT1 wrote letters to her abusers. CBT1, PCT6, PCT8 wrote diaries of their thoughts, CBT4 wrote a list of the things that were bothering her, which they then worked through in the sessions. PCT5 wrote lists and PCT6 wrote lists and mindmaps.

Participants also described **thinking and reflecting** ((1 CBT, 4 PCT) in between sessions

PCT7. I`d go away and that night I`d go out walking the dog and it was only then that things would slowly sink in, when I was out of that environment and I had time on my own and I would realise things that she`d said. And then I would start thinking about them and when I came back to the next session I`d say, "Actually, when you said such a thing....."

CBT4. Between sessions, you know, I did think a lot.

PCT6 described engaging in a significant amount of reflection in between sessions. This seems to have involved a process by which he compared what happened during the session with his own internal valuing system.

PCT6. And a few times I`d just go back and just sit quietly and for a few hours just think, "Well, what went on there?".... I used to go off and just sit quietly and think about what had been said just, not over analyse it, but just think about, well, does that ring true for me, does that work for me.

CBT participants reported **carrying out tasks** (6 CBT), set by their therapist. For example, CBT5 had been unable to drive her car due to her *intrusive thoughts* that something dreadful was going to happen. She described the tasks set by her therapist which were to help her back into driving again.

CBT5. I used to think to myself, "I need to get back myself in this car." And I kept saying, "I`m going to do it, I`m going to do it." I think I just literally got in and I did what she said, I`ve just got to put up with it. And I used to drive round just – drove back round, just drove anywhere.

I. So just around the area.

CBT5. Yeah, and I started driving locally where I, sort of, felt comfortable. And then I`d go that bit further, and then I`d go that bit further.

This also involved her stopping her *safety behaviours* where she would phone somebody for reassurance.

CBT5: I left my phone in my bag. And then when it came, the urge came that I needed – "O it`s really bad now," I just, sort of, stayed and thought, "Right, well I`m only..." Like she said, "Look around you. Where are you?" I thought, "Well, I know where I am (laughs) and I know it`s not far from anybody." I think I just used to leave it at the side – that was like my thing, not to touch it while I were in the car. And I think I got to the stage where I left it on the dashboard and then I got to the stage where I could put it in my bag. And then I got to the stage where I wouldn`t think of it.

Some PCT participants described setting themselves tasks (3 PCT). PCT6 pushed himself out of his *comfort zone*. He joined weightwatchers and took dancing lessons.

PCT6. I thought, "I`m going to do something about that." I joined weight watchers, that was scary – a room full of women, I was the only bloke there. That was really putting myself out there. That was good too. I`ve lost 3 stone and I`m getting fitter and just generally healthier.

PCT9 described the importance of *doing things for me*

PCT9. We were discussing things that used to make me happy. And I thought, "I don`t feel happy about anything." I went to a funeral (laughs) and there was a girl there singing and playing the piano and she was fantastic, and I just thought, "I think I might start singing again." And I told the counsellor that was what I was

going to do and she said, "That`s a good idea." ..... I had 6 or 8 lessons and it was great to go once a week and do some – it was a bit of me time.

CBT4 described making a number of changes in her life.

CBT4. It was about the last 3 weeks of therapy I decided to go back to church, decided to get up early in the morning..... finishing the decorating that I should have finished 12 months ago, doing all that, you know, in the house.....I was doing it to make my home better so, you know, I felt good when I was doing it.

PCT1 described taking herself back to the place where the childhood abuse occurred in order to *let it all to rest.* She described thinking about it when she was writing letters to her abusers, but making the decision on the spur of the moment.

PCT1: When I was writing the letters - it came from that that I needed to go back to where it was to let it all to rest..... I had to confront it so for me, it gave me the confidence – I actually sat on the grass – and obviously it didn`t just happen in one place, but there was an area where it systematically happened. I had to go back and I remember sitting there, and it was quite cold. It didn`t make me emotional. I remember just sitting there and going "This is it now. Enough." In my head. I wasn`t talking out loud. And I went at a time when I knew there weren`t many people there, and I went and did that. And it was all that kind of closure kind of thing of just like – enough.

- **Activity During Sessions**

Participants spent much of the interview describing how they engaged in **activity during sessions**. Not surprisingly the category **talking** featured a great deal throughout all the interviews. This category contains both **content** and **process.** In terms of **content**, participants talked about **past experiences** (5 CBT, 8 PCT) which were part of their journey to therapy. They talked about **present experiences** (4 CBT, 6 PCT) or *things that were going on at the time.* Participants discussed how they could manage their problematic situations in a different way and reported back after they had done so. Participants also reported the significance of talking **about feelings** (1 CBT, 3 PCT),

how they felt or how a situation had made them feel. This was particularly the case for PCT6:

PCT6. Just talking though my background and asking me what my feelings were about it. And feelings are things I`d never thought of before. What`s feelings got to do with it? There`s results, there`s output (laughs), you know. Part of the assessment I went to at the hospital when I first had my crisis, they said, "Well, you`ve got an extreme male brain." I`m borderline Aspergers. I`m really focused on detail and facts and social interaction isn`t brilliant. And the feeling side of it, I just.
I. You`d not thought about feelings before.
PCT6. No.

In terms of **process** some participants described **deciding what to talk about** (4 CBT, 4 PCT).

CBT1. I knew it was a problem. I knew it was a problem because it was not something that was part of my personality. I thought, "I`m going to say something,"

PCT6. There were a couple of times I went to the session with – I want to talk about this because this is bothering me, you know, this has upset me. Or, so yeah, there were a couple of times when I just took a problem in there and put it on the table (laughs).

Others described how they did not know what they would talk about until they were prompted by the therapist in the session.

PCT8. I`ve gone in and sat down and thought, "I`ve nothing to talk about," and sort of said, "It`s a nice day isn`t it?" or whatever, and thought, "Why am I here?" And then she will have said, "How are you feeling?" Then, you know, you start saying, "Not too bad, but - blah blah," and then eventually – but you don`t go pre-armed with information because you don`t see what it is you`re trying to sort out. You don`t see that until you start talking. Then it starts then to, "Well yeah, that must have bothered me and that must have bothered me." You don`t see it.

CBT6. It was very interesting the way it - when you first go she`d say, "How are you today?".....You`d start off, something happened earlier today, and you`d get in and you`d talk about it. And then there`d be a trough of, you know, this isn`t happening today and she`d, sort of, bring it to a point where you`d think, "O, I`m quite happy today." And then you`d walk out.

PCT9 seemed to have little control over what she talked about.

PCT9. We`d sort of have a catch up at the beginning of the session and sort of, say how the week or fortnight had been. We`d set off like that and then suddenly I kept – I think I did keep going off on a lot of tangents, to be fair, and I`d be thinking, "Why am I doing this?" And I was like jumping around a bit. But in doing that I found I was, like, talking about a lot of things I`d not talked about in years. And again, I thought, "Well, why am I doing this?" But I thought, "Well it`s obviously important, I must obviously want to talk about it, to get it off my chest," because it`s all connected in lots of ways. I could see – you know, I understand about things happen in your childhood affect your adult life, I understand all that. And it was just – it was like a volcano, I think, just all this stuff came out.

CBT1 described how she had decided not to talk about something.

CBT1. I`d started to talk about something totally unrelated to work, but that had still had a major impact on my life. The session ended before we`d before I`d really talked a great deal about it. On the next session my therapist didn`t ask me if I wanted to pick up on it again. But I`d already decided I wasn`t going to bring it up again, and I`d left it - in a box.

I. That was uncomfortable, talking about it.

CBT1. I just recognised that, O if I take the lid off that I`m going to be coming here forever.

Several participants reported **avoiding painful subjects** (1 CBT, 2 PCT), but were brought back to them by the therapist. PCT4 described how he had tried to avoid talking about the death of his wife and daughter.

PCT4. Very hard. Very, very hard. I used to start on about (name of wife and daughter) and then I used to sideline to something else and he used to say, "No, come back on that, we`re not going anywhere."

CBT4 described how she avoided talking about her childhood.

CBT4. It just didn`t happen again. I think maybe, although I didn`t say I wanted to talk about it again or I didn`t want to talk about it again, I did end up in tears and it was quite painful.
I. And she didn`t ask you?
CBT4. She did say to me, "Are you OK? Was that painful?" and I said, "Yes." I think I was the one that, sort of - when I look back now – yes…..I think she wanted to go deeper but I started talking about something else.
I. So you, kind of, changed the subject.
CBT4. I think it was me. It was painful and I felt slightly embarrassed at crying in front of someone, and I shouldn`t be really, should I but, I don`t know, I just felt like I`d gone a bit weak and started crying, you know…..Yeah it was me that actually didn`t go there again.

The concept of the **flow** of the session featured in many interviews (2 CBT, 9 PCT). Both CBT4 and PCT2 described how the process *flowed.*

PCT2. It was all extremely natural, and it sort of flowed from talking about one thing to another. It wasn`t that (name of therapist) had a list of questions or anything of that nature. It just sort of flowed.

CBT4. Every session I went to, it just flowed.

PCT2 described how it was *all very natural,* it *panned out,* and how *one thing led to another.*
PCT6 described and how they would *follow how it branched.* In contrast PCT3, one of the negative cases, described how she had become *stuck.*

PCT3. I didn`t know where to start. But when she prompted I started to talk about that little bit and then I`d get stuck..... My mind just goes blank.

Participants were often unsure of the process and found it difficult to put into words. PCT1 took some time and effort in the interview trying to explain the process.

PCT1. She did quite a bit of talking, but I never felt at any point that she was either telling me what to do, or steering me in a particular direction. It was almost kind of like (pause). I can`t even describe it, I just, I just - and I can remember her just doing it (pause). And then she`d just go with whatever came from me (pause.)
I But you`re not entirely sure what her part in it was.
PCT1. I think because she – it`s weird. I just get this feeling she was so skilled and, and got me. I can`t describe it in any other way. It`s almost like she just used to kind of – just what she would say was very minimal, but it would be the right thing.

Other participants described how *things started to come out,* or *came up,* sometimes that they were not expecting, in ways that suggested they had little control over the process. PCT9 described how she could not talk about the real reason for her accessing therapy in the first session, *what the real crux of the problem was,* but that she had *blurted it out* in the second session because she was *getting upset.* She also described observing and reflecting on her process, asking herself *why am I doing this?* and answering, *I must obviously want to get it off my chest.*

Some participants were aware of the therapist`s influence on the process. PCT3 described the therapist as *prompting* her. PCT6 described how the therapist asked him probing questions, PCT4 described how the therapist *drew it* or *fetched it* out of him

PCT4. He knew it were hard work for me, he drew it out. He`d say, "Now how are we? Let`s start where we finished last time. No," he said, "Come on," he said, "Let`s talk," and we did.

Participants described **creating order** (1 CBT, 8 PCT). PCT participants described a process of exploring, making connections and sorting by which they came to a greater understanding and acceptance of themselves and their difficulties.

PCT1: My relationship with my parents, my sister, me, was all, you know, just who I am, was all explored which then made me fit together why I`d made the decisions I`d made. And that was all part of – a bit of that had come before the letters, but probably more of it came after the letters.

I. So after the letters you did a process of exploring and fitting and

PCT1. Sorting.

Some CBT participants described **taking part in exercises** (3 CBT), which were easily identified as relating to the CBT model.

CBT3: I can`t remember what it was now, but whatever I`d done, I said, "That makes me really evil" or something like that. She said, "Evil, right." She put on the board - Evil. "Who`s evil?" I said "Osama Bin Laden." She said, "Are you as bad as him?" I said, "No." She said, "Who else?" I said "Saddam Hussein." And we listed a few people who are evil. I can`t even remember who they were. And then she went, "At the other end of the scale whose actually perfect?" I went, "Mother Theresa,"(laughs). And she said, "Are you either end of them scales?" I said "No, probably somewhere in the middle really." And she got me – and that was good.

Throughout their engagement with the therapy, participants reported **attending to the therapist and the relationship** (7 CBT, 5 PCT). They assessed their personal qualities and their skill as a therapist.

PCT1. I felt she was skilled. So not only did I like her, she was a lovely lady, which made me feel really safe. I also thought "You know what you`re talking about."

CBT2. She is quite a genius, I think. She is excellent at what she does, excellent. I think so, that`s my opinion, having come across quite a lot of people who are involved with that sort of thing.

Participants assessed their therapist`s reactions, monitoring the impact on their therapist of what they were talking about. For example, PCT was very concerned about the affect the intensity of his grief had on his therapist.

PCT4. I started talking but all I ever did was cry and cry and cry. And I even had (name of therapist) crying, because

I. So what was that like?

PCT4. I felt, I felt very, very – I don`t know. Myself crying – I needed to release, but to see (name of therapist) getting upset. I thought, "What am I doing? What am I doing to people? I shouldn`t be doing this?"

They were concerned about what their therapist thought about them.

CBT1. I was ashamed of, and slightly concerned when, what this anger was about and I thought, "O what will she think if I tell her."

They worked out what their therapist was doing, and how therapy worked. PCT7 worked out that it was for him to start to talk about whatever he wanted to talk about.

PCT7. But then after a while when I came in (laughs) and she`d sit there and she`d look at me and smile and I got to the stage where I said, "You freak me out." She said, "Why?" I said, "You just sit there and smile at me."

I. You found it uncomfortable?

P. Not uncomfortable. It was just that I`d gone through so many sessions before I realised that it was – suddenly it`s for me, it`s for me to start.

CBT4 deduced that her therapist had decided against talking further about her childhood because she could see how painful it was for her.

CBT4. I just talked about it in the one session. It didn`t really come up again. (Name of therapist) saw how painful it was for me and she didn`t want to go there, but I wish that I could have actually given her permission to.

CBT5 worked out that the purpose of the exercises she was given was to get her to focus on the *here and now* and to realise that the intrusive images were only in her head, were just thoughts and not reality

Engaging in therapy had a significant emotional component and participants described **managing and expressing emotions** (2 CBT, 7 PCT). Some highlighted the significance of expressing emotions during the session by **getting it off my chest** (2 CBT, 4 PCT). PCT5 described *venting* her bottled up emotions, and how helpful this was.

PCT5. It was good just to know that there was someone there just to vent things at.

For PCT9, too being able to *vent my spleen* and *get things off my chest* was very important. CBT2 vividly described the emotional relief she experienced when she talked about her problems.

CBT2. It was all terrific pressure, terrific pressure, to the point of being frightening actually. Because you lose the concept of what`s real and what`s not real. Because that feeling, when one thing was happening after the other with my family, my head was like, you`d want to explode. You hear of these people stood on top of a mountain and scream. That`s what you`d want to do because you feel as though you have to relieve the pressure somehow. And that`s when (name of therapist) would be, "Talk about it. Tell me about it. What could you have done to alter things?"

I. So that relieved the pressure.

CBT2. Yeah, yeah. Me sat here with my head exploding. "What can I do, what can I do, what can I do for them?" And (name of therapist) would say to me, "What can you do? You can`t do anything. They`re grown up people. They will sort it out. It`s not you. You`re not the one to worry." And you`d feel your head going back to normal. You`d feel the pressure come off.

5. THERAPIST ACTIVITY

Although the focus of this study was on the contribution of the client to therapy, those participants who talked with energy and enthusiasm about their own activity and contribution also talked with equal energy and enthusiasm about their therapist. Although participants were aware of their own agency, they also reported the **therapist as an agent of change** (6 CBT, 7 PCT), describing them, variously as *enabling,*

helping, getting or even *making* them change. Some participants experienced their therapist as **giving permission** (2 CBT, 2 PCT).

CBT4. I think I always wanted to say no, but it was like going to therapy I, sort of, had permission to say - I could be allowed to say no.

PCT6. And it`s kind of, given me permission to say no to some stuff.

Participants described **the caring therapist** (4 CBT, 7 PCT). They described feeling comfortable, safe, supported and cared for, and valued by their therapist.

PCT1. It made me feel valued. You know, it made me feel that actually she wasn`t just my counsellor she was relating to me as another human being. She wasn`t just doing her job, I guess is what I`m kind of saying.

CBT4. I know she really did care, and I got on well with (name of therapist). I know it`s their job to listen and to care, but she did have that warmth about her, you know, like she really cared.

They described their therapist as non-judgemental and experienced their therapist **listening** (2 CBT, 2 PCT) and **understanding** (4 PCT).

PCT9. Just the fact that somebody was listening and not judging me.

CBT2. I think it`s because she actually listened, like you see some people and they seem like they`re listening but they`re not really and they`ll go off on something else when you ask them something, (name of therapist) didn`t.

PCT1`s experience of her therapist`s understanding was particularly notable. She described the way her therapist *weighed me up and got me.* She took some time to describe it in the following way:

PCT1. I know how I can describe it. It felt like she was walking along side me (pause.) That`s what it was. She was just with me.

Participants also described the **therapist`s interventions.** In terms of the process of exploring and analysing, participants experienced their therapist **questioning** (5 CBT, 5 PCT). In the CBT interviews this was sometimes clearly identifiable as Socratic questioning one would expect from a CBT therapist.

CBT3. Or she would put it in a way as like, "Why aren`t you as important as somebody else," to try and make me – she was good in the way she said things to try and make me come up with the answer, do you know what I mean.

PCT participants also described the therapist asking them direct questions.

PCT2. It was through talking about the pressures that I felt that it was probably raised with me, "Why, why do you feel that`s your responsibility? Why do you feel that`s your job or that you should do that?" It was sort of questioning some of the responsibilities that I felt I had that were getting so on top of me that I couldn`t think straight. It was questioning why I sort of felt that I had to be responsible for a lot of people that are around me.

Participants also experienced their therapist as **giving an explanation** (4 CBT, 4 PCT) of their difficulties. CBT1 found it helpful to be given an explanation in terms of a diagnosis or formulation.

CBT1. We`d talked previously about post traumatic stress. That had been mentioned very early on when I`d had my initial assessment for CBT. But to actually put a name to it, I thought, "Right well, at least - I know what it possibly might be. I know it`s going to be, it is part and parcel of my illness." But the other thing I`d been telling her about - you know it was like OCD, but I hadn`t got a name for why I was doing these. I know what OCD is but I wasn`t recognising that some of the things I was doing was actually that. Being able to get a name, something, was so helpful.

Some participants described their therapists as **putting me straight** (3 CBT, 1 PCT).

CBT2. Like (name of therapist) said, "It`s not killed you. It`s not killed you so far, doing it, so it`s unlikely it`s going to kill you in the future." When you`ve got this thing with panic, you`re going to die. "Well have you dropped dead so far? No, you haven`t, so – and you`ve had some pretty bad ones. So it`s unlikely it`s going to happen."

PCT4. That`s (name of counsellor) that. He`d say, "No, you are a person. You are not nothing. You are a person. You do have a say."

For CBT5 the therapist **sharing experiences** was important.

CBT5. And she herself shared her own experiences with me, and about what had happened to her in her past, and it made me feel like I weren`t on my own.

Participants also described their therapist **giving affirmation and encouragement** (3 CBT, 3 PCT).

CBT4. She was pleased when I said I`d decided to go to college. She really admired me because she said I`ve really tried, I`ve really, considering I think I had 9 weeks of therapy with her, she said I`d come a long way.

Both CBT3 and PCT9 described their therapist **giving approval and reassurance** to the way they were planning to manage a situation differently.

CBT3. I would say to her, "I`m having problems with my brother and I think I should do this, I think I should say this to him," and she`d say, "Yeah, that`s right." And it`s like I needed that reassurance.

PCT9. It was the only way I could do it. It just came to me, talking to the counsellor and I said, "Does this sound wrong?" And it was like I was wanting reassurance or somebody`s approval to say, "Well, yeah that`s fine." But obviously she couldn`t give that fully, but she was saying, "You`re doing what you think is right."

Some participants described their therapist **giving confidence** (2 CBT, 1 PCT).

CBT2. I`d read "Feel the fear but do it anyway" dozens of times (laughs) and still not been brave enough. But she did give me the courage to go and do stuff.

CBT3. She would do stuff like role play. She`d say, "I`ll pretend to be your brother and you say what you`d say to me, and she`d come up with a response that he wouldn`t come up with. So I`d say, "O no, he`d say this." So, you know, between us, we`d work out a new way of saying it. Which is good. It gave me confidence.

CBT participants described their therapist **giving exercises and techniques** (6 CBT) to challenge their thoughts and change their behaviour. They described how their therapist wrote and drew on a whiteboard in sessions.

CBT2. And as she`d be writing things on the board, she`d put – you`d have like a circle with all the things off – work, family, retirement, how you feel about all the different things, you know. And she`d say, "What are your thoughts on that, on retirement? You know." ..... "Now, which have you lost?" And I`d lost all of them, I`d lost the whole thing.....
I. Had you realised that you`d lost such a lot?
CBT2. No. No, I hadn`t realised. Not until she actually wrote it on the board I didn`t realise.

CBT5 described how her therapist challenged her intrusive thoughts that she would harm someone.

CBT5. I remember her getting about 6 carving knives out and put them on the table (laughs). And then she said, "How do you feel?" And I think I cried, I said, "Fine," and she said, "Is it too distressing for you?" and I said, "No," and she said, "Do you think you`re going to use them on me today? Now think of it, think of the thought." And I`m like, "I don`t want to." .....I remember (name of therapist) saying "I`ve got an hour with you, and I can do anything in this hour that we need to do to make you believe they`re not going to happen."

CBT 2 described her therapist **adapting exercises** to accommodate her heart condition.

CBT2. She explained about things that she would normally do with someone, like going out with them, which she wasn`t sure how my heart would react.....she said, "Well I would have taken you to a roundabout, sent you round and round and round. And then when you step off that is actually the feeling that you have.....and to show you how quickly that goes. But she couldn`t do that with me, but she could do the mental exercises with me.

Participants described their therapist **making suggestions** (3 CBT, 1 PCT). CBT4`s therapist suggested that she set her alarm clock in order to get up in the morning. PCT5 had recently become disabled due to an accident at work. Her therapist suggested she pace herself in order to manage the pain caused by activity, and do something she enjoyed when she was feeling down.

CBT participants highlighted the value of their therapist **reminding and reinforcing** (3 CBT).

CBT3. I suppose the most significant thing that came out for me was that I`m just equally as valuable as everybody else. Yeah, because I`ve always put everybody else before me. I`m not even convinced I still believe it, but the fact somebody was telling it me every week.

CBT6. She said, "Break it down." Every time I went to her, she said, "Are you following this? Break it down. Remember, use these." (laughs). And that helped. It really did help.

Some of the ways in which the participants engaged with the therapy were particularly memorable and significant in the process by which they began to experience themselves differently. These were categorised as **It did the trick.** I mention this category here, in context, but will give it detailed consideration in the next section.

6. MAKING SENSE

While participants were engaging with the therapy a concurrent process was occurring where they were **making sense** of themselves and their experiences. Where therapy was successful all participants described the importance of **understanding myself** (7 CBT, 8 PCT).

PCT4. It helped me with the reason of why I was what I was.

CBT3. It just helped me to understand, I suppose, why I felt the way I did.

Participants in both therapy groups reported **understanding where things came from** (5 CBT, 8 PCT) or how past experiences were continuing to affect them in the present. This occurred in the two therapies, but was individual and personal to each participant. Both CBT1 and PCT6, for example, came to an understanding of how their mood was related to taking responsibility for colleagues at work. PCT6 also understood how this, in turn, had come from the way he had been given responsibility for his younger brother when he was a child.

PCT6. And when we talked about it and she kept probing and going back further and further, it all went back to when I was really young as a child, I was responsible for my younger brother. And it all came back from that. It was always my responsibility. Anything that happened, anything that went wrong or anything, I should have known better. I was the eldest, and I was the one who should have seen, I should have stopped it. All my desires to get things right were centred in that, which - I would never have put those 2 together.

CBT3 also understood how her reaction to the way she had been treated by her employers was related to her childhood.

CBT3. One of the problems I`ve got, which is still ongoing now is that I don`t feel like I`ve been treated fairly and a lot of that, when you come back to it, it`s my values from when I was a lot younger, about how I think life should be fair. And it`s not is it? But it`s hard for me to deal with that.

CBT6 and PCT7 both understood how they were reacting to people in the present in the same way as they had reacted to people in the past. CBT6 understood how his difficulties with management at work had its origins in his experiences in the army.

CBT6. The consequences back then, if I`d said, "No," would have been devastating for me. I could have ended up in a military gaol. I was married, I could have lost my quarter. You know – everything snowballs, you think, "Aaargh, everything – I`m going to lose it." But here, if I say, "No," I can walk out the door. But, I couldn`t differentiate between the two.

I. So, (name of therapist) helped you differentiate.

CBT6. Yes, between army life and civilian life. I just really couldn`t make the two -. It`s just strange the way she helped me. It was sort of like a trigger - O there are two different parts. Can you see? You see, I was acting like I was still in the army and I couldn`t say, "No."

PCT7 understood that his difficulties with his managers came from the childhood bullying he had experienced from his brothers.

PCT7. It really has altered – I mean there was seven children and it did pick up on points where I understand – the youngest of seven children brought up on a farm where you work, work, work. But it was like when everybody ganged up on you – your brothers. And I went into the (company) and suddenly the management were like older brothers.

Participants also described understanding how their actions and behaviour, **realising what I do** (CBT 7, PCT 5), was contributing to the way they were feeling.

PCT2. I was sort of helped to see how some aspects of my personality really, the way I deal with things, sort of contribute to some of the ways I feel.....It`s sort of put things more in perspective that I do certain things that probably put more pressure on me..

CBT5. It were funny because the things I thought I were doing, I didn`t realise what I was – it made me understand what actually I was doing.

PCT8 described her understanding of the way her thinking style changes when she was depressed.

PCT8. It`s, sort of, lurking there all the time, just waiting for something to trigger it. Not that I think like that – I don`t. That`s what I think happens. And you do tend to read in things. Somebody might ignore you, or – then that starts you off that they`ve ignored you because of whatever and then that gets shut in there and then that starts to build up the big picture again. And then you can say that`s not logical, you know, maybe they didn`t hear you, see you or whatever.

I. So when you`re well what happens, if somebody ignores you now. Do you not think these things?

PCT8. It happens. I`d just think, "Please yourself."..... It doesn`t bother you. But sometimes it does. It`s like, at the minute my step daughter – I`ve a feeling that I`ve done something to offend her. I don`t think I have, but in my mind I think I have because she`s being a bit quiet. After saying that she`s mega busy at the minute. But, you know, I`ll go and see her and say, "Is there a problem?" But if I was ill I`d make the problem. I`d decide what it was without knowing what it was and then it would become a major issue. But when I`m not ill I don`t do that.

Others reported **understanding myself according to diagnosis, formulation** (2 CBT, 2 PCT). CBT1 understood why she was having anxiety attacks in relation to the CBT model.

CBT1. What I found interesting was reading about myself in a lot of the stuff I read. And that was, that was really useful. I thought, "There are other people, it`s not a weakness, it`s real, it happens for," You know - I could identify some of the reasons why it happens. And then I could – I`d look back to when I was working, and I`d think, "Gosh I used to do that."

CBT5 understood the role of her safety behaviours in maintaining her intrusive thoughts.

CBT5. She made me understand about – I think she just made me see that safety behaviour, and I was doing that and it was keeping the thought going. Because, for me, it was like, "Get your phone, thoughts are here now, get the phone, talk to someone, take your mind off it." Then I would see that person. Well it started off that I didn`t want to drive on my own because it were there. But again, that were a safety behaviour because it were keeping the thought alive, you know, like it were real.

I. It sounds like the therapist helped you to see how you were, kind of, making things worse.

CBT5. Or believing it, that it was happening, or something dreadful was going to happen. And I think that was it, I were keeping the belief of it going.

I. So it helped to understand, really, what it was you were doing yourself.

CBT5. Yeah, I was making it worse, a lot worse.

CBT1 understood that she had aspects of OCD and PTSD, and CBT5 that she had "intrusive thoughts" form of OCD. PCT6 was told at his initial assessment (by an CPN) that he was "Borderline Aspergers."

PCT6. At the initial assessment when they said, "you`re borderline Aspergers, you`ve got this, you`ve got that." Having labels helped me, because I thought, "If they give me a label they know how to deal with it.

Most participants reported understanding themselves in a way which was helpful and which was integral to the process by which they began to experience themselves differently. However, increased understanding was not helpful in the negative cases. CBT7 seemed to have come to an understanding of himself which was unhelpful and which reinforced his negative view of himself.

CBT7. It is because these core beliefs are, you know – everything`s this way. They do rule the brain, they do rule your thinking. When you`re not used to it, takes so much and it`s so difficult to put it into practice. It`s - you know, it`s like you`re trying to do an impossible job, aren`t you, because apparently – I don`t know how they have found this out, I`m not questioning it, but basically my brain is not wired up correctly. That`s why I`m in depression state most of the time.

In further contrast, PCT3, also a negative case, described **not understanding myself.**

PCT3. (Name of therapist) said there was a few breakthroughs but I couldn`t see them, but then – I`m sat here. She`s listening and she`s the expert so she would notice.

I. Do you know what they were?

PCT3. I can`t remember. You`ll have to ask (name of therapist) that.

Participants also described **coming to terms** (4 CBT, 7 PCT) with their experiences. As a consequence of engaging with the therapy they came to an acceptance of both the past and the present. PCT5, recently disabled due to an accident at work, made progress in coming to terms with the restrictions and limitations of her condition.

PCT5: I still get frustrated but I think, "D`you know what (name of participant) there`s other things you can do." You know, "Accept the fact that you can`t do this any more." And I am a lot more accepting of stuff I can`t do any more.

PCT2 and PCT4 both made progress in coming to terms with loss, PCT4 with the death of both his wife and daughter from cancer within 18 months of each other, and PCT2 with the death of her mother.

PCT2: In the past I`d always cried when I talked about her and the first couple of times in counselling that I talked about her I cried (sighs). And I became a bit more stronger about talking about her during the sessions, you know. Towards the end I talked about her more like I am doing now and didn`t end up crying, where as, you know, in the past it was, it was always that I`d start thinking about her and I`d cry. And it`s just made me realise that things happened and my life has changed for ever.

CBT4, who gave the only CBT interview where this category was found, came to terms with the loss of her daughters, who had become estranged from her.

CBT4: I`ve just got to let certain situations go because I can talk until the end of the world, sort of thing, if I`m still here. Things will still have been the same, you know,

these things will still have happened. But going to therapy, it`s learned me, like I used to sit crying every night about my daughters, you know. I haven`t cried very much in the last few months.

In contrast, CBT3 had not come to terms with *unresolved issues* from her unfair treatment by her manager.

CBT3: I raised a grievance last year and he was off sick and he`s just come back now and they said that they would speak to him and they just haven`t spoken to him. There`s a lot of stuff inside here that I want to say to him about what happened, about the way I feel. I`ve been told I`m not allowed to contact him in any way shape or form or I could be disciplined, that they`d sort it out through the grievance. But they`ve not and it`s gone to appeal now and time`s running out, we`ve only got three weeks. And really I should be able to let it go, but I can`t until I`ve had my say.

Some participants described **finding meaning** (2 CBT, 3 PCT) where they found something good or positive in the experiences which had brought them to therapy and which they had previously seen only as damaging and distressing. PCT1 was able to find meaning in her experiences of abuse

PCT1. It`s actually made me who I am in terms of being a stronger person. So I actually – and it sounds a bit perverse that from abuse can come a positive thing really. It sounds weird saying that – it sounds a little bit odd that you can find something positive out of something so horrible.

CBT4, who had been a victim of domestic violence and whose *so called friends* had used her and taken her for granted, was able to use her experiences to make sure she was not used or abused again.

CBT4. I suppose, in a way, it`s a good thing, because no-one else will ever go that way with me again, because I won`t take it, you know, so I know I`ve got a lot stronger.

Some of the ways in which participants made sense of themselves and their problems were of particular significance. These were categorised as **The key**. I mention it briefly here, in context, but will consider it in detail in the next section along with **It did the trick.**

7. CHANGE IN PERSPECTIVE

Where therapy was successful, both PCT and CBT participants described **looking at myself differently** (7 CBT, 8 PCT). Both PCT and CBT participants reported valuing themselves more.

CBT2. I`m a person. Yeah, I`m an individual and I am a person and I matter.

PCT4. I am a person, I do have a say and I do have a life, really. And I don`t have to please everybody and if I upset somebody along the way, jog on, simple as that.

They saw and appreciated qualities that they had not seen before such as strength and goodness.

PCT1. I`m taking the control back and actually I`m going to change my story now. My story is not being a victim. My story is I can be strong and I can be courageous and I can have a life without you guys in my head all the time.

CBT4. I got to like myself a lot more, and I`ve got stronger, and I`m quite choosy now who I mix with ..... But, therapy – it`s made me see that there`s nothing wrong with me, that I`m a good person and I am strong.

These participants described their new view of themselves with confidence, where as CBT3 described a dimension of this category that represents a different position in the change process. After therapy she saw herself as a person of value

CBT3. I suppose the most significant thing that came out for me was that I`m just equally as valuable as everybody else.

However her account also indicated that she was experiencing some internal conflict with her new view of herself.

CBT3. It feels like, in a way, it feels like I`ve got quite selfish really. Which I probably have, but I think possibly I wasn`t selfish enough. You know, I don`t think I`ve got more selfish in a bad way (pause) I`ve not got more selfish in a bad way (pause) no, I`ve not got more selfish in a bad way, I`ve just got more looking after myself a bit more (pause). No, I`ll have to think now. No (laughs).

She recognised that this conflict was due to her values acquired from her childhood, where she was taught to put others before herself

CBT3. It is difficult because probably just from the way I`ve been brought up, a catholic upbringing, you know, where you put everybody else before yourself. And I think that`s probably got a lot to do with it, you know, putting yourself first is looked on as a negative thing.
I. But you`re not seeing it as negative any more.
CBT3. I`m not seeing it as <u>as</u> negative, I think. I`m still not entirely comfortable with it but I`m feeling the benefit for doing it.

In further contrast, where therapy was unsuccessful, the participants` view of their reality did not change.

CBT7. Everything she did say was helpful and did work and did cheer me up and did change my train of thought, but - I think I`ve just sunk back into the er - the depths of the black hole that`s full of shit. It`s, I don`t know, it`s just crap all the time. I don`t know how you find life, but it`s just crap all the time.

Both PCT3 and CBT7, the negative cases blamed themselves that they had not improved after therapy, PCT3 for still feeling anxious, and CBT7 for not being able to remember the CBT techniques and put them into practice, and for the therapy not meeting his expectations.

CBT7. That`s where I`m failing. I can`t seem to put it into practice when I`m under these, er, situations. That`s my fault, for not remembering it.

CBT7. Well, I don`t know, you know. Sometimes I have high expectations of things, you know, that they`re going to. work miracles, it`s just er....
I. You do sound a bit disappointed.
CBT7. Well, it`s just - dreaming and hoping for too much, you know. That`s one of my other problems.

Participants also reported **seeing myself differently in the past** (6 CBT, 8 PCT). Those participants who had begun to value themselves saw how they had allowed others to take advantage of them.

PCT1. It`s almost like I`ve been a kind of carpet for a long time. A lot of people – I`ve felt like, you know- push me to my limit and I`ll take it, take it, take it.

CBT4. I just realised that I was being a door mat and I`ve been a door mat practically all my life."

Participants no longer saw themselves at fault for situations which had affected them in their past.

CBT4. I`ve done nothing, it wasn`t my fault I went through domestic violence.

PCT4. Sometimes I do think back and I think, like, "What did I do wrong?" And it`s not been me. And I`ve started to think that, "It wasn`t you."
I. But previously you were thinking it was you.
P. That`s it. I thought I`d done something and I`d done nothing.

Participants also reported **looking at others differently** (7 CBT, 9 PCT).

CBT3. I`m not really as bothered about what other people think of me as I used to be.

PCT6. There are some people at work who look at me like I`ve got the plague, I should be ringing a bell, but that`s their problem not mine. Whereas in the past I`d have taken it upon myself to say, "Look, I`ve got to prove them wrong." I don`t. What have I got to prove to them?

Participants also saw that other people experienced similar difficulties

CBT5. It`s not just me going through this.

PCT6. It`s also been quite refreshing when you start talking about this at work how many more people are in the same boat.

In contrast, CBT7 did not see people differently.

CBT7. There`s always somebody wanting to upset somebody, somebody scheming or somebody telling lies. I must be getting old, because I`m tired of it.

8. DOING THINGS DIFFERENTLY

The eighth higher category reflects how, where therapy was successful, participants went on to behave differently and to manage their lives in ways which were congruent with their new, more positive view of themselves as a person of value. They stood up for themselves, looked after themselves, put themselves first, and said, "No" to the demands of others. Again, the following extracts demonstrate the similarity between participants who had received the different therapies

CBT2. It was me that was thinking about me, which I`ve never done before.

PCT5. It`s OK to say no to people because I can`t do everything for everyone.

CBT6. No, I`m a civilian now, I don`t have to do it (laughs). I can walk away and say (blows raspberry, and puts up 2 fingers), (laughs) Can you see what I mean, I don`t have to do it.

PCT6. I`m looking after myself more, that`s what it boils down to.

The process by which participants started **doing things differently** varied. CBT participants described **implementing techniques** (6 CBT) they had learned in therapy. CBT1 continued to implement the responsibility pie chart she had been introduced to in therapy.

CBT1. And that is something that I can now mentally do instead of automatically assuming, well that`s all my responsibility. I can just take a second or two to think, "Well actually no - Who do I share this responsibility with? Who else has got responsibility?" A very easy technique.

CBT5 highlighted the importance of **practising** the techniques she had learned.

CBT5. Basically she said, "You know what you`ve got to do." And I do now. I know, when I feel terrible, when I`m having a really bad day with it, I`ll think, "I can`t go in my car today because they`ll be really bad and I`ll think something could happen." And now I know that I have to get in the car to show myself it`s not going to happen.

Participants described **implementing plans** (1 CBT, 1 PCT) they had formulated with the therapist in order to manage specific situations. CBT3 was caring for her elderly father, which involved accompanying him to hospital appointments. Her brother would make excuses which left her taking him to all his hospital appointments and feeling stressed and resentful. She and her therapist had worked out together how she would approach her brother differently.

CBT3. I would ask my brother and I would say, "Can you take dad?" And his first reaction would be, "O I can`t take him on such a day. I can`t do this." And straight away he`d be saying why he couldn`t do it. And I think one of the things we did talk through was approaching him differently. Don`t say, "Can you do it?" Say, "I can`t take him on this day. You`ll have to take him." Or say to him - well, one of the things we did work through was – he`d had 2 appointments and I said, it was really good, because I just said to him, "There`s 2 appointments come for dad. Which one do you want to take him to?" Which, in the past, I would have just took him to both. And I thought, well, I`ll give him first dips and then he can`t say he can`t do one of them.

PCT4 thought his two sons were taking advantage of him. He planned how he would manage the situation by talking it over with his therapist.

PCT4. I used to keep on board what he`d said to me, how to approach stuff, because this is what I was doing wrong as well. I`m one of these with a short fuse. I`m like – (whoosh). And then come back and think, "I shouldn`t have done that." But he said, "Don`t," he said, "Just talk calmly, smoothly, one pitch," He said, "Tell them what you think." And I did and I sat my two lads and their girlfriends down and I said, "Look," I said, "When you want something, "I said, "That`s when you want me," I said, "any other time you don`t come to my house."

I. So you sat down and told them what you thought. Did you plan that?

PCT4. With a lot of help off (name of therapist).....Because we talked about it and he said, "What do you do?" And I said what I did, and he said, "Just do it that way." I took a lot on board, what he said, because he really did make me – instead of sounding like a stupid idiot, screaming, balling whatever – calm, cool, collected. And they hadn`t seen that before, you see.

In contrast others described **deciding what to do** (3 CBT, 4 PCT). PCT9, for example, found the behaviour of her autistic daughter very distressing. It came to her in the therapy that she could put an emotional wall between herself and her daughter to protect herself.

PCT9. Just thinking, you know that – when obviously (name of daughter) was having a go at me, being abusive and thinking, "OK, it`s not me. She`s not having a go at me. I know she is having a go at me, but try not to take it personally. Yes it`s hurtful, but she can`t help it." But it was like – I know this sounds - there is a wall between us, an invisible wall, but that`s the only way I can deal with it - not to be as cold back, but that is how I feel. Emotionally it feels cold, which isn`t me, but that`s the only way I can deal with it – to just be there to support, but not to take any – try not to take it in, any of the hurt coming my way. And that`s the only way I can deal with it.

In further contrast, some participants described how their different way of doing things **happened naturally** (2 CBT, 3 PCT). PCT1, for example, had a sister with bipolar disorder. Her sister had made several suicide attempts and the fear that her sister might make another attempt to kill herself meant that she had always allowed her sister to be abusive towards her.

PCT1. I`ve managed that and I just said, "You will not speak to me like that. You will not do that." ..... I guess you don`t know it until the situation arises again - so it just so happened that a situation arose where my sister was very abusive. I just naturally went into – it`s weird. I hadn`t really thought about it any great depth. I`d thought in the counselling that I was going to manage it differently, but I didn`t know until it happened how I`d manage it. So it just kind of came quite naturally that I just said, "No, enough."

CBT2 described how she spontaneously joined in with her family`s Christmas celebrations.

CBT2. I was quite surprised and they were quite surprised how much I wanted to integrate into what they were doing, you know, when I was there at Christmas. And that`s the first time it`s been like that for years.
I. And it sounds like you didn`t plan anything. You were surprised?
CBT2. It was all spontaneous, yeah.

Similarly, PCT7 describes the way he stood up to his brother when they were talking together about the disciplinary hearing he was going through at work. He was unaware of the significance of what he was doing until he reflected on it afterwards

PCT7. My brother said, "Well, you know, your word against theirs." I said, "Hang on a minute (name of brother). You don`t know what`s gone on." And he actually stopped and listened. Or when I say listened, or whether he was a bit taken aback that I was actually saying, "Look, this is ...." And I said, "Right, I`m going now." And I walked out and I went down the fields and I just sat by the river with my dog and I thought, "It`s the first time I`ve actually told our (name of brother), "Hang on a minute, just stop and listen for once."

I. So you surprised yourself.

P. I did surprise myself. And a couple of days later I saw (name of therapist). I said, you know, this is what went on. She`s like, "Wow, you`ve actually done that."

I. And it doesn`t sound like you planned it.

P. No, I didn`t plan it. I wasn`t expecting it. I`d just gone walking down and he happened to be there and I just told him.

Participants varied in the way they felt about doing things differently. CBT2 felt *good* when she put herself first and stood up to the demands of her granddaughter and CBT6 felt *great* when he said, "No," to people.

CBT6. (Name of therapist) said in the last one, she said, "I`ve turned you into a monster." "No, no, no, you`ve helped me." Now I turn round and go, "No." (laughs) And I chuckle all the time. People in work, even the Polish girls say, when they ask me things, only jokingly, they ask me things and I say, "No," and walk off. So they all go round saying, "No, no no." (laughs). It`s great, it`s great.

Other participants did not find it so easy and reported **having difficulties** (3 CBT, 3 PCT). CBT1, for example, reported that she was *able to say, "No" without feeling too guilty.* Others had difficulty doing things differently. PCT5 described how she struggled to say "No," and put herself first.

PCT5. It`s still hard to do but, you know, I do it. I do say, "No," and not all the time, but I have started to do it (laughs). I still have to stop and think, "Well, you know, if I say, "Yes," you know, I`m going to suffer this that and the other. Or if I say "No," I`m, you know, how it`s going to affect me rather than how it`s going to affect other people. Which sounds really selfish (laughs), but I`ve got to put me first for a bit.

CBT3 described feeling *mean* and *bad when she said,* "No" to her father,

CBT3. The situation with my dad`s better but I still feel mean about it. But, like, one of the things she was saying was – my dad always wants me to do stuff for him and she would say, sometimes say to him, "Look dad I can`t do it this week because I`m busy." And I do, but I still feel bad about it.

In further contrast, PCT2 described **doing things the same**. In therapy she realised that she was taking responsibility for her family after the death of her mother, but was not ready to change and do things differently.

PCT2. I maybe not completely and utterly ready to give up responsibility towards some of those family members. I might not be particularly ready to actually make those changes, but I think that in time I will. You know, I still feel a lot of responsibility for my family and, you know, they`ve all lost my mum and I`ve lost my mum and it`s about making sure that we`re all OK really and that we all stick together.

9. CONTINUING THE JOURNEY

The final higher category is small, reflecting the small amount of time participants spent in talking about this aspect of their journey. It relates to the participants experiences after leaving therapy**.** All participants reported **having ongoing difficulties** (3 CBT, 5 PCT) with continuing stress, anxiety, physical difficulties, relationship difficulties, financial problems, grief etc.

PCT5. I asked to be referred again, I`ve not heard anything yet, but it`s – I ended it with still stuff to sort out. There`s still stuff I wanted to go through and carry on talking about but because there was only 12 sessions I couldn`t.

I. Stuff that you`d talked about and you needed to talk more or stuff that you hadn`t even talked about yet?

PCT5. Just stuff that I wanted to carry on talking about. Stuff that`s still ongoing, like the committee things and my accident with my shoulder and - because I think that was the final thing that got me really down, on top of my back and all this hassle with my mum, and (name of partner) moving away.....and the hassle and the trouble we`re having with the club and what not and it`s all, it`s stuff I`d still like to talk about.

They described **engaging in activity after therapy** (1 CBT, 2 PCT), both continuing to reflect and make sense of their difficulties and to implement and practise the techniques they had learned.

PCT6 continued with relationship therapy.

PCT6. In my relationship as well – my marital breakdown was part of this – we`re still working on trying to rebuild that..... since I finished that therapy we have been to relate as well to do couples therapy which has helped.

Participants were also **engaging in activity in the interview** (1 CBT, 7 PCT), using the opportunity to reflect on their therapy, assess and consolidate their progress.

PCT4. It`s made me, actually feel a little bit better because I`ve realised how far I`ve come and it`s good. Just saying and expressing, you know, can help because there was nothing in me before and it`s just made see, from where I was to where I`ve come to now.

Several participants reported **needing more help** (2 CBT, 2 PCT). PCT3 used the interview to ask for more therapy.

PCT3. I`ve been to the GP this morning as well, to see if I can get some more counselling.

This concludes the main categories which emerged from the analysis, and in the next section I will give a more detailed elaboration of two of the categories which became pivotal to the analysis, **It did the trick** and **The key**.

4.4. IT DID THE TRICK AND THE KEY

These two categories conceptualise an important part of the process by which an individual`s view of their reality changes. Where therapy was successful, each participant talked about a key realisation, or understanding, about themselves, how their experiences had affected them, or how what they were doing was contributing to their difficulties and the way they were feeling. These were categorised as **The key. It did the trick** conceptualises the process by which this key realisation came about. This may have been a sudden event, a moment of insight, illumination or clarity which took place within the therapy session, or it may have been a longer process, much of which took place outside the sessions. The negative cases, PCT3 or CBT7 did not describe new realisations or understandings, so neither **It did the trick** nor **The key** were found in these interviews. In this section I will explain how these two important categories emerged early in the analysis. I will then give a detailed account of the different elements of therapy that did the trick resulting in the key realisations for each participant.

All participants, where therapy was successful, talked about an event or events in therapy which they found particularly memorable or significant. Participants talked about these events with energy, usually unprompted, and they seem to have regarded them as important in their change process. The category, **It did the trick** was first conceptualised from the first CBT interview as an invivo category, where I used the words of the participant, rather than my own. (I have given a full analysis of this extract in the Methodology chapter).

> *CBT1.....One of the other things is that because of the job I did, and we`d a lot of younger workers that, as an older and more experienced worker, I felt a lot of*

responsibility to them, therefore I couldn`t show any sign of weakness or not coping. Having gone through CBT now I realise how hard I was on myself, because, even something as simple as - I remember once we were doing a pie chart where I took on all the responsibility for what we were talking about. Then my therapist got me to look at it in a different way, where the responsibility wasn`t totally mine. And that simple exercise was like lifting a weight off my shoulders

I. Do you know how that happened, how you saw that it wasn`t all your responsibility?

CBT1. In a way a lot of it was common sense. But this sense of responsibility, I`d taken, far too serious, well too - I`d taken too much of it on. And I felt guilty that it - you know, I am responsible for everything that happens, where in fact I`m not. The trick was actually - I remember it clearly - the trick was actually seeing it physically drawn, and divided far more equally.

The event described in this extract demonstrates a change in this participant`s view of her reality. Before therapy she experienced herself as a person who *had to cope* and who was *responsible for everything that happened*. After therapy she saw that she was not solely responsible for what happens and that others share the responsibility too. She also saw herself differently in the past, recognising that in taking on too much of the responsibility she had been hard on herself. The element of therapy that did the trick was seeing it drawn, where the therapist used a CBT technique, the responsibility pie, to represent and divide up the responsibility. The phrase "to do the trick" represents "a skilful expedient, a special technique, a knack or special way of doing something," "to accomplish one`s purpose, to achieve the required result," (Shorter Oxford English Dictionary). Her account demonstrates a number of properties of such change processes. It was a discreet event, it was memorable (*I remember it clearly*) and it was accompanied by an emotional response, *(like lifting a weight off my shoulders).*

The category **The key** also emerged as an invivo category, where I used the words of the participant, from the second PCT interview.

PCT2. She helped me realise more about myself, I think that`s the key. The things that I never realised about myself she made me realise about myself.

PCT2 had come for therapy because she was still grieving over the death of her mother, three years previously. One of the key realisations was that she was taking responsibility for everyone in her family.

PCT2. She questioned me, "Why is it your responsibility, Why?" And I couldn`t answer those questions and I though well, "Why is it my responsibility?" And I didn`t – to be honest with you – before I spoke to her I didn`t even realise that I was taking responsibility for other people. ..... That never came onto my radar. I didn`t realise that, you know, when they asked me to lend them money – which I haven`t got a problem with, I`ll still carry on doing. Even if I`m overdrawn it`s like, "Yeah, O come and get it." I didn`t realise I do that.

There were further key realisations in PCT2`s case. One was that she was *stepping into her mother`s shoes* by taking responsibility for everyone in her family. The other is that she was finding it so difficult to *get over* losing her mum, because if she *felt OK* about her dying, she would feel that she didn`t care about her. The faltering nature of her delivery and the difficulty she has explaining herself in this extract shows that she is still in the process of making sense of her thoughts and feelings.

PCT2. I suppose I`ve just realised that, yes I didn`t cope with the trauma very well, but, she also made me realise as well – this was the other key thing that I think probably is really important – she made me realise that - I put that on myself to a certain extent. Because I feel - that if I get over my mum and I don`t - let`s say that if I`m OK about it – it`s almost like I didn`t care. So, there is an element of me, as well, that - that needs, probably to still feel - I don`t know how to explain it properly - that I bring myself down. That if I`m OK about losing my mum it`s, in my head – I`m not saying in reality – but in my head it`s like saying to me, "You didn`t care about her. You`re alright about losing her. You didn`t care about her." So in a way – I - I don`t know how to put this really – she did make me realise that there`s a part of me that doesn`t want – does this make sense? – I`m making me feel mental again – but there`s a part of me that doesn`t want to get over losing my mum.

She was also able to find meaning in losing her mother. Her severe grief reaction showed her how close they had been, and how lucky she had been to have had such a close relationship.

> *PCT2. So, as far as I was concerned, losing my mum – it was the most traumatic thing that`s ever happened to me in my life. I didn`t cope with it maybe like other people cope with it. But - do you know something? – in a way, I think I`m lucky because, yeah it`s been an extremely painful time, but it`s only been that painful because we had such a good relationship. We were so close to each other. If we weren`t as close maybe it wouldn`t have been as painful as it has been.*

In PCT2`s case there were a number of elements of the therapy by which these key realisations came about, which are elaborated in the next section. As I reflected on these first interviews, these two categories struck me as pivotal to the study, and so began the main path of analytical of inquiry. What other elements of CBT might do the trick? What did the trick in PCT? Were they the same or different in the two different therapies? Further analysis revealed the same categories could be found in all interviews where therapy was successful. There were a number of elements of the therapy which did the trick and resulted in key realisations and understandings for the participant. A full list of these can be found in Table 2. Participants often described more than one key understanding and the element of therapy that brought it about. I have chosen those listed as they were the ones that participants talked about unprompted and with the most energy and enthusiasm. The aim of Table 2 is not to construct an exhaustive list of all client and therapist activities that appeared to bring about change in this study, but to demonstrate the range of different elements described by participants in this study, therefore I have not included the number of participants or units of text represented. In the rest of this section I will give an elaboration of the key realisations from Table 2 and the elements of therapy that did the trick and achieved the result with supporting extracts from the interview transcripts.

Table 2

Key realisations and the elements of therapy that did the trick

Participant	**The key** realisation, understanding, insight.	**It did the trick**
I am a person and I matter		
PCT1	Not a victim, strong, courageous	Therapist`s reaction
PCT4	I`m somebody, a person, I have a life	Therapist putting me straight
PCT7	I have a voice	It came to me
CBT2	I`m an individual, a person, I matter	Talking, therapist`s reaction
CBT3	I`m equally as valuable as anyone else	Therapist questioning
CBT4	I`m a good person, strong	Talking, Getting it off my chest, It came to me.
CBT6	I`m somebody, not a nobody, I`ve achieved something	Therapist putting me straight
I can say, "No."		
PCT5	I can say no	Therapist questioning
CBT6	I can say no	Carrying out tasks
It`s not all my responsibility		
CBT1	Not all my responsibility	Seeing it drawn
PCT2	Not all my responsibility	Therapist questioning, Saying it out loud, It came to me.
PCT6	Not all my responsibility	Therapist questioning
It`s not me it`s the situation		
PCT8	It`s the situation makes you ill	Therapist`s explanation
PCT9	It`s not my fault, it`s the situation	Getting it off my chest, Therapist`s reaction
My thoughts are just a thought		
CBT5	Thoughts are just thoughts, not real	Carrying out tasks

4.5. KEY REALISATIONS

1. I am a person and I matter

For a number of participants in both therapy groups (PCT1, PCT4, PCT7, CBT2, CBT3, CBT4, CBT6) the key realisation was similar, that they were individuals of worth and importance. There were a number of different elements of the therapy that brought this about. PCT1, for example, describes a lengthy process of change which began with her writing letters to her abusers. She describes this as a *directed activity* by the therapist. An important aspect of her being able to do this was that she felt safe enough to share them with her therapist. It was not until she shared her letters with her therapist that it *hit* her, that what she had done was *brave* and *courageous*, and that she was no longer *a victim*. It was the **therapist`s reaction** to reading her letters that **did the trick**.

PCT1. There was an absolute, absolute point in the counselling that turned everything for me. I had to write letters. I had to write letters to my abusers. And it was – I can`t tell you how much – it was almost like a switch was turned on. And it was terrifying.....I remember walking in and going, "I can`t talk to you. I need to hand you my letters. Please can you turn your back on me." I was really prescriptive and bossy really. I remember saying, "Can you turn your back on me because I don`t want to see your face when you`re reading them." It`s really important to me that I didn`t see her face. I didn`t want to see her reaction. And, and then I just sat quiet. And, O my God she was amazing. She just went, "Do you mean you`ve done your letters?" And I had them in my hand, like, just like three little piles and I went, "yeah" and she went, "OK". She never said anything more to me. And I sat and waited while she read them.....And I remember her just – it was how she said it, and what she said was minimal, but she said, "(Name of participant) I`m absolutely touched by your letters. I felt your courage and I just wanted to tell you that." And just that acknowledgement, that actually - because I`d never thought that that was a brave thing to do - I never even – but when she said it, it kind of felt – it is actually a brave thing to do (laughs).

I. So you kind of saw yourself differently.

P. Yeah. I wasn`t a victim any more.

Later in the interview she describes how *crucial* and *hugely important* her therapist`s reaction was to this change process.

> *PCT1. I thought, "If I see a glimmer of disgust or judgment or repulsion or all the things that would absolutely make me crumble," that would have finished everything for me. So that, I don`t – well she does know `cause I told her - but that, how she turned to me was absolutely crucial.....And that time of not saying anything, even though it felt like a lifetime, but was a tiny period, she just knew not to say anything. She knew to give me that time to compose myself. But to tell me that I was safe, that was so important. When she said that it was so important.*

PCT1 certainly regarded this experience as a moment of change.

> *PCT1. It was quite a beautiful moment because it, it meant so much to me that I was turning my corner at last. That I`d actually addressed it, and I felt like - from that point on it was move forward.*

Her account demonstrates a number of properties of the category. PCT1 uses a number of different metaphors to represent her experience that convey a sense of suddeness. It was an *absolute point in the counselling that turned everything* when a *switch was turned on.* The experience was *terrifying* but also *weird* and *beautiful* conveying a sense of wonder and astonishment. Like CBT1 she remembered it clearly.

> *PCT1. It`s quite vivid. I can actually see myself sitting there. I remember what I was wearing. I can remember what she was wearing. I can remember what kind of a day it was `cause it was hugely significant to me.*

The moment was also accompanied by an emotional response, a sense of relief.

> *PCT1. I remember relaxing. It was almost like, it was just, "Phew, flipping heck." (sighs)*

The significance of the therapist reaction was also demonstrated by one of the CBT participants, although not in such a specific and detailed way. For CBT2 it was the way she was treated by her therapist over a period of time that resulted in a key understanding that she was a person in her own right and that she had been putting her family first to the detriment of herself.

CBT2. I didn`t realise, well, I must have realised, but I didn`t think of me as a person. I thought of me as a mother or a grandmother. I didn`t know where I came into it. (Name of therapist) helped me find that. She helped me do that. Not in any particular way, but the way that she puts over, the way that she does things. That`s what I`ve gleaned out of it, that I`m a person as well. She said, "And what about you?" And I said, "O that don`t matter." "But it does. You do matter." But I`d never considered myself as mattering before.

CBT2 described how she was unable to engage with the exercises and tasks her therapist suggested, because of the stresses she was experiencing from her ongoing problems. She highlighted the importance of her therapist *allowing* her to talk, and listening to her concerns,

CBT2. We talked a great deal and she was willing to listen.
I. So she set you these little tasks, but you couldn`t do them because of what was happening in your life. So you talked about what was -.
CBT2. Well we talked, yeah. She actually allowed me to talk

CBT2. I think it`s because she actually listened and she – you know, like you see some people and they seem like they`re listening but they`re not really and they`ll go off on something else when you ask them something, (name of therapist) didn`t. As I say, with all the things that happened over the 12 months she`s listened to me every time.

In contrast and in a way which appears more congruent with the CBT model, it was the **therapist questioning** over the course of the therapy which helped CBT3 to see herself as valuable and important.

CBT3. Or she would put it in a way as like, "Why aren`t you as important as somebody else?" to try and make me – she was good in the way she said things to try and make me come up with the answer, do you know what I mean? So it`s like, "Why aren`t you as equally as important?" And it`s very difficult to find a reason why you`re not as equally as important, so you start thinking, "Well perhaps I am as equally as important."

She appears to be describing a longer process, although also managing to convey a sense of suddenness.

CBT3. Probably about half way through it I remember going to one of the sessions saying, "I don`t know what it is, but something`s working, because I feel so much better." ..... I couldn`t put my finger on what it was that suddenly seemed to click into place..... it seemed to be really subtle. Nothing dramatic seemed to happen at any of the sessions and then I suddenly realised I was feeling better. I was dealing with situations better.

It was the **therapist putting me straight** which enabled PCT4 to realise his value and worth as a person.

PCT4. That`s (name of counsellor) that. He`d say, "No, you are a person. You are not nothing. You are a person. You do have a say." He said, "Give yourself a bit of self esteem. You are a person. You`re not running round for everybody. You`re not this and you`re not that." And I took it all on board. And I did.
I. When you say you took it on board, did you, kind of, think about it?
PCT4. Yeah, I did. I used to go home and think like, "Yeah, I am 52. Now, I`m not bad looking for 52." It buttered me up, like, and since (name of therapist) said that, other people have said that, and I thought, "He was right."

Similarly CBT6 explained how, after he had left the army, he had felt *a nobody* and it was the **therapist putting me straight** that helped CBT6 to see himself as a person of value and worth.

CBT6. (Name of therapist) helped me to say that, you know, "You should be proud." She told me herself, you know, "You should be proud of yourself, you should be."

For CBT4, who was recovering from a violent relationship, there were several elements of the therapy which appeared to do the trick. Just **talking** was very important for her.

CBT4. Just talking about it, what had happened to me and, you know, about the things that I had to do, you know, the way I was controlled and humiliated and abused and all that. It was really good to be able to sit down and talk to someone about that, you know.
I. So you found talking helpful, just talking.
CBT4. Yeah, I found it that way, yeah.
I. Your therapist made a few suggestions about what you could maybe do. She didn`t set you any homework?
CBT4. No.
I. Did she ever do any exercises? Draw on a whiteboard?
CBT4. No, we were just in a little room, talking.

She described being *in a lot of emotional pain* and **getting it off my chest**.

CBT4. It was just having that 1 hour with someone every week just to talk. Because I just needed to unload a lot of emotional baggage, anger – I don`t mean anger like I wanted to smash things or just angry that people had treated me like, that I`ve allowed them to treat me like that.

Her new understanding of herself *that that there`s nothing wrong with me, that I`m a good person and I am strong* **came to me** while she was talking with her therapist about her experiences.

CBT4. I talked about how, you know, how he made me feel. And that I`d become a lot more vulnerable because of what I`d gone through and so I was scared of anyone being my friend. But it doesn`t have to be like that, you know, I mean. You know, we were talking and I decided it didn`t have to be like that, that I didn`t have to be

vulnerable and I didn`t have to be desperate, you know, that I could be myself and look after myself.

The key realisation for PCT7 is closely aligned to this new sense of value and importance. In therapy he realised that he had a voice, and that if he stood up for himself and used it people would listen. He was unsure, in the interview, how this had happened, but it appears that it **came to me** in a similar way to CBT4.

I. I guess (name of therapist) didn`t say to you, "You have a voice," or maybe she did?
PCT7. In a roundabout way she did that yes, you do have a voice, you`re no longer that little boy (pause)I`m trying to think (pause).Yeah, yeah I am no longer that little boy. I`m no longer that little person that can be walked all over. I mean, she didn`t say that but that`s what came to me.

However, he also appears to be describing a longer process as he reported gaining understanding after a time of reflection outside the session.

PCT7. I`d go away and that night I`d go out walking the dog and it was only then that things would slowly sink in, when I was out of that environment and I had time on my own and I would realise things that she`d said. And then I would start thinking about them.

2. **I can say, "No."**

Although the key realisation for both PCT5 and CBT6 was that they could *say "No,"* the element of therapy that did the trick was very different in each case. It was the **therapist questioning** that resulted in PCT5 realising she could say no.

PCT5. She just asked me, Why? and, What made me say, Yes? And, What would happen if I said, No? And, Why should I put myself last? And basically making me realise that it`s OK for me to say, "No" if I`ve got too much on my plate and that, it`s really, it`s OK for me to be putting me first for a bit and not everybody else. And the fact that I, I worry a lot and I don`t like letting people down and, you know, she said,

you know, What would happen? Would it be the end of the world? And it`s like, well, No, so, you know.

CBT6 was an army veteran, and the element of therapy that did the trick for him involved **carrying out tasks**, a structured CBT procedure which he called *breaking it down* which enabled him to see that the consequences of saying no to people now he was a civilian were very different from the consequences when he was in the army.

CBT6. She gave me this leaflet and it helped me break it down.

I. Can you tell me about that leaflet?

CBT6. Well, what it was, was a flyer and it said, er, basically – from what I can remember – is er, What is causing the problem? How is it affecting you? Er, What is the likely outcome? And What was the outcome? So I broke them down into them sections. And then that came, I thought, "O that`s really good." And every scenario that I got I was, "O, I`ll write it down," and got the outcome. And you break it down to those segments and – O yeah, it`s quite clever, that.

He saw how he had been reacting to his manager as if he was his commanding officer in the army.

CBT6. Well it`s the fact that she, (name of therapist) broke it down into them little things, saying, "You`re not in the army now. You don`t have to take orders from anybody. You don`t – you`ve got to think of the consequences. The consequences are a lot less now." You know, the consequences back then, if I`d said, "No," would have been devastating for me. I could have ended up in a military gaol. I was married, I could have lost my quarter. You know – everything snowballs, you think, "Aaargh, everything – I`m going to lose it." But here, if I say, "No," I can walk out the door. But, I couldn`t differentiate between, between the two, between army life and civilian life. I just really couldn`t make the two - It`s just strange the way she helped me. It was sort of like a trigger - O there are two different parts. Can you see? You see, I was acting like I was still in the army and I couldn`t say, "No."

By his use of the word *trigger* this participant conveys a sense of suddenness in his description of the realisation that he could separate his past army life from the present, although he describes how he had to practice breaking it down.

3. It`s not all my responsibility

For CBT1, PCT2 and PCT6 the key realisations were similar and relate to the realisation that they had been taking responsibility for everything, and they did not have to. As I have already described earlier in this section, the element of therapy that did the trick for CBT1 was constructing the responsibility pie chart with her therapist and **seeing it drawn**. In contrast, the element that did the trick for PCT6 was the **therapist questioning** his need to take responsibility for his work colleagues in a way which put unsustainable pressure on himself.

> *PCT6. It came back to just simple probing questions of, "What would happen if you didn`t do that?" That`s why my initial scepticism of going into the counselling told me because I can`t help myself, I went and read about counselling, found out what they do. And it was, well how can just asking simple questions, how can that solve anything? And each time, when she was asking those questions it was around, "Well, what would happen if you didn`t do those things? And it helped me better understand, well I can just leave some stuff alone.*

PCT2`s account was more complex. It was the **therapist questioning** that brought about the key realisation that she was taking responsibility for her family

> *PCT2. She questioned me, "Why is it your responsibility, Why?" And I couldn`t answer those questions and I thought well, "Why is it my responsibility?"*

She also described how **saying it out loud** enabled her to see that if she gave up some of her responsibility to her family in order to *follow my dreams* her mother would understand

PCT2. I think, talking to the counsellor about that, knowing she`d forgive me. I know 100% she would. And yet I spend a lot of time saying, "I`m sorry," to her and asking for her forgiveness, you know.

I. And that came out of the counselling too, that that`s what you do?

PCT2. Partially, I think, yeah.

I. Or you kind of knew that anyway?

PCT2. I knew deep down, I`m really lucky, I knew deep down that she loved me.

I. And that she would forgive you.

PCT2. She would. But I think it`s saying it, probably, saying it out loud. Deep down I knew that she loved me more than anything and - I know she did – but probably saying it out loud helped me to make it real that I know that she would have forgiven me anything and I mean anything.

She described a moment when **it came to me**

PCT2. I remember how it came to talking about my dreams, you know, about what I wanted to do long term. And it was about what my mum would think about that and, you know, whether she would be OK with me, I suppose, going for my dreams..... So it was through talking about that: Would my mum understand, that we got – actually it just come on like a light bulb in my head, and I said to her "Well, actually, through talking to you about, would she understand? I`ve realised that she would.

4. It`s not me it`s the situation

PCT9, PCT8 and CBT1 had key realisations that neither their problems nor their feelings of depression were their fault, but where due to their situations and experiences. Again, the process by which this came about was different in each case. PCT9 had a daughter with autism who could behave in very challenging and hurtful ways. She highlighted the importance of **getting it off my chest.**

PCT9. I found I was, like, talking about a lot of things I`d not talked about in years. And again, I thought, "Well, why am I doing this?" But I thought, "Well it`s obviously important, I must obviously want to talk about it, to get it off my chest," because it`s all connected in lots of ways. I could see – you know, I understand

about things happen in your childhood affect your adult life, I understand all that. And it was just – it was like a volcano, I think, just all this stuff came out

PCT9. A couple of sessions after that we looked at it again and again and it – each time was – it was easier to talk about and it was – I still felt sad, but at the same time it was like a relief. It was a release because I was obviously getting this off my chest, talking about issues that really hurt me and were really important to me.

It was the **therapist`s reaction** to her disclosure that helped her to see that *it was understandable why I felt as low as I did*. Her account also demonstrates the suddenness and the emotional response also described by CBT1 and PCT1, a feeling of relief and the release of tension.

PCT9. On the first session I just couldn`t talk about why I was there, what the real crux of the problem was, but by the second session I was opening up. It was very hard, I was very upset.....I think about half way through that second session I was just getting very upset and I just blurted it out I think, if I remember rightly, because I was so upset. And when I told the counsellor it`s this, this and this. This is why it`s affecting me so badly she understood that and she understood why I felt like that. So that for me – that`s the first time really somebody`s said, "That is understandable," you know, "I would feel exactly the same.".....*It was really - they call it a Gestalt moment don`t they? when it`s like Eureka, isn`t it? Breakthrough. And I think I just slumped in the chair at that point – I was just exhausted, it was like "Thank God for that," you know (laughs).*

In contrast it was the **therapist`s explanation** that helped PCT8 to understand that she was depressed because of the number of problems and difficulties she had experienced and was still going through in her life

PCT8. I found that helpful, because it made me understand that it didn`t have to be the big disaster, it can be the little things. Because there`s so much in my life that are just horrendous, that when I start feeling ill I live it all. And what I do is I live in the past, I never live for tomorrow. I never see tomorrow. And all I could see was a blank wall. Last time there was no tomorrow, just the wall.

I. So the therapist helped you to just understand why you`re like that, what`s going on.

PCT8. It`s very difficult not to live through your past life if it`s been traumatic, and you tend to carry it with you for a while.

She described how, before therapy, she lived in the past, could not see tomorrow, only a blank, brick wall in front of her that she could not get through.

PCT8. Well, the first time, when I first went, when the doctor referred me, I sort of sat there and said, "Well I`ve got nothing to say," you know, "There`s nothing bothering me."..... And then you get chatting and then you start going through what`s happening over the last few months, couple of years. And I kept saying to her, "All I see is a brick wall. I don`t see past the brick wall. I can`t get through the brick wall. It`s just like this cloud is there and my life is just the back of it, and I don`t want that life because it`s not nice a lot of it."

The therapist explained that her experiences were all in one big compartment in her head, which left no room for any further, current stressful experiences. In order to go forward she needed to put her past experiences into smaller compartments in her mind, which would leave room for current stressful experiences.

PCT8. I didn`t realise it was all the little bits. Obviously there`s always little bits in life, isn`t there that - whatever? And they obviously just lock into your brain, till eventually..... it starts to make you feel (depressed).....She made me see that - yeah it`s a problem, yeah it affects me, yeah I`ve done everything I can to help, which I have. And really to go forward I needed to put them all back in these compartments in my head. Instead of them all being in one big compartment, which causes me the stress, if I put them all in the little ones and they only come out when they need to, it`s not as traumatic.

She describes the moment this happened, and how, on hearing this explanation she started to experience herself differently.

PCT8. It actually is like a blank wall in front of your face. It is weird. It was all I could see.

I. Can you tell me how that went?

PCT8. .....I don`t know, probably about week 8, because I was sat in a room a bit similar to this and there were trees all outside the window. And I kept on about this wall and suddenly there were no wall it were trees.

I. So it just disappeared.

PCT8. Mmm. Yeah I think suddenly your mind has put these things into compartments and the space is back, so the wall`s gone. I don`t know. It was there one minute and the next minute gone.

I. Do you know what was going on in the therapy at the time?

PCT8. I think just chatting like we`re chatting now. It was, you know, chatting about – I think it was the day she explained to me that everything that we talked about was in my head anyway. It was real but it was in my head, and they all needed to go back in these compartments. It felt like I`d suddenly stood up and filed it all. When I walked out I felt like that`s what I`d done. And because I`d filed them, and put them on a list, I didn`t need to worry about them

5. My thoughts are just a thought

CBT5 received CBT for Obsessive Compulsive Disorder as she was unable to drive her car due to intrusive thoughts that something dreadful would happen. The key realisation for her was that her thoughts were just a thought and she should not believe them. She described how she *didn`t take them on or dwell on them*, but was *just trying to let them float past.*

CBT5. I know, when I feel terrible, when I`m having a really bad day with it, I`ll think, "I can`t go in my car today because they`ll be really bad and I`ll think something could happen." And now I know that I have to get in the car to show myself it`s not going to happen.

I. So it`s important not to believe these thoughts.

CBT5. Yeah. And just to put them as that, as a thought like any other thought.

For this participant, the element that did the trick was by **carrying out tasks** set by her therapist, getting back in her car and dropping the safety behaviours that maintained her intrusive thoughts, a recognisable CBT technique. This helped her to realise *it was only in my head, these images. They weren`t happening, they weren`t real.*

CBT5. And I think how it was that she made me understand, like, what was I doing in the car to distract myself. And....the one thing I did was ring someone, either (name of partner) or my sister or my mum. And wouldn`t probably tell them what I was doing or why. I`d just sort of go, "I won`t be long, I`m nearly there now." It was something like that, to hear a friendly voice really..... I left my phone in my bag. And then when the urge came that I needed – "O it`s really bad now," I just, sort of thought, like she said, "Look around you. Where are you?" I thought, "Well, I know where I am (laughs) and I know it`s not far from anybody." And then I said, "Right." I think I just used to leave it at the side and I never touched – that was like my thing, like, not to touch it while I were in the car. And I think I got to the stage where I left it on the dashboard and then I got to the stage where I could put it in my bag. And then I got to the stage where I wouldn`t think of it.....She made me understand about – I think she just made me see that safety behaviour, and I was doing that and it was keeping the thought going. Because, for me, it was like, "Get your phone, thoughts are here now, get the phone, talk to someone, take your mind off it." But that were a safety behaviour because it were keeping the thought alive, you know, like it were real.

I. It sounds like the therapist helped you to see how you were, kind of, making things worse.

CBT5. Or believing it, that it was happening, or something dreadful was going to happen. And I think that was it, I were keeping the belief of it going.

This concludes the elaboration of the key realisations and the events in therapy that achieved them. As I stated earlier in this chapter, this is not intended as a comprehensive list of the change processes experienced by the participants in this study, but serves only to illustrate the range of different events that they identified as important in their therapy. Each participant talked about other events, which I have not included in order to make the account manageable, but which may have been just as essential to the whole change process. It was my growing appreciation of the wide range of

possible change events which was fundamental to the following part of the analysis. In the next section I will describe how I concluded the analysis by integrating the categories and how the core category and the theory emerged during this process.

4.6. CONCLUDING THE ANALYSIS

As I explained in the Methodology chapter, it was at this point that I returned to the Grounded Theory literature. To have ended the analysis here would have resulted in a Generic Inductive Qualitative study (Hood, 2007), which describes the similarities and differences between the participants` experiences of change in therapy. I therefore resolved to try to conceptualise a core category and construct a theory. I decided I was looking for a concept which would explain the variety of different change experiences, their similarities and differences in successful therapy, and also their absence where therapy was not successful. It is not easy to explain this part of the process and without the therapists` accounts it is not possible to proceed with any degree of certainty. I hope the reader will appreciate that this part of the analysis is presented tentatively.

Consideration of the different elements in Table 2 indicated that similar ones occurred in each therapy group. **Therapist questioning**, for example, was described by CBT3, PCT5, PCT2 and PCT6. **It came to me**, was described by CBT4, PCT2 and PCT7. This suggests that the different elements which bring about change are not specific to either therapy. Further consideration indicated that some of elements of therapy which brought about change appeared contrary to what might be expected according to the theory and practice of the different approaches. Asking probing questions (**Therapist questioning)**, is not considered an appropriate PCT response. **Therapist putting me straight** suggest directivity, which is also considered inappropriate in PCT. Just **talking** is not considered sufficient in CBT. In relation to the active client theory, only a small number of the accounts appeared to locate the key understanding within the frame of reference of the client (**it came to me**) and the element of therapy that did the trick to the activity of the client (**getting it off my chest**, **saying it out loud**). Most of the participants in both therapy groups described their therapists suggesting tasks or exercises, reacting to their disclosures, asking them questions, putting them straight, or giving them an explanation, so that the therapist helped, got or made the participant see

things differently. The question, "Where does the element of therapy which does the trick lie, within the client or within the therapist?" became an important line of analytical enquiry, which I will elaborate in the next section.

- **Integrating categories**

When analysing the interview with CBT1, from which **It did the trick** first emerged, it appeared that, although it was necessary that the participant engaged with the exercise it was the therapist who did the trick as it was she who implemented the technique, who *got* this participant to look at her responsibility in a different way.

> *CBT1. I remember once we were doing a pie chart where I took on all the responsibility for what we were talking about. Then my therapist got me to look at it in a different way, where the responsibility wasn`t totally mine.*

It could be concluded that it is the therapist who should be given the credit for this participant`s changed perspective of her reality. However, as the study proceeded, I became more sensitized to approaching the analysis from the perspective of the client. Further consideration of the original extract from the interview with CBT1, as I returned to it over and over again, in the light of further analysis, showed that it was *seeing* it drawn which was critical to the change process.

> *CBT1. The trick was actually - I remember it clearly - the trick was actually seeing it physically drawn, and divided far more equally.*

This therapist may well have implemented the same technique with another client who may not have *seen* it, so what did the trick, in this case also resides in the quality of the *seeing*. The therapist introduced the exercise, CBT1 saw it drawn, but it also made sense to her. She accepted it as a valid, alternative way of looking at her responsibilities and she has now owned it as her own way of looking at them.

Both PCT4 and CBT6 experienced their **therapist putting me straight**. PCT4`s therapist put him straight about his value and worth as a person, but he also described how he *took it all on board.*

PCT4. Yeah, he said, "Give yourself a bit of self esteem. You are a person. You`re not running round for everybody. You`re not this and you`re not that." And I took it all on board. And I did.

CBT6 explained how, before therapy he felt *a nobody,* and how he had hidden his military medals in a drawer. During therapy his therapist told him he should be proud of his army service. He took his medals out of the drawer where he had hidden them, polished them and wore them to a remembrance day parade in the town centre. The following extract demonstrates that he accepted what she had said and made her view his own.

I. What I`m interested in (name of participant) if you can get a handle on it – how did that shift inside you from not being proud at all so that you kept your medals in a drawer to being proud and positive about what you did. That`s a huge shift, isn`t it?
CBT6. It was for me.
I. So how did that happen? Because it sounds like your saying it was just (name of therapist) saying that you should be proud of it.
CBT6. .....Yeah, I can see what you mean.....No, just one person saying it, just one. I had memories in the background, you know, but it was just her saying that to me, "You are somebody, you`re not a nobody. You`ve achieved something. You`ve achieved something and you should be rightly showing people that you`ve achieved." Yeah.

In a similar way, PCT8 heard the **therapist`s explanation** of her depression. It made sense to her and she accepted it. It is feasible that the same explanation would not have made sense to a different client, and they would neither have accepted or believed it. In CBT6`s case, what the therapist said connected in some way with his experiences, (*I had memories in the background,*) which meant he could accept the alternative view of his reality offered by the therapist. What did the trick in all these cases appears to involve the quality of the participant`s *hearing* and suggests that it is the way the therapist`s interventions are accepted and acted on by the client that brings about change.

This suggestion is supported by the following extract from CBT3`s account. She had difficulty accepting the alternative view offered by her therapist.

CBT3. I suppose the most significant thing that came out for me was that I`m just equally as valuable as everybody else. Yeah, because I`ve always put everybody else before me. I`m not even convinced I still believe it.

It is also supported by the account of CBT7, one of the negative cases. He was unable to take on board the alternative view. Either he did not *hear* it, or *see* it, or he did not believe it, could not own it and make it his own.

CBT7. It was just looking at things from a, like anything, from a different angle, trying to see things from the other side and not, you know, not only jumping to the core beliefs, you know, that we have, that I have, er. But it were difficult, in that, you know, your brain gets used to doing things, you know, making conclusions, following its same, you know, thought pattern and it`s difficult to try and change that, really difficult, you know, because it just takes over.

In other cases it was the **therapist questioning** which did the trick and resulted in the new realisation. Here the important aspect of the change process appears to be how the client responds to the question posed by the therapist.

PCT6. Talking around sporting achievements, other things I`d done where I was dead proud that I`d achieved something. And she just turned it back to me and said, "And what if you hadn`t won? What if you hadn`t done this?" And just getting me to realise, "Well yeah, what if I hadn`t won, so what?" Just again, taking that pressure off myself.

I. So she, kind of, questioned what you did in some way.

PCT6. Yeah, challenging me – so what? (laughs). It helped me to ask myself that question, "So what?"

PCT6 described how asking himself "So what?" meant that he could be less critical of himself and put less pressure on himself at work.

PCT6. And I`m better able now just to step back a bit and say, "Well, I didn`t get that bit, So what? I got a lot of it right."

PCT2 and CBT3 both described how they could not adequately answer the therapist`s questions. They both described how they went on to reflect on the questions and begin to formulate answers.

PCT2. She questioned me, "Why is it your responsibility, Why?" And I couldn`t answer those questions and I thought well, "Why is it my responsibility?"

CBT3. Or she would put it in a way as like....."Why aren`t you as equally as important?" And it`s very difficult to find a reason why you`re not as equally as important, so you start thinking, "Well perhaps I am as equally as important."

In contrast, PCT3 described how the therapist questioned her, and put her straight, but this did not result in a change in her view of herself or her world. It is possible that she was unable either to go on to question herself and formulate answers or to take on board the alternative view offered by her therapist in the way that other participants were able to.

PCT3. I never think good of myself. I don`t like bothering people. (Name of therapist) would say, "Well why? How do you know that you`re bothering people?" "Well they don`t want to listen," "How do you know?"..... Sometimes I got stuck and other times I just answered it.

I. Could you answer that?

PCT3. I think they`ve enough of their own problems. Some people will listen, but they`re not listening. And you don`t feel comfortable.

I. You know there`s lots of problems out there and people don`t listen.

PCT3. Yes. The other thing was when I said that other people have worse problems than I have and (name of therapist) said, "Well maybe they have, but your problem is just as bad to you as theirs is to them. Which is true, in that sense. But there is people far, far worse than me. Then I get feeling guilty then.

I. Has anything changed do you think? Do you see anything differently or think differently?

PCT3. Not the way I feel at the moment.

Further consideration revealed a more complicated picture, involving the therapist`s permission and approval.

CBT3 described how she needed the permission of her therapist to see herself as valuable and to say, "No" to the demands of others.

CBT3. I`m not even convinced I still believe it, but the fact somebody was telling it me every week. Because I said this to her, I said, "Sometimes I just feel like I need your permission to say no to things, because it`s like it`s still not wired into me."

PCT6 also highlighted the importance of permission from the therapist.

PCT6. Again it came to the, "O, I didn`t want to get out of bed," "Well, did you?" "Yeah, I did." "Well, what if you`d stayed in bed? What would have changed? What would have been different?" And that, kind of – she`s given me permission to ask myself these questions as well. It`s given myself the space - just writing stuff down and trying new things, taking risks and being prepared to fail at stuff.

PCT9 highlighted the significance of the therapist`s approval.

PCT9. It was good to have the therapist there to say, "Look, this is how I feel, this is how I`m going to deal with it." I think it`s that approval.

At this point in the analysis **It did the trick** appeared to be a complex process involving both therapist and client. However, I was still unable to explain the differences and similarities between the different participants. In the next section I will show how the relationships between the categories emerged during the analysis, how I linked the categories around a central or core category, and how I generated the theory.

- **Conceptualising the Core Category**

As the analysis progressed, I began to see a link between the participants` experience of therapy and their expectations of therapy. As I have described earlier in this chapter, some participants knew what to expect when they accessed therapy as they had researched it or had had previous experiences of therapy. Some expected therapy to be helpful

CBT4. I`d read a bit about it so, you know, I thought, yeah, it would be OK for me.

Others did not expect it to be helpful

CBT6: I just didn`t think, I didn`t think it would help at all, but it did.....I thought, you know, give it a try. And it worked.

PCT6: Initially I found it very difficult. I couldn`t see how it would work. I was a bit sceptical, just talking about stuff .....Willing to try anything, yeah. I was desperate. I was in a pretty awful place. I contemplated suicide. I didn`t see the point in anything. Yeah, I was looking for help.

Others did not know what to expect

PCT2. So when I was referred to the counsellor on this occasion it wasn`t because I knew exactly what counselling was about or what I would get out of it..... I think things were that low with me that I thought well I`m willing really to try anything if it`s going to help.....It was just basically trying anything that would help me to feel a little bit better in myself....Anything that`s going to help really. I`ll give it a go.

PCT7. I walked in and (name of therapist) just sat there and I didn`t understand what this person centred counselling is."

For others therapy was different to what they were expecting

PCT5. A lot of stuff came up that I wasn`t expecting.

CBT1. It was hard work actually, harder than I`d anticipated

All these participants did well with the therapy they received, so they appear to have been able to respond to what their therapist was offering to their benefit. On the other hand CBT2 was unable to respond to the CBT initially offered due to the stressful life situations she was experiencing *getting in the way*. She described how she *blocked* her therapist.

> *CBT2. She was very, very down to earth, "This is what we`re going to do. This is how we`re going to do it." And I blocked her at every path, I have to say, because I was so hurt over 12 months, every 3 weeks or so. And there were things happening in my life - one after the other, after the other, after the other. .... She wanted me to do like – to try and do this, to try and do that, you know what I mean – go to the end of the garden, walk round this little block, you know.....Anyway, all these things kept coming in that were happening in the family. Where I should have been getting on the bus to go for one stop, you know, I couldn`t do it because there was so much happening, so many stressful things one after the other. .....It was all getting in the way of me doing what I should have been doing.*

Her account suggests that it was her therapist who responded to this and *allowed* her to talk about the current stressors in her life.

> *CBT2. We talked a great deal and she was willing to listen.*
> *I. So she set you these little tasks, but you couldn`t do them because of what was happening in your life. So you talked about what was -.*
> *CBT2. Well we talked, yeah. She actually allowed me to talk*

So far the analysis suggested that the success of the therapy depended on either the client responding to what the therapist offered or the therapist responding to the client`s needs and adapting the therapy accordingly. In a manner that could be described as an "aha" experience (Corbin and Strauss, 2008, p. 109) the term **Responsiveness** came to me as a possible core category to describe what was happening. It was at this point I turned again to the literature. I had not reviewed the literature relating to responsiveness before the analysis, as the term did not have a particular significance for me. I found that responsiveness is a recognised phenomena with limited literature

which is concerned predominantly with the responsiveness of the therapist (I will discuss this in more detail in the next chapter). However, I perceived a sense of a shared, reciprocal interaction in the data.

PCT1, for example, had very specific expectations of therapy.

> *PCT1. To try and put it, lay it to rest a little bit and, and be OK with it*

PCT1 was so sure of what she needed that she would have asked for a different therapist in order to achieve it.

> *PCT1. When I met this counsellor for the first time, initially I was like, "O I`m not so sure. I`m not so sure." But I consciously went home and almost talked to myself, saying, "You have got to give this lady a chance. You`ve got to try that therapeutic relationship. You can`t just panic, because you know it`s going to be painful and it`s going to be hard and everything`s going to change for a while, and it`s scary. You`ve just got to try." ..... If it hadn`t have grown. If the second time I`d have gone I hadn`t felt comfortable enough.....I would have had the confidence to say, "No." I would have said, "I don`t know what it is, that therapist isn`t going to work for me. Can I see somebody else?"*

She was concerned when she heard that her counsellor described herself as person-centred as she wanted *a more concrete kind of help*.

> *PCT1. When the counsellor had said to me what kind of approach she was going to use I kind of went, O No, I don`t just want to talk to you. I want, I kind of want some – I don`t know what it is, but I don`t just want to talk about it. (I did want to talk about it) but I want to kind of, I don`t know, <u>do</u> something with it.*

It is unclear if she communicated this in words to her therapist, but the resulting task *I had to write letters to my abusers* resulted in her having something specific to <u>do</u>, and a more concrete kind of help, rather than just talking about it. This generated an intense inner dialogue, none of which appears to have been shared with the therapist

PCT1. It was terrifying, and when my counsellor broached it with me on about session three, I remember just thinking, "I can`t, no, I can`t do that. Please don`t, I just don`t want to do it." I didn`t say that to the counsellor. I felt inside, and I remember saying to the counsellor, "I will do anything that you think. I will try anything." But inside I was thinking "I can`t do that, please don`t make me do that."

She describes overcoming her initial fears and engaged with the activity, because she felt her therapist was skilled, and this enabled her to trust her. Her therapist had explained the reasoning behind the task very well and so she thought *"You know what you`re talking about."* She also *felt safe enough that I could share it with her*. It may have been that this demonstrates the therapist responding to the particular needs of this client to <u>do</u> something with her abuse, and giving her a task to <u>do</u>. As PCT1 seems to have shared little of her internal processing with the therapist this would mean the therapist responding to the needs of the client which were unspoken. Alternatively, the therapist may have been unaware of her client`s expectations and PCT1 may have responded to the therapist`s empathic reflections and perceived direction and instruction where non was intended.

PCT1 also described the way her therapist reacted to her letters as *crucial*. She described her therapist as knowing not to say anything straight away, but to give her time to compose herself, and that when she did say something it was minimal, but just the right thing.

PCT1. And there is no way at that point that she knew that - `cause you could say anything at that point couldn`t you? She could have said absolutely anything. She could have said nothing for a longer period of time. It came quite early for me in the sessions. I think it was only about session four and – so she didn`t really know me. So again it made me feel that she was – she had a lot of skill and that she actually had listened to me. That was a huge thing, that I felt that – her response meant that in those previous ones she kind of weighed me up and she got me and that was really important.

PCT1`s interpretation of the situation was that he therapist had come to understand her so well during the preceding sessions that she knew exactly how to respond to her letters. If this is the case it would demonstrate a very high degree of sensitivity. It is also possible that the therapist did not know what was "right" but responded in a way which she hoped would be appropriate.

The category **therapist putting me straight** was conceptualised as an invivo category from the interview with PCT4

PCT4. He put me straight a hell of a lot. He was very good.

PCT4`s expectations of therapy were for someone to *put me on the straight and narrow,*

I. Did you know what kind of help you wanted?
PCT4. I think it was just somebody to try to put me on the straight and narrow.

PCT4`s therapist may have been responding to his client`s need for more direction at this time in his life and adapted the therapy accordingly. On the other hand PCT4 may have interpreted the therapist`s responses to meet his own needs and may have created direction where direction was not intended. In common with most participants PCT4 entered therapy in a state of confusion. He may not have known what he wanted when he entered therapy. It may only be with hindsight that he recognised this is what he needed. If this case the therapist may have responded to the needs of the client which were not only unspoken, but were not within his awareness

CBT4`s expectations of therapy were to change her life and her way of thinking.

CBT4. I just needed to change my life, to change my way of thinking, change my life.

She knew when she came to therapy that she needed to talk to someone.

CBT4. The antidepressants were starting to work but they weren`t the answer. I really needed to talk to someone.

What did the trick appears to have been talking to her therapist who listened and cared. This may have been because her therapist responded to her need to talk about her difficulties and "allowed" her to talk about them in a similar way to CBT2. On the other hand she may have been introducing CBT principles and techniques in a way which the participant either selectively ignored or was influenced by in ways that she was unaware of.

At this stage the analysis appeared to be suggesting that there is a subtle interaction going on between therapist and client whereby either the client is able to obtain they need from the therapist or the therapist is able to provide what the client needs, and that these needs are not necessarily articulated. This suggestion was supported by the continuing analysis. PCT8 wanted to understand why she was depressed and what she could do about it.

> *PCT8. I think, out of the three people I saw, she probably explained it a little bit more, which I found helpful. Because you don`t understand it. And a lot of the time it is off loading, but you`ve still got the problem and you still want somebody to say, "Go out of here, do this, it`ll sort it out." And, of course, nobody can tell you that because it`s your problem, isn`t it? But that`s what you`re hoping for all the time. You`re hoping they`re going to tell you what to do to solve the problem.*

As already described earlier in this chapter, her therapist gave her an explanation and told her what she needed to do.

> *PCT8. I think it was the day she explained to me that everything that we talked about was in my head anyway. It was real but it was in my head, and they all needed to go back in these compartments. It felt like I`d suddenly stood up and filed it all. When I walked out I felt like that`s what I`d done. And because I`d filed them, and put them on a list, I didn`t need to worry about them*

It may have been the case that the therapist responded to her expectations and gave her an explanation, on the other hand this participant may have interpreted one of the therapist`s reflective responses as the explanation she was looking for.

In a similar way, PCT9 described how she wanted reassurance and approval, which she seems to have obtained from her therapist.

PCT9. It was the only way I could do it. It just came to me, talking to the counsellor and I said, "Does this sound wrong?" And it was like I was wanting reassurance or somebody`s approval to say, "Well, yeah that`s fine." But obviously she couldn`t give that fully, but she was saying, "You`re doing what you think is right."

A different picture emerged from PCT6`s account. He described using therapy to talk through his problems, then engaging in problem solving and setting himself behavioural activation goals.

I. You mentioned something earlier about mind mapping. Could you tell me about that?
PCT6. It`s a technique we use at work where we just write down what the problem is and branching off from that, what the solutions are. I just – again, drawing lots of pictures of how you want to work out a problem or a solution. It works for me. I like to have things down pictorially and chuck some colours on or highlight which I think are the problems and it helps me just to organise my thoughts. And I find it a good tool for describing to other people what I`m thinking as well. It`s something I`ve used at work for ages.
I. Who came up with that?
PCT6. I just did it myself. That was in my comfort zone. It`s how I`m used to problem solving.
I. So it wasn`t discussed in the therapy.
PCT6. No. In fact I don`t think I mentioned mind mapping at all.

This suggests that this participant was able to respond by adapting the therapy to meet his own needs and in ways which did not involve the therapist at all.

The concept of responsiveness is further supported by CBT3. As described earlier in this chapter, her view of herself changed after therapy as she realised she was a person of value, but she was not sure she believed the new view of herself, she experienced some internal conflict, and found it difficult to do things differently. She described how

therapy did not meet her expectations.

CBT3. Yeah, it wasn`t what I expected. Because I was expecting to have to change the way I thought, really, and it didn`t really work out like that. It seemed more subtle really..... I was disappointed, really, because everything had seemed to me, this was working, really well and I was dealing better and then all of a sudden everything was getting on top of me again and I just felt like I just can`t cope with it. And she said, "There`s just a lot to cope with at the moment." And she said, "Anybody would struggle to cope with all this at the moment." So I suppose – perhaps I was expecting too much. Or perhaps I`d had my hopes raised early on. Yeah, I think perhaps I was probably expecting too much of myself as well, thinking, "O yeah I`m alright now. I know how to deal with things." But when everything, a lot of stuff happens at once I suppose -

This suggests that this participant`s ability to respond to the therapy or the therapist`s ability to respond to what she needed was limited.

The concept of responsiveness is further supported by the negative cases. Therapy did not meet CBT7`s expectations.

CBT7. I didn`t know what to expect, er. I mean ... you always expect more, don`t you? You know, to be ... dazzled and shown the light, so to speak, you know, but..... I`m not saying it was a disappointment, but ... you just expected something, er ...

I. So you did expect more.

CBT7. Well, I don`t know, you know. Sometimes I have high expectations of things, you know, that they`re going to ... work miracles, it`s just er....

I. You do sound a bit disappointed.

CBT7. Well, it`s just - dreaming and hoping for too much, you know. That`s one of my other problems.

CBT7`s view of himself did not change, suggesting that he was unable to respond to the therapy provided and the therapist was unable to give him what he wanted.

At this point in the analysis **It did the trick** had become a complex process which appeared specific to the individual client-therapist interaction. The findings suggest that sometimes the participant responded to the therapy which was offered, while sometimes the therapist responded to the needs of the participant. I settled on the term **Reciprocal Responsiveness** for the Core Category. The reciprocal nature of this concept gives a possible explanation for the differences between the accounts, as each reacts to the other in ways which are unique to a particular therapeutic relationship. It also gives a possible explanation for the similarities, as each reacts to the other in ways which are not specific to the therapy. It is also possible to take the next step in theory generation. The theory I suggest is that where reciprocal responsiveness occurs to a sufficient extent therapy is effective, while, where reciprocal responsiveness does not occur or is limited, therapy is not effective or has limited effectiveness. I am aware that including an interpretation of the therapist`s responsiveness risks imposing theory onto the data. However, I also believe that the therapist`s responsiveness was experienced by the participant and was reflected in their accounts. In writing this I admit that I am not a naive researcher and that my knowledge and experience as a therapist is likely to have informed my interpretation.

4.7. CHAPTER REVIEW

In this chapter I have presented the main findings of the research, which showed both individual differences and similarities between the participant`s experiences of therapy. I initially presented and described the higher categories which emerged from the analysis, organised in the chronological order of the participants` journey through therapy. I then presented two of the categories, **It did the trick** and **The key** in more detail as they were central to the analysis. **The key** represented key new realisations and understandings which resulted in therapeutic change, and **It did the trick** represented the elements of the therapy which brought this about. The findings suggest that there were a range of different processes which appeared to be personal to the individual client-therapist relationship and not specific to either therapy.

I chose the core category **Reciprocal Responsiveness** to explain the differences and similarities between individuals and the two therapy groups. I constructed the theory of

how the outcome of therapy may be determined by the occurrence of a sufficient degree of Reciprocal Responsiveness. The client may respond to the therapy provided or the therapist may respond to the individual needs of the client and adjust the therapy accordingly. Alternatively the client may interpret the activities of the therapist in ways which appear counterintuitive to the therapy, but which were more in tune with their needs and expectations.

In the next chapter I will discuss these findings in the light of the literature reviewed earlier and in relation to the research questions. I will also elaborate a number of discussion points relating to the core category. I will consider the implications for the assessment process and I will also discuss the role of clinical guidelines, and the current implementation, within the NHS in the UK, of standardised treatments, the use of therapy manuals and therapy adherence scales and how these findings may make a contribution to that debate.

5. DISCUSSION

5.1. INTRODUCTION TO THE CHAPTER

The aim of this chapter is to reflect on the findings of this research project in the light of the published literature. The chapter is divided into a number of sections. The first three sections relate directly to the research questions set out earlier. In the first of these I will discuss how the findings have answered the first two research questions:

5. How do clients report that they make use of therapeutic interventions in CBT and PCT?
6. How do clients modify and adapt interventions to suit their own particular needs?

In the second section I will consider the third research question:

7. What part do the therapeutic conditions, as theorised by Rogers, play in this process?

The third section relates to the fourth research question:

8. What is the mechanism by which clients receiving both PCT and CBT undergo change?

In the fourth section which follows this I will discuss the core category and the theory developed from it. The findings from this study have the potential to contribute to a number of discussions taking place in the psychotherapy world at the moment, and I will elaborate on this in the fifth section. Coming, as I do, from the perspective of a clinician and service manager it is important that these findings have a practical implication, which I will discuss in the sixth and final section. In this chapter I will continue with the notation used previously, where categories are presented in bold text and direct quotes are presented in italics.

5.2. THE ACTIVE CLIENT

The active client literature reviewed earlier proposes that clients are active in the process of self healing (Bohart and Tallman, 1999, Duncan, Miller and Sparks, 2004). The findings of the analysis are consistent with that view. Even though the participants had the same tendency as psychotherapy researchers to privilege the role of the therapist, describing them as helping, enabling and even making them change, the accounts of the therapy given by the participants in this study do not portray a passive recipient who found himself or herself changing as a result of something which was done to them. Instead the accounts portray the participants as active, resourceful co-workers in the process of recovery. In this section I will discuss the findings from this study which support the active client theory in more detail.

- **Activity before therapy**

Most participants reported that they had already spent significant time and energy in attempts to help themselves before they entered therapy. They tried to work out what was wrong with them, how they could address their difficulties themselves and had been using self help materials from books and the internet. Several described how they had attended therapy previously. Crucial to their accessing this episode of therapy was the psychological state of darkness, fear and confusion they had reached, resulting in the recognition that they could not do it alone, and that they needed the assistance of another person. This may have been the need for collaborative support, the help and advice of a professional or the discipline of attending appointments.

The accounts suggest that even the first step of accessing therapy was an active process on the part of the participant. Some participants described how they asked for therapy, or to see or talk to someone, while others attended therapy after it was suggested by their GP or another health professional. This step in itself involves activity and purpose. Some participants did not like asking for help and had to overcome this reluctance. Some initially turned down a referral to the PMHT, preferring to sort out their difficulties on their own. When PCT9 finally accepted the offer, she was

disappointed with herself and felt that she had, *given in to the counselling*. Participants who had found previous experiences of therapy unhelpful described how they had to overcome their misgivings about trying again. Those who were sceptical about the usefulness of therapy had to overcome their initial doubts. PCT1 described how she overcame her misgivings about her therapist by actively telling herself that she must give her a chance. CBT2 took action when she had doubts about her therapist, contacted the service and asked for a different therapist. Clarke, Rees and Hardy (2004), who investigated the experiences of clients who had had a brief course of CBT, also found that clients described a number of anxieties and reservations about the therapy and the therapist, which they had to manage.

- **Activity outside sessions**

Assay and Lambert (1999) calculated that 40% of the success of therapy can be attributed to factors outside the therapy. In this category they describe, in particular, self change, spontaneous remission, social support and fortuitous events. The participants in this study did not describe spontaneous remission, or fortuitous events. Instead they reported involving themselves in numerous activities to address their difficulties. Regardless of the therapy they received, participants described thinking creatively about what they could do to help themselves by trying out new activities and new behaviours. CBT4 had been so depressed before therapy that she had stayed in bed for most of the day. She decided to get up early, acted on the suggestion of her therapist that she set an alarm clock, and used the time to decorate her house. She went back to church and, at the time of the interview, was planning to enrol on a college course. PCT9 decided that she must spend time on herself and took singing lessons. PCT6 described pushing himself out of his comfort zone by joining weightwatchers and taking dancing lessons. In processing the abuse she suffered as a child, PCT1 revisited the site of her abuse, a recognised CBT technique for the treatment of trauma. She thought about doing this outside therapy and made the decision on the spur of the moment, without the involvement of her therapist.

As would be expected, CBT participants described engaging in the exercises and techniques suggested by their therapist. Even so, they examined what they were doing, the reason and intention of the activity and monitored their own progress. They

integrated the exercises and techniques into their lives, adapting them to their own particular circumstances as they arose. Participants in both therapy groups thought up exercises for themselves which included reading and researching their difficulties, writing diaries of their thoughts and feelings, and writing lists. PCT6, for example, drew mindmaps as a problem solving technique and CBT4 wrote the story of her life in poetry. These activities may have been discussed beforehand with their therapist, or the participant may have reported back afterwards, but sometimes it was done without the knowledge of their therapist. These findings are consistent with the work of Dreier (1998), who studied clients in family therapy, and who found that clients continued to process those aspects of the sessions that they selected and took away. They used aspects of the sessions in ways that differ from the therapist`s intentions. They modified, changed and reinterpreted them in many ways that their therapists did not know about. Some participants in this study reported having reservations in trying out new exercises and activities. CBT3 had reservations about putting herself first. It conflicted with her values and beliefs that if she put herself first she would be selfish. However she used the evidence that she was feeling better to validate what she was doing. In a strikingly similar way, PCT5 worried that she might be selfish, if she put herself first. This was resolved when she recognised how putting everyone else first was having a detrimental effect on her mood.

Participants reported reflecting on the therapy in between sessions, how it worked, the intentions of the therapist, and what was expected of them. The findings suggest that they continued the process of therapy in between sessions. They described thinking and reflecting, talking to others, questioning and challenging themselves, making connections and comparisons between what was happening in therapy and what was happening in their lives outside. These findings are similar to those of Levitt, Butler and Hill (2006), who found that their participants continued the process of self-reflection between sessions by reading self-help books, thinking about the therapeutic dialogue and engaging in self-questioning. PCT4, for example, compared what his therapist was saying about his importance as a person with the way he was treated by others in his life and decided that they tallied, so his therapist must be right. PCT7 described how he tried out his new found voice by talking to people and discovered that people listened to him. CBT3 decided to share the responsibility for her fathers` hospital appointments with her brother by offering him the choice of appointments to

take their father to. PCT6 described a significant amount of reflection in between sessions. He described a process by which he appeared to compare what happened during the session with his own internal valuing system, checking d*oes that ring true for me?, does that work for me?* He reflected on the therapy, decided how it worked and that the intention of the therapist was not to give him answers but to help him find his own answers. He posed questions to himself and decided what he could do differently to help himself.

Participants also described managing their emotions outside sessions. They managed their anxieties, beforehand, about what the session might hold and, at the end of the therapy hour, they managed the distressing and disturbing emotions evoked during the session. This is consistent with the findings of Levitt, Butler and Hill (2006) who found that clients negotiated the transition between the two worlds of therapy and real life by using strategies to manage their emotions.

- **Activity within sessions**

As both PCT and CBT are talking therapies it is not surprising that most of the participants gave lengthy descriptions about the exchanges they remembered from the therapy. In addition, some participants reported a significant event which seemed to have little to do with the therapy itself, but which was important in the change process. CBT2, for example described arriving late for her therapy session, due to the late arrival of the hospital transport which brought her, and the understanding and accepting way her therapist reacted to her distress. This event appears to have been integral to the change process as it helped her to realise that she was a person of worth and importance. This is consistent with the work of Dreier (1998) who found that clients are selective, taking away only some, sometimes minor aspects of the session, often different aspects than the therapist thought they had or that the therapist had not thought important. It is also consistent with other research findings of the significant events literature that some of the client-identified significant events are seemingly minor occurrences (Elliott, et al, 1994).

In a series of studies of client experiences of therapy, Rennie (1994a; 1994b; 2000b) found that clients try to exercise control over the therapy sessions. The findings from

this study appear to be consistent with this. Some participants reported that they decided what to talk about. PCT6 described how he had *put a problem on the table*. CBT1 decided to talk about her angry outbursts because she was frightened and confused by them. CBT4 made a list of all the things that were bothering her, which she and her therapist worked through in the therapy. At other times participants reported that they made a conscious decision not to talk about a subject. In CBT1`s case this was because she did not think it could be adequately addressed within the timescale. PCT4 described trying to avoid talking about his bereavements, although he also described how the therapist directed him back. CBT4 described successfully steering the conversation away from the painful subject of her childhood, although she regretted this at the time of the interview.

The studies by Rennie (1994a; 1994b), suggest that clients actively manipulate the therapy to make it more useful to them. In considering if the findings from this study are consistent with this, it may be useful to remind the reader of the different elements of the therapy which were identified by the participants in this study as important components of the change process. Some of the elements of the therapy that did the trick appeared contrary to what might be expected. **Therapist`s reaction**, **talking** and **getting it of my chest** would not be considered an active component of CBT. CBT2, for example, described how she was unable to implement the CBT techniques and that the therapist *allowed* her to talk and *listened* to her. The impression given by CBT4`s account of her experiences is that very little CBT took place in the sessions and they *were just in a little room, talking*. One interpretation is that both of these CBT participants successfully manipulated the therapy to get what they needed, which was the space to talk and express their feelings, although this is impossible to substantiate due to the absence of the therapist`s perspective.

The studies by Rennie together with those of Dreier (1998), and Bohart and Tallman (1999) suggest clients interpret their therapist`s responses to make them more relevant to their needs. The categories found in this analysis, **therapist questioning**, **therapist putting me straight** might not be considered compatible with PCT. Several PCT participants described their therapist asking a direct question. Socratic questioning is a recognised technique in CBT, but many would argue that asking a direct question is not an appropriate response in PCT. Rogers believed probing questions are "unlikely to

lead to any sort of psychological reorganization on the part of the client," (Rogers, 1942, p.160). A possible interpretation is that participants have taken an empathic reflection, turned it into a question which they have asked of themselves, then remembered that it was the therapist who asked it. As I elaborated in the findings chapter, what may be crucial in the change process is the way the participant reflects on a question. It appears that it does not matter whether the therapist asks a direct question or this is how the individual perceives the response. The way the response is presented leads to the individual asking the question of themselves. If they cannot adequately answer it to their satisfaction, they then reorganise their view of themselves and their reality in order to accommodate an answer. This reorganising was clearly articulated by CBT3 when she explained that, *it`s difficult to think of a reason why you`re not as important as everyone else so you start thinking, well maybe I am as important as everyone else.*

Consideration of the category the **therapist putting me straight** suggests that a similar process may have taken place. Again, this cannot be corroborated without the therapist`s account, but the participant, PCT4, may have acted on an empathic reflection and created direction from it because that was what he wanted. The **therapist giving an explanation**, could also be interpreted in a similar way. PCT8 may have taken an empathic reflection by the therapist and turned it into an explanation because that was what she was looking for. This is supported by research evidence. Previous studies have indicated that clients perceived empathy in different ways. Bohart and Tallman (2010) found that clients perceived empathic responses as support or insight depending on what they believed they needed at the time. In a study by Cooper (2004) of person-centred counselling in schools, counsellors described themselves as giving young people an opportunity to talk without giving advice. However, according to the students they were counselling, 'advice' was rated second as the thing they would most want from a counsellor, and they reported that they found it most helpful when their therapists asked questions and offered suggestions or advice. This may indicate that counsellors do not accurately covey what they do in therapy. Alternatively it may indicate that the students interpreted the empathic responses of their therapists as suggestions or advice because this was what they wanted.

Another discussion point concerns how participants attended to the therapist and the relationship, at the same time as attending to themselves and their problems. In a similar way to the participants in Rennie`s studies (1994a; 1994b) participants in both therapy groups described how they spent time working out how therapy operated, and the intentions of their therapist. PCT7, for example, worked out that it was for him to decide what to talk about and to start the conversation. CBT4 thought that her therapist avoided talking about her childhood as she thought it was too painful for her. CBT5 worked out that the purpose of her therapist`s interventions were to demonstrate to her that her thoughts were not real. Participants also described reassuring the therapist when they showed concern. When her therapist was going on holiday, and they would miss their weekly session, PCT1 reassured her therapist that she would be safe. PCT4 was concerned that the intensity of his grief was upsetting his therapist. Participants described their concern about the judgement of their therapist. CBT1, for example, worried what her therapist would think about her angry outbursts, and PCT9 was concerned what her therapist would think about the way she decided to handle her daughter.

In ways which are consistent with the research of Levitt, Butler and Hill (2006), who found that clients scrutinised their therapists for signs of caring, and the relational depth research (McMillan and McLeod, 2006; Knox and Cooper, 2011) that showed how clients controlled what they talked about and would not allow the relationship to develop if they did not find their therapist was sufficiently safe and caring, participants in this study assessed the personal qualities of their therapist. They decided whether they felt able to talk to them. This was demonstrated vividly by PCT1 who described the importance of her therapist being *the right person*. Participants also reported that they assessed the skill and competence of their therapist and if the therapy would meet their needs. PCT1, for example *thought, "You know what you`re talking about."* CBT2 thought her therapist was *a genius* and *excellent at what she does.* The findings therefore suggest that, during therapy, clients are able to actively attend to themselves, the therapist and the therapy in different ways and at different levels at once. Rennie conceptualised the term "reflexivity" to describe this ability to attend to a number of different aspects of experiencing at any one time (eg. Rennie, 1998, p.11; Rennie, 2006, p.71). He describes a complex set of circumstances where an individual is thinking

about what to say, reflecting on what is being said, and thinking about what they are feeling at the same time.

The concept of flow featured in most of the interviews. Both CBT4 and PCT2 described how the process *flowed.* The concept of flow was often difficult for participants to put into words. PCT2 described how it was *all very natural,* it *panned out,* and how *one thing led to another.* PCT6 and his therapist would *follow how it branched.* Participants often appeared unsure of the process, not knowing how it happened that they had ended up talking about a particularly helpful subject. Things that they were not expecting *came out,* or *came up.* Rennie (1998, p.143) gives a brief discussion of the concept of flow as a state distinctly different from a state of reflexivity where, in a state of flow, individuals do not think about what to say, they just say it. Rennie speculates that this state of non-reflexive communication may be the ideal toward which we should all strive. He also suggests that people alternate between a state of flow and a state of reflexivity. This appears to be articulated by PCT9 when she described a process over which she seemed to have little control that was *like a volcano…..just all this stuff came out.* She also described how, while she was talking about her problems, she was also observing and reflecting on her process, asking herself *why am I doing this?* and answering herself, *I must obviously want to get it off my chest.*

The findings from this study, therefore, appear consistent with the theory that clients are not passive recipients of therapy, but active partners in the process of change. Participants described actively examining themselves and their world, exploring and analysing their problems, questioning and challenging themselves, thinking creatively, having ideas, making decisions, trying out new activities and innovative ways of managing their difficulties. They also described being active in the process of therapy and the therapeutic relationship. They described managing emotions related to the session. They worked out what their therapist was doing, assessed their abilities and personal qualities, and asked their advice and opinions. They tried to exercise control over the therapeutic process by deciding what to talk about and what to withhold and they appear to have creatively operated on therapist responses in order to meet their specific needs. In the next section I will consider the part that the therapeutic conditions may play in the process of change.

5.3. THE THERAPEUTIC CONDITIONS

As I elaborated in the Literature Review, the therapeutic conditions here refer to the three "core conditions", which are provided by the therapist, specifically those of empathy, congruence and unconditional positive regard, the experiencing of which, by the client, results in therapeutic movement (Rogers 1957; 1959). The findings suggest that, regardless of the therapy they received, the therapeutic conditions played a role in the change process. Participants in both therapy groups described how they experienced their therapist as understanding, listening and non-judgemental. They felt comfortable and safe with their therapist and supported by them. PCT1 described how she felt valued by her therapist. CBT4 remarked that she knew that the therapist`s job was to listen and to care, but that her therapist had been genuinely warm and caring. PCT1 described how she experienced her therapist as *with* her and *walking alongside* her, and that her therapist had *weighed* her up and *got* her. This could be interpreted to mean that she felt understood in a way consistent with the concept of relational depth (Mearns and Cooper, 2005). PCT1 experienced her therapist as *relating to me as another human being, she wasn`t just doing her job.* Studies of relational depth have shown that when clients felt deeply understood, accepted, supported and cared for by the therapist, they experienced their therapist as being real and human or genuine. They described them as a person, offering something over and above their professional role (Knox, 2008). Others described their experience of the therapist in terms of other significant relationships, CBT2 as a mother, PCT4 as a mate and PCT5 as a friend.

Participants in this study did not describe empathic responses as such, but many aspects of the relationship were interpreted as empathic. This is consistent with Bohart`s theory of "invariants," that clients extract their perception of the therapist as empathic, not from specific responses, but from a variety of behaviours and responses over the whole course of therapy (Bohart, 2004; 2007). CBT2 described the understanding and accepting way the therapist reacted to her late attendance at a session. PCT9 described how she was talking about a problematic situation with her daughter, and her feelings regarding the way she had been treated, where her therapist responded by saying that she would feel exactly the same if she had been in the same situation. PCT9 interpreted this response as her therapist`s understanding of her situation and feelings. CBT5 found

her therapist`s self disclosure about her own thoughts conveyed her understanding of what she was thinking. CBT5 also reported how the therapist made her laugh when she was talking about her intrusive thoughts of wanting to stab her partner. She found this light hearted treatment of something so serious and frightening contributed to her sense of being understood. This is also consistent with the work of Clarke, Rees and Hardy (2004), where one of their CBT participants found it helpful when the therapist made a joke instead of being serious, and that this seemed to have led to a greater sense of safety.

According to CBT theory the therapeutic conditions facilitate engagement with the exercises, particularly when they are emotionally difficult and challenging (Thwaites and Bennett-Levy, 2007). The findings from this study appear to agree with this. CBT2 described how her therapist gave her courage to push herself to do the exposure exercises. CBT3 described how the therapy had given her the confidence to try out new ways of thinking and managing difficult situations. There is also a growing recognition within the third wave CBT approaches that an empathic relationship can be an agent of change in itself (Thwaites and Bennett-Levy, 2007), although the mechanism by which this happens is uncertain. According to person-centred theory the therapeutic conditions provide the environment in which the client`s actualising tendency can become a reality and the client will grow and develop in a constructive direction (Rogers, 1961). However, even among person-centred practitioners there is still a tendency to take a therapy-centric view that it is the conditions which are "active ingredient of change," (eg. Watson, 2001, p.460). If one takes a client centred view, then it is the client who is the active ingredient and who uses the conditions to help him or herself. In the next section I will discuss the role of the therapeutic conditions from the perspective of the active client theory.

- **The therapeutic conditions and the active client theory**

According to Rogers (1961, p.32) if an individual experienced the therapeutic conditions he would discover within himself the capacity to use that relationship for growth, and change. Taking the perspective of the active client, Bohart (2004) believes that people extract from the way they are being treated that the therapist intends that they should treat themselves in the same way. Therefore if a client experiences being

prized over a period of time they will take from the experience that they should prize themselves. The findings from this study appear to support his. Although the participants appear to favour the role of the therapist, describing the experience as, s*he made me feel valued* (PCT1), and s*he gave an importance to you* (CBT2), it seems reasonable to infer that they have taken from this experience that they are worth valuing and caring for. This is clearly articulated by CBT2, who described how she *gleaned* from the way she was treated by the therapist that she was *a person as well.* This then enabled her to think about her own needs, rather than the needs of her family. This also suggests that the role of empathy in CBT is not just to enable the participant to engage with difficult and emotionally challenging tasks. Bohart (2004, p.113) proposes that this new experiencing of themselves as a person of value and importance ought naturally to operate on dysfunctional negative self-thoughts to reduce self-criticism and so on. This is supported by the findings that some of the participants` reported that the change in their thinking and behaviour *happened naturally*.

Bohart (2004, p.113) suggests that, in PCT, clients extract that the therapist does not intend to give them direction, that therapy is for them to use to work things out for themselves. They take from it that the therapist trusts that they can do this and therefore they extract that they have the power to help themselves. Two of the PCT participants, PCT6, PCT7, neither of whom understood *how it would work* appear to have articulated this process. PCT6 was sceptical about therapy`s usefulness and PCT7 was anxious about engaging, having had a bad experience of therapy previously. Both of these participants struggled to understand what was expected of them. PCT6 worked out that the therapist was not going to give him answers and that he had to find the answers for himself. The therapy gave him the confidence and the permission to start trying new ways of behaving and dealing with his problems outside therapy. PCT7 realised that it was for him to lead the dialogue and that he could talk about whatever he wanted. This was led to the key realisation, that he has *a voice*. As he grew in confidence in using his voice to speak up for himself, his experience of being listened to and heard, then led to a changed perspective of other people, that they would listen to him.

According to Rogers (1951), the purpose of the therapist`s empathic responses is for the therapist to check the accuracy of her understanding of the client. Bohart (2004) also suggests that clients use empathic reflections to further their understanding of

themselves and to test out their beliefs, to "see if I am making sense or not." The findings from this study appear to support this. One of the main categories, **making sense,** included participants` increased understanding of themselves and their difficulties. Sometimes this understanding came from the therapist while sometimes it was the participant who generated the new understanding themselves. Other participants described how therapy had helped to validate understandings that may have been tentative. PCT2, for example, knew *deep down* that her mother loved her, but *saying it out* loud helped her to *realise* it and helped her *to make it real*. PCT1 thought that she had prevented the abuse she suffered as a child affecting her relationship with her son in the same way as it had adversely affected all her other relationships. Talking to her therapist confirmed this.

Bohart (2002) believes that clients use the therapeutic conditions to further productive thinking. The findings from this study appear to agree with this. Participants in both therapy groups described having ideas and making decisions, which they discussed with their therapist before they tried them out or reported back afterwards. In this way they obtained the confidence, approval, reassurance and permission to think differently and to try out new ways of managing their difficulties. PCT9, for example, described how a new way of dealing with her daughter`s behaviour *just came to me, talking to the counsellor.* She asked her therapist, *"Does this sound wrong?"* and her therapist`s response gave her the *reassurance* and *approval* to begin putting it into practice.

Participants in this study also described how their experience of therapy helped them to normalise their situation. The understanding and accepting relationship enabled participants to realise that *it`s not just me,* and *I`m not mad,* and helped reduce the state of fear and confusion in which they entered therapy. It is interesting to note that CBT1 used the literature in the same way. It was by reading the handouts given to her by her therapist that she realised other people felt the same way she did.

Therefore the findings of this study can be interpreted as consistent with the active client theory where clients are active participants in the therapeutic process, and who use the therapeutic conditions to help themselves. In the next section I will consider if the findings shed light on the fourth research question regarding the mechanism by which clients receiving both PCT and CBT undergo change.

5.4. MECHANISMS OF CHANGE

In this section I will first consider if the participant`s accounts are consistent with the change theories described in the literature review. I will go on to look in more detail at the two categories which, according to the participants` accounts, seemed important in the change process, **It did the trick** and **The key**. I will discuss how the findings from this study suggest that there are a number of different change mechanisms and how this relates to the change theories of CBT and PCT and the active client theory. I will first remind the reader of the change theories of the two approaches, which were set out in more detail in the Literature Review. Briefly put, the aim of CBT is to change the core beliefs, thinking styles and behaviour of clients to more beneficial thoughts and behaviour, and so reduce distressing symptoms. The aim of PCT, on the other hand, is to provide the therapeutic conditions in which individuals can grow and develop, where their self concept becomes more congruent with their internal valuing system and their thoughts and behaviour change as a consequence of this. According to the active client theory clients may use either approach to meet their own needs.

Both PCT and CBT participants entered therapy describing themselves in ways that could be interpreted as negative or incongruent, which included feelings of worthlessness, involving processes of self-blame and self-criticism. Where therapy was successful, participants in both therapy groups described changes in thinking stiles and behaviour. They also talked about themselves in ways that could be interpreted as changes in their core beliefs or their self concept, where the way they experienced themselves, other people and their world became more balanced and realistic. The changes described by the participants could therefore be accommodated by either CBT or PCT theory, by a change in self concept as a consequence of experiencing the therapeutic conditions, or by a change in core beliefs and a more positive style of thinking and behaving resulting from the CBT interventions.

Clarke, Rees and Hardy (2004), who investigated clients` experiences of CBT found that their participants mentioned “the model” a number of times. In contrast, none of the CBT participants in this study used the term. The nearest approaching this was

CBT3, who described *the cycle thing,* suggestive of the five areas model (eg. Williams and Garland, 2002). Few CBT participants used terms recognisable from CBT theory. CBT7, one of the negative cases, was the only CBT participant who used the term, *core beliefs,* by describing how they still ruled his thinking and how it was difficult to change them. CBT5 described the role of her *safety behaviours* in maintaining her intrusive thoughts that something dreadful would happen. Her description of her key realisation that her thoughts *weren`t real,* but *a thought like any other thought,* and the way she did not *take* her thoughts on, or *dwell on them,* but was *just trying to let them float past,* is reminiscent of the theory underlying the third wave CBT approaches where change occurs by the achievement of a metacognitive state where thoughts are observed and accepted as mental events rather than expressions of reality (Teasdale, 1999).

In a similar way, few PCT participants used person-centred terms related to theory. In an interesting turn of events, it was a person-centred participant, PCT8, who clearly articulated how her cognitive style changes from when she is ill to when she is well. When she is depressed she interprets people`s words and behaviour in a negative way. When someone is quiet she assumes they are ignoring her and she has offended them. When she is well she knows this is illogical, and challenges these assumptions with alternatives, but when she is ill she cannot see an alternative. This account was given in the present tense, showing that she believes this fluctuation between illness and wellness is ongoing. She described her depression as *lurking* and *waiting for something to trigger it*. PCT8 did not seem to attribute her recovery to changing her thinking style, but that her thinking changed as a result of her feeling better by putting all her past experiences into compartments. This is consistent with the findings of a number of researchers (eg. Burns and Spangler, 2001), who have been unable to demonstrate that a change in dysfunctional attitudes is the cause of a change in levels of anxiety and depression.

From a third wave CBT perspective, Teasdale (1999) described a process of "stepping back" as a way to solve problems. This is supported by Allen, et al (2007), who found this concept in their study of the experiences of clients who had undergone mindfulness training. According to the literature this concept of spaciousness to solve life`s problems better can be achieved by using the technique of mindfulness meditation. Participants in both therapy groups described a similar concept. PCT6 described how

he could now *take a step back and look at it,* while CBT1 described how she could now *take a second or two to think,* and *take some time to work it out.* Neither of these participants described learning mindfulness and so it is likely to have been the result of a different mechanism. This state of spaciousness appears also to have been achieved by PCT8 by filing her past distressing experiences away which gave more space in her head to cope with current life difficulties.

In order to elaborate this further I will look at the two categories which participants reported were important in their change process.

- **The Key**

The review of the literature revealed that one of the helpful aspects of therapy identified by clients is an increase in self knowledge, often conceptualised as "insight" (eg. Timulak, 2007). Rees, et al (2001) found that insight was involved in the change process of a problem clarification event in CBT. Clarke, Rees and Hardy (2004) investigated clients` perceptions of the change process in CBT. An important component was the participant understanding and realising things about themselves and their core beliefs. In a grounded theory study of women who had recovered from depression, Shreiber (1996; 1998) found that they had been through a process of "Cluing In" where the women came to a true understanding of themselves and their world. The conceptualisation of **The key** as one of the main categories is therefore consistent with that literature. There have been many attempts to formulate a pan-theoretical model of change in therapy and the attainment of insight, or a phenomenon similar to insight appears to be an important stage in most of them. For example, the assimilation of problematic experiences model includes insight as a stage in process of assimilation (Stiles, et al, 1990), the perceptual control theory (Higginson, Mansell, and Wood, 2011) includes a shift in higher order cognition which could also represent insight, and the innovative moments model of Goncalves, Matos and Santos (2009) regards re-conceptualisation innovative moments as an important part of the change process, which could also be seen as moments of insight or understanding. Wampold, et al (2007) propose insight as a common factor and a group of thirty two eminent psychotherapists and researchers have put the case for insight as an important mechanism of change in psychotherapy (Hill, et al, 2007).

The range of different experiences included in this category suggests that each participant came to a new understanding of themselves and their reality in ways which related directly to themselves and their personal circumstances. This is consistent with a theory of change put forward by Wampold (2007) and Wampold, et al (2007). He and his colleagues propose that an important part of the change process is the client`s acquisition of an explanation for their problems and difficulties. Bohart and Tallman (2000), describe how clients come into therapy feeling demoralised and anxious because things don`t make sense, and how making sense of things brings coherence and reduces anxiety. This is demonstrated by PCT2. The realisation that she was taking responsibility for her family was helpful in itself, even though she was not yet ready to act on this insight. Wampold, et al (2007), make the point that the truth of the way the individual understands his reality is not necessary for its efficacy, and that what is important is its acceptability to the client. The findings from this study appear consistent with this. PCT8`s explanation that she needed to put her past stressful experiences into compartments in her head to leave room for current stressful experiences is not necessarily "true," but it was certainly very helpful to her. The findings also show that some people are able to extract something positive, and so find meaning in the problematic experiences which brought them to therapy. In this study, this was not dependent on the therapy they received as both PCT1 and CBT4 reported that they thought they were stronger as a result of recovering from their experiences. This is consistent with Joseph and Linley`s work where individuals have been able to grow and change positively following trauma and adversity (Linley and Joseph, 2004; Joseph and Linley, 2005).

As I reported in the Findings chapter, in several cases, the new understanding appeared to come from the frame of reference of the therapist, while in fewer cases the understanding appeared to come from the participants` own frame of reference. It is consistent with a psycho-educational aspect of CBT for a new understanding to be given by the therapist. However, in order to be consistent with the PCT model of change it would be expected that the new understandings would have come from the participants own frame of reference. The findings from this study suggest that it does not matter whether the new realisation and understanding came from the therapist or from within the participant and in this way it fits with either the PCT or the CBT models of change.

Participants in both therapy groups described their new understanding coming from within themselves. They also described needing the reassurance or permission of their therapist to consolidate their new understanding. Participants in both therapy groups also described receiving the understanding from the therapist. Where this was the case, the findings suggest that it was necessary for the participant to "see it," believe it and make it his or her own. When this new view of themselves conflicted with the old view, both CBT and PCT participants described having difficulty believing the new view of themselves. Those who were able to overcome this difficulty described some degree of change and benefitted from the therapy. Those negative cases, who could not see or believe what the therapist was saying and who did not arrive at a new understanding from within themselves did not describe change.

- **It did the trick**

I categorised the process by which the new realisations and understandings came about as **It did the trick.** The findings suggest that a range of different elements of therapy could bring about similar key realisations (Table 2). I will elaborate on this with particular reference to the realisation that one is taking too much responsibility. This realisation came to several participants in different ways:

- CBT1 felt responsible for her colleagues at work. She realised that she had been taking too much responsibility when her therapist drew a pie chart, sharing the responsibility between the different people involved in the situation they were discussing. She willingly accepted this alternative view, seeing it as simple common sense. She learned how to implement the technique to manage situations in which she might find herself. She practised it and now implements it when faced with potentially difficult situations. This has become easier with time although she felt guilty for giving up the responsibility for others and she had to actively give up that responsibility.

- PCT6 had also taken responsibility for work colleagues. He realised that this had its origins in his childhood experiences in a process of self exploration prompted by the probing questions of his therapist. In talking about his childhood he made the connection between his sense of responsibility as an

adult and the responsibility he had been given for his younger brother by his parents. This gave him the permission to say no to some of the demands at work.

- PCT2 had been taking responsibility for her family when her therapist asked her why she was doing so. Her inability to answer this question led to the realisation that she was taking too much responsibility for her family, and gave her the permission to give it up in the future, although she did not feel ready to do so at the time.

- CBT3 was taking all the responsibility for her elderly and ailing father. In therapy she learned how this was affecting her mood. She also learned how to share the responsibility with her brother, or to say no to her father, by trying out new strategies for managing situations which were suggested by and discussed with her therapist. This caused her some discomfort. She felt guilty as the strategies conflicted with her values and beliefs that she should put other people before herself. However she continued to use the strategies and, by using them, she began to feel better. This gave her the confidence to continue with the strategies.

- PCT1, on the suggestion of her therapist, wrote letters to the boys who had abused her as a child, which she then discussed with her therapist. In a process of self-exploration, the question arose why she had not told her parents about the abuse. She realised that she had taken responsibility for her family because her sister had mental health problems and her parents had enough to concern them without worrying about what was happening to her. She began to experience herself differently due to the way her therapist reacted to reading her letters. She found that she naturally managed her relationship with her sister in a new way, as a consequence of her new feelings of strength and courage.

Just as a range of different elements of therapy appear to do the trick and result in similar key realisations, the findings also suggest that similar elements could bring about a range of different key realisations. For example, the therapist`s questions were instrumental in the process whereby PCT2 realised that she was taking responsibility for her family, it also helped CBT3 realise that she was equally as valuable as anyone else,

helped PCT3 to realise that it was *OK to say, "no*," and put herself first, and helped PCT6 to realise that he could put less pressure on himself at work.

The range of different tricks and keys found in the analysis suggests that there were different processes by which the different participants changed. Some participants described how a key new understanding lead to a change in their perspective of their reality, which, in turn, lead to a change in behaviour. Others described how a deliberate change in their behaviour lead to a new understanding, which then lead to a change in their view of their reality. Others seemed to experience a spontaneous change in behaviour, which lead to a new understanding and view of their reality, and so on. This interpretation is consistent with the pluralistic standpoint described by Cooper McLeod (2007, p.4), that there are multiple of models of psychological distress and pathways of change and there is no need to try and reduce these into one, unified model. Instead they propose a framework of therapeutic practice which allows for the different models and pathways (Cooper and Mcleod, 2011). This view is also supported elsewhere in the research literature. From their study of sudden gains in CBT, Tang and de Rubeis (1999) hypothesised that clients who recover with sudden gains do so by a different mechanism from those who recover without showing such sudden gains. The findings of an investigation into individuals` experiences of mindfulness-based cognitive therapy lead Allen, et al (2009, p. 424) to suggest that the change process is different for different people.

In this study change appears to have occurred at different speeds. Some participants in this study described a sudden change event, a moment of insight, illumination or clarity. PCT1 described a *turning point*, PCT2 described it as like a *light bulb* going on in her head, CBT6 described it as like *a trigger*. Some participants in this study described a longer, more gradual process, where they reflected after the session on what had occurred or been said. Sometimes participants described surprising themselves by behaving differently and only recognising that they had changed when they reflected on their changed behaviour. This supports the proposal that there are multiple change processes. Other research studies have shown how change can occur at different speeds. This can happen without therapy (eg. Shreiber, 1996; 1998), or in a range of different therapies (Carey, et al, 2007). Several participants describe the emotional impact of the change moment. For CBT1 it was like a weight lifted off her shoulders. PCT9

described it as *a gestalt moment, eureka, a breakthrough*. She remembered slumping in her chair exhausted, thinking, t*hank God for that.* The memories of such moments were vivid and detailed so that PCT1, for example, could remember what her therapist was wearing and how she was sitting. This is similar to the findings from the study conducted by Carey, et al (2007), whose participants had vivid memories of change moments that they could see and hear. They also described the emotional impact as relief or release, "like letting steam out of a kettle." The phenomenon of a "moment" of change is common in the person-centred literature. Rogers described the therapeutic process in terms of a continuum, but he recognised that a client`s progress in therapy is neither gradual nor smooth but often happens in fits and starts. He called those times when change actually occurs "moments of movement," (Rogers 1961, p.130).

It may be useful, at this point, to summarise the discussion so far. I have discussed the different ways that participants in this study appeared to be actively using the two different therapies, how the findings suggest that they modified and adapted interventions to meet their own particular needs, and how their ways of using the interventions were not always in keeping with the theory underlying the therapy they were receiving. I have considered how the therapeutic conditions were integral to this process in both therapies. I have also discussed how it appeared there were different change processes which participants went through which were particular to the individual, and not always consistent with the theory of the therapy they received.

The finding that there appeared to be different change processes, particular to the individual, led on to the final stage of the analysis. In the next section I will reflect on the concept of responsiveness and reciprocal responsiveness which emerged as the Core Category, and on the theory I generated, that it is the ability of the client and therapist to respond sufficiently to each other which governs the outcome of therapy.

5.5. THE CORE CATEGORY

In the previous Findings chapter I described how my returning to the literature relating to the concluding analysis was an important part of the process of conceptualising the

core category. I also described how an important step in the analysis was seeing a link between the elements of therapy which the participants reported were important in the change process and their expectations of the therapy. Before discussing the concept of responsiveness and in line with the order in which the analysis unfolded, I will first give brief consideration to the role played by the clients` expectations of therapy in the change process

- **Having expectations of therapy**

When I turned to the literature, I found that hope, expectations, preferences and ideas of cure are closely related concepts which are all aspects of the client`s preconceptions before starting therapy. Hope (Snyder, Michael and Cheavens, 1999) conceptualises a general positive anticipation that therapy will be helpful. A closely related concept is that of outcome expectations or the extent to which the client believes that a treatment will help with their problems (Greenberg, Constantino and Bruce, 2006; Constantino, et al, 2011). Client expectations have been regarded as a common factor affecting the process and outcome of therapy for many years (eg. Grencavage and Norcross, 1990) and there have been a number of studies that have shown that clients` outcome expectations are positively correlated with therapy outcome (Greenberg, Constantino and Bruce, 2006). This has led to the view that clients who have positive expectations that the therapy will be helpful will have better outcomes.

The findings from this study do not fully support this. Participants reported a range of expectations which do not appear to have been related to the outcome. CBT4, for example, reported positive expectations, while neither CBT6 nor PCT6 expected therapy to help at all. All three reported a positive outcome to their therapy. Others, such as PCT2 and PCT7, who did not know what to expect, reported positive outcomes too. Constantino, Ametrano and Greenberg (2012) have developed clinical guidelines in which they recommend various clinical strategies that a clinician might use in order to heighten positive expectations. The danger of this is demonstrated by CBT3. She described an early improvement in her mood and was disappointed when *everything was getting on top of me again* thought *perhaps I was expecting too much, or perhaps I`d had my hopes raised early on.* CBT7 demonstrates the danger of creating unrealistic

expectations. He was disappointed because he expected to be *dazzled and shown the light* and that his therapist was going to *work miracles.*

Treatment expectations, the beliefs the client holds about what will happen in therapy, is another related concept found in the literature (Greenberg, Constantino and Bruce, 2006; Constantino, et al, 2011). The CBT community have long appreciated the importance of treatment expectations. "Socialising into the CBT model" is an important component of the early sessions and is incorporated into therapy manuals. The aim is to educate the client about the therapy, so that they know what to expect and what will be expected of them in order to maximise compliance with the therapy. In this study, participants appear to have had a wide range of treatment expectations, which again do not appear to relate to the outcome. PCT1, for example, knew what to expect, where as PCT7 did not. Both described a positive outcome to therapy. CBT2 described how her therapist was very clear about what would happen and what was expected of her, but she was unable to do it. Other participants spent time trying to work out the intentions of their therapist and what was expected of them, but reported a positive outcome. At the time of the interview PCT2, who found therapy helpful, was *not even 100% sure now, what you get out of it, what it`s for.*

Some participants in this study describe specific expectations. PCT1 described how she did not *just want to talk about it* (the abuse), she wanted to *do something with it.* PCT4 reported that he wanted someone to put him on the straight and narrow. PCT8, wanted someone to give her an explanation while PCT9 wanted reassurance. Both CBT2 and CBT4 reported that they had wanted to talk about their problems. Similar concepts are found in the literature. Preferences (Swift, Callahan and Vollmer, 2011) represents the specific aspects of the therapy or attributes of the therapist that the client wants or desires, and ideas of cure (Philips, et al, 2007) represents how clients have their own ideas about the nature of their difficulties and what will help them recover. Several studies support the view that clients are less likely to drop out of therapy and will have better outcomes if the therapy they receive matches their ideas and preferences (Philips, et al, 2007; Swift, Callahan and Vollmer, 2011; Valkonen Hanninen and Lindfors, 2011). However research also suggests that clients can respond the therapy which is at odds with their ideas and preferences. Mackrill (2008), Valkonen, Hanninen and Lindfors (2011) both found that some clients abandoned their own ideas about therapy

and applied the strategies suggested by the therapist. Studies have also suggested that clients have adapted the therapy to fit with their ideas and beliefs (Mackrill, 2008, Dundas, et al, 2009). The findings from this study appear to be consistent with this and suggest, in line with the active client theory, that participants responded to the therapy in ways which accommodated their own expectations and preferences and were able to obtain what they needed from the therapy. Thus PCT1 may have extracted a directed activity enabling her *to <u>do</u> something* with her abuse, PCT8 may have extracted the explanation she wanted, PCT9 the reassurance she was looking for, while CBT2 and CBT4 both may have taken the opportunity to talk.

The alternative interpretation is that it was the therapist who adapted the therapy in line with the participant`s expectations. Thus PCT1`s therapist may have suggested the letter writing activity, PCT8`s therapist may have given her an explanation, while CBT2 and CBT4`s therapists allowed them both the time and space to talk.

When I turned to the literature relating to responsiveness I found it is limited, but I established that it can be conceptualised in terms of two elements, the responsiveness of the client to the therapy and the therapist on the one hand, and the responsiveness of the therapist to the client on the other. The responsiveness of the client to the therapy and therapist appears closely related to the concept of the activity of the client and so has already been covered at length in this account. The responsiveness literature is concerned primarily with the responsiveness of the therapist and I will give consideration to this in the next section.

- **Therapist responsiveness**

Evidence supporting therapist responsiveness has been derived from the RCT research, where the researchers who studied recordings of therapy to monitor therapy adherence found that, while most therapists applied the techniques described in the therapy manual, there was variability in how they were applied. Connolly Gibbons, et al (2003) found that the therapists of the different approaches studied in the NIMH project responded to client differences in similar ways. As part of the second Sheffield psychotherapy project which compared CBT and IPT, studies found that therapists

offered different interventions to clients based on their particular interpersonal style (Hardy, et al, 1998) and styles of attachment (Hardy, et al, 1999).

Stiles, Honos-Webb and Surko (1998, p.439) define responsiveness as "behaviour that is affected by emerging context, including emerging perceptions of others` characteristics and behaviour." They describe the responsiveness of the therapist in terms of the way the therapist responds *to* the requirements emerging from the client *with* some intervention. This occurs at different levels within the therapy, at the levels of treatment assignment, treatment strategies, treatment tactics and moment-to-moment. Responsiveness at the level of treatment assignment occurs when clients are allocated to different treatments (this study was designed to inform responsiveness at that level). At the level of treatment strategies, responsiveness occurs when the therapist chooses the best course of action from within their particular approach. A CBT therapist, for example, formulates the client`s problem and implements the model of the therapy recommended for that problem. If different problems emerge, the therapist may revise this formulation and decide to implement a different one. Responsiveness at the level of treatment tactics occurs when therapists select specific interventions in response the individual`s particular needs. Thus, a therapist may suggest different homework assignments according to a particular client`s capabilities or situation.

The responsiveness of the therapist appears to be reflected in the accounts of the participants. CBT participants in this study described how their therapist related CBT exercises and techniques to their personal situation. CBT1, for example, described how her therapist drew the pie chart in response to what they *were talking about at the time*, while CBT4`s therapist responded to her comment that something she had done made her sound *really evil* by conducting an exercise on the whiteboard which challenged that statement. CBT2 described how her therapist adapted the therapy to accommodate her heart condition. Her therapist was reluctant to introduce physical exercises to induce panic symptoms and limited her interventions to mental exercises. Participants in the PCT group were aware of the therapist`s influence on the process of exploration. PCT3 described her therapist as *prompting* her. PCT6 remembered how his therapist had asked him *probing questions*. PCT4 reported that his therapist drew or *fetched* his account of his difficulties out of him, and how he had tried to avoid talking about the death of his wife and daughter, but was brought back to them by the therapist.

A further level of responsiveness described by Stiles, Honos-Webb and Surko (1998) is that of moment-to-moment, which occurs when therapists respond to clients` reactions to their interventions. A therapist may rephrase an intervention when a client does not appear to understand or, more subtly, alter the wording of a response midsentence in reaction to the change in a client`s facial expression or body language (Elliott, et al, 1994). PCT1`s interpretation of the way her therapist reacted to her letters was that her therapist understood her so well that she knew how to respond in a way that would be helpful. This may well be an accurate assessment of the interaction. The therapist may have had a deep understanding of this participant and have thoughtfully assessed the situation before she planned her response. On the other hand she may not have known what her client would find helpful, but may have been reacting spontaneously in the moment. This interpretation is supported by the literature. Anderson, Lunnen and Ogles (2010) take the view that much of the responsiveness of therapists to their clients is implicit and without much forethought, at a "gut level" of hunches and intuitions rather than carefully planned hypotheses. Hardy, et al (1999), the researchers who found that therapists in the Second Sheffield Psychotherapy Project responded in different ways to different client characteristics, speculated on whether this was the result of a decision making process on the part of the therapist or whether it was done unconsciously. Bohart (1999) argues that the process of therapy can be fast moving and that the therapist must react in the moment and come up with creative ways to manage situations. He believes that creativity is an inherent part of human nature which arises from tacit, intuitive knowledge. This kind of knowledge is grounded in bodily, experiencing and is non-conceptual. In line with Gendlin`s theory of experiencing (eg. Gendlin, 1996, p.16), therapists have a "felt sense" of something which informs the way they respond to their clients.

Stiles, Honos Webb and Surko (1998) make careful use of the term "requirements," which refers to the possibility that the therapist must respond, not to just the needs of the client, but also to their ability to make use of what the therapist is providing. So a client`s ability to make use of questions may limit his requirement for them. This distinguishes the phenomena from the client`s preferences or expressed wishes. A client may wish for something, but not be able to make productive use of it. For example, a client may wish to be challenged but, in the event, find it too confrontational

and therefore not be able to make use of the challenge. They emphasise that effective responsiveness is "appropriate" to the emerging requirements of the client, which may change during the course of the therapy. This leads on to the reciprocal nature of responsiveness, which I will discuss in the next section.

- **Reciprocal Responsiveness**

In the final stage of the analysis I conceptualised the core category as **Reciprocal Responsiveness** as the findings appeared to suggest that both the activity and the responsiveness of the client, and the responsiveness of the therapist contribute to the success of therapy. I discussed earlier how participants described their activity in therapy. Just as therapists respond to what is emerging from the client, clients also respond to what is emerging from the therapist. Combining the two elements of client activity and therapist responsiveness gives therapy the sense of a shared, give and take venture, as each assesses and reacts to the other. Norcross and Wampold (2011, p.426) capture this reciprocal nature by their description of responsiveness as "the ebb and flow of clinical interaction." This is also supported by Stiles, Honos-Webb and Surko (1998), who describe the complex nature of responsiveness as a dynamic relationship between variables, involving bidirectional causation and feedback loops. They explain that, in the feedback system of the therapeutic conversation, outcome is reciprocally affecting process. Therapists make adjustments to their interventions in response to the way clients reacted to previous interventions. Clients behave responsively too, so any adjustments made by therapists causes complementary or compensating adjustments by clients, which elicit further adjustments by therapists, and so forth, and which mean that the progress of therapy cannot be predicted in advance. They elaborate how, in this system, minor events can initiate chain reactions or cascades of events that may have large effects. Thus, a therapist may comment on a small remark made by the client, which may then send the session in a new and unexpected direction, with possible implications for the effectiveness of the treatment.

The findings from this study appear to support this view. CBT4 described how she had talked about her abusive childhood. The subject had been *quite painful* for her, she *did end up in tears* and had *felt slightly embarrassed at crying in front of someone* and *felt like I`d gone a bit weak.* She avoided the pain of talking further about her childhood by

changing the subject. Her account suggests that her therapist responded by going along with this. Her first account was that her therapist *saw how painful it was for me and she didn`t want to go there.* Later on in the interview she described how she thought her therapist *had wanted to go deeper* but that she, the participant, had *started talking about something else.* Her regret, voiced in the interview, that she wished she had talked more in therapy about her childhood and wished she had *given her* (therapist) *permission* to do so certainly suggests the complexity of the situation.

I also generated the theory that when reciprocal responsiveness occurs to a sufficient degree then therapy is successful. This is also supported by Stiles, Honos-Webb and Surko (1998) who make the point that both therapists and clients are trying to be helpful. They continually monitor emerging outcome and adjust their behaviour to achieve the best results. If they discover a productive approach they tend to continue with it. If they try something that doesn`t work they stop doing it or modify it. This may be far from perfect, but each is doing their best and when it happens to a sufficient degree then therapy will be successful.

In the next section I will look at some of the implications of the reciprocal nature of client activity and therapist responsiveness. I will first consider the interesting paradoxes regarding responsiveness and outcome research and the evidence based paradigm, then go on to discuss the implications of responsiveness in the use of manuals, adherence scales and clinical guidelines.

5.6. INTERESTING PARADOXES

- **Reciprocal responsiveness and evidence based practice**

According to the literature, therapist responsiveness is a confounding variable in trials which compare different therapies (Elkin, 1999; Krause and Lutz, 2009). Efforts are made to ensure that all participants in a particular treatment group receive the same therapy by training therapists to conduct therapy in accordance with the therapy manual and checking their adherence to the manual by using therapy adherence scales. However, as I highlighted earlier, a number of researchers in such trials have found

considerable variation in the way therapists deliver the same therapy (eg. Connolly Gibbons, et al, 2003; Hardy, et al, 1998; Hardy, et al, 1999). In fact, Ablon and Jones (2002), who compared therapy adherence in the NIMH Treatment of Depression Collaborative Research Program, found considerable overlap between the different approaches and concluded that the basic premise of clinical trials, that they are comparing distinct and different treatments, may not have been met. According to Stiles, Honos-Webb and Surko (1998) therapist responsiveness may explain the dodo-bird effect and the equivalence paradox because therapists try to respond appropriately to each client so that, overall, clients achieve equivalent outcomes because each receives an intervention appropriate to their differing needs.

According to Bohart and Tallman (1999) it is the activity of the client which is responsible for the dodo-bird effect and the equivalence of therapies, because the client is able to transcend any differences between approaches. Each approach works equally well because, overall, clients are able to use whatever each approach provides to help themselves. The responsiveness of the client as a confounding variable is not so frequently addressed in the literature. The use of strict inclusion and exclusion criteria are attempts to control for client differences, but the active client literature suggests that client may well be responding to the therapy in ways which cannot be controlled for.

In the same way, client activity and therapist responsiveness may also explain the lack of success in correlating client characteristics with outcome and efforts to match clients with particular characteristics with the most suitable therapy (Project Match, 1997), and the apparent lack of success in demonstrating a correlation between process variables and outcome (Llewellyn and Hardy, 2011).

- **The use of clinical guidelines, therapy manuals and adherence scales**

Therapy manuals and therapy adherence scales were originally devised for use in clinical trials in order to standardise the therapies under investigation. There are an abundance of CBT manuals and adherence scales due to the amount of research that has been carried out. Historically the person-centred community have not involved themselves in the evidence based paradigm and so there are considerably fewer PCT manuals and adherence scales (Friere and Grafanaki, 2011). Opinion seems to be

divided regarding their use. Some studies have suggested that where therapists stick rigidly to the therapy manual outcomes are adversely affected. Ahn and Wampold (2001) found no evidence that adherence to a treatment protocol results in better outcomes. Rather they suggest that poorer outcomes are the result of ruptures in the alliance due to strict adherence to the manual rather than responding to the individual client. Several authors write about the skill required to implement manual based therapies while being responsive to the changing needs of the client (eg. Wilson, 1998). Qualitative studies have highlighted the importance to clients of the therapist`s responsiveness. In a study investigating unhelpful experiences, participants reported that a lack of responsiveness on the part of the therapist was one of the hindering aspects of therapy (Paulson, Everall and Stuart, 2001). Perren, Godfrey and Rowland (2009) found that, in the clients view, the therapist`s ability to adapt to individual need was critical for the long term success of therapy.

On the other hand, there is the belief that a lack of adherence to the manual may be one of the reasons why some clients do not have a positive outcome to CBT (eg. Roth and Pilling, 2008). In a study of CBT for anxiety, Schulte and Eifert (2002) found that therapists changed their methods and goals repeatedly throughout the course of treatment in order to avoid failure. However the findings demonstrated that the more changes the therapists made, the less successful the therapy, and they concluded that more stringent adherence to the therapy manual should result in better outcomes. Waller (2009, p.126) describes the phenomenon of "therapist drift," where therapists drift away from the model in response to perceived crises and difficulties in therapy. He suggests that CBT therapists play an active part in making therapy go wrong by allowing therapy to drift off target, so that a "What should be at least partly a `doing therapy` turns wholly into a `talking therapy`".

Studies have also shown that CBT therapists often over-rate their competence (Brosan, Reynolds, and Moore, 2008) and often perform below a recognised acceptable level of competence in CBT (Brosan, Reynolds, and Moore, 2007). In response to these findings the IAPT programme commissioned a project to identify the competences required for practitioners to offer effective treatments. The CBT competence model was developed and concentrated on identifying the competences needed to deliver good quality CBT (Roth and Pilling, 2007; 2008). The competences for Humanistic therapies

were developed, based on the CBT competence model (Roth, Hill and Pilling, 2009). In the IAPT program, manuals and therapy adherence scales are used in the different modality training. Therapists are expected to offer the modality in which they have been trained according to the competences for that particular modality in order to be in line with the clinical guidance and the evidence base.

However, both the NICE guidance and the IAPT competences appear to recognise the importance of therapist responsiveness. The NICE guidance for depression offers guidance for the "average" client and maintain that "clinical guidelines are a guide for clinicians and not a substitute for clinical judgement, which often involves tailoring the recommendation to the needs of the individual," (NICE, 2010, p.164). The IAPT competences describe how therapy cannot be delivered in a `cook book` manner or by rote. Metacompetences, described as higher-order and more abstract, are the procedures used by therapists to guide practice. One of the metacompetences, the ability to respond to the individual needs of a client, is described as an important hallmark of competent therapists. On the other hand another metacompetency is the ability to maintain adherence to a therapy without inappropriate switching between modalities when minor difficulties arise (Roth and Pilling, 2007; Roth, Hill and Pilling, 2009).

The case has been made that the psychotherapy world is on the horns of a dilemma in terms of the apparent equivalence of outcome and the apparent non-equivalence of process (Stiles, 1999). It would appear the psychotherapy world is on the horns of another dilemma. On one horn is the need the need to adhere to the therapy model in order to comply with the evidence base. On the other horn is the need to respond to the individual client. The IAPT competences attempt to tread a fine line between the two horns acknowledging that the ability to adhere to a model of therapy while working flexibly to meet the client`s individual needs is a complex activity. They acknowledge that trying to implement both these two competencies may pull the therapist in different directions, and that the aim is to resist being pulled to one extreme or another, but to strike a thoughtful balance (Roth, Hill and Pilling, 2009, p.15). The findings from this study suggest, in line with the active client theory, that there may be a third horn, that regardless of the way therapists deliver therapy, clients will use what is provided in their own way, to meet their own needs.

There are a number of possible practical implications which come out of this study which I will present in the next section.

5.7. PRACTICAL IMPLICATIONS

The implications fall into two areas. Firstly I will discuss the practice of individual psychotherapy and the challenge for a therapist to be responsive to an active client. Secondly I will look at the implications for the delivery of services and consider the nature of a responsive mental health service.

- **The practice of individual psychotherapy**

The implications of the findings which suggest that both the activity and the responsiveness of the client and the responsiveness of the therapist contribute to the success of therapy, is far from straightforward. The reciprocal and dynamic nature of the interaction means that it is difficult to predict how an individual client and an individual therapist will respond to each other and therefore how therapy will progress and the likely outcome. The contribution made by the responsiveness of the client suggests that some clients will be able to use one approach more easily than another while others may be able to make use of either of them. The contribution of the responsiveness of the therapist suggests that therapy is more likely to be successful if therapists do not adhere strictly to the model. The significance of the activity of the client suggests that, despite the intentions of the therapist, the client may use therapy in ways that the therapist does not intend and is not aware of.

One appraisal of this, which challenges the unimodel of therapy endorsed by the IAPT program, is that therapists should be able to offer a range of different approaches. The literature on integrative and eclectic approaches to therapy is extensive and space does not allow for a detailed discussion of therapy integration or eclecticism (See McLeod (2009) or Norcross and Goldfried (2005) for examples of such discussions). Suffice it to say that there are many different theories of integration and ways of integrating different approaches. Many of these maintain a therapy-centric view of change and so I will limit my discussion to those which privilege the activity of the client.

One approach is based on the work of Duncan and Millar (2000), and Duncan, Miller and Sparks (2004). In an effort to cast the client as the primary agent of change and the "hero" of therapy, they have put the case for therapy which is client-directed and outcome-informed. The client-directed component of their approach involves operating therapy in a way which privileges the client`s expectations, preferences and their own theory of change. Rather than formulating the clients problems into the theory underlying a particular approach they suggest the opposite, that therapists allow the client`s own theory of change to direct the therapy. They set out some practical guidelines as to how to involve the client in the process, by listening carefully to the client`s language, making direct enquiries about the client`s goals and asking how the client thinks their goals may be accomplished. They also suggest that privileging the client`s theory of change provides ways to integrate the large number of approaches, it enables creative solutions from a broad base of different ideas and methods (Duncan, Miller and Sparks, p.120). The outcome-informed component involves the use of outcome measures and the use of collaborative discussion with the client about the progress of therapy.

A similar development involves the use of "outcomes management systems" (Lambert, 2010). He has conducted research over a number of years which has shown that outcomes improved when outcomes were measured each session and fed back to the therapist. When additional information was provided about the client`s assessment of the therapeutic alliance, then outcomes improved even more (eg. Lambert, et al, 2001; Lambert, et al 2002). Lambert and his colleagues have developed a system whereby outcome measures are used to monitor the progress of clients and statistical modelling techniques are used to identify those clients who are not demonstrating improvement or are in danger of deteriorating. This is fed back to the clinician in a timely manner to alert them to clients who are not responding to the therapy. The clinician can then address this directly with the client with the aim of making the therapy more responsive to the needs of the client.

A further recent development in this area is the pluralistic approach of Cooper and McLeod (2007; 2011). They start from the belief that there is no unified model of change. Instead there are a multiplicity of causes of psychological distress and multiple

pathways of change, and it is likely that different therapeutic methods will help different people at different points in time. Their approach to pluralism "opens up possibilities for working creatively in ways that most closely reflect the needs of individual clients: a genuine 'responsivity' to clients' wants," (Cooper and McLeod, 2007, p.6). It therefore has much in common with the active client theory and supports the finding from this study that responsiveness is important in determining the outcome of therapy. Cooper and McLeod (2011, p.10) propose a pluralistic framework for therapy consisting of three overlapping domains of goals, tasks and methods, where goals are what clients want from life and from therapy, tasks are the strategies by which clients can achieve their goals, and methods are the specific activities. Therapists work collaboratively with clients to set goals and decide which tasks and methods will be best for each individual client to realise them.

There have been some attempts to produce guidelines for therapist responsiveness (Levitt, Butler and Hill, 2006; Schulte and Eifert, 2001; Edwards, 2010). From a humanistic perspective, there is a potential debate to be had about whether it is possible to operationalise therapist responsiveness, the danger being that in doing so, the creative, intuitive nature of therapy is lost (Norcross and Wampold, 2011). Nevertheless, an American Psychological Association (APA) Division of Psychotherapy task force undertook a review of the evidence for the effectiveness of the therapeutic relationship and made recommendations about how therapists could tailor and adapt therapy to the needs of individual clients in order to improve outcomes (Norcross, 2011).

There is also a potential debate to be had about whether one individual therapist can have sufficient knowledge and expertise in a sufficient range of orientations to be able to be appropriately responsive to the requirements of all clients. Another interpretation of these findings is that the approach used by the therapist less important than the client`s ability to make use of the therapy they are providing. What is important is that the therapist has mastered the approach and is consistent in it. This was the belief of Rosenzweig, the originator of the dodo-bird effect:

> "It may be said that given a therapist who has an effective personality and who consistently adheres in his treatment to a system of concepts which he has mastered

> and which is in one significant way or another adapted to the problems of the sick personality, then it is of comparatively little consequence what particular method that therapist uses." (Rosenzweig ,1936/2010, p.12)

This links up with Bohart`s theory of how clients make therapy work by using the concept of "affordances," (Bohart, 2004; 2007), where the therapist`s interventions are tools which the clients can use to create change. In the same way that a stick has a variety of uses, but they are not infinite (a stick can be used to support a growing plant or as a weapon, but cannot be used to conduct brain surgery), the affordances of a therapeutic intervention cannot be infinite and the therapist`s interventions must provide some kind of useful structure. The findings from this study suggest that either CBT or PCT provide such a structure.

Here there may be another dilemma and another balance to be struck. As already examined earlier in this chapter, within the evidence based paradigm, the need to be responsive to the client is balanced with the requirement to implement evidence based interventions. Within a pluralistic framework, the need to be responsive to the client is balanced with the need for consistency and mastery of approaches. Alternatively it may be better to think in terms of pluralistic services where clinicians are specialists in different approaches. This last point leads on to my final discussion regarding the nature of a responsive mental health service.

- **Responsive service delivery**

The findings demonstrate how different people have unique experiences of therapy and that there are a range of different elements of therapy which people may find helpful in facilitating change. This suggests that, when designing a mental health service to meet the needs of a diverse population, it is sensible to take into account the range of requirements and to develop flexible services, with a variety of interventions, where therapy can be tailored to the individual. This has the potential to challenge the model implemented in IAPT, where the NICE recommendations are based on diagnosis, and where CBT is the preferred model of therapy on offer.

However these same findings also make it difficult for a clinician conducting an initial assessment to predict which therapy will benefit which individual prospective client. It is interesting to speculate if those negative cases found in this study would have fared better, or if those who reported that therapy had been successful would have fared equally well, if they had received the alternative therapy. It may be the case that some individuals will find one therapy more beneficial than another. On the other hand it may be that the same individual would benefit from a number of different approaches and so it would not matter which therapy they were referred for. Equally some clients may not benefit from either therapy, and would not achieve a positive outcome which ever therapy they received.

This means that the kind of therapy an individual is referred for will inevitably be influenced by a number of factors, including the preferences of the individuals involved in the assessment procedure, the availability of therapy within a service and the relative lengths of the waiting lists. From a commissioning point of view it will be influenced by the relative efficiency of the different therapies and their cost-effectiveness.

5.8. CHAPTER REVIEW

My aim, in this chapter, was to discuss the findings of this research project and relate them to the published literature. The first of the discussions related directly to the research questions set out in the introduction. I examined the findings in the light of the active client literature and showed how the findings suggest that the participants in this study actively made use of the therapeutic interventions in the two different therapies, and that they did, indeed, adapt the interventions to meet their own needs. I went on to look at how the therapeutic conditions appeared to be important factors in the change process in both therapy groups. I then discussed how the findings suggested that there were different mechanisms of change which were particular to the individual and did not seem to be specific to the therapy they had received. I discussed the phenomenon of responsiveness and how the reciprocal nature of therapist and client responsiveness to each other appears to be an important factor in determining the outcome of therapy. I showed how this creates methodological difficulties in clinical trials and how it has the potential to challenge some of the assumptions of the evidence based model which

underpins both NICE and IAPT. Finally I looked at some of the practical implications of the findings for both the practice of individual psychological therapy and the delivery of services.

In the next and final chapter, I will give a summary of the project and the conclusions which may be drawn from it. I will briefly discuss the methodology I employed and some possible avenues for future investigations, and I will end with some final personal reflections.

6. FINAL SUMMARY AND CONCLUSIONS

This chapter draws the thesis, and the research project to a close. First of all I will give a brief overall summary of the project and the findings which resulted from my collecting and analysing the data. I will follow this with an account of some of the conclusions which may be drawn from the project. This leads on to a discussion about the strengths and weaknesses of the methodology used in the research and its appropriateness in answering the research questions. I will then go on to consider some of the possibilities for future research and I will end with some personal reflections.

6.1. A BRIEF SUMMARY OF THE PROJECT

In this thesis I have given an account of the research into the experiences of clients who received therapy in a busy PMHT in the UK. The PMHT acted as the "single point of access" for all mental health referrals from the locality, providing assessment and referral on to the most appropriate treatment. The two therapeutic approaches available within the PMHT are CBT and PCT and this research was intended to inform the assessment and referral process to the two different therapies. The aim was to ensure that individuals were referred to the most appropriate therapy to meet their needs, and to increase the overall effectiveness of the PMHT. In order to meet this aim I collected accounts of clients` experiences of the two therapies. A total of 16 participants responded to an invitation to an interview to talk about their experiences, and the resulting transcripts were submitted to a Grounded Theory analysis. I broke the transcripts down into meaning units and conceptualised categories, using the constant comparison method. I then integrated the categories, conceptualised a core category and generated a theory.

The study fulfilled one of its main purposes, which was to capture the lived experiences of clients who had been through therapy in the PMHT. The findings revealed both individual differences and striking similarities between the participants` experiences of therapy. All the participants, who reported that they had benefitted from therapy,

described coming to a new realisation or understanding of themselves and their difficulties (conceptualised as **The key**). However, they also described a variety of different processes which brought this about, which appeared to be personal to the individual and did not appear to be specific to a particular therapy (conceptualised as **It did the trick**). The findings suggested that the participants were active in this process, responding to the therapist and the therapy in different ways according to their wants and needs. The findings also suggested that therapists responded to the individual expectations of the participant and tailored the therapy accordingly. I chose the core category **Reciprocal Responsiveness** to conceptualise the complex way in which therapists and clients appear to respond to each other to make therapy "work." I generated a theory that the outcome of therapy is influenced by the ability of the client and therapist to respond to each other in this way.

6.2. CONCLUSIONS

I think it is fair to say that the main conclusion I have drawn from the findings of this research study is that the situation is far more complex that I had originally anticipated and so the conclusions are not as straightforward as I had hoped. From the point of view of psychological theory, the findings suggest that there is no common, overarching or pan-theoretical model of change. Rather, there are a range of possible, different change processes which is the result of a dynamic interactive process which is personal to the individual client-therapist relationship. The reciprocal and dynamic nature of the interaction means that it is difficult to predict how an individual client and an individual therapist will respond to each other, and therefore how therapy will progress and the likely outcome. This makes it difficult for clinicians involved in the assessment and referral process to predict which therapy will benefit which individual prospective client. However, it is possible to draw a number of conclusions which have implications for the assessment and referral process and for the practice of psychotherapy.

The findings from this study suggest that:

1. Some clients will make use of whatever therapy is given them.

2. In deciding what therapy is most appropriate for prospective clients, it is probably better to take into account clients` wants and needs rather than relying on diagnosis.
3. When delivering therapy, it is probably better to be responsive to the needs of the client rather than keeping strictly to one approach
4. A mental health service is more likely to meet the needs of a diverse population if it is flexible, with a variety of interventions, and where therapy can be tailored to the individual.
5. It may be useful to remember that clients may be using what is given them in ways that therapists do not intend and are not aware of

6.3. METHODOLOGICAL DISCUSSION

In this section I will consider some of the strengths, weaknesses and limitations of the methodology. This study was carried out in the context of routine clinical practice. It was relatively small scale and it was therefore manageable and had little impact on the day to day running of the service. As service manager, I was responsible for the systems and processes that the participants had been through. In some cases I had interacted with them as part of the assessment and referral system, sometimes making arrangements for them which may have involved talking to them on the telephone. There was no formal diagnosis, assessment and referral to services was based on clinical grounds, which is not clear, and, with regard to the therapy they received, therapy adherence was not checked. However, I believe the naturalistic nature of the study is consistent with my constructivist epistemological position.

The participants represented a range in terms of their age, gender, socioeconomic group and presenting problems, but were all of the same ethnic group and this may have affected the findings. The participants` route into the service was not recorded, is likely to have been different from each other and may have shaped their experience of therapy. It is unclear if the participants knew about the stepped model of care as this information is not routinely given to prospective clients. It is also unclear if they had participated in step 2, if they had been given self help material or if they had been referred straight for counselling or CBT. Often step 2 includes an educational aspect where clients are given

explanation of what to expect from CBT, which again may have influenced their expectations or ability to engage with the therapy. Some may have received an assessment where the different therapies were explained and discussed. The quality of this discussion may also have influenced their experience of therapy. However, the range of experiences is, I believe, consistent with a Grounded Theory methodology.

As I described in the Methodology chapter, the choice of retrospective interviews as the method of data collection was pragmatic, as it seemed the best way of obtaining rich data with the minimum effect on potentially vulnerable participants. However the drawback is that the participants` accounts are constructed from memory, which may have changed the original experience. There is no way of supporting or comparing their account of what happened in the therapy. However, the method of data collection is consistent with the constructivist nature of the study, and the objective of the study, which was explicitly to investigate the therapeutic encounter from the perspective of the client.

I did not meet major challenges in terms of data collection as sufficient participants responded to my invitation to be interviewed. I had intended to alternate PCT and CBT interviews and analyse the two concurrently, making constant comparisons between the two approaches. However this was not possible due to the uneven response rate. As I discussed earlier I was unable to employ a true Grounded Theory, theoretical sampling method due to the limitation of time and resources. Fortunately there was a sufficient number of respondents with a breadth and variation of experience to conduct a Grounded Theory analysis. There were also enough respondents to ensure a range of different therapists, in order to avoid idiosyncratic ways of working distorting the data. Even so, participants were self selected so it is pertinent to bear in mind the motivation for someone to agree to participate in a study like this. It is clear, for example, that PCT3 was motivated to participate in order to ask for further therapy. This does not appear to have been the motivation for other participants, but there may have been other underlying reasons which influenced the data I collected. There will inevitably have been psychological processes and impression management strategies which may have been involved in the way participants presented themselves and their therapists.

It is also relevant to bear in mind that the interviews were unstructured. Participants spoke about issues that were important for them, within their own experience of therapy, rather than being asked about consistent areas of information. On one hand this makes it difficult to make comparisons across participants, but on the other it makes it even more noteworthy that there was such consistency in the findings. It is also important to take account of my role as an interviewer. Just as client and therapist respond to each other in therapy, it is likely that the same phenomenon will have occurred in the interview. My responses will therefore have influenced the direction and content of the interview. However, the unstructured nature of the interviews is, I believe, consistent with the constructivist nature of the study, and I recognise that a different interviewer may have achieved a different account from the same participant. My role as interviewer may have been influenced by my person-centred background. However, I hope that the findings suggest I have been able to challenge my possible pre-conceptions. As a person centred therapist I would have been very happy to hear that CBT participants thought that they had changed in response to feeling understood and respected by a genuine person, rather than due to the CBT exercises and strategies. However, this was not the case. CBT participants found the exercises and strategies very helpful and PCT participants reported finding aspects of the therapy helpful that do not appear consistent with the person centred approach.

One of the strengths of the methodology, in terms of its appropriateness in investigating therapy from the client`s perspective, and in answering the research questions, was the large amount of data. This shed considerable light on the process of therapy as viewed from the point of view of the client. If this is one of its strengths it is also one of its weaknesses, as it produced so much data that, at times, it felt quite overwhelming. A qualitative study such as this yields rich descriptive data and reveals processes that are complex, multi-layered and difficult to organise and make sense of. Although the Grounded Theory methodology gave an adequate procedure and structure to organise the data, the sheer quantity carries the danger that aspects may have been lost or that I failed to give them the weight of importance they perhaps deserved.

In a true Grounded Theory study the researcher does not familiarise himself with the literature before engaging with the analysis. However I was already familiar with much of the person-centred literature and this is likely to have informed the analysis, as is my

experience as a therapist. This means there is a danger that I have imposed person-centred categories onto the data. I certainly encountered difficulties in discerning meanings during the categorisation process where the same words may have different meanings in the two approaches. Consider, for example, the phrase, "I know what to do now." In CBT the term "know" can be used to represent such processes as learning, practicing or habituating, while in PCT it can represent an intuitive certainty related to the individual`s internal valuing system. There is also a danger that I have imposed theory onto the data by my interpretation of the therapist`s part of the reciprocal nature of responsiveness, without the support of their accounts. However, as I recorded at the beginning of this thesis, my intention was to focus on the activity of the client rather than the therapist or the therapy. I would therefore have been very happy if the participants had focussed on their activity in their accounts of their experiences. The findings show this was not the case and, although participants acknowledged their role in the process, most attributed the success of their therapy to the therapist and the therapy.

The findings may have been influenced by my role as manager. I had a strong sense of each of the therapists as a person, as I interacted with them in many different ways both personally and professionally and I was party to many clinical discussions both with individuals and in groups. My experiences in these contexts resonated with what I was hearing in the research interviews. I took part in case management discussions with CBT therapists, who often described their belief in the importance of the relationship. I heard about the difficulties they were experiencing with formulation. Often the recommended treatment did not seem appropriate and they reported adapting it to the individual under discussion. I also heard about how the CBT interventions are often offered in a subtle way so that the client may not be aware of it, and that this is the mark of a good CBT therapist. I took part in professional development discussions with the counsellors, where it was apparent that they did not believe they asked questions or made suggestions. The findings may also have been influenced by my role as a therapist. Even though I consider myself as non-directive, clients have reported that they have taken my advice of the previous session or done what I had told them to do.

The limitations highlighted here may be considered weaknesses of the methodology. However, I believe that these points are consistent with the constructivist nature of the

study. I therefore present the research project in this light, acknowledging that the findings and conclusions are the result of my interpretation and construction of my participants` interpretation and construction of their experiences, and is only one of many possible, plausible sets of findings.

6.4. POSSIBILITIES FOR FUTURE RESEARCH

This study is limited to two therapies within a primary care setting. Future studies may consider clients experiences within other settings and with other therapeutic approaches. Future studies could also compare the perspective of the client with that of the therapist, or with recordings of the sessions.

Llewellyn and Hardy (2001) believe that the aim of future research should be to help therapists become more appropriately responsive to client requirements, and thereby improve their practice. Taking a therapy-centric view of therapy, one way forward would be to investigate how effective therapists respond to their clients in order for others to respond in similar ways. However, if the effectiveness of responsiveness lies in the way a particular therapist responds to an individual client`s particular circumstances, it will be difficult, if not impossible to generalise. Another line of enquiry might be to investigate the decision making processes of effective therapists. Do effective therapists consciously make decisions about responding differently to individual clients, or are their ways of responding more intuitive and creative? If decisions are consciously made what guides and informs their decisions?

Cooper and McLeod (2011, p.121), who take the view that there are no certainties about the way people change, suggest that research can help identify potential pathways by which people might change. Future research could focus on investigating which particular therapist and client activities lead to the successful fulfilment of particular tasks, which lead to the achievement of particular goals. An example of a task, from this study, might be the ability to say, "No" to the demands of others. The findings show that a number of participants achieved this task (although it may not have been conceptualised as such in the therapy) but there were several different pathways by which this was achieved. Qualitative research into the experiences of clients involving

numbers of participants such as this study, or single case studies (McLeod, 2010) and the Hermeneutic Single-Case Efficacy Design (Elliott, 2002) could be used to build up a picture of the potential change pathways.

Llewellyn and Hardy (2001) stress the importance, for process research, of establishing productive links between researchers and clinicians. They believe practitioners are often aware of significant aspects in working with particular client groups, and may have developed useful rules-of-thumb for intervention and these are precisely the insights which researchers may be able to sharpen into effective process studies. Cooper and McLeod (2011, p.127) suggest the creation of an open-access library of "goal-task method narratives". These are personal accounts of what a therapist and/or a client did in order to accomplish a certain kind of therapeutic task. This would be a means of understanding the different pathways of change and a useful resource for therapists and clients alike. It would be "a treasure-house of hopefulness in terms of ways of dealing with everyday problems in living."

Taking the active client perspective, Cooper and McLeod (2011, p.130) also suggest that the outcome of therapy could be enhanced by enabling people to be better clients. Recently there has been increasing recognition of the value of research in understanding how clients can be helped to engage with the therapy (eg. Aviram and Westra, 2011). A focus of future research could be to investigate the different ways in which clients can become more effective in using therapy.

6.5. FINAL PERSONAL REFLECTIONS

The NHS is difficult place for a person-centred therapist. Person-centred therapists operate within completely different models to medical practitioners. Effectively they inhabit different worlds (Gibbard, 2008). Some see the two worlds as irreconcilable (e.g. Binder, 2007), others experience the medical world as dehumanising and oppressive (e.g. Freeth, 2007). I have always tried to inhabit both worlds at once, but this has become an increasingly uncomfortable place to be. The psychotherapy world can also be an uncomfortable place to be, too, with "schoolism" (eg. Feltham, 1997) causing rivalries between approaches, where proponents of the different approaches

defend their own approach by attacking others. Like Norcross (2011, p.3), I believe that "such polarizations only impede therapists from working together and hinder attempts to provide the most efficacious psychological service to our patients." I used my time as manager of both CBT and PCT services to try to foster a more accepting and productive relationship between the two approaches. However, competition for scarce resources, and the more recent advent of IAPT and has meant that there were times when I have felt as if I were on the front line of a battle in the "culture wars." The temptation, in embarking on this project, would be to find myself looking for evidence to support PCT at the expense of CBT. This was certainly the expectation of others, as one of my colleagues asked, "So, which one comes out on top?"

I have found, in line with Etherington (2004), that the research also influences the researcher. Throughout this research project, my journey towards constructivism as a researcher has been reflected in my journey towards pluralism as a practitioner. As a result I found myself at variance with the IAPT requirements for manualised therapy and the evidence based agenda, which had now become mandatory. I therefore negotiated a change from a management to a clinical role in a neighbouring PMHT.

I conducted this research during the most turbulent time in the history of the NHS, where the pace of change and the organisational pressures have been relentless, and I hope the reader has received a flavour of this. What happens next is uncertain for all. The requirement to implement IAPT and the recommendations of NICE remains government policy (DoH, 2011). On the other hand the responsibility for commissioning services has recently passed to consortia of GP practices, which have the power to commission services according to local need. What effect, if any, this will have remains to be seen. I began this research with the support of the organisation I worked for, with the intention of influencing the operational management of the PMHT. The reorganisation of the NHS, and the implementation of IAPT means that the culture has changed and the likelihood that this research will have an impact on operational procedures, seems unlikely.

However, in giving a voice to individual clients I hope to make a contribution to the body of evidence of people`s experiences of mental health services on the one hand, and of the process of therapy on the other. In this way, I hope this thesis will contribute to

wider discussions regarding the process and outcome of different therapies, and the role and importance of the client.

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APPENDIX 1

CBT participant information

Participant	gender	age	Presenting problems	Number of sessions	PHQ9 scores		GAD7 scores		Employment /living information	Time between last therapy session and interview
					Pre-therapy	Post-therapy	Pre-therapy	Post-therapy		
CBT1	F	58	Anxiety, depression, work related stress.	12	17	2	17	1	Retired social worker, living with partner, disabled son.	6 weeks
CBT2	F	67	Depression, agoraphobia.	12	-	-	-	-	Retired, living alone.	7 weeks
CBT3	F	40	Anxiety, depression, work related stress.	12	13	3	16	5	Employed locally, on sickness absence, living alone.	5 weeks
CBT4	F	55	Depression, abusive relationship.	8	-	-	-	-	Unemployed, living alone.	9 weeks
CBT5	F	26	Obsessive Compulsive Disorder - intrusive thoughts.	15	6	2	18	14	Employed locally, on maternity leave, living with partner, baby.	8 weeks

CBT6	M	48	Post Traumatic Stress Disorder.	12	4	2	5	3	X services, employed manger in local firm, living with partner.	11 weeks
CBT7	M	48	Depression, anger.	14	25	3	20	7	Unemployed healthcare worker, living with partner.	12 weeks
mean		49		12.14	13	2.4	15.2	6		

PCT participant information

Participant	gender	age	Presenting problems	Number of sessions	PHQ9 scores		GAD7 scores		Employment /living information	Time between last therapy session and interview
					Pre-therapy	Post-therapy	Pre-therapy	Post-therapy		
PCT1	F	43	Anxiety, child abuse.	12	5	1	13	3	Healthcare worker, living with partner, teenage son.	7 weeks
PCT2	F	44	Depression, bereavement mother.	6	6	6	5	5	Social worker, living with partner.	7 weeks
PCT3	F	63	Anxiety.	12	7	6	13	7	Retired, living alone.	8 weeks

PCT4	M	52	Depression, bereavement	12	20	9	16	7	Employed manual. worker, living alone.	5 weeks
PCT5	F	37	Depression, adjustment to disability.	12	23	8	16	13	Unemployed, disabled. Living with father.	9 weeks
PCT6	M	43	Depression, work stress, relationship difficulties.	12	18	3	11	3	Employed manager, living with partner.	7 weeks
PCT7	M	47	Depression, work related stress.	9	9	2	6	1	Prison Officer, early retirement due to ill health, living with partner and children.	13 weeks
PCT8	F	63	Chronic depression.	11	16	6	11	2	Retired, living with partner.	8 weeks
PCT9	F	49	Depression, coping with daughter with autism.	10	25	12	18	6	Unemployed, living with partner and teenage daughter.	9 weeks
mean		49		10.67	14.33	5.89	12.11	5.22		

APPENDIX 2

Patient Health Questionnaire - PHQ-9

Over the *last 2 weeks*, how often have you been bothered by the following problems? (Use ✓ to indicate your answer)

	0	1	2	3
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
4. Feeling tired, or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself – or that you are a failure or have let yourself or someone else down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thoughts you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

Total score: _____

Patient Health Questionnaire - PHQ-7 GAD

Over the last 2 weeks, how often have you been bothered by the following problems? (Use ✓ to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
1. Feeling nervous, anxious or on edge	☐	☐	☐	☐
2. Not being able to stop or control worrying	☐	☐	☐	☐
3. Worrying too much about different things	☐	☐	☐	☐
4. Trouble relaxing	☐	☐	☐	☐
5. Being so restless that it is hard to sit still	☐	☐	☐	☐
6. Becoming easily annoyed or irritable	☐	☐	☐	☐
7. Feeling afraid as if something awful might happen	☐	☐	☐	☐

Total score: _____

APPENDIX 3

Introductory Information and Opt-in sheets

Dear

You have recently undergone a course of therapy and I am writing to invite you to take part in a research project I am currently undertaking with the University of Manchester.

I would be grateful if you would read the enclosed sheet which gives some information about the research. If you are willing to participate, please complete the enclosed reply slip and return it in the pre-paid envelope provided. The researcher will then contact you to arrange an initial interview.

Thank you for taking the time to read this letter. If you would like further information please feel free to telephone Isabel Gibbard for an informal discussion 01772 643168. Additionally, if you would like to contact the research supervisor of the project please contact Dr Terry Hanley at the University of Manchester by telephoning 0161 2758815 or by emailing terry.hanley@manchester.ac.uk.

Yours Sincerely,

Isabel Gibbard

Lead Counsellor

PMHT

HOW DO CLIENTS MAKE THERAPY WORK?

PARTICIPANT INFORMATION SHEET

What is the research about?

I am interested in looking at therapy from the point of view of the client to find out how clients make therapy work.

What does it involve?

Taking part in the research project would involve attending an interview in a primary care location convenient to you. Following the interview you will also be offered the opportunity to comment on how I have made sense of our meeting.

What happens at the interview?

This will last approximately 60 minutes and will be conducted by the researcher. You will be asked to reflect on the therapy you have just finished and to talk about your experience .

You will be asked a number of questions about the therapy. The questions may cover a number of different areas:

- Your experience of therapy overall
- Any aspects of therapy which were particularly memorable or that you would like to comment on.
- Your involvement in the therapy.
- What you have done to help yourself
- Changes you have experienced in yourself since starting therapy

This interview will be recorded, notes made and the original recording deleted.

What are the benefits?

It is hoped that you will find the interview beneficial as it will give you an opportunity to reflect on the therapy you received. The results of this research will be shared with other mental health professionals locally and nationally and may improve future services for yourself and other clients.

What are the risks?

It is hoped that the interview will not be emotionally distressing and you will not be asked directly about the issues which brought you into therapy. However there is the possibility that the interview may remind you of these. The researcher conducting the interviews will be an experienced therapist, able to deal with any sensitive or emotional issues which might arise.

Confidentiality

The interview will be confidential in the same way as therapy sessions are confidential. When the interview has been transcribed names and other personal details will not be used, so neither you nor your therapist will be identified and the information you give to the researcher will not be relayed to your therapist. All electronic information will be kept in password protected files and any paper copies will be kept in locked filing cabinets in line with the clinical records policy of the PCT. When the research is published no names or personal information will be used.

Limits to confidentiality

There are some circumstances in which the confidentiality agreement would need to be broken and some professionals involved in your care might need to be informed of certain information collected during the interview. This will only apply if you have indicated that you are at risk of harm from yourself or another person or if information was given about harm to another person.

Do I have to take part?

No. You do not have to take part. If you decide not to, this will not affect your future mental healthcare in any way. If you decide to take part you are free to withdraw from the research at any time, without giving a reason. This will not affect any future mental health care in any way.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do her best to answer your questions. If she is unable to resolve your concern or you wish to make a complaint regarding the study, please contact a University Research Practice and Governance Co-ordinator on 0161 2757583 or 0161 2758093 or by email to research-governance@manchester.ac.uk

HOW DO CLIENTS MAKE THERAPY WORK?

REPLY SLIP

Name …….

Address …….

……

……

Daytime contact tel. no.……

- **I would like to participate in the research**
- **I do not wish to participate in the research**

(Please tick)

If you would like to participate, please indicate whether it is acceptable for us to telephone you on the above number

YES/NO

Please indicate if it is acceptable for us to leave a message

YES/NO

Please indicate in which locality you would prefer to attend an interview

- Chorley
- Leyland
- Penwortham

(Please tick)

Please give below the times and days you would **NOT** be able to attend an interview

…….

…….

Do you have any particular needs or difficulties?

…….

…….

APPENDIX 4

Interview Protocol

Before the interview

1. Thank you for agreeing to take part

2. Explain the rationale for the study:
Most research from the point of view of the therapy – it is the therapy that works. I am interested to know how you made therapy work for you.

3. Explain what will happen at the interview
Taped. Transcribed. Wiped and analysed. Storage of data. Written up as dissertation (few years time). Published in paper. Nothing identifiable.

Interview questions

1. Overall

Can you tell me, overall what therapy was like for you?

2. Before Therapy

Can you tell me how you decided to ask for help?

Can you tell me how it was decided that you would be referred for counselling/CBT?

What was your involvement in the decision making process?

What do you think about that decision?

3. During therapy sessions

Is there anything that stands out as particularly important or memorable in your therapy?

Prompts - What was significant about it?
What were you thinking/feeling?
What did you do?
Did you say anything to your therapist?

3. Between sessions

Can you tell me anything about what happened in between sessions?

Prompts - What was significant about it?
What were you thinking/feeling?
What did you do?
Did you say anything to your therapist?

4. Changes

Can you tell me what has changed since starting therapy?

What do you think caused the changes?

At the end of the interview

1. How are you feeling?

2. Is there anything I have not asked you about that seems important to you?

3. Is there anything I can do in future interviews that could make this an easier or better experience?

When the study is finished I will be very interested to hear what you think about the findings. If you agree, I will send a summary to you and I would be very grateful if you would return the feedback form.

Thank you for coming.

APPENDIX 5

Member Check

Dear

I have completed a preliminary analysis of your interview and would be very grateful if you would comment on the findings so far by completing the attached questionnaire.

I have identified the components of therapy which seemed important to you. On the following pages there is a list of the main themes which emerged from your interview. Each of the themes is illustrated by an example or brief quote from the interview. After each theme there are some boxes. Please put a tick in one of the boxes to say whether you agree or disagree with the finding.

If you would like to make further comments about your therapy or the themes I have identified please put them on the extra sheet. I would also be grateful if you would comment on what it was like to complete this questionnaire as this will help guide the future research process.

Please return the completed questionnaire in the envelope provided.

Thank you again for agreeing to take part in this research project.

With all best wishes for the future

Isabel Gibbard
Lead Counsellor
PMHT

CBT1

RESEARCH FINDINGS

OVERALL

In therapy you undertook certain activities which were helpful to you, both on your own and with your therapist.
This resulted in a number of changes.
Your view of yourself and your situation in the past and in the present changed.
You were able to manage situations, which had caused you difficulties, in a different way

Agree	disagree	Don`t know
✓		

YOUR ACTIVITIES

Reading

validated - other people felt like me/ got into the same difficulties
learned about myself/ understood myself
gave me answers/ techniques,

Agree	disagree	Don`t know
✓		

Talking

made the decision to talk about something I knew was a problem
took the risk to be honest

Agree	disagree	Don`t know
✓		

Pie chart

learned the exercise of sharing responsibility
the trick was seeing it drawn

Agree	disagree	Don`t know
✓		

Writing thoughts down

Positive thought provoking activity though do wish to share these with family. Needed to keep these private.

Agree	disagree	Don`t know
✓		

THERAPIST ACTIVITIES

Drawing pie chart

Got me to look at responsibility in a different way

Agree	disagree	Don`t know
✓		

Naming OCD/PTSD

Relief to put a name to these behaviours - made me more aware of them but also able to accept & manage them to a greater degree.

Agree	disagree	Don`t know
✓		

CBTI

CHANGES

Changed view of myself in past

I realised I had taken on too much responsibility for other people
I realised how hard I was on myself

Agree	disagree	Don`t know
✓		

Changed view of my self in present

the way I feel is not a weakness.
there are reasons why I feel the way I feel
I`m not responsible for everything that happens

Agree	disagree	Don`t know
✓		

Feeling differently in present

I don`t feel too guilty when I say, "no."
I have stopped worrying and feeling I`m not doing enough to help

Agree	disagree	Don`t know
✓		

MANAGING SITUATIONS DIFFERENTLY

Employing strategies and techniques learned in therapy:

Responsibility

I take a second or two to think, "Who do I share this responsibility with?"
I have let go of feeling guilty for not being responsible

Agree	disagree	Don`t know
✓		

Anxiety

I am aware of feeling anxious and take time to work it out
I use breathing exercises and do some physical activity

Agree	disagree	Don`t know
✓		

Procrastination

I recognise when I am avoiding something
I tell myself to just do it or take steps to at least start. When I do this I find I can often finish what I've been putting off.

Agree	disagree	Don`t know
✓		

Anger

I recognising anger as a symptom of PTSD
I understand why I am angry

Agree	disagree	Don`t know
	✓	

Thank you for completing this questionnaire

IF YOU HAVE ANY COMMENTS PLEASE WRITE ON THE EXTRA SHEET

CBTI

ANY FURTHER COMMENTS

Re - anger. I did not know where the anger was coming from as there were often no apparent antecedents. Discussed with therapist who identified it as a symptom of PTSD. This was a relief to me as sudden anger was generally not part of my personality in the past. Episodes of deep & sudden anger have dramatically decreased.

ANY COMMENTS ABOUT COMPLETING THIS QUESTIONNAIRE

I initially looked at the questionaire & put it back in the envelope as seeing it made me feel anxious & uneasy. Looked at it twice more over next few days. Decided on the spur of the moment to complete it and accepted that while it referenced what I had been through I was able to stay calm & complete it. This was about saying my illness and work are in the past; I have to keep looking forward, not back.

APPENDIX 6

Consent Form

HOW DO CLIENTS MAKE THERAPY WORK?

If you are happy to participate in this research project please complete and sign the form below

	Please add your initials in the box if you agree
1. I have read and understood the information sheet (28.06.11 version 3) about the above project	☐
2. I have had the opportunity to consider the information and ask questions about the project. Also my questions have been answered satisfactorily.	☐
3. I understand that my participation in the study is voluntary and that I am free to withdraw at any time without giving a reason	☐
3. I understand that the interviews will be audio recorded	☐
4. I agree to the use of direct quotes in reports that are made	☐
6. I agree that any anonymous data collected may be passed to my academic supervisor	☐
7. I understand that data collected during the study may be looked at by individuals from regulatory authorities or from the NHS Trust where it is relevant to my taking part in this research. I give permission for these individuals to have access to this information	☐
8. I understand that I can ask for the tape to be stopped at any time and request that information be deleted or changed	☐

I agree to take part in the above project

----------	----------	----------
(name of participant)	(date)	(signature)

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APPENDIX 7

Full Categories

JOURNEY TO THERAPY

Experiencing problems and difficulties - abuse, trauma, bereavement, work related stress, relationship difficulties agoraphobia, intrusive thoughts depression, panic and anxiety

Engaging in activity before therapy – reading, researching

Having therapy before – helpful, unhelpful

Changing before therapy – being ready

ACCESSING THERAPY

Being in a dark place – black hole, frightened, going mad, in chaos, stuck, not me

Seeking help - asking for therapy, referred by a professional

Having expectations of therapy - high expectations, feeling sceptical, daunted, knowing what to expect, knowing what I needed

SEEING THINGS BEFORE THERAPY

Seeing myself before therapy - blaming myself, critical of myself, doubting myself, couldn`t say no. putting others first, feeling responsible, taking things personally, worrying about what others think, thinking the worst is going to happen, feeling worthless, I don`t have a voice, emotional, having to cope, not coping.

Seeing myself in the past – positive, confident.

Seeing others before therapy – not listening, blaming, difficult to trust

ENGAGING WITH THE THERAPY

- **Activity outside sessions**

Managing emotions – managing anxiety, scepticism

Reading and researching - reading handouts, researching on the internet

Writing – diary of feelings, thoughts, lists, mindmaps, letters to abusers

Thinking and reflecting – reflecting on the session, making decisions, plans for the future

Doing what the therapist suggested – pacing, crying

Carrying out tasks – breaking it down, getting into the car, going out of the house, blocking/not carrying out tasks

- **Activity during sessions**

Talking

Content - about past experiences, about present experiences, about doing things differently, about between session activity, about emotions, not talking about subjects.

Process - saying it out loud, deciding what to talk about/not deciding what to talk about, flow, unsure of process, avoiding/ trying to avoid painful subjects, talking about everything I needed to/ having things left to talk about

Creating order – exploring, analysing, making connections, sorting

Taking part in exercises– going through the cycle, doing the pie chart, breaking it down.

Attending to therapist and the relationship - assessing the therapist, assessing the impact on the therapist, working out the therapist`s intentions

Managing and Expressing emotion – crying, getting it off my chest

THERAPIST ACTIVITY

Therapist as the agent of change - helping/making/giving permission

The caring therapist – listening, understanding, safe, caring, non-judgemental, relating like a human being, sharing own experiences, making me laugh

Reacting to incident/disclosure

The therapist`s interventions

Questioning, giving explanation, giving a different way of looking at things, giving opinion, putting me straight, sharing experiences, challenging my thoughts,

Giving affirmation and encouragement, approval, reassurance, giving assurance, confidence

Giving exercises and techniques, adapting exercises, giving paperwork, giving procedures for doing things differently, making suggestions

Reminding and reinforcing

It did the trick - seeing it drawn, carrying out tasks, therapist questioning, therapist putting me straight, therapist giving an explanation, therapist`s reaction, talking, it came to me, saying it out loud, getting it off my chest, no trick

MAKING SENSE

Putting it into perspective

Understanding myself - understanding where things came from, realising what I do, understanding it`s the situation makes me ill, understanding myself according to diagnosis, formulation, label, not understanding myself

Coming to terms - accepting the past, accepting the present, coming to terms with loss, not coming to terms

Finding meaning, not finding meaning

The key – insight, understanding and realisation, no key

CHANGE IN PERSPECTIVE

Confirming my view of myself

Looking at myself differently - feeling better, happier, feeling calm, relaxed, a different person, finding myself, having a positive, more realistic view of myself, not taking things personally, being emotionally aware, not looking at myself differently

Seeing myself differently in the past – I was hard on myself, being used, it wasn`t my fault, I did a lot, I was ill, needed help, not seeing myself differently in the past

Looking at others differently – others feel the same as me, not so concerned what others think, not looking at others differently

DOING THINGS DIFFERENTLY

Observing and evaluating my self – stepping back, reflecting, checking out, talking to myself, thinking about therapist

Implementing techniques – managing anxiety, managing thoughts, breaking it down, going places on my own, saying no, sharing the responsibility, practising, putting self first

Deciding what to do

Implementing plans

Happened naturally

Having difficulties – difficulty remembering, putting it into practice, conflicting with values and beliefs, not doing things differently

Doing things the same

CONTINUING THE JOURNEY

Having ongoing difficulties – work stress, physical difficulties, relationship difficulties, financial problems, grief

Engaging in activity after therapy - reflecting, exploring, practising, further therapy

Engaging in activity in the interview – reflecting on the therapy, assessing progress.

Needing more help